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The Abaris Group

The TAG Line

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Practical Guidelines for Improving ED Physician Productivity

Part 1 of 2-part Series

By James J. Augustine, M.D., FACEP

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In the first of a two-part series, Dr. Augustine offers physicians some advice on improving their productivity in the ED.

A successful ED moves a patient in and out of the department with ease and efficiency. The staff – physicians, nurses and administration – are crucial players in this process, and developing a set of best practices for ED physicians can ultimately improve patient flow.

Step 1: Organize Yourself and Your Work

Bring your meal with you. After almost 20 years in practice, I still pack a sandwich for every shift and eat in the ED. Hypoglycemia does not serve you well, and 30 minute lunches in the cafeteria are deadly.

You are the captain of the ship; prevent others from hitting the rocks.

Work hard early in the shift, setting the tone for the rest of the day. Physicians can generally walk in and see 5 to 10 patients in the first hour, as long as the outgoing physician is going to disposition almost all of his/her patients. You can see additional patients if one or more of the nurses will go along with you, carrying the charts and scribing your orders and important notes.

Step 2: Organize the ED to Work Effectively

You are the captain of the ship; prevent others from hitting the rocks. Where possible, position yourself near a place where the patients and their charts enter the ED. Keep the entire department functioning, not just at the patient in front of you.

Evaluate the patients as they enter and briefly review the chart as it is placed in the "to be seen" area. This allows the physician to perform secondary triage and also get some labs and x-rays ordered quickly.

(Continued on page 2)

The Abaris Group *announces*

Five-Part Series on Improving ED and Trauma Services

The Abaris Group will be presenting a five-part Webinar series throughout the year designed to assist emergency, trauma and other healthcare providers with effective strategies to use in hospital and out-of-hospital environments. Led by experts in the field, the Webinars provide participants with tools and tactics to use in the everyday healthcare setting.

More information on each Webinar will be announced prior to the scheduled date. If you are interested in participating in the Webinars or would like further information about the series, please email webinars@abarisgroup.com or visit abarisgroup.com.

Five-Part Series Timeline

Enhancing Revenue for Trauma Centers
March 2, 2005

Revisiting ED Nursing Ratios
May 4, 2005

Implementing New Product Lines in the ED
July 12, 2005

Enhancing Medical Staff Coverage for the ED and Trauma Center
September 7, 2005

Developing New ED Revenue
November 2, 2005

Practical Guidelines for Improving ED Physician Productivity, *continued*

(Continued from page 1)

Some physicians carry a log of patients seen. This allows them to have a name, complaint and age if the physician calls and the chart is not available. It also organizes your day with other notes, and keeps your list of active patients, undone dictations and important lab values.

Know where all the equipment and supplies are in the ED. This includes every important piece of equipment (intubation kits, Doppler monitor, hemoccult cards and developer) to the medications and disposables. In the case of an event, you will know where this important equipment is, you will be less reliant on others, and you will know when there is a need to restock.

In most EDs, the unit clerk is your best friend. A unit clerk makes you efficient, picks up things you missed ("Doctor, did you mean to do a chest x-ray on that chest pain patient?"), organizes phone calls and doesn't forget them, and knows the nuances of how to contact medical staff, particularly on evening and night shifts. Kiss the feet of a good unit clerk routinely.

Delegate as much as possible and encourage nursing initiatives that help you move patients through the ED. Nurses should work ahead of you and have the patient and the equipment prepared. In return, you should be very consistent in your approach to them and the patients, and thank them for everything they do.

Try to implement a greeting and bedside registration process. This gets the patient to you faster and allows you to plug the patient into the evaluation and treatment process very quickly. Encourage the greeting (or triage) staff to ask you about ordering tests, even if you will not ultimately be seeing the patient. If that staff will ask the doctor first ("Do you want a foot or ankle x-ray on this injured person?"), the right test will get done, and when the EDP sees the patient, the right diagnostics will be completed.

Decisiveness is a key issue in managing patient flow.

Decisiveness is a key issue in managing patient flow. As a practical goal: no serial testing. After five minutes with the patient, initiate lab or x-ray studies that are indicated. You can always add unusual labs or x-rays if you discover something later, and have the consulting physician follow those results. Treat the patient in your first group of orders. The patient came for treatment and you cannot do disposition until some treatment is rendered. Don't wait for diagnostics to order and give treatment.

Remember to multitask. Begin discharge papers or initiate computerized orders during downtime. Oftentimes, you are able to generate specific discharge instructions based on your years of clinical experience before ever having the lab and x-ray results available (e.g., ankle sprain or back injury).

Review the patients you are responsible for and determine what the outstanding items that are preventing disposition. Use a concept called the "minimum data set" or "what is the minimum information required to make a presentation to an attending physician for the patient that I know needs to be admitted?"

The patient perceives you are spending more time with them if you sit down. Place a stool in every room, mark it "Doctor," and use it for most of your patient interactions. It will improve your patient satisfaction.

Vary your practice style with the situation. When it is busy enough:

- Forego optional tests when they will not determine immediate admission, or set tests up for outpatient visit (e.g., MRI, US gallbladder).
- When it is clear the patient will need admission, pull the trigger with the admitting physician and explain that the ED is in marginal status.
- Consultants want a precise presentation. Give them that version.
- Have your turbocharger available, if only for 60 minutes.

In part two of this article, Dr. Augustine will share with The TAG Line readers three additional steps to strive toward in everyday productivity. Look for this helpful information in Issue 2, March-April.

Tsunami Calls for Emergency Relief

The December 26, 2004, South Asian tsunami shattered the lives of thousands living and visiting the eleven countries surrounding the Indian Ocean. A recent *Washington Post* article (Jan. 27, 2005) reported that at least 12 countries provided military support operations and about 100 U.N. agencies and private humanitarian groups issued relief efforts to these areas. Throughout the recovery process, the international emergency response community has joined together in rebuilding the stricken areas.

Individuals and businesses throughout the world are collecting cash donations to provide the needed aid to rebuild these countries. According to the Red Cross, approximately $1.2 billion has been given or pledged by donors to Red Cross and Red Crescent national societies around the world (Jan. 26, 2005).

For more information and updates on the tsunami relief, and to make a contribution, visit the Red Cross Web site at www.redcross.org.

Ambulance Units Face Increase in Training Hours

Proposed national EMS standards could more than double the amount of training emergency medical technicians (EMTs) must have, from 110 hours to about 240 hours.

The proposed standards introduce a challenge to rural ambulance providers, where most EMTs are volunteers. Rural areas fear that increased requirement hours will deter new recruits and drive experienced EMTs to quit (*Associated Press*, Dec. 28, 2004).

Although the proposal is facing opposition, the changes are designed to give EMTs the training they need to treat conditions generally encountered at an emergency site, such as epinephrine, a form of adrenaline given to people suffering severe allergic reactions.

The proposed standards are part of the National EMS Scope of Practice Model, being developed jointly by the National Association of State EMS Directors (NASEMSD) and the National Council of State EMS Training Coordinators (NCSEMSTC) under contract with the National Highway Traffic Safety Administration (NHTSA). The Model defines the national levels of EMS providers and the range of skills at each level. As the foundation for state licensure, the Model promotes consistent levels of certification throughout the U.S., and defines national entry-level requirements and outer limits for practice.

A final draft of the Model is due later this year and changes will not take place until 2006. Comments and suggestions for improvements to the draft Model were accepted during January. For further information and updates, visit www.emsscopeofpractice.org.

Air Ambulance Average Rates

The Abaris Group recently conducted a West Coast survey to determine average air ambulance rates. The following information provides the average BLS base rate and mileage rate, and 20-mile transport estimates. Also provided are the air ambulance cost comparisons for more details.

Air Ambulance Average Rates

Statistic	ALS Base Rate	Mileage Rate	Other Fees	20-Mile Transport Estimate
Average	$5,292	$89	$264	$7,281
Max	$7,500	$120	$902	$9,480
Min	$3,250	$48	$40	$4,450

Source: The Abaris Group Survey, 2004-2005

Air Ambulance Provider Cost Comparison

Air Ambulance Provider	State	ALS Base Rate	Mileage Rate	Other Fees
A	CA	$5,821	$118	
B	CA	$4,150	$86	Yes
C	CA	$4,790	$79	Yes
D	CA	$6,336	$48	
E	CA	$5,100	$115	Yes
F	CA	$5,100	$115	
G	CA	$5,830	$118	Yes
H	CA	$4,440	$56	Yes
I	CA	$6,950	$89	Yes
J	CA	$3,960	$79	
K	CA	$4,950	$120	
L	CA	$5,830	$118	Yes
M	CA	$3,250	$50	Yes
N	CA	$7,500	$89	Yes
O	AZ	$5,830	$118	Yes
P	AZ	$4,790	$79	Yes
Q	NM	$4,184	$55	
R	CO	$6,451	$79	

Source: The Abaris Group Survey, 2004-2005

Mental Health Patients and the Emergency Room

Throughout the country, emergency rooms are facing increased visits from mental health patients. According to a survey conducted last year by mental health organizations and the American College of Emergency Physicians (ACEP), 6 in 10 emergency physicians surveyed reported that an increase in psychiatric patients is negatively affecting access to emergency medical care for all patients.

The problem is affecting communities of all sizes. In Los Angeles County, patient volume at psychiatric EDs has increased 16 percent since 2003 (*Los Angeles Times*, Nov. 2004). Louisiana State University Health Sciences Center's ED is averaging 167 psychiatric patients per month during the current fiscal year, an increase from 135 per month in the previous year (*Shreveport Times*, Jan. 2, 2005). Arden Hill campus of Orange Regional Medical Center in New York triaged and treated 2,214 behavioral health patients in 2003, compared with 1,835 in 1997 (*Times Herald Record*, Dec. 12, 2004). The end of TennCare benefits to 30,000 Tennesseans with severe mental illnesses is going to have an impact on emergency services in the state.

The problem in Riverside County, Calif., is affecting the three EDs in the area. According to a report in Riverside's *Enterprise-Record* (Jan. 26, 2005), the closure of a psychiatric ED in Indio has increased the number of psychiatric patients in its EDs.

Public officials cite a variety of reasons for shortfalls in the health system, including closures of psychiatric centers, such as that in Riverside County. In Los Angeles County, seven private hospitals have closed since 2002, and statewide budgets are discontinuing public programs like TennCare that provide needed treatment.

States and health providers have proposed and are initiating a mixed bag of solutions to serve the psychiatric ED overcrowding issue. California's Proposition 63 will make therapists and other care providers available in community settings by increasing the state personal income tax on people whose annual incomes exceed $1 million by 1 percent. LSU's Health Sciences Center is putting mental health counselors in the ED to check psychiatric patients and find out if that patient has been treated before and what medicines they need. St. Luke's Cornwall Hospital in New York has a separate behavioral health intake unit in the ED with two treatment rooms, a waiting room and an office for an in-house psychiatrist (*Times Herald Record*, Dec. 12, 2004).

For more information on the ACEP survey, visit www.acep.org.

DMHC Probes Reimbursement to ED and Hospital-based Doctors

The California Department of Managed Health Care (DMHC) fined Health Net of California, the state's fourth largest HMO, for failing to correctly and accurately pay claims to ED and other hospital-based doctors not contracted with the HMO. According to a DMHC news release (Jan. 13, 2005), Health Net acknowledged that it failed to pay the correct amount on approximately 65,000 claims for services provided for hospital care or in EDs during the first 10 months of 2004.

The six-month investigation by the DMHC determined that Health Net's payment actions violated the Department's claims payment requirements regulation that became effective on Jan. 1, 2004. Under the law, HMOs are prohibited from adopting payment practices that would result in systematic underpayments to doctors and healthcare providers.

"Emergency rooms, hospitals and the doctors who work there every day to save lives are the backbone of our healthcare system and form the 'safety net' upon which 37 million Californians rely," said Cindy Ehnes, director of the DMHC. "These doctors must be paid promptly and fairly in order for Californians to get the right care at the right time."

For additional information, visit the DMHC Web site at www.dmhc.ca.gov.

In Memoriam

- Dr. Frank Pantridge developed the portable defibrillator.
- Dr. John Wiegenstein was ACEP's co-founder and first president.

State Senator Proposes Bill to Fund Trauma Care

California State Sen. Richard Alarcon introduced legislation that would raise $100 million annually for trauma and emergency care in the state. SB 57 imposes a penalty of $2 for every $10 penalties of violations in seatbelt use, speed limits, driving under the influence and domestic violence.

About $15 million of the $100 million raised would be allowed for equipping and reimbursing trauma care facilities that provide pediatric trauma care.

Sen. Alarcon lost his 3-year-old son in 1987 when he was injured in a traffic accident. According to a *Los Angeles Times* article (Jan. 14, 2005), because there was no pediatric trauma center in the area where the accident occurred, the boy was airlifted to Children's Hospital Los Angeles, but died a day later.

To view and learn more about SB 57, visit the California State Senate Web site at www.sen.ca.gov.

Updated Ambulance Fee Schedule – Medical Conditions List

Medicare has released the new list of ambulance condition codes allowing providers and suppliers of ambulance services as well as Medicare contractors to document patients' signs and symptoms on scene and during ambulance transportation. The Ambulance Medical Conditions List provides a crosswalk from the ICD-9-CM code that may be used to describe the patient's clinical condition during the transport to the HCPCS code. Each transport situation is different, so each transport is numbered consecutively, and the general and specific conditions are described in English.

The Ambulance Medical Conditions List is intended primarily as an educational guideline. It will help ambulance providers and suppliers to communicate the patients' conditions to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Neither the presence nor absence of a code affects whether the claim will be paid or denied.

Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient's

condition, other on-scene information, and details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled), all of which may be subject to medical review by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage, not simply the HCPCS code or the condition code by themselves. All current Medicare ambulance policies remain in place.

Providers/suppliers should use the ICD-9-CM code (not the ambulance condition code) on the Ambulance Claim Form.

For additional information and details about the Ambulance Fee Schedule – Medical Conditions List, visit the Centers for Medicare and Medicaid Services at www.cms.hhs.gov.

Study Finds ED Users and Nonusers Similar

In a study released in the January 2005 *Annals of Emergency Medicine*, researchers found that ED users are similar to nonusers with regard to health insurance and usual source of care but are more likely to be in poor health and have experienced disruptions in regular care.

"Does Lack of a Usual Source of Care or Health Insurance Increase the Likelihood of an Emergency Department Visit? Results of a National Population-Based Study" used 2000-01 nationally representative Community Tracking Study Household Survey data to assess the independent association of usual source of care, health insurance, income and health status with the likelihood of making one or more ED visits in the previous year.

Adults without a usual source of care were less likely to report an ED visit in the prior year compared to those whose usual source of care was a private physician. Also, the uninsured were no more likely to report an ED visit than insured individuals. However, ED users are more likely to be in poor health and to experience disruptions in regular care.

The authors conclude that policies designed to decrease ED use may need to focus on improving delivery of outpatient care.

To review the full study, please visit the American College of Emergency Physicians and the *Annals of Emergency Medicine* Web site at www.acep.org.

PART ONE
Enhancing Revenue for Trauma Centers Webinar
March 2, 2005
1 p.m. – 2:30 p.m. EST

Mike Williams, President of The Abaris Group, will be the featured speaker for the Webinar, **Enhancing Revenue for Trauma Centers**. Learn to:

- Identify the key areas of difficulty for trauma and emergency care as it relates to billing.
- Identify unique and unusual sources of payment for trauma and emergency care.
- List the common problems of charging for trauma and emergency care services.
- Identify unique and unusual sources of insurance coverage of trauma patients.
- Distinguish between the best reimbursement codes and those that are less than ideal for reimbursement.
- Identify the appropriate use of the new trauma revenue codes.
- Enumerate the steps that practitioners may take to respond to managed care contracting issues and emergency and trauma care.

Educate your entire staff for one low cost. Visit www.abarisgroup.com for additional details and savings when you register for more than one Webinar.

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The Abaris Group is a consulting firm that specializes in emergency and outpatient services. We provide clients with help on a wide range of topics, including strategic planning, operational improvement, and financial enhancement, to help them achieve their goals.

We pride ourselves on delivering value to our clients in the form of quality recommendations and strategies that work. To achieve this, we conduct detailed analyses, blending insight and experience from all spectrums of the healthcare and emergency care fields to meet our client's unique needs.

Whether it is evaluation of new programs, studies of existing ones or assistance with implementation, we will extend this superior level of service to you and your organization.

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