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INSIDE

Palliative Care Occupies Growing Presence in ED

Experts note that identifying palliative care options is the first step toward making such services accessible to ED patients

Palliative care receives high marks from patients and families, and the cost of care generally is reduced when they reject intensive care options in favor of measures more focused on comfort and quality of life.

However, in many cases, patients who potentially could benefit from palliative care are presented with this option only after a lengthy stay in an inpatient setting, following days or weeks of suffering with no sign of improvement. For this reason, the subspecialty is experiencing a growing presence in the ED — an earlier stage where many experts believe more benefits could be realized along with heightened patient and family satisfaction.

Although most studies tallying the benefits of palliative care have thus far have involved patients who were introduced to this option as inpatients, investigators in this area have begun to focus more attention on how and when palliative care could be introduced most effectively in the ED, and what happens when appropriate emergency patients receive early access to palliative care consultations.

Ashley Shreves, MD, an emergency physician at Ochsner Medical Center in New Orleans, observes that emergency medicine clinicians and leaders are much more interested in palliative care now than they were when she completed her fellowship training in palliative care in 2009.

"Change happens slowly and it takes a while for the people [with fellowship training in palliative care] to go out and change their departments ... and infiltrate leadership," she says. "But those things are now happening, and people are talking about it more at the national meetings."

Identify Palliative Care Resources

The integration of palliative care into the emergency setting has been the focus of much of the research conducted by **Corita Grudzen**, MD, MSHS, FACEP, the vice chair of research and an as-

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sociate professor in the Ronald O. Perelman Department of Emergency Medicine at New York University Langone Medical Center. She has found that, particularly for terminally ill patients, palliative care interventions can affect quality of life more positively in line with a patient's wishes while disrupting a trajectory of intensive measures that drives up costs without making an appreciable difference in outcomes.

However, with limited palliative care resources in much of the country, Grudzen advises emergency medicine leaders who are interested in giving the subspecialty more of a presence in their departments to take stock of what services they offer, both in the hospital and in the community.

"Do you have a palliative care team in your hospital? Most hospitals do," she says. "A lot of hospitals also have partnerships with outpatient clinics, although some of them are disease-specific."

For example, Grudzen explains that cancer centers often operate under an integrated model whereby a palliative care provider will work with oncologists. Advanced cardiology clinics or end-stage renal disease centers also may offer this kind of support to patients.

Another point to consider is that even for hospitals with extensive palliative care resources, it can be difficult to arrange for timely consults in the ED.

"Emergency departments are busiest in the evenings, so it really doesn't help us to have [consults] available from 9 to 5," Grudzen observes. "We are available 24/7, and most patients come to the ED when the doctor's office is closed."

In such cases, it is important to know whether palliative care experts are available after hours or how one can arrange for services most effectively.

Palliative care encompasses a range of multidisciplinary services, from effective symptom management to social supports and expertly driven goals-of-care discussions. Although it is not practical to deliver all of these services within the context of an ED visit, making a palliative care specialist available to patients and providers in the ED can facilitate decision-making so that a plan of care that is in line with the patient's wishes is initiated.

"Thinking through all these things in advance is really helpful," Grudzen says. "Know what your services are, find out if they are just inpatient or outpatient, and whether [these resource providers] are receptive to being called and at what times."

Partner with Hospices

For EDs that don't have adequate options for palliative care in house, Grudzen suggests finding hospices to partner with in the community.

"I found that these partnerships can be really fruitful," she says. "Find out if [the hospice] has people who can come to the ED and talk with patients and families, and explain the services available. This can be a great way to get patients out of the hospital and back home."

Shreves agrees that more EDs should consider partnering with community-based hospices.

"I think people would be surprised by how much — particularly inpatient hospices — can accommodate [their palliative care service needs], so that is one potential solution," she says.

Of course, not all patients who could benefit from palliative care consultations are candidates for

hospice, Shreves notes. However, for those patients who are near the end of life or have a terminal disease, many hospices can deliver good end-of-life symptom management and appropriate social supports, she explains.

In fact, Shreves, who works both as an emergency physician in the ED and as a palliative care physician on the inpatient side, has turned to a community-based hospice when appropriate patients with palliative care needs have presented to the ED.

"I can get a hospice to come in and evaluate people fairly quickly," she explains. "It is amazing what some of the more sophisticated hospices can and will accommodate, and what they can deliver in terms of patient care," she says. "A lot of people think that when you go to a hospice it means getting put on a morphine drip and that is it, but most of them are way more sophisticated than that. They provide highly nuanced care, and so I think that is one thing to consider."

Prioritize the Call for a Consult

Although emergency staff will not always be able to arrange for palliative care consults during a patient's stay in the ED or even on the same day, Grudzen has found that just initiating the call for a consult makes a difference in terms of quality of life for patients with advanced disease.

"It is one of the few things we can do as emergency physicians where we are actually changing the trajectory of quality of life and care," she says. "It is a really simple thing we can do, and it takes very little time."

Grudzen notes that what typically happens when patients with end-stage illnesses present to the ED is that the emergency physician will determine that a patient is too sick to go home and will admit him or her to the hospital.

"Then seven, 10, or 14 days later, someone will say that this patient is dying, let's call palliative care, so the patient will have this very long hospital stay," she says. "So, we basically made a trigger so if someone had metastatic cancer and they were ill enough to be coming into the hospital, we would call palliative care the second we made the decision to admit them."

Looking at this mechanism in a research study, Grudzen found that the early call for a palliative care consult made a difference for patients even three months later.[1]

"I used to think of emergency medicine practice as kind of just triage for these patients ... where at the end of life I didn't think we could do much," she says. "And I have done a complete 180-degree mindset change on that because it is just incredible to see the improvements in a study months later from something that we in emergency medicine can do."

Shreves adds that while physicians may not benefit financially from enlisting the support of palliative care specialists, they do value these services.

"A lot of physicians have been traumatized by their experiences of providing invasive, aggressive care to people at the end of life," she says. "Physicians are inspired and motivated to [provide palliative care] because they feel like it is the right thing to do."

Of course, the key to this approach is knowing when the call for a palliative care consult is appropriate. Grudzen notes that she has seen many different types of triggers. Some hospitals use a checklist while others consider age plus disease or instruct providers to consider palliative care if they think the patient has less than six months to live.

"There are more complex algorithms that are disease specific ... and there are also utilization-based triggers; for instance, a 30-day readmission might be an automatic trigger for palliative care," she says. "There are many different examples and none of them are perfect, but they are a good starting place." The most important thing is to have criteria that are flexible, Grudzen adds.

But even with established criteria, many emergency providers are

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As the benefits of palliative care become more evident in clinical trials, there is growing interest in making such resources available to patients at an earlier stage, such as the ED. However, experts note that emergency staff first must identify available resources and make sure that providers have the primary palliative care skills needed to effectively introduce the topic to appropriate patients and families.

- Research shows that initiating the call for a palliative care consult while the patient is in the ED can deliver quality-of-life benefits even three months later.
- For EDs that lack resources in house, experts advise staff to form partnerships with hospices in the community; some offer sophisticated services and will come to the ED to evaluate patients.
- Emergency staff should establish flexible criteria to identify when palliative care is an appropriate option to introduce to patients and families.

reluctant to introduce palliative care, Grudzen observes.

"There are two problems: The provider will say that the patient is not ready when what the provider is really saying is that he or she is not ready, so there is that," she says. "Then, I think people just don't have the skills."

Although emergency providers are not expected to have tertiary palliative care skills — an advanced skill set one might acquire through fellowship training in palliative care — it is important that they develop primary palliative care skills, such as how to introduce the topic, Grudzen observes. For example, she notes that emergency providers often make the mistake of automatically asking family members if they want everything done for the patient.

"Well, of course they want everything done for a loved done. Who doesn't want everything done for their loved one or themselves?" she asks.

Instead, Grudzen might ask family members what they understand about a loved one's prognosis, or she will inquire about what the goals are for the visit.

"If it is obvious that the patient has a very advanced disease, you want to know where the family is at, what their understanding is, and where the patient is at," she says.

Shreves agrees that a huge part of the palliative care skill set involves learning the advanced communications skills needed to help people understand their treatment options and to globally engage in goals-of-care discussions.

Additionally, while it is not practical to conduct all the psychosocial interventions of palliative care in the ED, it is important for emergency providers to be able to recognize when it makes sense to help patients understand that it may make more sense to focus on their comfort and quality of life rather than to pursue aggressive, invasive treatment. However, Shreves stresses that this is not necessarily an easy call.

"If someone has cancer and they are cachectic ... most people can recognize [that they are near the end of life], but what about if someone has dementia or CHF [congestive heart failure] and COPD and they are frail and elderly?" she asks. "With some diseases, I think it is easy to recognize when the end is near, and for other diseases, it is way more complicated."

Shreves notes that some emergency physicians have this knowledge base, but it is not an area that residency programs stress generally.

"If you don't recognize that someone is at a place in their disease where it makes more sense potentially to focus on comfort, you don't even know when to have that conversation," Shreves notes. "There is a real variation in practice. Some people will tackle these issues and do it fairly well, and some people will avoid them like the plague because of their own inexperience, discomfort, or lack of training." *(See below: "Tools to Enhance Palliative Care Skills.")*

However, even for emergency providers who have well-developed palliative care skills, time is a universal barrier to engaging in palliative care discussions, Shreves says. However, she notes there are some interesting tradeoffs.

"It is weird when you will make the time to go do an intubation or central line. These things take huge chunks of time, but often if you have a 15-minute goals-of-care discussion, you end up not doing any of those procedures," Shreves observes. "When you think about it that way, [a goals-of-care discussion] is not always a big investment of time."

Another barrier that emergency providers must contend with is a lack of information.

"The reality is when you are going to talk to someone about transitioning away from invasive treatment and potentially refocusing on comfort or some in-between pathway, you want to make sure that makes sense, is medically appropriate, and in the patient's best interest," Shreves explains. "But that is often a highly complex decision-making process on the physician end, and it requires a lot of data input."

Consequently, it is not just a matter of taking the time to engage the patient and family in a discussion; it

Tools to Enhance Palliative Care Skills

Experts note that, ideally, primary palliative care skills should be part of the emergency medicine curriculum, but there are many ways for practicing providers to improve their performance in this area as well. The following resources may be of use to busy clinicians who are interested in enhancing their primary palliative care skill set.

- Vital Talk: http://bit.ly/1pecVtg;
- Education in Palliative and End-of-Life Care: http://bit.ly/2p0LKZa;
- Gemcast. Practical Tips for Providing Palliative Care in the ED: http://bit.ly/2oPqUQB;
- American College of Emergency Physicians. Palliative Medicine Section: http://bit.ly/2pxGOw6;
- EMDocs. Palliative Care in the Emergency Department: A Practical Overview of Why and How: http://bit.ly/2pnaHRc. ■

often involves going through reams of medical records to make sure that a shift toward palliative care is a sound option for the patient.

"That is another challenge," Shreves observes. ■

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Assessing Risk for Future Firearms Violence in Young People Who Present to ED

A new 10-point scale offers potential intervention methods for patients most in need of prevention services

The CDC reports that people 15-24 years of age are particularly vulnerable to firearm violence. Not only is homicide the third leading cause of death in this group, but most of these deaths stem from gunfire.

Further, emergency providers in urban areas know well the burden of caring for young patients who present with non-fatal firearm injuries. Medical and lost-work costs related to victims who presented to EDs with these injuries in 2010 neared $3 billion, according to government data.

Although prevention services potentially can short-circuit the cycle of violence often seen in young people, it is not possible to provide such help to every at-risk individual who presents to the ED for care. However, researchers at the University of Michigan (UM) School of Medicine in Ann Arbor, have developed a new clinical risk tool that could make this job easier.[1] Designed specifically for the emergency care setting, researchers say the tool is very brief, enabling providers to quickly identify the young emergency patients who are most vulnerable to future firearm violence so preventive interventions can be applied where they are needed most.

Tool Focuses on Firearm Violence

Investigators focused specifically on developing a tool for the ED because this setting provides both a key access point for identifying youth at risk for firearm violence and the opportunity for a "potential teachable moment," according to **Jason Goldstick**, PhD, the lead author of the study and research assistant professor in the department of emergency medicine at UM School of Medicine.

Researchers report that they looked at existing screening tools that assess for risk of violence, but noted that the instruments lacked a focus on firearms and took too long to administer in the emergency setting.

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A new clinical index tool designed specifically for the emergency environment predicts the risk for future firearms violence in young people 14-24 years of age. The approach employs a brief, 10-point instrument that can be administered in one to two minutes, according to investigators. They also note that while the tool is based on data from a single ED in Flint, MI, the tool should be applicable to urban EDs in regions that have similar characteristics.

- To create the tool, investigators used data from the Flint Youth Injury Study, an investigation of a group of patients 14-24 years of age who reported using drugs in the previous six months and accessed care at a Level I trauma center.
- Using a machine learning classification approach, investigators combed through the data, finding that the most predictive factors for firearm violence could be categorized into four domains: peer and partner violence victimization, community violence exposure, peer/family influences, and fighting.
- Ideally, investigators note the tool will be employed along with interventions targeted toward patients at high risk for future firearms violence.

To create the new tool, investigators used data from the Flint Youth Injury Study,[2] an investigation of a group of patients 14-24 years of age who reported using drugs in the previous six months, and accessed care at a Level I trauma center. That study, which compared patients who were victims of assault with patients seen in the ED for other reasons, included 599 participants who completed a 115-item survey that contained questions pertaining to violence, alcohol and drug use, and the influence of peers.

"The study participants were assessed five times over two years. Using that data, we were able to determine which of the participants [experienced] gun violence, either as a victim or perpetrator, during that two-year period," Goldstick explains. "We then used measurements taken at the start of the study to see which [factors] were most predictive of [future] firearm violence."

Using a machine learning classification approach, investigators found that the most predictive factors could be categorized into four domains: peer and partner violence victimization, community violence exposure, peer/family influences, and fighting. Consequently, the researchers took one item from each domain to create a 10-point score that is specific to firearm violence. They named the score SaFETy, so that it could be used as a mnemonic to help providers remember the four items:

- serious fighting frequency (0-4 points, depending on frequency in the previous six months);
- friends who carry weapons (0-1 point, depending on the number);
- community environment (0-1 point, depending on the frequency of hearing gunshots in the previous six months);
- firearm threats (0-4 points, depending on how frequently someone was threatened with a gun).

In the study, every increase of a single point in the SaFETy score was indicative of an increased risk of firearm violence, with a score of 8 or more being 100% specific for predicting risk for future firearm violence.

External Validation Needed

Goldstick acknowledges that emergency providers are loathe to take on any additional screening responsibilities, but notes that this tool is very specific to the needs of the ED, both because of the study population used to devise it and the fact that it was designed to be very brief.

"We believe this score could be administered in one to two minutes," he says.

Goldstick adds that two of the key collaborators on the study are emergency physicians, including the principal investigator, Rebecca Cunningham, MD, a professor of emergency medicine at UM, and the lead author of the Flint Youth Injury Study.

"That is the primary reason why we placed such great priority on making this risk assessment tool as brief as possible," he says.

However, Goldstick allows that the tool might not be applicable to every patient population.

"This was a tremendously high-risk study population. Over half of [the study participants] we could ascertain had firearm violence, as a perpetrator or a victim, during the two-year follow-up period. Therefore, we have no evidence that this index would be useful in, for example, a suburban emergency department," he observes. "[However], while additional validation is required, there is reason to think it would be applicable for risk stratification at EDs in urban centers similar to Flint, MI, such as Youngstown, OH, Camden, NJ, and Oakland, CA, when applied to similarly aged individuals."

At press time, the SaFETy score had just been unveiled, and had not yet been administered beyond the scope of the study, but investigators look forward to opportunities to validate the score externally, and to determine how it can be modified to suit different populations, Goldstick explains.

"More broadly, we envision coupling this type of risk stratification with appropriate levels of preventive services which ... means that such services need to be developed," he says. "Effectively utilizing those resources requires a basis for risk stratification, and that is the piece of the puzzle this work is meant to provide." ■

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SOURCE

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Team-based Pod System Reduces Lengths of Stay for Treat-and-Release Patients

Administrators note an expanded role for clinicians assigned to treat lower-acuity patients and a revamped pediatric area have contributed to improved flow and rising patient satisfaction

Implementing a new model of care in the ED can be daunting, but when there are good reasons for such a transition — and a well-thought-out plan for implementation — the results can be well worth the effort.

For example, consider the experience of ED leaders and staff at NYU Lutheran Medical Center in Brooklyn, NY. In 2015, a physician working a shift in the large, 55-bed ED could be seeing a patient anywhere in the department, explains **Nicholas Gavin**, MD, the chief of service in the ED. The approach kept physicians constantly on the move; it also created communications obstacles and resulted in longer lengths of stay (LOS) for patients, he explains.

To fix the problem, Gavin decided to implement a pod system in which physicians and nurses would be assigned to work in teams in specific geographic areas. This transition took place in August 2016.

"Now, when I come on to a shift, I know that my patient is going to be in one of 10 beds, and that the patients who go into those 10 beds will be cared for by a specific team of nurses that I know I am going to work with throughout the day," Gavin explains. "Previously, I would be working with every nurse in the department on a given shift. Now, I am working with a team of a couple of nurses, so you can imagine how much better the communication is throughout that shift as opposed to being spread across a large ED."

Further, in just a few months, the move to a pod system has delivered improved efficiency which, in turn, has affected the patient experience positively.

"The most important thing we track is LOS for treat-and-release patients," Gavin explains. "And through this team initiative, along with point-of-care testing and a couple of other [changes], we have been able to get our LOS for all treat-and-release patients below three hours for the first time in the history of the department."

What's more, Gavin notes that patient satisfaction is trending in the right direction.

Although transitioning to a pod system sounds straightforward, there were multiple challenges involved, Gavin acknowledges.

"In order to effectively implement team-based care, you have to match arrivals with the capacity of providers, and that had not been done in the past," he explains.

Perhaps not surprisingly, massaging the physician schedule so that it matched patient volume did not please everyone.

"We also switched [the physicians] from 12-hour shifts to eight-hour shifts," observes Gavin, explaining that the change meant that physicians were working more days for fewer hours. "That didn't win over a couple of people, but most have actually come to like the eight-hour vs. 12-hour shifts."

The adjustment to a pod system was not as dramatic for the nurses because they were assigned to geographic areas under the old system,

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To boost performance on a range of metrics, the 55-bed ED at NYU Lutheran Medical Center in Brooklyn, NY, transitioned to a pod system in August 2016. The approach, which is designed to foster team-based care, involves assigning physicians and nurses to designated geographic areas throughout the day, minimizing the movement of physicians as well as the need for phone communication.

- When coupled with other changes, including the introduction of point-of-care testing, the pod initiative has enabled the ED to reduce lengths of stay for all treat-and-release patients to less than three hours for the first time in the history of the department, according to administrators.
- There were multiple challenges involved with the transition to a pod system, including the need to match physician schedules with patient volume, but clinicians note the approach has produced improved physician-nurse communications.
- Administrators credit the creation of a process improvement team with giving frontline staff a voice in planned improvements while also facilitating the change process.

and they continue to work 12-hour shifts, observes **Kathy Peterson**, RN, MSN, CEN, the director of nursing in the ED at NYU Lutheran, but she agrees that the transition has been positive.

"Before [the change to a pod system], the physicians could be two departments over in another area of the ED and not necessarily where their patients were," she says. "The face-to-face interaction is better ... and the physicians and the nurses like having that interaction together."

Now, the ED is divided into five pods, three of which are in operation on a 24/7 basis, with the two additional pods open only during peak hours. While managing physician hours presented some initial hurdles, it was always clear that both the physicians and nurses favored the move to a pod approach, Gavin observes.

"We spend a lot less time on the phone with each other because we are in the same proximity and we can talk to each other," he says.

In fact, Peterson adds that staff members do their best to have both the physician and a nurse on hand to see a patient together so that they can both listen to the complaint at the same time.

"It doesn't always work that way, but the physician is always in the area and in full view of the patient and the nurse, so it just works better geographically, and it has had a very positive effect," she says.

Give Pediatrics a Distinct Area

The ED improvements have not stopped with the move to a pod system. Layered onto the pod approach are some additional changes that have made a difference for patient care. For instance, one of the most visible changes involves a revamped approach for caring for pediatric cases.

"In November of 2015, one of the first things I noticed was that our pediatric space was three open bays in the middle of the ED," Gavin explains. "It was right next to the lower-acuity area in the ED, so you could have an intoxicated, homeless 55-year-old [being treated] 10 feet away from a toddler with the flu."

From both a patient safety and a family-centered care standpoint, Gavin felt that pediatric care should be delivered in its own separate, secure space, so he decided to redesign what was then the fast-track area into a five-bed pediatric ED, which is now one of the five pods.

"We decided to ... prioritize the care of children and families over the lower-acuity adults, mostly because when you bring your young child to the ED, it can be a pretty traumatic and dramatic experience, and we wanted it to be the best experience possible," Gavin explains.

Converting the fast-track area to a pediatric ED was not easy. It required equipment and safety assessments, and administrators needed to make sure that the space was equipped with all the appropriate medicines for young patients.

"We needed to do a complete revamp to allow for the safe care of pediatric emergency medicine patients," Gavin says.

Further, at the time of this change, the pediatric beds were staffed entirely by pediatricians, but in a move to boost quality, Gavin added the services of pediatric emergency medicine specialists to the team.

"We now cover about one-third of our shifts with pediatric emergency medicine specialists and two-thirds with pediatricians," he explains. "In addition, we have dedicated nurse's aides for the area, and we recently started a child life specialist program so that at peak hours the pediatric ED is staffed by a physician, nurse, nurse's aide, and a child life specialist."

Gavin explains that while child life specialists are more well-known for their work with inpatient populations, they also deliver value in the ED.

"A child life specialist will meet with the patient and their family prior to a procedure and set expectations for what is going to happen," he says.

Additionally, during procedures, the child life specialist will take steps to distract the young patient from what is going on, perhaps using a computer tablet, a video game, or music therapy.

"We have found that patients and families have a much better experience when the child life specialist is involved," Gavin explains.

Fine-tune Flow Patterns

Along with the creation of a new, designated area for pediatric emergency patients, administrators expanded the role of the team taking care of lower-acuity or fast-track patients in the main ED.

"Now, we see not only ESI [Emergency Severity Index] 4s and 5s, which are treat-and-release patients, but also ESI 3 patients, which are a little bit higher acuity," Peterson notes. "We had a process improvement team come together and develop criteria regarding which patients would fit into this category."

This single adjustment changed the flow right away, Peterson observes.

"It impacts the other areas because not everybody needs to be on a stretcher in the ED," she says. "It was a positive change. We had some kinks, but we worked through them."

Involve Frontline Staff

In fact, Peterson views the use of a process improvement team as a key element in the drive to boost performance in the department. She explains that this team includes representatives from all the different disciplines in the ED, and they work together to devise solutions and make implementation plans.

"We like to get staff input, we like to let staff know what is going on, and we like to listen to them because they often have very important things to say because they work on the frontlines," Peterson explains.

For instance, during the week prior to the planned transition to a pod system, administrators took steps to make sure staff members were fully informed and prepared to make the change, Peterson notes.

"We huddled every day before we started this process," she says, noting that the huddles occurred on both the day and the evening shifts.

The process improvement team and the commitment to keeping staff informed was a roadmap for success, according to Peterson.

"I think just preparing the staff, getting their input, talking about it ahead of time, and being willing to adapt to changes [were key elements]," she explains.

Further, Peterson notes that administrators timed the switch to a pod system so that it was about one month before the ED transitioned to a new electronic medical record (EMR).

"We changed over to a new EMR system at the end of August, and we started [the pod system] at the beginning of August so that there would not be a whole bunch of big changes at once," she says. "We tried to space them out a little bit ... and that was helpful."

The biggest lesson Gavin has learned from the transition to a pod system is the extent to which nurses appreciate a team approach.

"I knew that physicians would be a lot happier because they wouldn't be running around as much, but our nurses already had geographic assignments, so they knew where they were going to treat patients every day, but switching to team-based care, I didn't realize how much satisfaction the nurses would have with their experience of working with the physicians," he says. "Nurses only ever ask for better communication, and this was an enormous step in that direction. I can't oversell the value of that." ■

SOURCES

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ED CODING UPDATE

Institute a Thorough Process to Manage Payer Audits

[This quarterly column is written by Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC, President, Edelberg Compliance Associates, Baton Rouge, LA.]

The increase in payer audits has turned into a major resource drain for many hospitals and emergency medicine practices. Without established processes for managing these audits, providers stand to lose revenues through lost/repaid payments and increased resource costs associated with managing the complexities involved with defending coding.

To review what is happening across the country, private and governmental payers are using medical necessity issues to deny claims, determining payment levels based on internal pay and no-pay diagnosis lists, and redefining elements of the documentation guidelines to facilitate paying lower E/M levels than billed.

Compounding such problems significantly, hospitals that bill for their emergency physicians and/or faculty practice plans often fail to respond to record requests or audit findings in a timely manner, resulting in providers being placed on pre-payment audits. Although it is simple to say that many revenue cycle processes appear to be broken, it is far more difficult to ensure that the individuals managing each of the processes are knowledgeable in the nuances of coding and audit rebuttal. This is not something every billing manager can handle well.

A well-designed audit management process requires focused atten-

tion to several elements. Hospitals that bill for their provider groups (e.g., faculty practice plans, recently acquired practices, etc.) seem to have a tougher time of it. In general, there must be a mechanism for identifying payer communications relating to record audits.

This should start a timeline/process to ensure that a trained, certified coder can review the record(s) in question, and the provider responsible for the record will have an opportunity to defend the documentation on the record with a written response as necessary. In addition, the auditor must prepare a well-written response or rebuttal to the payer within the time allocated and continue to track the incoming correspondence for a response while monitoring the payer website for any policy updates.

As this day-to-day process occurs, notification of the provider and/or coding staff is required to alert responsible individuals about payer activities and the issues on which payers are focused.

When we look across the country at what coding/payment issues seem most prevalent, a few continue to pop up on the compliance radar. Let's dissect some of the more pressing issues emergency medicine sees today.

What Constitutes a 'Work-up'?

As ED patients are considered "new," the choice for this MDM component is between "additional work-up planned" and "no additional work-up planned." There are no nationally published criteria that define "work-up" for purposes of scoring this element of MDM. However, the Marshfield Clinic coding tool in use by many providers and payers, provides a scoring mechanism for the elements of an Evaluation and Management level and offers a more objective approach to determining each level of service.

However, absent an objective scoring system or clear guidance as to what constitutes "work-up," some payers are attempting to define "work-up" as diagnostic testing performed *after* the patient leaves the ED, which seldom happens on any level of ED patient. This approach is problematic, as patients who receive no work-up according to the payer definition would qualify for a lower level for this element of MDM — not to mention the narrow definition of "work-up" as being related only to diagnostic testing.

This will require monitoring on a state and national payer basis so ED providers and supporting coding and billing vendors can be aware and push back when this creeps into coding and audit programs for resolution.

Determining Medical Necessity by ICD-10 Codes

Several payers are studying the final diagnosis code to determine whether the billing of higher level ED E/M codes is justified. As often may be the case, the problems identified in the HPI may point to a significant medical problem that can be ruled out only after a medically appropriate diagnostic work-up. It's a different spin but is similar to the down-code/payment reduction activities of the 1990s when Medicare reduced the ED provider payment for E/M services that were not determined to be a "bona fide emergency" by whatever criteria du jour payers were using at the time.

It is important to address this issue on a state and national level before it takes hold and further reduces ED provider income. The final diagnosis, determined by established coding rules, may not significantly address the reason for ED interventions and testing. Payers often require our assistance to help them understand that the nature of the presenting problem and elements referenced in the HPI, ROS, and PFSH are more accurate indicators of a patient's need to be in the ED prior to work-up.

Prepayment Audits

Before your Medicare Administrative Contractor (MAC) places an ED provider in prepayment audit status, a process has taken place in and around your practice. Long before the notification goes out, the ED practice or institution has been notified that it has been audited, the billed services are under question, and records for a designated number of patients have been requested. If this request for records is ignored, each is considered an error, a return of funds is requested, and the provider is expected to provide a corrective action plan. If no corrective action plan is received within the designated time, generally 45 days, the provider is placed on prepayment review. If records are provided, the payer audits, scores, and notifies the provider of their findings, which may or may not result in a take back of previously paid claim amounts.

The rebuttal process is the most critical. This is your right as a provider to dispute Medicare's findings with a written review of your own. If this does not happen, Medicare assumes you agree with their find-

ings, generally down-coded from the original codes assigned by the practice, and places you on prepayment review. This means that your records will be reviewed by Medicare, and payment for the level determined to be appropriate *by Medicare* will be paid.

This seems to be a good place to establish a "stop sign" in the process that gives emergency medicine providers a perfect opportunity to educate the payer. Defend coding as accurate based on existing industry standards and published coding criteria, and begin the process of constant vigilance, which is occurring in many ED practices and hospital compliance departments across the country.

Ongoing Coding and Billing Policy Revisions

The MACs stay busy these days modifying, clarifying, and developing coding policy. Generally, this is published in each MAC's frequently asked questions sections or in policy statements. Here are a few examples you might want to know about:

National Government Services (NGS) will be implementing a new policy defining the content of 99283 and 99284 physical examinations. For services on or after July 1, 2017, NGS will require performance and documentation as follows: The 99283 Expanded Problem Focused physical examination is defined as an exam of two to five organ systems or body areas; the 99284 Detailed exam should consist of six to seven organ systems or body areas. This is a significant departure from current expectations.

From Noridian comes an interesting take on medical necessity (which payers often confuse with medical decision-making) that could benefit emergency medicine, assuming that providers appropriately document the elements listed below. Also, this is an excellent audit response template, although certainly not intended as one by Noridian:

"Medical necessity cannot be quantified using a points system. Determining the medically necessary [length of stay] involves many factors and is not the same from patient to patient and day to day. Medical necessity is determined through a culmination of vital factors, including, but not limited to: clinical judgment, standards of practice, why the patient needs to be seen (chief complaint), any acute exacerbations/onsets of medical conditions or injuries, the stability/acuity of the patient, multiple medical co-morbidities, and the management of the patient for that specific DOS."

The underlying message of all this recent payer activity is to stay vigilant, prepare your defense strategy, and stay the course. Time has proven that constant interaction with payers on these issues results in improved payment, greater communication, and a better understanding of issues. ■

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Apply new information about various approaches to ED management;
2. Discuss how developments in the regulatory arena apply to the ED setting; and
3. Implement managerial procedures suggested by your peers in the publication.

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log on to **AHCMedia.com** and click on My Account. First-time users must register on the site using the eight-digit subscriber number printed on their mailing label, invoice, or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

COMING IN FUTURE MONTHS

- Reassessing the use of observation
- Boosting patient satisfaction in the ED
- New guidance on the diagnosis, treatment of vertigo
- Managing patient surges in pediatric hospitals

ED MANAGEMENT

CME/CE QUESTIONS

1. **Corita Grudzen, MD, MSHS, FACEP, the vice chair of research and an associate professor in the Ronald O. Perelman Department of Emergency Medicine at New York University Langone Medical Center in New York, NY, advises emergency medicine leaders who are interested in giving palliative care more of a presence in their departments to first:**

   a. take stock of what services they offer.
   b. develop a crash course on palliative care for staff.
   c. form a task force.
   d. poll providers on whether there is interest.

2. **While emergency staff will not always be able to arrange for palliative care consults during a patient's stay in the ED or even on the same day, Grudzen has found that which of the following makes a difference in terms of quality of life for patients with advanced disease?**

   a. Expediting transfer of the patient to an inpatient unit
   b. Keeping the patient in the ED for an extra day
   c. Initiating the call for a palliative care consult
   d. None of the above

3. **When establishing guidance for when an emergency provider should consider palliative care, Grudzen notes that the most important thing is to:**

   a. perform a review of the literature in this area.
   b. develop criteria that are flexible.
   c. make sure providers are prepared to follow the policy.
   d. direct providers to practice the policy through role playing.

4. **According to Nicholas Gavin, MD, the chief of service in the ED at NYU Lutheran Medical Center in Brooklyn, NY, to effectively implement team-based care, one must:**

   a. conduct team-building exercises once per month.
   b. hold regular planning sessions including physicians and nurses.
   c. match patient arrivals with the capacity of providers.
   d. establish a system of incentives to promote the concept.

ED ACCREDITATION UPDATE
COVERING COMPLIANCE WITH JOINT COMMISSION STANDARDS

Health Systems Turn to Communication and Resolution Programs to Identify Errors

Pioneering adherents of this approach note that a policy of extreme honesty gets high marks from both patients and providers while enabling hospitals to prevent repeat errors

In its most recent Sentinel Event Alert, The Joint Commission (TJC) noted that too often healthcare leaders fail to create an effective safety culture, a problem that invariably leads to many types of adverse events. The accrediting organization cites several ways that inadequate leadership plays a role in adverse outcomes, but "insufficient support of patient safety event reporting" and "lack of feedback or response to staff and others who report safety vulnerabilities" are high on TJC's list. *(http://bit.ly/2pExxo2)*

However, a few pioneering organizations have made great strides in significantly boosting the volume of errors that staff report dutifully, markedly improving the way these matters are reviewed and resolved. Organizations that have performed well in this area place a priority on making sure that preventable errors never happen again — a key goal inherent in any true culture of safety, but one that easily can fall by the wayside when legal matters take precedence over patient safety.

The good news for hospitals that are just now realizing that the traditional "deny and defend" approach for dealing with errors is due for a major overhaul? The early pioneers in this area have developed comprehensive tools and guidance so that the road can be smoother for those who follow suit. In line with TJC's Sentinel Event Alert, **Richard Boothman**, JD, chief risk officer in the University of Michigan Health System (UMHS) in Ann Arbor, maintains that there is no changing behavior with respect to the way errors and adverse events are handled without strong signals from leadership on what the expectations are and why.

"People can talk about safety all they want ... but if the bottom line of any administrator is what the balance sheet looks like, the culture of the organization will be far more affected by bottom-line finances and not so much patient safety," he explains. "So, culture is something that emerges over time, and it emerges from both messaging and the way an organization is structured."

> A FEW PIONEERING ORGANIZATIONS HAVE MADE GREAT STRIDES IN SIGNIFICANTLY BOOSTING THE VOLUME OF ERRORS THAT STAFF REPORT DUTIFULLY.

Boothman is well-positioned to understand how such culture change occurs. He was the driving force behind a transformation at UMHS, where error reports exploded from roughly 2,500 in 2008 to 36,000 in 2016. How does one convince healthcare workers to report errors and adverse events willingly? There are three main requirements, according to Boothman:

- Healthcare workers must be in a culture that makes it safe to report;
- They must be encouraged to report with consistent messaging;
- It must be reasonably clear that good things will happen if they report errors and adverse events.

What is most important to clinicians is the rationale behind the reporting, and what it will mean for patients.

"Honesty and transparency with each injured patient becomes important to the organizational mission of continuing quality improvement, of sparing our staff unnecessary litigation, and ... preserving the patient/physician relationship, even when things go badly," Boothman observes. "It was that message that made a big difference in our staff's acceptance of this, and in truth, their embracing of it."

The results have been revelatory. Since Boothman began implementing the new approach in 2002, UMHS has experienced a steep drop in new lawsuits, malpractice cases that land in court, and the amount of compensation doled out to patients. At the same time, clinicians have been able to learn from their mistakes, and the health system has been able to go after the root causes of errors quickly so that they are not repeated.

Support the Patient, Family

Most errors or near misses are reported through an electronic patient incident reporting system at UMHS, and these are divided promptly between events that harm patients and those that do not.

"If there is any injury at all, those get weeded out very quickly ... and we have a 24/7 response team, folks in the trenches at all hours of every day, who make an assessment almost immediately as to whether or not someone needs to get to the bedside," Boothman notes. "The first thing we want to do is always support the patient and family."

Boothman notes it is important to convey to the patient that you are sorry this happened to him or her, that you will get to the bottom of exactly what happened, and that once you have that information, you will bring it to the patient. Meanwhile, you must take care of the patient's medical needs.

"Concomitantly, we also need to take care of our staff because when these things happen, often it creates emotional harm and sometimes even physical harm to staff," Boothman adds. "Thirdly, but most importantly, we need to make sure that whatever happened doesn't represent an imminent threat to other patients."

For instance, if there is a problem with a pump of some sort in one patient, it potentially could harm other patients.

"Our staff members are trained in stabilizing the situation, supporting the patient and staff, and preserving evidence, but also making sure that the environment is safe in the short term while we figure things out," Boothman says.

Disclose and Engage

A risk management team will begin investigating an error or adverse event immediately to determine whether the care the injured patient received was reasonable under the circumstances or whether the patient should be offered compensation. At the same time, another team under the patient safety office will "fly into action" to make sure the adverse event never happens again, Boothman notes. This team will perform the root cause analysis, determine if there was a sentinel event, and then come up with an action plan, he explains.

If the risk management team determines that the patient deserves compensation, then an offer will be

EXECUTIVE SUMMARY

With healthcare leaders on notice that it is up to them to establish a safety culture, hospital systems are turning to communication and resolution programs (CRP) to identify errors and adverse events, and make sure patients are informed fully and compensated appropriately. Organizations that have pioneered such programs note that a policy of transparency is good for both patients and providers, and does away with the traditional "deny and defend" approach in which mistakes are buried.

- Since the University of Michigan Health System implemented a pioneering CRP program, error reporting has exploded from 2,500 in 2008 to 36,000 in 2016. At the same time, there has been a steep decline in new lawsuits, malpractice cases that land in court, and the amount of compensation awarded to patients.
- The Massachusetts Alliance for Communication and Resolution following Medical Injury has implemented a similar approach in participating hospitals across the state as well as in a multispecialty physician group.
- Experts have observed a dramatic increase in healthcare organizations interested in developing CRPs in the past 12-18 months, but warn that the inconsistent implementation of such a program will send a corrosive message to healthcare workers.

made. Conversely, if it is determined that the caregivers acted reasonably, the patient is entitled to a full explanation, Boothman notes.

"That patient is still entitled to us staying in the saddle with them clinically and doing our best for them to make sure their care is handled, but I might not compensate," he says. "We still view that entire explanation and engagement with the patient as a form of resolution."

In the past, hospital lawyers have defended against everything, regardless of the circumstances, Boothman observes. That's why he maintains that the impetus for this type of approach must come from clinical leaders.

"You don't do us any favors defending care we are not proud of," he says. "You must conform your insurance, your risk management, and your legal response in these situations to be consistent with [the hospital's] own evaluation because in this whole business of disclosure, the first disclosure is the one we make to ourselves when we look in the mirror and say we should have done better in this circumstance."

However, Boothman argues that hospitals must be equally aggressive at defending clinicians who have done nothing wrong.

"I had a client once who thought every single case had value as long as he could settle it [at less expense] than it would cost to defend the case," he recalls. "I think that is just as toxic as turning people away who deserve compensation because then staff get the idea that this is just a legal game, and they don't have to be accountable."

Boothman has worked with the Agency for Healthcare Research and Quality to develop resources for other healthcare organizations that are interested in the approach used at UMHS. The Communication and Optimal Resolution (CANDOR) toolkit has been tested at 14 hospitals in three health systems in recent years. *(http://bit.ly/2m9fch7)*

Get Stakeholders on Board

Other health systems also have made progress in revolutionizing the way they handle mistakes and resolve these issues with affected patients and families. The Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI) has developed a model that has grown to include several hospitals throughout the state as well as a multispecialty group of physicians.

"Our interest was how do you take a model that has worked in a closed system with its own insurer, [such as UMHS], and disseminate it across the state," observes **Alan Woodward**, MD, an emergency medicine physician and chair of the committee on professional liability at the Massachusetts Medical Society in Waltham, MA.

With the help of $300,000 in grant funding, investigators developed a roadmap for how to implement a system that had never been implemented or disseminated as a statewide initiative.

"We identified the 12 significant impediments and strategies on how to overcome each of those," Woodward notes. *(http://bit.ly/2qubcaH)*

For starters, Woodward says that the group had to get lawyers and hospital administrators on board, and it had to pass enabling legislation.

"We had to get a whole host of groups to buy into this concept, so you have to find champions within every entity and organization," he advises.

The MACRMI board includes representatives from the Massachusetts Health and Hospital Association, the Massachusetts Medical Society, the most prominent legal associations in the state, patient safety and advocacy groups, and liability insurers.

"We also got the health insurers on board, and they were the ones who helped fund us with the implementation of this," Woodward explains.

Go for Extreme Honesty

The MACRMI approach includes a CARe Timeline that plots what steps must be completed, beginning within 48 hours of when an error or adverse event occurs, and culminating three to six months after the event when a meeting between all stakeholders occurs for resolution, and potentially an offer of compensation to the patient. *(http://bit.ly/2qA8LTk)*

The pillars behind the approach echo what Boothman installed at UMHS, and similar results have followed.

"If you develop first the Just Culture and second of all, a commitment to this model, the incident reports of near misses and actual misses will go up," Woodward observes. "That is what we find at the institutions that implement this, but it isn't just a matter of getting physicians to report; it is getting them to buy into the concept."

This is difficult because most providers have been told for decades that if something goes wrong, they shouldn't talk to anybody, Woodward explains.

"You can't even talk to your spouse because anyone you talk to

other than your lawyer will be deposed if you carry on a conversation, which is incredibly damaging to physicians and providers," he says. "The institution doesn't learn, and instead it buries its mistakes."

Further, when cases end up in court, a process that generally takes years, patients never get an apology, Woodward observes.

"That is critically important to them in dealing with their anger, and it is also critically important for the providers in dealing with their grief," he says. "This is the concept that extreme honesty is the best policy, and it doesn't cost more. It improves patient relationships with the institution and it improves provider satisfaction dramatically. It is hard to get physicians to agree with anything, but satisfaction with this program is incredible. It is overwhelmingly positive."

Consistent Transparency

Thomas Gallagher, MD, a professor and associate chair in the department of medicine at the University of Washington, and executive director of the Collaborative for Accountability and Improvement, an organization committed to advancing the spread of Communication and Resolution Programs (CRP), is heartened to observe a dramatic increase in healthcare organizations interested in developing CRPs in the past 12-18 months.

"We are seeing a lot of organizations that are aware of peers that are moving in this direction, and they're increasingly realizing that this is the direction in which the field is headed, and they can either be behind the curve or try to be part of one of the earlier waves of these types of programs," he explains. "I think the field has really hit a tipping point."

Further, the research and evidence base has been strengthening, so there is more information on the benefits that can be achieved as well as some of the challenges involved with trying to implement an effective CRP, Gallagher observes. For instance, he notes that some of the early programs have been too dependent on the leadership of charismatic individuals to drive their success.

"WE ARE SEEING A LOT OF ORGANIZATIONS THAT ARE AWARE OF PEERS THAT ARE MOVING IN THIS DIRECTION, AND THEY'RE INCREASINGLY REALIZING THAT THIS IS THE DIRECTION IN WHICH THE FIELD IS HEADED."

"That does pose a threat when those individuals leave before a program is really institutionalized," he says. However, Gallagher notes that the biggest threat he sees in the field today has to do with inconsistent implementation. "That inconsistent use happens in one of two ways. One is that they use the whole CRP, so all of the essential elements, in some cases but not others, or they use some aspects of the CRP for a given case, but not all of the essential elements," he says.

An example of this would be an organization that has early event reporting for a case, speaks to the patient and family about what happened, analyzes the event, makes plans to prevent recurrences, and has care for the caregiver, but then decides not to make an offer of financial compensation to the patient when compensation is warranted, Gallagher explains.

"The big problem of inconsistent implementation is it sends a corrosive message to the healthcare workers at the organization," Gallagher stresses. "If they see that the organization is open and transparent with patients, except when it is inconvenient or embarrassing, or when the patient wouldn't know about what happened unless you tell them, then what the healthcare workers take away from that is that they can report adverse events except when they don't feel like it or it is embarrassing or inconvenient."

Gallagher adds that when institutions use the programs inconsistently, it degrades the culture.

"These are first and foremost patient safety programs, and they rely on driving that culture of complete openness, transparency, and learning," he says. ■

SOURCES

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