Washington State Health Care Authority

Report to the Legislature

Emergency Department Utilization: Assumed Savings from Best Practices Implementation

Third Engrossed Substitute House Bill 2127
Chapter 7, Laws of 2012, 2nd Special Session (Partial Veto)
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Executive Summary

Section 213(43) of Third Engrossed Substitute House Bill 2127, enacted as Chapter 7, Laws of 2012, 2nd Special Session (Partial Veto), directs the Health Care Authority (HCA) to report, by January 15, 2013, whether assumed savings based on preliminary trend and forecasted data are on target and if additional best practices or other actions need to be implemented.

The aforementioned bill states, *"…The authority shall by January 15, 2013, perform a preliminary fiscal analysis of trends in implementing the best practices in this subsection, focusing on outlier hospitals with high rates of unnecessary visits by medicaid clients, high emergency room visit rates for patient review and coordination clients, low rates of completion of treatment plans for patient review and coordination clients assigned to the hospital, and high rates of prescribed long-acting opiates. In cooperation with the leadership of the hospital, medical, and emergency physician associations, additional efforts shall be focused on assisting those outlier hospitals and providers to achieve more substantial savings. The authority by January 15, 2013, will report to the legislature about whether assumed savings based on preliminary trend and forecasted data are on target and if additional best practices or other actions need to be implemented..."*

This report, Emergency Department Utilization: Assumed Savings from Best Practices Implementation, examines Medicaid utilization data to identify the costs and trends of Medicaid visits. Due to the brief project timeline and limitations of available data, the Health Care Authority recommends further monitoring of the emergency department best practices. A full report to the legislature by October 30, 2013 would allow for twelve months of data to be examined and a more informed conclusion to be drawn. Early positive signs include the increased emergency department adoption of electronic information exchange, improved patient care plan coordination, and indications of reduced spending trends, At this point, continuation of the best practices appears to be clinically beneficial and in the best interest of Medicaid clients through the notable improvements in health care coordination but further analysis is necessary.

Project Overview

In Washington State, as in other states, patients may visit the hospital emergency department (ED) for conditions that could be more effectively treated in an alternative, less costly setting. Third Engrossed Substitute House Bill 2127 set forth seven best practices aimed at reducing unnecessary emergency department use by Medicaid clients. All Washington hospitals with emergency departments serving Medicaid clients attested to their agreement to these practices on or before July 1, 2012. These best practices include:

(a) Adoption of a system to exchange patient information electronically among emergency departments. In order to reduce unnecessary use of the emergency room, hospitals need to be able to identify frequent users and share information regarding their care. Previously, the ED physician had no way of knowing, for example, that a patient had visited multiple EDs in the past week with the same complaint. The electronic information system allows emergency department physicians to see all of the patient's emergency room visits from all hospitals over the past twelve months, and to know the diagnosis and treatment given on these previous visits. If a patient is seeking narcotics, the emergency department physician will know this and will respond accordingly.

(b) Adoption of a system to educate patients that the emergency department should be used only for true emergencies. Every hospital has now agreed to provide patients with a brochure and/or discharge instructions discussing the most appropriate setting for their health care. Hospitals have also attested that they have trained ED physicians in how to talk to patients about where they should receive care for non-emergent needs.

(c) Implementation of a process to disseminate lists of frequent users to hospital personnel to ensure they can be identified by the electronic information exchange system discussed above.

(d) Implementation of processes to assist frequent users with their care plans, and to make appointments for these patients to see their primary care provider within 72-96 hours of their emergency room visit.

(e) Adoption of strict guidelines for the prescribing of narcotics. Hospitals have also attested they have trained ED physicians in how to enforce these guidelines.

(f) Enrollment of at least 75 percent of ED prescribers in the state's Prescription Monitoring Program by July 1, with a goal of 90 percent enrollment by December 31, 2012. The PMP is an electronic online database used to collect data on patients who are prescribed controlled substances. It enables prescribers to see which prescriptions have been previously filled by a patient. This is essential information to reduce the number of patients seeking narcotics.

(g) Designation of hospital personnel to review feedback reports regarding ED utilization and to take appropriate action in response to the information provided by those reports.

Over the past six months, the HCA has met monthly with an ED workgroup which includes representatives of the Washington Chapter of the American College of Emergency Physicians, the Washington State Medical Association, and the Washington State Hospital Association. This workgroup monitored trends in emergency department use and developed clear guidelines for hospitals to implement the seven best practices. The workgroup brought together primary care and emergency department physicians to develop ways to better coordinate care. Seven web conferences were held with more than 1,100 attendees, three informational videos were created to help hospitals rapidly implement the required changes, and brochures were published to educate patients on appropriate settings for health care treatment. Members of the workgroup also hosted an in-person Safe Table Learning Cooperative in September, with approximately 150 attendees, to educate emergency department personnel from across the state in how to implement the seven best practices, and to learn from national experts on reducing emergency department use.

The workgroup also collaborated in the development of metrics for monthly utilization and prescribing reports to be issued to hospitals, as noted in best practice G. These measures include identification of utilization patterns by frequent ED users, visits with a primary diagnosis identified as "low acuity", visits with a scheduled drug prescription, and others. Feedback reports provide both peer-to-peer comparison views as well as historical data that enable hospitals to track their own progress over time.

In an effort to assist hospitals in ensuring appropriate prescribing of scheduled drugs, the HCA made available an additional monthly feedback report with prescriber-specific data. The feedback report identifies, per prescriber, the number of scheduled drug prescriptions, average number of units (pills, capsules, etc) per scheduled drug prescription, and number of narcotic prescriptions to clients enrolled in the Patient Review and Coordination (PRC) program.

Project Impact

Although only a few months of data post-implementation is available, there are promising signs of improvement to quality and coordination of care.

- The number of hospitals sharing emergency department information electronically increased over 500 percent between November of 2011 and October of 2012. This means emergency medicine

physicians have more critical patient information, and can respond appropriately. In addition to the 85 hospitals currently exchanging information electronically, ten other hospitals are in the process of implementing an information exchange system.[i]

- The percent of total emergency department visits by frequent users decreased by 23 percent between June and October of 2012 among 32 hospitals for which data are available for this five-month period.[ii]
- The 32 hospitals mentioned above completed over twice as many care plans for frequent users by the end of this five-month period. In June of 2012, they were completing care plans for 28 percent of frequent users; by the end of October, this number was 64 percent. These care plans are now available via an electronic information exchange system in 85 emergency rooms across the state, and will soon be available in ten more ER's, for a total of 95. This means virtually all emergency department providers in our state have access to the care guidelines for these clients. If a client has a chronic condition, is seeking opioids, or needs mental health services, these facts and others are stated in their care plans. Work is ongoing to create a standardized care plan format that can be adopted for future use by emergency departments.

Fiscal Impact

The fiscal impact of the saving has both managed care and fee-for-service components. Savings from managed care are built into the premiums. For the Healthy Options Clients, the impact of the best practices from the 2012 budget proviso was a reduction of $0.79 per member per month (PMPM). The corresponding savings amount for the Healthy Options Blind Disabled population was $5.85 PMPM.

Fee-for-service savings estimates are extremely preliminary. Reporting on July through September savings requires that we look at months with very immature data. However, we can adjust these data using lag factors to approximate mature data. Using this lag-adjusted data, we see a drop in the PMPM in the July through September period from $7.70 in 2011 to $6.88 in 2012, a drop of $0.82 (10.6%) from SFY2011Q1 to SFY2012Q1. Anticipated savings for State FY 2013 are shown in the table below.

HCA - Emergency Room Analysis - Anticipated Savings for SFY2013

	Annual		Monthly Average	
	GFS	Total	GFS	Total
Fee for Service:	($4,422,863)	($10,206,633)	($368,572)	($850,553)
Managed Care:	($10,158,601)	($23,442,985)	($846,550)	($1,953,582)
Total	($14,581,464)	($33,649,618)	($1,215,122)	($2,804,135)

While these data demonstrate savings, they must be considered very preliminary. Looking at savings over a longer timespan would allow for a much more mature and robust set of data for analysis. Because hospitals began implementing the seven best practices less than six months ago, it is not yet possible to measure definitively the fiscal impact of the 2012 budget proviso.

Next Steps:

The seven best practices adopted by hospitals represent just the first step in reducing unnecessary use of the emergency room. To address the demand side of emergency department care, our state must address the larger, systemic reasons why Medicaid clients go to the emergency room for their care.[iii] To address the supply side of emergency department care, our state must address the competing nature of free standing emergency departments, urgent and hospital care that compete with primary care for after-hours and weekend care. Examples include:

Dental care: Adult Medicaid patients now rely on the emergency room for dental care due to a lack of services in the community for these medical conditions.[iv] In 2011, the Washington State Legislature eliminated all but emergent dental coverage for adult Medicaid clients (that is emergent use is covered but not preventive). As a result of their lack of preventive dental care, Medicaid clients and the uninsured resort to the emergency room when they experience a dental crisis.[v] Unfortunately, the emergency room can only offer them pain relief, extraction or referral of the tooth to dental provider with timely available appointments. Without access to preventive care, it is unlikely that use of the emergency room for dental care will decline in any significant way.[vi]

Mental health and chemical dependency issues: According to a 2011 analysis of 53 hospitals by Washington State Hospital Association, many frequent users of the emergency department are challenged by mental illness (over 80%) and/or chemical dependency (over 40%).[vii] Finding appropriate treatment for them quickly can be difficult and securing ongoing treatment is critical. Without it, these patients may end up becoming seriously ill and return to the emergency department at a higher cost to the health care system. The best practices adopted to date, such as better at-risk patient identification and coordination through use of health information technology, are promising system changes to improve care. However, ultimately, more service integration with mental health and primary care is necessary. Hospitals and providers should consider more ways to improve integration. The HCA will work with DSHS through its behavioral health system project[viii] to develop and improve measures for better patient care.

Potential challenges with primary care access: In some cases, a lack of adequate or timely access to primary care may contribute to unnecessary use of the emergency department. If a client does not have a primary care physician, or cannot be seen in a reasonable amount of time for a low-acuity need, he or she may turn to the emergency department. For some patients, even if they have a primary care provider assigned to them, they may have never seen that provider. Although the patient theoretically has access, they may not have developed a meaningful connection to primary care, which exacerbates the problem of over-utilization of the emergency department. As the state moves toward implementation of health homes, these changes may reduce over-utilization of the emergency department. Coordination of care across the social, physical, and psychological spectrum as well as integrated care between local providers is necessary for the highest utilizers of the emergency department.[ix]

Recommendations

The official implementation of the emergency department best practices began on July 1, 2012. Due to the brief project timeline and limitations for real-time data, the Health Care Authority recommends monitoring the emergency department best practices project until claims data are available for a full twelve months. A continuation of the best practices appears to be clinically beneficial and in the best interest of Medicaid clients

through the promising improvements in health care coordination. A full report to the legislature by October 30, 2013 would allow for twelve months of data to be examined and a more informed conclusion to be drawn.

During this time, the HCA recommends the following actions to strengthen and enhance the current efforts:

1) Continue the emergency department assessment of savings through this fiscal year before determining that the seven best practices will achieve a $31 million dollar savings;

2) Facilitate promoting and monitoring the seven best practices beyond fee-for-service Medicaid and Healthy Options plans into Public Employee Benefits and Basic Health;

3) Report publicly on emergency department utilization and prescribing trends after the ED Workgroup and appropriate stakeholders have validated reported data; and

4) Promote the electronic client care plans throughout the Medicaid Health Information Technology (HIT) solutions with primary care provider integration, medical home use, multi-payer use, and improvement on the return on investment for meaningful use.

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[i] Data Source: Collective Medical Technologies LLC, Emergency Department Information Exchange, and Inland Northwest Health Services.

[ii] These data come from the 32 hospitals that had adopted the Emergency Department Information Exchange as of June 1, 2012. Hospitals were not required to implement their electronic information exchange system until October 1, 2012, so statewide data are not yet available to measure the effects of the seven best practices to reduce unnecessary ER use.

[iii] In a 2007 report to the Washington State Legislature, a task force concluded that unnecessary use of the emergency room stems from the following systemic reasons: 1) A lack of primary care providers or access to those providers; 2) The fact that patients with mental illness and substance abuse issues use the ER as their medical home; 3) The lack of incentives for primary care health delivery; and 4) The lack of disincentives to use the ER for non-emergent conditions. ESSB 5930 Report: Reducing Unnecessary Emergency Room Use. Presentation to the Washington State House Health Care and Wellness Committee (2007).

[iv] "Emergency Room Use," Washington State Hospital Association, October 2010, pages 12 and 15.

[v] Medicaid recipients and the uninsured account for two-thirds of all ER dental visits in Washington State. "Potentially Avoidable Emergency Room Use," Washington State Hospital Association, February 2011. (These data come from information supplied by 53 hospitals in Washington.)

[vi] Although dental care accounts for 2 percent of all ER visits, it represents just .3 percent of all ER charges because dental visits are much less expensive than the average ER visit. "Potentially Avoidable Emergency Room Use," Washington State Hospital Association, February 2011. (These data come from data supplied by 53 hospitals in Washington.)

[vii] Mental illness and substance abuse cases brought to the emergency room are usually require immediate care. Although these visits are not "unnecessary," many of them would be avoided through better care in our community for these patients. Doing so would significantly reduce the cost of avoidable visits to the emergency room. These visits cost, on average, $4,487, compared to the average cost of other avoidable visits to the ER, which is $1,601. "Potentially Avoidable Emergency Room Use," Washington State Hospital Association, February 2011. (These data come from data supplied by 53 hospitals in Washington.)

[viii] Information regarding this project may be found at http://www.dshs.wa.gov/pdf/dbhr/BH%20Redesign.pdf

[ix] Hurley H, Emergency Room Use and Primary Care Case Management: Evidence from Four Medicaid Demonstration Programs, AJPH July 1989, Vol. 79, No. 7