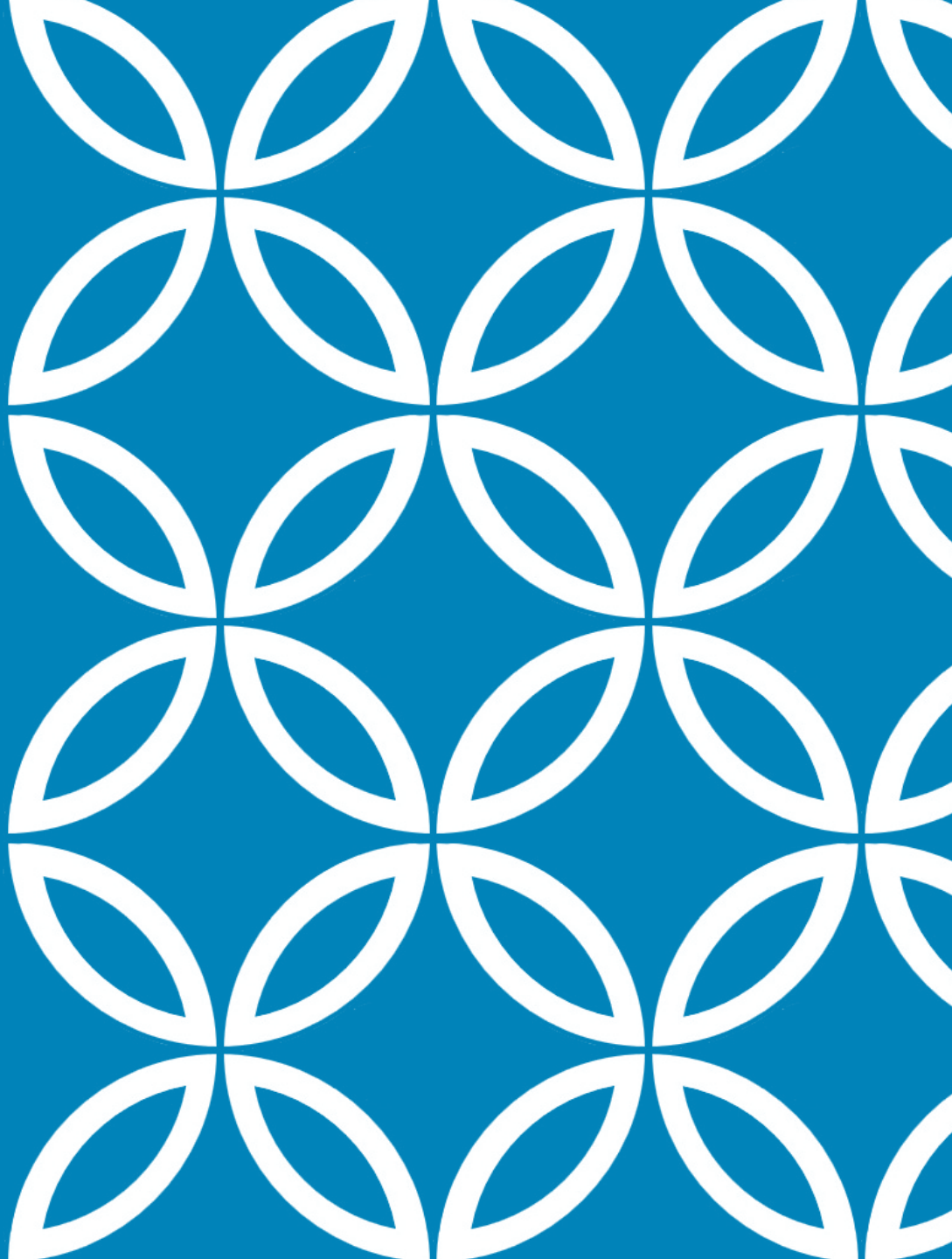
EMERGENCY DEPARTMENT EFFICIENCIES:

Quality and Finance Working Together

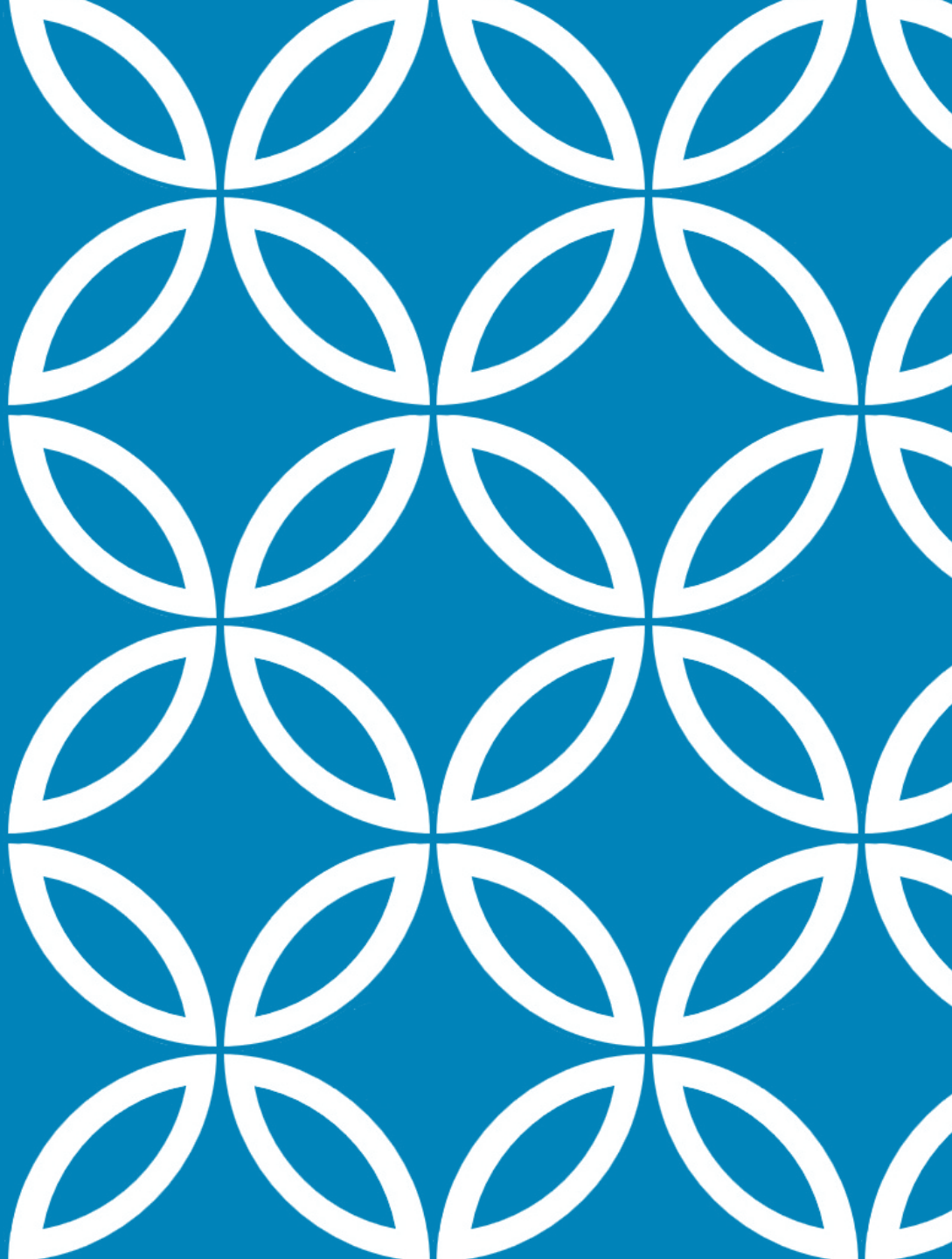


ED PROCESS BARRIERS

What do you consider to be barriers to efficiency in your Emergency Department

- Patient
- Family
- Staff
- Facility

ENGAGING PATIENT, FAMILY AND COMMUNITY



PATIENT AND FAMILY ENGAGEMENT CAN LEAD TO….

- Improved clinical outcomes
- Better health
- Increased **satisfaction** and **engagement** among **health care workers**
- Enhanced financial performance

IMPROVED PATIENT EXPERIENCES OF CARE

Patient and family engagement offers a promising pathway:

- better quality health care
- more efficient care
- better patient and employee satisfaction
- improved population health

HOSPITAL WEBSITE TOP 10 THINGS PATIENTS WANT TO SEE

1. Detailed list of services and price list
2. Booking an appointment
3. Online chat
4. The emergency call
5. Interactive map
6. Blog
7. Information about the practitioners
8. Description of hospital's departments
9. Feedback form
10. Interactive advanced search to help find the necessary information

DISCHARGE INSTRUCTIONS

40-80 percent of medical information provided by healthcare practitioners is forgotten immediately

The greater amount of information presented, the lower proportion correctly recalled

Almost half of information that is remembered is incorrect

PATIENT AND FAMILY CENTERED CARE

Waiting room	Forms (Admission paperwork, billing statements, privacy)	Signage
Privacy	White boards	Discharge paperwork (Transfer forms/ instructions)

COMMUNITY ENGAGEMENT

- CEO Corner
- Website information
- Press release
- Open house
- Education
- Local physician publication partnership
- Lunch/Walk with a doctor topic
- Nurse/provider visit senior center lunch

PATIENT SATISFACTION

How many measure in the ED?

- Vendor
- Self

What do you measure?

PATIENT SATISFACTION

Literature search using ED Patient Satisfaction identified 100s of publications

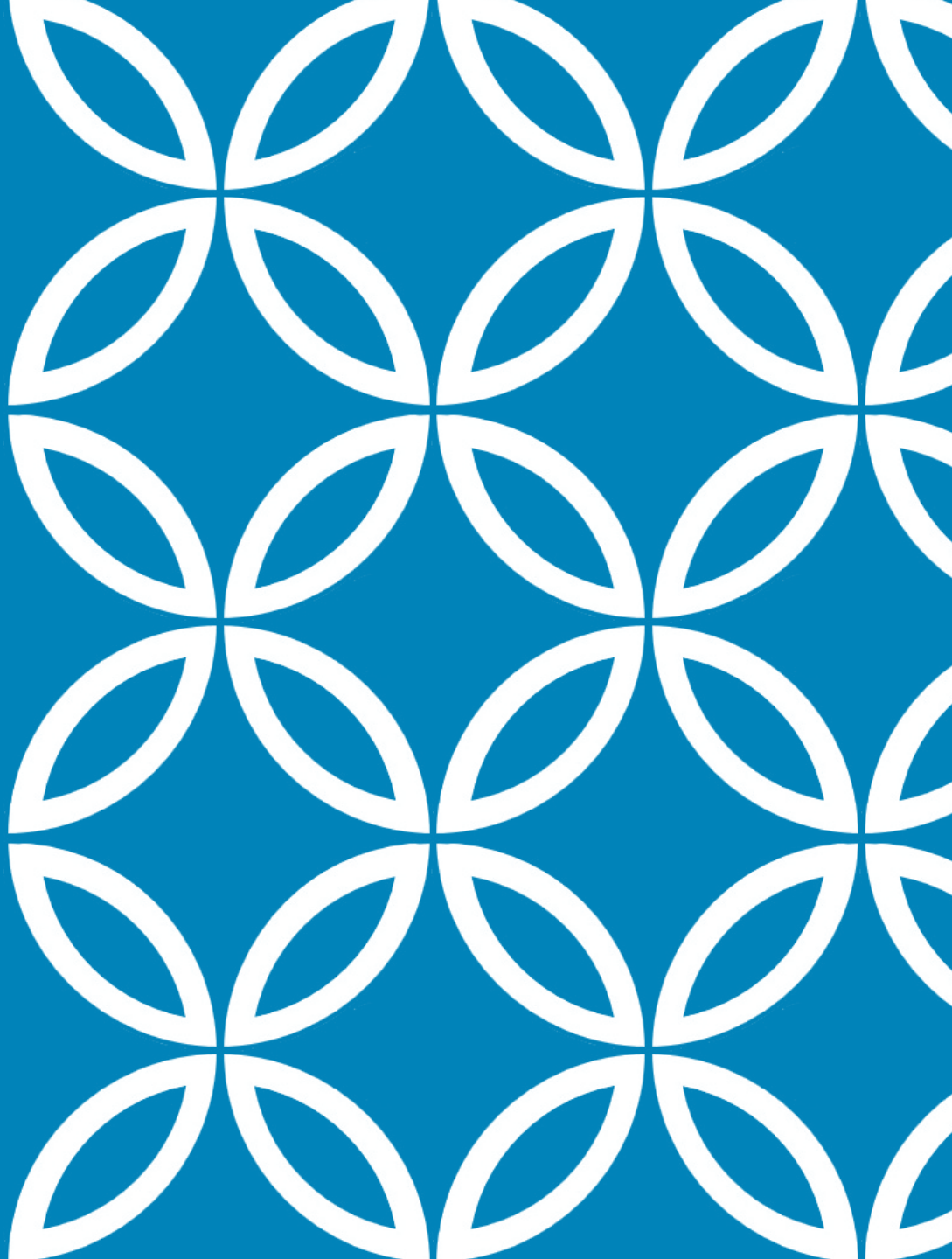
Most commonly identified items which influenced the ED experience:

- Communication
- Wait times
- Staff empathy/Compassion

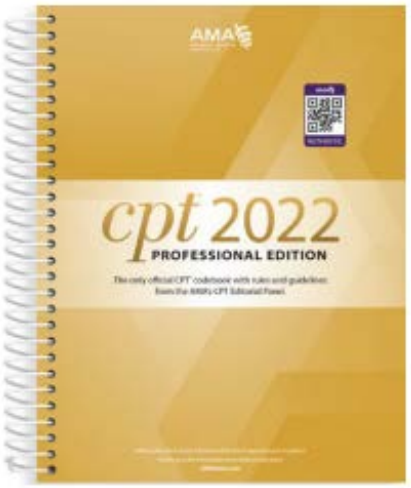
EMERGENCY DEPARTMENT CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (ED CAHPS) SURVEY

- Development started 2012 (ED Pt Exp of Care [EDPEC] Survey)
- Trademarked to CMS CAHPS survey in March 2020
- Mixed modes of email web link, phone, or mail can be used for distribution, notification, or collection
- Survey asks 35 questions to patients about experiences arriving, during care, and discharge – only 'home' dismissals
- Surveys provide patient experience data that enables comparison of EDs across nation and promotes effective communication and coordination

REVENUE CYCLE AND THE EMERGENCY DEPARTMENT



EMERGENCY DEPARTMENT FACILITY CHARGING



Hospitals charge for the "technical" component for all costs that it took to provide the ED visit and for all staff that it took to perform all interventions and services from the time the patient presents to the ED until they are discharged or admitted. Physicians charge for the "professional" component.

99281– Emergency department visit for evaluation and management of a patient, which requires 3 key components. Presenting problems are self-limited or minor.

99282 – Emergency department visit for evaluation and management of a patient, which requires 3 key components. Presenting problems are of low to moderate severity.

99283 – Emergency department visit for the evaluation and management of a patient, which requires 3 key components. Presenting problems are of moderate severity.

99284 – Emergency department visit for the evaluation and management of a patient, which requires 3 key components. Presenting problems are of high severity and require urgent evaluation, but do not pose an immediate significant threat to life or physiologic function.

99285 – Emergency department visit for the evaluation of management of a patient, which requires 3 key components. Presenting problems are of high severity and pose an immediate significant threat to life of physiologic function.

FACILITY E&M CODE ASSIGNMENT IN ED

Centers for Medicare & Medicaid Services (CMS) April 2000 Outpatient Prospective Payment System (OPPS) Final Rule (page 18451)

- While these CPT codes appropriately represent different levels of physician effort, they do not adequately describe non-physician resources. However, in the same way that each CPT code represents a different degree of physician effort, the same concept can be applied to each code in terms of the differences in resource utilization.
- CMS would not expect to see an exact degree of correlation between the CPT code reported by the physician and that reported by the facility.

FACILITY E&M CODE ASSIGNMENT IN ED

Centers for Medicare & Medicaid Services (CMS) April 2000 Outpatient Prospective Payment System (OPPS) Final Rule (page 18451)

- Therefore, CMS instructed facilities to develop internal guidelines and a system for mapping the provided services furnished in the ED to the different levels of effort represented by the codes.
- CMS will hold each facility accountable for following its own system for assigning the different levels of CPT codes. As long as the services furnished are documents and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of CPT codes, CMS will assume the facility is in compliance.

FACILITY E&M CODE ASSIGNMENT IN ED

In the 2008 OPPS Final Rule (page 66805), CMS finalized some guidelines for Hospital E&M code assignment, which include:

- The coding guidelines should follow the intent of the CPT code description to reasonably relate to the intensity of hospital resources
- The coding guidelines should be based on hospital facility resources, not based on physician resources.
- The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits and be written or recorded, well-documented, and provide the basis for the selection of the specific code.
- Should not promote "upcoding."
- The coding guidelines should be readily available for Medicare Administrative Contractor (MAC) review.

FACILITY E&M CODE ASSIGNMENT IN ED

Samples of E&M acuity mapping tools for hospitals

- Typically based on number and types of interventions
  - ED Matrix Tool within the Hospital's electronic health record
  - ED Acuity Sheet based on points assigned for each service or intervention

- Do you know what your facility uses?
- Could you produce your mapping tool in the event of an audit by Medicare or some other payer?
- Does your EHR clearly document:
  - The number and type of interventions used
  - Patient signs/symptoms to support medical necessity

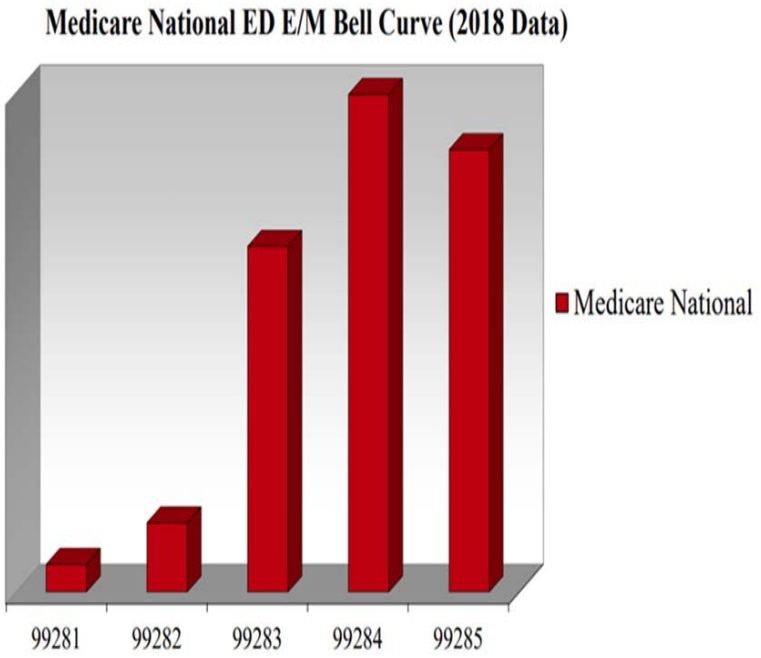
An individual hospital's ER level distribution does not have to be a bell curve, but it would be expected to be a reasonable graph that fits with the acuity of the facility's ER patients and services:

- Teaching hospital in large metro area
- Primary hospital in urban area
- One of many hospitals in metro area
- Rural hospital
- Presence of close urgent care centers

CMS states they would expect that a small community hospital might provide a greater percentage of low-level services than high-level services, while an academic medical center or trauma center might provide a greater percentage of high- level services.

Review claims for "reasonableness"

- An ED visit for a minor respiratory infection versus a visit for a broken bone or a possible heart attack



INTERNAL AUDITS OF **E&M CODE ASSIGNMENT IN ED**

INTERNAL AUDIT CONTROLS

Monitor contracts with insurance companies

- Be aware of audit provisions within each health plan including timelines for claims reviews and appeals

Periodically review E&M mapping system

- Ensure changes made to hospital chargemaster are accurately reflected
- Ensure changes with Medicare regulations and CPT code changes are updated

Audit medical record

- Ensure documentation exists to support level of E&M charged and services rendered

EXTERNAL REVIEWS OF **E&M CODE ASSIGNMENT**

Guidelines and auditing tools vary, payer to payer

- Traditional Medicare
  - Targeted Probe and Educate Audits, OIG Audits
- Medicare Advantage plans (UnitedHealthcare, Humana, Aetna, etc.)
  - May use own proprietary software to review claims (such as Optum)
- Medicaid fee-for-service
- Commercial payers (UnitedHealthcare, Blue Cross, Anthem, etc.)
  - May use own proprietary software to review claims (such as Optum)

Payers have claims data from hospitals to identify abnormalities among types
of hospitals, regions, etc.

CHALLENGES OF EMERGENCY DEPARTMENT COLLECTIONS

Point of service collections in the ED can be challenging…..

- Must follow EMTALA guidelines
- More patients on high deductible health plans (increase in patient out of pocket liability)
- More health plans reviewing ER visits (decrease in expected reimbursement)
  - Reduce level of E&M billed
  - Deny coverage as non-emergent
- Evolution of health "benefit" plans that are NOT health "insurance" plans (i.e. Christian Health Ministries)

CHALLENGES OF EMERGENCY DEPARTMENT COLLECTIONS

Point of service collections in the ED can be challenging…..

- Lack of accurate or complete patient and insurance information during the registration process, especially in trauma cases
- Uninsured adults more likely to visit ER (no other place to go)
- CDC report on ER use among adults aged 18-64 from 2012 https://www.cdc.gov/nchs/data/nhis/earlyrelease/emergency_room_use_january-june_2011.pdf
- Updated Kaiser Family Foundation report from 2020 https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

TIPS TO IMPROVE ED COLLECTIONS

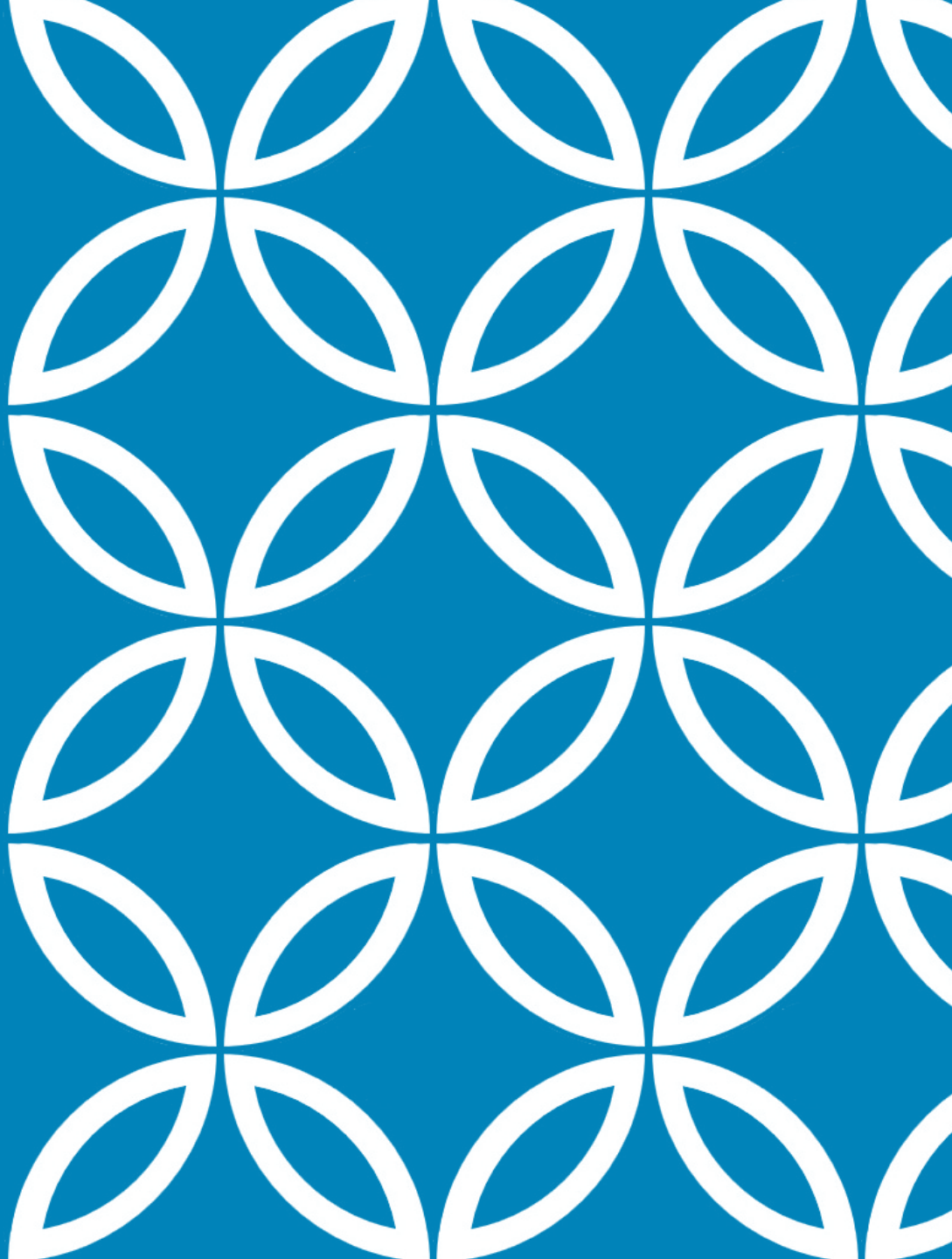
Engage patients early and provide transparency

- Provide flyers and post notices that explain billing procedures, who to contact with questions, and information about payment and financing options
- Provide multiple ways to pay bills

Use technology to give patients more payment and financing options

- Determine ED co-pay and request payment at discharge
- Set up a designated “checkout office” or process after treatment
- Use electronic payment estimation tools from payers and third-party vendors
- Create an online portal for patients to make payments

LEAN THINKING IN THE EMERGENCY DEPARTMENT

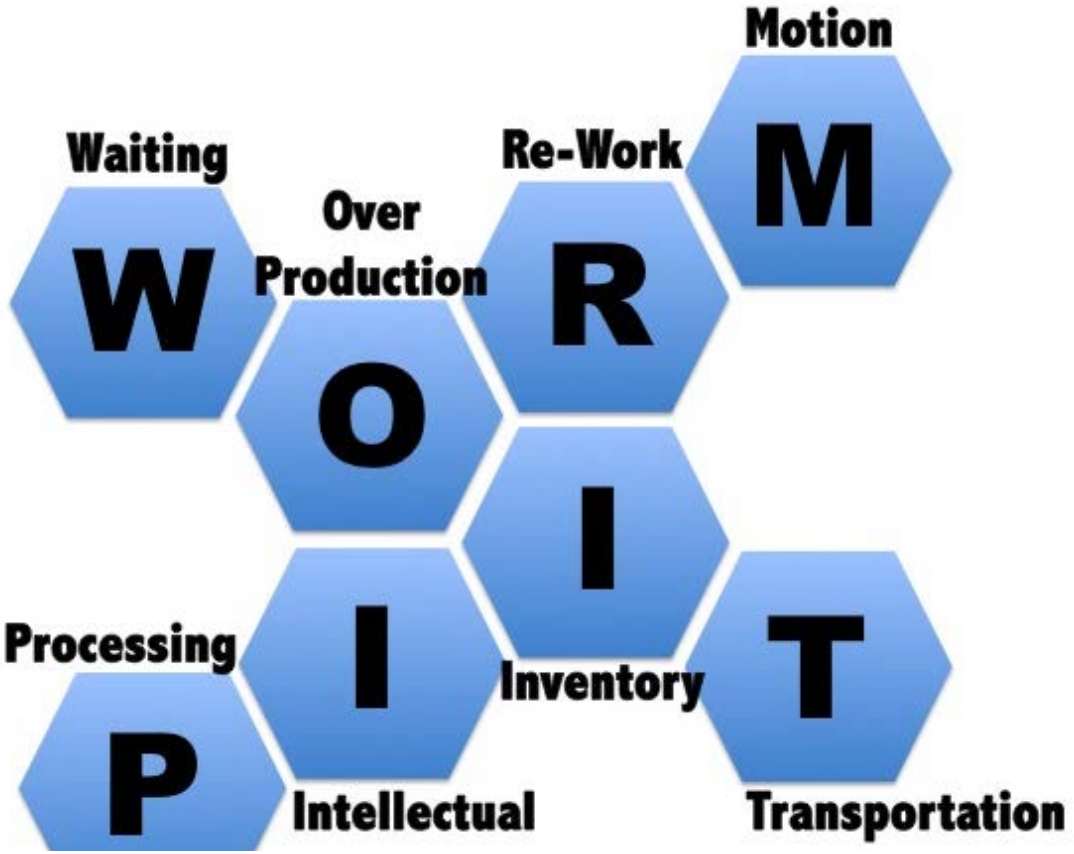


WHAT IS LEAN?

Lean is a philosophy, mindset and set of tools focused on delivering value to customers/ patients through elimination of waste in business process

Two founding concepts of Lean:

- Increase process efficiency by consistently and thoroughly eliminating waste and
- Respect humanity by developing every worker to his or her full ability



SEVEN (EIGHT) WASTES - WORMPIT

Waiting

Over-Production

Rework/Defects

Motion

Processing (excess)

Inventory/Intellectual

Transportation

Not Clear (Confusion)

OBSERVATION

What it is…….

- In person
- First-hand
- One at a time
- Capture what ‘is’
- Recording of actual happenings

What it is not…….

- Monitoring
- Following
- Interviewing
- Watching
- Self-performed

Title:	Fresh Eyes:	Team:	Start Date:
Owner:	SME:		Revision Date:

PLAN

1. Problem Statement or Need

2. Current Situation/State

3. Goal Statement - Target State

4. Analysis / Root Cause (5 Whys)

PLAN

5. Brainstorm/Countermeasures

DO

6. Countermeasures Implementation Plan (Who, What, When)

STUDY

7. Study (Planned vs. Actual Results)

ACT/ADJUST

8. Update Standard Work

Notes:

A3 PROBLEM SOLVING

There is no "magic" in the steps of A3 Problem Solving. The steps are basically:

1. Identify problem or need
2. Understand current situation/state
3. Develop goal statement – develop target state
4. Perform root cause analysis (5 whys)
5. Brainstorm/determine countermeasures
6. Create a countermeasures implementation plan
7. Study results – confirm effect
8. Update standard work

A3 PROBLEM SOLVING

Steps follow the Deming Plan-Do-Study-Act (PDSA) cycle:

- Steps 1 through 5 = the "Plan"
- Step 6 = the "Do"
- Step 7 = the "Study"
- Step 8 = the "Act"

REGISTRATION

Several Lean projects have covered registration for ED

- After hours
- Only nursing staff available
- Obtain information for a temp registration
- Patient over computer
- Observe the current process

CURRENT PROCESS REVIEWS

- Admission Paperwork – providing what is needed for all parties
- Evidence based protocols – utilization
- Billing – insurance and private pay
- Coding – timing and accuracy
- Discharge Paperwork – understandable to a 3rd grade student

LEAN PROCESS ED TEAM

- Team leader (often QI coordinator/manager)
- Nurse leader
- Front line staff – nurses and aides
- Physician champion
- Business office staff
- Registration
- Unit coordinator
- Health information management representative
- Information technology representative

LEAN PROCESS ED TEAM

Quality Improvement teams should include:

- Clinical leadership
- Technical expertise
- Day-to-day staff
- Project sponsorship

Team should consist of 5-8 individuals

LEAN PROCESS ED TEAM

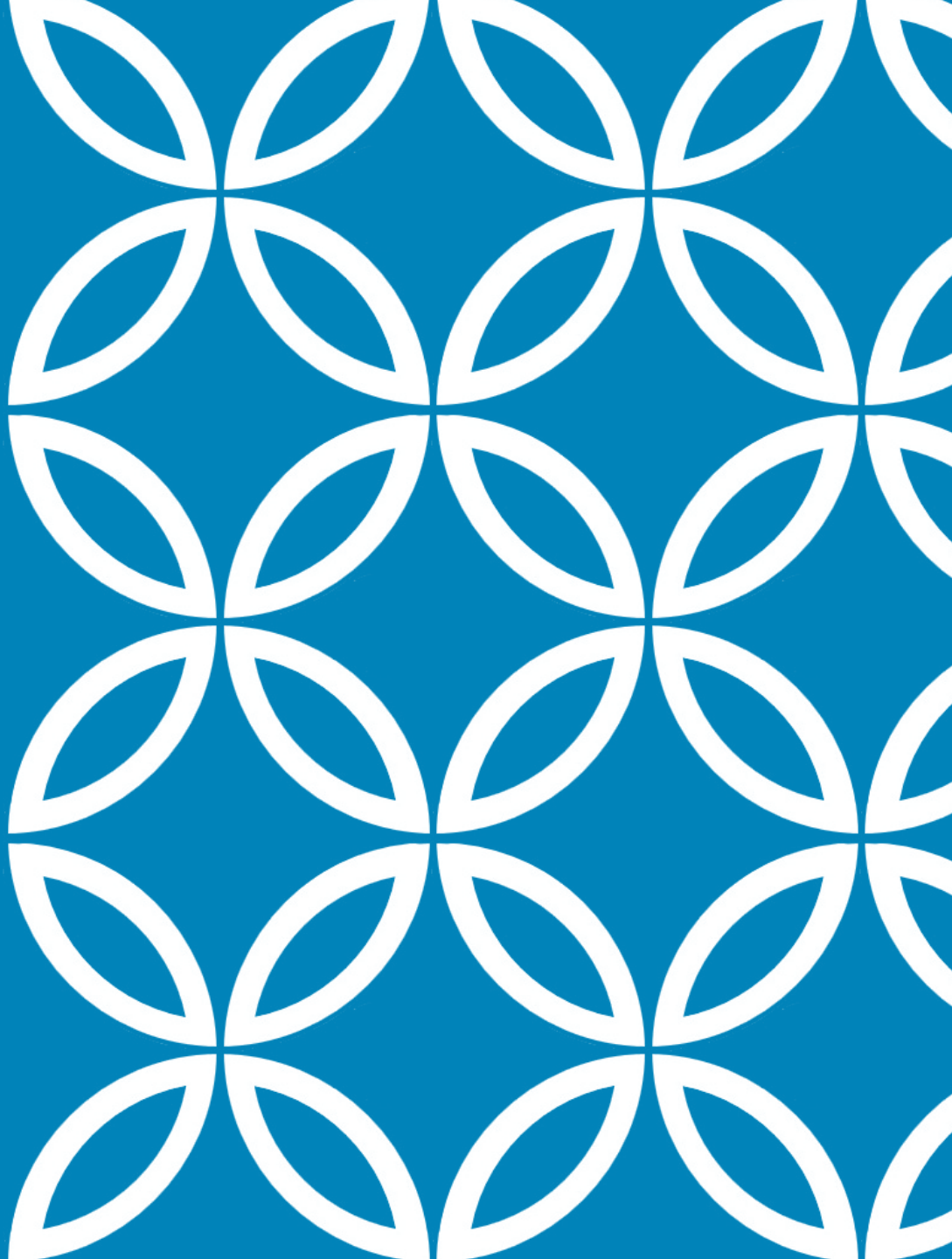
Show them the data

Identify realistic timeframe

Share how this aligns with other health care efforts:

- Continuity of care
- Reduction of errors
- Improved outcomes
- Increased patient and family satisfaction
- Increased employee satisfaction
- Increased reimbursement

QUALITY REPORTING IN THE EMERGENCY DEPARTMENT



QUALITY DATA FROM THE ED

- MBQIP Patient Safety and Outpatient Quality Report: Improving Care Through Patient Safety and Outpatient Measures
- MBQIP EDTC Report
- ED Patient Satisfaction?
- Other?

Hospital-Level Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report

Quarter 2 - 2021

Generated on 12/15/21

	AMI Cardiac Care Measures	Your Hospital's Performance by Quarter				State Current Quarter			National Current Quarter		Bench-mark
		Q3 2020	Q4 2020	Q1 2021	Q2 2021	# CAHs Reporting	Median Time/ Overall Rate	90th Percentile	# CAHs Reporting	Median Time/ Overall Rate	Median Time/ Overall Rate
OP-2	Fibrinolytic Therapy Received within 30 Minutes of ED Arrival	N/A†	*	0%	*	72	37%	100%	971	51%	100%
	Number of Patients (N)	N/A	*	N=1	*						
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention	N/A†	*	*	*	72	77 min	9 min	971	67 min	33 min
	Number of Patients (N)	N/A	*	*	*						

	Emergency Department – Quarterly Measure	Your Hospital's Performance by Quarter				State Current Quarter			National Current Quarter		Bench-mark
		Q3 2020	Q4 2020	Q1 2021	Q2 2021	# CAHs Reporting	Median Time	90th Percentile	# CAHs Reporting	Median Time	Median Time
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	N/A	122 min	133 min	130 min	75	106 min	77 min	1,017	111 min	79 min
	Number of Patients (N)	N/A	N=60	N=58	N=61						

"*" indicates that the CAH either:

- Reported a population of 0, meaning there were no patients that met the patient population, or
- Submitted eligible cases that were accepted to the CMS Clinical Warehouse, but those cases were excluded for the measure.

"N/A" indicates that a CAH either:

- Did not submit any measure data, or
- Submitted data that was rejected/not accepted into the CMS Clinical Warehouse.

"†" indicates the measure may not accurately reflect the true value of the data. Due to a lapse in access to population and sampling data prior to Q4 2020, it could not be determined whether a CAH submitted that they had no eligible patients in the measure population or chose not to submit data.
"#" indicates that the CAH did not have a signed MOU at the time of reporting for this time period.

Hospital-Level Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report

Quarter 2 - 2021

Generated on 12/15/21

		Your Hospital's Performance by Calendar Year			State Current Year			National Current Year		Bench-mark
	Emergency Department – Annual Measure	CY 2018	CY 2019	CY 2020	# CAHs Reporting	CAH Overall Rate	90th Percentile	# CAHs Reporting	CAH Overall Rate	CAH Overall Rate
OP-22	Patient Left Without Being Seen	0%	0%	N/A	46	0%	0%	789	1%	0%
	Number of Patients (N)	N=804	N=851	N/A						

		Your Hospital's Reported Adherence Percentage			State Current Flu Season			National Current Flu Season		Bench-mark
	NHSN Immunization Measure	4Q18 - 1Q19	4Q19 - 1Q20	4Q20 - 1Q21	# CAHs Reporting	CAH Overall Rate	90th Percentile	# CAHs Reporting	CAH Overall Rate	CAH Overall Rate
HCP/IMM-3	Healthcare Provider Influenza Vaccination	85%	85%	80%	55	87%	99%	903	87%	100%

"N/A" indicates that the CAH did not submit any data for this measure.
"#" indicates that the CAH did not have a signed MOU at the time of reporting for this time period.

Hospital-Level Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report

Quarter 2 - 2021

Generated on 12/15/21

	Your Hospital's Performance by Survey Year		State Percentage for Current Survey Year		National Percentage for Current Survey Year		Benchmark
Antibiotic Stewardship Measure – CDC Core Elements	Survey Year 2019	Survey Year 2020	# CAHs Reporting	% of CAHs Meeting Element	# CAHs Reporting	% of CAHs Meeting Element	% of CAHs Meeting Element
Number of Elements Met	7	6	75	69%	1,118	83%	100%
Element 1: Leadership	Y	Y	75	100%	1,118	99%	100%
Element 2: Accountability	Y	Y	75	89%	1,118	97%	100%
Element 3: Drug Expertise	Y	Y	75	84%	1,118	95%	100%
Element 4: Action	Y	Y	75	96%	1,118	98%	100%
Element 5: Tracking	Y	N	75	92%	1,118	97%	100%
Element 6: Reporting	Y	Y	75	85%	1,118	92%	100%
Element 7: Education	Y	Y	75	85%	1,118	91%	100%

"N/A" indicates that the CAH did not submit any data for this measure.

"#" indicates that the CAH did not have a signed MOU at the time of reporting for this time period.

Hospital-Level Care Transition Core Measures/EDTC Report

Quarter 3 - 2021

Generated on 12/14/21

		Your Hospital's Performance by Quarter					State Current Quarter			National Current Quarter		Bench-mark
	MBQIP Quality Measure	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Aggregate for All Four Quarters	# CAHs Report-ing	Average Current Quarter	90th Per-centile	# CAHs Report-ing	Average Current Quarter	Average Current Quarter
EDTC-All	Composite	92%	75%	100%	80%	89%	80	81%	100%	1,200	90%	100%
	Home Medications	92%	100%	100%	80%	93%	80	91%	100%	1,200	94%	100%
	Allergies and/or Reactions	100%	100%	100%	100%	100%	80	95%	100%	1,200	96%	100%
	Medications Administered in ED	92%	100%	100%	100%	96%	80	95%	100%	1,200	96%	100%
	ED Provider Note	92%	75%	100%	100%	93%	80	89%	100%	1,200	94%	100%
	Mental Status/Orientation Assessment	100%	100%	100%	100%	100%	80	94%	100%	1,200	95%	100%
	Reason for Transfer and/or Plan of Care	100%	100%	100%	100%	100%	80	95%	100%	1,200	97%	100%
	Tests and/or Procedures Performed	100%	100%	100%	100%	100%	80	93%	100%	1,200	96%	100%
	Tests and/or Procedures Results	92%	100%	100%	100%	96%	80	91%	100%	1,200	96%	100%
	Total Medical Records Reviewed (N)	N=13	N=4	N=5	N=5	N=27	N=2,212			N=50,830		

"N/A" indicates that the CAH did not submit any data.

# indicates that the CAH did not have a signed MOU at the time of reporting for this period.

NEXT STEPS

QUALITY IMPROVEMENT

95 percent of time and attention to QI and process improvement activities is given to monitoring stage of process

Little attention is paid to evaluating data and determining process improvements

Most important component of QI is sharing data and discussing ways to improve results

Positive systems outcome in any process depends on measuring, analyzing data, and then educating staff

TAKE ACTION – AGAINST THE BARRIERS IDENTIFIED

Review EMTALA practices

- Audit a few records for documentation
- Processes strong or need refresh?

Patient and Family Engagement focus

- Walk around ED
  - Check signage
  - White boards complete w/ information understandable to patients
- Review discharge instructions for clarity

Finance overview

- Check for a facility E&M Level Assignment policy/procedure
- Audit a few records for consistency w/ policy

Lean processes

- Review registration process
- Talk with the business office about what it takes to 'clean up' registrations

Quality data

- Talk with quality management about all data reported out of ED
- Low hanging fruit for improvement

OREGON OFFICE of RURAL HEALTH

Runyan Health Care Quality Consulting

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