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Latest ACEP national, state-level report cards cite ample room for improvement

ACEP leaders urge emergency providers to use findings to advocate for positive change

The American College of Emergency Physicians (ACEP) has issued what the group is terming a call to action to state and national policy makers on emergency care. In its latest report card on the emergency care environment, ACEP finds that conditions have declined since the last report in 2009. Today, while some individual states have made progress in certain areas, ACEP says overall conditions and policies under which emergency care is delivered in this country get a grade of D+ — down slightly from the grade of C- ACEP issued on its national report card in 2009.

EXECUTIVE SUMMARY

In its latest round of report cards on the emergency care environment, the American College of Emergency Physicians (ACEP) gave the nation an overall ranking of D+, a slight decline from the rankings unveiled in 2009. Overall state-level rankings were also unveiled, as well as individual rankings for access, quality and safety, medical liability environment, public health and injury prevention, and disaster preparedness. Leaders at ACEP urge providers to use the rankings to advocate for change in their states; however, there is concern that the report cards are already being misinterpreted as being a reflection of care quality rather than the emergency care environment.

- Notably, on the national report card, access to emergency care received an overall grade of D-, and it accounted for 30% of the overall grade.
- Among the state-level rankings, Washington, DC, Massachusetts, Maine, and Nebraska were the top performers, earning an overall grade of B-.
- At the other end of the spectrum, Wyoming received an overall grade of F, Arizona received a D-, and Montana, New Mexico, and Kentucky each received a grade of D.

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The lower grade reflects what ACEP President **Alex Rosenau**, DO, FACEP, calls a "misguided focus" on slashing resources for emergency care because of the widely held view that emergency care is expensive. In reality, Rosenau points out that emergency care is a very cost-effective element American health care, and makes up less than 5% of health care costs.

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Further, with demand for emergency services expected to increase as more Americans gain coverage under full implementation of the Affordable Care Act (ACA), ACEP is urging policymakers to prioritize the strengthening of America's emergency care system.

"The ACEP report card is very important to the American community, whose members rely on the emergency care system for all forms of care, and as a safety net. This comes from the success of the prevention and public health components of the emergency system in preventing premature death," explains **James Augustine**, MD, FACEP, executive editor of *ED Management*, a member of the board of directors of ACEP, and director of clinical operations for Emergency Medicine Physicians in Canton, OH. "Both primary care and specialty physicians rely on the ED to provide complex diagnostic workups, to initiate care, and to facilitate the admission of about 68% of inpatients."

Augustine adds that the report highlights the difficulties that both federal and state leaders have in allocating resources for emergency services and in addressing quality and patient safety, the burden of medical liability, and preparedness for disasters and other major incidents. "We look to discussions around the report card for assistance to the emergency system. The providers are dealing with patient boarding, the burden of mental health and chemical dependence patients in the ED, workforce stress, and the implementation of unfriendly information technology programs, as well as the many difficult financial issues," he adds.

Get the correct message out

To arrive at its conclusions, ACEP considered 136 different measures, and it broke its findings down into five different categories, each of which received an individual grade.

- Access to emergency care received a D- and accounted for 30% of the overall grade;
- Quality and patient safety received a grade of C and accounted for 20% of the overall grade;
- Medical liability environment received a grade of C- and accounted for 20% of the overall grade;
- Public health and injury prevention received a grade of C and accounted for 15% of the overall grade;
- Disaster preparedness received a grade of C- and accounted for 15% of the overall grade.

Further, each state received its own report card rankings. For example, the top performing states included Washington, DC, Massachusetts, Maine,

and Nebraska, all of which received an overall grade of B-. At the other end of the spectrum, Wyoming received an overall grade of F, Arizona received a D-, and Montana, New Mexico, and Kentucky each received a grade of D.

State-level ACEP leaders are hoping to use the report card findings to spur policymakers toward providing more support for emergency care. However, a big concern is that rather than viewing the rankings as a reflection on the emergency care environment, various media are instead linking the grades with emergency providers.

"I have already seen this misinterpreted [to mean that] the ACEP was commenting on the quality of the clinical care that was delivered [in the ED], and that was really not our intent. What we really need to message out is that we are commenting on the health care environment that we are practicing in as physicians," stresses **Michael Lozano**, MD, FACEP, president of the Florida chapter of ACEP.

Florida received an overall grade of C- on the report card, but on access to emergency care specifically, the state received a grade of F, making it 49th in the nation on this metric. Lozano is hoping to use the ACEP findings to advocate for change. "We don't want legislators to fall into the trap of thinking that having an insurance card is the same thing as access," he says. "Our focus is really on educating them that Florida needs to become more of a destination state. We need to become more physician-friendly."

Advocate for change

The latest round of ACEP report cards is, in fact, intended to influence the ongoing policy debate over emergency care while also focusing attention on the feedback loop that EDs have become for social policy, observes **Nicholas Vasquez**, MD, FACEP, a councillor and past president of the Arizona chapter of ACEP in Phoenix, AZ. "Each ED doc who uses the results of the report card should be focusing their advocacy on the specific policy packages that will improve care in their state," he says.

For instance, while Arizona received a B+ on patient safety and quality of care, which is an improvement over the last round of report cards, its overall ranking of D- is near the bottom. Of particular concern to Vasquez is the lack of providers. There aren't enough providers to meet the current demand, let alone the increased demand from an aging population, he says.

"One clear way to improve the number of providers is to increase the number of residency slots here in Arizona. Studies show many doctors stay in the same state where they trained, so while we are increasing the number of medical students passing through Arizona, we're missing the opportunity to keep them in state by making them go out of state for residency," says Vasquez.

Consequently, Vasquez intends to use the report card findings to push for an increase in state funding to open up more of these slots. "We anticipate that EDs will be busier after [full implementation] of the ACA. We think that GME [graduate medical education] funding is the best way to help find [providers] for people to go to," he says. "What we're asking for is a public investment in the health and welfare of the citizens of Arizona by increasing the number of training slots for doctors." ■

Editor's note: For more on the ACEP's report card rankings, visit www.emreportcard.org.

SOURCES

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New findings underscore value of palliative care consultations

Experts: Earlier goals-of-care discussions better align patient needs with treatment decisions

There is new evidence that initiating palliative care consults in the ED results in shorter hospital length-of-stay (LOS) than when palliative care consults are not provided until after admission. Researchers looking specifically at the impact of earlier palliative care consults report that in an analysis of 1,435 palliative care consults, 50 of which took place in the ED over a

four-year period, consultation in the ED was associated with hospital stays that were 3.6 days shorter, on average, than the hospital stays of patients who received palliative care consults following admission.[1]

While the study is small, it reinforces the observation that the longer palliative care consultation is delayed the less impact it has, explains **Abraham Brady**, RN, PhD, GNP-BC, an assistant professor at New York University College of Nursing in New York, NY, and a co-author of the study. "There are certain patients who come into the ED who really should have been seen by palliative care [clinicians] sooner," he explains. "If we start their [palliative care consult] in the ED rather than waiting until they are up on the floor or in the ICU [intensive care unit], we might be able to improve their quality of life or quality of care within the hospital and meet their needs and goals better."

What should trigger a palliative care consult in the ED? In the study, the mechanism was fairly straightforward, explains Brady. "We gave every provider within the ED, both physicians and RNs, a set of guidelines for patients who would be appropriate [for a palliative care referral]," he says. "Providers could refer patients outside of that set of guidelines, but the guidelines focused on the groups of patients we believe are seen most heavily in the ED."

For instance, patients with metastatic cancer, advanced congestive heart failure, advanced chronic obstructive pulmonary disease, or advanced dementia were candidates for palliative care consultation, notes Brady. "These are probably the four top groups of patients who can best use goals-of-care discussions, quality-of-care discussions, and other quality-of-life services offered by palliative care teams," he says.

Focus on goals of care, patient needs

The aim of palliative care is to be holistic, to improve the quality of life of patients, and to meet the needs of patients and their families; consequently, a palliative care consult needs to include several components, explains Brady. "The palliative care provider will have an extensive goals-of-care discussion with the patient or a family member to try to ascertain what the needs of the patient are," he says. "The provider will also make sure that the patient's symptoms are managed appropriately, and then they will bring in other areas of care."

For instance, many palliative care teams have chaplains or other spiritual advisors, and some have social workers or psychologists involved as well. Also, many palliative care teams are led by nurses or nurse practitioners rather than physicians. "The overall goal of this comprehensive team is to help make sure that the patient's needs are met so it is all about patient-centered care, and making sure that the patient has their needs met rather than the health system having its needs met," observes Brady.

When patients present to the ED, for example, one goal of the ED clinicians is to get the patients out one way or another to make way for incoming patients, explains Brady. "Whether a patient is discharged or sent up to the ICU or one of the other medical units of the hospital, that is the traditional pathway," he says.

However, the traditional pathway is not always the best or the preferred approach for some patients, suggests Brady. For instance, he recalls the case of a patient with advanced dementia who could have been admitted to the hospital. "That would have been the easy way to go," he says. "But the palliative care team involved was able to arrange for the patient to go directly back home with home hospice services to prevent an admis-

EXECUTIVE SUMMARY

A new study suggests that introducing palliative care consultations while patients are still in the ED, rather than waiting until after patients have been admitted, can significantly reduce inpatient length of stay. Experts say the approach may also improve quality of care while patients are in the hospital, and do a better job of meeting patient goals.

- Researchers analyzed 1,435 palliative care consults, including 50 that took place in the ED over a four-year period. They found that consultation in the ED was associated with hospital stays that were 3.6 days shorter, on average, than the hospital stays of patients who received palliative care consults following admission to the hospital.
- Palliative care typically includes an extensive goals-of-care discussion with patients and families, symptom management, and other services focused on meeting patient needs and improving quality of life.
- Experts say the top four groups of patients who can benefit from goals-of-care discussions are patients with metastatic cancer, advanced congestive heart failure, advanced chronic obstructive pulmonary disease, and advanced dementia.
- ED administrators interested in making improvements in their approach to palliative care should perform a needs assessment, forge partnerships with community resources, and identify a champion, according to palliative care experts.

sion to the hospital and insure that the patient was cared for in the setting he wanted," he says.

Address barriers

Integrating palliative care into the emergency setting isn't always an easy fit, acknowledges Brady. "The way the business model is set up within an ED is that you have to get the patients out the door into a more appropriate environment, whether that is the home environment or the hospital," he says. "At the same time, however, ED physicians and nurses get very frustrated when they see the same patients returning again and again."

Consequently, while there can be some resistance to palliative care in the emergency setting, Brady observes that emergency clinicians may also see palliative care services as being a solution for some of the patients who frequent the ED, but do not necessarily require emergency care. "Emergency clinicians don't want to see patients coming back again and again for a heart failure exacerbation — something that should be managed in an outpatient setting, so there is some buy-in [for palliative care consults in the ED]," adds Brady.

However, even when there is ample buy-in, the availability of on-site palliative care clinicians is less than optimal. In the study, there were many patients who met the criteria for palliative care consults, but they were not referred, explains Brady. "A lot of these cases were on nights and weekends when there was no palliative care coverage … so one of the biggest barriers was that there wasn't 24/7 on-site availability of palliative care team members in the hospital," he says. "Most palliative care teams have 24/7 coverage in that someone is available by phone, but most do not have a 24/7 presence in the hospital."

Given the significantly reduced LOS of patients who received palliative care consults, it is possible that it would be cost-effective to provide 24/7 on-site palliative care coverage in the ED, acknowledges Brady, but he notes that studies need to be done that show this is the case.

Another barrier is the dearth of clinicians equipped with palliative care training. "We can just about meet the needs in the inpatient setting, but as we move into having more and more palliative care clinicians in the outpatient setting, that is something where we don't have enough training slots to meet those needs," explains Brady.

Identify palliative care resources

The American College of Emergency Physicians (ACEP) is fully on board with efforts to integrate palliative care treatment options into the treatment of appropriate patients who present to the ED with chronic or terminal diseases. In October, ACEP cited the early introduction of palliative and hospice care services as one of the organization's five top recommendations as a co-sponsor of the "Choosing Wisely" campaign, a multi-year effort of the American Board of Internal Medicine (ABIM) Foundation aimed at promoting conversations among physicians and patients about the appropriate use of tests and procedures, and avoiding care when harm may outweigh the benefits.

"Palliative care has risen to the top of the radar screen for emergency medicine," notes **Tammie Quest**, MD, an emergency medicine physician and director of the Emory Palliative Care Center for Emory University's Woodruff Health Sciences Center in Atlanta, Georgia. "What has happened is a growing awareness of the role of palliative care and end-of-life support services."

While it is not clear how many EDs thus far have integrated palliative care into their service options, Quest stresses that when emergency clinicians have resources such as palliative care units, consultants, or hospice services available to them, they will use them. "Culturally, the field is very open to change. Emergency medicine is one of the most flexible and adaptable specialties," she says. "My own experience is that when you teach emergency providers what the resources of palliative care are, either by them learning additional skills themselves or by utilizing skills that may be in a system, there is very good uptake of these skills and/or resources."

Find a champion

At Emory, there is no formal list of triggers to prompt an emergency provider to call for a palliative care consult. "After more than a decade of education between our residents and faculty, we have very good emergency clinicians who can recognize the need for palliative care in seriously ill patients," notes Quest. "More than 10% of admissions to our hospice unit are sent directly from the ED, so our emergency providers here are very good at goals-of-care conversations and assessment of patient and family needs, so they will often call with people who they feel are appropriate."

However, in systems where primary palliative care may not be as rich, it can be helpful to have a palliative care specialist available to emergency clinicians when they have a patient who could benefit from palliative care services. In fact, Quest is director of Improving Palliative Care in Emergency Medicine (IPAL-EM), an effort to equip EDs with the tools and knowledge required to improve palliative care in emergency settings. She advises administrators to begin the process with a needs assessment.

"Sit down with a group of people who are in the ED, figure out where the greatest need is, and find an ED champion," says Quest, noting that the needs assessment form is just one of a number of tools that are available free of charge through the IPAL-EM website, which is operated by the Center to Advance Palliative Care (www.CAPC.org), headquartered at the Icahn School of Medicine at Mount Sinai in New York, NY. "You need an ED champion who will peel the onion back layer by layer, and just take a deeper look to determine, of all the things that need to be done, what really needs to be prioritized."

Once palliative care priorities are established, you can create an action plan for how to achieve them, says Quest. "I would suggest that emergency clinicians reach out to their hospital-based palliative care services or their community hospice providers to see what partnerships can be forged to get their needs met."

Consider new payment models

Accountable care organizations (ACO) and other new payment models that reward quality and efficiency are likely to focus more attention on the benefits of palliative care. In the case of ACOs, for example, providers who are successful at keeping patients out of the hospital and the ED are able to share in the savings that result from the avoidance of unnecessary, expensive care. "Similarly, if patients go on hospice earlier, that saves money because in order to get the full benefit of hospice you need [patients in the program for] 50 to 100 days at least. And right now, patients are in hospice for about seven days, on average," says Brady.

Another positive financial impact comes from the avoidance of the penalty Medicare imposes on hospitals that have elevated readmission rates. "Palliative care teams have been shown to reduce readmission rates," adds Brady.

While financial considerations are not what drive decision making in palliative care, the model is aligned with an ACO's emphasis on better resource utilization and better outcomes, notes Quest. The decreased costs and more effective use of resources do not come from withholding care, but rather by aligning patient-centered goals around whatever the care and treatment options are, she says. "I think that the way palliative care stands to benefit emergency care providers, patients, and ACOs is really by consistently using patient-centered models of assessing what patient goals of care are, what the outcomes and perceived expectations are from the patient and family, and what we are clinically able to deliver." ■

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Community paramedics fill gaps, take load off EDs

With demand for emergency care straining hospital resources, some health care systems are exploring new ways to leverage paramedics to better meet the needs of patients who don't necessarily require emergency care. For instance, Wake County Emergency Medical Services (EMS) in Raleigh, NC, is testing a pilot program that enables specially trained paramedics to assess patients with mental health care or addiction problems, and to transport these patients to alternative facilities, when appropriate.

The program, which is now in its third year of operation, was first initiated by **Brent Myers**, MD, MPH, FACEP, an emergency physician who is well acquainted with the flood of mental health patients that routinely present to the ED for care. However, given that Myers is also the medical director of

Wake County Emergency Medical Services, he also sees an opportunity to address the problem with what he views as an under-utilized resource: paramedics. "We have an infrastructure to respond to emergencies that is very robust," explains Myers. "We have just been in a silo for the past 20 or 30 years."

Enlist experienced paramedics

At the federal level, EMS resides in the Department of Transportation, not the Department of Health and Human Services, observes Myers. "We were created to respond to traffic accidents," he says. "Every year, 8% of the population calls EMS for medical assistance, but our payment structure treats every one of those people as if they had a car accident on the interstate highway."

Under the terms of the pilot program, Wake County is enabling a group of paramedics who have received additional training to transport patients to alternative facilities when the ED is not the most appropriate setting for their needs. Currently, the facilities participating in the program include a crisis and assessment intake center, two faith-based detoxification centers, and a private psychiatric hospital, explains Myers. "We know that in the first two years of the pilot program, we had about 200 patients per year who were diverted [to these alternative facilities]," he says.

At press time, the data for 2013, the third year of the pilot, were still being compiled, but Myers notes that more than 300 patients were diverted. "We know there were no bad outcomes for those patients, but it looks like 20% to 25% of these patients ended up going to the hospital [after being diverted to an alternative facility], although in some cases, this was 48 hours later," he says. "The patients have all been safe and fine, but we are still looking at the process, and why those patients required a hospital visit."

The paramedics participating in the program are a select group of medics who have each seen at least 750 patients in the system before becoming eligible to participate in a special academy consisting of 240 hours of additional education. "The first 40 hours of the curriculum come from a law enforcement/critical incident course," explains Myers. "We modified some of the law enforcement [content] to make sense on the medical side, and then we used faculty from the state poison center to come talk about substance abuse, toxicology, and those types of concerns."

Myers estimates that the paramedics spend about 60 hours focused on toxicology, substance abuse, and dealing with an acute mental health crisis. "The medics then also rotate through each of the [alternative] facilities that are participating in the program," he says.

In a system that is designed to serve about one million people, only 16 paramedics out of a total of 300 are currently trained and authorized to do this work, notes Myers. Consequently, while the impact is relatively small, there is at least one way to calculate the value. "We know that these [mental health] patients spend, on average, 14 hours in an ED bed … so every time we successfully divert a patient [away from the ED toward one of the participating facilities], we return 14 bed-hours to the ED," he explains. "When we take that average, we can calculate that we return at least 2,500 bed hours to the ED each year."

Collaborate on protocols

There is a real potential to make even more impact, notes Myers. Currently, the participating facilities in the program want EMS to expand the pilot's protocol so that the paramedics can actually come to the participating facilities and screen

EXECUTIVE SUMMARY

In a continuing effort to ease demand on busy EDs, some communities are coming up with new ways to leverage paramedics. Under a three-year pilot program in Raleigh, NC, a select group of paramedics with added training are being used to assess patients with mental health or addiction problems and transfer them to alternative facilities when appropriate. In Robbinsdale, MN, a community paramedicine program is filling in care gaps for patients with chronic diseases and other complaints who are at risk for repeat ED visits or inpatient hospitalizations.

- Administrators of the Raleigh, NC, program say that in 2013, paramedics diverted more than 300 patients to alternative facilities. Of these, only 20% to 25% need further transport to the hospital.
- Every time the NC paramedics divert a patient from the ED to an alternative facility, they return an estimated 14 bed-hours back to the ED.
- In addition to responding to patients with non-urgent needs, the Robbinsdale, MN, community paramedicine program is a referral source for ED physicians who are concerned about follow-up care for patients who have presented to the ED with medical problems that require ongoing attention.

certain patients who are asymptomatic following a reported overdose to determine whether they require transfer to the hospital. This routinely involves a large group of patients, says Myers. "We have worked with our psychiatry group and our emergency medicine group to develop a protocol that will actually allow these paramedics to go into a facility, do a blood draw, do an assessment, document all of that, and leave patients safely behind once we have screened them to be safe," he says. "This is the next step to help to further decrease the burden on the ED while still doing the right thing for the patient."

While patients with mental health and addiction issues are the focus of this pilot program, Wake County EMS is also operating a second pilot that focuses on patients who experience falls in an assisted-living facility but have no obvious injuries. The program is being coordinated with the facility's primary care physician (PCP) group. "We will evaluate these patients in their assisted-living facility, call the PCP on the phone and discuss our findings, and then ask them whether the patients need to go to the ED or if they can be seen by the PCP," says Myers. "The promise we have with that group is that they will see these patients within 18 hours in their homes."

Thus far, paramedics have evaluated about 150 patients who have suffered falls in the assisted-living facility, and of this group, about half have been safely left behind to be seen by their PCP with no bad outcomes, explains Myers. "Our next step is to branch this out to patients in hospice care, and then our next step after that will be to [expand it to include] falls that occur in private homes," he says. "Right now, we are just doing this in the assisted-living facility as a pilot because it is an easy population to monitor, but once we are satisfied that it is a safe protocol, then we will expand it to other areas as well."

One not so insignificant stumbling block to the continued use of this approach is funding. "The EMS visits are currently not paid for in any way, and that is the push we are making now," offers Myers. "The state Medicaid program has bought in, and is looking at being able to pay us; we have had good conversations with private payers … and we are getting ready to sit down with accountable care organizations. I think this is a short-term problem."

Target gaps in care

North Memorial Medical Center in Robbinsdale, MN, has also started a community paramedicine program aimed at reaching patients who might otherwise present to the ED for care for non-urgent concerns, and to address medical issues before they escalate to the point at which an ED visit or hospitalization is necessary.

Barb Andrews, NREMT-P, CP, RN, has been managing the program since it was first rolled out in October of 2012. "We have a lot of complicated patients who are not entirely successful at following through with their care plans," she explains. "These people kind of fall through the cracks in that they are not eligible for home health care, but they need additional resources that our previous system did not have a way to address."

For instance, if a patient is seen in the ED, and the physician is concerned that the individual is at risk for a return visit to the ED or an inpatient hospitalization, the physician can put in a referral for a community paramedicine home visit, explains Andrews. "Also, any one of our PCPs can refer one of their patients to the program," she says. The paramedic visits are often triggered when a patient's eligibility for home health care has expired, but he or she still needs to be followed, or the home health care nurse is concerned the patient will relapse and end up back in the hospital.

While the paramedic home visits are usually scheduled, there are occasions when they occur on the fly. Andrews recalls one recent case in which a PCP received a call from a patient who was feeling despondent and potentially suicidal. "The PCP tried to talk the patient into coming into the clinic, but the patient refused, so the physician called the community paramedic," she explains. "The paramedic went to patient's house, did some intervention, arranged for a hold to be placed, and had the patient transported."

Previously, the only option available to the physician would have been to call the police, who would have then sent squad cars over to the house. "That is not the most patient-friendly way to deal with a psychological emergency," notes Andrews.

Get state backing

In Minnesota, the training and credentialing of community paramedics has been formalized by the state legislature. "All of our community paramedics are certified community paramedics, which is regulated by the Minnesota Emergency Medical Services regulatory board," says

Andrews, who has gone through the process herself. "The program includes more than 300 hours of additional training that focuses on community needs, community resources, social intervention, psychological intervention, and chronic disease management."

Paramedics spend most of this training in the clinical environment, performing wound care, spending time in primary care clinics, and gaining an understanding of chronic disease management, observes Andrews. "[Paramedics] are really good at dealing with an emergent need, but we don't know as much about how to manage patients longer term … so the training really expands upon our existing knowledge," she says.

For instance, Andrews notes that the paramedics learn how blood pressure medications interact with other medicines, how much weight is too much to gain in a 24-hour period for a patient with congestive heart failure, and other critical issues that come up with respect to the management of chronic conditions. Further, once the paramedics are certified as community paramedics, there are continuing education requirements to maintain the certification.

The state legislation that governs the training and credentialing of community paramedics also stipulates that visits performed by community paramedics are paid for by the state's Medicaid program, but Andrews notes that many commercial insurers are either paying for the visits or are in the process of negotiating reimbursement for such services. "It is much less expensive to send a community paramedic out to someone's home than to pay for an ED visit," says Andrews.

However, there have been times when the community paramedic has determined that the patient really needs to go the ED. In those instances, the paramedic will either coordinate through the system's ambulance service or through 911 if the location is not in the health system's service area, explains Andrews. However, the more common scenario is that a trip to the ED or an inpatient hospitalization is prevented.

For instance, Andrews recalls the case of a diabetic patient who had been dealing with open wounds for the past eight years. "Besides home health care, the patient had spent time in the hospital and in transitional care units, and all of these failed [to improve his condition], so [the patient's providers] were ready to move forward with amputation," says Andrews. "In a last-ditch effort, a podiatrist who had used us before successfully referred him to the community paramedicine program."

The patient's wound is now healed and he is currently volunteering at one of the transitional care units where he spent time as a patient, says Andrews. "There is obviously an impact on life that is hard to measure," she says, "but we figured out that it would have taken 10 years of three-times-a-week paramedic visits to cost what a couple of toe amputations would have cost the system."

Explore paramedics as a resource

While community paramedics can help to relieve the ED of some frequent utilizers, the program is also a referral source for ED physicians who have concerns about the ongoing care of patients. "We might refer patients who need frequent wound checks who have a hard time getting to their PCP office, or [patients] who need help managing a chronic disease like diabetes or COPD [chronic obstructive pulmonary disease] so we can stay on top of their disease before it gets so bad that they end up back in the ED or worse, admitted to the hospital," explains **Joey Duren**, MD, an emergency physician and director of Urgency Centers and Affiliated Facilities at North Memorial Medical Center.

It will take time to gauge the larger impact of the program on ED utilization and overall costs. There are currently only eight certified community paramedics who still spend most of their time serving as traditional paramedics. "They work one day per week as a community paramedic. It involves a different uniform and different equipment, and they drive their own personal vehicles when they make visits," explains Andrews. "Some people don't want the neighbors knowing that [medical personnel] are coming by, so they prefer not having an ambulance pull up in front of their home."

The community paramedicine program is still in its infancy at North Memorial, but Andrews believes that other health systems should consider going down a similar road. "It is absolutely worth exploring because our current system is broken, and there are a lot of patients who fall through the cracks of the structure we already have," she says. "Tapping into paramedics and expanding their training as community paramedics is a resource that has great potential." ■

SOURCES

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ED Coding Update

Getting the ED Ready for ICD-10

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

The official countdown for ICD-10 implementation is well underway. However, as many hospitals are managing so many different issues, including EMR implementation, two-midnight rules, and revisions to observation documentation and billing, ICD-10 implementation and documentation improvement have yet to begin. Emergency medicine dodged the outpatient prospective payment system (OPPS) bullet that proposed to collapse the emergency medicine facility levels from five to one. Unfortunately, our friends in the clinics and outpatient areas weren't as lucky, and saw 10 levels (new and established) collapsed. Prioritizing issues for 2014 will be a daunting task with ICD-10 scheduled for implementation in October.

Coding professionals seem to have embraced this dramatic conversion well. As future coding certifications will depend on expertise in ICD-10, coders started with early learning on how to train for and implement this new system. Physicians, however, are still dependent on feedback to ramp up to this new coding system, and few health information management (HIM) departments are staffed appropriately to educate physicians *and* coding staff simultaneously, which guarantees a rocky implementation for this conversion.

There is, however, a quick fix that will address many of the ED diagnosis statements that will be used to determine the ICD-10 codes after October. As the ED manages many acute and chronic conditions with underlying problems, physicians may want to consider the following when developing the diagnosis statement:

• When patients are admitted, a sign and symptom diagnosis often results in a lower relative weight for the hospital diagnosis-related group (DRG), and this equates to lower reimbursement. Hospital inpatient coding guidelines allow the reporting of uncertain diagnoses if they remain uncertain at the time of discharge. Coders should review the health record for clinical indicators and assure that the provider addresses the "probable," "suspected," or "likely" cause of the symptom in the record to facilitate inpatient coding of the probable problem and avoid the symptom diagnosis for inpatient coding of the claim.

• ED physicians should address all underlying problems and chronic diseases that increase the risk of an adverse outcome. Unfortunately, not all conditions documented on the ED record can be reported when the claim is billed. The condition must be relevant to the current episode of care, so the health care performance index (HPI), review of systems (ROS), and ED course should reference any risk factors and/or underlying conditions that affect ED treatment. If the patient has a "history of" condition that is not relevant to the current visit, it cannot be coded. However, those conditions that are relevant should be identified.

• When Medicare patients are admitted following an ED visit, the newly established "two-midnight" rule will apply. Although the admitting physician's documentation will be used to support

COMING IN FUTURE MONTHS

■ New approach to managing delirium
■ Steps toward more effective infection control
■ Combatting burnout in the ED
■ Meeting the needs of transgender patients

the need for admission, if the patient is discharged prior to two midnights, the ED documentation of the patient's condition throughout the ED course can be used to establish the need for admission. With ICD-10, this information is used to bill the physician claim. However, the same information will be used to designate the DRG for the inpatient admission. Thus, the more information on the record to support the need for the ED service as well as the subsequent admission, the more likely the hospital will be paid regardless of the discharge before two midnights.

• Medical necessity is the new frontier with many unknowns. Many payers use extremely subjective criteria to deny payment if the final diagnosis does not support medical necessity for the evaluation and management level to be billed. When this occurs, the physician and/or hospital should refute the findings with a copy of a well-documented record to support medical necessity for the visit. Medical necessity may be supported by signs and symptoms in the medical record as recorded in the HPI and ROS. It may be further supported by a detailed description of the ED course illustrating the steps taken to resolve the problem. Signs and symptoms are important for establishing medical necessity even though they may not contribute to the final diagnosis. Therefore, when the chart is sent to the payer for reconsideration of the charge, the documentation should be there to support the entire service.

• By way of definition, a "sign" is objective evidence of a disease that the examining physician can observe; a "symptom" is a subjective observation that the patient reports but that the physician does not objectively confirm. Both contribute to the medical necessity of treatment if corroborated by the actions taken during the ED course or the physician discussion of their effect on treatment during the visit.

• Not otherwise specified (NOS), not elsewhere classified (NEC), and unspecified diagnoses can still be coded under ICD-10 just as they were with ICD-9; however, the use of these terms in ICD-10 is limited. They present a challenge to correct coding and may result in records being held for additional clarification. Any ICD-9 code that ends with a "9" indicates a non-specified diagnosis and offers an opportunity to further educate physicians about adding specificity where possible. For example, with the ICD-9 code 402.9 hypertensive heart disease unspecified, a fifth digit is required to differentiate the heart disease as either without heart failure (ICD-9 402.90) or with heart failure (ICD-9 402.91). These crosswalk to ICD-10 codes specified as either with heart failure or without heart failure, but would not be considered "unspecified" under ICD-10 coding rules. Further, if classified as hypertension with heart failure, ICD-10 requires additional coding of the specific type of heart failure, requiring additional detail from the emergency physician.

This all sounds confusing, but the take-away for documentation improvement is to provide as much detail and clarification as is known at the time of service to help support medical necessity and facilitate correct coding with the ICD-10 rules. ■

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. Scan the QR code below, or 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. In its latest round of report cards on the emergency care environment, ACEP indicates that the overall emergency care environment has decreased from a C- to a D+. ACEP President **Alex Rosenau**, DO, FACEP, says this is due, in part, to:
A. increased demand for emergency services
B. a misguided focus on slashing resources for emergency care
C. congressional gridlock
D. confusion over the Affordable Care Act

2. **Nicholas Vasquez**, MD, FACEP, says one clear way to improve the number of providers in Arizona is to:
A. increase the pay for emergency physicians
B. improve quality of life for emergency physicians
C. increase the number of residency slots
D. improve the medical liability environment

3. Experts recommend that ED administrators interested in making improvements in their department's approach to palliative care should:
A. perform a needs assessment
B. forge partnerships with community resources
C. identify a champion
D. all of the above

4. According to **Abraham Brady**, RN, PhD, GNP-BC, in order to get the full financial benefit from hospice, patients need to be in the program for:
A. at least 7 days
B. at least 15 days
C. at least 30 days
D. 50 to 100 days

5. **Brent Myers**, MD, MPH, FACEP, says that every time a community paramedic successfully diverts a patient away from the ED toward one of the alternative facilities participating in his community paramedicine pilot program, the program returns about how many bed hours to the ED?
A. 14 bed hours
B. 24 bed hours
C. 30 bed hours
D. 48 bed hours

6. In Minnesota, the training and credentialing of community paramedics has been formalized by:
A. the state chapter of ACEP
B. the state university system
C. the state legislature
D. the Minnesota Hospital Association

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

Medication huddles slash adverse drug events (ADE), promote safety culture across all hospital units, including the ED

Developers: A strong system of error reporting is essential to making the intervention work

With preventable medication errors accounting for two-thirds of all reported cases of patient harm, Nationwide Children's Hospital (NCH) in Columbus, OH, has decided to tackle the problem head-on, establishing a multidisciplinary process for both evaluating instances of adverse drug events (ADE) and identifying solutions that will prevent each specific ADE from happening again.

Key to the new process is what NCH refers to as a medication huddle, an encounter that is triggered soon after every reported ADE. The huddle includes both the clinicians involved with the ADE as well as a core huddle team. They discuss how and why the ADE occurred, as well as potential solutions to prevent similar ADEs from happening in the future. Lessons and improvements from this process are then shared with other units.

Since the intervention was first implemented in 2010, researchers report that NCH has conducted more than 800 medication huddles and more than 3,000 potential improvements, most of which have been successfully implemented. Furthermore, they note that the number of harmful ADEs has decreased by an astounding 74%, and the rate of ADEs per 1,000 dispensed doses has decreased by 85%.[1]

The process has clearly worked for NCH, and developers of the intervention believe it could work for other hospitals as well, although they note for the process to work as intended, culture and leadership are key.

Promote a safety culture, error reporting

To address medication errors, you have to know when they have occurred, and that requires an environment that encourages reporting, explains **Shelly Morvay**, PharmD, RPh, a medication

EXECUTIVE SUMMARY

To make a big dent in adverse drug events (ADE), Nationwide Children's Hospital devised medication huddles: a process that takes place after every reported ADE. A core huddle team meets with clinicians from the specific unit involved to discuss why the ADE occurred, and what can be done to prevent future events. In three years, the approach has reduced ADEs by 74%, and the rate of ADEs per 1,000 dispensed doses has decreased by 85%.

- Administrators say a safety culture that encourages error reporting is key to making the process work.
- To facilitate the huddle discussions, developers created a data collection tool that prompts huddle participants to describe the ADE, what factors were involved, and potential solutions.
- While the medication huddles were first implemented in the hospital's critical care units, the process has since been expanded to include all areas of the hospital, including the ED.

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safety pharmacist at NCH. "This is something we have been working on for more than 10 years to help improve our safety culture and get people to keep reporting," she explains. "We do have a good bit of self-reporting, where people actually report errors that they themselves were involved in."

People are forthcoming, in part, because of oft-repeated demonstrations that the purpose of this reporting is to determine what process improvements the hospital can make rather than to determine what individuals need to be punished, observes Morvay.

Dorcas Lewe, RN, MS, a quality improvement services coordinator at NCH, agrees, noting that this non-punitive, patient-focused approach carries over into the huddle discussions. "We can definitely see the safety-culture effect of people becoming more comfortable [with reporting]," she explains, noting that it is not at all uncommon to see more error reporting from people after they have been involved in a huddle discussion. "The huddle is a discussion and it is brainstorming; it is not punitive."

Devise a data collection tool

To facilitate the huddle process, administrators developed a data collection tool that is used to prompt discussion about all the key factors surrounding a specific ADE. (*See Figure 1, p. 4.*) For example, the two-page tool includes space to summarize the ADE, the time and date when it occurred, and the people who were involved. The tool also covers any environmental or staff-related factors that may have played a role in the ADE, and it concludes with a section devoted to suggested interventions or solutions.

Huddles are trigged whenever an ADE causes patient harm or has the potential to cause harm. At this point, Lewe, who manages the event reporting system for all types of events at NCH, will take steps to schedule a huddle between the core huddle team — consisting of a nurse quality coordinator, a medication safety pharmacist, and a quality expert for the specific unit involved, and either the vice president for clinical services or the medical director for QIS — and key clinical leaders and staff from the unit where the ADE occurred.

While Lewe initially anticipated that there would be considerable resistance to the huddle invitations from the various units in the hospital, such concerns turned out to be unfounded. "I think the reason for this is just the culture work that we have done here," she says. "In the few cases where we have encountered resistance, we usually then ask our quality director to assist us with making sure people know the value of this, and it is very rare that we don't get people involved."

In fact, Lewe notes there is often positive feedback, even from clinicians who may have been reluctant to participate in the huddle process at first. "That has really been encouraging to our core group," she says.

Utilize flexible scheduling

While the medication huddles were first implemented in the hospital's critical care units, the process has since been expanded to include all areas of the hospital, including the ED. However, Dorcas acknowledges that when she is scheduling a huddle involving emergency staff, she needs to work around the hectic nature of the environment.

"Especially when there are attending physicians involved, their workflow is very different from an inpatient attending physician. Typically what we do is work with them, either by emailing them directly or sometimes through a secretary, depending on their preferences," says Dorcas. "Some of them prefer to come in and huddle on a day when they are not actually scheduled in the ED, or they may prefer to come in 30 minutes before or after a [shift]."

Some physicians try to get the huddles scheduled during a time when the ED is typically not very busy, but things can change quickly in the ED. "We try very hard to see what is going to work best for them, but also know that patient care comes first," observes Dorcas. "If we have a huddle scheduled and things go crazy [in the ED], then we reschedule the huddle."

Scheduling huddles with inpatient attending physicians involves a very different scenario, says Dorcas. "They tend to round in the mornings and say that afternoons are a good time [for huddles], or a time during their business office day, so the scheduling has a very different feel," she says. "However, as long as we are working with them on it, we are successful at making those accommodations."

Initially, developers of the intervention planned on transitioning the responsibilities of the core huddle team to the individual units, but they realized that having an experienced core team to run the process consistently provides value. "We actually piloted this with a unit that had experience with us on multiple huddles," says Lewe. "We thought the

unit would want to take the process over, but what we found was they didn't want to. They saw great value to our team being there."

Unit participants felt that the core huddle team added a richness to the discovery process, suggested improvements, and selected who can best move solutions forward, says Lewe. Consequently, the core huddle team has remained a key part of the process.

Translate improvements to other units

Many of the solutions or improvements that have come to light during the huddle process have been translatable to other units. "We have several examples of changes that we have made to our EMR [electronic medical record], which have then gone on to impact the entire organization," observes Morvay. "One example involved looking at the medication administration record (MAR) and making sure that the nurses have all the information they need when programming PCA pumps," she says. The same process has carried over to other medications as well. "We make sure that nurses have the information they need in an organized format so that the MAR is of the highest utility."

Huddle teams have found that there is often extraneous information on the MAR that interferes with an accurate understanding of the information. "Some of [the improvements] have involved removing [unneeded] information or adding more discrete information," says Lewe. "However, if we hadn't been sitting with the people who were involved with the events, looking at the [information] screens, and looking at the pumps with them, we would not have discovered what was really creating the problems."

There have been so many improvements resulting from the huddle process that NCH plans to take a closer look at all the data and all the changes that have been implemented to see what more clinicians and administrators can learn from them. "We have hundreds and even thousands of interventions that have come from medication event huddles," says Morvay. "We want to see more in-depth exactly where those process changes reside."

Develop an infrastructure

At the same time, developers of the intervention are eager to pass along what they have learned about implementing the medication huddle process to other organizations interested in going down a similar road. For instance, Morvay stresses that establishing a culture conducive to this type of process is a major key to success. "It is very important to have a culture in place where the huddle is nonpunitive in itself, but where you are still holding people accountable for their actions and for using the safety tools that are in place," she says.

On the front end, it is also important to establish criteria for what types of events you will huddle on, says Lewe. "We review our criteria periodically, asking ourselves whether these are still the right criteria," she says. "We haven't made any adjustments to the criteria since we started the huddle process, but we still review them regularly to see if we are on track."

One of the biggest lessons developers learned while implementing the process was that the core huddle group was very well accepted, says Lewe. "We have people who request huddles on some events that don't meet the criteria, but we have always been committed to being there if the units want us to come," she says.

On the management end, it was clear early on that keeping track of all the new ideas and improvements coming out of the huddle process was going to require more than the paper-based system NCH had in place at the beginning of the implementation. "We quickly learned that was not a tool that was going to allow us to proceed as we wanted to with the huddles," says Lewe. "So developing an infrastructure for how we would document the huddles, how we would track the interventions, and how we would know what is happening with them became very key for us."

Today, NCH manages much of this information through a centralized website, and there are automated tools in place so that clinicians are reminded about interventions or improvements that were developed through the huddle process. "Looking back, that was essential," says Lewe. "Had we gotten that in place earlier, it would have helped us in the long run."

When devising a medication huddle team, Morvay advises colleagues to assemble an interdisciplinary group. "I know there are things that I would never think to ask during a huddle because I don't have a nursing background, and I think [Lewe] would say the same thing about not thinking to ask questions about certain pharmacy processes," she says.

Lewe adds that it is also important to include representatives from leadership on the huddle team.

Medication Data Collection Tool

Nationwide Children's Hospital - Medication Safety Quick Investigation

Patient Name: _____ MRN:_____ Event Reporting System # _____
Date of Event Occurrence: _____ Time of Occurrence: _____ Date Event Reported: _____
Unit: _____ Scheduled for : _____

Huddle Participants:_____

Medication/Fluid involved: _____

Brief Summary of event:_____
_____
_____
_____

Staff Involved:

Name	Discipline	Years on Unit

Was accurate handoff performed? Yes No NA _____
When did it occur: _____ Was it near end of shift? (last 1-2 hours) Yes No
What was your assignment like during shift? Usual for unit Busy Slow Unusual/difficult patient
Other: _____
Other staff factors: NA Physically tired emotionally tired hungry Other: _____
Equipment/computer difficulties: NA _____

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"One of our vice presidents of nursing attends many of our huddles, and then our medical director of the quality department attends many huddles as well," she says. "It is very visible to everyone that this is important to our institution."

The medication huddles typically take 30 minutes to complete, so they definitely require a commitment of time and resources, and they can be very cumbersome, acknowledges Morvay. That's why it is important to have strong hospital support for the initiative, she stresses. "At NCH, the idea for doing the huddles actually came from a discussion with our chief medical officer," she says. "Having our vice president for patient care services and also the medical director for quality improvement services on board helps us to get everyone to cooperate." ■

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1. Morvay S, Lewe D, Stewart B, et al. Medication event huddles: A tool for reducing adverse drug events. *The Joint Commission Journal on Quality and Patient Safety* 2014;40:39-45.

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