AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
SCIENTIFIC ASSEMBLY
1999

In Pursuit of Revenue: Innovative Ways to Support Your Department's Bottom Line

There is little question that the emergency department of yesterday in which the only duty was to treat emergency patients is gone. In the market of the next century, the successful department may need to find new sources of revenue. The speaker will explore opportunities and discuss ways to develop programs and services to help support the sagging bottom line.

- List several potential areas of revenue for the emergency department, including observation units, chest pain centers, occupational medicine, IV therapy, inpatient care, travel medicine, hyperbarics, and public health.
- Describe ways of finding such areas.
- Describe the steps in pursuing and developing such programs.
- Describe the advantages and disadvantages of each program.

TH-219
Thursday, October 14, 1999
11:00 AM - 11:55 AM
Room # N219
Las Vegas Convention Center

FACULTY

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In Pursuit of Revenue:

Innovative Ways to Improve Your Department's Bottom Line

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Revenue vs. Profit

- Revenue: The gross income received, before deductions for expenses, discounts, returns, bad debt, etc… Also called "sales" in many companies.
- Profit: The same as "net income" or "net profit". This is the amount remaining after all expenses have been met or deducted, calculated by taking the difference between total sales, and total cost plus expenses. "Total cost" covers cost of all goods sold, including depreciation. "Total expenses" are made up of selling, general, and administrative expenses, and income deductions.
- Fixed expense: The cost that remains constant regardless of sales volume. Fixed expense include salaries, interest expenses, rent, depreciation, and insurance expenses.
- Variable expense: Costs that change directly with the amount of volume. For example, supplies and labor costs that increase as volume increases.
- EBITDA: Earnings before interest, tax, depreciation, and amortization, are deducted.

Improving the Bottom Line

- Low hanging fruit: Before embarking on new and innovative measures to improve the bottom line, it is important to make sure you have fully evaluated all possible avenues of improvement on current practices.
- Creativity counts: It is crucial to look at the old ways with "new eyes." Sometimes, a different perspective will uncover new and creative ways to improve processes and revenue.
- Change agents: "*There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in it's success, than to take the lead in the introduction of a new order of things. Because the innovator has for enemies, all those who have done well under the old conditions, as well as only lukewarm defenders in those that may do well under the new*." - Machiavelli
- Collaborative vs. Combative: There are clearly two different ways to encourage change. If you chose the combative style, make certain you can win decisively. This style is rarely, if ever, necessary. Only the

collaborative style can create win-win situations.

Who's Job is it Anyway?

- Ensconcing yourself: If you elect to be the agent of change, beware of winning the battle, only to lose the war. It is important to be well ensconced within your group and medical staff before you start. Change rarely comes easy, and there is always some fallout.
- Ensconcing your group: If you are not the contract holder, make certain you have the approval of your group prior to implementation of change.
- Improving the department = Improving the hospital: Remember that improving the department means improving the hospital. The ED is often the point of entry into the hospital system, and process improvement in the department goes a long way toward improving the patient's overall hospital experience.
- Improving the department = Improving patient care: Improvements in the department serve to improve the quality of care provided to patients and their families. Even a simple improvement to enhance the aesthetics of the department, serves to improve the physical plant, which provides an atmosphere more amenable to quality care.

Techniques for Increasing Profit

- A penny saved: Prior to implementing new methods aimed at increasing profit, strong consideration should be given to reducing costs in the ED. When you examine the situation, you will be amazed at the amount of excess in the ED. A dollar of cost savings hits the same bottom line as does a dollar of new revenue. In the end, the dollar saved is even more beneficial because it does not carry the expense associated with new revenue.

- Expense reduction: Most expense in the ED is fixed. Regardless of the number of patients, you maintain the constant expenses of the space, the staff, and the utilities. The expense associated with volume, or, variable expense, generally consists of the non-billable supplies and utilities used for patients.
  - Decrease per patient expenses: Look for alternatives in supplies. Much of what we use in the ED is expensive. There are often disposable alternatives that may, in the long run, be less expensive to use.
  - Identify fixed revenue patients: Patients covered under capitated, or flat rate plans should be identified early in the process. These patient's problems must be outlined and addressed in consultation with their PCPs, in order to avoid duplication of efforts, increased

costs, and prolonged length of stay.
- Judicious lab and X-ray utilization: Before ordering a battery of tests, providers must make it a habit to ask themselves, "is this really necessary to make the diagnosis?" There is often an alternative: I-Stat, as opposed to CBC and Chem-7; thorough history and HEENT exam, as opposed to rapid strep; proper joint exam, as opposed to ankle or knee x-rays; adequate auscultation, as opposed to CXR; etc…
- MDIs vs. SVN: Using the MDI for patients with mild RAD, as opposed to using an SVN machine, allows the patient to go home with the treatment after instruction of proper technique.
- PO vs. IV hydration: PO hydration, if tolerated, is a more reasonable alternative to IV hydration in the mildly dehydrated patient. This method saves time and money, and is usually preferable to the patient and family.
- PO vs. IV steroids: PO Prednisone is as effective as IV Prednisolone in mild asthmatic exacerbations. This saves time and expense while accomplishing the same end result.
- Pre-printed note templates vs. dictation: Preprinted templates improve documentation, and nearly eliminate transcription costs. For EDs with students, templates have the added benefit of leading the student down a reasonable diagnostic path, with the appropriate questions and exam points.

- Creative staffing alternatives: On the professional side, using mid-level providers in a fast-track, or urgent care setting, can significantly lower overhead. On the facility side, using paramedics to substitute in some of the roles that have traditionally been filled by nurses, may curb expenses.
  - Allow RNs to supervise and direct: RNs currently spend a large portion of their time performing non-nursing tasks. Many of these duties can be accomplished using $10/hr employees instead. This technique improves nurse retention, and job satisfaction
  - Use techs to perform most of the labor: This leave more time for the nurses to perform nursing tasks, which improves retention, and decreases the need for many expensive RNs
  - Allow nurses to nurse and teach: Most nurses deplore the time they spend on non-nursing tasks. Reducing nursing staff and supplementing it with medical assistants or medics provides nurses with the time required to actively nurse.
  - Improve bed turn-time: Improving bed turn time by having techs focus on the transporting of patients etc…, decreases average patient stay, and removes the bottleneck that is often associated with waiting for the RN to perform the task.

- Decrease department length of stay: Increased LOS drives costs up. It requires more staffing hours, more supplies, and more utilities. Efficient EDs will have less staffing needs, because the patients spend less time in the rooms, and thus will require less nursing care, and less face time. It also reduces physician face time, which reduces the need for multiple physician coverage.
  - POC testing: Point of Care testing in the ED improves turn-around-time, lowers cost, and brings added revenue to the ED. Readily available POC tests include UDS, urine dipsticks, UCG, rapid strep, I-Stat, cardiac enzymes, blood sugar, and ABGs. The downside of POC testing is the voluminous QA monitoring associated with them.
  - Bedside registration: This approach changes the patient perception of the entire ED visit. The patient is being treated **while** registration is taking place, and medical screening is completed before financial information is discussed. This technique reduced LOS in our department by approximately 30 minutes, and improved patient satisfaction dramatically.
  - Dedicated housekeeping and tech support: A dedicated housekeeping department facilitates more efficient bed turnover, while techs provide the support needed for POC testing, and rapid treatment, by performing EKGs, SVNs, and simple splinting tasks.
  - Efficient staff and providers: Hiring the "right" providers and nurses is crucial to the process. Some people are simply more efficient in the ED than others. This seems to be an innate, rather than a learned trait.
  - Streamline paperwork: Redundant paperwork slows the entire department. Eliminating multiple areas with repetitive documentation will increase ED efficiency.

- Revenue generation: Revenue generation should be the last area of concentration towards improving the bottom line. The time and effort needed to implement new programs is costly, and, at least initially, would be more effectively invested in expense reduction.

Increasing Patient Volume/Reimbursement

- Volume business: In a non-capitated environment, revenue is tied directly to volume. Even in contracts with lower reimbursement, covering the fixed cost is a crucial step towards improving the bottom line.
- High fixed costs, and minimal variable costs: Emergency Medicine has

inherently high fixed overhead. Hospital-based programs, in general, are more costly to operate due to the many extra costs added on top of the routine patient care expenses. The variable costs are minimal. They are composed of non-billable patient supply items, and the extra utilities that increase with volume. Because a large percentage of the cost is fixed, after the break-even volume is hit, and all the fixed costs are covered, a large percentage of the net revenue drops to the bottom line (shows up as profit).

Techniques to increase volume

- Superior customer service: The first technique is to simply provide exceptional service. Word will quickly spread that your ED strives to provide high quality customer service.
- Market to PCPs: Letting the PCPs in your area know that you are available to perform efficient service, and that you will refer their patients directly back to them with summaries of patient visits, for follow-up care, will go a long way toward establishing effective relationships with these colleagues.
- Public awareness campaign: Every time you positively change an aspect of your service, publicize it! Do not let improvements go unnoticed in the community, or in the administration. Emergency Medicine is a hot topic in the media, so take advantage of the public's appetite.
- School / Athletic physicals: Although these are typically lower revenue services, they provide you with the opportunity to show off the department to the community. In addition, they provide a mechanism for distribution of literature to the community about the department, and the hospital.
- EMS campaign: If you are competing with other EDs for patient volume, make the use of your service appealing to the local EMS community. A little effort goes along way. Take the time to instruct medics, being careful not to criticize or critique in public. Provide them with a place to sit and chart, and provide them with coffee and doughnuts, etc... Medics can be influential, and valuable ambassadors for your department!
- Decreasing department LOS: By decreasing LOS, you provide more efficient bed turnover, and can accommodate more patients. If you are successful in your campaign to attract new revenue via volume, you must concomitantly increase the available space in your ED, either by expansion of the physical plant, or by improvements in the efficiency of the current facilities.

Increasing Per-Patient Reimbursement

- Complete chart notes: Complete chart notes, and proper coding, are essential components to maximizing collections. The ROS, PMH, PSH

and social and family history, must be completed in order to bill at higher levels.

- Templates: If used appropriately, templated charting can improve both documentation, and collections.
- Coding classes for physicians: Most physicians need some education in adequate charting, and coding procedures. They must be instructed on how to chart based upon documentation, and medical decision making algorithms. The small improvements that may add up to a mere five dollars more per chart will accumulate to a significant amount of money over years.
- Charge capture assurance: Studies have shown that a significant amount of revenue is lost in EDs secondary to missed charges, and poor documentation. This amount, over time, is, again, extremely significant.
- Fixed professional charges: Fixed charges may be categorized as either "flat rate", or "tiered" professional charges. Flat rate implies a set fee for services rendered. Tiered charges are staggered depending upon an established set of diagnoses. For example, a diagnosis of pharyngitis will be reimbursed at a lesser rate than a diagnosis of CVA, under a tiered charge plan. Fixed professional charges may improve collections because the reimbursement rate is firmly established, despite the degree of complexity associated with the presenting complaint. Documentation and collection procedures are, therefore, more straightforward.

Increasing Per-Patient Collections

- Improve front-end data collection: Unfortunately, getting the patients in the front door is only half the battle. Proper front-end data collection is the most crucial step in billing.
- Address/ payer verification: The old phrase, "garbage in, garbage out" applies here. Documentation, and address verification are vital to this process.
- Cash discounts: In our ED, cash discounts for uninsured patients are arranged in the following manner: The day after the patient visit, we phone the patient, and give them the option of making a one time payment of $50-75. This allows them to receive discounts similar to those afforded by managed care plans, and it allows us to collect earlier.
- Rapid bill dropping: Often times, the first company to deliver a bill, is the first company to receive payment. Mailing the bill within two working days will, most often, accomplish this goal.
- Downside: There are, of course, downsides to aggressive bill collecting techniques.
    - Customer service concerns: The major obstacle to aggressive collections is the associated customer relations fallout. The patient may get the unfortunate impression that you are holding people

hostage for their health care. It is important to hire a suitably diplomatic person for this job!

Revenue Increasing Programs

Chest Pain Evaluation Units

- Decrease LOS for R/Os: CPEUs accomplish rapid evaluation of patients with chest pain. Rule out protocol takes between 6 to 12 hours. This reduces the hospital LOS for chest pain diagnosis, thereby allowing the hospital to increase bed turns, or number of patients in a bed per day.
- Generate Hospital Revenue: By increasing bed turns, you increase hospital revenue, and can potentially feed other services.
- Allow you to take advantage of "**new service"** opportunity for publicity: Hospitals can use this new service to launch a chest pain service, or to act as a point of entry to cardiology service. Whatever the approach, this is another chance to make your name heard.
- Increase professional revenue for EM: EM physicians cannot bill twice for the same patient encounter. If an EM physician manages the patient in the CPEU, you can bill for an extended stay. If the physician, performs the H&P, and completes the progress note, and discharge summary, you may bill for those instead of for the ED visit. Whether you choose to bill for the CPEU, or for the ED visit, will depend upon which is more profitable given the particular situation.
- Improve bed turn time for hospital: The hospital can use the bed for more than one patient during the course of the day, which increases hospital revenue. Also, you will, most likely, perform some form of cardiac imaging procedure during the stay to effectively rule-out an ischemic origin for chest pain. In our hospital, this was an added bonus, as those services were not previously available on a stat basis.
- Provide point of entry for "Heart Program": If your hospital has a "heart program" this will offer a new point of entry into it. This places those patients in the queue for further evaluation.

Occupational Medicine

- On campus vs. off campus: This decision rests upon the density of the businesses towards which you are marketing. Proximity of this service to the businesses is an important marketing tool. Most employers will preferentially use clinics within a 3-5 mile radius.
- Structure of relationship: The structure of the proposed relationship is of vital importance in the decision to proceed with an on-campus occ-med center. If your group is using a joint venture model with the hospital, and the clinic is siphoning patients out of the ED, you are taking a double hit in lost revenue, because the reimbursement is less in an occ-med clinic.

    - Risk vs. Reward: The structure of the relationship is vital. Increased reward equals increased risk. This risk can be partially or even wholly transferred to a JV partner with a concomitant loss of a percentage of the bottom line. The upside in a hospital JV is that it further ensconces your group within the hospital. Often times, the hassle of dissolving the relationship and changing groups is too much for the hospital to undertake. This improves the security of your contract.
- Market driven: It is vital to be nimble enough to respond to the needs of the employers in the area that you hope to attract. Market studies prior to opening can direct you towards services that area businesses need.
- Marketing to employers: Start this process early by personally calling up or visiting HR people in the larger companies. Let them know of your plans to expand a service line and inform them that you would value their input in determining which services to offer.
- Physicals: This is part of contract services. You bill the employers directly for the physicals that you perform. These may be relatively straight forward, or they may be highly detailed, depending upon the employee's history, and upon the demands of the job. Exams may even include a PT evaluation and/or a respirator fit.
- Drug screens: Drug screens are performed under the following circumstances: for-hire, for cause, random, and post accident. The handling of this information is vitally important to the employer, with particular focus on the chain of custody. Drug screens, like physicals, are low margin businesses.
    - MRO services: Medical Review Officer services can also be sold to employers as a separate item. An MRO reviews drug screen positives, in order to differentiate between the possibility of abuse, and the presence of by-products of prescription drugs.
- Acute injury care: This is the mainstay of occ-med, and the majority of the revenue lies here. Many occ-med companies "give away" the contract services in order to get the acute injuries.
- Follow-up care: On average, acute injuries receive two follow-up checks. During these checks, work status is reviewed, and the injury, and the patient's perceived progress, is re-evaluated.
- Physical Therapy: Many occ-med centers include on-site PT. This enables the injured worker to begin treatment immediately, and hastens their return to work. Approximately 60% of patients require PT after on the job injuries. Therapy averages between 3 and 6 visits.
- Radiology: The ability to take plain radiographs is crucial in an occ-med center. These must be over-read by a contracted radiologist. With large volumes of films, comes the ability to seek per-case discount rates.
- Referral source: One important aspect of an occ med center is the

capacity to refer patients to colleagues on the medical staff. In order to be effective, the clinic must closely follow the patients during outside referrals. A tight reign is needed on both the injured worker and on the referral physician.

- Pain medicine: occ-med patients with chronic pain can be evaluated by your hospital's pain med specialists.
- Orthopedics: operative and non-operative orthopedic injuries can be referred to your hospital's orthopedists.
- Physical Medicine and Rehab: This is another specialty that can benefit form the presence of an occ-med clinic.

Urgent Care Centers

- On campus vs. off campus: There are pluses and minuses associated with each option. On campus centers have the potential of taking revenue away from the ED. This being the case, you will be best served if it is your center! Otherwise, be on the lookout for lost margins from the on-campus site. If you are losing patients because of long waits, or high prices, an on campus site may be beneficial, even if it is a joint venture. Off campus sites can direct patients into the hospital system, and probably take very little business away from the ED.
- Structure of relationship: The structure of the relationship between you, the hospital, and the administrators is of vital importance in the decision to proceed with an on-campus urgent care center. If your group is using a joint venture model with the hospital, and you are losing ED patients to the Center without receiving adequate reimbursment, you are taking a double hit in the lost revenue.
    - Risk vs. Reward: The structure of the relationship is vital. Increased reward equals increased risk. This risk can be partially, or even wholly, transferred to a joint venture partner with the concomitant loss of a percentage of the bottom line. The upside in a hospital JV is that it further ensconces your group with-in the hospital. Often times, the hassle of dissolving the relationship, and changing groups, is too much for the hospital to undertake. This action improves the security of your contract.
- Become a referral source: Instead of being a "cost center", an urgent care can help you become a referral source to the hospital and specialist. This referral issue is especially important when contract negotiation is underway.
- Beware medical staff perception: Great care must be taken to prevent the perception of competition with the PCPs. This step is crucial. The many hours invested in meeting with the PCPs, in order to stay on the same page with your mutual patients, and maintain a relationship, will be paid back ten fold if it prevents future turf wars.

- Volume business model: Urgent care medicine's bottom line, much like ED medicine's bottom line, is volume driven. Once the break-even point is reached, about 70% of revenue drops to the bottom.
- Customer service: This is the key to attracting, and redrawing patients to your center. Patients are not accustomed to great service in medicine, especially in the ED.
- Staffing model: The most expensive area in an urgent care budget is employee salaries, especially the physician's salaries. EM physicians are typically too expensive to use in an urgent care model. Additionally, we are not trained to provide routine follow up care for diseases like HTN, DM etc... This position is better left to a well-trained family practitioner who is comfortable with procedures.
- Physical plant and equipment: To reduce initial expense and start-up costs, include tenant improvements in lease rate. Also, most capital equipment can be leased rather than purchased.
- Payer contracts: It is crucial to have payer contracts established prior to opening the doors. Most payers require that your providers are credentialled before payment is remitted. The failure to credential your providers with each health plan, can drastically slow your cash collection cycle.
- Marketing: There are a plethora of marketing techiniques available. Your efforts should be directed towards three fronts. The primary focus should be toward the end users, ie. the patients. The second target is the healthplans, which can direct patients towards your urgent care center via their nurse lines. Finally, you should market to local physician offices. This last avenue is the most difficult. As mentioned above, you must emphasize that you will be sending their patients back to them for follow-up, and that you are merely acting as their surrogate during busy times, after hours, or while they are on vacation.
- Ancillary services: CLIA waved tests, x-ray, SVNs, EKGs, O2 saturation, blood drawing, specimen collection, and IV therapy.
- Hours of operation: Extended hours is a key component. Weekend, holiday, and evening hours are the most highly utilized.
- Billing and coding: The physicians should be coding the charts, as they are seeing the patients. The back office staff adds all the medications and tests, and the front office staff reviews the chart prior to patient discharge. Small errors in coding can create large problems with HCFA. On the flip side, you can lose large amounts of money by overlooking reimbursable charges.

Hyperbaric Medicine

- Hyperbaric medicine: You can lease a single, or a dual place chamber, or may joint venture the concept with a supplier of the chamber. Depending

on your clientele, and on the availability of other chambers in the marketplace, a hyperbaric chamber can be a modest revenue producer. The procedure is staffed by an RN, who has specialized training in hyperbaric medicine. Depending on the conditions, you can treat between 8 and 12 patients in a twelve our period. The most common use for a chambers today, is for wound care.

- Wound care program: A wound care program can be developed around the hyperbaric chamber, with special emphasis on facilitating the healing of patients with peripheral vascular disease, or diabetes. The wound clinic can be run out of the ED, or fast track in cooperation with your surgical staff.
- Referral source for surgeons: This program allows the ED to become a referral source for general and plastic surgery. It also enables the ED team to become "experts" in the field of wound care and management.

Hospitalist Program

- Similar to EM: Hospitalists, like EM physicians, perform their duties exclusively in the hospital setting. The hospitalist movement began in response to PCP's reluctance to cut back on office hours in order to make time for rounds. A second factor in the evolution of the hospitalists, was the desire of managed care companies to reduce bed days per admission.
- Provides continuity for care: A hospitalist program provides continuity of care from the ED throughout the hospital stay. The programs are usually staffed by internists, who are in the hospital 24 hours per day.
- 24-hour inpatient coverage: This intensity of coverage reduces LOS (bed days), and lowers costs, while providing more face time with the physician.
- Better service to patients, staff, and physicians: A properly implemented and managed hospitalist program will improve the quality of care, thus benefiting patients, staff, and physicians alike.
- Like the ED, hospitalist programs must be sensitive to turf: A hospitalist operates in an environment similar to the ED, in the sense that they are in a virtual fishbowl. Care must be taken to communicate very closely with the PCPs regarding the status of their patients.
- Education of PCPs is crucial: Time invested in the implementation phase with the PCPs will have tremendous positive impact on the outcome of the program.
- Improves hospital margins in DRG based reimbursement: It is well documented that a hospitalist program can reduce the bed days. In a fixed reimbursement scenario, a well-implemented program will improve hospital margins by lowering costs.

Conclusions

- Collaboration and creativity count: In any new venture, cooperation is crucial for success. This cooperation is brought about by active participation of all parties, and by thorough planning and follow through.

- Knowledge of market and political environment is essential: "Knowledge is power." It is crucial to have a comprehensive understanding of both the hospital, and the community, business and political environments. In order to be effective, you must be capable of using this knowledge to make effective decisions, and you must posses the strength to act upon those decisions. In addition, you must maintain the ability to act quickly upon changes within these structures.