

Washington State Health Care Authority

Report to the Legislature

Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation

Third Engrossed Substitute House Bill 2127
Chapter 7, Laws of 2012,
Second Special Session (Partial Veto)
(Budget Proviso)
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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 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 Health Care Authority shall, *“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...”*

A preliminary report in January 2013 tentatively identified favorable utilization and cost trends but there was insufficient data to draw any definitive conclusions. This report, *Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation*, re-examines Medicaid utilization data to identify the costs and trends of emergency department visits. Savings were achieved through reductions to the Health Care Authority budget, with an estimated annual savings for state fiscal year 2013 of \$33,650,000. The savings from managed care health plans were built directly into the premiums from the preliminary assumption of savings identified in the Third Engrossed Substitute House Bill 2127 of 2012. The total savings cannot be definitively attributed to the Seven Best Practices and may be related to other factors. However, data also indicates a reduction in emergency department utilization and the rate of emergency department-related scheduled drug prescribing since the implementation of the Seven Best Practices. In coordination with our community partners, HCA will continue to work with hospitals and Medicaid health plans to sustain and enhance these best practices.

Project Overview

In Washington, as in other states, patients may visit the hospital emergency department (ED) for conditions that may be more effectively treated in an alternative, more appropriate setting that may be less costly. Third Engrossed Substitute House Bill 2127 set forth 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 or has a chronic condition, 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.

Project Impact

Since the project inception, the HCA has met regularly 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 has monitored trends in emergency department use, developed guidelines for hospitals to implement the Seven Best Practices, and identified next steps. Project implementation and impact has included the following:

- Educational materials have been made available throughout the state. Brochures aimed at helping patients determine the appropriate setting to seek care are now in use in hospitals and clinics. Signs are on display in emergency department waiting rooms outlining the narcotic prescribing guidelines.
- Statewide, 98 hospitals are now sharing emergency department information electronically¹. Thus, emergency medicine physicians can access critical patient information and are able to respond appropriately.
- Hospitals have developed a standardized care plan format that can be used across emergency departments, and these care plans are now available via an electronic information exchange

system in 97 emergency rooms across the state. This means virtually all emergency department providers in our state have access to the care guidelines for these clients.

- After initial success with increased care coordination among patients in the Patient Review and Coordination (PRC) program, the workgroup recommended hospitals begin applying this practice to all patients with five or more emergency room visits within the last twelve months. Hospitals began implementing this new recommendation in June 2013.
- EDs and primary care providers (PCPs) have new opportunities for improved coordination. The electronic information exchange now includes an option to automate notification of PCPs when assigned patients make an emergency room visit. A total of 424 PCPs now have notifications enabled when their patients enter the ED. From September of 2012 to August 2013, 3,000 notifications have been made to PCPs through the system. This unprecedented communication option enables PCPs to have more accurate and timely understanding of their patients' health.

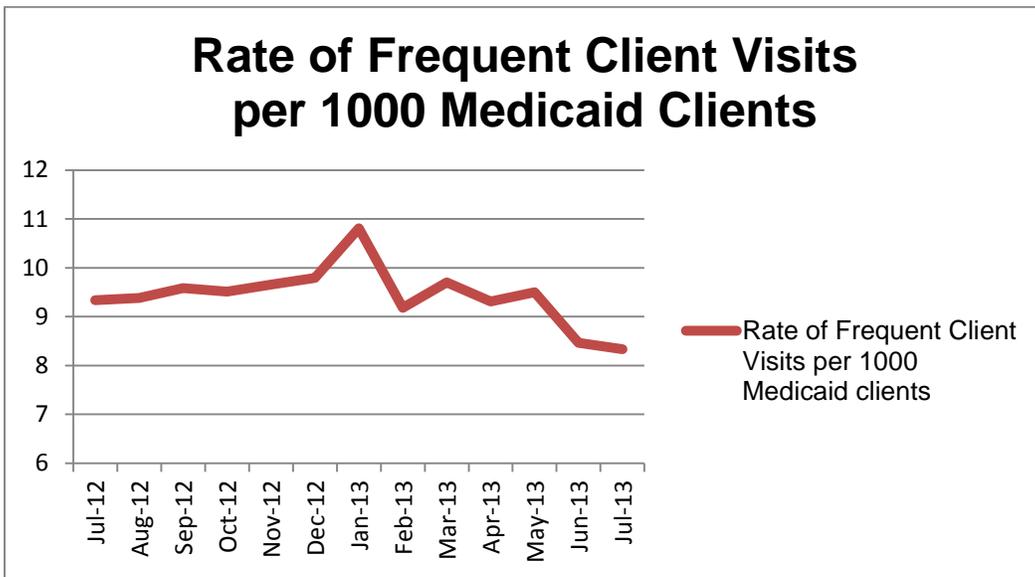
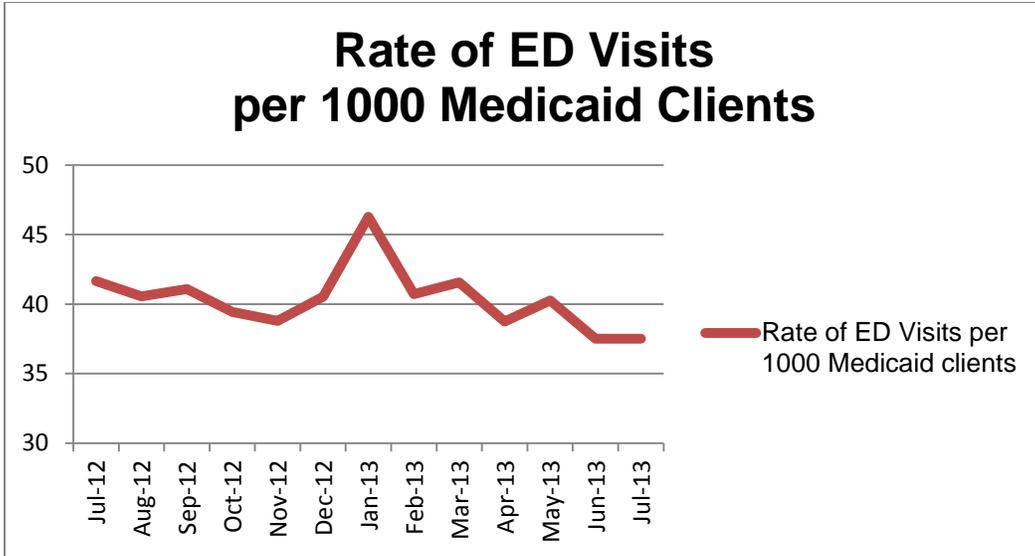
Beyond the collective efforts of the workgroup, the issue of reducing inappropriate emergency room use has become an area of focus statewide. Individual hospitals and clinics are taking innovative approaches to care coordination. For example:

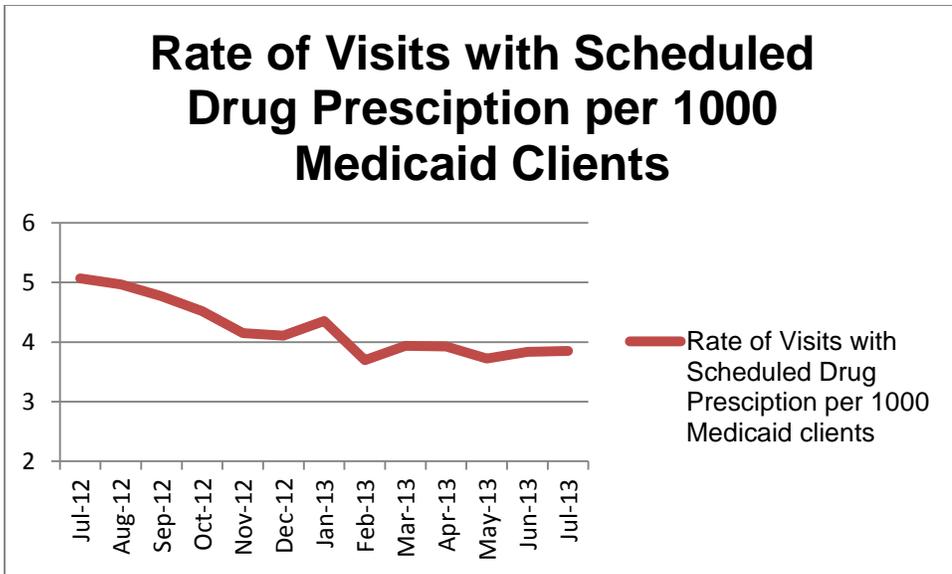
- Newport Hospital has secured funding to improve access to mental health services within the primary care setting and reduce crises that result in an ED visit. The pilot is focused on high risk patients who are frequent utilizers of the ED.
- PMH Medical Center in Prosser has implemented a community based paramedic programs to provide in-home visits to high risk patients with 24 to 48 hours of discharge. These visits include review of discharge instructions, physical evaluation, and making sure the patient has their medication and a follow-up appointment. While the project is still in the early phases, anecdotal evidence points to a reduction in visits by frequent utilizers. With nearly a year's worth of post-implementation data available, there are continued signs of improvement to quality and coordination of care.
- With grant funding from Center for Medicare and Medicaid Innovation, Kitsap Community Mental Health Center has developed an enhanced system of communication with the local ED enabling better coordination of care.

Claims data from both fee-for-service and managed care Medicaid clients' emergency department utilization was analyzed to examine ED utilization, frequent client utilization, visits resulting in a scheduled drug prescription, and visits with a low acuity diagnosisⁱⁱ. Between the formal implementation of the best practices (June 2012) and the most current available month of data (June 2013), all metrics show measurable improvement.

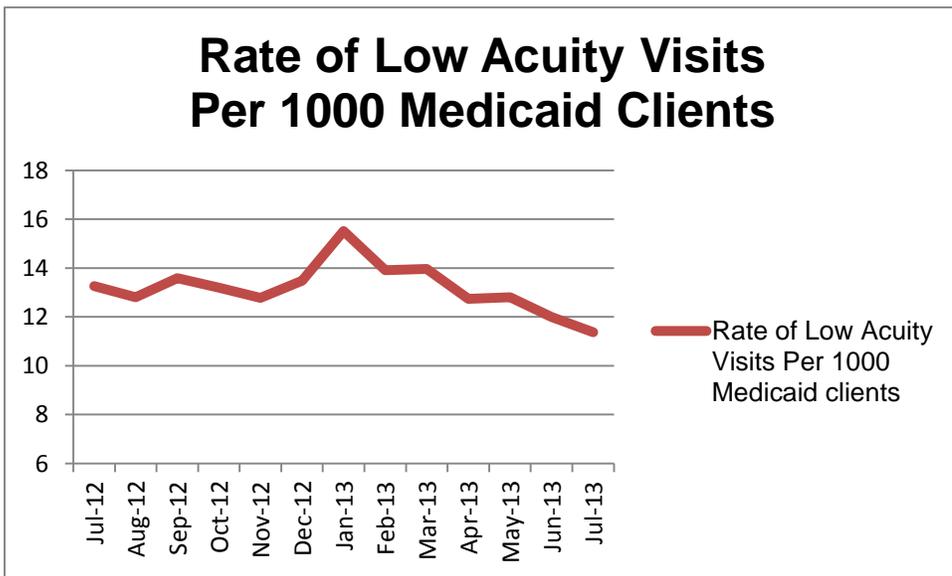
- Rate of emergency department visitsⁱⁱⁱ declined by 9.9%;
- Rate of visits by frequent clients (who visited five or more times annually) decreased by 10.7%;
- Rate of visits resulting in a scheduled drug prescription decreased by 24.0%; and
- Rate of visits with a low acuity diagnosis decreased by 14.2%

Although encouraging trends are concurrent of the implementation of the Seven Best Practices, other factors may also play a role, such as the recent transition of clients from the fee-for-service model to managed care organizations. The Health Care Authority will continue to monitor these trends in collaboration with the ED workgroup.





vi



vii

Fiscal Impact

Savings were achieved through reductions to the Health Care Authority budget, with an estimated annual savings for state fiscal year 2013 of \$33,650,000. The savings from managed care health plans were built directly into the premiums from the preliminary assumption of savings identified in the Third Engrossed Substitute House Bill 2127 of 2012. The total savings cannot be definitively attributed to the Seven Best Practices and may be related to other factors, including the previously mentioned transitioning of Medicaid fee-for-service clients into Medicaid managed care health plans during the same time period.

Next Steps

We anticipate upcoming changes to health policy and delivery will also positively impact ED utilization. In particular, the statewide roll out of medical health homes will help provide more comprehensive care management for clients with chronic health conditions. The restoration of a dental care benefit for adult Medicaid patients effective January 1, 2014, will very likely reduce ED utilization for Medicaid clients with non-emergent dental disease and pain. Moreover, given the apparent success of the Seven Best Practices in reducing ED utilization and the rate of ED-related scheduled drug prescribing, HCA will work with hospitals and health plans to sustain these efforts. In addition, the Health Care Authority will continue to identify and disseminate innovative practices that reduce utilization while improving client health outcomes. Specific next steps include the following:

- Encourage more robust information exchange by exploring new data linkages, such as January 2014 incorporation of Prescription Monitoring Program into hospitals' electronic information exchange system;
- Widen the conversation to address the roles of community mental health clinics, chemical dependency treatment providers, and primary care providers;
- Prepare for the impact of increased Medicaid population that began January 2014 on emergency department use by working with Medicaid managed care health plans to assure that Medicaid clients are educated about appropriate ED use;
- Work with local Emergency Medical Services (EMS) systems to identify alternative sites of care for patients who access EMS via 911, but do not need care in an emergency department; and
- 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.

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

ⁱⁱ Data was analyzed from July 2012 forward, as data required for the metric development from previously contracted Medicaid health plans (before July 2012) was not available.

ⁱⁱⁱ For these measures, an emergency department visit is defined by an outpatient claim identified as an emergency department visit, without either a transfer to an inpatient facility patient status, surgical procedure, or death of the patient.

^{iv} For these measures, an emergency department visit is defined by an outpatient claim identified as an emergency department visit, without either a transfer to an inpatient facility patient status, surgical procedure, or death of the patient.

^v Frequent client visits are defined as Medicaid clients who have visited an emergency department five or more times in the past 12 months.

^{vi} Measure is defined by an emergency department visit (as defined above) that results in a scheduled drug (2-5) prescription.

^{vii} Measure is defined by an emergency department visit (as defined above) that has a primary diagnosis which is included in the 527 low acuity list. Contact Health Care Authority for diagnostic details.