



Access, Quality, Cost: Emergency Department Action Plan to Reduce ED Overutilization

The Washington Chapter American College of Emergency Physicians (WA-ACEP), with the support of our fellow health care providers, is committed to reducing the cost of healthcare in Washington State, while ensuring that our Medicaid population has adequate access to quality healthcare.

We have developed a plan aimed at reducing the perceived “overutilization” and “inappropriate” use of the emergency department (ED) that **does not** impose an arbitrary cap on emergency room visits. Our solutions are based on the understanding that this small percentage of inappropriate use results primarily from inadequate access to primary care and from substance abuse issues.

The following tools will work towards the goal of real cost savings for the state and will encompass an effort to coordinate and integrate medical care and wellness within each community.

Access to Care

- Timely (24-48 hour) follow-up care by the primary care provider (PCP)
- Develop a working group for treatment of dental disorders in a cost effective setting
- Cabulance services will not be covered for non-emergent conditions

Quality Tools

- Implementation of a single state-wide, real time data feeds to track emergency department visits ¹
- Statewide Prescription Monitoring Program²
- Support generic drug use for DSHS patients
- Support enhancing the DSHS locked-in program
- Statewide adoption of opioid prescribing guidelines for emergency physicians to reduce prescription drug abuses³

Case Management

- Notification to patient after each unnecessary ED visit
- Notification of PCP after each visit to the emergency department
- Ensure each high utilize patient has a PCP
- Enhanced care plan utilization with ED tracking system

Significant Savings

Based on the plan that we have outlined, the potential savings to the state are 40 million dollars annually. This exceeds the amount that had been sought in the 3 visit rule and works to improve care instead of deny coverage. This plan can replace the overly generous estimated savings that the HCA estimated based on faulty clinical information and actually achieve significant savings.

1 Emergency Department Information Exchange (EDIE). Collective Medical Technologies LLC, www.collectivemedicaltech.com

2 RCW 70.225 Washington State Prescription Monitoring Program, www.wapmp.org

3 Washington Emergency Department Opioid Prescribing Guidelines, July 2011, www.washingtonacep.org/painmedication.htm

Generics First

The state cannot develop a mandatory formulary. The physicians of the state, as coordinated through a collaborative panel of physician representatives from the affected specialties, will create a voluntary formulary with feedback reports to providers.

Physician Role – The physicians will work to develop a collaborative formulary focusing on generics first. This process will be updated on a regular basis by a collaborative work group. No single group will be targeted as there are savings to be realized in all areas of medicine. Significant savings will be found in areas such as antipsychotics, pain medications, antibiotics, and chronic medications.

The physician groups will also establish a process for review of high utilizers in each specialty groups. Each specialty society will then conduct reviews based on the data provided and interface with the providers to work toward lower cost / generic first medications where possible.

State Responsibility – The state will provide feedback reports to physicians in the state to change behavior. The feedback reports will be to individual providers as well as directors of groups. Additionally, specialty societies will receive reports on the highest utilizers to be defined by the collaborative work group.

Timeline for Implementation – The physician group will have the voluntary formulary, data request material, and high utilize system established by July 1st, 2012. The state, through the HCA, will then work to enact the data and feedback process with the first report due after the close of the 1st quarter of fiscal year 2012.

Estimated Savings - State representatives have indicated that over \$100 million can be saved by utilization of generic psychiatric medications and prescription pain medications. WA-ACEP will support the state on the utilization of generic medications. A 20% reduction in utilization of these name brand medications could represent **\$20 million** a year in savings.

Opioid Prescription Monitoring

Substance abuse, especially the seeking of narcotic pain medications and other controlled substances, influences a small contingent of patients to seek inappropriate care from the Emergency Department for refills or additional controlled substances. Implementation of a statewide narcotic policy, review of high utilizers, and implementation of data driven feedback will help reduce prescriptions for controlled substances and decrease inappropriate ED utilization.

Physician Role – The Emergency Physicians have already implemented a statewide narcotic guideline and deployed it in emergency departments across the state. This policy will be supplemented by a review process within the specialty associations of emergency medicine and other specialty groups for their providers. Data reports will be provided to individual providers, medical directors, and specialty bodies. Each specialty society will then conduct reviews based on the data provided and interface with

the providers to work toward prescriptions more in keeping with the community standard where appropriate based on good medical care.

State Responsibility – The HCA has represented that they can provide individual physician feedback to each physician in the state, medical directors, and the affected specialty organizations. These reports will be generated quarterly by the HCA and distributed to the parties involved. Additionally, the state has had a prescription monitoring program on the books for years and now has funding to start utilization that will be necessary to improve individual patient care.

Timeline – The Prescription Monitoring Program is to be active by January 1st, 2012 per the Department of Health. The physician group will have the voluntary formulary, data request material, and high utilize system established by July 1st, 2012. The state, through the HCA, will then work to enact the data and feedback process with the first report due after the close of the 1st quarter of fiscal year 2012.

Estimated Savings – These will be reflected in the overall savings described in the section on case management as they interface with reduction in inappropriate ED utilization.

Case Management

The hallmark of any program to improve care, fix access, and reduce inappropriate ED utilization on frequent users of health care is case management. Many emergency departments across the state have case managers in their emergency departments already and are able to provide data on the overwhelming success of such programs in reducing ED utilization.

Physician / Hospital Role – Hospitals with case managers will begin to upload their care plans to the Emergency Department Information Exchange (EDIE) program or other equivalent single state-wide, real time data feeds to track emergency department visits for statewide access. This program will be adopted across the state for integration of care. The system communicates with the registration process at each hospital and provides real time feedback on utilization and prior visits to other hospitals for this patient.

Hospitals with case managers will work to coordinate with representatives of other institutions across the state. As such, there will be initially semi-annual meetings of the case managers in the state at a mutually agreed upon site.

State Role – The state will provide its claims data for all Medicaid clients to the EDIE system, a contract which they have already signed and begun to implement. They will also load their locked in program forms into the case management section of the EDIE system for real time feedback to the providers.

The state will also provide feedback to patients when they have presented for what the state deems to be an inappropriate emergency department visit based on criteria established with the physician collaborative. This notice will also be provided to the primary care providers. The state will also employ

case managers within the HCA system to coordinate with the hospital based case managers on access issues that challenge many communities.

Timeline for Implementation – The EDIE system continues to be implemented across the state and the affected parties are targeting completion by the July 2012. The quarterly meetings of case managers in the state will begin at the conclusion of the first fiscal quarter of 2012.

Cost Savings - The utilization of case managers and pathways for patient care has been shown to lead to substantial savings for recurrent chronic conditions. The state has identified that it will be placing patients with more than 8 ED visits per year on case management. This will affect approximately 30,000 visits per years based on the data provided by the state. If the experience from the Franciscan Health System Case Management program is applied to this visit frequency, this could result in a 18,600 visit reduction in the state per year. This would represent an approximate 40% savings of the estimated total of \$35-36 million, or **\$14 million** in savings per year.

Primary Care Access

The majority (65%) of utilization of emergency services is after business hours or on the weekends when primary care offices are not available. Access to timely appointments and close follow up for patients that visit the emergency department is critical.

Physician Role – The primary care specialties (family medicine, internal medicine, pediatrics), in conjunction with the emergency physicians, will work to establish a system of timely follow up when clinically indicated, generally within 24-72 hours. This system will be voluntary, but adopted in guideline form by all provider groups.

State Role – There are multiple areas in the state that have very poor coverage with primary care access for Medicaid recipients. As such, the state will work to ensure adequate coverage for primary care services and recruit additional providers as needed.

Timeline for Implementation – The physician collaborative will have guidelines for a system of timely follow up adopted by July 1st, 2012. The state recruitment of providers is ongoing.

Potential Savings - Patients with 4-8 visits per year represent at least a partial lack of timely access to primary care services for enrolled clients. This represents a total of 15,700 visits per year based on the provided data by the state. If one visit per affected client were saved through same or next day access for primary care services, there would be a 7450 visit reduction in visits. This would be a savings of 16.5% percent of visits for **\$5.95 million** per year in savings.

Additional Savings

There are other line items that can result in important savings and change patient behavior in seek care. These could include:

1. Reduction in cabulance coverage for inappropriate ED utilization. Providers will have the discretion and encouragement to deny cabulance services for patients that are deemed to be over-utilizing the system and have been warned.
2. Establishment of dental clinics for ED follow up. Dental care is an increasingly significant cost to the state in the emergency department. Appropriate follow up with dental care is critical. Use of dentists in close clinical follow up settings for ED patients can help save additional emergency department utilization and possibly aid in diversion of those patients prior to utilization. Pilot projects could be established in high utilization areas such as Seattle, Tacoma, and Spokane as test projects.