AMERICAN HEALTH CONSULTANTS®

ED Management®

The monthly update on Emergency Department Management

Vol. 11, No. 5

Inside

May 1999

Pinching pennies in the ED: Impress administrators with creative solutions

Cutting costs may be easier than you think

ED managers must get creative with cost-cutting, says **Sandra M. Schneider**, MD, FACEP, chair of the department of emergency medicine at the University of Rochester in NY. "It's clear that reimbursement for emergency services is only going to [decrease]," she says. "Everyone is going to be paying us less, so we will only have [fewer] dollars to work with. Keep in mind that the hospital which subsidizes us is also in a bind, and will probably not continue to subsidize an ED running a deficit."

Take advantage of the ED's unique position, recommends **Cheryl Grandlich**, RN, MSN, patient care director for the emergency and trauma center at Froedtert Memorial Lutheran Hospital in Milwaukee, WI. "The ED is basically a separate entity from the rest of the hospital. We are more encapsulated and almost our own business. So in some ways it's easier for us to look at specific revenues and cut costs," she says.

Cost is only one outcome

Process improvements should be considered along with cost issues, urges **James Espinosa,** MD, FACEP, FAAFP, chairman of the department of emergency medicine at Overlook Hospital in Summit, NJ. **(See related article on improving efficiency along with cost cutting on p. 52.)** "There are four types of outcomes to consider with any medical process: medical, patient satisfaction, cost, and quality of life," he explains. "The problem is that cost tends to be the easiest [measurement] for people to get their hands around."

If you affect one outcome, you have probably made an impact on the other outcomes, notes Espinosa. "So unless we're simultaneously studying the other three outcomes, we may not know what has happened," he says. "Cost should be studied as seriously as any other outcome, but it should be studied in the context of what's happening in other areas."

Cutting costs without attention to process reengineering is dangerous, says Espinosa. "We could attempt to reduce cost and improve medical outcomes at the same time. But if all we're looking at is one stream of data, and not the others, we are on dangerous ground," he says. "We ought to assume there are going to be some changes in medical outcomes, quality of life, and patient satisfaction."

Don't cut costs without considering the impact on care, Espinosa stresses. "Improve clinical care and allow costs to follow," he says. "To say 'we're over budget so we need to knock down labor costs by 10%,' without having process reengineering, is already dangerous."

Instead of reducing labor costs, it may be a better strategy to invest in the ED to increase volumes, says Espinosa. "You may have to spend money to save money," he explains. "Cost cutting needs to be part of a well-thought-out, rational business plan. When QI teams are tasked only with cost reductions, it could have a deleterious effect on quality of care."

Demonstrate money saved

It's essential to demonstrate dollars saved to administrators, emphasizes Schneider. "You've got to do it every single way you can, and do it repetitively," she says. "You need to continually bombard them with graphics. To accomplish this, you need to frequently meet with high-level administrators. Also, learn how the business world presents this, using language they understand, because many administrators are MBAs."

Many EDs are experiencing higher volumes and revenues are dipping, Schneider notes. "You need to portray that data in several different ways. You need a graph that says volume is going up and revenue going down, a graph showing revenue per patient, and also a graph that says if the average price-per-patient was what it was three years ago, this is how much money we'd be making now."

ED managers should be held accountable for volume, costs, and efficiency only, says Schneider. "We aren't accountable for what insurance companies are doing with their prices," she explains. "If that's the case, we should be there when contracts are being negotiated."

When Premier Healthcare Services polled hospital administrators, asking what improvement they most wanted in EDs, the number one response was cost containment, reports **Tom Syzek,** MD, FACEP, associate director of risk management for the Dayton, OH-based group. "It's not something they commonly bring up when talking to you. But realize they are under tremendous pressure from their customers, including managed care plans and major employers, to deliver quality care with lower costs," he says.

Even if administrators don't raise the issue, bring it up yourself, Syzek urges. "This demonstrates to them that you are a good partner with them, and helps continue, cement, and enhance your contracting ability as an ED group," he says.

Here are several approaches for cost-cutting in the ED, encompassing clinical care, supplies, staffing, and risk management:

Reduce unnecessary diagnostic testing. "Two areas where you can cut costs without compromising patient care are radiology and lab tests," says Syzek. "With every study you order, ask yourself: Is this necessary for patient diagnosis or treatment? Or is it something you are simply doing out of habit because of something you were taught in the past?"

By eliminating unnecessary films, you can save thousands of dollars, says Syzek. "For instance, there are very few indications left at all to do skull films, [lumbar spine] films, and rib detail films," he notes. "Research is ongoing on how to do cost-effective radiology without compromising patient care. Pay attention to the literature, because it backs up what you can safely delete in your workup."

Look critically for ways to eliminate laboratory tests, Syzek recommends. "It may be a kneejerk reaction to do CBC, electrolytes, cultures, and arterial blood gases," he says. "For patients with a kidney infection who are going home, do they really need blood cultures, is it really going to add anything to your urine culture and urinalysis? The evidence is showing [that it probably won't]."

Benefit from the cost savings of an observation unit. ED observation medicine is where the future of cost containment lies, stresses Syzek. "Four diagnoses have been shown to be less expensive than hospital care in the observation unit: ruling out myocardial infarction (MI) for chest pain patients, asthma, certain infections, and congestive heart failure," he says. "The charges and costs for these can be greatly reduced by a tightly run, protocol-driven observation unit. Even if these patients do end-up being admitted, it will be cheaper in the long run because of decreased length of stay."

Coordinate with home health care. Home health care should be closely tied to ED processes, Syzek recommends. "So if you know all a patient really needs is home health care with home IV antibiotics, walkers, hos-

COMING IN FUTURE MONTHS

- Update on new JCAHO standards
- Improve compliance with universal precautions
- Use simulation models in your ED
- Be aggressive with risk management

pital beds, or medications that need to be administered by a nurse, there should be a quick way to access these services right out of the ED instead of getting admitted," he says. "Otherwise, if a patient has a stable pelvic fracture and just needs home care while recovering, they will be admitted if you can't access those services."

Use bedside qualitative cardiac markers. "We are studying their effect on cost, patient satisfaction, and medical outcomes," reports Espinosa. "They are providing us real-time myoglobin, Troponin I, and CKMB. For ruling out the low-risk chest pain patient, we should be able to reduce LOS [length of stay] from an average of 11 hours to 6.5 hours, because these markers come back positive in five minutes and negative in 15 minutes."

Costs are also cut in half, says Espinosa. "We already have the advantage of not admitting that patient, which reduces costs, but now we will decrease costs by at least half again," he notes. "Patient satisfaction may also improve because they get to go home sooner, and the medical outcomes seem to be no different."

Invest in a pneumatic tube system. Overlook's ED switched to a pneumatic tube system, which sends medications from the pharmacy to the ED through a chute, eliminating the need for transport. "We have reduced the cost of medications because they are more accurately charged by going through the pharmacy, than by walking back and forth. We are also able to reduce the burden of storage," says Espinosa. "In addition, there is less shrinkage. At the same time, we reduced cycle time for medications to be acquired."

The pneumatic tube system has saved $120,000 annually for the past two years in increased capture of charges, Espinosa reports. "That required an investment of money by the hospital to install the tube," he notes. "However, the return on the investment was accomplished long ago."

Provide cash incentives for employees. Monetary incentives for employees are a good way to generate good ideas for saving money, says **Richard Garrison**, MD, FACEP, medical director for emergency services at Good Samaritan Hospital in Dayton, OH.

For instance, employees could receive cash incentives for pointing out that a certain supply item was wasteful or expensive and offering a solution, Garrison suggests. "If that idea represented X number of dollars savings, then the employee might hypothetically receive 5% of that proven savings as a reward," he says.

"Those who do the jobs know the ways to save cash and time," he explains. "Rewarding this with part of the savings just makes good sense and rewards people's egos for using their heads. It also makes for better management/employee relations."

Switch to shorter shifts. "The problem isn't simply staffing, it's appropriate management of capacity to demand," says Espinosa. "Typical cost-cutting moves tend to be slashes across the board, such as cutting a person's position."

Overlook's ED has created shorter shifts for physicians, Espinosa explains. "They were willing to trade this for a different model of quality of life, being at the hospital less," he says. "However, physicians will stay longer than their new shorter shifts, if there is heavy volume."

Those extra hours are in addition to budgeted hours, Espinosa notes. "So if you were only thinking about reducing costs, this would seem crazy. But if you look at the ratio of hours spent to volume in the ED, you find we have increased volume to our ED by 15%. So, actually, our efficiency, in terms of patients seen per hour, has gone up dramatically," he says.

Put staff on call for double coverage. Instead of continuous double coverage, put staff on call, recommends Schneider. "Clearly, the most expensive thing in the ED is labor," she says. "If you're doing double coverage because 50% of the time you need an extra person there for six hours, you are continuously paying for two people. If you put an individual on call, your costs would be halved."

During periods of heavy volume, double coverage should be continuous, says Schneider. "For example, we know that in January and February we are really busy, so [staff] would be assigned to a shift, but during other periods they are on call," she explains. "If you assume that a physician costs roughly $100 an hour, and you can eliminate three eight-hour shifts a week, you save $2,400 a week."

Use less expensive pharmaceuticals. Make staff aware of the cost of various pharmaceuticals, recommends Schneider. "Even something as simple as posting the difference between a high-cost and low-cost antibiotic will certainly cut costs," she says. "Since a fair amount of our business is free and uncompensated care, if you are routinely using a low-cost antibiotic, it not only saves on patient out of pocket, but for those people who don't pay, it's a low-cost alternative for the ED."

Orally administering antibiotics is also a cost savings, Schneider notes. "Giving the same antibiotic IV as opposed to orally, [creates] a dramatically different cost. We often give IV drugs just because we have an IV in," she says. "You are not advocating using a different product, just giving the same product in a different way."

ED physicians should look closely at their prescribing habits, with the goal of prescribing the least expensive, effective drug for the patient's condition, says Syzek. "Why use an expensive antibiotic when a $5 antibiotic will do?" he asks. "Three areas where there are very expensive drugs and a cheap alternative are antibiotics, anti-inflammatories, and antihypertensives. We are in charge of millions of prescriptions nationally in these three areas. By looking at evidence-based

medicine, using the least expensive drug will add up to a lot of savings."

Use a database for insured patients. "Insurance companies have made their database available to us, which tells us which patients are seeing which doctors, which pharmaceuticals they've had filled, and when they've had certain diagnostic tests," says Schneider. "That way, we don't duplicate a CT scan or give them an antibiotic when they're already on one."

Switch to electronic charting. "In terms of data acquisition for billing, it doesn't cut down on costs in the front end, but it does cut costs in the back end," says Schneider. "All the pages are together, the charts don't get lost, it's easy to archive a chart, and if I need to pull up a chart it's right there. You do get a lot of cost recovery because you don't lose charts and there are no incomplete charts."

Add trauma activation fees. "Our goal is not only cutting costs, but improving revenue," says Grandlich. "To increase our trauma revenue, we developed trauma activation fees, which we were not previously charging. This recoups the cost of having 24 hours of CAT scan, x-ray, and consulting services. The fees depend on the severity of the patient, and are included as part of their ED charge."

Examine supply charges. "We went through all of our equipment and supplies and looked at what they were costing the hospital, to make sure they were in line with what we were charging the patient," says Grandlich. "In some cases, we were actually charging less than the hospital was paying, because the charges were never updated with inflation or changes in vendors."

Get best prices from vendors. Contact various vendors to find the best price for each piece of equipment, says Grandlich. "We were able to significantly cut costs with our orthopedic supplies, such as knee immobilizers, by choosing the one that fit our usage at the best possible cost," she explains.

Patient care, efficiency helps you cut costs

It's a mistake to look at costs without also considering patient care, argues **Steven J. Davidson**, MD, MBA, chair of the department of emergency medicine at Maimonides Medical Center in Brooklyn, NY. "Costs are an important driving factor in the ED. But making costs your raison d'être instead of patient care is the wrong focus for physician leadership and clinical service leadership," he says.

By reducing waits, costs are also reduced, Davidson stresses. "Patients waiting around take up resources and distract staff from their work. When a patient is there for an extra hour, they will have to be taken to the bathroom; for two hours they may need to use the telephone; for four hours you may have to give them a meal. So if you want to reduce your costs, reduce the patient's total time in the ED."

The ED has achieved per-unit cost savings by improving efficiencies, says Davidson. "Reducing waits and delays improved efficiency and reduced costs. For example, proportionally, we do not use as many doctor hours as we did when we started our efforts," he explains.

The ED dramatically reduced costs of patients per doctor, he says. "In 1995, our ED saw 54,000 patients. To do this, we provided 100 hours daily of physician coverage and 12 hours daily of PA coverage. In 1998, our ED saw 71,000 patients, a 30% increase, yet we averaged only 104 hours of daily physician coverage and 16 hours daily of mid-level provider support," he reports.

During the same time period, the average time patients wait to see a doctor was reduced from 80 minutes to 50 minutes, says Davidson. "We improved the throughput in the ED so doctors could see more patients per hour, which reduced the cost of patient per doctor," he explains.

The hospital sees more patients and more admissions without spending more money for doctors, Davidson stresses. "Over the three-year period, the costs per hour for doctors didn't really change, and yet the doctors are seeing 30% more patients. The cost to the hospital and the group practice per patients seen went down, even as patient acuity went up, and a greater proportion got admitted," he says.

Turn-around time nearly halved

The overall admission rate increased from 25% to nearly 29%, Davidson reports. "Our total turn-around interval nearly halved, markedly reducing waits and delays for our patients, especially those discharged. The proportion of more ill patients (as measured by admissions) in our population showed a disproportionate (33+%) increase to the increase in our total census," he says.

Mid-level providers now call nearly 35% of the patients who were seen in the ED and discharged, Davidson notes. "These calls help patients with follow-up problems and help us assure that any 'misses' in the ED don't become catastrophes for our patients," he says.

A unified management model for the ED made it easier to reduce waits and delays and impact costs, says Davidson. **(See guest column on p. 45 in the April 1999 issue of *ED Management* on the benefits of a unified organizational structure.)**

"With this model, we don't have to pull together collaborative meetings with VPs in nursing and finance. We

Costs were cut by following up with problems, Grandlich says. "If we got defective items, we'd send them back and complain. In some cases, the vendor would give us 10 free items back because we had a problem. Many times, vendors will also give volume discounts, but a lot of times people just don't bother to ask about this," she notes.

Standardize equipment. "We had 52 different glove types in the hospital and we reduced that to several different types," says Grandlich. "We were able to get discounts for purchasing in bulk quantities, so that was a cost savings. Previously, specific physicians wanted specific gloves, which would be twice as expensive but we ordered them just because they were used to that brand or that vendor was courting them."

Eliminate excess shelf stock. "We cut down our par levels to the bare minimum," says Grandlich. "On a daily basis, we tracked our usage of supplies like IV solutions, and plotted that out over a couple months. That way, we were able to stock what we needed, and not have equipment sitting on the shelves. If you are not using those supplies, you have a lot of money tied up sitting on the shelf."

At Mercy Health Partners, a task force is focusing on reducing costs of supplies in the ED. "We are looking at which supplies we don't use any longer, such as suction catheters, or major trauma kits which are outdated, so that we can return them and get credit," says **Kathy Johnson**, RN, BA, director of emergency/ambulatory services Mercy Health Partners in Springfield, OH. "We are taking a long, hard look at how we can be more judicious in our use of supplies, and we're hoping for a 5%-10% savings."

Audit charts for charges. At Mercy's ED, a part-time ED nurse was hired as a billing specialist. "She audits 100% of our charts for correct charges to make sure that everything was correctly billed," Grandlich says. On a monthly basis, the nurse has captured approximately $200,000-$300,000 in charges, she reports.

can make the decisions ourselves within our own unit," he explains.

When a change affected the ED's registration clerks, it wasn't necessary to consult the hospital's finance department, Davidson notes. "We removed the registration booths, so our clerks actually roam the ED and can register a patient at any PC," he says. "We were able to make that change without consulting other departments."

Another key change involved the way doctors are assigned patients. "We switched from the triage nurse doling patients out to doctors, to a system used in most EDs, where the charts are stacked and the doctor picks up the next chart in order," says Davidson.

As a result, the time from the patient's arrival until being seen by a doctor lengthened. "But we also tracked the time from when the doctor first sees the patient, until the disposition of the patient," says Davidson. "We learned that by letting the doctor pick up the charts, the sum total of that time shortened. So patients waited longer to see the doctor, but got care more expeditiously and got dispositioned quicker, and the total result was a time savings."

Use incentives to improve staff efficiency

"We have moved toward an incentive program based on the number of patients seen per hour," says **Daniel DeBenke**, MD, FACEP, associate professor and director of clinical services at Froedtert Memorial Lutheran Hospital in Milwaukee, WI. "Additional patients can be seen for a small variable cost, which decreases the cost per patient."

Physicians get bonuses each year based on how they compare to rest of the group. "As a result, we have improved the number of patients seen per hour from 2.6 to 3.1 in this quarter," says DeBenke. "That means decreased length of stay, better throughput, and less bed crunch and backlog."

Physicians are data-driven individuals who respond well to the incentive program, says DeBenke. "When we give them the report card showing how they compare to the rest of the group, if they're at the bottom of list they want to be at top of the list," he notes. "Individual physician customer satisfaction numbers will be added to the incentive program."

A physician-nurse team concept was also implemented, DeBenke reports. "In the past, nursing would be assigned to a group of five rooms. That had some degree of inefficiency, because there wasn't a huge incentive to empty out the assignment, since they'd simply get another patient," he says.

There was also no physician ownership of patients, says DeBenke. "Physicians used a greaseboard for tracking, but patients were just put up as 'ready' to be seen, so whoever was able to see the patient would sign up," he explains. "But if a physician was busy or felt it was near the end of their shift, they tended to let it sit. So patients languished for a long time waiting for physicians to see them," he explains.

A team system was developed. "We have a red and blue team, each consisting of one or two residents and two nurses. Patients are assigned to them instead of using room assignments, so obviously there is an incentive for nursing and physician teams to quickly move their patients in and out of the system," says DeBenke.

Average length of stay was decreased by 20 minutes. "The time spent with each patient is less," says DeBenke. "So patients aren't using personnel in the ED as long, resulting in reduced costs." ■

A nurse was selected because of the benefit of clinical knowledge, Grandlich notes. "That person is technically overqualified for that type of position, but a nurse knows how to read the charts and knows what is done in the ED," she says.

In some cases, patients were not charged at all, or charges were missing, says Grandlich. "Before we hired her, we tried other alternatives to get the charging improved on the nursing end, but nothing worked," she explains. "We tried revising our charge sheets to make it simpler, audited every chart, and gave feedback to the nurses. But because of the busy nature of the ED, nurses spend more time with patients than paperwork, and that tends to be pushed to the end of the shift."

To justify the new position, the nurse initially worked on a trial basis, says Grandlich. "We paid the nurse her regular staffing hours as a staff nurse, and on her days off we'd pay her to come in to do the chart auditing," she explains. "Hospitals are looking at cutting FTEs, not adding new positions. But when you look at the savings, it pays for her salary many times over."

Restructure skill mix. "We have decreased our RN hours slightly, but increased our paramedic hours to revamp our skill mix," says Johnson. "Paramedics will be working as partners with the RN in collaboration for the patient's care, working under the direction of the RN. We will realize a significant savings by going to this model." ■

Get an edge by giving MCOs a report card

ED managers can gain leverage by giving MCOs report cards, says **Jim Augustine**, MD, FACEP, CEO of Premier Health Care Services in Dayton, OH, and member of the Benchmarking Alliance, which developed a managed care report card. **(See report card in this issue on p. 55.)** "Managed care plans put together report cards on us, but we have never thought about giving them a report card on how they treat us," he argues. "The concept of collecting and reporting data on payors is an increasing trend."

A report card is a valuable tool for ED groups, emphasizes Augustine. "It would be most useful as a source of data on how we are to interface with managed care, and identify those payors that globally have poor relationships with providers, have very punitive preauthorization requirements, or who flat out don't pay." he says.

Having reliable data to rate MCOs can be a major advantage for EDs, Augustine stresses. "You will be able to compare your data with other EDs and say, we either do or don't have problems here," he says. "This could help us level the playing field with payors and give us more leverage in coming negotiations."

Here are things to consider when creating a report card for MCOs:

Share data with other entities. "First you need to assess whether there is an audience that cares [about MCOs] in your community," says Augustine. "There may be business coalitions or governmental entities who you can work with to draft standards for the report card. That can either be done at your ED level, group level, or with other ED peer groups or a local chapter of the American College of Emergency Physicians (ACEP)."

The data could be shared with participating ED groups, emergency medicine groups in the state, the state medical association, the media, other MCOs, legislators, and the department of insurance, Augustine suggests. "It should also be shared with local, major employers, who would be very interested in how EDs would work to develop care—very helpful during open enrollment periods," he says. "Suggest that the employers use their negotiating power to open up discussions with managed care."

Meet with local employers to discuss MCOs. "Unless you take the opportunity to work with them, they will think you are nothing but a cost center," says Augustine. "Tell them how much money you save them, and how good you take care of their employees. Discuss with them the nature of your business, and how well you do it."

Employers may be completely unaware of how well MCOs are performing, Augustine stresses. "They often don't know how well they perform clinically. For example, how easy is it for you to send one of their employees to an orthopedist for follow-up care?" he says. "Some have poor networks, and there is a great deal of difficulty. We may have to refer the employee back to his or her primary care provider, and it may take a couple of visits to get them to the orthopedist. The employer may not realize any of that."

Address denials. "You can share with local employers the fact that 50% of their employees have their visits denied when they come to the ED," Augustine suggests. "That means the employee has to pay out of pocket, including serious problems like auto accidents, which is an emergency situation, but the MCO says it's not," he says. "Tell them, 'We think you ought to know that the next time you are going to negotiate your contracts.'"

Consider antitrust provisions. "You have to consider antitrust provisions in collecting data. Because if you begin to share information about charges and pricing you are into a problem area," warns Augustine. "We feel that outside entities would be better suited to do data collection, and make sure it doesn't include information on pricing."

Make sure data is reliable. If you collect data, make sure they are reliable and there is an objective nature to them, Augustine advises. "Otherwise, an MCO could allege that you were libeling or slandering them, so those are some significant considerations. The American Hospital Association, ACEP, or Emergency Nurses Association (ENA) may be appropriate bodies to pull data from hospitals that may be considered competitors, and allow data to be collated."

Only collated data should be reported, Augustine emphasizes. "You will need to produce a reporting scale for each issue, so it allows data to blend well from different institutions," he says. "For example, if there is not a uniform definition for denials, you will get unreliable data."

Address HEDIS standards. The results could also impact the MCO's national rating scores, such as the Health Plan Employer Data and Information Set (HEDIS) standards, published by the Washington, DC-based National Committee for Quality Assurance (NCQA), says **Mike Williams**, president of the Abaris Group, Walnut Creek, CA.

"This is the national benchmark for all plans. The NCQA just released a draft of HEDIS 2000 standards, which is an update of this performance measurement tool, used by more than 90% of the nation's health plans," says Williams. "They also have standards for Medicare plans, which many EDs have problems with."

If an ED physician group looks closely at the HEDIS standards, they can gain leverage with regard to specific issues, Williams notes. "Learn about the standards and how they are applicable to your practice," he urges. "This is another tool that we can use when [we're] frustrated about managed care. We are empowered to help the plans, therefore they will be interested in working with us on other issues," he says.

Certain HEDIS standards can be useful during future contract negotiations, says Willliams. "Discuss your willingness to work with the plan on meeting these standards," he suggests. "For example, they can say, 'As a group, we could help you meet the HEDIS standard if you will just pay us faster."'

ED managers should be familiar with this national rating system, Williams stresses. "There are service delivery standards that can only be met by EDs," he says. "For example, there is a whole series of standards for response and treatment of asthma patients that

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Managed Care Report Card from the Perspective of Emergency Medicine

What is the degree of managed care penetration in the service area?

Which groups have managed care presence and what percentage: Medicare, Medicaid, commercial?

Practice Aspects

- What is the availability of primary care physicians for follow-up. Not just a call list, but actually able to see a new patient within a reasonable period? Can an established patient be seen within 24 hours on a regular basis?
- What percent of MCO patients can identify their primary care physician?
- What percent of MCO pediatric patients are up to date on needed immunizations?
- What percent of MCO patients know how, when, and where to access urgent or emergency services?
- If patients have a chronic disease process, do they have a case manager?
- Is a case management process available, and accessible, to emergency physicians?
- Are specialty follow-up appointments available? Are there specialty groups at risk or unavailable? Do referral problems to specialists cause increased length of care in the ED?

Credentialing Process

- Is it done by individual emergency physician or by the group?
- What is the volume and complexity of the process to credential physicians?
- What is average length of process to obtain credentials?
- How are claims handled until credentialling is complete?

Business Process

- Are there difficulties in receiving payment for services rendered?
- On average, how long from claim submission until payment rendered?
- How many claims have requests for further information?
- What percent of claims are denied?
- Why do claims get denied?
- Are denials for inappropriate reasons?
- What is the appeals process? What is success rate of appeals?
- Are claims always paid at contracted rates? If not, why not?
- What percent of charts are downcoded?

Source: James Augustine, MD, FACEP, Premier Health Services, Dayton, OH.

Evaluating Access to Emergency Care through Your Health Plan

A Checklist for Consumers

Many individuals learn about the emergency medical benefits of their health plan when they are in the midst of a medical crisis. The American College of Emergency Physicians (ACEP) has developed this checklist to assist you in evaluating your health plan's emergency medical benefits in advance.

1. The insurance/health plan has given me written materials that clearly explain what to do if I need emergency care, including:

   when to call for an ambulance or 911;
   Yes ❑ No ❑ Don't Know ❑

   how to call for an ambulance or 911;
   Yes ❑ No ❑ Don't Know ❑

   when to seek emergency care;
   Yes ❑ No ❑ Don't Know ❑

   and where to go for emergency care.
   Yes ❑ No ❑ Don't Know ❑

2. The insurance/health plan encourages me to call an ambulance or go directly to the emergency department if I think I have an emergency medical condition.
   Yes ❑ No ❑ Don't Know ❑

3. The insurance/health plan has given me written material that clearly explains that they will pay for a visit to an emergency department if I have symptoms that most people would consider an emergency (the "prudent layperson" standard), even if it later turns out that my condition was not a true emergency. For example, I have chest pain that I think is a heart attack, but it turns out to be indigestion.
   Yes ❑ No ❑ Don't Know ❑

4. The insurance/health plan has given me a telephone number that I can call when my doctor's office is closed.
   Yes ❑ No ❑ Don't Know ❑

5. When I call this number I am able to speak with a qualified nurse or doctor who can give me advice about my problem and help me decide if I need to go to an emergency department or other health care site for treatment of my problem.
   Yes ❑ No ❑ Don't Know ❑

6. The insurance/health plan does not require that I call them before I go to an emergency department as a condition for paying for the emergency services (i.e., there is no "preauthorization requirement").
   Yes ❑ No ❑ Don't Know ❑

7. The insurance/health plan does not require the emergency department staff to call them before an emergency physician or nurse has examined me to determine if I have a medical emergency. (Federal law requires that a medical screening examination must be performed on every emergency department patient regardless of ability to pay).
   Yes ❑ No ❑ Don't Know ❑

8. After the emergency physician has evaluated me, the health plan has qualified medical professionals readily available to discuss my condition and make arrangements for any further treatment.
   Yes ❑ No ❑ Don't Know ❑

9. The extra payment (co-payment or deposit) I have to pay out of my own pocket is not so high that it would discourage me from going to an emergency department when I believe I need emergency medical care.
   Yes ❑ No ❑ Don't Know ❑

10. Hospitals approved by the plan are located conveniently to me.
    Yes ❑ No ❑ Don't Know ❑

11. I am able to see my regular doctor, as well as any specialists I might need, in a timely manner for urgent and routine medical conditions.
    Yes ❑ No ❑ Don't Know ❑

Rating Your Insurance Plan and Services

"Yes" responses to the above questions tend to indicate that your health plan supports appropriate emergency care access. "No" responses indicate that there may be a problem. "Don't know" responses may indicate that you need to ask additional questions of your insurance plan in order to fully understand your coverage.

To obtain more information, check with the plan's customer service representative or the agency responsible for regulating health care plans in your state (in most cases this is the Department of Insurance or Department of Corporations).

Source: American College of Emergency Physicians, Dallas, TX.

Evaluating Access to Emergency Care through Your Health Plan

Emergency Physicians' Checklist for Evaluating Managed Care Plans

Dissemination of Information

1. Does the plan *not* contain gag clauses in the contract?
2. Is the plan responsive to physician inquiries?
3. Are the provider reports required by the plan reasonable and of value in improvement of the quality of patient care?
4. Does the plan furnish reports that are of significant value to providers?
5. Is the plan financially stable?
6. Do providers have access to the health plan information that is distributed to employers and patients?
7. Does the plan keep its enrollee list current?
8. Does the plan keep its provider list current?
9. Does the plan provide prospective physicians with a list of current and former providers?
10. Are the plan's provider physician profiles and the utilization management plans available to providers?

Reimbursement

1. Does the plan provide or allow for stop-loss coverage?
2. Are the plan capitation rates fair and equitable?
3. Are payments to physicians timely and consistent with state and local practices?
4. Are payment denials appropriate?
5. Are physician payments and explanations of benefits (EOBs) accurate and complete?
6. Does the plan take responsibility for correction of financial abuses of providers when it sub-contracts with other provider groups or entities?
7. Does the plan reimburse non-plan consultants when plan consultants are unavailable?
8. Does the plan use appropriate CPT and ICD-9 coding methodology in reports and claims?
9. Does the plan review presentational acuity rather than final diagnosis in adjudicating payment for ED visits?
10. Does the plan guarantee payment for a federally-mandated emergency medical screening exam (EMSE)?
11. Does the plan agree to honor and pay for all ED visits that are authorized by any provider on the plan's most current provider list, regardless of the accuracy of that list?
12. Does the plan pay for all CPT codes on each claim and bundle CPT codes only when appropriate?
13. Do IPAs or medical groups sub-contracted to the primary contracting plan or group pay for all CPT codes on each claim and bundle CPT codes only when appropriate?
14. Does the plan delegate contractual fee schedules or other contract provisions *only* to entities indicated in the contract, and *not* to undisclosed subsidiary contractors (so-called "silent contract")?

Source: American College of Emergency Physicians, Dallas, TX

Dispute Resolution

1. Does the plan provide due process prior to potential deselection?
2. Is the plan willing to re-negotiate contracts that have resulted in adverse financial or operational consequences to physicians?
3. Are the appeals and grievance procedures of the plan fair and timely?

Credentialing/Certification

1. Does the plan enroll all members of a physician group?
2. Is the plan accredited by a recognized review body?
3. Is the plan's credentialing process reasonable and not burdensome?
4. Does the plan credential applicants within reasonable time frames?

Delivery of Care

1. Are the plan's mandated clinical guidelines for emergency services appropriate and medically sound?

Contract

1. Does the plan conduct contract negotiations in an honest and forthright manner?

Access to Care

1. Following completion of the mandated emergency medical screening examination, does the plan have a 24-hour, readily accessible source for approval or denial of payment for post-stabilization care?
2. Regarding post-stabilization evaluation and care: Are the plan-designated authorizing personnel (i.e., those with authority to approve or deny payment for post-stabilization care) qualified to make such determinations?
3. Does the PCP or the plan assume responsibility for maintaining a full range of specialists/consultants for the plan's patients and facilitate arrangements for necessary specialty consultations?
4. Does the plan have adequate numbers of well-qualified primary care physicians?
5. Does the plan have adequate numbers of high-quality hospitals under contract to adequately serve the post-stabilization needs of ED patients?
6. Does the plan allow a broad range of ED prescriptions that is not limited to its own unique pharmaceutical formulary?
7. Does the plan have a post-stabilization case management system that functions appropriately and safely in regard to transfers of the plan's patients?
8. Do the plan's policies and procedures rarely delay or hinder appropriate patient care?

It is up to each group or physician to make an independent judgment on the relative value of each issue raised in this checklist. This guide is not meant to be used as a scorecard, since each issue may have different importance to each physician or group. Instead, it should be used as an opportunity to consider the various issues that may have an impact on your relationship with a managed care organization.

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specifically address ED visits."

Another standard involves adult access to preventive/ambulatory services. "This includes how the plan will provide services for patients after hours. So if there is a low-cost alternative in the ED for ambulatory access, the plan can get credit for that," says Williams.

By helping MCOs meet these standards, plans will have an incentive to meet the ED's needs, Williams explains. "You can gain leverage by cooperating with the plan and helping them meet the standards," he says. "As you are negotiating contracts, reinforce the plan by looking good on the report card, especially if the ED has a significant membership in the plan."

HEDIS standards can be accessed via the Internet, Williams advises. "Right now we have HEDIS 3.0 standards, but we are moving toward 2000 standards, so ED managers should be familiar with those," he says. "That way, you can evaluate what potential opportunity your particular ED might be able to respond to." **(Both the existing and new draft standards can be downloaded at http://www.ncqa.org.)**

Give input for national standards. If ED groups develop standards for local MCOs, they could be adopted as the national standard, says Williams. "ACEP worked with Kaiser Hospitals to develop the prudent layperson standard, and that became an adopted standard by American Association of Health Plans," he notes. "This has been adopted in 15 states as standard for payment. It represents an ED physician-driven issue that has become a national benchmark."

There is tremendous interest in access for ED patients, Williams notes. "The Cardin bill has just been introduced again, so it is a great time for emergency medicine to design standards that are either legislative or voluntarily adopted by health plans," he says.

Rate reimbursement behavior. Grade managed care plans on the basis of reimbursement behavior, advises **Lorne Johnson,** MD, FACEP, president of health Access Associates in Davis, CA. "For example, in California, we find that many of the plans still discount, downcode, and delay their payments to emergency physicians both in and out of contract," he says. "Out of contract, they often pay a contract rate, and tell the patient that under state law, the emergency provider is not allowed to balance bill, and that is not true, so they misinform patients."

Involve local businesses. "The standards can be adopted by businesses who are purchasing health care services, when they choose one plan or another," says Williams. "This is not something that is done overnight, but groups need to network together. A group has a lot more leverage on a single issue than separate entities. In some communities, going to business coalitions who are interested in health care will give you significant leverage."

Surveys can be shared with local organizations, suggests Johnson. "In California, a business group on health was working on standards for disclosure information standards for health plans, and they specifically have a project on health plan member ID cards," he explains. "So the California ACEP chapter did a survey of cards and shared this information with the group."

Concerns about emergency care access information printed on the back of various health plan cards was noted, with the recommendation that cards print the following two statements:

- In case of emergency, call 911 or obtain emergency care in the nearest appropriate facility.
- Prior authorization for emergency services is not required.

Ask patients for input on MCOs. ACEP's Emergency Medicine Practice Committee developed an 11-question checklist for consumers, reports Johnson. **(See checklist in this issue on p. 56.)** "This is a patient-based report card regarding emergency access. It can be used as a feedback information tool to reflect patient dissatisfaction with access barriers and delays in care resulting from managed care plans," he explains.

Create a checklist for physicians. A checklist for physicians was also developed by ACEP. **(See checklist in this issue on p. 57.)** "This would be valuable for a group working in a transitional environment where managed care is making aggressive moves toward contracting emergency services," says Johnson. "We need to get more aggressive in other parts of the country that are still going through the early stages of managed care maturation. EDs could benefit from this analysis of how a plan should be evaluated."

Address access to care. "Kaiser has a statewide hotline with an ED physician available 24 hours a day to make prompt decisions. So under that report card category, they would get an A," says Johnson. "Network plans might not score so high, since the representative would more likely be the patient's primary care physician. Therefore, by and large they don't understand the requirements of the law, and there is much more variability in the quality of the response." ■

Patient transport codes give paramedics options

EDs in Akron, OH, have created a novel, tiered transport program that allows paramedics to rate patients according to how urgently they require care. When

paramedics respond to a 911 call, they call medical control and recommend a transport option using one of three codes. "They may say, 'We have a 6-year old who fell and hit his head, with brief loss of consciousness. We feel a code 3 transport is appropriate,"' says **Kim Jetter**, RN, EMT, pediatric EMS coordinator at Children's Medical Center in Akron.

If the paramedics believe the patient doesn't need immediate transport, a different code is used. "The paramedics can [make] that patient to a Code 2 transfer, which frees up the paramedics to get back into circulation," explains **Norman Christopher**, MD, FACEP, director of emergency and trauma services at Children's.

They also have the option to not transport the patient at all. "Code 1 transport is actually a non transfer, because an emergency does not exist. They may feel the child is fine to drive to the hospital or doctor's office. This protects a valuable resource," says Christopher. "Our paramedics are getting back into circulation more quickly, instead of being tied up with non-emergency work."

The following codes are used:

Code 1: No transport. "Those are your really minor injuries, such as a cut hand," says **Roger Hoover**, district chief for EMS at the Akron Fire Department. "In that case, we will dress it, wrap it up, and call it in. But the patient is made a code 1, meaning they do not need an ambulance for transport."

The decision is always jointly made by the paramedics and the physician at med control, says Jetter. "They both need to be comfortable with the code 1 status," she adds.

Code 2. Transport by private ambulance. "Once it's determined a patient is a code 2, a private ambulance is called. They are supposed to guarantee a 15-minute response time," says Hoover. "We stay until they assume care of the patient. The patient is then transported to the hospital, and the team is freed up and back in service. This way, they are able to immediately respond to another call."

Examples of code 2s include post-seizure patients, diabetics who need to be observed, and most orthopedic injuries. "These aren't life- or limb-threatening conditions, and they don't need a lights-and-siren ride. The extra time won't make a difference in care, and they will likely be waiting in the ED for several hours before they are evaluated," says Hoover.

Code 3: Transport by ambulance. "This is the highest level of transport, for life- or limb-threatening conditions, such as severe trauma, chest pains, uncontrolled seizures, imminent childbirth, and strokes," says Hoover.

Paramedics freed up

Patient care is improved because delays are reduced, says Jetter. "The last thing we want to do is needlessly tie-up a squad, especially if the whole city is busy. If we have med units unnecessarily tied up, their response time is longer and that can be detrimental to a patient," she notes.

The system ensures that patients are treated appropriately. "A lot of non-urgent care isn't dumped on the hospitals, and the public is educated that EMS is not a taxi service," says Christopher. "The impact that it has on ED care delivery is incredible. Because our paramedics remain in service, our EMS staff isn't twice as large as it needs to be. They are doing what they are trained to do, instead of providing a carpool service for families."

A smaller force is able to focus its resources on patients who need its level of skill, says Christopher. "This ensures availability of higher level providers in the field, and better triage," he notes.

The arrangement with private ambulances also helps when there is a catastrophe, notes Hoover. "By allowing them to generate the revenue from Code 2s, we have a built-in backup system when we need it.

ED Management® (ISSN 1044-9167) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA. POSTMASTER: Send address changes to ED Management®, P.O. Box 740059, Atlanta, GA 30374-9815.

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Subscription rates: U.S.A., one year (12 issues), $379. With 18 Category 1 CME hours, $429. For 21 ANA hours, $429. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $180 per year; 10 or more additional copies, $114 per year. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $63 each. (GST registration number R128870672.)

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The worst thing is to not have anybody to respond. We had a couple close calls on very busy days," he explains. "For example, if we have a bad car accident, and several units are out on other calls, there may not be enough units to handle it. If we need a few private ambulances, they will drop anything else to respond to our requests."

Failsafe system

If there is a disagreement about which code should be used, the higher code always prevails, says Hoover. "If the paramedic says to the physician, 'Based on our evaluation we feel this can be a code 2, but the physician feels it's a code 3, the physician wins, or vice versa," he explains.

A failsafe system ensures that a decision is never made to downgrade a patient's status without a physician consult. "If for some reason med control cannot be contacted, then no matter how minor the problem, the patient is transported Code 3 by the ambulance," Hoover explains. "A perception exists that the paramedics make the decisions by themselves and if they don't want to bother to transport a patient, they'll make it a code 2, but that's never the case."

Strict controls are used. "The paramedics would never make a decision to not transport a patient without contacting medical control first," stresses Christopher. "If they explain that a child vomited two weeks ago and it doesn't appear to be anything urgent, I have the option to ask more questions or not agree with their decisions. The onus is on us to review our medical control decisions."

The Code 1 patients are harder to track than Code 2s since the patients who aren't transported may not come in, notes Christopher. "However, we can follow to see if they come in the next day. That way we can ascertain if a bad decision was made and they wind up sicker," he says. "But from our research, we have every indication to believe that our field triage is accurate. The system is very conservative."

Of 450 calls in a recent month, 160 were made Code 1s. "Roughly one-third of the patients were not transported," says Christopher. " Of that group, about half didn't wind up coming in. It's a little troubling that we don't have accurate follow-up for patients who don't come in at all."

Patients are never told they don't need to go to the hospital, says Hoover. Even with Code 1 patients, they are advised that this situation does need further evaluation, wherever the patient chooses to go," he notes. "Paramedics never tell anybody 'You don't need further evaluation,' because that would be a dangerous practice. These are transport modes, not treatment modes." ■

CE objectives

After reading this issue of *ED Management*, the continuing education participant should be able to:

1. Discuss and apply new information about various approaches to ED management.
2. Explain developments in the regulatory arena and how they apply to the ED setting.
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by one's peers.