Alaska ACEP Recommendations for Medicaid Redesign

The Alaska chapter of the American College of Emergency Physicians shares the goals of Medicaid redesign. We would like to help seize the opportunity to improve patient outcomes, optimize access, increase the value of services, and provide cost containment for all patients, not just Medicaid enrollees.

Improved Patient Access to Appropriate Care: Focus on coordinating care between ED's and further outpatient care has been shown in Washington state to save Medicaid dollars. When patients have Medicaid we should be able to assess, treat, stabilize, and, when they do not require admission, point them toward timely primary care and specialist follow up. This will decrease revisits, potentially avoid admissions, and decompress waiting rooms. It may also help decrease individual ED visit time and cost when we feel confident appropriate further work up will happen. (1,4) We specifically suggest doing this by the following suggestions.

1. **Assigning Primary Care Physicians at Time of Enrollment**: Making enrollment as simple as possible and assigning a PCP at time of enrollment will create an immediate medical home. This would also improve patients' access to care, as they know where to start and have an advocate for their health. PCP information could be available every time a Medicaid Patient uses their insurance so pharmacies, ED, specialist, case works can all easily identify the medical "home" for this patient. This would help provide continuity of care to patients, reducing redundancy in testing or delayed preventive care. The State will need to create an adequate network of primary care physicians in all regions to achieve this. Adequate compensation and a model that does not shift risk onto primary care will be necessary. (4)
2. **Encouraging Participating Primary Care Providers to Hold "Urgent Openings" for ED Follow Up:** Access to primary care follow up will help avoid repeat ED visits. A mechanism to notify participating primary care and specialists of the need for ASAP follow up will be key to avoiding repeat visits for the same issue. This could be as simple as a voice message system to leave a notification of encounter and requested time to follow up. A patient should be able to leave the ED assured they will get appropriate further care. (1)
3. **Ensure Adequate Specialist Networks.** While this is important for primary care, it is important for specialist too. The ED operates under EMTALA which mandates we have specialists on call to help treat and stabilize emergent patients. The EMTALA specialist also sees urgent follow up in their office. Adequate participation of specialists will be key to ensuring follow up is seamless, and that patients are not confronted with an uncovered visit. Adequate compensation will be necessary to gain participation. Medicaid should cover all EMTALA follow up care, or a patient will end up back in the ED with a costlier, emergency complication.

4. **Continuity of Coverage:** A system (and staff) that helps patients enrolled in Medicaid stay enrolled in Medicaid without gaps in coverage will help patients maintain appropriate outpatient care. When patients no longer qualify for Medicaid, a process that helps them get onto appropriate coverage will save Medicaid dollars, and ensure seamless patient care.

Addressing the Needs of the Vulnerable and High Utilizing Patients: Behavioral Health, Drug and EtOH treatment, Case Management:

5. **Care Coordination of High Utilizers of the System**. High Utilizer to the emergency department often have difficult social environments, behavioral health issues, substance abuse, and complex medical issues. Care coordination of behavioral health and medical care will help to improve care and contain cost for patients that often struggle to follow through with both their medical and behavioral health care. Care coordinators who are community based, and focused on ED high utilization, with 24 hr access, are key for this to be successful. We see this as a collaboration between the Emergency Department, primary care providers, mental health providers, the court, state funded case mangers, and hospital based social workers. (1)
6. **Creating Financial Incentives to Build Acute Psychiatric Crisis and Drug and Alcohol Centers to Stabilize Substance Abuse and Psychiatric patients.** Psychiatric emergency departments are often built in connection to emergency departments to allow a single point of access for patients facing a crisis that is often multifactorial. There is currently only one in the state. More ED's in all regions of the state need this capability without unduly impacting their care for medical patients. By doing so, we could avoid unnecessary inpatient psychiatric admission, unclog emergency departments and help to provide treatment for those ready to receive it. Drug and alcohol detox centers are in extremely short supply in all areas of the state; increasing availability would provide supervised detox for patients ready for this process and help patients avoid repeat visits. For example, please see the Alameda Model Reference.(2)
7. **Increasing Inpatient Psychiatric Beds:** This will allow sick patients with acute exacerbation of psychiatric disease to be treated appropriately rather than being treated in jail or sent back to their outpatient setting in a decompensated state. Many patients are spending multiple nights held in an Emergency Department bed awaiting transfer to inpatient psychiatric care.

Information Exchange:

9. **Improved Medical Information Exchange.** This would improve quality of care, decrease redundancy in care and testing, decrease prescribing errors, and improve ability to track ED use in real time. Currently PAMC and Alaska Regional are on a compatible system that allows providers to see the other facilities testing results

and notes (since ARH started using EPIC). It also allows providers to see that a patient had been in the other facility, something that previously is only known if a patient discloses the information. Creating a way for Emergency Departments to share visit information without relying on inter hospital requests for information would be a huge step in improving and streamlining care. Supporting systems like the EDIE system would allow all hospitals to receive "pushed" data and prevent over testing and improve coordinated care.

10. **Fully Funding and Improving the Interface with the AK Prescription Database**. The database is our most effective tool to track narcotic use and abuse. The current system has tenuous funding and is difficult to use. An improved system will not only help curb inappropriate prescriptions, but will also save lives.

Supporting Systems of Care:

11. **Developing a Statewide Transfer Call Center to Improve Statewide Coordinated Services.** A statewide transfer call center would streamline movement of patients from more rural or regional care centers to a higher level of care for trauma, cardiac, stroke, complex medical and behavioral health care. Statewide mapping of resources available in real time accessible to providers and EMS would also help facilitate efficient movement of patients. This would allow improved use of current resources and reduce medical transport services. A statewide transfer center could implement standardized air transport guidelines and prevent bypassing the closest appropriate center, saving cost. Longterm data from a transfer center would also allow the state to ensure there are adequate networks of specialist to serve the regional needs of the patient population given longterm transfer patterns.
12. **Coordination of statewide EMS including protocol standardization, training and direction.** While we recognize the need for variable EMS service capabilities given the large geographic area, and highly variable population density, the disjointed nature of AK EMS direction and structure leads to unserved areas, highly variable protocols, increased air transportation, and a challenging urban to rural interface. Statewide coordination could improve EMS system interface, ensure modern treatment protocols across the state, and ensure adequate coverage. Statewide Coordination should also include increased state support for rural EMS staffing, and include development of road system EMS transport capability. This would further support rural crews, often volunteers, and their communities, who lose their only ambulance and crew when transporting to the nearest facility. Road system EMS transport could not only avoid air transport and save cost for patients that do not need flight transfer, but also serve as a valuable back up for flight transfer when weather is bad, saving a patient from weather hold in a facility unable to give definitive care.

Creating a Safety Net While Minimizing Defensive Medicine:

12. **True Tort Reform:** Reform would go a long way to encourage rational medicine as opposed to defensive medicine. Emergency Department providers and the community specialists on EMTALA call are the only physicians required to see and treat any patient that needs their services. This places providers at a different level of liability risk in an environment that often requires care and stabilization to be performed with limited information. Removing individual liability in this environment while encouraging a strong QA/QI process would go a long way to improve quality of care, encounter value, and contain costs. Creating a patient compensation fund from multiple stakeholder sources could ensure that patients that are harmed by misdiagnosis or medical error are cared for and compensated appropriately, while also improving access and quality to EMTALA care. Decreasing risk of providing EMTALA care may increase subspecialty amiability when helping to provide an EMTALA safety net. Please see reference for ACEP EMTALA legislation proposal. (3)

Thank you for allowing AK ACEP to be a partner in the development of Medicaid expansion. Other resources, including a link to the Washington State ACEP 7 best practices shown to save 33 million dollars annually, are below. (1)

(1) "Implementing Best Practices Improves Emergency Care, Reduces States Medicaid Costs" July 24, 2013 ACEP press release
http://www.acep.org/Legislation-and-Advocacy/State-Legislation---Advocacy/Implementing-Best-Practices-Improves-Emergency-Care,-Reduces-States--Medicaid-Costs/

(2) Effects of a Dedicated Regional Psychiatric Emergency Service in Boarding of Psychiatric Patients in Are Emergency Departments. Western Journal of Emergency Medicine. Zeller et al. Volume XV No 1, February 2014
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3935777/pdf/wjem-15-1.pdf

(3) ACEP EMTALA Reform
http://www.acep.org/Liability-Reform-HR-836/

(4)Medicaid and CHIP Payment and Access Commission "Revisiting Emergency Department Use in Medicaid" July 2014
http://2c4xez132caw2w3cpr1il98fssf.wpengine.netdna-cdn.com/wp-content/uploads/2014/08/MACFacts-EDuse_2014-07.pdf