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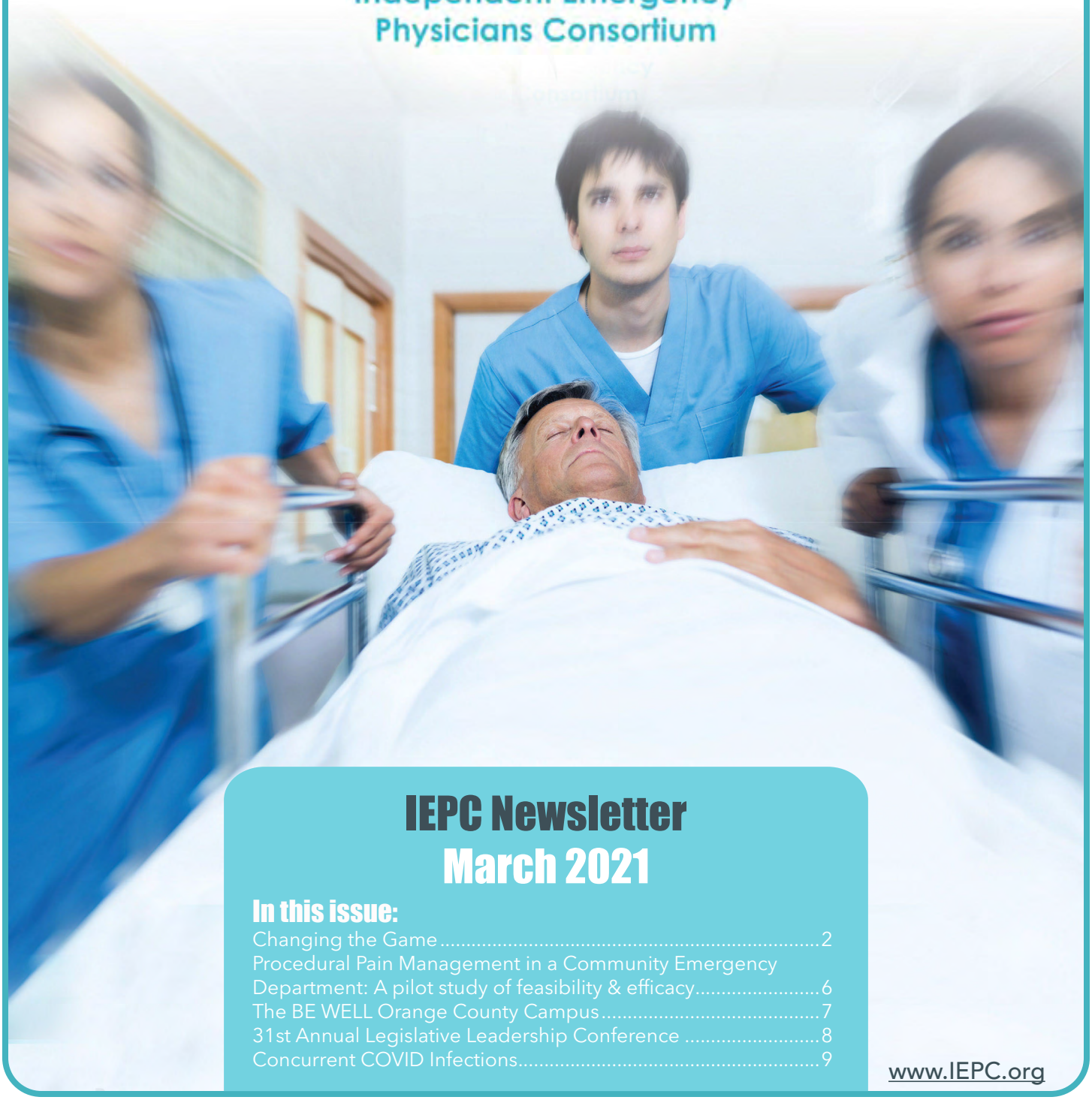

IEPC Newsletter
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Changing the Game

7 Issues Impacting Emergency Medicine and How Financial PPE Can Help Practices Meet Them Head On

John G. Holstein
Zotec Partners

As we usher in 2021, the emergency medicine specialty continues to battle the largest healthcare crisis in modern history. The loss of life due to COVID-19 has impacted many clinicians, as portrayed at the ACEP 2020 Unconventional conference in one of the headline events, Theater of War. There is also no doubt that COVID-19 has placed emergency department practices under duress, with many practices experiencing some form of negative financial impact. However, all is not lost if we view the pandemic as a unique opportunity to evaluate the strengths and potential weaknesses of emergency medicine practices, and ways to improve their performance in the weeks and years ahead.

It is true today's practices are facing multiple complex challenges, but there are ways to recover from the impacts of the pandemic with a model of preparedness. Below I map out seven issues impacting today's practices, with strategies practice leaders can use to conduct performance evaluations, and ensuring they're staying on track during the pandemic and beyond.

Volume Depression

Virtually every emergency department has seen a dramatic loss in patient visits. Much is being said on this issue by the specialty and more broadly in the industry. A very recent report shows 57% of surveyed patients with chronic illnesses have delayed seeking care. An on-going and continuing trend here may likely result in these same patients ending up in our emergency departments, with their acuities being high. This is already occurring in many departments.

An added component of the volume declines, aside the impact of COVID-19 is the pressure being exerted by the retail pharmacy players of the industry who have effectively announced they are targeting the traditional, lower acuity patients of our emergency departments. An impact analysis on a hypothetical emergency practice being reimbursed at Medicare rates seeing 120,000 patients annually, losing all 99281, 99282 and 25% of 99283s to an outside provider, be it retail and/or urgent care providers will lose $667,065; if the volume loss encompasses all 99281s,99282s and 50% of the 99283s, the financial impact is $1,229,952. It is very prudent to recognize the changing landscape and to be prepared

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for these types of potential tectonic shifts. In addition to the financial impact new staffing challenges resulting from shifts to higher acuities will predictably prompt analyses of the role of advanced practice providers

Payer-Mix Shifts
There are several aspects impacting the payer-mix of emergency medicine practices today. First, Medicaid expansion can have a positive impact on the finances of practices, however, that applies only if these patients have previously been accurately categorized as true self-pay. If, as some predict, Medicaid increases at the expense of a decrease in previously commercially insured patients, the impact will be financially negative. This is certainly a possibility with millions of people having lost employer-based insurance coverage, due to COVID-19 employer lay-offs.

Out-of-Network/Balance Billing/PLP/Inappropriate Claim Denials
The constellation of these issues is nothing new for the specialty. The overarching irony particularly with PLP denials is the history of these denials dating back to the original evolution of PLP in 1988. Since this landmark criterion was set payers have persisted for decades denying and delaying emergency medicine claims. Today the issue extends beyond Medicaid programs into virtually all commercial plans, all aimed at denying and/or reducing both hospital and emergency physician reimbursement.

Down-coding of E/M Visit Codes
This is similarly a historical and on-going issue with the added component today being the insertion of AI-driven, auto denials, coupled with usage of diagnosis lists by payers used in adjudicating emergency medicine claims. This at best impacts cash flow and at worst results in actual/real revenue loss. If the issue is not identified timely, the revenue can be irrevocably lost.

Compliance and Certifications
It is becoming more and more significant that compliance become the backbone of all revenue cycle processing. The increasing incidence of cyber-attacks on healthcare facilities has triggered an increased focus on all revenue cycle processes, particularly authenticated and evidenced via outside agency certifications. It is becoming more and more important that revenue cycle companies be at minimum SOC-1 and SOC-2 certified.

Telehealth and Virtual Care
COVID-19 has brought the issue of telehealth to the forefront of all discussions of care across many specialties. It remains to be seen where and to what extent emergency medicine will embrace and adopt telehealth as being integral to the specialty's tool-kit. The ACEP APM models of care incorporate telehealth as the specialty focuses on authenticating its core care commitment as necessarily extending beyond the bricks-and-mortar of our emergency departments. This is definitely a change already embraced by some emergency medicine practices today; it remains to be seen if it becomes recognized as an integral service in the specialty's tool-kit.

Emergency Medicine's Financial PPE Model is The Answer
Given these challenges, it's important that practices consider a "PPE Model" that will help them form a new path for financial success as they move into a post-COVID-19 future.

P: Profile Your Practice
It is imperative that every practice take inventory of key indices as they existed prior to the pandemic, today and forecast them for the immediate future. These indices, at minimum should include the following:

- Days in AR benchmarked against similar practice types
- Acuity Mix to evaluate how these levels have changed and whether or not they can be expected to maintain current levels. These analyses must be very current, not weeks or even months after the fact. Reporting capabilities supporting the tracking of day-to-day shifts in the acuity mixes for staffing, financial monitoring and future financial modeling purposes is critical.
- Payer Mix to evaluate critical shifts impacting cash flow and the overall financial picture of practices. Does your practice have processes in place to monitor payer mix shifts and patient engagement protocols, particularly of high deductible patients today? Similar to acuity mix monitoring practices need reporting that is current, not dated. Today's efficient practice must be equipped with reporting that is provided 24/7/365, mirroring a true hallmark of the specialty's readiness and commitment to patients.
- RVU monitoring across attending physicians and advanced practice providers.

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- Cash flow monitoring and predictive analyses are critical. COVID-19 has brought to the forefront the necessity of practices having accrual analyses reporting tools allowing for predictive and forward looking analyses.

- Denial reporting, tracking and appeal processing have become even more important as payers continue developing both historical and new methods of delaying and/or outright denying legitimate emergency medicine claims. The issue of timing of the recognition of a problem with a payer(s) is paramount. Analyses provided weeks and/or months after the problem started force practice executives to adjust to negative cash flow impacts as well as a very real possibility of lost payments. The importance of inappropriate denial recognition and immediate appeal activation protocols cannot be understated as being critical tools for every emergency medicine practice today.

- Reporting needs and requirements. Defining the critical metrics important and unique to each practice and the timely delivery of these reports has become critical to anticipating future practice needs. 24/7/365 data accessibility is of paramount importance for the financial survival of practices.

P: Performance Evaluation of Your Revenue Cycle Partner
It has never been more important as the present to critically evaluate both the performance and support your revenue cycle partner is providing you on the methods and processes they are using to address today's issues. Some recommended critical evaluations are as follows:

- Customer Support- Is your practice being supported by personnel with emergency medicine specific experience and knowledge? Do you have direct access to these individuals; are they responsive to your needs; are you satisfied? When did you last ask these questions?

- Reporting- Your department is open 24/7/365. Do you similarly have access to all of the key metrics of your practice 24/7/365? There is no better example of the value of current information than when the COVID-19 virus started to spike resulting in patient volume declines. It became critical for emergency medicine executives to be able to quickly pivot in evaluating staffing needs for the short-run and future weeks and months ahead. Your revenue cycle partner must support you in these efforts with accurate and very versatile reporting.

- AR Processes- One of the most critical aspects of accounts receivable processing today is the recognition of a problem, trending of the data and an action plan based technological solution to address these issues before they can have a financially devastating impact on your practice. There is a balance required here of experienced people managing your receivable who are supported by sophisticated technological tools to expeditiously assure your practice will not be seriously impacted by any pattern of inappropriate claim delays and/or denials. Conversations with your revenue cycle partner should include detailed discussion of their processes to insure you have confidence in their processing. These discussions should include demonstrated results. Do not be satisfied with someone telling you "Doctor, don't worry, we have your back." You are entitled to results of demonstrated accounts receivable follow up processes reported to you. When was the last time you saw a denial report with follow

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up results from appeals?

- Patient Engagement- Today's emergency medicine payer mix is a moving target. The patient experience, however, has never before been such a critical component for your practice's success. The increasing incidence of high deductible plan coverages, coverage shifts and eligibility issues requires an omni-channel service approach of patient engagement that includes such components as "live" call center expertise, interactive voice response, patient portal access, patient texting, live chat functionality and educational patient video functionality, all coupled with sophisticated capabilities for selectively holding claims to produce the best financial results for your practice. This is all an "active" process of engaging today's patients with protocols and pathways they are used to in other areas of their lives and which they demand from your practice. A committed and dedicated revenue cycle company is a partner not a vendor.

- People today legitimately focus on the constant increase in patient high deductible plan coverage, which is absolutely important. That said, with millions of people losing employer-based insurance coverage the specialty may likely face a new wave of true self-pay patients, historically the nemesis of the specialty. These patients need to be engaged very quickly, again with omni-channel technological processes to ensure emergency medicine practices have their best chance of collection from these patients. The issue of calculated timing and early engagement protocols is critical with this subset of patients. Every generation of patient deserves to be serviced via their preferred method and modality of engagement. As the healthcare industry has evolved today to include clear patient expectations of an Amazon/Google type of experience your practice needs to be supported by a revenue cycle partner who not only has these capabilities today but is also committed to constantly developing new solutions to anticipate new, future patient demands. A positive patient billing experience delivered seamlessly will best match the quality, clinical care your practice is delivering.

- Compliance and Certifications- The ever increasing incidence of cyber-attacks is heightening the significance of both compliance processes and protocols and data security certifications. SOC-1 and SOC-2, both outside organization service organization control certifications, will assure you that your revenue cycle partner has been evaluated and certified on all of their processes impacting financial reporting (SOC-1) and data confidentiality, integrity and security (SOC-2). PCI-DSS (Payment Card Industry Data Security Standard) additionally gives you confidence in the credit card processing of your patients.

- Telehealth- However your practice addresses telehealth it is important that you are convinced your revenue cycle partner can adapt and has the expertise to properly code, bill and collect for these services.

E: Execute on Your Findings: A Call-to-Action

By now you have effectively built a scorecard on your revenue cycle partner. It is now the time to critically evaluate their performance on the recommended indices above, decide about their current day level of support for your practice and the capabilities they bring to the table to anticipate tomorrow's changing challenges. COVID-19 has brought the specialty to a critical point in evaluating its business partners. Today there is a glaring need within the specialty. That need which must be respected is, in a word, "Time." First a "time-to-heal" from the onslaught of the virus and your resultant exhaustion and second, time expressed in providing you the capability to calmly, effectively and efficiently manage your practice. Having all of your key metrics on every one of your devices 24/7/365, mirrors your own commitment to being available to all of us 24/7/365. It is a needed and definitely justified expectation of the specialty. Ask yourself- "Do I have this today?" Emergency Medicine deserves that level of support every single day, provided in a spirit of partnership. It is a question that has never been as important as it is today to give you confidence in the financial future of your practice.

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Procedural Pain Management in a Community Emergency Department

A pilot study of feasibility & efficacy

Casey Grover and Reb Close
IEPC members
Community Hospital of the Monterey Peninsula.

Drs. Casey Grover and Reb Close are IEPC emergency physicians at Community Hospital of the Monterey Peninsula. They let a pilot project of an ED physician-led procedural pain management program that was successful in reducing patients' pain in a non-opioid fashion, and patients were satisfied with their pain relief from the program. To move to a permanent program, Emergency Departments will have to analyze their volume and payor mix to determine financial sustainability.
This is a summary of their study that was published in Emergency Medicine and Health Care.

This study was conducted at a suburban community hospital, with an annual Emergency Department census of approximately 55,000 yearly visits. The hospital does not have a pain medicine department, but does have a Pain Management Workgroup (PMWG). The PMWG is a multi-disciplinary committee tasked with both introducing new and innovative pain management strategies and ensuring patients have access to quality and evidence-based pain management protocols. This project was designed and developed by the PMWG.

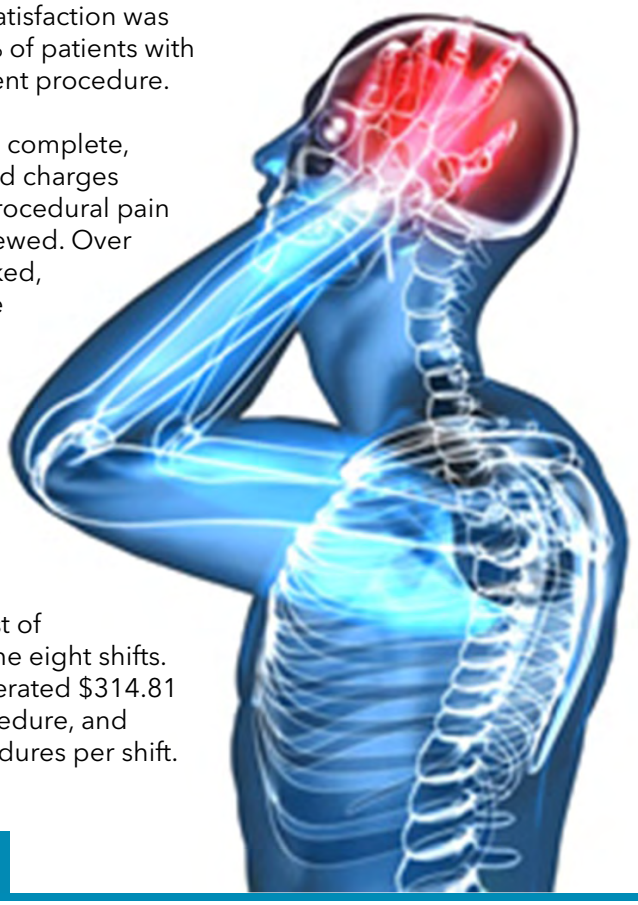
Two physicians at the hospital were dedicated to pain management procedures in their ED over eight 8-hour ED shifts. Procedures performed included nerve blocks, trigger point injections, cervical injections, and osteopathic manipulation. The number of procedures per shift was variable from day to day. The minimum number of procedures done per shift was four, the maximum number of procedures done per shift was eleven, and the average number of procedures done per shift was 7.1. The number of procedures done per shift did not appear to correlate with how busy the ED was on the day of the pain shift.

The physicians treated 47 patients with a total of 57 procedures. The average pain score before pain management procedures in the ED was 8.8 out of 10, which decreased to 1.9 out of 10 after the procedure ($p<0.001$). Patient satisfaction was expressed in 97.9 % of patients with the pain management procedure.

After the shifts were complete, the billing codes and charges generated by the procedural pain physician were reviewed. Over the eight shifts worked, 57 procedures were coded, with a total of $17,944.00 in charges billed for the procedures. The physicians were paid an hourly rate of $150 per hour for this pilot study, for a total cost of $9,600.00 to fund the eight shifts. The physicians generated $314.81 in charges per procedure, and averaged 7.1 procedures per shift. Reimbursement for charges is dependent on payor mix.

In general, they found that the pilot project of an ED physician led procedural pain management program was successful in that it improved patients' pain in a non-opioid fashion and patients were satisfied with the service provided. Additionally, depending on the payor mix and volume of procedures done, such a service may be financially self-sustaining.

Original research by Casey Grover, Thomas Heflin, Rory Smith, Aya Deborah Chato, Gabriel Molina, Susan Burnell and Reb Close
Procedural pain management in a community emergency department: A pilot study of feasibility and efficacy.
Emergency Medicine and Health Care. Feb 2020.



The BE WELL Orange County Campus

Pete Anderson, MD IEPC Member, Orange County California, retired

This missive is to all you emergency docs who have and continue to struggle with caring for patients with behavioral health, drug, and alcohol problems in your departments. In too many instances, we have had to hold patients in our departments for hours and days while attempting to obtain suitable dispositions for them. You know the dance. These patients desperately need care. Too often our facilities do not have the capacity to offer that care. This an especially acute problem when it comes to patients under 5150 designations.

Some counties in California have historically done a better job than others in setting up systems to handle patients with behavioral and substance abuse problems. The John George facility in Alameda has been a leader. The Exodus programs in Los Angeles County also have made inroads in offering care outside of emergency departments.

However, there still is a lot of misery out there. There may be value in looking at what is happening in Orange County. We have just opened a 60,000 square foot newly built from the ground up facility to care for these patients. By "we" I mean the County of Orange Health Care Agency in collaboration with our Hospital Association, our CalOptima Medi-Cal Managed Care system, and a multitude of other interested organizations including our Orange County Medical Association.

This new facility will offer a multitude of services including psychiatric crisis stabilization, a sobering/recovery/withdrawal station, and opportunities to keep patients longer than the usual 24-hour limits in certain instances. Many of these patients will be able to be directly transported from the field to this facility thus bypassing our emergency departments. For we emergency physicians here in Orange County, this new facility is potentially a "game changer." While it is not fully open yet and just had it ribbon cutting in January, it sure looks like this new facility could be a start of addressing the behavioral health holding dilemma in our emergency departments.

In addition, Orange County and this consortium of interested parties are in the planning stages of building two more similar facilities in other parts of our county. In order for you to grasp the significance and magnitude of this new facility, I ask that you watch this video. First, skip over to "minute 20" on this video, and you will get a short but interesting tour.

This BE WELL ORANGE CAMPUS building is amazing with a lot services and an incredible uplifting environment. If you have the time, you can listen on this video link to some of the many speakers who are touting the building and how their organizations helped to

BE WELL ORANGE COUNTY continued from last page

make it happen. It is somewhat of a info-commercial at times with all these speakers. Yet, it is absolutely true that many organizations came together to make this happen. Below is a link that is from our Orange County Register newspaper detailing the BE WELL campus programs. It is a good summary of what it offers.

How did this happen? Did Orange County always have a great county directed behavioral health system that made it easier to move to this next level? The answer is a resounding "no." The following link from an investigative article by the Orange County Register newspaper from 2015 details the struggles of our emergency departments in handling behavioral health crisis situations.

I have just retired after 45 years of practicing emergency medicine here in Orange County, and I lived the agony of not having a county run hospital and of having almost no county run medical services and few behavioral health services. I attended these county behavior health meetings for more than 20 years. During these years, there seemed to be little progress made to improve care. The County of Orange ran a ten bed 5150 receiving center that was chronically filled resulting in incredibly long ED holds for behavioral health 5150 designated patients. We all have these same problems.

What changed was our community effort of hospitals, physicians, and activists coming together and demanding change. The charge was led by our Hospital Association. We set up the BE WELL organization. There were a lot of meetings and much time spent brain storming. We were fortunate in that there were changes in direction at our County Board of Supervisors and at our local Orange County Health Care Agency which resulted in a new willingness to help problem solve. $40 M was raised to build the new crisis stabilization facility. Our County chipped in $16.6 M, our CalOptima Medi-Cal organization put in $11.4 M, and the other $12 M came from outside contributions including hospitals in Orange County. The yearly costs to run the programs at this facility are estimated to be in the range of $20 M. You may question where Orange County and the system is obtaining this funding. I am certainly not an authority on specifics here. However, as I understand, a large portion of the funding for these types of California behavioral health crisis stabilization facilities is by Medi-Cal which may pay almost $200 an hour for patients cared for by these centers. That means that if the patient is in the facility for 20 hours, Medi-Cal could pony up $4,000. In addition, there is money allotted each year to all California counties for behavioral health care through the Mental Health Services Act. This is the 1% state tax on personal incomes over $1M a year and results in almost $2 billion each year being collected by our state. Your county is getting their portion of these dollars each year. You may want to check into how they are being used.

There is obviously a lot more to come with this story. We do not yet have a track record as to whether this facility and the new system of wrap around services surrounding it will achieve the improvement in care that is envisioned. I personally believe that it will.

31st Annual Legislative Leadership Conference

The 31st Annual Emergency Medicine Legislative Leadership Conference (LLC) is your opportunity to talk to your legislators and advocate for your specialty and your patients.

Whether you are a medical student, a resident or a physician nearing retirement, California ACEP's annual LLC is your chance to lobby elected officials on the issues facing emergency medicine. You don't have to be an expert on the legislative process, your experiences reflect the impact policy has on patient care. It's as easy as telling a story from your last shift.

With a history of stellar LLC programs and the most robust advocacy program of any medical specialty society in California, California ACEP's 2021 LLC promises to be another exceptional event headlined by healthcare experts. This year LLC is going virtual, but will still provide the education and advocacy opportunities that LLC is known for!

Register Today!

Concurrent COVID Infections

Sameer Mistry, MD, CPE, FACEP, FAAEM – IEPC Vice President, Southern California Emergency Medical Group

Emergency physicians across the world are now experts in treating COVID. The following are two cases from February, 2021 illustrate COVID plus Influenza and COVID plus strep. We can see pandemic infectious together with our routine bread and butter infections.

Case 1: 38-year-old with sore throat

This 38-year-old man presented to the ED with two days of sharp sore throat, pain on swallowing, and radiation of pain to the left head and ear. His vital signs were normal. On exam he had exudates to the tonsils with no abscess. He was treated with decadron and bicillin LA. His rapid strep was positive. He was discharged home with a diagnosis of exudative pharyngitis.

This seems like a straight forward ED or even an urgent care patient - and it is. The following day his COVID test was positive.

The case illustrates what we all know, that if you can get strep throat, can you get COVID at the same time. It is also another warning that all ED patients should be approached with a mask and precautions as if have COVID.

Case 2: 85-year-old with respiratory distress

This 85-year-old female presented to the ED with respiratory distress. The patient was a long-term chronic ventilator patient from on skilled nursing facility (SNF) with 50% FiO2 at her baseline. She desaturated and referred to the emergency department. On arrival she is suctioned and her saturations have come up. The patient was nonverbal and could not give additional history.

What are you thinking? COVID in a nursing home patient?

Her vital signs noted a temperature of 37.8 °C (100 °F), blood pressure 109/50, heart rate 62, respiratory rate 27, and oxygenation of 96 % on oxygen. Her exam was remarkable for rhonchi bilaterally, she had a G-tube, her eyes were open and seemed to be tracking, but she could not follow commands. Her CXR showed bibasilar infiltrates – of course. EKG was unremarkable. Her WBC was 13.5. She was started on Azithromycin and Cefepime.

Her influenza came back positive and Tamiflu was added to her treatment as she was admitted to the hospital.

The poor SNF, they had an COVID-19 outbreak compounded along with an influenza outbreak. If you are protected from one infection at the SNF, then you are susceptible to others.

Have an idea for an upcoming IEPC guest speaker or topic? Interested in contributing an article for an upcoming issue of the IEPC newsletter? Email admin@iepc.org

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