



Management

Best Practices – Patient Flow – Federal Regulations – Accreditation

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In the wake of the Supreme Court's ruling on health care reform, hospitals and EDs still grapple with uncertainty, continued stress

State decisions regarding Medicaid expansion loom large for hospitals and EDs

While the U.S. Supreme Court has settled the issue of constitutionality, President Obama's signature health reform legislation, the Accountable Care Act (ACA), still faces significant political

EXECUTIVE SUMMARY

Even though the U.S. Supreme Court has upheld the bulk of President Obama's signature health care legislation, the Accountable Care Act (ACA), the prospects for full implementation of the law remain uncertain as political opponents still vow to strike down portions of the law at the earliest opportunity. Further, the high court's decision to leave the law's Medicaid expansion provisions up to the states leaves hospitals and EDs in a particularly precarious position as they will still face mandated cuts that the law's authors anticipated would be offset by Medicaid dollars. Experts recommend that ED administrators prepare for continued stress on their departments and get involved with shaping the way emergency medicine fits into ACOs and other emerging models of care.

- Some experts predict that EDs will see a flood of new patients when the Medicaid expansion provisions go into effect in 2014, but this trend may be tempered by the fact that newly insured patients will be able to seek care in other settings.
- The health reform transition is expected to be most difficult in states with large uninsured populations, and experts agree that a shortage of primary care physicians will drive ED volume in many communities.
- Hospitals and health care business interests are putting pressure on states to opt in to the ACA's Medicaid expansion provisions because it will make federal dollars available to cover 100% of the cost to cover newly insured Medicaid patients for three years, and 90% of the cost after that.



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headwinds that could chip away at provisions in the landmark health care law. Further, by enabling states the ability to opt out of the law's Medicaid expansion provisions, the high court has left hospitals and EDs in a precarious position. If their states go along with the expansion, scheduled to go into effect in 2014, millions of federal dollars

will flow into the states to pay for the care of newly insured Medicaid recipients. However, if states opt out of the Medicaid expansion provisions in the law, as a handful of states have already pledged to do, hospitals and EDs will still have to care for these patients. (See more on this aspect of the law in *"Hospitals and EDs have a lot riding on state-level decisions to opt in or out of plans to expand Medicaid in 2014,"* p. 100.)

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Such uncertainties make it more difficult for hospital administrators to plan for the future, but many believe all signs point to continued stress on the nation's EDs. "If we think crowding is bad now, I suspect we haven't seen anything yet," observes **Brent King**, MD, chair of the Department of Emergency Medicine at the University of Texas Health Science Center in Houston, TX. "Many of the newly insured patients will have chronic illnesses that have not been appropriately evaluated or treated. While EDs are very good at managing acute exacerbations of chronic illnesses, they are not the best places for patients to receive ongoing care. Emergency department leaders will need to consider how they can meet this new challenge."

Look to the Massachusetts experience with reform

Vidor Friedman, MD, FACEP, president of the Florida College of Emergency Physicians, and vice president of governmental affairs for Florida Emergency Physicians in Maitland, FL, agrees that EDs will face challenges, but he does not anticipate the flood of newly insured patients that some are predicting. "In emergency medicine we don't pick our patients; we take care of everybody regardless of their ability to pay, so we are already taking care of these patients in the ED," he explains. "We may see a few more because some people may access care more frequently once they receive coverage, but right now they can come to the ED anywhere in the country and be seen. The issue of payment comes later."

However, another factor that may drive demand up a bit, says Friedman, is the change in insurance status that many patients will see. "One of the things that has been shown in a number of studies is that when an individual's insurance status changes — either they get new insurance or they lose insurance — that tends to be when they use health care more than normally for whatever reason," adds Friedman.

When Massachusetts passed its health reform law in 2006, there was an 8% increase in volume

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to the state's EDs, observes Friedman. However, Massachusetts had a very low percentage of uninsured citizens, so it is not necessarily a model for how things will play out in states like Texas where roughly 25% of the population is uninsured.

"When Massachusetts expanded coverage, the mismatch between the number of people who wanted care and the number of providers became apparent," adds King, explaining that when people tried and failed to find care in office settings, they came to the ED. "Even more concerning is the fact that Massachusetts has one of the largest supplies of physicians in the country. In states that have fewer physicians, the situation could become far worse, so I think hospitals should be prepared to see even more crowding in their EDs. Most of these patients will have some form of insurance, but that will not solve the problem of crowding."

While there was an initial surge in demand when health reform was enacted in Massachusetts, the Associated Press (AP) reports that ED visits have now decreased by 4%, and 98% of the state population has insurance coverage. However, the AP also notes that access is still a problem there, as less than half of the primary care physicians (PCPs) in the state are accepting new patients, and there are long waits for PCP visits.

Anticipate continued problems with primary care access

Douglas Hough, PhD, an associate professor at both the Carey Business School and the Department of Health Policy and Management in the Bloomberg School of Public Health at Johns Hopkins University in Baltimore, MD, sees the health care law impacting EDs in two divergent ways. "More of the uninsured will have insurance, which means that they will at least have the ability to access primary care providers and not have to use the ED as their source of primary care. I would think that will then relieve some of the pressure off of EDs," says Hough.

However, Hough agrees with King, noting that newly insured patients may still have a tough time accessing PCPs because of supply pressures. "There are few PCPs that I speak with who are working at significantly below capacity. Many of them are not looking to expand their patient pool. In fact, you see many of them who are closing their practices to new patients," he explains. "So you may have, in a sense, a revolution of rising expectations where people who gain insurance may think they can get a PCP, but then when they

call around, they find they are unable to find a PCP because there is a shortage, and so then they turn to the ED."

Further, there is no question that while states with large uninsured populations may have the most to gain financially from a federally-funded expansion of Medicaid, the transition in these states is going to be more difficult. "If, in fact, a state like Texas engages in this, and all of a sudden 25% of their population has insurance and, theoretically at least, has access to health care, the pressures on that health care delivery system are going to be enormous," says Hough, "because it is built on a model where only 75% of the population is insured."

Another complicating factor is the reluctance among some PCPs to accept Medicaid patients. "They are looking at the cost of running a practice, and if a particular payer is not paying anywhere close to enough to cover the cost of care, then it would be almost foolish for a physician to say he or she is going to accept a Medicaid patient instead of a private pay patient," says Hough.

This is precisely the situation in Florida where Medicaid reimbursements are among the lowest in the nation, notes Friedman. "Medicaid patients have a very difficult time finding primary care, let alone specialty access in Florida, so a lot of them use the ED as the de facto primary care place because they can't get into a physician's office," he says.

There are some provisions in the ACA designed to boost the supply of PCPs, notes **Matthew McHugh**, PhD, CRNP, MPH, JD, an assistant professor of nursing at the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing in Philadelphia, PA. However, he stresses that states need to do more to leverage the expertise of nurse practitioners and physician assistants. Such measures could further expand access to primary care, and take pressure off of EDs, he says.

"Some states restrict the scope of practice [of these midlevel providers] which, in essence, limits their ability to be able to provide care," says McHugh. "It puts them under a physician's supervision and really doubles everyone's work. It doesn't make the most efficient use of everyone's time, and it is really not a rational use of human capital."

Get involved with shaping new models

Perhaps the biggest wild card in any discussion

about health reform is what impact new models of care will have on outcomes and cost. “I have been analyzing the health care sector for 30 years, and it seems like every 10 years or so there is a promise of more integrated care — a new way of getting providers to think about the patient holistically, to treat them holistically, and to eliminate the fragmentation of care,” says Hough, recalling the advent of HMOs, PHOs, and other models. “Maybe this will be the time, and Accountable Care Organizations (ACOs) will be the mechanism by which we collectively will be able to treat patients on a continuum as opposed to the fragmentation we now have. Obviously, emergency medicine would have to be included in that continuum.”

While the politics of health reform get sorted out, McHugh advises ED administrators and clinicians to focus more on how they might contribute to ACOs, medical homes, and other emerging models. “Emergency department providers need to have a seat at the table to direct how they think they will fit in and direct pathways for patients so that they get the best care and the most appropriate care,” says McHugh. “We want exceptionally trained providers and specialists using the highest end of their skills, not the lowest end of their skills. And we want to make sure that the patients with the highest need are going to the right places, and the patients with lower acuity needs are going to the right providers so that there is room in the ED for really emergent needs.” ■

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Hospitals and EDs have a lot riding on state-level decisions to opt in or out of plans to expand Medicaid in 2014

One of the key planks in the Accountable Care Act (ACA) is an expansion of Medicaid coverage to citizens who earn up to 133% of the federal poverty level, beginning in 2014. The Congressional Budget Office estimates this provision would provide coverage for 33 million people who currently lack insurance. However, in its ruling on the ACA in June, the Supreme Court indicated that states cannot be coerced into going along with the expansion, giving states the ability to opt out of this provision if they so choose.

At press time, the governors of at least seven states had already pledged that they intend to opt out of the ACA's Medicaid expansion provisions, but many expert observers believe that in the end, few if any states will ultimately refuse the billions of federal dollars that the government is making available to the states to cover these newly insured Medicaid patients. Under the law, the federal government will pick up the tab for 100% of the cost associated with covering the new Medicaid recipients until 2017, and at least 90% of the cost after that. What's more, all states will be subject to cuts programmed into the law that legislators intended to be offset by the Medicaid dollars.

The bottom line is that hospitals and EDs in states that opt out of the Medicaid expansion would be severely short-changed. “Each state is going to have to make a decision, and hopefully we can get the states to understand that this is at least a first step of appropriately funding public policy with public dollars,” observes **Vidor Friedman**, MD, FACEP, president of the Florida College of Emergency Physicians. “If you don't expand the Medicaid rolls and you don't give these people some form of insurance, what you are doing is continuing to dump the total cost of caring for these people on the private sector, and while hospitals get some reimbursement from low-income pool dollars for taking care of indigent patients, physicians don't.”

Already, powerful business and health care interests are pressuring states to go along with the Medicaid expansion, but many states appear to be

awaiting the results of the presidential election in November before indicating how they intend to move forward.

Even if every state falls into line, however, Friedman emphasizes that the ACA is only a first step. “We don’t know exactly what all the ramifications of the bill are going to be, but I do think we are going to continue to see efforts towards health reform because the fundamental problem we have in this country is that we spend an enormous amount of money on health care,” he says. “There are going to be hard choices that need to be made as we go forward. This [legislation] was difficult enough, and it didn’t really do anything about cost-containment.” ■

Palliative care options can ease strain on EDs, improve care for patients with poor prognoses or difficult symptoms

New analysis questions use of the ED, inpatient admissions toward the end of life

In the intense focus of late on use of the ED by patients with non-emergent needs, it is perhaps easy to overlook another group of patients that

EXECUTIVE SUMMARY

A new study suggests that for too many older patients, a trip to the ED leads to a hospital admission, where many of these patients spend their final hours. Instead, experts argue that many of these patients could be better served by palliative care options. Experts note that palliative care consultation teams and staff education on how to have “goals-of-care” discussions can help EDs deliver more responsive care to these patients while also reducing use of the ICU and other costly procedures.

- Investigators found that roughly half of 4,500 older patients who died while participating in the Health and Retirement study, made at least one ED visit in the last month of their life, and that three-quarters of these visits resulted in hospital admissions.
- More than two-thirds of the patients who were admitted to the hospital died there.
- Study participants who enrolled in hospice at least one month prior to their death were much less likely to visit the ED or to die in the hospital.

is strongly linked with the ED: patients who are nearing the end of life. A new study suggests that for many of these mostly older patients, the ED visit triggers a hospital admission and a cascade of costly procedures that are nothing like what the patient would have chosen.

The study, which was published in *Health Affairs*, was based on an analysis of more than 4,500 health records of patients older than the age of 65 who died while participating in the Health and Retirement Study, a longitudinal study of older adults in the years between 1992 and 2006.¹ The authors linked the Health and Retirement survey data to Medicare claims to ascertain ED utilization patterns. They found that half of these adults made at least one ED visit in the last month of their life, and that three-quarters of these visits resulted in hospital admissions. In addition, more than two-thirds of the patients who were admitted to the hospital died there. However, the authors note that the 10% of study participants who enrolled in hospice at least one month prior to their death were much less likely to visit the ED or to die in the hospital.

What’s wrong with this picture? Study authors maintain that the ED’s traditional focus on stabilization and triage is far from ideal for patients nearing the end of life, and that this type of trajectory only contributes to the high cost of care for both health care systems and the families. Further, they observe that it is not the kind of care that most of these patients and their families would prefer.

“If you were at the end-of-life stage, and you were not expected to live long, would you rather be sleeping in your own bed with the appropriate comfort measures, or would you rather be in a hospital ward with monitors beeping?” questions **Jonathan Fisher, MD, MPH**, a co-author of the study, and an assistant professor of emergency medicine at Tufts University, and vice chair of the Committee on Clinical Investigations at Beth Israel Deaconess Medical Center in Boston, MA. “I think there is going to be more discussion about this in the future as we try to figure out how to keep patients out of hospitals.”

Fisher acknowledges that a discussion about end-of-life care should ideally occur before a patient reaches the final stages of a terminal illness. Then both the patient and his or her primary care providers will have a care plan in place, and it won’t come as a surprise to the patient. However, such discussions are often delayed until a patient ends up in the

ED with some type of acute exacerbation of their disease. “Someone may come in with a devastating illness, such as an intracranial hemorrhage, for example, that is clearly not going to result in a good outcome for the patient,” he says. “If a return of function and survival is not predicted to be good, then I think you need to have a discussion at that time about what the goal of care should be.”

Unfortunately, transitioning the patient to a hospice setting or arranging for palliative care services is difficult if the ED does not already have relationships established with these types of community resources. “The education piece is the easy part. I think most ED providers have a fairly good sense of what patients would be good candidates for this type of care,” says Fisher. “It is delivering on the resources that is the hard part.”

Help patients make informed decisions

There are clear advantages available to EDs that have palliative care resources at close hand. For example, Virginia Commonwealth University Medical Center (VCUMC) in Richmond, VA, has had a dedicated palliative care unit on the VCCUMC campus since May of 2000, and it has always worked closely with the ED, explains **Laurie Lyckholm, MD**, director of the VCU School of Medicine’s Hospice and Palliative Medicine fellowship program.

“The ED is a priority with us because we know that the sooner we can get to the patients who may need a palliative care consultation, the better the outcome will be,” explains Lyckholm. “Instead of having patients wait for one of those very precious ICU beds, we may be able to get them either into our 11-bed unit or into the hospital with a palliative care consult, with the idea of eventually bringing them to our unit. That improves ED throughput, which is a really critical problem right now.”

The physicians and nurses in the ED don’t have a specific trigger for when to call for a palliative care consultation, but they have a “pretty high index of suspicion” when patients have a high degree of debility, or they are in the late stages of a disease, explains Lyckholm. However, she explains that patients don’t necessarily have to have a poor prognosis to benefit from palliative care; they could be experiencing very difficult symptoms such as a high degree of pain.

For example, a teenage patient with sickle cell disease who may have years to live but is in terrible pain, or an early-stage breast cancer patient who is having extreme difficulty with nausea from

chemotherapy, could both benefit from palliative care consultations, offers Lyckholm.

“The ED will call us about symptom management whenever they think someone is experiencing symptoms that are beyond the realm of a general physician treating them successfully,” explains Lyckholm, “or they will call when somebody has a poor prognosis and is presenting with an acute or chronic illness that they think might be better served with palliative care than an acute inpatient admission or admission to the ICU.”

In fact, the palliative care process is so well ingrained at VCUMC at this point that little, if any, time is lost when a patient who presents to the ED for care requires a palliative care consultation. “Sometimes we will see the patient at the same time ICU staff are meeting with the patient,” explains Lyckholm. “We will discuss what the goals of care are, and whether there is any chance this patient is going to get much better.”

During this discussion, patients and/or their families can make an informed decision about whether to opt for aggressive treatment in the ICU or palliative care, where their symptoms will be managed, and they can possibly be discharged that same day with hospice, avoiding an inpatient hospital admission, explains Lyckholm.

“The physicians and nurses in the ED are critical to getting us down there,” stresses Lyckholm. “We try to be very open to them even when they are calling us about a patient who we think is probably not a good candidate for palliative care. We will go down there no matter what because we want to keep the lines of communication open. The more that we see these patients, the better the outcomes.”

Understand the financial impact

It is not unusual to encounter patients in the ED who have no real understanding that they are in the final stages of a terminal disease, observes Lyckholm. “We may see a patient with late-stage cancer who has nausea and pain, and no one has talked with them yet about what their real prognosis is yet,” she says. “Sometimes what is required is lots of calls [to the patient’s other providers] and lots of discussion, which is another reason why the ED physicians appreciate having us come down because we can take more time to have the goals-of-care discussion, where we talk about what the patient’s preferences are and what they understand about their disease.”

There are definitely patients in these circumstances who opt for aggressive treatment, and that is their prerogative, explains Lyckholm. “We want

them to make a really good, informed decision... and to know that we can make them comfortable, and allow them to have some really good time without terrible suffering, and without being in the hospital.”

The strong palliative care presence at VCUMC has produced educational benefits in the sense that all hospital clinicians are now more knowledgeable about palliative care and skilled at discussing it with their patients, notes Lyckholm. “When we first started [the palliative care program] some of our very best customers were the neurosurgeons. They would have patients who came in with very severe head injuries, and they would do everything possible, but they would get to a point where there wasn’t anything else that could be done, and then they would call us,” she says. “They became very used to having family meetings, having discussions about goals of care, and transferring patients to us, so there is a lot of informal [education] that is happening, and it is very exciting.”

Further, while cost has never been the reasoning behind VCUMC’s palliative care program, there is no question that the cost of care goes down when patients avoid going to the ICU or avoid hospital admissions. “We have some pretty significant cost-of-care data that shows much improved cost margins,” adds Lyckholm. However, she stresses that offering palliative care options is not about the money. “It is important to know about [the financial impact] because there are really good administrative points to make when you want more funding and more people on your [palliative care] team, but we are not doing this for cost savings.”

Lobby for a palliative care consult team

While dedicated palliative care units are not very common in the hospital setting, there are still good palliative care options available to EDs. Lyckholm recommends that ED leaders lobby for the creation of palliative care consult teams who can respond to cases anywhere in the hospital, including the ED. “There are palliative care teams in many hospitals now. They may consist of a nurse practitioner and a social worker, and there may be a physician hospitalist who champions the approach,” she says. “We conduct about 1500 consults a year, and we go everywhere, from the ED to outpatient departments to the dialysis unit and the psych units.”

Further, even in hospitals that don’t have formal palliative care options, physicians and nurses can

be educated about how to identify patients who might be good candidates for palliative care, and how to have goals-of-care discussions. “Learning those skills goes a long way,” stresses Lyckholm.

Emergency department administrators can find a wealth of information, tools, and resources at Improving Palliative Care in the Emergency Medicine, an online portal that has been set up with the support of the Center to Advance Palliative Care and the Olive Branch Foundation: www.capc.org/ipal/ipal-em. ■

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ED flow facilitators make throughput center stage, achieve decreases in LWBS, LOS, and door-to-bed times

Position frees up charge nurses to oversee core measures, quality assurance, and staffing

On any given day, the ED at Mercy Hospital in Springfield, MO, has two zone captains acting as mini-charge nurses, for the east and west sides of the department. There is also an up-front triage nurse who is the first person most patients see when they walk in the door, and a lobby nurse who regularly rounds through the waiting room, taking vital

signs and monitoring patients who have yet to see a provider.

These types of personnel are common to many busy EDs, but in the fall of 2010, ED staff decided the department needed someone who could focus all of his or her energy on throughput. Yearly volume at the time was 93,000, but it was rising rapidly along with the left-without-being-seen (LWBS) rate, which was hovering in 8% territory at the time.

Administrators decided to put the problem in the hands of front-line staff to resolve, believing they had the best understanding of the issues involved. Consequently, the staff created a new position with the formal title of “ED flow facilitator,” although they often use different terminology, referring to person filling this position as the “bed wizard.”

Look for good multi-taskers

“The role of the bed wizard or ED flow facilitator is to monitor the in-and-out throughput on each zone, and she also takes charge of ambulance calls,” explains **Ted Shockley**, RN, CNRN, administrative director of the Emergency Trauma Center at Mercy Hospital Springfield. “We have anywhere from 60 to 80 ambulances that arrive between 11 a.m. and 11 p.m. every day.”

The ambulances were getting to be too much to handle at the triage desk, so it made sense to couple this task with the overall responsibility of managing flow, adds Shockley. “The flow facilitator assigns

EXECUTIVE SUMMARY

With volume and the left-without-being-seen (LWBS) rate on the increase, Mercy Hospital in Springfield, MO, created a new ED flow facilitator position to take charge of throughput. The ED flow facilitator is a nurse who assigns patients to the east and west zones of the department, and also handles all ambulance calls. The approach has helped the ED bring the LWBS rate from 8% to the 3% to 5% range, and it has also made a dent in length-of-stay and door-to-bed times, but rising volume continues to be a challenge. When the flow facilitators were first implemented in late 2010, yearly volume in the ED was 93,000. This year the ED is on track to see 97,000 to 100,000 patients, which is still very high compared to other EDs.

- Good flow facilitators are nurses with supervisor potential who typically prefer to stay involved with nursing care. They need to be able to multi-task and handle high levels of stress.

- Hospital administrators note that patient flow patterns need to be under constant review in order to fashion solutions that make sense for the ED.

patients, so her main job is to watch the flow of patients coming in through the waiting room to each zone, and to try to distribute the flow as equally as possible.”

While the zone captains coordinate with the flow facilitator, they focus on managing their respective areas, facilitating tests, taking in new patients, and getting patients discharged or admitted. “On rare occasions, the flow facilitator will take in a new patient,” says Shockley, but he stresses that the ED tries to avoid that because it takes the focus off of throughput. “As soon as she gets bogged down with patients, the whole team kind of slows down.”

Meanwhile, the charge nurse is able to oversee the entire department, focusing on core measures, quality assurance, and staffing. “They look several shifts down the line and make sure we are not short somewhere because doing a schedule for 200 people is tough,” says Shockley. “They concentrate on functional, departmental issues and the flow facilitator does throughput.”

The most challenging aspect of the job is finding space for higher acuity patients when the ED or hospital is overwhelmed, according to **Gayla Reynolds**, RN, one of the ED’s flow facilitators. This is the boarding issue that affects many EDs, and is associated with poor ED flow. “A typical bottleneck is when people have been seen and admitted, but the hospital has no beds or is waiting on discharges,” says Reynolds. To resolve the problem, flow facilitators usually call a hospital supervisor, who can then take steps to speed up the discharge process, she says.

What type of person makes a good flow facilitator? “They have to have a deep understanding of throughput, and generally we use nurses who have been here a while,” explains Shockley. Some of the flow facilitators would make good supervisors, but many prefer to stay involved with nursing care, he adds. “They may work as a flow facilitator two days a week, and then the other days of the week they will be a general nurse. They like that mix.”

Reynolds adds that flow-facilitators need to be able to multi-task, and to be “willing to get their hands dirty,” if need be, cleaning beds, or whatever is necessary to keep the patients moving. “It can be highly stressful, so flow-facilitators must be able to remain professional and to keep things in perspective,” adds Reynolds.

For solutions, listen to staff

The home-grown position has clearly delivered.

Within months of implementing the flow facilitator position, the LWBS rate declined to the 3% to 5% range, and there were also slight declines in length-of-stay and door-to-bed placement times, says Shockley, but he notes that managing volume remains a challenge as the daily census continues to climb. "We treated 95,740 patients last year, and we are now on track to see 97,000 or maybe even 100,000 this year," he says. "We had one day not long ago when we had 31 walk-in patients in one hour, and I only have 45 rooms."

Other busy EDs could definitely benefit from the use of patient flow facilitators, says Shockley, but he emphasizes that each ED needs to fashion a solution that fits its own circumstances, and it is critical to stay on top of patient use patterns. "You can't do the same staffing pattern when your patient patterns change," he says. "We look at [our numbers] at least quarterly, if not more," he says.

Shockley also advises ED administrators to look to their front-line staff for solutions when trying to improve a process. "Sitting back in this office from the 30,000 mile mark, I don't know all the details," he says. "The staff came up with the idea for a patient flow facilitator, and it is working quite well." ■

SOURCES

- **Gayla Reynolds**, RN, ED Flow Facilitator, Emergency Trauma Center, Mercy Hospital, Springfield, MO. Phone: 417-820-2115.
- **Ted Shockley**, RN, CNRN, Administrative Director, Emergency Trauma Center, Mercy Hospital, Springfield, MO. Phone: 417-820-2000.

OIG Report: Only a tiny percentage of adverse events being reported by hospitals

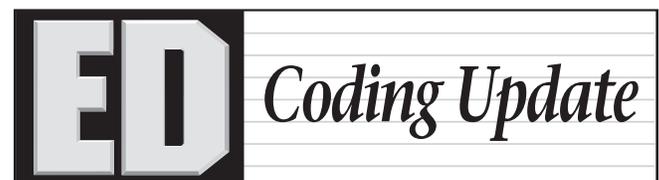
There is new evidence that hospitals are failing to report incidents of patients being harmed during medical treatment. The Health and Human Services' Office of Inspector General (OIG) reports

that while half of the states have reporting systems in place for adverse events, a paltry number of these incidents are being brought to the attention of authorities.

The findings come from a review the OIG conducted of a nationally representative sample of 780 Medicare beneficiaries hospitalized in October of 2008. The OIG found that while 60% of patient harm events occurred at hospitals in states that have reporting systems in place, only 12% of the events met state requirements for reporting. The OIG also found that hospitals only reported 1% of adverse events.

The OIG suggests that the low level of reporting to state systems is likely due to hospital staff being unaware that patient-safety incidents are reportable events. However, it stresses that it is an issue that states and providers need to consider as they develop strategies aimed at reducing adverse events.

In earlier reporting, the OIG found that that roughly 27% of the Medicare beneficiaries in the same 2008 sample experienced harm resulting from medical care. As a result of this and other reports, officials say that hospitals are implementing systems and processes aimed at reducing the risk of harm as well as the likelihood of human error. ■



The controversy over billing for EKG/rhythm strip interpretations in the ED

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

Increasing payer scrutiny over diagnostic interpretations and continued belt-tightening at the private payer level has resulted in a resurfacing of the EKG interpretation payment issue for emergency physicians. There is no doubt that the

interpretation of diagnostic tests for ED patients is an invaluable service. However, payer audit departments seem to be increasing their scrutiny of many ED-based diagnostic interpretations, and are attempting to bundle this service into the E/M level or deny the services outright.

Thus, two very separate issues remain. The first, do Medicare and private payers pay for EKG interpretations in the ED? The answer is “yes” for Medicare and varies from one private payer to the next. The second and an increasingly troublesome issue is, once paid, does the documentation in the record appropriately provide the rationale for the test as well as evidence that a formal interpretation was provided when the record is audited? If you are getting paid for this valuable service you may still want to review the rules governing interpretations to assure you won’t lose your audit appeal if audited.

The two most frequently billed EKG interpretations in the ED are:

- 93010 (Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only); and
- 93042 (Rhythm ECG 1-3 leads; interpretation and report only).

Some requirements to bill for the interpretation of these services include:

- There must be a specific order;
- Following the order, there must be a separate, signed, written and retrievable report;
- Documentation should provide the rationale to support the need for the service as well as the detailed interpretation report, which does not need to be on a separate record but must be a separate entry in the ED record.

93010 EKG Interpretation

Medicare rules have been clarified over the past years, and private payers have their own policies for payment of EKG interpretations. Per Medicare clarifications, the interpretation and report should address current findings, relevant clinical issues, and comparative data when available. Recent carrier audit activity indicates Medicare auditors are looking closely at the comparative data issue and denying payment when it is not documented, so it’s a good idea to provide comparative data when it is available and clearly reference when it is not, as part of the formal interpretation.

Medicare will pay for the interpretation that contributes to the diagnosis — the contemporaneous reading in the ED rather than an over-read

after the patient has left the ED.

Medicare differentiates between a review and a formal interpretation, so documentation of the interpretation that is billed separately from the evaluation and management service must clearly support that the ED provider is writing the official interpretative report which should address the pertinent elements of the following:

- Rhythm
- Rate
- Axis
- Intervals
- ST segment change
- Comparison to a prior EKG
- Summary of clinical condition and findings.

Although Medicare has not officially clarified how many of these elements must be addressed in a formal interpretation, industry standards for the ED seems to require at least three.

A review is not a separately billable service. The value of a review is included in an evaluation and is not separately billable. So, the documentation must specify the elements of an official interpretation in order to be a separately billable service.

93042 Rhythm Strip

This service is often billed inaccurately when the physician simply reviews the telemetry monitor strips generated by the monitoring system. In order to bill for a rhythm strip interpretation, there must be a diagnosis or triggering event documented in the medical record. Also, stay clear of ordering an EKG interpretation but bill for a rhythm strip if payers don’t reimburse for EKG interpretation, but *do* bill for rhythm strip interpretations. You should bill for the service that most accurately describes the service you provide.

COMING IN FUTURE MONTHS

- Managing the intake and care of patients from a violent attack
- Streamlining the transition from ED to hospital inpatient
- Can technology play a role in curbing non-emergent use of the ED?
- How to leverage patient navigators in the ED

What about residents and teaching physicians?

If the resident prepares and signs an interpretation, the teaching physician (TP) must indicate that he or she personally reviewed the image and the resident's interpretation, and that he or she either agreed with or revised the findings. Medicare does not pay for an interpretation if the TP only countersigns the resident interpretation. To be payable to the TP, the TP must personally provide an identifiable and separate service. (CMS Transmittal 2303 September 14, 2011).

Internal reviews of your billed EKG and rhythm strip interpretations should be performed on a routine basis to assure you can defend your billing of these services if audited. ■

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CNE/CME INSTRUCTIONS

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

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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. **Douglas Hough**, PhD, an associate professor at both the Carey Business School and the Department of Health Policy and Management in the Bloomberg School of Public Health at Johns Hopkins University, refers to the potential for "a revolution of rising expectations" in response to health care reform. What is he referring to?
A. Demand for care will skyrocket.
B. People will think that there is no need for additional reform.
C. People will make increasing demands on their providers.
D. Newly insured people may think they can access a primary care provider, but then resort to using the ED for care because there is a shortage of PCPs.

2. To take pressure off of EDs, **Matthew McHugh**, PhD, CRNP, MPH, JD, an assistant professor of nursing at the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing in Philadelphia, PA, believes that states need to do more to:
- drive hospital efficiency
 - leverage the expertise of nurse practitioners and physician assistants
 - train more primary care physicians
 - fund more outpatient clinics

3. Under the Medicaid expansion provisions of the Accountable Care Act, the federal government will initially pick up how much of the tab for caring for newly insured Medicaid patients?
- 100%
 - 90%
 - 75%
 - 50%

4. A new study suggests that the ED's traditional focus on stabilization and triage is far from ideal for what group of patients?
- children
 - people with chronic disease
 - patients nearing the end of life
 - domestic abuse victims

5. **Laurie Lyckholm**, MD, director of the Virginia Commonwealth University School of Medicine's Hospice and Palliative Medicine fellowship program, says that even in hospitals that don't have formal palliative care options, doctors and nurses can be educated about how to identify patients who would be good candidates for palliative care and how to:
- deliver comfort care
 - have goals-of-care discussions
 - establish links with outside resources
 - adjust treatment regimens

6. According to **Gayla Reynolds**, RN, an ED flow facilitator at Mercy Hospital in Springfield, MO, the most challenging aspect of the flow facilitator job is:
- finding space for higher-acuity patients when the ED or hospital is overwhelmed
 - coordinating with the zone captains and charge nurse
 - communicating with ED physicians
 - staying on top of housekeeping to prepare rooms

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ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

Standards governing ED patient flow, patient boarding are strengthened

Ultimate responsibility for action is pushed up the chain of command

As demand for emergency care continues its upward climb, The Joint Commission is taking steps to strengthen its accreditation standards pertaining to patient throughput, and it is putting hospital leaders on notice that they will be held accountable for patient flow challenges that occur in the ED.

Under revisions to Standard LD.04.03.11, it will soon no longer suffice for hospitals to simply measure elements of patient flow. Hospital leaders will also have to use this data to set goals for improvement, explains **Jeannie Kelly**, RN, MHA, LHRM, an expert on risk management and quality assurance at Soyring Consulting in St. Petersburg, FL.

“This involves setting goals and reporting them up to leadership so that the CEO, COO, and CNO all know what is going on, and they are charged with making sure that [problems] get fixed,” observes Kelly. “In the past, [the requirements] never went up that

high. Managers had to be aware of what was going on, but now The Joint Commission has really pushed it up the chain of command to hospital leadership, and I think that is very important because they are the ones with the power to make things happen.”

Further, The Joint Commission has expanded the standard to include all areas where patients receive care, treatment, and services, including inpatient units, laboratory, operating rooms, telemetry, radiology and PACU, as well as support services such as housekeeping and patient transport, observes Kelly. “This allows department managers and leadership to identify issues that impact patient throughput,” she stresses. “Hospital leadership must take action to ensure that barriers, whether real or imagined, are removed so that patients are either admitted or transferred as appropriate.”

Kelly suggests that data associated with the patient flow process could be part of the hospital’s Quality Assurance and Performance Improvement (QAPI) plan. “This provides a ready-made platform for performance measurement and evaluation,” she says.

EXECUTIVE SUMMARY

The Joint Commission has revised its standards regarding ED patient flow and patient boarding so that hospital leaders must establish measures, set goals, and take responsibility for resolving throughput challenges. Some experts applaud the change, noting that problems with ED crowding often require system-level solutions.

- Experts suggest that one way for hospitals to meet the new standards *and* drive improvement is to make patient-flow goals part of the hospital’s Quality Assurance and Performance Improvement (QAPI) plan.
- Hospitals and EDs need to look at how they will address behavioral health patients who are waiting for transfer to another facility. Safety needs to be the key consideration.

Boarding: Safety needs to be the priority

The Joint Commission has also revised Standard PC.01.01.01, which covers the issue of behavioral health patients who present for care to the ED, and the common practice of boarding these patients in the

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department while other care arrangements are made.

The revisions state that hospitals that do not primarily provide psychiatric care or substance abuse services must have a written plan of care that “defines the care, treatment, and services or the referral process for patients who are emotionally ill or who suffer the effects of alcoholism or substance abuse.” And the agency recommends that patients should not be boarded for longer than four hours.

Further, the revisions spell out specific standards that need to be met when behavioral health patients are boarded while awaiting care. “Patients with behavioral issues should be monitored in a safe area that is clear of items that the patient could use to harm himself or others,” explains Kelly. “Also, patients need to be medically stabilized before transfer. Psychiatric issues can be caused or exacerbated by medical conditions. Failure to properly medically assess patients can lead to negative outcomes, including EMTALA violations.”

Kelly acknowledges that meeting these standards will be challenging, as most EDs are not physically set up to monitor patients with behavioral health or substance abuse issues for an extended amount of time. “[Hospital administrators] are going to have to start looking at where these behavioral health patients are going to be held while they are awaiting transfer,” she says. “And they are going to have to look at it from the point of view of safety.”

Revisions will assist over-burdened EDs

Sue Dill Calloway, RN, CPHRM, AD, BSN, MSN, JD, president, Patient Safety and Health Care Consulting, Dublin, OH, and chief learning officer, Emergency Medicine Patient Safety Foundation, based in Folsom, CA, believes the revised standards will help to provide ED administrators with the kind of support they need to resolve patient throughput problems. “It is not an ED problem, it is a hospital problem,” says Calloway. “So hospital leaders need to be doing studies and coming up with ways to mitigate problems with patient flow.”

Calloway notes that the leaders of all the major emergency medicine organizations recognize hospital overcrowding and the practice of boarding patients in the ED as among their top challenges. However, she stresses that many of these problems require system-level solutions.

“I was visiting a hospital that had a six-bed ED hold that was staffed not by ED staff, but behavioral health staff,” she says. “Leadership needs to do that. The ED can’t do that alone.”

In another instance, hospital leaders stepped in with

a creative solution for an ED that had 20 boarded patients. “They decided that they would put one of these patients on every unit,” she says. “It was a lot more manageable to have one additional patient on each unit than it was to have 20 sitting around the ED, so again, that was a leadership solution.” ■

SOURCES

- **Sue Dill Calloway**, RN, CPHRM, AD, BSN, MSN, JD, President, Patient Safety and Health Care Consulting, Dublin, OH, and Chief Learning Officer, Emergency Medicine Patient Safety Foundation, Folsom, CA. E-mail: sdill1@columbus.rr.com.
- **Jeannie Kelly**, RN, MHA, LHRM, Health Care Consultant, Soyring Consulting, St. Petersburg, FL. Phone: 866-345-3887.

Six health care organizations sign on to participate in project aimed at curbing sepsis mortality

Hospitals and EDs across the country continue to struggle with how to most effectively identify and treat patients who present with sepsis or develop the condition sometime after they have been admitted. The Joint Commission (JC) reports that sepsis is the leading cause of death in hospitalized patients, and it is also the most expensive condition to treat, costing hospitals upwards of \$17 billion annually.

For all of these reasons, the JC’s Center on Transforming Healthcare has decided to tackle sepsis mortality head-on for its eighth project. It has assembled a team of six health system participants to both identify barriers to effective care and devise solutions to improve patient outcomes. (*See “Project team for participants for reducing sepsis mortality,” p. 4*) The ultimate goal of the project is a targeted solutions tool that will be shared with the JC’s 19,000 member institutions.

The task is a tall order, but also just the type of challenge that the Center for Transforming Healthcare — a separate entity from The Joint Commission’s accreditation arm — was set up to take on, according

to **Donise Musheno**, RN, MS, center project lead at the Center for Transforming Healthcare. “Every year 750,000 Americans are diagnosed with sepsis and 220,000 of these people die, so the mortality rate is 30%,” she explains. “When we looked at the statistics around this issue, we certainly saw a burning platform.”

Early detection is challenging

Sepsis, or the body’s own life-threatening, inflammatory response to an infection, can result from pneumonia, a urinary tract infection, a surgical site infection, or any other infection site, says Musheno. “The signs and symptoms of sepsis are really the signs and symptoms of an infection until it gets to the very late stages, so it is challenging to detect.”

Thomas Russell, MD, assistant chief, Department of Emergency Medicine, Roseville Medical Center, Roseville, CA, agrees, noting that simply identifying that there is a risk is the most difficult aspect. “Several of the tools that have been talked about overlap with disease entities other than sepsis. For example, specific criteria can be positive in a pregnant woman, an asthmatic, and many people who have no infection at all, so identifying the sepsis patient is difficult,” he says. “While there are vital sign triggers, historical triggers, and laboratory tests that can be done, no one piece of it is diagnostic. It actually takes accumulating multiple pieces to put the disease in context so that it can be identified.”

Once a case of sepsis is confirmed, the complexity continues as the patient needs to be risk-stratified to

determine the proper course of treatment. “Sepsis actually represents a continuum of illness,” observes Russell. Clinicians must decide when to be aggressive and when to take a more conservative approach, he says. “Risk-stratifying into that spectrum is something that really has not been well discussed in the medical community.”

However, it is an area that Kaiser Permanente has investigated extensively, so the organization is bringing that knowledge base to the table as a participant in The Joint Commission’s sepsis project. “We have quite a robust division of research, and it has enabled us to look at well over 20,000 cases, and to use those cases to risk-stratify sepsis patients,” explains Russell. “So we have some clues on which patients we can be more aggressive with and which ones we can be more conservative with.”

Key skill lacking in many EDs

What’s missing at this point, especially in ED settings, is a systematic approach for identifying and treating the sepsis patient, explains **Boris Khodorkovsky**, MD, FACEP, assistant director, Emergency Medicine Department, Staten Island University Hospital in Staten Island, NY, which is part of the North Shore Long Island Jewish Health System. “When people are doing different things, you don’t really create a unified front,” he explains. “By decreasing variations you can create a better effect, and you can also decrease the wait. Unfortunately, there is still a lot of time wasted on doing things that are completely unnecessary, so if we create a tool, establish goals, and reduce sepsis mortality, then we will have succeeded in creating a benefit and eliminating the waste.”

However, while experts agree that a systematic approach is important, many EDs lack an important skill set that is integral to a systematic approach for treating the sickest sepsis patients — and that is the placing of central lines, says Russell. “Over the last decade or so, many ED physicians moved away from placing central lines. We had other options and other ways of doing things that had traditionally been done by using central lines, so the skills have been lost by many ED physicians,” he explains.

Musheno, who worked as an ED nurse before coming to The Joint Commission, agrees, noting that central line access is a barrier for many EDs when they first start looking at a sepsis initiative. “Some organizations have residents or interns who can provide central line support, but other organizations often have to rely on critical care teams to come to the ED to place

EXECUTIVE SUMMARY

Recognizing that sepsis is the leading cause of death in hospitalized patients and a huge drain on health care resources, The Joint Commission’s Center for Transforming Health Care, is taking aim at the problem in a new project that is already underway. Six participating health care systems are working to develop a targeted solutions tool that Joint Commission members can use to reduce the incidence of sepsis in their own settings.

- Sepsis is difficult to identify because the signs and symptoms are often subtle, and they mirror the signs and symptoms of other conditions.
- Many EDs face logistics barriers that can hinder response times. For example, ED physicians in many systems no longer place central lines, a key component of care in serious sepsis cases.
- Screening tools used to identify sepsis in adults have no validity in children, making identification of sepsis in youngsters particularly difficult.

central lines,” she explains. “That, of course, leaves the ICU not covered for a period of time, so it all about resources and time.”

Bringing this skill back, and enhancing it with the use of ultrasound so that placing a central line is no longer a blind procedure, has been a significant challenge for emergency medicine, says Russell. While placing a central line is an invasive procedure that has been associated with infections, Russell points out that with proper technique and diligence, central line infections can be dramatically reduced. “In our 21-hospital system in northern California, our central line infection rate is well below national averages, and it is simply because we are very aggressive at removing central lines when they are no longer needed,” he says.

Another area that needs more attention is the identification and treatment of sepsis in children. “The screening tools we use for adults have virtually no validity in children. We have to have a whole new screening system for children which is, frankly, somewhat in development,” says Russell. “This is one of the big challenges in sepsis care, and it is one of the reasons why Kaiser Permanente is participating in The Joint Commission sepsis project — to look at tools for screening for sepsis in children.”

Working with the six participating health care organizations, the Center for Transforming Healthcare will leverage its own Robust Process Improvement (RPI) methods to identify problems and develop solutions to reduce sepsis mortality. The RPI approach borrows heavily from the Lean Six Sigma and other change management methodologies to develop data-driven solutions. Musheno emphasizes that the project has an aggressive timeline for results. The goal is to make a web-based, targeted solutions tool available to all member organizations by the end of 2013. “This is important,” stresses Musheno. “We need to move on this and make sure it gets out there.” ■

Project Team Participants for Reducing Sepsis Mortality Project

- Atlantic Health System, NJ
- Floyd Medical Center, GA
- Kaiser Permanente, California
- Nebraska Medical Center, Nebraska
- North Shore Long Island Jewish Health System, New York
- Texas Health Resources, Texas ■

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