



DOCUMENTATION & CODING UPDATE

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The pros and cons of template charting: What you need to know

How to figure out what's best for your facility

Challenged by increasingly stringent documentation requirements, many emergency departments (EDs) are turning to template charting systems as a way to cut documentation time, eliminate transcript costs, and ensure accurate coding.

But systems vary widely in terms of cost, specificity, and other factors. How do you know what's best for your facility?

To be sure, template charting has its critics — primarily physicians, who may view any type of standardized documentation tool as a form of cookbook medicine.

"In the 50% to 60% of departments that don't use any kind of templated documentation, you find that you have physicians who, for one reason or another, say, 'You know, we're documenting a certain way; we're comfortable with that way; we don't want to change,'" says **David H. Moss**, MD, president of Emergency Resources Group and chief developer with AAEM Templates in Milwaukee.

"Some physicians just don't want to be shepherded down a particular path. So when you say to an entire department, 'We're going to be adopting template use,' there's invariably going to be some physicians in some departments who say, 'No way am I going to do what everybody else is doing,'" he adds.

Nevertheless, in light of tougher documentation requirements from the Centers for Medicare & Medicaid Services, increasing numbers of physicians are going along with the move toward template documentation, according to **Larry B. Mellick**, MS, MD, FAAP, FACEP, chair and professor, of the department of emergency medicine and section chief of pediatric emergency medicine, at the Medical College of Georgia in Augusta.

"I think you're obligated to, for ease of documentation and for coding purposes of capturing all of the information, as well as making it easier for your coders to identify when something's missing," he says.

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Mellick says it's "almost unfair" to make coders work through a nonstructured dictation or a scribbled handwritten chart to find the appropriate documentation elements. Such practices also may increase the risk of coding errors. "Or the coders simply will not be able to find things and, when rushed, will simply down-code so there won't be accusations of fraud," he explains.

Patrice Spath, RHIT, a health care information consultant with Brown-Spath & Associates in Forest

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Grove, OR, adds that, "from a patient safety standpoint and from a quality of care standpoint, any time you can make it easier for people to do the right thing, then it adds value."

"Any time you can reduce variation in a process, it adds value. So a template would be no different from a clinical pathway or an algorithm or anything else that essentially puts reminders in front of peoples' faces about what they ought to do," she says.

Currently, Moss says, EDs have five choices when it comes to documentation:

1. handwritten charts;
2. dictated charts;
3. voice-activated charts;
4. paper-based template systems;
5. computerized systems.

Of those choices, paper-based and computerized template systems come out on top because only they prospectively help to improve the quality of care because of their prompting mechanisms.

For example, when a patient presents to the ED with chest pain, "the template can prompt you to address the patient's risk factors for myocardial infarction, or for pulmonary embolus," Moss says. "Handwritten charts and dictated charts fail to do that totally, because they're done after the fact."

"[Templates] just remind people to think about what they should be thinking about," Spath adds. And that goes beyond quality of care to legal and regulatory issues as well.

"From an EMTALA [Emergency Medical Treatment and Labor Act] standpoint, making sure that certain things get documented in a consistent fashion is valuable also. It comes down to making it easier for people to do the right thing," she explains.

Another way templates shine is by allowing efficient, real-time entry of documentation, Moss says. "Handwritten charts allow real-time documentation of information, but they're very inefficient. Dictation fails to provide real-time entry of information. You always do it after the fact."

Documentation should complete 7 tasks

According to Moss, documentation should fulfill seven different tasks:

- gathering, organizing, and entering information;
- patient management;
- databasing and research;
- reimbursement;
- communication to other caregivers;
- medicolegal defense;
- continuous quality improvement.

"I think ED templates do the single best job of any

potential documentation solution in fulfilling most of those tasks, and doing it in the most efficient and thorough way possible," he says.

Even so, Moss cautions against using one approach to the exclusion of all others. In reality, the best approach might be a combination system.

"Where templates have a weakness is in conveying information to other caregivers," he says. "We're basically a society of storytellers, and that's where a dictated chart excels, because it follows a narrative format. You can abstract information and get a gestalt of the patient more easily with dictated charts." But dictated charts have their own weakness — most notably, they're expensive and time-consuming.

"My suggestion is that the ideal approach should be to use templates for the majority of information, but use dictation to convey complex information, where you just want to summarize what's going on with the patient because you're going to use that for communication purposes," Moss says.

"If you had an emergency department where you utilized templates and you allow supplemental dictation, I think you'll find that you'll be using dictation probably 10% of the level you were using it before. But that 10% is important. Those are the complex cases, the cases where you really want to convey important information. And I would give physicians that opportunity," he explains.

Of course, not all template systems are created equal, and some may be overly burdensome in their requirements. Mellick criticizes systems that "have a chart for every possible patient complaint."

"You ought to have a template that's broad and general and covers enough categories, and not get into chief-complaint-specific templates," he says.

The problem, Mellick says, is that a physician has to choose, up front, from as many as 50 potential templates, and that initial choice may "take you down a pathway that is not appropriate for the patient. For example, someone may come in with leg pain and really turn out to have thrombophlebitis."

"Oftentimes, a particular chart for the particular complaint, like leg pain, really is set up for a lower

"So there has to be some flexibility. And that's an inherent weakness of templates, but frankly, you have the same problem with a handwritten chart and a computerized system also."

level of documentation, as well as a lower level of coding," he adds.

Mellick adds that, all too frequently, what seems to be a simple complaint that merits a low coding level turns out to be a critical care situation.

Mellick and his colleagues at the Medical College of Georgia have addressed this problem by creating templates of their own. (**See related story, p. 9.**)

Moss acknowledges that having a small number of more generalized templates makes it easier to select the correct template on the front end.

"But then it's not very helpful, frankly. And if you want a template that will prompt you to address the patient's problems and efficiently document information, you have to tailor it toward the presenting complaint," he says.

According to Moss, 90% of the time, it's easy to select the correct template. "And somewhere between 5% and 10% of the time, patients complain with multiple problems, and you have to prioritize, which we do clinically anyway."

He acknowledges that there are some patients whose presentation evolves as they progress through the ED. "So there has to be some flexibility. And that's an inherent weakness of templates, but frankly, you have the same problem with a handwritten chart and a computerized system also." Moss adds that he regards this a minor weakness. "It just doesn't come up all that often."

Mellick also notes that the cost of using commercial charts can be exorbitant. His facility went that route for about a year, paying \$1 per chart for about 60,000 patients.

"We said, 'Why are we paying so much money for charts that don't work for us?' It did help in our coding, but it also hurt us in our coding, because it was not uncommon to have charts that were set up to be a level 1, 2, or 3, but the complaint was a more critical problem," he points out.

Moss says that handwritten charts probably have the cheapest out-of-pocket price tag. "The problem is, you're really going to lose on reimbursement by relying on handwritten charts, and you're also going to have medical-legal costs."

Dictated charts probably are the most expensive. "If you're using an agency outside the hospital, you're probably paying between \$5 and \$6 a patient. In the hospital, it's actually probably more expensive," he says.

Meanwhile, costs for computerized systems are "all over the place." With templated systems, "you're looking at anywhere from 50 cents a patient to a couple of dollars. So I think, generally, they're pretty reasonable," Moss explains. ■

**Medical College of Georgia and Children's Medical Center
Emergency and Express Care Services Record
Chest Pain**

Source: Medical College of Georgia and Children's Medical Center, Augusta.

The Documentation-Coding Connection

OPPS: The emergency department challenge

ED facility and fees and procedure codes

By **Deborah K. Hale**, CCS, President
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"The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, the application of all coding guidelines is a difficult, if not impossible task."
— As published in *Coding Clinic*, Quarter 2, 1990.

The Outpatient Prospective Payment System (OPPS) implemented on Aug. 1, 2000, was a significant turning point for hospitals, moving them from a cost-based reimbursement to a CPT-4 and HCPCS level II line item prospective payment methodology, referred to as ambulatory payment classifications (APCs).

Each APC has a pre-established prospective payment amount associated with it. The hospital can earn profits if costs are lower than the payment rate or face losses if costs are higher than the payments.

Since that day, hospitals have struggled to understand the confusing and frequently changing OPPS guidelines for hospital outpatient departments.

The emergency department (ED) tops the list of challenges for most hospitals. This department generates a large percentage of outpatient revenues and also has complex coding and billing guidelines for facility fees. Numerous ancillary services frequently are provided during the ED visit.

Before the implementation of OPPS, many facilities reported all clinic and emergency visits with the lowest level of service (for example, CPT codes 99211, 99201, and 99281) simply to minimize administrative burden. (For example, chargemasters might include only one level of service.)

Because the correct HCPCS code did not influence payment, there was little incentive to correctly report the level of service. This situation changed with the implementation of the OPPS. The OPPS requires correct reporting of services using HCPCS codes as a prerequisite to payment.

Beginning Aug. 1, 2000, the Centers for Medicare & Medicaid Services (CMS) instructed hospitals to use all CPT evaluation and management (E/M) codes to report clinic and ED visits.

CMS told hospitals to develop their own mapping system or internal set of guidelines to report services represented by these codes. The only requirements were that the ED services be documented, be medically necessary, and that the mapping should reasonably reflect the intensity of the hospital's resource consumption.

Hospitals have struggled to create their own acuity systems. Initially, there were no specific guidelines as to what could or could not be included in determining the E/M level, and they did not have historical data to assess the impact of their mapping system.

ED visits are charged by levels of service based on the acuity level of the patient and the intensity of supplies and services provided. Hospitals are to build six charges based on acuity and intensity of service using 99281-99285 CPT codes and 99291 for critical care.

(See **ED acuity charts, pp. 6-7.**)

These codes were defined to reflect the activities of physicians. It is generally agreed, however, that they do not describe well the range and mix of services provided by facilities to clinic and emergency patients (for example, ongoing nursing care, preparation for diagnostic tests, and patient education).

Some hospitals are reluctant to use the critical-care code (99291) because of the CPT definition. Remember, that definition does not apply to the ED facility. While a physician can bill both critical-care codes based upon time, a single code (99291) will suffice for the entire critical-care facility visit regardless of the time factor.

The most recent instruction was published in the *Federal Register* Nov. 1, 2002, (66793-66794) for OPPS Final Rule for 2003. It reads as follows: "We [CMS] do not believe that facilities and physicians

(Continued on page 7)

(Continued on page 7)

Source: Administrative Consultant Service Inc., Shawnee, OK.

would be expected to bill similar levels of service for the same encounter. The resources used by a facility for a visit may be quite different from the resources used by a physician for the same visit. Facilities should code a level of service based on facility resource consumption, not physician resource consumption. This includes situations where patients may see a physician only briefly, or not at all.”

CMS also stated that if hospitals set up these guidelines (mapping systems) and follow them, they would be in compliance with OPPS coding requirements for the visits.

An additional requirement added by CMS was that the distribution of E/M codes should result in a normal

bell curve. If a facility is using an accurate ED acuity form to report the six levels of service, a bell curve should be the result when developed into a graph.

To assess the appropriateness of a hospital’s E/M mapping system for facility ED visits, display frequency of billing for each E/M code in a graph format. **The bell-curve graph on p. 8** shows billing patterns for a community hospital that sees 20,000 ED patients per year and is using an acuity form that does not properly identify the appropriate E/M level based on the resources consumed.

- Approximate national Medicare reimbursement for the accurate bell curve: \$3,021,782 per 12 months.
- Approximate national Medicare reimbursement for

Bell-Curve Graph

■ Hospital A

□ Accurate Bell Curve

the inaccurate bell curve: \$2,540,568 per 12 months.

When the facility accurately identifies E/M services provided, the hospital should expect an increase in reimbursement of approximately \$481,241 per 12 months. As this example indicates, it is of great importance to make sure the mapping system the hospital is using is accurately assigning all levels of care.

From 2002 OPPS claims data (as published in the *Federal Register*, Nov. 1, 2002), more than 50% of the ED visits were considered “multiple procedure claims” because the claim includes services such as diagnostic tests (for example, EKGs and X-rays) or therapeutic interventions (for example, intravenous infusions).

The distribution of all emergency services was in a bell-shaped curve with a slight left shift because there were more claims for CPT codes 99281 and 99282 than for CPT codes 99284 and 99285. This pattern of coding is significantly different from physician billing for emergency services, which is skewed and peaks at CPT code 99284.

Furthermore, CMS announced that it would be reviewing the issue and plans to set national guidelines for coding clinic and emergency visits in the future. In the Aug. 24, 2001, proposed rule (66 *Fed Reg* 44,672), it asked for public comments regarding national guidelines for hospital coding of emergency and clinic visits. These comments were compiled and presented at the January 2002 APC panel meeting.

CMS was unable to make a final decision based on the comments submitted and has now announced it plans to finalize uniform national facility coding guidelines in the proposed rule for the 2004 OPPS.

These guidelines will help facilities greatly with understanding the difference between physician coding rules and facility coding rules which hospitals have struggled with since the beginning of OPPS.

In addition to E/M facility fees, hospitals must report CPT-4 codes and HCPCS level II codes for all procedures and services provided in the outpatient department setting in order to receive accurate reimbursement from Medicare. ■

CPT and HCPCS codes are required for reporting all of the following outpatient services to ensure additional payment for invasive procedures (injections, infusions, laceration repair to name only a few), radiology, other diagnostic procedures, clinical diagnostic laboratory services, durable medical equipment (DME), orthotic-prosthetic devices, take-home surgical dressings, therapies, preventive services, immunosuppressive drugs identified in the *Medicare Hospital Manual*, section 422.

The *Medicare Hospital Manual*, transmittal 747, revised the applicable coding guidelines that apply as of Aug. 1, 2000.

What to do now:

- ✓ Review the OPPS final rule [67 *Fed Reg* 66,717-67,046 (Nov. 1, 2002)].
- ✓ Create a report showing the number of E/M levels provided over a 12-month period. Develop a graph to show current rate of billing for each of the E/M facility codes (99281-99285 and 99291) and compare with bell-shaped curve.
- ✓ Evaluate your current ED acuity system and determine if your existing system meets CMS requirements to reflect intervention and resource consumption. Make sure that separately billable procedures and services are not used to determine the E/M level of care.
- ✓ Review a sampling of ED records using your current acuity system guidelines to ensure you are able to produce the same E/M level as the coder.
- ✓ Create a charge sheet for the ED to report procedures that are performed separately, i.e., injections, infusion, CPR, intubation, wound repairs, fracture treatment, burn care, etc.)
- ✓ Keep the hospital’s chargemaster up to date and have current chargemaster meetings to help with this process.
- ✓ Provide for an external audit of ED claims to get an “outside” perspective.

In our experience, hospitals can manage the coding and billing requirements for the ED APC reimbursement methodology more effectively by assigning a coder or coders to the ED. Then, give them responsibility for review of the total ED chart to capture all documented, billable services and perform final review of the ED codes billed on each claim using an APC pricer software system.

The software will help identify any edits or other billing errors prior to final billing. The coders should not rely on the acuity form or ED charge sheet alone to code procedures performed in the ED.

With their workstation located in the ED, the coder or coders can readily access staff for documentation improvement needed to code and billing completely and accurately. ■

ED creates homegrown template system

Charts include space for handwritten notes

Unsatisfied with the quality and the cost of the template charting system they were using, emergency department (ED) personnel at the Medical College of Georgia and Children's Medical Center in Augusta went their own way, creating a limited number of broad-based templates. (**For an example of one of their templates, see p. 4.**)

At the top of each template is a large box to allow for handwritten notes. "We allow enough room for people to put in what they need," says **Larry B. Mellick, MS, MD, FAAP, FACEP**, chair and professor of the department of emergency medicine and section chief for pediatric emergency medicine.

"Then you go through your past, medical past, social and family histories, as well as your review of systems — all as check boxes," Mellick says.

The physical examination also is in check-box format, "but then there's a fairly large section at the bottom that allows people to handwrite in additional elements. We find that this allows you to take one of these charts to the bedside and document as you're talking to the patient," he adds.

Once complete, the charts are scanned. "So we do get an electronic format of the chart, and our coders then have the scanned chart for their review," Mellick says.

"Just the actual process of having someone take the chart and look at it carefully before scanning it actually is a very important step — a funnel through which things slow down just enough that there's someone carefully reviewing the 200 charts you do a day," he explains.

Mellick says any facility could take similar steps to create its own template system. "It's just a matter of investing a little time and energy, researching what you need to have documented, and doing it," he says.

"We found that finally when we did it, it was fairly painless, and it's completely under our control. If we don't like something, think we need to add something, or think we need to change the phraseology around, we just go in and do it, and then have another batch printed."

He notes that they probably will make some changes to their templates soon to reflect new documentation guidelines for teaching hospitals from the Centers for Medicare & Medicaid Services.

"We've been very pleased with how we made the

transition from paying a dollar a chart to paying pennies a chart, if less, for these forms," Mellick adds.

"My bias is that a lot of these template charts are way too expensive. Someone's making a lot of money, and if you just went to your business manager and said, 'Go into a room for two days and make up our own templates. . . .'" ■

ED case manager improves physician documentation

Efforts focused on staff, clerks as well

While few hospitals have yet extended their case management system into the emergency department (ED), some have discovered the value of ED case managers in ensuring accurate documentation and coding.

A good case in point is Saint Vincent's Hospital and Medical Center in New York City. **Susanne Greenblatt, RN, MA**, the hospital's ED case manager, and consulting editor for *ED Documentation & Coding Update*, says her focus varies from day to day and sometimes from hour to hour, depending upon what she thinks is most important. However, a primary focus is reimbursement.

Her other immediate concern is to screen ED admissions for appropriateness. That includes reviewing the initial admission diagnosis prepared by the physician.

Greenblatt explains that double-checking the first diagnosis is key "because that is what gets faxed to the insurance company, and then they get into a certain mindset about the patient." And that mindset can have an impact on whether a claim ultimately is denied or reimbursed appropriately.

For example, it's fairly typical for Greenblatt to come across a chart on which the admission diagnosis is listed as "pneumonia. I ask, 'Isn't that the elderly person who is intubated and on a ventilator, on vaso-pressors, going to go to the medical intensive care unit?' I then suggest pneumonia requiring mechanical ventilation adding clinical sepsis, or septic shock, depending on the patient's blood pressure."

Such accuracy is important even at the very beginning, Greenblatt says. "Because if the insurance company gets something faxed that just says 'pneumonia,' they're going to ask why the person didn't go home on oral antibiotics."

Some of it is knowing the semantics, she says. "Any time you use rule-out in a diagnosis, if that disease

process is ruled out, it opens the door for the insurer to say, ‘Oh, you were wrong. We’re not going to pay for the admission.’ Whereas if the doctor changes just one word and uses ‘clinical’ — for instance, ‘clinical sepsis’ — then even if the blood cultures are all negative, if they clinically thought the patient was septic, and they are treating the patient for that, the insurance company will pay.”

Educating physicians about terminology

“So some of that is just learning the terminology that the insurers demand we use in order to be reimbursed for the admission. And doctors certainly aren’t educated about these kinds of things,” she says.

Greenblatt, however, is doing her part to help educate them, through one-on-one interaction as well as at the biweekly meetings of attending physicians.

She notes that the physicians generally are receptive when she suggests that something be documented in a certain way.

These days, physicians often will come to her when they’re unsure how to document something. “They’ll think that the words that they would use might not be correct, and they’ll actually come and say, ‘How do you want me to write this?’ That’s actually how they put it — how do I want them to write it.”

In the Saint Vincent’s ED, on any given shift, there may be up to four attending physicians, four medical or surgical residents, and two interns.

Maintaining proper documentation can be particularly challenging when the ED is especially busy. That’s when Greenblatt is most dependent on physicians taking the initiative to let her know when they’re admitting someone. “And they either tell me what diagnosis they’re going to use, or I ask them how they’re going to word it.”

She notes that the clerks have been very helpful in this area. “When they see a chart that has ‘abdominal pain’ as the admission diagnosis and somehow I didn’t hear about that patient because I’ve been busy doing something else, they’ll call me. Now, they actually think it’s funny: ‘You’re going to love this,’ they say. Or they’ll actually tell the doctor, ‘Susanne’s going to be talking to you about this; don’t you need to write more?’”

Physicians often don’t take credit for all that they do, particular at the beginning stages of a case, Greenblatt points out.

For example, “if someone comes in respiratory arrest, there are many diagnoses that go with that — depending on the length and cause of the condition.” If the physician effectively addresses those problems right away, “then they tend not to use them as diagnoses, because

those problems have already been corrected.”

Greenblatt stresses, not only to physicians but to staff as well, that proper documentation is important to the survival of the organization.

“It benefits everybody to do this right from the beginning. I say to the doctors, ‘You have to care about this because you have to have a hospital to practice in.’ And to the clerks, ‘I want the hospital to get paid so you get paid.’ That makes it a little more personal,” she adds. ■

Scorecard helps measure, document ED performance

Standardizing data presentation was key

Using the balanced scorecard concept, the multidisciplinary Emergency Services Performance Improvement Team at WakeMed health system in Raleigh, NC, was able to standardize the way data were collected and presented. This, in turn, allowed stakeholders at the facility to better understand, analyze, and improve specific processes.

The balanced scorecard concept was developed for business and industry in 1992 by Robert. S. Kaplan and David P. Norton in their book, *Translating Strategy into Action: The Balanced Scorecard* (Harvard Business School Press).

Health care has been slow in jumping on the bandwagon, but that has been changing in recent years as consultants and quality experts look at how a commerce-designed vehicle for performance improvement can translate to hospital management.

Indeed, during a presentation given at the Institute for Healthcare Improvement’s 14th Annual National Forum in Orlando last December, a team from WakeMed including **Janice Frohman**, MS, RN, administrative director for emergency services, discovered that fully one-quarter of their audience had used some type of balanced scorecard.

Essentially, the balanced scorecard is a conceptual framework for translating an organization’s vision into a set of performance indicators distributed among four perspectives:

- financial perspective;
- customer perspective;
- internal business processes perspective;
- learning and growth perspective.

Within each perspective, performance objectives are established that constitute critical success factors in

achieving the organization's mission, vision, and strategy. Each objective, in turn, is supported by at least one measure that indicates how the organization will measure performance against that objective. Selecting and agreeing on indicators in each perspective forces people in the organization to define what is strategically important to them. Most organizations limit the number of indicators to no more than 20.

At WakeMed, the idea of launching an improvement program involving the ED came about because of the issue of patient time in the department.

Staff had made an effective effort to reduce wait times, but an increase in the volume of patients visiting the ED "was making those changes look negligible," Frohman says.

Rather than address the problem solely within the ED, Frohman and her colleagues decided to view it "from a hospital standpoint, to say, 'We believe that improvements within the emergency department involve all the departments within the hospital who are impacted by emergency department patients,'" she says.

This decision led to the creation of the Emergency Services Performance Improvement Team, headed by an operational vice president and including the chief operating officer, medical staff representatives, the ED medical director, ED physicians, Frohman, and others.

The team's external facilitator was A. Blanton Godfrey, PhD, dean of the college of textiles at North

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers given to test their knowledge.

To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the June 2003 issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a certificate of completion.

When your evaluation is received, a certificate will be mailed to you. ■

CE/CME questions

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1. Which of the following is not one of the seven tasks documentation should fulfill, according to David H. Moss, MD, president of Emergency Resources Group and chief developer, AAEM Templates in Milwaukee?
 - A. patient management
 - B. reimbursement
 - C. EMTALA compliance
 - D. medicolegal defense
2. In the emergency department at Saint Vincent's Hospital and Medical Center in New York City, how many attending physicians are on duty during any given shift?
 - A. up to four
 - B. up to five
 - C. up to seven
 - D. up to 10
3. Which of the following is one of the four perspectives within the balanced scorecard?
 - A. sales perspective
 - B. clinical perspective
 - C. legal perspective
 - D. customer perspective
4. According to 2002 OPPS claims data, more than 50% of ED visits were considered "multiple procedure claims" because the claim included services such as diagnostic tests.
 - A. true
 - B. false

Answer Key: 1. C; 2. A; 3. D; 4. A

COMING IN FUTURE MONTHS

■ Documentation-Coding Connection: 2003 OPPS changes, Part two

■ What you need to know about documenting for EMTALA

■ Computerized documentation in the ED

■ More sample forms and templates to help improve documentation in your ED

Carolina State University in Raleigh, an expert in quality improvement who brought the balanced scorecard concept to the team.

The team's first order of business was to standardize how data were presented. It was a difficult process, Frohman notes. "We have a manual of data that's probably 4 inches thick. That was where we started. Basically, what we found was that we had way too much data, and the data weren't necessarily meaningful. That led us to say, 'OK, wait a second. We've got to put this in a meaningful format so that we can begin to look at where the changes need to be, or if changes need to be made.' You can't look at that much data."

Frohman says she is convinced that, had the team not come up with some standard to use, "we would have continued to beat each other with data that weren't meaningful and weren't helping us move forward in the process."

Godfrey's initial presentation to the team regarding the balanced scorecard led in part to some significant changes. These included "the understanding of these different indicators and what they meant and the questions that arose from the information presented on the scorecard, which gave us the ability to do a better job to make decisions that ultimately would help show some performance improvement," Frohman says.

Under the four primary quadrants of the balanced scorecard, the team chose indicators specific to WakeMed and began the process of standardizing graphs. "For all of our indicators, we keep a 12-month rolling graph. Some people have difficulty interpreting graphs; therefore, a data sheet is attached to all the graphs, which makes it very clear where the information comes from and what it means. About 20 different parameters have to be attached to each graph." Having graphs standardized, right down to the designated color of trend lines (black) and average lines (red), "certainly makes it a whole lot easier for everybody to understand any graphed information over the course of time."

"When you see trend lines over the course of time, you're going to see something meaningful," she adds. "What people are really looking at is not the month-to-month changes but certainly the trends over time and progress toward the target or goal."

Frohman says one of the team's greatest successes has been developing a process that helps people in the organization understand the data presented to them. Without such a process, "everybody pulls out of graphs or data what they want, depending on their perspective," she says. The process also has helped winnow out useless data that serve more to overwhelm than enlighten.

Frohman says the process has been a learning

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experience for her. "I'm thrilled that we're standardizing data displays and making it easier for people to understand. Because we have challenges every day, there needs to be an organized approach to address whatever challenge happens to come up. I think this certainly has put us on the road to making some important changes." ■

CE/CME objectives

After reading this month's issue of *ED Documentation and Coding Update*, the CE/CME participant should be able to do the following:

1. List documentation techniques that can be used for reducing claims denials and ensuring proper reimbursement.
2. Describe the latest legal and regulatory developments affecting your documentation and/or coding responsibilities.
3. Cite sample forms and templates that can be used to improve or facilitate emergency department documentation.
4. Measure, document, and analyze clinical and financial outcomes in the emergency department. ■