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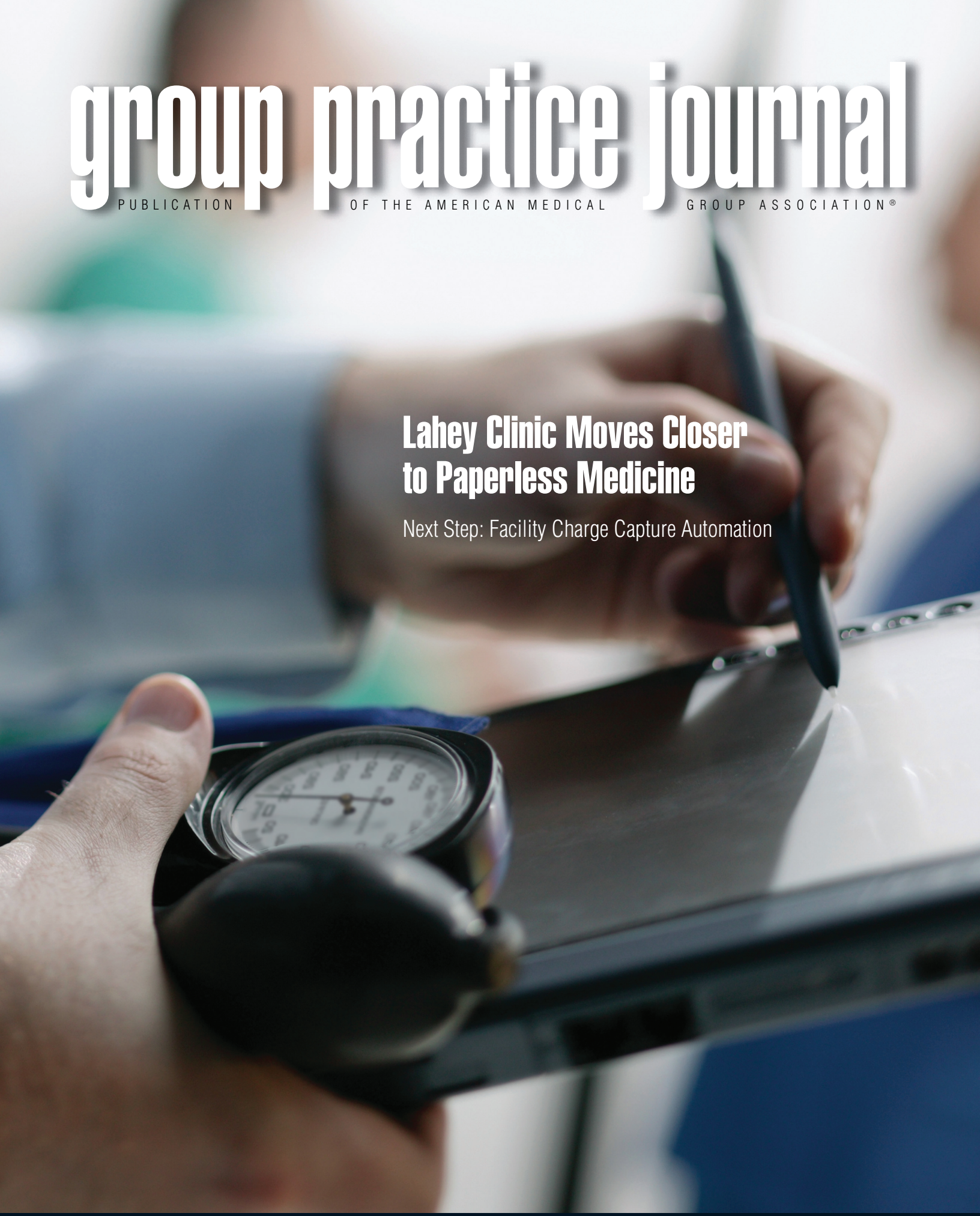

Lahey Clinic Moves Closer to Paperless Medicine

Next Step: Facility Charge Capture Automation

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INSIDE: E-LEARNING AND ROBOTIC-ASSISTED SURGERY

Facility Charge Capture Automation: Lahey Clinic Moves Closer to Paperless Medicine

BY CYNTHIA TRAPP

Achieving paperless medicine has been the objective of forward-thinking group practices for more than a decade. And the stakes have never been higher. The consequences of paper-based processes—specifically, coding and billing—were once largely workflow and revenue cycle inefficiencies that could be mitigated somewhat with strict policies and additional staff resources. However, current realities of ICD-10, RAC audits, and pay-for-performance programs illustrate an intensifying need for group practices to migrate from paper-based systems to technology solutions or face increasingly steep financial risks, including penalties and revenue loss.

Lahey Clinic's foray into the realm of paperless medicine started nearly 10 years ago when in 2001, we decided to implement mobile charge capture technology as a replacement for physician encounter forms. This initiative was launched in response to labor-intensive and costly coding and billing processes that, while tightly controlled due to enormous efforts to ensure capture and accuracy of charges, still resulted in a number of lost charges and denials or in rework from coding errors.

Ultimately, we selected PDA-based software and a new wireless network to offer a mobile option that would permit charge submission from anywhere within our clinic and hospital system. Since that time, our efforts regarding clinician-oriented technologies have burgeoned dramatically. More than 500 providers are now using professional charge capture for submission of inpatient and outpatient encounters as well as surgical charges from the operating room. Providers also have access to mobile electronic prescribing, and will have an electronic medical record (EMR) system at their disposal once our current implementation is complete.

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Seeking a Facility Complement

While the aforementioned systems are generally physician-oriented, we recently deployed automation to expedite coding and billing processes for clinical staff in our 40-plus outpatient hospital clinics. Facility charge capture has been a desired system since the early days of our professional charge capture roll-out. While the implementation of professional charge capture has been highly successful, yielding compliance gains, improved coding, better reconciliation processes, reduced cost, and a variety of improved revenue cycle metrics, we were still faced with a paper form for our outpatient hospital charges. This was because the tool was designed for professional charges, not for capturing technical components, such as facility utilization, related to a patient's clinic visit. This was still a manual, paper-based process.

Given our continued desire to reduce reliance on paper as well as the related administrative overhead of photocopying, updating, filing, and storing forms to document nearly 3,000 patient visits daily, the development of a complementary facility charge capture system was something we contemplated for several years. Our vision was a tool that would not only complement professional charge capture, but also enhance compliance through the cross-reconciliation of professional and technical data elements related to a single visit.

In 2006 our vision started to look more like a reality when we approached our charge capture solution vendor MedAptus about partnering on the design of software to address our technical coding and reconciliation challenges—common to many clinics our size. Given a lack of existing software for facility charge documentation in the healthcare information technology market, MedAptus agreed.

Design Attributes: Fast, Flexible, and Friendly

While professional charge capture technology has become increasingly popular across larger, multispecialty

clinics—given its ability to rapidly drive financial improvements, streamline processes, and enhance compliance efforts—automation capable of providing the same benefits for the technical side of billing is still new territory for most hospitals. However, with growing demand for outpatient service delivery by organizations seeking to reduce costs (and leverage newer technologies and surgical advances) in a time of declining reimbursement, the need to optimize the outpatient revenue cycle is a critical one. Technology, as opposed to people, paper, and processes, is the ideal approach because adhering to complex and evolving Outpatient Prospective Payment System (OPPS) rules can be quite challenging.

In helping to design facility charge capture software, we sought an end product that would be as easy to use as the physicians' professional tool. It needed to be flexible, given the number of specialties that would be utilizing it, and able to automatically generate a facility evaluation and management (E&M) code based on entered tasks and time allotted to each task (per patient visit). Integration with our charge data master (CDM) was also a critical function.

Another important system requirement was the ability to merge the facility portion of a patient encounter with the corresponding professional charge from the physician in order to provide the facility revenue cycle staff with a complete picture of the charge so that they could utilize required components of the physician charge, including code category and diagnosis code. This mechanism, a cross-reconciliation engine, would avoid potential compliance issues such as inaccurate coding and discrepancies between the hospital charge and the physician charge. In addition, any potential revenue loss could be identified and proactively addressed (e.g., a medication is entered for the facility charge, but the corresponding physician injection code has been omitted).

By early 2007 the product was developed and ready for deployment at Lahey Clinic. The first department to utilize facility charge capture was neurosurgery. A pilot approach was undertaken in the event that performance or adoption issues were encountered. However, shortly after the system went live, we achieved 100 percent staff adoption with 100 percent of patient charges submitted electronically.

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Ending the Paper Chase

Prior to implementing facility charge capture, Lahey Clinic's outpatient coding and billing process was multi-step and fairly time consuming. Once a patient was seen by his or her physician, the professional charge was submitted electronically using the synchronization feature on the doctor's handheld device. Ideally and typically this would happen on the same day of service. Any technical components would then be documented by clinical staff on an encounter form, which had many different versions to manage. Next, the technical encounter form was stapled to a printout of the physician's corresponding charge, once reviewed and approved by coding staff.

When considered at a high level, our process seemed fairly straightforward, as it does to the countless large clinics that follow one of similar design. However, it included many opportunities for inefficiency, particularly if a provider was delayed in submitting his or her charge component. When this happened, staff would have to stay late to collate the forms, or charges would be held up until the next day or sometimes many days or even weeks later. This was particularly troublesome at month's end, especially for higher-volume clinics that were missing forms or waiting for corrected information.

Initial feedback from clinical staff regarding usage of the new tool was not just positive, it was euphoric. Because automation eliminated forms and associated batching and stapling tasks, as well as the need for research or re-creation of an encounter in the event of a lost form, clinical staff members reported being able to devote more time to patient care. In fact, one staff member was quoted as saying that she would "quit if anyone were to take this away!" In an attempt to measure the rollout's success more quantitatively, a time-and-motion study was undertaken and revealed that an encounter could be completed in less than 10 seconds using the new technology once a user was logged in; the manual process could have taken anywhere from 5 to 90 minutes, depending on the particulars of the encounter.

Another benefit of the system stems from the integration of facility charge capture with our CDM. This tight coupling provides seamless propagation of changes—a frequent occurrence in an organization of our size. Without such a link, there is a risk of billing outdated codes. And beyond the potential for loss of revenue and noncompliance, manual CDM updating processes require resources and oversight to create and distribute new forms while collecting and destroying outdated ones.

Currently there are 26 departments live on facility charge capture representing more than 200 clinical users. The system processes nearly 100,000 charges monthly and has yielded many staff efficiencies, particularly in our busier outpatient areas such as internal medicine, orthopedics and dermatology. Staff continue to react favorably to the automation and enjoy enhanced

personal productivity, more time to interact with patients, and the satisfaction of completing their post-appointment work on the same day the service was performed. In addition, it allows clinical staff to ensure reconciliation of charges on a daily basis.

Insights

For groups contemplating the purchase of a charge capture automation solution, there are many things to take into consideration, depending on your approach. For example, it is important to clearly set end-user expectations in regards to workflow impact. When Lahey Clinic first deployed the professional charge capture solution, it was a significant adjustment for the physicians—not only did they have to learn how to use handheld devices, but also they had to become more proficient with coding. Over time they adapted and gained in efficiency. With the facility tool, however, the efficiency gains were practically immediate, though there still may be some challenges with clinic staff who do not have extensive computer experience.

Another critical piece in the adoption of facility charge capture is understanding the nuances of day-to-day clinic operations. Obviously, busier clinics will need more support initially so as not to disrupt patient care. Another consideration is any additional reliance on encounter forms; for example, serving as an order to be brought to a lab for blood work or the charge for the administration of drugs. For larger institutions, fully grasping these types of differences may be challenging, but doing so, with the early involvement of clinical end users, will yield success at rollout.

Facility charge capture technology has allowed Lahey Clinic to advance closer to our longstanding vision of paperless medicine. Though the journey has been long, we have realized tremendous benefits that go beyond the measurable financial improvements yielded by revenue cycle solutions. Increased staff morale, rapid clinician adoption of computing—setting the stage for an EMR—and even enhanced care team member communication are all attributable to the adoption of tools initially sought merely to replace encounter forms.

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