

**Frequently Asked Questions**

**May 9, 2012**

**ER is for Emergencies**

**Seven Best Practices**

**1. How many hospitals need to adopt these seven best practices?**

The legislation requires hospitals representing 75 percent of Medicaid ER visits in 2010 to attest they have adopted all seven best practices. If enough hospitals do so by June 15, 2012, hospitals and ER physicians will avoid implementation of the no-payment policy on July 1, 2012. These best practices will improve care in our state by better linking patients to a primary care provider. All hospitals need to participate because the state legislature is expecting the best practices to produce $31.2 million in savings over the next year.

**2. Do the seven practices negate the need for hospitals to comply with EMTALA? *(New)***

Hospitals still need to provide the proper medical screening and stabilization as required by federal law through EMTALA. Emergency department staff may provide the patient education on accessing health care in the appropriate settings during the ED visit. This is not in lieu of the ED visit but meant to help educate patient and prevent future unnecessary visits.

**3. Is the state's expectation that these seven best practices would also be implemented for Medicaid Managed Care patients?**

Yes, these measures apply to all Medicaid patients including managed Medicaid and fee-for-service.

**4. Should the attestation process be taken seriously?**

Yes, hospitals must take this seriously because the attestations are going to a government agency and could be audited. Hospitals also need to take this seriously because commitments were made to the legislature regarding the amount of savings these best practices will generate. Working with the Washington State Medical Association and the Washington Chapter of the American Academy of Emergency Physicians, we told legislators implementation of the best practices would save $31.2 million over the next year. The alternative was a $38 million cut to hospitals. If we do not demonstrate sufficient savings by January, the state could implement the no-payment policy in 2013.

**5. How are primary care providers being included and educated on this program?**

Collaboration with primary care providers is essential to the success of this transformation. The Washington State Medical Association (WSMA), Washington Chapter of the American College of Emergency Physicians (ACEP), and primary care providers have been key members in the ED Workgroup in formulating the best practice guidelines. Both WSMA and ACEP are working closely with the primary care community.

**6. How much savings is needed by January 15, 2013 as determined by HCA to prevent additional penalties?**

The legislature is looking for progress. The first goal is to meet the attestation requirement by June 15, 2012 or the state will implement the no-payment policy in July 2012. The next step is an evaluation of savings as of January 2013. Hospitals must demonstrate the state will achieve a reduction of $31.2 million by June 30th, 2013. Measurable progress must be shown when the legislature reconvenes in January 2013.

**7. Are CAHs exempt? What happens if they cannot afford an information system?**

All hospitals are strongly encouraged to participate. In the best practices, a Critical Access Hospital can be exempt from the requirement to purchase the electronic health system if it would cause demonstrable financial burden, but not from meeting the additional best practices. Any CAH that does not purchase an electronic health system must submit its financial justification with the attestation due on June 15, 2012.

If a critical access hospital determines it is unable to purchase an electronic health system for exchange of information it will need to work with the ED Workgroup on an alternate plan to meet the best practice guideline. If your facility needs to pursue an alternative please notify ambert@wsha.org at WSHA soon so we can discuss alternative arrangements with the ED workgroup.

**8. Our hospital is surrounded by CAH facilities. How effective will information exchange be for us, if neighboring facilities do not use an electronic information exchange system?**

Critical access facilities will need to include how they will exchange information in their region in their alternate plan.

**Best Practice A: Electronic Health Information**

**1. What is the timeline for implementing the best practice on the information exchange? Is it realistic to have this in place before June 15, 2012?**

Yes, we believe it is realistic. While the goal is to have the system implemented by July 1, it is sufficient for hospitals to attest they have a purchase order in place by June 15, 2012 and that the hospital expects the system to be operational by October 1, 2012.

**2. How does an emergency department information exchange system fit into a pure pediatric ED setting? Will we be required to check every ED patient arrival?**

Yes, an information exchange that meets the guidelines will need to be implemented for pediatric hospitals. Studies have shown that pediatric patients make up a significant percentage of low acuity visits with ear infections and other such ailments.

**3. Will an information exchange system work with the Health Information Exchange?**

Yes, we are told that these systems can be made to work with one another.

**4. Does the emergency visit information exchange system need to integrate with the hospital’s electronic medical record?**

The hospital information exchange will link with your admitting system so that information can be sent over at to help inform care providers while the patient is in the emergency department. Additional linkages are being done in some hospitals to provide information that a patient is a PRC client as the clinician charts in the electronic medical record.

**5. How fast and how does EDIE work? *(New Question)***

Turnaround time for the fax is likely to be less than 5 minutes. The fax report from EDIE includes all emergency department patients not just Medicaid. PRC patients are automatically included in the fax based on a monthly file which the Health Care Authority sends EDIE. There is also automatic calculation of the number of visits the patient has had in the last twelve months. EDIE uses a rolling twelve month cycle.

The hospital will be responsible for acting on the information and putting or updating the care plan.

EDIE has been implemented in with most types of computer systems in Washington. EDIE has been successfully implemented at facilities with EPIC, Meditec and Healthland. CPSI can vary and would require a conversation with your facilities analyst and EDIE. The uplink and downlink are done through standard connections such as VPN and HL7.

**6. What about system down time? How often? How long? *(New Question)***

Per conversations with EDIE their longest downtime has been 5 hours but that was very unique situation. They have imbedded double and triple redundancy and deploy updates at lowest census times.

**7. Since Fax, HTML, and EHR integration are all possible and fax seems the quickest minimum requirement, what are the additional advantages of tighter integration options to the ED provider and to the goal of reducing unnecessary ED visits? *(New Question)***

Some of the advantages to doing a tighter electronic integration for the inbound notifications are:

1. The information can be introduced to the physician without having to change processes or workflow in the ED.
- With the fax you have to decide where the notification will be faxed to and who will check the fax and pick it up. You have to train a staff member will need to be trained to know what the EDIE notifications look like and what to do with them when they arrive. In some instances, there is not a fax nearby and faxes can be overlooked. These issues can be addressed (this is the approach several hospitals have taken) but it adds extra steps that could prevent a timely delivery of the notification to the physician or care manager.

2. The information gets pushed into the EHR automatically so the hospital does not have to worry about where to put it for legal discoverability issues
- Some hospitals have a little difficulty knowing what to do with the fax once they've received it in terms of where to save it to their EHR.

Some of the disadvantages of the electronic integration are:

For the CAHs having the notification come in electronically can increase their cost. For the hospitals using CPSI it doubles their interface costs to around $10,000.

**8. Does EDIE currently notify the PCP when a PRC patient comes to the ED? *(New Question)***

EDIE can be set up to fax to a primary care physician regarding a visit by a PRC client.

**9. Can anyone from the hospital access EDIE via the website? What information is needed to access the EDIE website? *(New Question)***

Initial user accounts are created on signing and the facility manages users after go-live.

**10. Will the managed Medicaid patients’ information be in EDIE? *(New Question)***

Currently, Fee for Service and Molina patient information is available in EDIE. The EDIE leaders are currently looking into how they can get all the plan information in the system.

**11. Can you enter a patient’s information who is not Medicaid into EDIE? *(New Question)***

Yes, care plans can be entered for any patient regardless of payer.

**12. What is the average yearly cost of EDIE per year? Is there a cost per user at one facility or a flat fee? *(New Question)***

The average cost varies by the size of your facility and how many ED visits it has per year. EDIE does not charge a per user licensing fee. If your hospital is having difficulty affording EDIE, contact Adam Green for a discussion.

**13. Does EDIE have any standard reporting capabilities? If so, is the reporting available at the individual facility as well as the overall system levels? *(New Question)***

EDIE does have reporting capabilities which are currently undergoing enhancement to support the Best Practices.

**14. Regarding EDIE care guidelines & patient interaction fields- Are the template guideline fields modifiable by the hospital? *(New Question)***

EDIE is open to modifying the template. The facility should contact EDIE and explain what they would like to see on the template. They are trying to standardize the template across all facilities as much as possible for consistency, but can work with facilities on individual needs.

**15. How is patient health information (PHI) protected in EDIE? *(New Question)***

EDIE has provided the following summary of measures they use to protect PHI from being accessed inappropriately.

**Data Center**
- 24/7 guarded facility
- two factor security feature (id badge + biometric hand scan) to enter facility
- servers are under lock and key with only two people having access to them
- data center is fully redundant with environmental controls, power, and internet connectivity

**Servers**
- partitioned networks (firewall/lan) to prevent attack surface to public
- server software has been hardened according to best practices
- PHI at rest is encrypted
- restricted access by CMT employees (only two people have access to servers with PHI data on them)
- all unused ports locked down
- only white list IP addresses allowed to connect to public facing servers (we proactively filter out traffic from Russia, China, and anywhere outside US)

**Website (user connection to EDIE)**
- username / password OR SSO required to access site
- information is encrypted (HTTPS)
- can do IP filtering for facility

**Interface (facility/system connection to EDIE)**
- done over VPN

For people who should have access to EDIE (physicians, care managers etc.) we prevent inappropriate access of PHI with the following measures.

All of the above plus,

EDIE Data Share MOU
EDIE Terms of Use
Facility BAA
Establish that a treatment relationship exists at the facility prior to allowing a provider to access that information. Basically, the providerhas the same access/limitations on searching for PHI as he/she does with the facility's EMR.

**Best Practice B: Patient Education**

**In an attempt to educate the Medicaid clients on our facilities plan should the hospital attempt to mail out educational pamphlets? *(New Question)***

This is not currently a requirement of the practice guideline but would be helpful for your patients. There has been some discussion on the Health Care Authority helping to educate.

**Best Practice C and D: Patient Review and Coordination Program (PRC)**

**1. How do hospitals get a list of PRC clients?**

The Health Care Authority will send a list of PRC clients to hospitals specified contact monthly. The information system will also provide that information electronically.

**2. Do clients know they are on the PRC program?**

Yes, clients are made aware that they are on this program related to high utilization. They don’t always recognize the PRC terminology. Sometimes they understand the term restricted program. They are given an opportunity to pick a pharmacy, a primary care physician, and hospital. If they do not make these choices themselves, their preferred service providers are assigned to them. This communication is done in writing to both the patient and providers.

**In Best Practice D: PRC Client Care Plans**

**1. What is considered as a "substantial effort” to make an appointment with a primary care provider (PCP)?**

The guideline stipulates that a “documented attempt” must be made to notify the primary care provider within a maximum of 72-96 hours. Ideally, hospitals would have an established process to contact the PCP during business hours for current patients and a process for those seen during off hours.

**2. EDIE can generate a notification report. Is that adequate documentation of communication? *(New Question)***

It depends upon the severity of the illness of the patient. There are times there should be physician to physician conversations. Ordinarily, this would meet the purpose of notifying the primary care provider for the afterhours contact or when contact could not be made during the ED visit and a follow-up appointment is not needed.

**3. Who is responsible for creating the care plan and what if they don’t have an assigned PCP?**

Care plan should be started and updated as soon as possible for patients who are having frequent visits and are PRC clients.

**4. Are there guidelines or restrictions on who can provide case management in the ED?**

There is currently no restriction on how hospitals meet this function. The decision should be based on what is most effective for your hospital.

**5. These best practices seem to concentrate on patients with review and coordination. Are these the patients considered frequent users?**

HCA believes many PRC patients are a prime target for this work since many use too many ER services. Frequent users, however, are defined as any patient who has visited the emergency room five times or more in the past twelve months.

**6. Is the PRC program the same as *Restricted*? *(New Question)***

Yes, this program has also been referenced as the “Restricted” program.

**7. When will we start receiving PRC lists from the HCA? *(New Question)***

Hospitals are already receiving the PRC client list. The majority of these are sent by mail to the ED Director or Manager. If you do not know who is receiving your list or would like to change how the list is received please contact Scott Best at bestse@dshs.wa.gov.

**8. Are the PRC clients able to change their provider during the time that they are on PRC? *(New Question)***

Yes, PRC clients can change their provider one time per 12 month period. They can also change providers if they move, their current provider moves, or if their current provider chooses to no longer accept them as a patient.

**9. How many PRC clients are there in the state? Can you provide the range in terms of numbers of PRC clients per hospital? *(New Question)***

Currently, there are about 3600 clients in the state. The number of PRC clients per hospital varies greatly anywhere from zero to 200 patients.

**10. The guidelines require care guidelines be set up on each PRC patient. Do we need to begin care plans on each patient who hits 5 or more visits in the year? *(New Question)***

Although you are not required it would be recommended to set up a care plan so that care can be better coordinated to prevent the need for additional visits.

**11. Do care plans developed on a health information exchange become part of the legal medical record for hospitals? *(New Question)***

This would be decided by the hospital on what works best for them. However, there should be some form of documentation in the record that these guidelines were used in the patient’s care and treatment.

**A webcast was provided on Tuesday, May 1, 2012 on the PRC program. Those slides are on the WSHA website at** [**http://www.wsha.org/0443.cfm**](http://www.wsha.org/0443.cfm)**.**

**There is also a PRC FAQ sheet at** [**http://hrsa.dshs.wa.gov/prr/Frequent\_Questions.htm**](http://hrsa.dshs.wa.gov/prr/Frequent_Questions.htm)

**Best Practice E and F: Prescription Monitoring and Narcotic Guidelines?**

**1. Will valid data for Best Practice E: Prescription Monitoring be available to work with providers who are not achieving the benchmarks?**

We are working with the state to have data available by individual physician. Hospitals will be responsible for acting upon this information.

**2. Where is the educational materials for emergency room physicians?**

Videos has been created by the Washington State Medical Association, along with the Washington Chapter of the American College of Emergency Physicians and WSHA to help hospitals and providers rapidly implement the changes needed to decrease the number of low acuity Medicaid emergency room visits and avoid the state enacting payment cuts implement the best practices. The videos can be found on the [WSMA YouTube channel](http://www.youtube.com/user/WSMAVideos?feature=mhee). All feature Dr. Nathan Schlicher, a leader of this effort and a great spokesperson. They are:

* Overview of the seven best practices
* Role of primary care and community physicians in achieving ER is for Emergencies
* Narcotics guidelines and the prescription monitoring program

**3. Can an institution or group sign up ED providers in the Prescription Monitoring Program or do the providers need to do this on their own?**

Each physician will need to register individually. To avoid registration difficulties, the provider needs to ensure all of the numbers in their license are used including the zeros in the beginning.

**4. For teaching hospitals, are residents who rotate through the Emergency Department for only one month at a time, required to register for the PMP?**

Residents will not be required to register for PMP.

**5. Will EDIE be available in the Prescription Monitoring System?**

This is currently something that is being researched in an attempt at one-stop shopping for providers.

**6. Is there a plan for integrating non-ED narcotic prescribers in the Prescription Monitoring Program?**

This system is available to all prescribers of narcotics and is not restricted to just emergency physicians.

**7. What proof is needed to demonstrate compliance?**

It is best if you have the email from the PMP confirming enrollment. As this is not always possible, a physician may attest that they have enrolled.

**Best Practice E: Feedback Reports**

**1. For its feedback reports, will the Health Care Authority define low acuity visits solely by the latest diagnosis code list or will they also exclude cases qualifying for Expedited Prior Authorization as under their previous draft policy?**

HCA will use the list of 500 codes.

**2. When will the list of performance metrics be available? What is the baseline timeframe? How often will these need to be reported? Where do reports need to be filed? Benchmark data will be from what timeframe?**

The state is working to get the reports together for the performance metrics. The list will be out in May.

**3. How are you going to demonstrate to the state that we are saving dollars by Jan 2013? *(New Question)***

The ED workgroup is in the process of defining the measures. The report will focus on data related to frequent users of the ED and evaluation of narcotic prescribing practices. The group is working very hard to limit the hospitals burden related to the data collection and reporting.

**4. Will those "outlier" hospitals be notified in advance by WSHA or HCA that they are "outliers" and should take proactive action? *(New Question)***

WSHA, WSMA, and ACEP will strongly encourage HCA to notify outlier hospitals so that they can take proactive action.

**Resources**

Additional information is available at http://www.wsha.org/0443.cfm.

A recording of all the ER Is For Emergencies web casts and the accompanying slides have been posted on our website. http://www.wsha.org/webcasts.cfm.

The Patient Education Brochure can be downloaded at: <http://www.wsha.org/0443.cfm>

It is available in English and Spanish

**PRC FAQ** [**http://hrsa.dshs.wa.gov/prr/Frequent\_Questions.htm**](http://hrsa.dshs.wa.gov/prr/Frequent_Questions.htm)

Narcotic Guidelines <http://www.wsha.org/ernarcotics.cfm>