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New research highlights misconceptions about frequent ED users, utilization patterns

Experts find fault with growing focus on cost of ED care

In an effort to drive down health care expenditures, a key target of state legislatures and health care policy makers in recent years has been frequent users of the ED. The thought is that many of these patients are using the ED for routine or non-urgent care when they really should be opting for less-expensive care settings. However, new research into exactly who these frequent users are suggests that a high percentage of these patients are, in fact, using the ED for urgent or emergent concerns, and that efforts to find cost-savings could be better focused elsewhere.

As this issue is of high concern to the American College of Emergency Physicians (ACEP), several investigations looking at this issue were presented in October at the group's scientific meeting in Denver, CO. **Robert O'Connor**, MD, MPH, chair of Emergency Medicine at the University of Virginia School

EXECUTIVE SUMMARY

Several new studies presented at ACEP's scientific meeting in October poke holes in the conventional wisdom that frequent ED users are abusing the ED for routine health care needs. Instead, investigators say patients typically have urgent or emergent concerns, regardless of their insurance status. Experts suggest that rather than trying to keep patients out of the ED, cost-control efforts should focus on establishing better referral systems of care.

- The studies suggest that frequent users actually represent a small percentage of ED patients, ranging from 2.1% in one study to 20% on the high end in another.
- For frequent ED users, the distribution by payer type tends to reflect the community. Similarly, the most common diagnoses for frequent users are similar to that of occasional users.
- According to one study, while Medicaid patients use the ED roughly twice as often as patients with private insurance, the triage decisions for these patients show that they have urgent or emergent concerns.

of Medicine, Charlottesville, VA, and a co-author of one of the studies presented at the ACEP meeting, notes that while the investigations utilized varying definitions of how many visits to the ED qualified a patient as a frequent user, they did arrive at many similar insights about this patient group.

"Despite the widespread belief that these patients can easily be directed elsewhere in the health care system for less-expensive care, and that these patients are somehow abusing the system, the reality is much more complicated," says O'Connor. "These patients actually need, for the most part, to be treated when they come in. And regardless of the definition used, most of the studies found frequent users to be a very small percentage of the total number of emergency patients, although these patients did make up a disproportionate share of ED visits." *(Also, see "Dearth of referral resources a source of frustration for emergency providers." p. 136.)*

In his own study looking at the characteristics of repeat ED users at a university medical center, O'Connor found that frequent users made up about 20% of the volume in the ED and accounted for nearly 40% of the visits.[1] However, in most of the other studies, O'Connor notes that frequent users made up a smaller proportion of the ED volume.

For example, in a study out of Harvard, frequent users made up 2.1% of all emergency patients and accounted for 11.5% of all visits.[2] Similarly, a study conducted at the University of Wisconsin (UW) found that frequent users represented about 8% of all emergency patients and accounted for about 26% of all visits.[3] And a study out of the University of California at San Diego (UCSD) found that frequent users represented 3.1% of all emergency patients and accounted for 16.5% of all emergency visits.[4]

New re-admission penalty unfair?

Another insight O'Connor notes from these studies is that while many health care experts believe that frequent users tend to be uninsured, it turns out that is not true. "Most frequent users are likely to be insured by Medicare or Medicaid," he says. "What we found in our study was that the distribution by type of insurer roughly represents the community as a whole."

Similarly, O'Connor notes the UCSD study found that the percentage of frequent users who were self-pay patients was similar to the percentage of uninsured patients overall, which was about 14.2%.

The UCSD study found that the most common diagnoses among frequent users were the same as for the occasional users: respiratory complaints and abdominal symptoms. Being a frequent user was also linked with a pain diagnosis or a heart failure diagnosis, says O'Connor.

O'Connor notes that the UW study found that 77% of the frequent users with seven or more visits during a 12-month period were only frequent users for one year, and most of these patients had the same rates of non-urgent visits as the non-frequent users.

"In our study, low and moderate repeat users were

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just as likely as non-repeat users to be admitted to the hospital from the ED," says O'Connor. "This suggests that the ED visits for these patients are justified as necessary for an acute illness, and high repeat users, once admitted to the hospital, were more likely to require re-admission."

Such findings raise questions about the recently implemented Medicare rule that penalizes hospitals for higher than average 30-day re-admission rates, notes O'Connor. "If you have a sick population that you are caring for, such as at a university hospital, I think it is unfair to the patients and to the hospital to penalize them for re-admission rates."

Misconceptions persist

ACEP's incoming president, **Andrew Sama**, MD, FACEP, senior vice president, Emergency Services, North Shore — Long Island Jewish Health System, Manhasset, NY, notes that the studies make clear that there are a number of misconceptions about who these frequent users are and how they use the health care system.

"The perception is that these are only people who are uninsured or they have mental health problems or they are abusing pain medication. In fact, there is a significant number of patients who fall into those categories, but this is also a group of people who, over a period of time, have a significant medical or surgical illness, have complications, and require recurrent and intermittent evaluation and treatment," says Sama. "Some of these folks are medically very sick and do present with new, acute problems in percentages that are very similar to the general population."

Sama adds that it is important to recognize that frequent users are actually a heterogeneous group of patients rather than a single patient type that can be easily matched with a single solution. "What we are trying to do as emergency physicians, state by state, and location by location, is put together intelligent processes and policies and procedures to begin to manage the very types of patients who are frequent users of emergency care so we can actually make improvements that can preclude some of this activity from occurring," he says. "It is not a simple problem; it is a social, medical, mental health, and community resource problem."

Further, Sama notes that the type of patients being seen in the ED today are more complex and require higher-level medical decision-making than in the past. "Five years ago, there were very few retail clinics and maybe half as many urgent care centers. Currently, there are 170-180 million patients who are being seen in retail clinics and urgent care centers, and these are the lower-acuity patients who used to be seen in the ED," he says. "We are seeing a shift."

While the studies did not specifically look at the cost associated with frequent ED users, O'Connor points out that most of these patients lack other care options. "Someone who is five days post surgery, who is having nausea and vomiting and can't keep anything down at 3 o'clock in the morning, has nowhere else to go, so they come to the ED," he observes. "They then may go home and develop a second complication from the surgery, which is totally unforeseen, and so they come back."

In this instance, O'Connor notes that utilizing the ED is actually less expensive than to trying to replicate the kind of care offered in the ED somewhere else. "Where else is someone going to go at 3 o'clock in the morning, unless you set up a parallel emergency care system?"

While the financial implications of frequent ED utilization are a concern, Sama points out that EDs are open every day around the clock, and they have 136 million encounters every year. "Emergency care in the United States only costs 2% of the entire national health care budget," he explains. "Only spending 2% on all of those acute care encounters is actually a pretty good return on investment."

Triage decisions tell a different story

Many of the findings about frequent ED users unveiled at ACEP's scientific meeting echo the results of similar studies released earlier this year. For example, a study unveiled in July by the Washington, DC-based Center for Studying Health System Change (CSHC) found that contrary to common belief, the majority of ED visits made by non-elderly Medicaid patients are for symptoms that suggest they have urgent or emergent problems.[5]

Such findings contrast with earlier research, but **Emily Carrier**, MD, MCSI, an emergency physician and senior health researcher at CSHC, explains that this is because most researchers have based their findings on claims data, which reflect final diagnoses. "When looking at final diagnoses, you end up with one picture of why people use the ED, but when a patient on Medicaid (or some other type of coverage) enters they ED, they obviously don't know what their final diagnosis is going to be," says Carrier. "We looked at triage acuity, and that gives you a very different picture."

For example, Carrier observes that most patients who come to the ED complaining of chest pain are not having a heart attack, but they do what public information campaigns tell them to do, which is to

come to the ED and get checked out. "For many of these people, the problem is going to turn out to be something as benign as reflux disease or heartburn," she says. "Most of these people are not going to have a heart attack and die, but they don't know that in the beginning."

Similarly, parents commonly come to the ED with young children who have high fevers and appear to be very sick. Many of these cases turn out to be viruses for which there is supportive care and reassurance available in the ED.

"In retrospect, you could say that they didn't really need to come in, but at the time the parent was bringing in the child, they were very concerned, and a small proportion of those kids are going to be really sick and have a potentially life-threatening illness," she says. "What our study shows is that most of the patients who came in had concerns that appeared to be significant — not just to them, but to the triage staff who evaluated them as well."

While the researchers found no evidence that patients on Medicaid have any special propensity to abuse the ED, Medicaid patients did tend to use the ED about twice as often as patients with private insurance. "If you went to an ED waiting room and started interviewing people, you would find a lot more who had Medicaid relative to the overall proportion of the population who have Medicaid than you would for people with private insurance," says Carrier. "But if you asked them what brings them here, you would find that folks with Medicaid were about as likely as folks with private insurance to describe a really concerning symptom or a minor symptom."

The CSHSC study notes that diagnoses of acute respiratory and other common infections in children and injuries accounted for more than half of the ED visits by children on Medicaid younger than the age of 12 years and more than 60% of ED visits by children younger than 12 years covered by private payers. The authors concluded that the greatest potential to reduce ED use lies in developing appropriate alternative care settings for these conditions, but they caution that such alternative sites would have to be able to provide prompt care. ■

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Dearth of referral resources a source of frustration for emergency providers

In the emergency care setting, providers treat all users, regardless of their acuity level or their ability to pay. However, when clinicians see the same patients coming back for care frequently, they are troubled by it.

"Physicians want patients to get better, so if someone comes back frequently, we almost view it as a failure of what we have done because now our usual diagnostic and treatment modalities aren't working as well as they should," explains **Robert O'Connor**, MD, MPH, chair of Emergency Medicine at the University of Virginia School of Medicine in Charlottesville. "Now we have to dig a little deeper into what we are going to offer the patient, so it becomes a much more challenging case if someone is not getting better."

Such situations become particularly frustrating when the reason a patient is back in the ED is related to the fact he has had trouble accessing the health resources he needed. "We sometimes have trouble getting patients in to see specialists or primary care physicians," adds O'Connor. In other cases, setting up home health care or getting a patient into a nursing

home may prove challenging, he says.

"There is some frustration, but we have to step back, be professional, and make sure the patient doesn't have a new problem or a worsening of their existing problem, and take proper care of them," observed O'Connor.

In fact, if better systems of referral were in place, many patients who now come to the ED and are then hospitalized could instead be sent home with appropriate home health care and/or follow-up, notes O'Connor.

Of particular concern is a lack of access to mental health services, stresses **Andrew Sama**, MD, FACEP, the incoming president of the American College of Emergency Physicians and senior vice president, Emergency Services, North Shore — Long Island Jewish Health System, Manhasset, NY. "There is not very good access to good inpatient or outpatient mental health services, particularly if the patient is on Medicaid or the patient is uninsured," he explained.

Rather than trying to keep patients out of the ED, what O'Connor would like to see is a hub-and-spoke model in which the ED can re-direct patients to needed resources. "What is happening now is things are fragmented. I have difficulty referring patients out, and I also have difficulty accessing records from other hospitals," he explained.

It's a mistake to just key in on one system or department for new efficiencies or cost savings, notes O'Connor. "We really need to step back and look at the whole picture, but focus on the patient as the unit of study," he says. "This is something we are all in." ■

ED navigators steer patients with social, financial, or behavioral health needs to appropriate resources

Approach relies on effective working relationships between the navigators and ED staff

While studies show that most people come to the ED because of an urgent or emergent medical concern, some people wind up in an emergency setting because they are not plugged in to the kind of social or medical resources that could more appropriately meet their needs.

At Sutter General and Sutter Memorial Hospitals in Sacramento, CA, this problem became particularly acute at the height of the country's financial woes a few years ago. "People lost their jobs and lost their health insurance, and county clinics were closing," explains **Holly Harper**, the regional community benefits manager for Sutter Health's Sacramento Sierra region. "We have many programs that meet the needs of under-served populations, but what we were finding was that the ED was flooded with people who were in there for non-urgent reasons."

To address the problem, Sutter partnered with The Effort, the local federally qualified health center (FQHC), to establish ED navigators on-site in each of the hospitals' EDs between 1 p.m. and 10 p.m., seven days a week. The way it works is ED staff will alert the navigators to patients who arrive with no insurance coverage or primary care home, as well as patients who have mental health problems or significant social needs.

The navigators, who are employees of The Effort, will then meet with the patients while they are still in the ED to explore what types of health care connections these patients have, explains **Rodney Kennedy**, MFT, director of Behavioral Health Programs for The Effort. "A lot of these patients are either homeless or have mental health conditions, and they don't necessarily feel comfortable going to a regular health care provider," he explains. "So in working with them and engaging with them, we are able to assist in all those areas."

For example, for a patient who has no insurance coverage, the navigator will attempt to get him or her qualified for health care benefits and establish a follow-up appointment with a specific health care provider at one of The Effort's clinics. "We have five clinic sites in the Sacramento region," notes Kennedy.

EXECUTIVE SUMMARY

Especially in times of economic distress, patients who lack health care connections tend to wind up in the ED. However, administrators at Sutter General and Sutter Memorial hospitals in Sacramento, CA, have discovered that by pairing these patients with ED navigators, they can be plugged into appropriate resources and follow-up care so that they are less likely to return to the ED for non-emergent problems.

- The ED navigators are employees of The Effort, the regional federally qualified health center (FQHC), but they are located in each of the hospitals' EDs.
- The navigators can schedule same-day or next-day appointments for patients with a provider at one of the FQHC's clinics.
- The ED navigator program works in concert with the Triage, Transport, and Treatment (T3) program, a similar program also run by the FQHC that targets frequent ED users with more complex needs. Studies show the T3 program has reduced return visits to the ED by 65%.

"We also have blocks of medical appointments every day that are identified specifically for patients referred from Sutter EDs. The navigator can go right into our electronic health scheduling system and get the patient scheduled to see a provider that day, or the next day if it is in the evening."

Address 'the whole person'

Many of the patients have complex needs that require social and medical interventions. "We often have patients come in who are homeless, and one of the more common diagnoses that they present with is diabetes with insulin dependence that is poorly managed," explains **Amber Salazar**, MSC, The Effort's healthcare access and case management program manager. "The insulin has to be refrigerated, which is difficult to do when you are homeless, so these patients will come through the ED frequently for a variety of issues related to their unmanaged diabetes."

The navigator will first link these patients up with a primary care provider (PCP), but then she will work on addressing the social needs. "We address the whole person, so we start with the medical condition and their case management needs; then we begin looking for a shelter or appropriate housing for them. We also address their mental health needs, so it is all integrated care," says Salazar. "Then we follow the client to insure that they are continuing to engage with the PCP and with case management services."

The navigator program was pilot tested for a year before it got the green light to proceed on a permanent basis in November of 2011. Sutter pays The Effort $150,000 per year to run the program, and as a FQHC, The Effort receives reimbursement from the government to care for patients who have no insurance or who are on Medicaid.

The ED navigator program isn't the first Sutter/Effort collaboration. The organizations first established the Triage, Transport, and Treatment (T3) program, which targets frequent ED users with more complicated needs. Administrators credit that program with reducing return visits to the ED by 65%. The navigator program's approach is similar to the T3 program, and, in fact, ED navigators can refer patients who have more complicated needs into the T3 program. In addition, many of the ED navigators — typically personnel with college degrees in human services-related fields — began working with patients as part of the T3 program before moving over to the newer navigator program.

"One of the reasons we believe our navigators are successful is because they are so closely linked with the T3 program where they can hand off individuals to that team when it is appropriate and provide an additional range of services, which includes supported housing," adds Kennedy.

Build effective relationships

To be effective, ED navigators have to earn the trust and respect of hospital personnel. "It is the relationship that gets developed with the hospital personnel that really facilitates our efforts to identify and engage with these patients," says Kennedy. "It is really kind of a teaming approach that makes it successful."

Further, as a program is being rolled out and fine-tuned, it is important for administrators at both organizations to work closely together. Kennedy notes that early on in the roll-out of the navigator program, there were regular meetings about what was working and not working, and administrators were able to remove barriers. For example, when one of the hospitals was undergoing renovations, the ED navigator got shuffled off to the radiology department, which didn't work too well, says Kennedy. With close communications between the two organizations, the problem was resolved quickly, he says.

It is also critical for the organization providing the navigators to be well-connected with community resources. "The more resources we can pull together, that really makes the navigator's job that much easier," says Kennedy.

Salazar adds that navigators should receive extensive on-the-job training. For example, she points out that The Effort's ED navigators spend time shadowing case managers, hospital staff, and the psychiatric response team.

Harper advises colleagues interested in establishing ED navigator programs to develop a solid relationship with the FQHCs in your region because they are a crucial point of access. "They will be a huge part of the capacity solution when health care reform kicks in," she says.

Salazar echoes this point, noting that The Effort's ED navigator and T3 programs are perfectly aligned with the mission of accountable care organizations and health care reform going forward. "That is really important, and more of the physicians and hospital administrators are recognizing that," she says. ■

SOURCES

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Patient Flow
SOLUTIONS

Lean-driven solutions slash ED wait times, LOS

Next target for ED improvement effort is the hospital admissions process

You know there is a problem when the average wait time to see a provider is in the four-to-five-hour range, and 3% to 7% of incoming patients are routinely leaving the ED without being seen (LWBS). And when confronted with these dismal statistics roughly two years ago, administrators at The Aroostook Medical Center (TAMC) in Presque Isle, ME, certainly understood that big changes were in order. "Our wait times and length-of-stay [figures] were terrible compared to national numbers," acknowledges **Daryl Boucher**, MS, the director of Emergency Services at TAMC.

To right the ship, administrators brought in a lean expert and spent more than a year identifying inefficiencies and reengineering patient flow processes. Then they shifted to implementation mode, where over a period of four to five months, a number of parallel processes were put to the test and refined, explains Boucher.

In fact, the lean-driven improvement process continues to this day, but the effort has already produced dramatic results. Boucher notes that the LWBS rate is now under 1%, and wait times typically hover around the five-minute range.

How did they do it? There were literally dozens of changes, ranging from redesigned registration and triage processes to strengthened responsibilities for charge nurses and more point-of-care testing. None of it came easy, stresses Boucher, noting that almost any change goes along with a fair amount of employee pushback. However, he observes that ED clinicians and staff are now eager to see the monthly performance metrics. "Continuing to see the results is a motivator these days," he says.

EXECUTIVE SUMMARY

The ED at The Aroostook Medical Center (TAMC) in Presque Isle, ME, is a level II trauma center. It is the largest in the region, with only 89 beds. It has undergone a transformation in recent months, with average wait times to see a provider going from four to five hours down to less than five minutes, and the left-without-being-seen (LWBS) rate has been slashed from a high of 7% down to less than 1%. The hospital says the improvements are the result of lean-driven, staff-designed solutions, coupled with administrative engagement and oversight. And administrators say more improvements are on the way in 2013 when a hospital-wide workgroup will try to clear away obstacles and inefficiencies from the hospital admissions process.

• To tackle long wait times among patients with lower triage levels, the ED instituted a fast-track system, manned by mid-level providers and a tech or LPN.
• Responsibilities for charge nurses have been redesigned so that they have the power to monitor and facilitate patient flow.
• The ED has initiated more point-of-care testing so that nurses and techs can conduct many routine tests on their own.
• While the lean model relies on staff-driven solutions, administrators make the difference when it comes to sustaining changes and minimizing employee resistance.

First, highlight inefficiencies

Tim Doak, PE, the project manager and facilities engineer at TAMC, has managed the improvement effort from the start, providing outside perspective to personnel who are consumed with ED processes on a daily basis. "People are so involved in their own piece of the care delivery system that sometimes no one really takes the time to take a step back and look at the end-to-end process," he explains. "We had a very clunky registration and triage process that required the patient to bounce back between the waiting room and triage and the registrar numerous times. It made great sense for the people doing the work and their piece of it, but when you looked at it from the patient's standpoint, it was very frustrating."

To turn things around, a workgroup consisting of a select group of ED personnel, as well as representatives from all the departments that interact with the ED on a daily basis, was assembled to consider how ED processes could be streamlined and improved, explains Doak. "We continued having project meetings, and step-by-step we rolled out new process changes, made new obser-

vations, and determined whether the changes were having the effect we had hoped or not. If they were, we continued them, and if they were not, we tweaked them a little bit and went in a different direction."

For example, what became clear early on in the improvement effort was that a majority of the patient complaints the ED was receiving came from the lower triage levels, says Boucher. This made sense because patients with acute problems were typically seen right away while patients with sore throats or ear aches typically had to wait.

To resolve this problem, the first thing the improvement team did was implement a fast-track system during the peak hours between 9 a.m. and 11 p.m. "Now, any lower triage patients go through fast track," says Boucher. "We do direct bedding with them and direct bedside triage, so essentially for those people who come in with something minor, we just take them to a room, a physician assistant (PA) or nurse practitioner (NP) sees them, and then discharge typically occurs in less than 20 minutes."

To implement this change, one room was set aside for the fast-track patients, and the ED hired two mid-level providers to provide care along with a tech or LPN. While this may sound like a straight-forward solution, Boucher explains that getting all the staff on board proved challenging. "It was a huge shift in culture for us because the motivation has always been to treat our sickest patients first. That is the point of triage. You come in with something bad and you are treated first," explains Boucher. "But what we discovered was if we could get those quick in-and-outs taken care of, our rooms were available for those sicker patients, so it has really flip-flopped how we treat patients."

Coupled with the new fast-track system, the workgroup redesigned the responsibilities of charge nurses, essentially giving them new powers to monitor and facilitate the flow of patients to providers. Under this new approach, if three patients with minor problems arrive in the ED at the same time, the charge nurse is able to assign at least one of these patients to an ED physician, rather than the mid-level provider manning the fast track.

The idea is to minimize wait times and move patients through the system, but it is a major culture change because the ED physicians only want to take care of the sicker patients, explains Boucher. "This is an ongoing challenge," he says. "It is a team approach. Instead of playing man-to-man, we are playing zone, and everybody is responsible for something."

Consider point-of-care testing

When pouring over the ED's data, the workgroup observed that patients with relatively minor problems were often experiencing a long LOS because they were waiting for the results of routine lab tests. "One of the things we discovered is that for some routine, in-and-out, triage level four and five patient exams, our lab transport times and result times were significant primarily because the lab didn't see some of these tests as critical," explains Boucher. "If they received a request for a urinalysis and a troponin, they were going to run the troponin because that involves a cardiac patient."

To get around this problem, ED administrators decided to bolster the number of point-of-care tests done right at the bedside in the ED, especially for patients who were likely to be discharged from the ED. "We didn't get much resistance to this because the nurses were frequently frustrated waiting on lab results, so this was a way to do the tests themselves and get the results quickly," says Boucher.

The point-of-care testing program is still being ramped up, with the nurses and techs being trained to perform the tests. Further, the lab is overseeing the program, so lab administrators are developing the policies and procedures as well as a quality assurance program, explains Boucher. Most of the point-of-care tests cost about the same as the lab-based versions, and there is no added cost to the patient, he adds.

Fix processes before renovating

With positive press about the reductions in wait times in the ED at TAMC, volume is on the increase, but, thus far, the increase has not adversely impacted wait times or LOS. Currently, the ED sees about 50 patients a day and 17,000 patients per year, says Boucher. What's more, he stresses that additional changes are on the way that will further streamline care delivery.

For example, the ED is in the midst of completing renovations that have been designed with the new process in mind. "We wanted to fix the process before we fixed bricks and mortar," notes Boucher. "We are not even increasing the rooms dramatically. We are renovating for the sole purpose of increasing flow and movement within the ED."

In the revamped ED it will be easier to block rooms that are assigned to nurses so that they don't have to go from one end of the hall to the other, and the nurse's station will be redesigned so that the charge nurse is centrally located and accessible, observes Boucher.

In addition, following a trend in many redesigned EDs, specialty rooms that are now set aside for orthopedics, OB/GYN issues, or other disease-specific procedures will be turned into all-purpose rooms. "What we have done is taken all the supplies and equipment out of the disease-specific rooms and put them on carts that can then be moved to any room," says Boucher. "Instead of a patient waiting for a particular room to be available, they will be able to go to any room and we can then bring the equipment needed to that room."

Boucher adds that the renovations were a tough sell because they will not be increasing the number of beds in the ED. "It is all ease and efficiency," he says.

Also on the agenda for 2013 is a new focus on the hospital's admissions process. Boucher notes that it is the next logical step in TAMC's performance improvement effort. "We have gotten very efficient at getting people into rooms quickly. We have wait times under five minutes at this point," he says. "The problem is when we have no inpatient beds or we can't move people out of our beds because we are waiting for a hospitalist or a consultant to come do an admission when we are stuck, so the goal is to really look at outflow: how we can improve efficiency in getting patients out of the ED and into each of the units."

Get buy-in from core personnel

Under a lean approach to performance improvement, it is true that selected frontline staff members devise solutions and drive the process, acknowledges Boucher. However, he stresses that administrators need to understand that this does not eliminate resistance to change. "Once you roll out [the solutions] so that everybody is impacted, suddenly new perspectives come out," he says. This is where leadership can makes the key difference.

"Lean doesn't really provide a mechanism for managing the culture change that is going to have to occur. It just identifies what your end point is and the steps you are going to have to take to get there," explains Boucher. "You will get to a point where there is some disagreement, and leadership really needs to play a role in making sure you are making the right decisions."

Doak agrees, emphasizing that leadership needs to stay engaged. "This is something that needs to be supported from the top down," he says. "Although the process changes happen from the bottom up, the sustainability piece is really a top-down function, so administrators need to understand what they are looking for, and they need to be on the floor frequently making observations for themselves."

Doak adds that administrators should not expect meaningful changes to take hold overnight; you have to be very patient, he stresses. "We have had a lot of instances where we would roll something out, and then over time staff would kind of digress a bit, and then we would have to go back and refresh what we were doing and get everyone focused on it," observes Doak. "The sustainability piece is often the toughest piece of this. It can be easy to change something. It is tougher to be very rigorous about it and continue on down that road."

Boucher advises colleagues who are embarking on a lean-driven performance improvement initiative to establish a clear goal of what they want to accomplish, and to stay focused on that goal even when potential solutions fall short. "Some of the processes that we thought would work didn't work at all, so then we regrouped and tried something else, but we never lost sight of what our goal was," he says. "A goal focus is really important because there will be lots of approaches that fail and lots of barriers that will be encountered."

Secondly, consider how you will deal with naysayers, because some people will inevitably leave or threaten to leave, adds Boucher. "My personal view is that cave dwellers always exist, so I just minimize what they contribute," he says. "Buy-in is important as long as you have buy-in from the core." ■

SOURCES

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• **Tim Doak,** PE, Project Manager and Facilities Engineer, The Aroostook Medical Center, Presque Isle, ME. E-mail: tdoak@tamc.org.

ED Coding Update

ED coding patterns and EMRs draw attention to the potential for upcoding

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

Coding patterns for emergency services have been scrutinized in the press recently. The *New York Times* published an article on August 14, 2012, detailing the extraordinary profits being earned by the health care industry giant HCA. In the article, HCA is lauded for its successful 20% ED growth from 2007-2011, while during part of this time it was under Medicare scrutiny from its Medicare fraud settlement and operating under a corporate integrity agreement.

Just prior to the conclusion of the governmental oversight period in 2008, HCA instituted its new emergency department coding system, based on the American College of Emergency Physicians facility coding guidelines. By 2010, HCA saw an increase it its two highest ED facility levels, which had increased up to 76% of total emergency department payments, while other hospitals were experiencing only 74% of their payments from these top two emergency department levels.

The overall impact of these coding improvements increased HCA's adjusted earnings by 7% in a single quarter, resulting in a $75-$100 million increase in earnings from ED coding revisions. No additional detail is provided to address whether or not these patients were admitted or discharged, which specific codes accounted for the increase in revenues, or whether or not there was any change in ED acuity. It is known that at the same time HCA was improving their coding system, they instituted controls to reduce the number of patients who did not seem to have a true medical emergency and were unable or unwilling to pay for emergency services.

Unrelated to the HCA article, Attorney General Eric Holder and Health and Human Services Secretary Kathleen Sebelius warned hospitals that the Obama administration will not accept attempts to "game the system" by using electronic health records (EHRs) to boost Medicare and Medicaid payments. Holder and Sebelius issued the warnings in a strongly worded letter sent to the American Hospital Association (AHA), Association of Academic Health Centers, Association of American Medical Colleges, Federation of American Hospitals, and National Association of Public Hospitals and Health Systems.

The letter stated that there is evidence that hospitals are using EHRs to obtain payment for which they are not qualified, a process known as "upcoding." Two recent reports found that EHRs are pushing up the cost of care, not saving money as they were expected to do.

Among the investigation's key findings:

- Doctors steadily billed Medicare for longer and more complex office visits between 2001 and the end of the decade, even though there's little hard evidence they spent more time with patients or that their patients were sicker and required more complicated — and time-consuming — care. The higher codes for routine office visits alone cost taxpayers an estimated $6.6 billion over the decade.
- More than 7,500 physicians billed the two top paying codes for three out of four office visits in 2008, a sharp rise from the numbers of doctors who did so at the start of the decade. Officials say such changes in billing can signal overcharges occurring on a broad scale. Medical groups deny that.
- The most lucrative codes are billed two to three times more often in some cities than in others, costly variations government officials say they could not explain or justify. In some instances, higher billing rates appear to be associated with the burgeoning use of EHRs and billing software.
- Medicare administrators have struggled for more than a decade to crack down on medical coding errors and abuses, often in the face of opposition from medical groups, including the American Medical Association, which helped design, and now controls, the codes. Whether they make honest mistakes or engage in willful misconduct, there's little

COMING IN FUTURE MONTHS

- Disaster response: Lessons learned
- How to address burnout among nurses
- New scrutiny on overused procedures
- What EDs can do to curb harmful drinking

chance doctors who pad their charges will face any serious penalties.

How can emergency physicians assure that all essential medical information is recorded for both clinical and billing purposes while avoiding the use of template statements and phrases? First and foremost, template statements that appear on all medical records in the same verbiage are a clear indication that the system, not a provider, formatted the information. Payer auditors look for the same statements on every patient, whether or not they are pertinent to the care given, as clear indicators of EHR formatting of statements.

Although medical decision making (MDM) is a strong indicator of the medical necessity for treatment, elements of MDM used for coding purposes can be subjective. This leads many Medicare Administrative Contractors (MACs) to revise the documentation guidelines published by CMS and AHA and has resulted in regional differences in how documentation can be "scored" to develop a billing code. This has further created wide regional variances in how ED codes are billed to Medicare.

Methods to consider that may help avoid "over-documenting" elements resulting in higher code levels that might be considered "upcoding" include:

1. Addressing risk factors pertinent to each visit and elaborating on those related systems.

2. Addressing history of present illness (HPI) in a separate notation from the review of symptoms (ROS). Assuring that problems documented in the HPI are expanded into pertinent positives and negatives in the ROS for all related systems. Some Medicare MACs require a statement about each system in order to qualify for the higher E/M levels so "all systems reviewed and negative unless otherwise notes" may not be acceptable.

3. Checking the website for your local Medicare MAC and reviewing their documentation guidelines and audit forms. This is where you can learn how your records will fare in a Medicare audit.

4. Remembering to include pertinent differential diagnoses to support testing and interventions where appropriate.

5. Assuring that statements are pertinent to the patient. Female gynecologic system reviews on male patients, and smoking and street drug use statements on pediatric patients are two areas that frequently present problems on review.

For hospitals using the same EHRs to assign facility levels, facility coding criteria should be developed to assure the following principles are addressed:

• Coding guidelines for emergency and clinic visits should be based on emergency department or clinic facility resource use, not physician resource use;

• Coding guidelines should be clear, facilitate accurate payment, be usable for compliance purposes and audits, and meet HIPAA requirements;

• Coding guidelines should only require documentation that is clinically necessary for patient care. Preferably coding guidelines should be based on current hospital documentation requirements;

• Coding guidelines should not facilitate upcoding or gaming;

• Coding guidelines should exclude any services or resources that were "separately billable" by the hospital;

•Coding guidelines should be usable by all health care payers.

Few data are available to track emergency department facility acuity distribution nationally. However, Medicare continues to reference in its OPPS final rule that hospitals continue to demonstrate a reasonable acuity distribution for emergency departments. ■

CNE/CME INSTRUCTIONS

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

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. ■

CNE/CME QUESTIONS

1. According to a study from the University of California, San Diego, the most common diagnoses among frequent users of the ED that are the same as for occasional users are:
A. chest pain and headache
B. extremity injuries and chest pain
C. respiratory complaints and abdominal symptoms
D. chest pain and pneumonia

2. According to **Andrew Sama**, MD, FACEP, emergency care in the United States costs:
A. 10% of the entire national health care budget
B. 5% of the entire national health care budget
C. 20% of the entire national health care budget
D. 2% of the entire national health care budget

3. According to **Robert O'Connor**, MD, MPH, repeat visits are particularly frustrating for emergency physicians when the reason a patient is back in the ED is:
A. The patient has had trouble accessing the health resources he needed.
B. The patient has a behavioral health problem.
C. The patient has a primary health care concern.
D. The patient is coming in for more pain medication.

4. According to **Rodney Kennedy**, MFT, in order to be effective, ED navigators have to:
A. undergo extensive on-the-job training
B. earn the trust and respect of hospital personnel
C. have well-developed interpersonal skills
D. be bilingual

5. **Holly Harper** advises hospitals interested in establishing an ED navigator program to:
A. study the health care needs of your frequent users
B. gauge interest in the program among ED personnel
C. perform a cost-benefit analysis to see if the program would be beneficial
D. develop a solid relationship with the federally qualified health center in your region

6. According to **Daryl Boucher**, MS, under a lean approach to performance improvement, it is true that selected frontline staff members devise solutions and drive the process; however, this does not eliminate:
A. resistance to change
B. costs
C. inefficiencies
D. all of the above

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

In a major three-year initiative, The Joint Commission puts transitions of care under scrutiny

New measures, requirements tied to care transitions planned for 2014

The Joint Commission (TJC) is in the process of developing new tools, solutions, and performance measures aimed at improving the processes used to transition patients from one health care setting to another. Studies show that this is where errors, omissions, or misunderstandings often lead to adverse outcomes or readmissions, so improvements have the potential to boost outcomes and reduce costs and inefficiencies.

• While the initiative will impact all of TJC's accredited programs, experts say transitions between hospitals and other health care settings are the most problematic.

• Developers intend to produce best practices, educational offerings, targeted solutions tools, and other products designed to help accredited organizations improve their transition processes.

• Also, TJC hopes to have new standards and performance measures related to care transitions in place by mid 2014. All such changes will undergo field testing before they are implemented.

With health reforms clearly moving toward a system that links reimbursements to patient outcomes, care transitions — or what happens when patients transfer from one care setting to another — are under increasing scrutiny. Why? Because this is where communication breakdowns can lead patients or their caregivers to misunderstand instructions, and where the ball is most often dropped with respect to follow-up care or referrals.

Recognizing the need for improvements in this area, TJC is in the midst of a three-year initiative aimed at defining methods for making care transitions more effective while also developing new standards and performance measures so that surveyors for TJC's accreditation programs can hold hospitals and other care settings accountable for the way they manage this important aspect of patient care.

The initiative involves all three components of the accrediting agency, including TJC, Joint Commission Resources, and the Center for Transforming Healthcare, and administrators say that the resources and interventions developed as a result of this work will apply to all accredited organizations, ranging from hospitals and long-term care facilities to ambulatory care settings and behavioral health care organizations.

While ineffective transitions can occur between any of these health care settings, experts note that the most problematic transitions typically occur when patients are leaving the hospital to go home or to receive care in another setting. In these cases, errors, oversights, or miscommunications can lead to readmissions and adverse events.

Timing is right

"We are all very well aware that this is not a new issue in health care; this has been around for decades," stresses **Sophie Duco**, RN, an associate project director specialist in the Department of Standards and

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Executive Editor James J. Augustine discloses that he is a stockholder of EMP Holdings and speaker for Masimo Corporation. Managing Editor Leslie Hamlin, Author Dorothy Brooks, Nurse Planner Diana S. Contino, and Executive Editor Shelly Morrow Mark report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

Survey Methods at TJC. However, she explains that with new health reform provisions unfolding, TJC leaders felt the timing was right to assist the organization's accredited organizations in making improvements to ensure safe patient care transition practices.

The multidisciplinary project is focused squarely on the movement of patients from one care setting to another rather than transitions that take place within an organization, say from one unit to another within a hospital setting, explains Duco. There are, in fact, already many standards covering internal patient transitions.

"The leadership here at TJC realized that although we have quite a few standards that address discharge planning, education for patients, and those types of things, what we had in place was very siloed within each of the programs," observes **Kathy Clark**, RN, who is also an associate project director specialist with the Department of Standards and Survey Methods at TJC. "The leaders felt we needed to look at that space in between, or that gap in between one provider and another or one health care organization and another, to see what we could do to provide for better safety for our patients."

New standards and survey processes are not the only goals of the initiative. The enterprise-wide effort also aims to develop best practices, educational offerings, targeted solutions tools, and other products designed to help accredited organizations improve their processes with respect to transitioning and transferring patients to the next care setting, whether that is home or another health care organization, explains Duco.

The project will impact every program that we have, stresses Clark. "It isn't just going to be hospital-based, it is going to affect all of our accreditation programs that are in different health care settings," she says.

Engage patients, families

While the project is still in its early stages, the research phase has already been completed, so project developers have some key insights on problems and processes that need work. "What was interesting is that the broad issues [impacting transitions] remain the same across all health care settings," explains Duco.

For example, problems often crop up during the medication reconciliation process, observes Duco. An effective medication reconciliation process should go well beyond establishing what medicines a patient has been taking, she says. Health care organizations also need to determine whether or not patients have the financial resources to obtain their medicines, and this ties into completing a comprehensive psycho-social transitional planning process. "It's about educating the family and providing support for the patient," adds Duco.

Another issue that surfaces across all health care settings is the need for leadership support when it comes to developing more robust transitional planning processes, says Duco. This pertains to both the allocation of needed resources as well as holding people accountable for their roles in the transitional planning process, she says.

In some cases, Duco notes that improvements may require members of the health care team to assume new roles or to apply their skills in a different way. Additionally, she says that leaders may need to re-prioritize responsibilities. "In a multidisciplinary approach, everyone needs to be involved, including the patient and their support person," she says.

Further, patient and family engagement needs to begin much earlier on in the care process, stresses Clark. "Make sure that they are part of the process, not just on the day of discharge, but all the way along in whatever setting they are in, and wherever it is they are going," she says. Health care providers should not just assume that patients have the support they need to manage once they return home, adds Clark.

Collaborate with community resources

Accountability can be a tricky issue in the ED because EDs are typically part of a larger organization, but ED personnel often feel separated from the hospital setting — perhaps because they don't necessarily receive resources or collaboration from the inpatient setting, explains Duco. She also stresses that collaboration with community resources is critical to successful transition processes.

While there is no one-size-fits-all model for transitional planning, Duco recalls visiting one large, urban center where all the physicians in the ED did their own discharge planning. "They knew who their community support contacts were, what primary care organizations they could work with in the area, and they had contacts they could utilize any time of the day or night to arrange follow-up appointments for ED patients," she explains.

In another community, a large physician group clinic in the area worked closely with the main hospital in town, several skilled nursing facilities, their home health agency, and all the community organizations to which a patient might transition as part of their care to develop better transitional processes, explains Clark.

It took several years to hone these processes, but one of the tweaks that has worked particularly well for the ED is what developers refer to as the one-call

admissions process. The way it works is if a physician in the clinic needs to admit a patient, he or she can directly call a hospitalist or an admissions nurse to explain why they are sending the patient over, explains Clark. The process enables patients to bypass the ED, thereby freeing up resources for urgent and emergent cases. "By doing this direct admit process, they are cutting down on the time and the costs, and they are facilitating a better transition to the hospital for the patient," observes Clark.

Another tweak worked out in the same type of collaborative process enables many patients to receive quick follow-up care rather than face admission to the hospital. "In the beginning, the process was just for deep-vein-thrombosis (DVT) patients," explains Clark. Whenever an ED physician diagnosed a patient with DVT, he would call the patient's primary care physician (PCP) and explain that the patient could either be admitted or sent to the DVT clinic, which was within the physician group, as long as the patient was seen in the next two days, she says.

"By doing this, the providers were able to cut down on their admissions for DVT patients, but the approach was so successful that they have instituted a similar process for other types of patients that end up coming into the ED," says Clark. "If a physician can see the patient the same day or the next day, or if the patient can follow up with a referral to home care or whatever type of care the patient needs, then admissions can be avoided in some cases."

New standards, measures coming

People are coming up with these types of fixes in different settings and regions, but it is clear that such solutions come with a fair amount of complexity. "There isn't going to be one fix for everybody because there is too much involved," explains Clark. "If it was that easy, this would have been fixed a long time ago."

The next step for TJC is to develop new products and tools that can help accredited organizations devise transition solutions that work in their communities. At the same time, planners are beginning to think about standards and performance measures that can capture the transitions aspect of care and drive improvement.

"The goal is to have requirements that would go into effect in July of 2014, but that is not a firm date," explains Clark. "Everything we do with standards and requirements is always first vetted internally and externally through field reviews that would go to different health care providers and customers to get their input and feedback."

With the Centers for Medicare and Medicaid Services clamping down on readmissions, there is already heightened awareness of problematic transitions of care. This is prompting health care organizations to take a look at how they can make transitions safer for patients, stresses Duco.

"There are no quick fixes or easy solutions to this decades-old issue, so our work will continue," she says. "But we want to be very thoughtful, considerate, and deliberate in our approach so that whatever solutions we put out are the best we can offer." ■

Editor's note: See tools, articles, guides, and other information developed by TJC on its Transitions of Care Portal at http://www.jointcommission.org/toc.aspx.

SOURCES

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• **Sophie Duco**, RN, Associate Project Director Specialist, Department of Standards and Survey Methods, The Joint Commission, Oakbrook Terrace, IL. Phone: 630-792-5000.

The Joint Commission: Hospitals struggle to comply with these five standards

A number of familiar standards proved most challenging for hospitals in the first half of 2012, according to reports from The Joint Commission (TJC). At the top of the list, the accrediting agency notes that surveyors found a 61% non-compliance rate with RC.01.01.01, the standard that calls on hospitals to maintain complete and accurate medical records for each individual patient.

Maintaining accurate medical records can be particularly problematic when patients are boarded in the ED, but there can be other issues involved as well, specifically with respect to documentation. "If a patient comes to the ED from a nursing home, and he has an existing pressure sore, but the nurse is so busy that she neglects to document that pressure sore, then when the patient is ultimately admitted, the hospital will be financially responsible for the pressure sore," explains **Jeannie Kelly**, RN, BA, MHA, LHRM, an expert on

risk management and quality assurance at Soyring Consulting in St. Petersburg, FL.

Confusion can also arise if a provider's orders for a patient are not clearly spelled out. "If the doctor writes 'admit,' but he is not more specific about the timing, ED staff may keep the patient in observation for another 24-48 hours when what the physician really wanted was for that individual to be an inpatient," explains Kelly. This type of incident, where the care delivered doesn't match the physician's orders, can leave you vulnerable to an audit by the Centers for Medicare and Medicaid Services (CMS), she adds.

To make improvements in this area, everyone in the ED needs to take responsibility, and leaders need to be vigilant about making accurate record-keeping a priority, says Kelly. She also advises EDs to conduct chart reviews on a routine basis so that any problems can be identified and addressed.

Keep hallways clear

Another standard that hospitals regularly struggle with is LS.02.01.20, the requirement that hospitals maintain the integrity of the means of egress. In the first half of 2012, TJC surveyors found a 52% non-compliance rate with this standard. Kelly explains that in a setting as busy as an ED, providers and staff are often in a hurry and under stress, so keeping the hallways clear may not be uppermost on their minds, but it is important to regulators.

"If gurneys, wheelchairs, linen carts, or computers-on-wheels are blocking access, then that is going to be an issue," she says. "If surveyors come in and see a gurney in the hallway for more than a half hour, then they are going to cite you."

Further, if patients are in the ED hallway, the hospital may also be cited for lack of patient privacy as well as patient safety because the patients don't have access to a call light, adds Kelly. This is another area where the entire ED staff need to be made aware of the standard and held accountable for keeping the hallways clear, she says.

Hospitals often fall short with respect to certain fire and safety requirements. In particular, TJC notes that there was a 47% non-compliance rate with respect to LS.02.01.10, a requirement that building and fire protection features be designed and maintained to minimize the effects of fire, smoke, and heat. Typically, ED staff run afoul of this provision when they prop open doors so that they can travel from place to place more quickly without impediments, explains Kelly. Fixing the problem requires staff awareness and continual reminders, she says.

This year, hospitals also had trouble complying with EC.02.03.05, a provision that requires hospitals to maintain fire safety equipment and fire safety building features. The accrediting agency reports there was a 40% non-compliance rate with this provision in the first half of 2012.

Emphasize personal responsibility

The fifth most commonly cited hospital provision by TJC surveyors this year was IC.02.02.01, a requirement that hospitals reduce the risk of infections associated with medical equipment, devices, and supplies. There was a 39% non-compliance rate associated with this provision, according to TJC.

Typically, problems with this provision relate to stethoscopes, glucometers, and other mobile devices that are used routinely in the ED, observes Kelly. Providers and staff need to remember to cleanse these devices after each and every use, she says. "It's everybody's responsibility to take care of this," adds Kelly. ■

SOURCES

• **Jeannie Kelly**, RN, MHA, LHRM, Health Care Consultant, Soyring Consulting, St. Petersburg, FL. Phone: 866-345-3887.

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When looking for information on a specific topic, back issues of *ED Management* may be useful. If you haven't activated your online subscription yet so that you can view back issues, go to www.ahcmedia.com. On the left side of the page, click on "activate your subscription." You will need your subscriber number from your mailing label. Or contact our customer service department at P.O. Box 740060, Atlanta, GA 30348. Telephone: (800) 688-2421 or (404) 262-5476. Fax: (800) 284-3291 or (404) 262-5560. E-mail: customerservice@ahcmedia.com.