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Washington state initiative trims Medicaid budget, ED utilization without denying access

Participants say collaborative effort is a model for states, providers

While the beginning stages of the effort may not have been pretty, Washington state's coordinated program to tamp down costs related to high ED utilization by Medicaid recipients has not only exceeded expectations in terms of cost savings, now emergency medicine professionals are eager to apply the partnerships formed as part of the approach to other health care problems. And why not? The infrastructure and the relationships are in place. And leaders of the "ER is for Emergencies" effort are eager to use the new tools at their disposal to bring more value to the table. With $33.6 million in Medicaid savings to

EXECUTIVE SUMMARY

In its first year of operation, Washington state's "ER is for Emergencies" initiative has helped to save the state's Medicaid budget $33.6 million. The initiative, which is based on the implementation of seven best practices, has succeeded in part by improving care coordination and by linking EDs across the state so information can be shared electronically. Leaders of the effort concede that while state pressure was essential in pushing providers to address excess use of the ED for non-emergency needs, they stress that the approach worked because all sides were willing to sit down and hammer out a solution. Further, they note that the infrastructure is now in place to address other problems in a similar fashion.

- An analysis of claims data shows that in the first year of the initiative, ED visits by Medicaid recipients declined by 9.9%, and the rate of visits by frequent ED utilizers declined by 10.7%.
- The analysis also shows that ED visits resulting in a scheduled drug prescription fell by 24%, and the rate of visits for a low-acuity diagnosis declined by 14.2%.
- While many EDs had to adjust their staffing and other resources to accommodate reduced volumes, others experienced few changes or even saw an uptick in volume, possibly from implementation of the Affordable Care Act.
- Leaders of the effort say the biggest challenge involved with implementing the initiative was securing administrative buy-in for investments that would likely result in improved efficiency and care, but also reduced revenue — at least initially.

report in the program's first year, it is no wonder why providers and policy makers from other states are eyeing the program as well.

However, it is worth remembering that what prompted the effort in the first place was a proposal made in 2011 by the state's Medicaid chief to put a lid on the number of "non-emergency" ED visits the state would pay for, leaving hospitals on the hook for any additional "non-emergency" visits. Outraged by the proposal, the state chapter of the American College of Emergency Physicians (ACEP) filed suit against the state with backing from the Washington State Hospital Association and the Washington State Medical Association.

The draconian proposal was put on hold while hospitals and physician providers came up with an alternative plan involving the implementation of seven best practices. *(See Box, p. 65)* Getting all the hospitals and EDs in a state to act in concert is never easy, but with the threat of non-payment hanging over their heads, they all fell in line.

Create a shared vision

While tempers were heated at the time, to say the least, emergency providers concede that state pressure is what pushed them to make needed reforms. "It was sort of the sword of Damocles over our heads that motivated change," observes **Nathan Schlicher**, MD, FACEP, JD, associate director of the ED at St. Joseph's Medical Center in Tacoma, WA, and one of the leaders of the "ER is for Emergencies" program. "It allowed us to save costs for the state, but in a way that enabled hospitals to save money by lowering their staffing if their volumes went down. The alternative, with the state plan, was to say you keep providing care, and you keep paying for it, and we are not going to pay you."

While ED volumes did go down significantly, each hospital was able to change its staffing to meet the new level of care rather than just face less reimbursement while providing more care, explains Schlicher. "With the overcrowding that exists in EDs across the country — and we have it here in Washington — this allowed many institutions to avoid having to do very expensive and massive remodels," he says. "So the incentives aligned well with doing the right thing, and I think that is what we needed: having a shared vision and a shared goal set, but then allowing the experts in the field — the providers of care — to figure out how we get there."

In addition to relieving pressure on the state's Medicaid budget, the "ER is for Emergencies" initiative also helped the state chart impressive gains on several other metrics. The Washington State Health Care Authority reports that an analysis of claims data for ED activity between June 2012 and June 2013 shows that:

- The rate of ED visits by Medicaid recipients declined by 9.9%;

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• The rate of visits by frequent utilizers (five or more visits per year) declined by 10.7%;
• The rate of visits resulting in a scheduled drug prescription fell by 24%;
• The rate of visits for a low-acuity diagnosis declined by 14.2%.

Anticipate challenges

From the start of the initiative, the biggest challenge was obtaining administrative buy-in to implement the seven best practices, explains **Stephen Anderson**, MD, FACEP, an emergency physician at MultiCare Auburn Medical Center in Auburn, WA, and past president of the Washington Chapter of ACEP. "We were going to administrations and saying that we needed them to spend money on infrastructure, and what we also needed them to anticipate is that by doing so, they would also see a drop in volume," he says. "That doesn't play out in the economic back rooms real well, so it was really critical that we had the whole team on board. We had the back up of the Washington State Hospital Association going into this."

A second challenge involved getting all the primary care providers (PCP) in the state to understand the process, and this continues to be a work in progress, made more difficult by the fact that Medicaid does not reimburse well for primary care visits, observes Anderson. "Clearly, it is a challenge to see some of the high utilizers that we have; they are high time-intensive patients," he stresses. "So explaining the seven best practices — [and in particular] what is called the PRC program — patients requiring coordination to primary care, and really pushing for that early follow-up within 72 hours was difficult." However, Anderson adds that the task was manageable because the initiative had the backing and support of the Washington State Medical Association.

Getting all the emergency providers in the state to support the initiative did not take long, given that they were well aware of the state's harsh non-payment alternative, says Anderson. But he also notes that providers were getting some tools that they had long requested, including the state's new prescription monitoring program (PMP) and the emergency department information exchange (EDIE). These tools give providers information about a patient's previous prescriptions and previous visits to EDs throughout the state.

Further, anticipating some of the issues that could result in cases in which emergency physicians decline to write prescriptions for patients identified as drug seekers, leaders of the initiative coached emergency providers with sample conversations, and they also created a letter providers can give to their administrators in anticipation of any patient complaints related to the denial of narcotic prescriptions. (To view the letter, visit this web address: http://www.washingtonacep.org/educationresources.html. Find the link at the bottom of the page.)

"Once we gave our providers the tools they were asking for, they bought into this really quickly, and part of that was having the Washington State Chapter of the American College of Emergency Physicians behind the effort," says Anderson. *(Also, see "Painkiller prescribing decisions don't influence patient satisfaction scores," p. 65.)*

Making sure consumers understood the initiative created some hurdles, acknowledges Anderson. For instance, in consultation with the Centers for Medicare and Medicaid Services (CMS), providers worked and reworked an educational poster to make sure that it didn't present any obstacles to patients prior to the medical screening exam. They also created pamphlets and videos to explain the initiative to patients.

Consider impact on patient volume

Interestingly, while state-level numbers show that ED volume is down, it's clear that the initiative did not impact all EDs in the same way. For instance, ED volume is up slightly at Providence Regional Medical Center (PRMC) in Everett, WA, according to **Enrique Richard Enguidanos**, MD, FACEP, an emergency physician at PRMC and president-elect of the Washington chapter of ACEP. He attributes at least some of that uptick in volume to implementation of the Affordable Care Act (ACA). "That has been our experience," says Enguidanos. "We have seen a bit more utilization in the last three or four months. We are monitoring it very closely."

Another potential reason for the consistent volume at PRMC is that the ED was already actively involved in case management when the "ER is for Emergencies" initiative was launched. "We are probably the biggest ED that does case management in the state. And we already had that going, so that [aspect of] the initiative wasn't as important to us," explains Enguidanos. "However, what really helped us was the state implementa-

tion of the emergency department information exchange (EDIE), which allowed us to view cases from across the state for individuals who came in. We knew if they had a management plan, and we knew how to get a hold of their provider, so that was extremely helpful, and it provided much better care for patients."

While PRMC saw little change as far as patient volume is concerned, the ED at MultiCare Auburn Medical Center in Auburn, WA, saw volume drop by more than 13%. Anderson suggests this is because the hospital serves a largely blue collar population that includes a high number of Medicaid recipients. "We actually even closed our fast track because our low-acuity visits decreased by at least 15%," he says. Anderson adds that his ED saw a reduction of at least 12% in visits by frequent utilizers.

Anderson does not attribute all of these decreases to the "ER is for Emergencies" initiative. There were also new care options available to consumers when additional urgent care centers opened in the region. Further, he notes that the hospital was in the process of being sold, and providers were also just going live with a new electronic medical record system.

While there were many contributing factors, Anderson acknowledges that providers did have to accept a loss in income from the reduced volume. "We made a conscious decision that we were going to do this right because we ultimately hoped if the ACA took off and was successful in our state, then the number of our private pay/no insurance patients would decrease," he says. "And now our volumes are starting to go up a little bit."

Patient volumes could well continue to rise. Reports suggest that by the end of March, more than 285,000 newly eligible adults had signed up for Medicaid coverage in Washington this year — far more than the state had anticipated.

Work collaboratively

There is more to do. Technical improvements to make the information-sharing aspects of the initiative faster and more efficient are planned. Further, there is currently nothing to stop drug-seeking patients from crossing state lines to visit EDs that do not have access to Washington state's EDIE, but such behavior may be short-lived. "Oregon is looking at implementing our program, and possibly even integrating with the system we use so that we would have shared visit records, and that way we would be able to see beyond those border communities," observes Schlicher. "The key thing is that through all of this no one has been denied access or care. No one has been told they shouldn't be in the ED. Instead we have created an environment that says the place for primary care is your PCP's office, and we would like to make sure that we get you there."

Anderson's advice to providers and policy makers in other states that are struggling with the same issues is to remember that success comes not from blocking access, but from coordinating the care of patients. "You really need to build an infrastructure that allows hospitals, PCPs, and care managers to coordinate the care — initially of high-utilizers and then all ED patients," he explains.

Further, while some economic input is needed to build the infrastructure, Anderson stresses that all the interested parties need to participate to make it work. "Get them to the table because cooperation is going to get you a whole lot further than arguing your own point without being able to realize that times are changing," he says. "When we stopped fighting in the media and the courts, and finally sat down and considered what will work to decrease low-acuity visits and high-utilizer return visits, it wasn't rocket science."

Enguidanos offers similar sentiments. "There is so much that gets done in medicine where all the parties involved think they are doing the right thing, but they don't understand the nuances of the other entities involved," he says. "In our case, Medicaid really had great things in mind, but I don't think they realized how their initial proposal was truly going to impact the patient coming into the ED and ED care. But once we were able to get Medicaid to sit down with the ED physicians, and then the hospital and medical associations, then we all started to understand the different perspectives."

With the results thus far exceeding expectations, emergency providers are eager to see colleagues in other states follow a similar path. "Right now, the system we have in Washington in terms of the EDIE, the prescription drug monitoring program, and the feedback reports, is arguably the envy of emergency medicine," suggest Schlicher. "It is what we have always dreamed of: the ability to know what is best for our patients, and to be able to get data on their medical history so that we can provide the best, most accurate care. Now we have that option." ■

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Painkiller prescribing decisions don't influence patient satisfaction scores

A new analysis of Press Ganey patient surveys suggests that whether or not a patient receives painkillers when they present to the ED for care may have much less impact on patient satisfaction than previous thought.[1]

In the study, published in March in an online version of the *Annals of Emergency Medicine*, researchers reviewed Press Ganey patient satisfaction surveys and electronic medical records for more than 4,700 patients who were discharged from two hospitals. Nearly half of these patients (48.5%) received analgesic medications in the ED, and of this group, 60.9% received opiates. However, the researchers found no relationship between ED patient satisfaction scores and the receipt of either analgesic or opioid medications. Rather, they found that higher patient scores were associated with older age and male patients.

While this is just one study, the findings should offer some comfort to emergency providers who worry that denying patient requests for painkillers will adversely impact patient satisfaction scores. This is a big concern, particularly in EDs where patient satisfaction scores have a bearing on provider compensation. The authors state that physicians should base their prescribing on clinical and patient factors without having concerns about the impact these decisions will have on patient satisfaction. ■

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Best practices from "ER is for Emergencies" initiative in Washington

1. Establish an electronic system to exchange patient information between emergency departments.
2. Implement patient education to help clients understand the difference between emergencies and non-emergencies.
3. Establish ED awareness of patients who are frequent visitors.
4. Implement systems that effectively refer non-emergency patients to primary care providers within three or four days.
5. Adopt stricter guidelines for prescribing of narcotics in EDs.
6. Enroll at least 90% of ED prescribers in the state's Prescription Monitoring Program (PMP).
7. Make sure hospital ED staff get regular feedback reports and take appropriate action when those reports show utilization problems. ■

Source: Washington State Hospital Association, Seattle, WA

Address burnout with a caring, nurturing environment

Expert: To promote patient safety, make physician wellness/wellbeing a priority

It's understandable that emergency physicians are particularly vulnerable to burnout. The long hours, unending stress, and immense responsibilities that go along with the job can take a toll. However, too often physicians are unwilling or unable to recognize that they need help. And in these circumstances, it's left to colleagues or administrators to intervene — hopefully before patient care is impacted.

While being alert to the signs or symptoms of burnout is critical, experts stress that hospital and ED leaders can make even greater headway against this occupational danger by pushing further upstream to decrease the likelihood that burnout will occur in the first place. They acknowledge that changing the culture of such a busy, high-stress environment isn't easy, but note that a caring, supportive workplace can deliver multiple dividends — not just to patients and providers, but also to a hospital's bottom line.

Consider the signs

Researchers have consistently found that burnout is common among medical providers. For example, when a national sample of more than 7,200 physicians agreed to take the Maslach Burnout Inventory, a survey tool used to measure burnout, nearly half (45.8%) reported at least one symptom of burnout.[1] Further, researchers found the highest rates of burnout among clinicians who work on the front lines — especially emergency providers. Well over half of the emergency providers participating in this study (65%) reported symptoms of burnout.

However, in tackling the issue, it is important not use the term "burnout" too broadly, explains **Gloria Kuhn**, DO, PhD, the vice chair for academic affairs in the Department of Emergency Medicine at Wayne State University in Detroit, MI. Kuhn, who has looked into the issue of burnout with colleagues, notes that working too many hours may result in fatigue, but that alone does not constitute burnout. A key distinguishing factor of burnout is disappointment in a relationship or relationships with others, she explains. "People may then distance themselves from those relationships and that situation almost as a protective mechanism," observes Kuhn. "And a third component is a feeling that what they have accomplished is not worthwhile."

Burnout is a concern on many levels, not least of which is the fact that it can prompt good emergency clinicians to second-guess their chosen profession. **Ricki Bander**, PhD, a Los Angeles, CA-based psychologist who frequently works with physicians who are experiencing burnout, says many report that they want to leave medicine completely. "Their attitude is no longer one of wanting to help or wanting to be involved. The caring, warmth, and compassion — things we associate with doctors and healers — are no longer evident," she says. "Rather, they become more cynical, more sarcastic, and they may avoid work. They may get irritable, impatient, and moody."

Bander notes that there may also be physical changes in physicians who are burned out. "They are exhausted all the time, they don't look well, and there may be changes in their weight or appetite," she explains. "They may be having trouble sleeping and there may be increased family issues. Some people on the extreme have difficulties in how they are handling food, alcohol, and drugs, so presuming that they didn't have problems with these things before, you may now suddenly start to see and suspect issues."

Kuhn adds that physicians who are burned out may order more tests and prescriptions rather than interact with patients and families. "They may be terse or abrupt, and they may start downplaying patient complaints," she says. As a result, patients may be less inclined to follow through with instructions. "There may be a whole host of things that are contributing to a change in [provider]

EXECUTIVE SUMMARY

With their hectic schedules and demanding work responsibilities, emergency physicians are particularly vulnerable to symptoms of burnout. One study showed that more than half of emergency providers reported at least one symptom of burnout when they were asked to fill out a survey tool used to measure burnout — more than any other type of provider. It's a concern because physicians experiencing burnout may be less attentive to their patients, and some ultimately choose to leave medicine because they are no longer satisfied with their work. However, there are steps health systems and administrators can take to help physicians who are struggling, and prevent isolated problems from escalating into larger issues.

- When a national sample of more than 7,200 physicians agreed to take the Maslach Burnout Inventory, a survey tool used to measure burnout, nearly half (45.8%) reported at least one symptom of burnout, and 65% of the emergency providers reported symptoms of burnout.
- Burnout is not just fatigue. It involves disappointment in a relationship or relationships, and lack of satisfaction or fulfillment with work, according to experts. Symptoms may include moodiness, irritability, sarcasm, and may result in performance issues as well. Further, there may be physical changes such as weight loss or changes in appetite.
- To prevent or address burnout, experts advise health systems to nurture a caring, collaborative environment, and to make sure that providers have mentors or resources to reach out to if they are experiencing any work-related problems. They also advise administrators to make sure that burnout is a safe topic of conversation.

behavior, but it is one of the things that an administrator might start noticing in a formerly compliant and really good physician [who is experiencing burnout.]"

Unfortunately, for many physicians, the pathway to burnout has been established long before they begin seeing patients. "Even though some medical schools and residencies now prescribe curriculums and core values around work-life balance, the culture of medicine is to overwork, to self-sacrifice, and to put yourself last," explains Banda. "That tends to start early in medical school … and people learn the culture."

Even the process of getting into medical school requires greater studiousness than many other career paths, so multiple things get delayed in order to become a physician, adds Banda. "There is a cumulative effect of stress, and people don't necessarily recognize the toll that it is taking on them," she says. "However, in the physician world, there is a lot of reluctance to admit that you are having trouble or you aren't enjoying your work, or that you are feeling less confident in your work."

As a result, rather than ask for help, physicians tend to muscle through their difficulties in a "maladaptive way," which can have negative repercussions on safety, patient care, medical decision-making, and their own health, explains Banda. "It is a process that starts early on … but the people who manifest the problem are typically in their 40s," she says.

Talk about it

As the founder of Physicians Helping Physicians, a Richmond, VA-based group that works with physicians who are considering career transitions, **Michelle Mudge-Riley**, DO, MHA, hears from physicians who are struggling with burnout all the time. They tell her that lack of autonomy, the regulatory environment, and escalating responsibilities are all contributing to their stress levels and dissatisfaction with their work. "At the end of the day, physicians know they have to do some of that stuff. They are just not feeling that sense of accomplishment in their careers and what they are doing," she says. "That is what is really driving that burnout, and people don't really talk about that."

Consequently, Mudge-Riley notes that a first step in confronting the issue is to make burnout a safe topic for discussion. "There has to be an understanding that it is not shameful and that a person is not a failure if they are feeling this way," she explains. "Being willing to talk about this and being aware that it is probably in your facility are very important pieces of this."

One way to get the issue of burnout out into the open is to have a physician generate a discussion about burnout, perhaps using a recent article or published research on the topic to get the conversation started, suggests Mudge-Riley. "Physicians will talk to each other," she says. "Everyone understands the background or life of another doctor, so I think that is the best way to start to combat this because once someone is willing to listen and willing to talk, then solutions can be identified."

Another way to encourage such discussion is to make it a policy to link incoming physicians who are new to the health care system or to the department with a mentor who can bring them up to speed on the culture of the organization, who the medical leaders are, and how to get involved, suggests Bander. The idea is to establish an ongoing relationship of trust between colleagues. "The mentor doesn't have to be someone in administration. It could be someone involved with clinical leadership who understands the physicians' goals and desires," she explains. "That is the person physicians will speak to about work-related problems they are seeing."

When such relationships are established early on, along with a culture of caring and collaboration, physicians are less inclined to feel isolated when problems arise, says Bander.

Prioritize physician wellness and well-being

A big issue with physicians these days is that many of them feel like they are not being heard by the hospital administration, observes Bander. This adds to their stress level and makes them feel like their thoughts don't count, she says. To counter this impression, Bander encourages hospital administrators and clinical leaders to make sure that when patients write letters of thanks to the hospital for the care that they received, these messages get passed along to the providers involved. "It is really important for physicians to hear that thank you, and if it comes from the CEO or the leader of the ED — whoever received the letter — it makes a huge difference," she says.

Further, when physicians make the case that they need more ancillary staff or other resources, administrators should give such requests a fair hearing. "The argument [against such requests] is

often around costs … but it will cost you more if a physician's productivity drops or they leave," says Bander. "One of the reasons why hospitals should want their physicians to be happy, healthy, satisfied people is because turnover is remarkably costly."

The types of incentives that corporations now commonly provide to employees to engage in preventive health activities should definitely be available to physicians because they tend to delay their own health care, observes Bander. "Have a dialog to find out what would help them get [to the gym] and then follow up," she says. "If there was [a fitness center] on site that was just dedicated to physicians at certain hours, they would use it, and that is a big thing for work-life balance."

Bander has a consulting contract with one health care system that regularly sends physicians to see her for a work-life balance check-up. "I see the physicians every year, so if they have troubles in between those appointments they are identified and they have extra sessions with me," she says. It is an ongoing relationship that helps physicians make adjustments or work through issues before they become larger problems, adds Bander.

Even small things — like making sure that healthy food is readily available so that providers don't have to rely on chocolate bars to sustain themselves through a long shift — can make a difference, especially in hectic settings like the ED, says Bander.

While such steps contribute to the health and well-being of physicians, they also send the message that the physicians are valued. "If you are promoting the goals of physician health, physician retention, and patient safety, I think you have to do what it takes," stresses Bander. "That sometimes means considering things that are more costly in the short term, but over the long term balance out or maybe even result in greater dollars."

Create a supportive environment

Kuhn emphasizes that it is the job of administrators to create as supportive an environment as possible, and to have open lines of communication with the physicians and nurses. "When a complaint comes in, find out both sides of the story without automatically blaming the physician or concluding that the physician was wrong," she advises. "Also, I have not noticed that we have a good support system for physicians who are experiencing a grief reaction because of a bad patient outcome. We also don't have good support for physicians who are involved in litigation, and these things do tend to contribute to burnout."

Administrators need to be particularly careful with schedules so that providers have time to recover from long shifts before returning to work, adds Kuhn. She suggests that administrators enable as much self-scheduling as possible so that providers have the ability to work around important personal- or family-related activities. Giving providers more autonomy over when they work may create new challenges when trying to put together a budget, but Kuhn stresses that health care leaders need to take a larger view.

"Everybody is concerned about patient safety, but very few people are concerned about physician wellness," says Kuhn. "The question is how do you create a healthy, safe environment for patients, and you do that by creating systems that support all the personnel involved." ■

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Health care IT, care coordination top list of 2014 patient safety concerns

In its first annual list of the top 10 patient safety concerns for health care organizations, the ECRI Institute, based in Plymouth Meeting, PA, placed health care information technology (IT) systems at the top of list, noting that while IT has great potential to improve patient safety, poorly designed systems or incorrect patient data can lead to patient harm.

With the federal government providing financial incentives for hospitals and individual providers to demonstrate meaningful use of electronic medical records, there has been a rush to adopt the technology. However, the ECRI report notes that substandard or poorly implemented systems can lead to data entry errors and other problems that can result in suboptimal or improper treatment. It is not the first time ECRI has highlighted this problem. The institute also cites similar concerns in another report, listing the top health technology hazards for 2014.

Second on the ECRI list of patient safety concerns is poor care coordination between different providers or settings of care. The report notes instances of critical information not being provided when patients transfer from one provider to another, and communications breakdowns between hospitals and different types of care facilities.

Other items on the list are delays and/or failures in reporting test results, drug shortages, mislabeled laboratory specimens, poor management of patients with mental health problems, items left inside patients during surgery, falls, substandard cleaning or disinfecting of surgical instruments, and poor monitoring of respiratory depression in patients who are taking opioids.

The list was compiled from data voluntarily provided to ECRI from 1,200 hospitals. While more than 20 patient safety concerns were originally identified, the list was whittled down to 10 by a multidisciplinary team that ranked the items. ■

Editor's note: To download the list, visit the ECRI website at https://www.ecri.org/PatientSafetyTop10.

ED Coding Update

Medical record cloning: When documenting, avoid the temptation

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

Medical record cloning is rapidly becoming a target of Medicare audits as more hospitals and medical practices move to electronic medical records (EMRs). As the health care industry has realized significant advantages from use of EMRs, documentation has drawn increasing governmental attention due to the increase in charges. In 2012, a *New York Times* analysis of Medicare data compiled by the American Hospital Directory found that hospitals received $1 billion more in Medicare reimbursements in 2010 than they had in 2006, at least in part by changing the billing codes assigned to emergency department visits.

The findings involved two potential abuses. One is cloning, a result of a doctor's process of cutting and pasting information from a patient's electronic record to suggest that the services were performed again at a later date or the use of the same documentation for other patients as well. The other potential abuse is "upcoding," in which providers exaggerate the intensity of care provided or the severity of a patient's condition to justify higher billings.

A letter from Department of Health and Human Services (HHS) Secretary Kathleen Sebelius and U.S. Attorney General Eric Holder was sent to the American Hospital Association (AHA), three other hospital groups, and the Association of American Medical Colleges. The letter stated that while electronic health records (EHRs) improve care quality and coordination, HHS has seen "troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled."

The letter was sent following various studies and news reports suggesting that EMR systems are contributing to a rise in upcoded and cloned bills. The Center for Public Integrity released an analysis of Medicare claims from 2001 to 2010 that showed over time, providers used higher Medicare billing codes "despite little evidence that Medicare patients as a whole are older or sicker than in past years, or that the amount of time doctors spent treating them on average was rising."

The AHA has since stated that the increased visit levels could be attributed to EMRs creating more accurate documentation that feeds more specific and accurate codes — and that not all reimbursement increases can be attributed to fraudulent practices. Regardless, the AHA said that more detailed national guidelines need to be developed for hospital emergency department and clinic visits that would simplify the "highly complex" Medicare and Medicaid payment rules.

Currently, Medicare Administrative Contractors (MACs) have increased their oversight of poten-

tial record cloning and upcoding through their audit programs and provider communications. For example, Palmetto GBA defines "cloning" as documentation that is worded exactly like previous entries. This may also be referred to as "cut and paste" or "carried forward." Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an EMR. While these methods of documenting are acceptable, it would not be expected that the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter.

The greater problem is that Medicare and Medicaid have addressed cloned documentation as it relates to medical necessity. They do not believe that cloned records meet medical necessity requirements for coverage of services. When identified, cloned documentation may lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Prior to EMRs, templates were widely used for handwritten records and allowed physicians to document comprehensive visit information in a fraction of the time required for fully handwritten charts. With EMRs, templates may also be used to record details of a visit by establishing standard elements of the history and physical examination. For example, when the physician checks "normal" for the GI system, the EMR system may automatically fill in other descriptors such as "abdomen soft" and "normal bowel sounds," etc. If the physician did not actually listen to the patient's bowels with a stethoscope, this potentially puts the provider at risk for issues related to payment as well as quality and legal issues.

Another problem with the EMR automatically filling in documentation for services that weren't performed is that it may lead to "over-documentation" and selection and billing of a higher E/M code than medically reasonable and necessary. A comprehensive history and physical examination for a patient with minimal risk factors and low acuity complaints could be perceived as over-documentation leading to upcoding. One could argue, however, that in the emergency department setting, patients and their problems are new to the ED physician, and comprehensive H&Ps are necessary to assure the patient has no additional underlying medical problems or complications that may affect treatment, even for a perceived "minor" problem.

Consider what these template statements express:

- "I personally reviewed the database, confirming and supplementing the data while obtaining the patient's comprehensive history from history source if other than the patient."
- "I have personally supervised the services provided to this patient by the resident and/or NPP and agree with all entries."
- "I have examined this patient and supervised the resident/PA during personal performance of all listed history and physical examination services."
- For male patients, "LMP as listed, neg for pregnancy."

Why does "over-documenting" matter? The Social Security Act, section 1862 (a)(1)(A) states: "No payment will be made ... for items or services ... not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member." This is the overarching criterion for determining medical necessity for Medicare. Word processing software, EMRs, voice recognition software, and templated records contribute to the cut and paste of medical information. Information that is not pertinent is not considered medically necessary for the visit or problem.

Documentation supporting services performed by residents and non-physician practitioners is especially vulnerable. Recovery Audit Contractors (RACs) continue to identify cloned documentation when the attending physician cuts and pastes from the resident's note or the non-physician practitioner's notes into his or her own or uses canned notes that are not specific to the patient. Centers for Medicare and Medicare Services (CMS) requires personalized documentation of each encounter so that the note stands on its own and represents the services personally provided by the attending physician for each date of service or encounter.

MACs that audit charts for medical necessity have been directed by the CMS to identify "sus-

pected fraud, including inappropriate copying of health information" under the Benefit Integrity/ Medical Review Determinations mandate.

All documentation in the medical record must be specific to the patient and his or her situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments.

Consider these documentation tips to avoid cloning issues:

- Empower coders and auditors in your practice/institution to identify inappropriate cloning/ template issues and meet with providers regularly to address these risk areas. It is not uncommon to find unacceptable language to support billing for services. ("Seen and agree, all systems negative, 14 point review unless indicated otherwise, etc.")
- Don't let your electronic billing/documentation system select the codes for you. It is important to review the service provided and bill accordingly.
- Read over any cloned documentation to make sure the notes make sense for that patient and problem. The chief complaint and risk factors should carry through to the exam and history and support the decisions made within medical necessity guidelines. The ED course should support the personalized information obtained through the history, physical exam, and medical decision-making.
- Review the record before you sign each note. Your signature, whether actual, stamped, or electronic, indicates you agree with the information provided on that date of service.
- Have clinical *and* coding/auditing staff review any templates in your EMR in advance.
- Template the most frequently performed services but avoid a chart with no personalization or inaccurate information and assure all elements of the template statement have been performed as medically necessary.
- Watch out for the auto-populate and recall functions with EMRs. This often results in documentation errors.
- Utilize speech recognition technology carefully to personalize records for specific patient issues and improved documentation. ■

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. What pushed emergency providers in Washington state to concede to make needed reforms when they developed the "ER is for Emergencies" initiative?
A. dwindling resources
B. soaring patient volumes
C. state pressure
D. implementation of the Affordable Care Act

2. According to **Stephen Anderson**, MD, FACEP, from the start of the "ER is for Emergencies" initiative in Washington state, the biggest challenge was:

A. controlling costs related to the seven best practices
B. obtaining administrative buy-in to implement the seven best practices
C. getting all the emergency providers in the state to buy-in to the seven best practices
D. getting patients to understand when it is appropriate to use an ED

3. Anderson also advises providers and policy makers in other states that success in curbing low-acuity ED visits comes not from blocking access, but through:
A. patient education about when the ED should be used
B. working with primary care providers to take these patients
C. coordinating the care of patients
D. working with state regulators so that they understand your point of view

4. When a national sample of more than 7,200 physicians agreed to take the Maslach Burnout Inventory, a tool used to measure burnout, nearly half reported at least one symptom of burnout. What percentage of emergency providers reported symptoms of burnout?
A. 30%
B. 45%
C. 50%
D. 65%

5. According to **Gloria Kuhn**, DO, PhD, a key distinguishing factor of burnout is:
A. disappointment in a relationship or relationships
B. fatigue
C. irritability
D. moodiness

6. **Michelle Mudge-Riley**, DO, MHA, states that a first step in confronting burnout is to:
A. recognize the symptoms
B. understand why it occurs
C. develop resources for physicians
D. make it a safe topic for conversation

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

New report: Cultural changes, technology enhancements needed to move the needle further on safe medication practices

Data show medication errors are still a big driver of patient harm

While hospitals have made progress in improving their use of safe medication practices, there is still ample room for improvement, according to the latest data from a survey developed by the Horsham, PA-based Institute for Safe Medication Practices (ISMP).

The updated 2011 Medication Safety Self-Assessment for Hospitals included more than 270 items, and was intended not only to measure what progress has been made since previous ISMP assessments in 2000 and 2004, but also to create a new baseline of hospital medication safety efforts, notes the ISMP. The organization also states that more than 1,300 hospitals voluntarily submitted data for the 2011 assessment. In a new report on the findings, ISMP spells out the particulars of where providers continue to fall short in this area, and it suggests focal points for improvement efforts going forward.[1]

EDs should take a leading role

Scores on the assessment have increased significantly since the first assessment was given in 2000. However, the ISMP report points out that medication errors are still the most common cause of patient harm, and they continue to cause at least one death in hospitalized patients every day. Consequently, while the 2011 findings demonstrate that there has been great progress in areas related to the communication of drug orders, patient education, quality processes, and risk man-

Executive Summary

A new analysis of data gleaned from the 2011 Medication Safety Self-Assessment for Hospitals shows that while hospitals have made great strides in adopting safe medication practices since the survey was first used in 2000, there is still considerable room for improvement, particularly in areas related to patient information, staff competency and education, and drug information. More than 1,300 hospitals voluntarily submitted data for latest survey, which was developed by the Institute for Safe Medication Practices (ISMP). From these findings, the ISMP has established a list of national priorities for improvement efforts in the coming years.

- Medication errors are still the most common cause of patient harm in hospitalized patients, causing at least one death per day.
- The authors of the new report stress that ED administrators and providers should take the lead in adopting many of the recommended safe medication practices.
- Going forward, the ISMP recommends that hospitals adopt specific technology enhancements, make full use of clinical pharmacists, appoint chief medication safety officers to oversee improvement efforts, and move to strengthen training and competency on medication safety.

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agement, they also reveal that hospitals scored the lowest in areas related to patient information, staff competency and education, and drug information. The findings pertain to all hospital departments. However, the lead author of the report, **Allen Vaida**, PharmD, FASHP, executive vice president, ISMP, stresses that it is especially important for ED administrators and ED practitioners to evaluate if their area is slow to implement safe practices that other areas of the hospital may have implemented. "Often, EDs may think that some of the recommendations won't work in the ED because 'we are so different,'" observes Vaida. "[However], EDs are gateways to hospitals, and they should be the leaders in some of the practices such as obtaining a weight in metric units on all patients, and obtaining a good medication history and reconciling it for those patients who may be admitted."

Enhance CPOE, utilize scale devices

The ISMP report outlines several problem areas that it thinks should be prioritized, many of which have clear relevance to the emergency setting. For instance, the authors note that certain technology enhancements could further reduce errors related to medication use. "In the ED in particular, one of the things we have come to understand is that not every patient is weighed. Many times, providers just get a stated weight from the patient," explains **Susan Paparella**, RN, MSN, vice president, ISMP.

Without accurate weights, dosing errors can occur, but Paparella acknowledges that getting a weight on every patient can be difficult in the ED because not all patients are ambulatory. Having scales that are built into stretchers or having roll-out scales so you can quickly get an accurate weight on patients early on in the care process can go a long way toward solving this problem, she says.

Another technical enhancement that can make a big difference in preventing medication errors is integrating the computerized physician order entry (CPOE) system with the medical record, adds Paparella. "Unfortunately, a lot of those CPOE systems are either stand-alone systems or they are not that sophisticated," she says. As a result, providers may miss out on automatic prompts that could alert them to the fact that a patient is allergic to a particular medication, or that another medication the patient is on interacts with a planned new medication.

Leverage clinical pharmacists

Clinical pharmacists can add considerable value when they are integrated into the ED as part of the care team, observes Paparella. This kind of expert input can guide medication selection, dosing, and preparation; pharmacists can also assist with emergency cases, medical history collection, and validation, adds Paparella.

"We definitely promote this idea, and would suggest it to any hospital. It is a resource issue, so if you can at least get a pharmacist [in the ED] during some of your busiest times, then the value would be enormous," says Paparella. "We are not talking about a dispensing pharmacist, but rather someone who can take much more of a clinical role in assisting with the care that is being provided."

Establish a medication safety officer

To make sure that the issue remains a top target for quality improvement, ISMP recommends that hospitals put a medication safety officer in charge of managing risk and protecting medication safety throughout the organization. "This can be a physician, a pharmacist, or a nurse, but he or she needs to have broad oversight over medication," explains Paparella. "It needs to be someone who has expert knowledge of the entire medication use process so that they understand how prescribing takes place, they understand the electronic medical record system and the prescribing and ordering process."

Further, this individual must be thoroughly acquainted with the pharmacy and dispensing model, as well as all of the ways that risk can enter the system, adds Paparella. "This is the person who will drive teams in charge of facilitating changes around medication use."

For instance, a medication safety officer might lead teams focused on improving medication reconciliation and transitions of care as well as the safe prescribing of high-alert medications such as anticoagulants, opioids, and insulin, observes Paparella. "These teams would be looking seriously at the ways patients are harmed with medications, and then facilitating improvements," she says.

It would also be the job of the medication safety officer to review all reports of medication errors. "Voluntary reporting in many organizations is not very robust, so there are other ways they are going

to look at the data to see how safe medication use is," observes Paparella. "They will look at the data that comes from technology [such as] the smart pumps, the bar coding, and the automated dispenser cabinets. They are going to see how people are using these devices, and how they can overcome any challenges." (Also, see "To boost error reporting, address operational issues, work on culture," p. 3.)

Medication officers can also monitor safety by tracking the use of rescue agents, regularly monitoring how medications are used and prescribed in practice, and seeking input from practitioners on what challenges they face when they are using medications, and what ideas they may have to make the institution's medication practices safer. "They can talk with staff about what keeps them up at night or where they think the next safety event is going to occur," notes Paparella. "They need to really listen to people and try to understand what makes them nervous about their workplace."

Medication safety officers are the face of medication safety in hospitals, so they may be the people presenting data to hospital boards, medical executive committees, and patient safety committees, adds Paparella. "They are often the ones who hear about adverse events first. The phone call is made to these individuals. They might sit on the root cause analysis teams, and they are certainly involved in all those investigations."

Strengthen education, competency

Organizations should consider putting more resources toward making sure that practitioners fully understand which drugs pose the most risk to patients if the agents are misused, suggests Paparella. Further, consider developing special procedures for these agents to minimize as much as possible any improper use.

For example, administrators may implement policies that require a second person to O.K. prescriptions for high-alert drugs, or they may require the use of technology whenever these drugs are prescribed so that dosages are rigorously reviewed and monitored.

Training should not just address prescribing, but also handling, storage, or labeling differences. Paparella observes that these are areas that may receive limited attention when organizations are developing training initiatives.

Another way to prevent errors and promote quality improvement with respect to medication safety is to continually share information with colleagues so that hospitals can learn from each other and potentially prevent errors that have happened at one facility from being repeated elsewhere.

"It is a matter of being proactive, and taking the lessons learned from other folks and applying them in your own setting," says Paparella. "We have to look to external sources of information to really appreciate the risk associated with some of this work," she says. "The errors are out there. They may not happen for several years at some organizations, so they may not look like a trend, but that is why external sources of information and good ideas about best practices need to be shared."

Keep the pressure on

Health care organizations are making progress in nurturing the kind of safety culture needed to root out medication errors; however, this is not a transformation that happens easily or quickly. Top-level leaders continually need to emphasize that medication safety is a top priority, and department heads need to be prepared to act when they observe problems. "Humans sometimes drift into risky processes. It is the role of the manager to understand that certain processes are riskier than others and may lead to errors," says Paparella.

Consequently, when mangers see people engaging in risky practices, they need to coach these individuals, encourage them, and tell them the stories about adverse events that have resulted from such practices, advises Paparella. "It is up to the middle managers to do the coaching, and it is up to the employees to make safe behavioral choices and to work together to give their input toward better system-building and design."

REFERENCE

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SOURCES

• **Susan Paparella**, RN, MSN, Vice President, Institute for Safe Medication Practices, Horsham, PA. E-mail: spaparella@ismp.org.
• **Allen Vaida**, PharmD, FASHP, Executive Vice President, Institute for Safe Medication Practices, Horsham, PA. E-mail: avaida@ismp.org.

To boost error reporting, address operational issues, work on culture

Even now that a culture of safety is being integrated into health care systems across the country, error reporting is still on the lower side, explains **Susan Paparella,** RN, MSN, vice president, Institute for Safe Medication Practices, Horsham , PA. "Some studies suggest that just 3% to 5% of all errors get reported, but there are many reasons why people don't report," she says.

For instance, there may not be a standard definition in the organization of what constitutes an error. If an error does not reach a patient, some may conclude that it does not need to be reported. "People might reason that it didn't reach the patient; it was caught in time, so it wasn't really an event," says Paparella. "Others may conclude if an error doesn't result in patient harm, then it doesn't need to be reported, so there are misperceptions about reporting and the value of what such information can offer towards protecting safety."

In some organizations, operational issues depress levels of reporting. People may not know how to report, or the process in place to report errors may be lengthy or bureaucratic. "Some people may feel challenged by that in the course of their busy ED day," observes Paparella.

However, perhaps not surprisingly, one of the biggest obstacles to error reporting is fear of punishment. Employees worry about getting themselves or colleagues in trouble, says Paparella. "A lot of organizations will say that they have a just culture or a culture of accountability, and that they don't want people to be afraid to report errors, but many people have been in health care for a while, and so they have a history of seeing people punished, receive remediation, or lose their jobs over errors," she explains. "That history stays with people for a long time, and sometimes perceptions are not 100% with reality, but that is where we are with the culture right now."

To surmount this obstacle, organizations need to strive to change the mindset that error reporting comes with all sorts of negative consequences. To the contrary, clinicians and staff need to "understand how important it is for the organization to learn about the things that create challenges in the workplace, and that people can learn from each other how to do a better job and to be safer," stresses Paparella. "This is a challenge because, truthfully, there are still organizations out there that, although they say they have a just culture or they are not punitive, they still have rules in place so that in cases where there is a repetitive error, a person gets disciplined," she says.

For instance, administrators may say they don't punish clinicians or staff, but they may have them do an online remediation program on medication safety that is recognized as punishment from a practitioner's standpoint; at the same time, the behaviors or system issues that led to the error remain the same, notes Paparella. "Unless, we address the bigger issues, we're probably not getting to the heart of the problem, and someone else could make the same error again," she says. "That is what we are trying to avoid." ■