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THE RICHARD MERKIN INITIATIVE ON PAYMENT REFORM AND CLINICAL LEADERSHIP

Washington State Medicaid: Implementation and Impact of "ER is for Emergencies" Program

May 4, 2015 | The Brookings Institution

Executive Summary

The "ER is for Emergencies" program was developed through a collaborative effort between the Washington State American College of Emergency Physician, the Washington State Medical Association, and the Washington State Hospital Association. Driven by concerns about costs associated with high ED use, this plan started in 2012 and aims to improve management of emergency department (ED) conditions and address overutilization through "seven best practices" that include interoperable health information exchange (HIE) technology referred to as the Emergency Department Information Exchange (EDIE), patient education on appropriate ED use, identification of frequent users of the ED and prehospital care, development of patient care plans, implementation narcotic guidelines, participation in prescription monitoring program, and use of feedback information.

EDIE integrates into existing ED electronic health records (EHR) to push basic information about resource utilization to providers such as past visit dates and chief complaints. In addition, EDIE includes a prescription management program and clinical pathways. For high utilizing patients, EDIE also includes care plans and case managers to work individually to follow-up with patients after discharge and help connect them to outside resources.

The ER is for Emergencies program is able to integrate the entire state with robust utilization to break down barriers between institutions and streamline information delivery. In the first year of the program, Medicaid ED costs fell by nearly $34 million through a reduction in ED visits. ED visits by Medicaid patients declined by nearly 10%, with rates of visits by high utilizers (5+ visits/year) declining by approximately 11%. For less serious conditions, the visit rate decreased by more than 14% over the year.

Finally, visits resulting in the prescription of controlled substances fell by 25% for the Medicaid population.[2] While this program may have helped avoid less effective payment reductions affecting emergency departments, sustaining and expanding such programs may require further payment changes to enable emergency departments to share in the overall savings from initiatives like this one.

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I. Program Overview

The recession of 2008 triggered a significant uptick in job losses and the subsequent loss of employer sponsored health insurance, swelling Medicaid rolls. This loss of tax revenue and increased spending caused many states to take a serious look at Medicaid spending.[1] In Washington State, several factors such as the poor interoperability of health information technology, gaps in access to primary care physicians, and the lack of communication and integration among providers and facilities led to high utilization of hospital-based emergency departments (EDs). In a single calendar year, some patients had over 100 visits to as many as 30 EDs throughout the state.

To address the high ED utilization, Washington State Medicaid, a part of the Washington Health Care Authority (HCA), introduced a plan in 2011 to limit the number of non-emergency visits to EDs to three visits per year. Deemed the "Three Visit Rule," Washington State Medicaid would no longer reimburse hospitals and physicians for conditions that were considered potentially treatable in alternative settings. The plan would have reduced ED payments by $36 million a year in the state, or an average of $375,000 per ED. The plan would have applied to more than 700 conditions; including not only low-acuity conditions but also potentially emergent conditions such as chest pain, abdominal pain, and seizures.

While that plan was not ultimately implemented, the Washington Governor called for the state's hospitals and physicians to develop a set of best practices that could be deployed rapidly and adopted statewide in place of the Three Visit Rule.[1] In April 2012, the Washington State American College of Emergency Physicians, the Washington State Medical Association, and the Washington State Hospital Association came together to collaboratively develop a way to better manage ED services and reduce over-utilization without dangerous denials of coverage and care.[3]

The high utilization was driven by a combination of drug seeking behavior, mental health challenges, and a fragmented health care delivery system. Indeed, it was found that 85% of frequent users of EDs had serious mental health issues and approximately 48% had substance abuse problems. Thus, the program targeted high utilizers by addressing their social, mental health, and substance abuse needs instead of just denying coverage.

Implementation of the ER is for Emergencies program began on July 1, 2012. If hospitals failed to comply with the plan, the HCA could reinstate its policy of nonpayment for ED visits determined to be nonemergency.[1] The program has since expanded to actively address all payers and patients with medical co-morbidities resulting in high ED utilization. The program includes seven best practices: [4]

1. Develop and use interoperable health information exchange (HIE) technology
2. Educate all patients about appropriate use of EDs
3. Identify frequent users of the ED and prehospital care
4. Develop patient care plans for frequent users
5. Implement narcotic guidelines to reduce narcotic seeking behaviors by patients
6. Participate in prescription monitoring program
7. Use of feedback information

II. Care Delivery Redesign

There are 3 main ways to reduce acute care costs: 1) preventing acute health problems and the associated care from happening in the first place; 2) create and expand less costly (and hopefully more convenient) alternatives to ED care so people with acute problems use less expensive hospital-based care; and 3) improve the function of the acute care system itself. In conceptualizing the Washington State approach to acute care services, it is important to understand several elements including care delivery redesign that incorporates all three of the strategies mentioned above, as well as the underlying incentives and information systems that support these services.

Provide referrals for low-acuity visits. ED's established systems for referrals for minor conditions that can safely wait to be seen to primary care providers within a 72-hour window. The care managers in the individual facilities have been tasked with arranging follow up in real time for primary care visits for high-utilizers of emergency services.

Identify frequent users of the ED and EMS and develop care plans. Case managers in the ED identify high utilizers (many with unmet psychosocial needs) defined as the patients with more than 5 ER visits or transports in the prior year. Frequent users are often part of the Patient Review and Coordination (PRC) effort. Once identified, hospitals receive a client list to identify patients upon arrival. Care plans are created and these patients receive coordinated case management.[5] PRC patients receive an individualized care plan that is integrated into the Emergency Department Information Exchange (EDIE) to help improve consistency of care amongst multiple providers and settings. In addition, case managers follow up with these patients within 72 hours of discharge and help them connect with primary care and outside providers to integrate the care plans to actively manage patients.

Implement narcotic guidelines to reduce drug-seeking behaviors by patients and participate in prescription drug monitoring. The Emergency Department Opioid Abuse Work Group sponsored by the Washington State Department of Health developed ED Opioid Prescribing Guidelines.[6] The guidelines include 17 recommendations ranging from not providing replacement prescriptions for controlled substances that were lost, destroyed, or stolen to limiting prescriptions to no more than 30 pills. EDIE also includes an integrated prescription management program that allows providers to track the utilization and standard plans for narcotic and controlled substance administration. Providers have more detailed information, including utilization patterns and a standard state plan for pain management, and clinical pathways for narcotics are included within the workflow.

Use of feedback information. The multi-organization supervising group reviews the data provided through EDIE at monthly meetings. Quality metrics, including rate of utilization, are calculated annually, with additional occasional spot checks. When outliers of practice are identified, the responsible organizations are tasked with follow up with those providers. Each hospital also gets monthly metric feedback on their rate as compared to others that has helped drive the group towards the mean via self-regulation. Each hospital has staff responsible for reviewing the reports to ensure the interventions are working and reporting back to executive leadership.

Educate all patients about appropriate use of EDs. The ER is for Emergencies program aims to educate patients about appropriate use of emergency services. As part of this aim, EDs distribute information to patients. Brochures are distributed that help patients choose the best place to go for health care.[7] Educational posters are displayed in hospitals that providers could use as a starting point to have a shared conversation with the patient.

III. Physician Payment and Information System Reforms

Payments. In Washington State, there was a clear threat of non-payment to hospitals that led to enhanced efforts to reform ED use. This pressure caused Washington State's EDs and hospitals to organize and ultimately improve care. To implement the seven best practices, providers and hospitals needed to allocate resources, and the hospitals paid in to develop a statewide health information exchange described below. In order to implement the program, a multi-disciplinary, team based approach of providers from different specialties and other clinical and non-clinical support staff such as nurses and social workers was used. The scope of care managers has expanded in many places to help address the combined psychosocial needs of the patient that are not actively being addressed.

Information Systems. In order provide EDs with important information about prior care, an interoperable health information exchange was created and supported by hospitals. EDIE allows ED physicians to view limited, ED relevant data about their patients. Information is pushed to ED physicians; it does not require any additional effort to view. EDIE is integrated into the existing electronic health records (EHRs) similarly to any patient note within the EHR system. The EDIE system allows real-time monitoring of emergency service utilization across the state by individual user and aggregate data for payers including the state. EDIE shares visit date, location, and chief complaint of prior patient visits. As of March 2014, 98 hospitals are sharing ED information electronically.[8]

IV. Costs of Implementation and Results

The ER is for Emergencies program produced some compelling results in the first year of the program, based on a report from the HCA to the legislature. On top of nearly $34 million of savings in emergency costs in 2013:[8]

- More than 420 primary care providers received notifications when their patients enter the ED.
- Standardized care plans are available via an EDIE in more than 90 emergency rooms across the state so all ED providers have access to care guidelines.
- Rate of ED visits declined by 9.9%
- Rate of visits by frequent clients (5+ visits annually) decreased by 10.7%
- Rate of visits resulting in a scheduled drug prescription decreased by 24.0%
- Rate of visits with a low acuity diagnosis decreased by 14.2%

The State of Washington did not provide any additional funding to hospitals to directly fund implementation of the program. Instead, the hospitals participated in the program because there was not only the promise to improve patient care, but there was the consequence of potentially returning to a less favored reimbursement reduction – the Three Visit Rule – if hospitals did not participate in the ER is for Emergencies Program. Had less than 75% of the hospitals participated, then all hospitals would have been subject to the Three Visit Rule no-payment plan and were at risk for $32 million a year in lost Medicaid payments (this is less than the $36 projected during the first year of the plan). Ultimately, 100% of hospitals participated.

However, there are some upfront and ongoing costs required by hospitals to implement elements of the seven best practices. Hospitals were required to pay the $10,000 to $20,000 per site in upfront costs to integrate EDIE, along with the annual program cost of $10,000 to $15,000 per year. Many hospitals also re-tasked a social worker from elsewhere in their system to become a care manager to high-utilizing ED

patients. Some payers have care managers working out of their offices. However, physician payments have not changed from a per patient basis.

V. Challenges, Policy Solutions, and Next Steps

Like with many health care innovations, the main challenge for developing and instituting ER is for Emergencies was engaging individuals and organizations that were originally resistant to change. However, the ER is for Emergencies program was a collaborative effort between many sets of stakeholders, including some groups that are not often included in the conversations, like emergency physicians themselves. Therefore, the program was attractive to those affected, and emergency physician buy-in to this program was relatively easy since it requires little additional work and provides them with important information to improve patients' care.

While the threat of returning to the Three Visit Rule provided impetus for all stakeholders to move forward in a constructive way, other payment models that reward providers for care coordination and improving care may be similarly effective. Possible approaches include a per-member, per-month (PMPM) capitated payment or shared savings arrangement tied to resulting cost reductions that can help support ED physicians to provide services not paid for under traditional Medicaid fee-for-service. These payments would need to be tied to quality measures to ensure providers maintain or improve quality of care while reducing unnecessary ED utilization.

The success for the initial year of the program has led to continued growth and the collaborative group continues to look for new ways to improve the care delivery system overall. The private Medicaid Health Maintenance Organization (HMO) contractors are now integrated and leaders of the program are reaching out to the private insurance market to participate. In addition, surrounding states, including Oregon, have joined the program to help develop an even broader network to expand these efforts.
Further, the program is working with payers on new patient populations, including patients with chronic disease states that have high costs or high frequency of utilization, such as congestive heart failure. A shared savings or PMPM payment might be utilized here, not only to help encourage programs like ER is for Emergencies, but to enhance efforts to reduce overall costs and improve care that may require additional resources.

ENDNOTES

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