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ACOs: Time for ED managers to get involved, shape how their departments will add value

For many months, the buzz among health care administrators and policy-makers has been all about accountable care organizations (ACOs), an emerging payment and delivery model that many hope will put an end to the fragmented nature of America's health care system while also bringing down costs. While it is not yet precisely clear how ACOs will operate, on March 31, 2011, the Department of Health and Human Services began to roll out its vision for the model in a proposed rule for the establishment of the Medicare Shared Savings Program for ACOs, one of the first health care delivery reforms to be carried out under the Accountable Care Act, the sweeping health reform legislation that was passed by Congress in 2010. *(See an outline of how ACOs would work under the proposed rule, p. 64.)*

While the 429-page rule goes a long way toward spelling out the rules

EXECUTIVE SUMMARY

Even with a proposed rule outlining how accountable care organizations (ACO) will be structured under fee-for-service Medicare, emergency medicine experts are concerned about how ACOs will impact patient access to the ED. Further, some see a clear need to beef-up case management staff, while others say ED managers need to get involved with ACO-development now so their interests and concerns are represented.

- Under a proposed rule unveiled by the Department of Health and Human Services, a handful of quality indicators will require the tracking of ED visits related to certain ambulatory care-sensitive conditions; experts say it could be a challenge for ED staff to differentiate between appropriate and inappropriate use of the ED.
- EDs that figure out how to contribute value under the ACO mission will be better positioned to prosper under the new model.
- The ACO model is likely to add considerable complexity to billing and reimbursement.

and policies that will govern ACOs, at least with respect to Medicare patients, less immediately apparent is how EDs will be impacted by a model that clearly aims to reward health care systems that are successful at steering patients toward less acute care settings. However, there is broad agreement that ED managers who get involved with the process now have a chance to shape how their own departments will fit into broader changes that are coming down the pike.

Find ways to provide value

In reviewing the proposed rule, **Dennis Beck**, MD, FACEP, president and CEO of Beacon Medical Services, an Aurora, CO-based emergency medicine consulting firm, and a past chairman of both the quality and reimbursement committees of the American College of Emergency Physicians (ACEP) based in Irving, TX, is concerned about a handful of quality indicators that pertain to ambulatory care-sensitive conditions, such as diabetes, congestive heart failure, and asthma, that have been developed by the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD.

"There are about eight [areas] where you are tracking ED visits as part of your quality indicators, so the assumption there is that you will have a greater likelihood of meeting your quality indicators and getting your shared benefit dollars if you reduce ED visits," says Beck. "And the challenge for EDs and emergency care will be how to differentiate appropriate visits from inappropriate visits."

If medical homes or primary care physicians (PCPs) fear that they will not meet their quality indicators if a patient goes beyond a specific number of ED visits, then they will likely do everything they can to keep a patient out of the ED, even if that patient needs to be there, stresses Beck. "There are going to be some challenges around patients who don't have access because of policies or procedures with that ACO."

At press time, ACEP was pouring over the proposed rule in preparation of a formal response to CMS, but Beck expects that quality indicators will remain part of the Medicare Shared Savings Program, and that the basic make-up of this program will be adopted by other payers. "You can't make a cost-effective ACO just to do Medicare," he says. "I think it is pretty much a given that ACOs will also be contracting with private payers."

In light of such trends, Beck advises ED managers to consider what they can most effectively contribute to the ACO model. "Emergency medicine has been either intentionally or unintentionally on the margins of some of these strategies like episodes of care and ACO development because there is this notion that if you can just keep all these people out of the ED, where care is expensive and inefficient, we will have a better health system," he says. "So I think what needs to be considered from an individual departmental perspective or physi-

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cian group perspective is what things you need to do, either as a department or group, to provide value to an ACO."

For example, if an ACO is committed to reducing fragmentation of care and reducing waste and inappropriate utilization, then groups need to look at how they can work with their hospital-based physicians and PCPs and show how they can improve coordination of care, advises Beck. "Good coordination of care on the front end and the back end is something we ought to be very vigorously working on now so that we can provide that value to the ACO."

Beef up case management

Elijah Berg, MD, president of the emergency physicians group at Melrose-Wakefield Hospital in Melrose, MA, observes that coordinating care with PCPs is going to become an increasingly important part of the emergency physician's job under the new model, but he stresses that the physicians cannot handle this burden entirely by themselves.

"We have always needed case managers and the ability to get services at home, and to the extent that hospitals now are serious about providing those resources, we will need to utilize them," says Berg. "ED managers should really be starting the conversation of getting additional continuing care or coordinated care staff within the hospital because emergency physicians cannot do it on their own. They're going to need case managers to help them."

Even with the proposed rule, it is difficult to predict how the ACO model will ultimately be shaped, but Berg believes emergency providers should never resist the vision to have quality, cost-effective care. "Emergency physicians have got to have a seat at the table and they've got to be willing to participate in designing the way these systems will work locally," says Berg. "We are well-positioned to help determine appropriate utilization of resources to provide the most cost-effective care in our current environment."

Consider patient protections

Edward Gaines, III, JD, CCP, the vice president and chief compliance officer of MMP, an Atlanta, GA-based firm that provides billing and practice-management services to hospital-based physicians, is concerned that ACO models could undermine some of the patient protections that have been built into the Emergency Medical Treatment and Labor Act (EMTALA) provisions.

"If I think that I am having an MI (myocardial infarction), I don't have to call around town to find out which groups or hospitals are in-network. I just go and present myself and the ED personnel take care of me. So how does all of that change if I am in an ACO?" observes Gaines. "The people who sponsored these [ACO] provisions don't want unnecessary ED visits on the one hand, but on the other hand, the ED is so unique because of the EMTALA provisions and the prudent layperson provisions, and I have seen nothing in the rules thus far that addresses those situations."

Gaines adds that there is a general sense among leaders in emergency medicine practice management that the ACO concept sounds a lot like capitation. "We have been there before with varying degrees of implementation," he says. "[Policy-makers] are wanting to change practice patterns from a fee-for-service concept to something else, but I am not, by any means, sure what that something else is."

Further, while the idea of shared benefits sounds good, Gaines points out that this type of arrangement adds considerable complexity to billing and reimbursement. For example, Gaines observes that emergency physicians who are involved with Medicare's ACE (Acute Care Episode) demonstration are having to wait much longer than the requisite 14 days to get paid for claims because the payments are bundled along with the other Medicare Part B service providers, as well as the hospitals, so it is taking much longer to sort it all out.

Further, Gaines has questions about what would happen to shared benefits under the ACO model if just one component of a patient's care falls short of recommended standards. "If the patient has to have a valve replaced, and cardiology does not meet its quality metric, is the ED physician going to be penalized for that because he or she is part of this greater entity called an ACO?" Gaines adds that he is anxious to see how such issues will be ironed out.

Get in on the ground floor

Jeffrey Bettinger, MD, FACEP, founder of Pinecrest, FL-based BSA Healthcare, a company that specializes in the billing and reimbursement arena for emergency medicine practice groups, has concerns about the move toward ACOs too, but sees ACOs having a much more profound impact on non-emergency medicine practices. "ACOs and global payments are really pushing a lot of [PCPs and internists] into an employed status. And I think some emergency physician groups will be slightly prodded to move in that direction as

well, but most emergency groups are so facile in their ability to adapt to new arrangements that I don't think ACOs or global payments are going to force the issue other than to a mild degree," says Bettinger.

Nonetheless, Bettinger insists that this is no time for ED managers to sit on the sidelines in wait-and-see mode. "Right now, they need to be knocking on the door and speaking to whoever is in charge of these global types of systems at their hospitals, and letting them know that they are interested in cooperating and that they want to be involved in the decision-making process," he says. This may involve sitting on an ACO board or participating in some other type of governance structure, says Bettinger, but he advises colleagues to make sure they are "almost leading the hospital planning process."

"A much bigger issue is going to be global payments, which already exist in some private payer arrangements," adds Bettinger. "Those are going to become bigger and bigger, and emergency physicians need to be on the ground floor of however their hospital is going to prepare and plan for those." ■

SOURCES

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ACOs: An outline of how they will work under the proposed rule established by the HHS

Under the proposed rule for the Medicare Shared Savings Program, the Department of Health and Human Services (HHS) has set out to define how physicians, hospitals, and other care providers can establish accountable care organizations (ACOs) and potentially reap financial rewards based on clinical and financial criteria.

The proposed rule offers ACOs two different models: one in which ACOs stand to gain a smaller share of benefits but no risk of loss for two years, and then in the third year transition to accepting risk; in the second model, organizations take on more risk, but also qualify for a higher proportion of shared savings from the start of the program.

The proposed rule further stipulates that ACOs will be governed by panels that primarily include representatives from the different organizations that have banded together to form the ACO, but also include representation from the community and Medicare patients served.

"Making sure that patients and all health care providers have the right information at the point of care will be a core competency of ACOs," stressed, **Donald Berwick**, MD, MPP, the administrator of CMS, in making his case for ACOs in the *New England Journal of Medicine* when the proposed rule was unveiled.[1] "Held to rigorous quality standards, ACOs will be expected to be proactive in their orientation and to regularly reach out to patients to help them meet their needs for preventive and chronic health care."[1]

Berwick further noted that patients who seek care at their designated ACO will know that their physicians are part of the ACO, but that as beneficiaries of fee-for-service Medicare, patients will be free to seek care from any Medicare provider they choose. Under the proposed rule, ACOs must notify beneficiaries that they are participating in the ACO program when they seek care services.

Initially, HHS anticipates that 75-150 ACOs will be formed and approved by CMS, and that these entities will care for 1.5 million to 4 million Medicare beneficiaries. Further, regulators project that these organizations will receive as much as $800 million over three years by spending fewer dollars on beneficiaries than CMS expects while also meeting quality standards. However, regulators also estimate that some ACOs will end up repaying as much as $40 million to the government for care that either fell short of quality standards or was more expensive than CMS expected. The new model is expected to save CMS between $170 million and $960 million in the first three years, although regulators expect these numbers to grow substantially as more ACOs are established.

Comments are being accepted on the proposed rule until June 6, and CMS expects to issue a final rule by the end of the year.

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1. Berwick D. Launching accountable care organizations: The proposed rule for the medicare shared savings program. *N Engl J Med* 2011;364:e32.

Study finds ways to boost care coordination between emergency and primary care providers

No quick fixes, but process improvements and alternative communication modes can help

If improved care coordination is integral to bending the health care cost curve, then the interchange between emergency physicians and primary care practitioners (PCPs) is in need of significant improvement, according to a new study on this issue conducted by the Washington, DC-based Center for Studying Health System Change (HSC) for the nonprofit National Institute for Health Care Reform (NIHCR).

The report, *Coordination Between Emergency and Primary Care Physicians,* is based on telephone interviews with 41 pairs of emergency physicians and PCPs who were matched so that researchers could obtain the perspectives of both specialties working in the same hospital settings. ***(See "Editor's Note" below for link to report.)*** The study concludes that poor communication and poor coordination undermine effective patient care, and that there are no quick fixes to these problems. However, the authors stress that there are things ED managers can do to address existing barriers while at the same time reducing inefficiency, waste, and errors.

EXECUTIVE SUMMARY

A new report suggests that poor communication between emergency and primary care providers has had a negative impact on care, and that this interface requires significant improvement if the country is to move toward more cost-effective care delivery models that prioritize quality. There are no easy solutions to the problem, but some health care organizations are making strides by using alternative communications modalities and by finding ways to strengthen the relationships between emergency and primary care physicians.

- Health systems and affiliated PCPs who utilize electronic health records (EHR) are better able to coordinate care with each other, but EHRs are not a silver bullet to the problem.
- In addition to documenting care tasks in the medical record, scribes can fill in care-coordination gaps by making follow-up calls to PCPs or specialists, or sending pages where appropriate.
- Some health systems are seeking to address problematic handoffs between the ED and PCPs by developing protocols that include care-coordination steps for diagnoses that are associated with high ED utilization.

Unique challenges surface in the ED

Emily Carrier, MD, MSCI, a co-author of the study and a senior researcher at HSC, decided to look into the issue because, as an emergency physician herself, she has experienced firsthand the challenges of trying to coordinate with PCPs, but she has seen little research on the subject. "I saw that there had been a lot of thinking about how care can be better coordinated, but it hasn't really focused on this particular interface, so I wanted to fill in this gap," she explains.

Patient encounters in the ED are distinctly different from other care encounters in a number of ways that add complexity to the care coordination piece, says Carrier. "If you think about the classic PCP-specialist interaction, the PCP might identify the need for a specialist consultation, he might help the patient to schedule it, and prepare some information to be sent to the specialist's office in advance of the visit," says Carrier. "Then, after the evaluation, the specialist might send the information back to the PCP and the next time he looks at the file, he will read it over."

Typically, everybody knows what is going to happen next in such a situation, but that is not always the case in the ED, stresses Carrier. "Many encounters in the ED are unplanned. Further, the patient may go there on his own, or he may be sent there by someone who is not the PCP," she says. "ED visits may occur at any time of the day or night, and they can involve a broad spectrum of illness ranging from something very minor to something that is critical."

All of these factors make communications and care coordination more challenging for both emergency physicians and PCPs, says Carrier, and both sets of providers expressed frustration to researchers about the time and inconvenience required to perform care coordination tasks. "Many felt this task doesn't bring them very much in terms of reward, and people also felt that the extra effort doesn't

decrease their risk in any meaningful way," she says.

There is no question that care coordination and communications are significantly streamlined in hospital-based health systems that have electronic health records (EHR) that are widely used by community PCPs, but Carrier emphasizes that the EHR is not a silver bullet.

"In most cases, EHR systems are not designed to facilitate a rapid overview and synthesis of information," she says. "They are very good at storing information and they are very good at retrieving information if you know what you are looking for, but if it is 2 o'clock in the morning and you've got to find out what a person's cardiac history is, the EHR can definitely be challenging."

In particular, Carrier explains that for those patients who could most benefit from care coordination — older patients and the chronically ill — you could be wading through screen after screen on a voluminous EHR, and it can be very difficult for either an emergency physician or a cross-coverage provider to figure out what is going on.

Time facilitates interactions

There are steps EDs can take to cut through such quagmires, but the most effective solution for one ED will not necessarily work well in another, says Carrier. "Let's say you work in an urban safety-net institution, and most of your patients are getting care through an ambulatory care clinic that is also part of your system," she says, noting that communicating back and forth isn't a big issue in this setting. "In that instance, the best [way to improve] care coordination might be through a proactive approach of setting up meetings between department leaders and coordinating ways to facilitate follow-up visits."

This type of solution would not, however, work well for an ED in a suburban setting that is surrounded by many small, independent PCP practices, observes Carrier. "There is no way you are going to get everybody at the same table, so the first challenge in this instance would be figuring out how you are going to talk to people," she says. (*Also, see "Consider relationship-building activities & alternative communications strategies to boost care coordination, quality," p. 67.)*

Any process or patient-flow improvements that free up time for emergency physicians and PCPs to interact will benefit virtually any ED setting, notes Carrier. "We see many practices that reward physicians for having a short LOS (length of stay), but sometimes making a discharge stick takes time; it takes making that extra phone call, making sure the patient has a safe place to go, or making sure that key information that needs to get passed along is passed along," she says. "These steps can be very frustrating for emergency physicians, and many of them complain, accurately, that their efforts are not rewarded."

However, there are so many different care circumstances that occur in the ED that you can't address the issue of care coordination with simple incentives, observes Carrier. Further, she notes that incentives can lead to unintended consequences. "If you decided to reward emergency physicians every time they communicate directly with a patient's PCP, that would probably lead to a lot of unnecessary calls related to lower back pain, ankle sprains, and things like that," she says.

Use protocols to drive care coordination

Recognizing that some diagnoses require more care coordination than others, the Cleveland Clinic's Quality Alliance, a consortium between the organization's employed and private-practice physicians, is developing condition-specific guidelines for the sharing of medical information between the Clinic's various affiliated offices, institutes, and hospitals, explains **Tarek Elsawy,** MD, an internist and medical director of the Quality Alliance.

"For certain diagnoses, such as congestive heart failure (CHF), for example, there is a really high rate of readmissions and people shuffling back into the ED," says Elsawy. "So one of the things we are trying to do is develop certain protocols that will make it part of the evaluation process that we use in terms of how well the ED physicians are getting back to the PCPs, and making sure the patient has follow-up with his PCP following a visit to the ED."

Many of the physicians affiliated with the Cleveland Clinic are already using the organization's EHR, so they have access to any patient labs, X-rays, or other studies in real time, notes Elsawy. "In a lot of cases, that is half the battle because many times patients aren't exactly sure what tests they have undergone, let alone what the results of those tests were," he says.

The Quality Alliance has also begun to track those patients who use the ED frequently to see

if there is a portion of their care that is missing, whether that involves gaining access to a PCP or perhaps another resource," explains Elsawy. "Let's say that we find a patient who has been back and forth to the ED three times with the same diagnosis," he says. "What we are trying to do is coordinate with the patient's PCP to get him set up so that he uses the CHF clinic as a means of regular follow-up rather than just going back to the ED all the time."

Initially, the Quality Alliance is focusing its attention on those conditions that have the highest impact in terms of patient readmissions, so conditions like CHF, chronic obstructive pulmonary disease, and pneumonia are being targeted first, says Elsawy. "Most of the EDs are already using protocols for CHF, but what are missing are the handoffs," he says. "If a patient goes from the ED to the hospital, that is one transition, but one of the other things we are working on is making sure that patients who have been discharged from the hospital get back to their appropriate PCP or CHF clinic in a timely fashion to prevent them from repeating the cycle all over again. That is the process we are trying to follow through."

Elsawy acknowledges that just like other providers, ED physicians don't generally favor adding steps or tasks to their workflow, but they nonetheless understand the rationale behind what the Quality Alliance is trying to do, and they are involved with the process. "What we are doing is an absolute transition point to developing an accountable care organization (ACO)," he says. "If we all speak the same language and have the same expectations in terms of the guidelines themselves and how to implement them, then I think that will take us a long way toward what will be an ACO." ■

Editor's note: To access Coordination Between Emergency and Primary Care Physicians *by Emily Carrier, MD, MSCI, Tracy Yee, PhD, and Rachel Holtzwart, visit this link: http://www.nihcr.org/ED-Coordination.html.*

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Consider relationship-building activities, alternative communications strategies to boost care coordination, quality

If you work in a health care system where primary care practitioners (PCPs) are willing to communicate via text pagers, that can facilitate care coordination with the ED, explains **Emily Carrier**, MD, MSCI, a senior researcher at the Center for Studying Health System Change (HSC) in Washington, DC, and co-author of the HSC report, *Coordination Between Emergency and Primary Care Physicians*. However, she stresses that there has to be buy-in from everyone involved, and there are limitations to what you can accomplish via text.

Further, there are always privacy concerns when you use texts, pages, or email to communicate, and unless you receive a fast response, there is no way to be sure that the intended recipient received your communication, notes Carrier. "If you have to follow up [one of these electronic messages] with a phone call, that eliminates the benefit of having an alternative communications modality," she says.

Some hospitals have also found that scribes, who are generally charged with documenting care tasks into the medical record and sometimes properly coding them as well, are also often ideally suited to contacting PCPs or other providers after one of their patients has been seen in the ED. "They can be incredibly helpful in taking on the burden of those 2nd or 3rd pages … and they can facilitate getting in touch with whatever PCP you need to speak with," says Carrier, an emergency medicine physician who has personally worked with scribes in this way. "Scribes are becoming more popular. They are sort of a low-tech, old-fashioned solution to a lot of different problems that people are having with electronic health records (EHR)."

Having a conversation with a PCP or other provider may seem like a simple task, but as busy as providers in all settings are these days, Carrier emphasizes that making that connection can be quite challenging. "Each of these interactions, taken alone, seems trivial and not a lot to ask of an emergency physician," she says. "But in practice, it involves dialing a number, and then you get a voice mail, and then you sit on hold for three minutes

before reaching an answering service. Then you are put on hold again, and the whole cycle repeats."

Another old-fashioned solution involves setting up regular meetings or other joint activities where PCPs and emergency physicians can establish stronger working relationships.

"When putting together the report, we heard a lot about how emergency physicians and PCPs were seeing each other a lot less than they used to," she says, noting that with the advent of hospitalists, PCPs are less likely to do rounds at hospitals, and emergency physicians have fewer opportunities to interact with them.

"We spoke with older providers who remembered when they used to be in the ED almost daily to evaluate patients who were going to be admitted or to write admission orders," says Carrier. "That kind of interaction where you get to know people and determine who you trust doesn't happen as much as it used to."

Making sure that both PCPs and emergency physicians are represented at interdepartmental meetings and committees is one way to create opportunities for interaction, but more informal gatherings can serve this purpose as well, says Carrier. "We heard about one physician who takes care of children with disabilities … and wants to be involved with every detail of their care, whether they are in a specialist's office or the ED," she says.

"Consequently, this physician plays on the soccer team of the main ED his patients go to, and he says that helps tremendously," adds Carrier. "The emergency physicians know his name if one of his patients comes in, and they know he really values a phone call, so even if it is a hassle, they are more likely to make that call, and they know he will call right back." ■

ACOs, RACs, and ICD-10 — Updates for the ED

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

To say our specialty has a full plate is an understatement. We are facing down a number of issues that are guaranteed to transition us to a new world. Each has a distinct universe of requirements for preparation, orientation, and management, and each will require the collaboration of providers, compliance, coding, and billing.

Accountable care organizations

Health care reform will look different to you depending on how your community and state resolve issues. Section 3022 of the Affordable Care Act added a new section 1899 to the Social Security Act (the Act) that requires the Secretary to establish the Shared Savings Program by January 1, 2012. This program is intended to encourage providers of services and suppliers (e.g., physicians, hospitals, and others involved in patient care) to create a new type of health care entity, which the statute calls an "Accountable Care Organization (ACO)" that agrees to be held accountable for improving the health and experience of care for individuals and improving the health of populations, while reducing the rate of growth in health care spending.

Even in the early stages of implementation, health care reform is pushing providers to join together in order to control health care costs and quality. The ACO may receive payments for shared savings if the ACO meets certain quality-performance standards and cost-saving requirements established by the government. (Key words: "shared savings" and "quality performance standards!")

Hospitals are purchasing physician practices at a rapid rate, and this could challenge ED groups who want to remain independent but are in any way financially dependent on the hospital. With ED volumes increasing, and the impact of the economic downturn evident in higher numbers of uninsured or minimally insured, it will be challenging for ED practices to maintain their status quo or improve their financial picture without stepping out of the box and looking at new opportunities and methods to ensure today's challenges are met.

ACOs will come in a variety of packages: hospital-owned, physician-owned, or a combination of both. The new model provides an opportunity for providers to take back controls in a way that is similar to the Physician Hospital Organizations (PHOs) of the past. In this case, however, ACOs will be required to demonstrate quality using an objective method of measurement. And their ability to control costs will determine success or failure.

ACOs are likely to take many different forms. Some regions will spawn independent practice associations (IPAs), while others may prefer PHOs; quality and efficiency will be the top priorities. We would expect some element of fee-for-service to continue, with additional new payment methods that require greater integration and increased risks assumed by all participating providers.

Recommended solutions to manage the transition

- Prepare your practice/department to track quality indicators and monitor by provider and location;
- Maintain detailed reporting on frequency of codes, charges, and payment by major payers;
- Monitor local and regional activities by hospitals and physicians as ACOs are formed;
- Monitor changes in acuity, revenue, and volumes; and
- Collaborate with other specialties within your region — particularly hospital-based — to form alliances, share information and patient statistics, and begin development of shared "best practices."

Recovery audit contractor (RAC) program

We continue to monitor regional RAC activities and, so far, emergency physician groups have been bypassed by RAC audit activities while RAC contractors concentrate on hospitals and higher-priced provider services. Evaluation and management codes, the backbone of emergency medicine, probably won't be on the RAC radar for another year or so, but our hospitals are already being RAC'd for a number of issues that involve services performed in the ED: medication dosages/units, blood transfusions, bronchoscopy services, physician orders, IV therapy, medical necessity based on pre-admission documentation, validation of short stay, uncomplicated admissions, and timed services. Additional problem areas include medical conditions that are present on admission (POA), which require detailed documentation by ED physicians to allow inpatient coders to identify conditions that were present and not hospital-acquired conditions (HACs).

Recommended solutions to manage the transition

- Assign task force of ED physicians, nurses, compliance, and coding and billing representatives to monitor RAC issues;
- Perform routine audits and "what-if" exercises to assure immediate identification of potential risk areas;
- Plan processes to appeal audit findings; and
- Expand focus to include impact of ED documentation and orders on inpatient services.

ICD-10

Fast approaching is October 1, 2013, the implementation date for a total revision in reporting of diagnoses and, unlike many governmental initiatives, we don't expect a last-minute reprieve. ICD-10-CM codes are codes used to document diagnoses. They are 3-7 characters in length and total 68,000, while ICD-9-CM diagnosis codes are 3-5 digits in length and number over 14,000. The ICD-10-PCS are procedure codes that are alphanumeric, 7 characters in length, and total approximately 87,000, while ICD-9-CM procedure codes are only 3-4 numbers in length and total approximately 4,000 codes.

The transition to ICD-10 will impact all physicians in some way. The number of codes has increased significantly, and the reformatting of the number of characters per code, and the demand for increased code specificity, require significant planning, training, and software/system upgrades/replacements. Prior to implementation of ICD-10, we will be required to implement an updated version of HIPAA transaction standards, known as 5010, by January 1, 2012, as the current version, 4010, does not accommodate use of the ICD-10 codes.

Don't let an implementation date two years away give you a false sense of security! The dramatic change in code descriptions will impact the way physicians document all levels of differential diagnoses, final diagnoses, operative notes, diagnostic interpretations, and more. For example, providers will be required to provide a higher level of anatomical detail in notes, as well as note details such as stabbing, visible, extreme, and a more specific and exact location of a problem. Expanding documentation "macros" and templates will be a significant component of the transition to ICD-10.

Recommended solutions to manage the transition

- Begin documentation improvement efforts NOW;
- Identify the most frequent diagnoses in your ED and develop documentation-improvement templates for each;
- Conduct "transition" exercises to understand

how most common diagnoses are coded today and how the transition to ICD-10 diagnosis codes will occur; and

• Plan to educate coding staff no later than the final 6 months prior to implementation of ICD-10 to assure all are trained, experienced, and good-to-go. ■

Slash door-to-doc time, boost patient satisfaction with staff-driven improvement effort

Streamlined triage process sets the tone for further improvements

Sumner Regional Medical Center in Gallatin, TN, offers good evidence that quick-turnarounds are indeed possible when you have motivated staff. Within just four months, Sumner went from the 5th percentile to the 98th percentile, according to patient reviews of their experience in the ED. **Mary Jo Lewis**, FACHE, the chief executive officer (CEO) at Sumner Regional since September 2010, emphasizes that the dramatic transformation is the result of a staff-driven improvement effort that is ongoing to this day; however, it is nonetheless clear that her own visit to the ED late last year served as a healthy catalyst for change.

It was hardly an undercover operation. Lewis had been cleaning her house on a Saturday morning when she began to experience chest pains. She wasn't dressed in her usual CEO garb at the time, so when she entered the ED, no one picked up on the fact that she was the boss. "Whenever someone walks in and says they're having mild chest pains, [ED personnel] don't ask you any more questions. They take you straight back and start hooking things up," says Lewis. "So, for the first 20 minutes of my visit, I was a totally anonymous patient."

While Lewis is quick to emphasize that the care she received was first rate, she noticed that people kept asking her the same questions over and over, and there were inexplicable delays. So, while her health turned out to be fine, the experience led to a top-to-bottom review of ED operations to see where processes could be tightened up.

EXECUTIVE SUMMARY

With patient satisfaction in the single digits and door-to-doc times unacceptably high, the ED at Sumner Regional Medical Center in Gallatin, TN, initiated a staff-driven improvement effort aimed at weeding out inefficiencies. By putting the triage process under close scrutiny, staff members were able to eliminate dozens of tasks from the triage process, thereby slashing wait times.

- ED patient satisfaction has gone from the 5th percentile to the 98th percentile in just four months.
- A 44-step triage process has been streamlined into four steps, and average door-to-doc times have decreased from 67 minutes to 18 minutes.
- Further improvements are anticipated when ED administrators put staff scheduling under the same scrutiny.

Put every task under scrutiny

Lewis brought in an efficiency expert from the health system's corporate office to help, but the improvement process was really driven by the ED personnel themselves. "We got staff nurses, emergency physicians, and other key players in the ED to spend two days looking at the process we use," explains **Donna Mason**, RN, MS, CEN, SAEN, director of the emergency department. "You get graded on door-to-doc time, so we first documented every step that takes place from the time people enter the ED to when they see a doctor."

The process was eye-opening, says Mason, recalling that staff tallied as many as 44 steps that patients and ED personnel would go through before a physician even entered the picture. These included social questionnaires, such as domestic-violence screening and suicide screening, finding out what medications patients were taking, and documenting whether patients had received various preventive vaccinations, adds Mason. "These were all things that were very important to patients, but we looked at whether they were being done in the right place," she says.

Ultimately, ED personnel drastically reduced the number of tasks involved with the triage process so that patients now only go through four steps before seeing a physician:

- they are immediately taken to a triage station as soon as they enter the ED;
- a triage nurse collects "quick-admit" information, including the patient's name, birth date, social security number, and primary complaint;
- the patient receives an arm band with identification information; and
- the triage nurse takes the patient to a bed.

Now, most of the screenings and documentation tasks that used to take place during triage are being carried out by the primary nurse, who takes care of the patient at the bedside. "This does add work for the bedside nurses, but they're collecting information that they need to take better care of

the patient," says Mason.

Such changes have slashed the average door-to-doc time from 67 minutes to just 18 minutes, and this all occurred while volume actually increased, explains Lewis. "In October of 2010, we had 2,649 ED visits, and in March of 2011, we had 2,946 ED visits, reflecting a 10.5% increase in volume in a community where the population did not change," she says. "Some of this increase is attributable to flu season, but ED personnel were able to accomplish these efficiencies at a time when ED volume was very high."

Include hospital's IT staff in the loop

Whenever you revamp patient flow, you need to make sure your information technology (IT) is working with the system, stresses Mason. In this case, IT people were part of the team, so they were on hand to make adjustments as needed. "We had to completely revamp the documentation system on the front end from quick registration to how we did triage," she says. "Our IT people were making changes every day to make the process work with the care of the patient instead of making the care of the patient work with the process of the computer."

However, there were plenty of low-tech changes as well, says Lewis. For example, when reviewing the patient-flow process, it came to light that whenever the person manning the switchboard went to lunch, incoming calls were then diverted to the ED registration clerk, overwhelming her with unnecessary tasks when she really needed to be focused on incoming patients. "That wasn't smart, so we fixed that, and now when someone comes in, she can give them her full attention," adds Lewis. "It wasn't rocket science. It was just identifying little things like that, and now the registration clerks are a lot happier."

With patient satisfaction way up, there are still more improvements yet to be made. For example, the next process to go under the microscope will be staffing, says Mason. She doesn't anticipate any changes in terms of adding or subtracting personnel, but she expects there will be adjustments in shift schedules. "Typical ED [volume] peaks are at 9 a.m., 11 a.m., and 1 p.m., but here we have a pretty significant peak at 8 a.m.," says Mason. "We have a 9 a.m. to 9 p.m. shift for nurses, so we may look to move that shift to 8 a.m. to 8 p.m."

There may also be adjustments made to later shift schedules to accommodate changing volume patterns. "Emergency department traffic used to slow down by 11 p.m.," observes Mason. "That doesn't happen anymore. Now the ED census doesn't drop off until about 1 a.m., so we may look at having our 1pm to 1am shifts moved to 2 p.m. to 2 a.m. We are really just adjusting our staffing to meet the needs of patients." ■

COMING IN FUTURE MONTHS

- How teamwork drives ED improvement
- What value-based purchasing means to the ED
- Why ED patient callbacks matter
- Keys to disaster preparedness in the ED

CNE/CME INSTRUCTIONS

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-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 last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the evaluation is received, a credit letter will be sent to you. ■

CNE/CME OBJECTIVES

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

SOURCE

Donna Mason, RN, MS, CEN, SAEN, Director, Emergency Department, Sumner Regional Medical Center. E-mail**:** donna.mason@lpnt.net.

CNE/CME QUESTIONS

1. **Dennis Beck**, MD, FACEP, believes one challenge for EDs under Medicare's Shared Savings Program for ACOs will be:
A. managing a surge in volume.
B. keeping ED physicians informed of changes in policy.
C. differentiating appropriate ED visits from inappropriate ED visits.
D. hiring enough staff to manage the program.

2. **Elijah Berg**, MD, believes what task will be an increasingly important part of an emergency physician's job in an ACO model?
A. Coding
B. Care coordination
C. Delivering primary care
D. Working with physician extenders

3. **Edward Gaines**, III, JD, CCP, suggests that one problem with health care models that provide "shared benefits" based on cost and quality is:
A. they can actually increase medical errors.
B. they take responsibility away from physicians.
C. they discourage patients from seeking care.
D. they add considerable complexity to billing and reimbursement.

4. **Donald Berwick**, MD, MPP, says a core competency of ACOs will be:
A. making sure that patients and all health care providers have the right information at the point of care.
B. making sure that ED staff access appropriate continuing medical education.
C. making sure that all patients are linked up with health insurance.
D. making sure that all hospitals form networks with PCPs.

5. According to **Emily Carrier**, MD, MSCI, what can EDs do to improve coordination between emergency and PCPs?
A. Enlist scribes to help with follow-up calls to PCPs and specialists.
B. Consider alternative communications modalities such as text messaging or email.
C. Arrange for formal or informal meetings between emergency and community physicians.
D. All of the above

6. Whenever you revamp a patient-flow process, what also needs to be changed along with this process, according to **Donna Mason**, RN, MS, CEN, SAEN?
A. Staffing
B. Discharge planning
C. Documentation system
D. Patient education

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

New Standards Address Patient-centered Communications

ED setting presents special challenges

In July 2011, Joint Commission (JC) surveyors will begin holding hospitals accountable for some of the elements of performance (EP) contained in new patient-centered communication standards that were first unveiled last summer. The new accreditation standards, which are currently in the pilot phase of implementation, are designed to ensure that hospitals take all necessary steps to make sure that patients get the information and support necessary to make appropriate decisions about their own care.

While the JC has had standards for patient-centered communications for years, **Christina Cordero**, PhD, MPH, associate project director, department of standards and survey methods, division of healthcare quality evaluation, the Joint Commission, explains that years of involvement with an initiative focused on hospital language and culture led the JC to conclude that new standards were needed. "One of the interesting things we found was that most of the organizations we worked with as part of that initiative had some type of language interpreting services," she says. "But when we interviewed the front-line staff, we found that many of the staff weren't using the services that were provided, for several reasons."

For example, many staff members would complain that the telephone interpreting services their hospitals offered tended to be cumbersome or difficult to use; in other cases, passwords would be required to use these services, but staff didn't have ready access to these passwords, says Cordero. "Many times, we also found that the telephones were locked in drawers or closets, and people didn't have keys in order to access these tools to their full potential," she adds. (Also, see "Use appropriate tools, strategies to overcome challenges of communicating in an emergency setting," p. 2.)

Problems like these prompted the JC to develop new accreditation standards and to develop a guidance monograph to help hospitals most effectively meet these standards. That document, Advancing Effective Communication, Cultural Competence, and Patient and Family-centered Care: A Roadmap for Hospitals, is

EXECUTIVE SUMMARY

The Joint Commission soon will be holding hospitals accountable for new standards that focus on making sure that patient needs regarding communications are identified and met.

- Standards that take effect in July 2011 focus on making sure patients are offered the opportunity to have a support person present during their care.
- Additional standards, to take effect later, call for hospitals to identify and accommodate language or other communications requirements.
- The fast pace and high stress of the ED environment create added challenges in meeting patient communications needs.

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available for download at www.jointcommission.org/Advancing_Effective_Communication.

Alleviate stress and fear

The first of these new accreditation standards to be fully implemented are EP 29, which states that hospitals are to prohibit discrimination "based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression," and EP 28, which states that the hospital will "allow a family member, friend, or other individual to be present with the patient for emotional support during the course of stay."

Hospitals will be held accountable to these accreditation standards beginning in July 2011, says Cordero. "The intent behind [EP 28] is to just make sure patients can identify an individual who they want to be with them in the hospital, and that the hospital will allow this person to be there. The policy is not intended to dictate visitation policies or to call for open visitation," she stresses. "It is really about alleviating fear and stress for patients when they are alone in the hospital. There was a lot concern that the presence of individuals would put stress on the patient, when the reality is that the opposite is true. It really does help patients feel better about being in the hospital."

For compliance with EP 28 and EP 29, JC surveyors may review a hospital's written policies, mission statement, staff training procedures, and they may gauge staff awareness and understanding of these standards, says Cordero. "We also put a note with this element of performance that the hospital would allow the presence of this individual, unless it infringed on the rights or safety of other patients or it is contraindicated by treatment, so there is some flexibility to determine whether or not it is appropriate to allow the presence of some people," adds Cordero. (See also "Patients can provide key information, vital linkages with primary care providers," p. 3.)

Determine patient needs

Hospitals will have at least until January 2012 before JC surveyors will include two other new patient-centered communications standards in their hospital reviews. The first of these, EP 1, directs hospitals to identify a "patient's oral and written communication needs, including the patient's preferred language for discussing health care." The second provision, EP 2, directs hospitals to then communicate with patients "in a manner that meets the patient's oral and written needs."

To be in compliance with these provisions, hospitals need to try to determine what written materials patients understand, or if they have health literacy needs, and what kind of materials they need, explains Cordero. "In addition, communications needs can be personal devices that people have brought with them to the hospital such as eyeglasses or hearing aids," she says. "Sometimes throughout the care continuum, people are separated from those devices, so it is a matter of bringing patients back their glasses or hearing aids to facilitate communication between patients and providers."

Surveyors are likely to review what policies and procedures are in place to insure patient communications are effective; they may also conduct patient interviews, review staff training procedures, look at what resources are in place to help with communications, and find out how these resources can be accessed, explains Cordero. ■

SOURCE

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Use appropriate tools, strategies to overcome challenges of communicating in an emergency setting

Most would agree that the concept of patient-centered communications makes sense and is a worthy goal, but getting there can be especially challenging in the ED, where decisions often must be made quickly and

families are frequently under great stress. "A fair number of people come into the ED not able to communicate in the way they normally would. They may be unconscious, they may be in extreme pain, they may be very frightened," explains **Matthew Wynia**, MD, MPH, director of the Institute for Ethics at the American Medical Association in Chicago, IL, and a member of the expert advisory panel on which the Joint Commission relied in establishing its accreditation standards for patient-centered communications. "These things are true in any health care encounter, but they are much more exaggerated, much more common, and much more severe in the ED."

Consider, for example, the case of someone who speaks English as a second language, and is quite fluent, until he becomes very sick, and then all of the English suddenly becomes inaccessible, says Wynia. "That kind of thing happens in EDs even more than it does in the inpatient, hospitalized setting," he says. "When people are really scared, they don't process information normally."

In these cases, it can be helpful to use the "teach-back" method, where you ask patients to repeat instructions or information you have provided to them. "Also, when you hear something from the patient, you should summarize what you heard and repeat it back to the patient," says Wynia. "I think it is the only way to know for sure that you and the patient are on the same page."

Wynia acknowledges that in a stressful situation, it is harder for patients to learn and absorb information, so they may not repeat back information correctly the first or second time. "That may require bringing in a support person, family member, or community resource for further education," he says. "The patient may also need a follow-up appointment that is a little sooner than otherwise."

Have competent interpreters on hand

In cases where there is an obvious language barrier, then EDs have a particular obligation to make sure they have resources in place to communicate, stresses Wynia. "This could be a telephone or an in-person interpreter, but it really should be someone who is competent and qualified to do interpretation," he says.

However, Wynia emphasizes that providers should never rely on a patient's child for interpretation. "You just don't get a quality interpretation of the material because the child is unlikely to know the types of terminology you are using," he says. "Children are also especially unlikely to ask their parents the kinds of questions you might need to ask — personal, probing questions that put the child in an uncomfortable position."

Language isn't the only barrier to communication that can occur in the ED. You could be treating a patient who is deaf, or someone who needs to be intubated. "In these types of cases, you need to have a language board on hand so that patients can at least write things to you," says Wynia. "And these tools need to be readily available in the ED as opposed to a less acute setting, where you might have more time to pull resources together. In the ED, you might not have that kind of time."

Find weak links

One way to find weak links in your communications pathways is to complete an organizational assessment across the entire hospital, says Wynia, noting that it is the first step toward creating an environment where good communication can take place. "It is pretty common for there to be big differences from one part of an organization to another, so when comparing the ED to an inpatient oncology service, for example, you can see big contrasts," he says.

For the ED part of this process, Wynia recommends a complete, across-the-board assessment of communications with regard to:

- engagement with patients in decision-making;
- health literacy;
- signage;
- follow-up care; and
- care transitions.

As with other aspects of health care, improvement needs to be driven by data, stresses Wynia. "The only way to do that is to do a formal assessment so that you've got some data as to where you are right now. Then you can reassess in a year and see where you are after your interventions," he says. ■

Editor's note: To help with an organizational assessment, ED managers can find a "Communications Climate Assessment Toolkit" and a range of other surveys and instruments at www.ethicalforce.org, which is sponsored by the American Medical Association.

SOURCE

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Patients can provide key information, vital linkages with primary care providers

New "Speak Up" brochure geared toward dialysis patients

A patient who is actively engaged in his or her own care can provide a wealth of information to a busy ED provider who lacks ready access to medical-record information. But sometimes it takes gentle prodding for the patient to feel comfortable about sharing such details. "ED physicians can have significant impact [in this regard] because they are often the first physicians a patient is going to see when they come into an organization," explains **Ana Pujols-McKee**, MD, executive vice president and chief medical officer, the Joint Commission (JC) in Oakbrook Terrace, IL. "Telling patients that you want them to participate in their care can be a very powerful message."

Such participation is especially critical when dealing with patients with highly complex medical issues, such as dialysis patients, for example. "The majority of these patients are going to see a completely different care team that knows very little about them, and most likely is totally unconnected with the facility where they are regularly receiving their care," says Pujols-McKee, "so medical history, allergies, medications — all of that knowledge and information does not follow the patient when he goes into the ED."

When such patients are engaged, they can not only bring providers up to speed about vital medical information quickly, they can also facilitate linkages between the ED providers and their primary care physician by providing contact information, and making it much easier for the ED physician to reach out, adds Pujols-McKee.

Recognizing that dialysis patients who seek emergency or inpatient care present special challenges, the Joint Commission has developed a brochure specifically geared toward encouraging these patients. *Dialysis: Five Ways To Be Active in Your Care at the Hospital*, discusses such topics as avoiding infections and drug interactions, speaking with the hospital dietitian, and planning for discharge.

The dialysis education campaign is the latest addition to the JC's "Speak Up" campaign, which has been urging patients to take a more active role in their care since 2002. Hospitals can download the brochure geared toward dialysis patients as well as the campaign's other brochures free of charge at www.jointcommission.org/speakup.aspx. ■

SOURCE

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