Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

February 12, 2015

The Honorable John A. Alario, Jr., President
Louisiana State Senate
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

The Honorable Charles E. Kleckley, Speaker
Louisiana State House of Representatives
P.O. Box 94062, Capitol Station
Baton Rouge, LA 70804-9062

The Honorable David Heitmeier, Chairman
Senate Health and Welfare Committee
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

The Honorable Scott Simon, Chairman
House Health and Welfare Committee
P.O. Box 94062, Capitol Station
Baton Rouge, LA 70804-9062

Re: SR 29 and SCR 47 of the 2014 Regular Legislative Session

Dear President Alario, Speaker Kleckley and Honorable Chairs:

Pursuant to Senate Resolution 29 and Senate Concurrent Resolution 47 by Senator David Heitmeier, the Department of Health and Hospitals (henceforth the Department) submits this report on strategies to decrease primary care utilization in hospital emergency departments across Louisiana.

According to the Centers for Disease Control, National Center for Health Statistics, demand for emergency services in the United States has been rising for more than a decade. While the number of EDs across the country has decreased, the number of ED visits has increased. As a result, EDs are experiencing higher patient volume and overcrowding, and patients seeking care are experiencing longer wait times. As national health care costs continue to rise, policymakers are increasingly interested in ways to make the health care system more efficient.

For state policymakers, ED use by Medicaid beneficiaries is of special interest. Medicaid program expenditures comprise a large and growing share of state budgets, competing against education and other priorities for limited state revenues. In addition, Medicaid beneficiaries visit the ED at a higher rate than other payers, almost twice that of the privately insured according to the Centers for Medicare and Medicaid Services. Decreasing ED visits for non-emergent conditions is one strategy that a number of states have used to reduce ED demand and constrain Medicaid program expenditure growth. Through the SR 29 working group, stakeholders developed Louisiana-specific strategies as described below.

Triage Fee Notice of Intent

In the March 2014 edition of the *Louisiana Register*, the Department proposed to adopt provisions to establish a triage fee for outpatient services rendered by hospital emergency departments when it is determined that the services provided were for treatment of a non-emergent condition. The triage fee was to be at a lower rate than that for treatment of emergent conditions. It was expected to reduce the cost associated with the treatment of non-emergent conditions and also deter inappropriate use of hospital

emergency departments. Towards implementation of the proposed rule, the Department developed a list of diagnosis codes to identify non-emergent ED visits for payment at the triage rate and distributed it to the Bayou Health Quality Committee for feedback. The Triage Fee Notice of Intent is included as Enclosure 1.

In response to the Notice of Intent and diagnosis code list, the Department received formal and informal comments from stakeholders representing primarily hospital and physician concerns. Respondents objected to the establishment of a triage fee in general and the diagnosis code-based methodology for identifying non-emergent visits in particular. Many cited a January 16, 2014 Centers for Medicare and Medicaid Services (CMS) Informational Bulletin *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings* and advocated as an alternative a public-private partnership modeled after Washington State's *ER is for Emergencies* initiative.

Washington State Initiative

The Washington State "ER is for Emergencies" initiative was in response to the Third Engrossed Substitute House Bill 2127 of the Second Special Session of 2011-2012 Washington State Legislature. The bill recognized that some patients visiting emergency departments could be treated effectively in a less costly setting and that there are evidence-based practices that can reduce low-acuity emergency room visits, coordinate care, and save health care dollars. The bill also required Washington hospitals to implement best practices aimed at reducing unnecessary emergency department use by Medicaid clients.

The initiative was a partnership of the Washington State Hospital Association, the Washington State Medical Association, and the Washington Chapter of the American College of Emergency Physicians as well as the Washington State Health Care Authority. The partnership developed and implemented Seven Best Practices, including:

1) Hospital use of an electronic system to exchange patient information across emergency departments
2) Education to help patients understand the difference between emergencies and non-emergencies
3) Identification of patients who are frequent emergency department visitors
4) Implementation of systems that effectively refer non-emergency patients to primary care providers within a few days
5) Adoption of stricter guidelines for prescribing of narcotics in emergency departments to discourage drug seeking
6) Enrollment of at least 90 percent of ER prescribers in the state's Prescription Monitoring Program for tracking narcotic use
7) Dissemination to hospital ER staff regular feedback reports so they can take appropriate action when the reports show utilization problems

Through the initiative, in its first year (FY 2013) the partnership:

- Reduced ED visits by 9.9%;
- Reduced number of visits by frequent clients by 10.7 %;
- Reduced visits resulting in a narcotic prescription by 24%;
- Reduced low-acuity visits by 14.2%; and,
- Achieved $33.65 million in savings to the Health Care Authority budget.

Further information on Washington State's program is included in Enclosure 2.

SR 29 Working Group

In consideration of stakeholder feedback, the Department abandoned the Triage Fee NOI and established its own "ER is for Emergencies" work group. Membership included representatives of the Louisiana Hospital Association, Bayou Health plans, Louisiana Behavioral Health Partnership Statewide Management Organization, Louisiana Health Care Quality Forum, Louisiana Nursing Home Alliance, Louisiana Chapter of the American College of Emergency Physicians, Louisiana State Medical Society, Louisiana Chapter of the American Academy of Pediatrics, and Louisiana Ambulance Alliance. The group met weekly from April 23 through June 25, 2014 and recessed in July. It reconvened as the SR 29 Working Group in August 2014 with the addition of the Louisiana Association of Health Plans as required by the resolution and continued to meet through the fall of 2014.

The group studied numerous facets of ED use by Medicaid recipients, including but not limited to:

- Identification, stratification, demographic and utilization profiles of ED visitors, including frequent visitors
- Strategies for patient education on appropriate ED use
- Primary care access
- Financial incentives for afterhours access to primary care providers
- Retail and urgent care clinic participation
- Telemedicine and telehealth opportunities
- Louisiana Health Information Exchange and alternative electronic systems for timely notice of member ED visits to Bayou Health plans
- Prompt health plan outreach to members who visit the ED, from basic education to care coordination to engagement in case management programs
- Stationing Bayou Health plan care managers in hospital EDs for real time facilitation of appropriate ED visit follow up
- ED prescribing patterns
- Use of pharmacy lock in programs
- Louisiana Board of Pharmacy Prescription Monitoring Program
- Guidelines for narcotics prescribing in the ED
- Legal requirements of EMTALA and prudent layperson standards
- Patient cost sharing for non-emergent ED use
- Prohibitions on ED wait time advertising
- Physician post-authorization of low level ED visits

Through its study, work group members agreed on the following strategies to decrease primary care utilization in hospital emergency departments across Louisiana:

1) Establish an electronic ED Visit Registry to provide timely notification of Medicaid members ED use to Bayou Health plans. Louisiana Medicaid will partner with the Louisiana Health Care Quality Forum (the state's designated health information exchange) to create this Registry. It will serve as a repository for data and will have reporting and notification functions. Emergency departments throughout Louisiana will transmit ED utilization data to LaHIE which will use the data to populate the Registry.
   With use of the ED Registry, Louisiana Medicaid anticipates a 25% reduction in ED utilization and a corresponding increase in more economical primary care utilization. The shift from ED to PCP is expected to generate an estimated savings of $1.6 million annually. More details on the ED Visit Registry are included in Enclosure 3.

2) Develop and implement a communications plan to educate patients on the appropriate use of hospital EDs and alternate access points to care. This communications plan will use unified messaging across the health care industry to educate all consumers on the right time to use the ED based upon best practices and Washington state's program. This will include outreach through a website, social media, brochures/push cards, billboards, and public service announcements. It will also identify and engage key stakeholders including non-profits and faith leaders to educate their membership. The Department will also work with its partners in state government to share information on the proper utilization of the ED. The full communications plan is included in Enclosure 4.
3) Develop and issue prescribing recommendations to discourage narcotic seeking in hospital EDs. The emergency ED is the largest ambulatory source for opioid analgesics with 39% of all opioids prescribed, administered, or continued coming from emergency departments. The Working Group developed recommendations to help EDs in reducing the inappropriate use of opioid analgesics while preserving the vital role of the ED to treat patients with emergent medical conditions. These recommendations are included in Enclosure 5.
4) Promote use of the Louisiana Board of Pharmacy's Prescription Monitoring Program to identify potential narcotic seekers in the ED. This is an electronic system that exists to monitor controlled substances dispensed in the state and can be used to help reduce the inappropriate use of narcotics in the ED.
5) Develop baseline and progress measures for quarterly reporting on the implementation of agreed upon strategies. These measures are hospital participation in the ED Visit Registry, the completeness of data reported to the ED Visit Registry, Accuracy of Medicaid member identification from the ED Visit Registry, pre-ED visit primary care contact rate, post-ED visit follow up rate, and the number of ED visits per 1,000 member months. The measure specifications and baselines are included in Enclosure 6.

The Department is optimistic about the potential for the strategies developed by the SR 29 Working Group to reduce ED demand and constrain Medicaid expenditure growth. We look forward to continued partnership with stakeholders in implementing these strategies and evaluating their effectiveness at reducing primary care utilization in hospital emergency departments by Medicaid recipients across our state.

Sincerely,

Kathy H. Kliebert
Secretary

Enclosures (7)

1) March 2014 *Louisiana Register*, Triage Fee Notice of Intent
2) Washington State Health Care Authority Report to the Legislature, *Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation,* March 20, 2014
3) Louisiana Emergency Department Visit Registry Brief
4) DHH Emergency Department Utilization Communications Plan
5) Louisiana Emergency Department Opioid Prescribing Recommendations and Background
6) Measures and Baselines for Quarterly Reporting on the Progress of SR 29 Strategies
7) Behavioral Health Use of Louisiana Hospital Emergency Departments in SFY14

cc: The Honorable Members of the Senate Health and Welfare Committee
The Honorable Members of the House Health and Welfare Committee
Senator J.P. Morrell
David R. Poynter Library

SR 29 AND SCR 47 of the 2014 Regular Legislative Session

Enclosure (1)

March 2014 *Louisiana Register*

Triage Fee Notice of Intent

NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing

Outpatient Hospital Services
Triage Fees for Non-Emergent Care
(LAC 50:V.5115)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to adopt LAC 50:V.5115 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing provides Medicaid coverage and reimbursement of outpatient hospital services rendered by emergency departments of acute care hospitals.

The department proposes to adopt provisions in the hospital program to establish a triage fee for outpatient services rendered by hospital emergency departments when it is determined that the services provided were for treatment of a non-emergent condition. The triage fee will be at a lower rate than that for treatment of emergent conditions. This is expected to reduce the escalating cost associated with the treatment of non-emergent conditions and will also deter inappropriate use of hospital emergency departments.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospitals
Subpart 5. Outpatient Hospitals
Chapter 51. General Provisions
§5115. Triage Fees for Non-Emergent Care

A. The Medicaid Program shall establish a special triage fee to reimburse outpatient services rendered by hospital emergency departments when it is determined that the services provided are for the treatment of a non-emergent condition.

B. The triage fee shall be an established flat rate which covers the facility fee and any testing and/or supplies that are associated with the non-emergent visit. The established rate shall be lower than the rates paid for the treatment of an emergent condition.

C. The department shall use the "prudent layperson standard" to determine if a visit to an emergency room was appropriate as a result of an emergency medical condition. For purposes of these provisions, an emergency medical condition shall be defined as follows.

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a "prudent layperson", who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b. serious impairment of bodily functions; or

c. serious dysfunction of any bodily organ or part.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule may have a positive impact on family functioning, stability or autonomy as described in R.S. 49:972 by directing care to a provider who is familiar with the family member's history and current medications/treatment regimen and will increase the quality and continuity of care for the individual and the entire family.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule may have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 by reducing the financial costs associated with recovery when a family's care is rendered by a provider who is familiar with the family member's history and current medications/treatment regimen.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, April 24, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Outpatient Hospital Services Triage Fees for Non-Emergent Care

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed Rule will result in estimated state general fund programmatic costs of $164 for FY 13-14 and savings of approximately $1,593,841 for FY 14-15 and $1,791,369 for FY 15-16. It is anticipated that $328 ($164 SGF and $164 FED) will be expended in FY 13-14 for the state's administrative expense for promulgation of this proposed Rule and the Final Rule. The

numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 61.48 percent in FY 14-15. The enhanced rate of 62.11 percent for the last nine months of FY 14 is the federal rate for disaster-recovery FMAP adjustment states.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed Rule will increase federal revenue collections by $164 for FY 13-14 and reduce federal revenue collections by approximately $2,607,110 for FY 14-15 and $2,928,972 for FY 15-16. It is anticipated that $164 will be expended in FY 13-14 for the federal administrative expenses for promulgation of this proposed Rule and the Final Rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 61.48 percent in FY 14-15. The enhanced rate of 62.11 percent for the last nine months of FY 14 is the federal rate for disaster-recovery FMAP adjustment states

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule adopts provisions in the Hospital Program to establish a triage fee for outpatient services rendered by hospital emergency departments when it is determined that the services provided were for treatment of a non-emergent condition. It is anticipated that implementation of this proposed Rule will reduce Medicaid Program expenditures by approximately $4,200,951 for FY 14-15 and $4,720,341 for FY 15-16.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed Rule will not have an effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1403#065

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Office of Public Health

Plumbing Fixtures, Water Supply and Distribution, and Referenced Standards (LAC 51:XIV.411, 609, and 1403)

Under the authority of R.S. 40:4 and 40:5, and in accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the state health officer, acting through the Department of Health and Hospitals, Office of Public Health (DHH, OPH), intends to amend Part XIV (Plumbing) of the Louisiana State Sanitary Code [LAC 51 (Public Health—Sanitary Code)]. This amendment will provide an exception for certain small retail stores to have a drinking fountain installed and available for public use. This exception will only be applicable to retail stores having 2,000 square feet or less of usable floor space.

When meeting certain specified criteria, the proposed Rule will provide a waiver to the normal requirement calling for the installation of a containment device backflow preventer for multiple residential dwelling units served by a master meter. This proposed waiver is only applicable to multiple residential dwelling units when serving only two units and their water service or water distribution lines are connected together by a master water meter.

Additionally, the proposed Rule corrects several typographical errors contained in the 2013 publication of LAC 51:XIV (Plumbing). The first involves a single word typographical omission on earlier versions of Table 411 relative to the calculation of the number of lavatories when over 750 persons are served in assembly type occupancies. The second correction involves referencing metal plating plants (instead of meat plating plants) in Table 609.F.5.

Title 51
PUBLIC HEALTH—SANITARY CODE
Part XIV. Plumbing
Chapter 4. Plumbing Fixtures
§411. Minimum Plumbing Fixtures

A. - A.10. ...

Table 411
Minimum Plumbing Fixtures
[The figures shown are based upon one fixture being the minimum required for the number of persons indicated or any fraction thereof, i.e., if the calculation yields any fraction (no matter how small), the next whole number greater than the fractional number is the minimum fixture requirement]

Building or Occupancy[1]	Occupant Content[1]	Water Closets (Urinals can be substituted for up to half of the required water closets)	Lavatories[2]	Bathtubs, Showers and Miscellaneous fixtures
Dwelling or Apt. House	Not Applicable	1 for each dwelling or dwelling unit	1 for each dwelling or dwelling unit	Washing machine connection per unit[3]. Bathtub or shower – one per dwelling or dwelling unit. Kitchen sink – one per dwelling or dwelling unit

SR 29 AND SCR 47 of the 2014 Regular Legislative Session

Enclosure (2)

Washington State Health Care Authority Report to the Legislature,

Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation,

March 20, 2014

Washington State Health Care Authority

Report to the Legislature

Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation

Third Engrossed Substitute House Bill 2127
Chapter 7, Laws of 2012,
Second Special Session (Partial Veto)
(Budget Proviso)
March 20, 2014

Washington State Health Care Authority
Office of the Chief Medical Officer
PO Box 45502
Olympia, WA. 98504-5502
(360) 725-1612
Fax: (360) 586-9551

Executive Summary

Section 213(43) of Third Engrossed Substitute House Bill 2127, enacted as Chapter 7, Laws of 2012, 2nd Special Session (Partial Veto), directs the Health Care Authority (HCA) to report whether assumed savings based on preliminary trend and forecasted data are on target and if additional best practices or other actions need to be implemented.

The aforementioned bill states the Health Care Authority shall, *"perform a preliminary fiscal analysis of trends in implementing the best practices in this subsection, focusing on outlier hospitals with high rates of unnecessary visits by medicaid clients, high emergency room visit rates for patient review and coordination clients, low rates of completion of treatment plans for patient review and coordination clients assigned to the hospital, and high rates of prescribed long-acting opiates. In cooperation with the leadership of the hospital, medical, and emergency physician associations, additional efforts shall be focused on assisting those outlier hospitals and providers to achieve more substantial savings. The authority by January 15, 2013, will report to the legislature about whether assumed savings based on preliminary trend and forecasted data are on target and if additional best practices or other actions need to be implemented..."*

A preliminary report in January 2013 tentatively identified favorable utilization and cost trends but there was insufficient data to draw any definitive conclusions. This report, *Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation*, re-examines Medicaid utilization data to identify the costs and trends of emergency department visits. Savings were achieved through reductions to the Health Care Authority budget, with an estimated annual savings for state fiscal year 2013 of $33,650,000. The savings from managed care health plans were built directly into the premiums from the preliminary assumption of savings identified in the Third Engrossed Substitute House Bill 2127 of 2012. The total savings cannot be definitively attributed to the Seven Best Practices and may be related to other factors. However, data also indicates a reduction in emergency department utilization and the rate of emergency department-related scheduled drug prescribing since the implementation of the Seven Best Practices. In coordination with our community partners, HCA will continue to work with hospitals and Medicaid health plans to sustain and enhance these best practices.

Project Overview

In Washington, as in other states, patients may visit the hospital emergency department (ED) for conditions that may be more effectively treated in an alternative, more appropriate setting that may be less costly. Third Engrossed Substitute House Bill 2127 set forth best practices aimed at reducing unnecessary emergency department use by Medicaid clients. All Washington hospitals with emergency departments serving Medicaid clients attested to their agreement to these practices on or before July 1, 2012. These best practices include:

(a) Adoption of a system to exchange patient information electronically among emergency departments. In order to reduce unnecessary use of the emergency room, hospitals need to be able to identify frequent users and share information regarding their care. Previously, the ED physician had no way of knowing, for example, that a patient had visited multiple EDs in the past week with the same complaint. The electronic information system allows emergency department

physicians to see all of the patient's emergency room visits from all hospitals over the past twelve months, and to know the diagnosis and treatment given on these previous visits. If a patient is seeking narcotics or has a chronic condition, the emergency department physician will know this and will respond accordingly.

(b) Adoption of a system to educate patients that the emergency department should be used only for true emergencies. Every hospital has now agreed to provide patients with a brochure and/or discharge instructions discussing the most appropriate setting for their health care. Hospitals have also attested that they have trained ED physicians in how to talk to patients about where they should receive care for non-emergent needs.

(c) Implementation of a process to disseminate lists of frequent users to hospital personnel to ensure they can be identified by the electronic information exchange system discussed above.

(d) Implementation of processes to assist frequent users with their care plans, and to make appointments for these patients to see their primary care provider within 72-96 hours of their emergency room visit.

(e) Adoption of strict guidelines for the prescribing of narcotics. Hospitals have also attested they have trained ED physicians in how to enforce these guidelines.

(f) Enrollment of at least 75 percent of ED prescribers in the state's Prescription Monitoring Program by July 1, with a goal of 90 percent enrollment by December 31, 2012. The PMP is an electronic online database used to collect data on patients who are prescribed controlled substances. It enables prescribers to see which prescriptions have been previously filled by a patient. This is essential information to reduce the number of patients seeking narcotics.

(g) Designation of hospital personnel to review feedback reports regarding ED utilization and to take appropriate action in response to the information provided by those reports.

Project Impact

Since the project inception, the HCA has met regularly with an ED workgroup which includes representatives of the Washington Chapter of the American College of Emergency Physicians, the Washington State Medical Association, and the Washington State Hospital Association. This workgroup has monitored trends in emergency department use, developed guidelines for hospitals to implement the Seven Best Practices, and identified next steps. Project implementation and impact has included the following:

- Educational materials have been made available throughout the state. Brochures aimed at helping patients determine the appropriate setting to seek care are now in use in hospitals and clinics. Signs are on display in emergency department waiting rooms outlining the narcotic prescribing guidelines.
- Statewide, 98 hospitals are now sharing emergency department information electronically[i]. Thus, emergency medicine physicians can access critical patient information and are able to respond appropriately.
- Hospitals have developed a standardized care plan format that can be used across emergency departments, and these care plans are now available via an electronic information exchange

system in 97 emergency rooms across the state. This means virtually all emergency department providers in our state have access to the care guidelines for these clients.

- After initial success with increased care coordination among patients in the Patient Review and Coordination (PRC) program, the workgroup recommended hospitals begin applying this practice to all patients with five or more emergency room visits within the last twelve months. Hospitals began implementing this new recommendation in June 2013.
- EDs and primary care providers (PCPs) have new opportunities for improved coordination. The electronic information exchange now includes an option to automate notification of PCPs when assigned patients make an emergency room visit. A total of 424 PCPs now have notifications enabled when their patients enter the ED. From September of 2012 to August 2013, 3,000 notifications have been made to PCPs through the system. This unprecedented communication option enables PCPs to have more accurate and timely understanding of their patients' health.

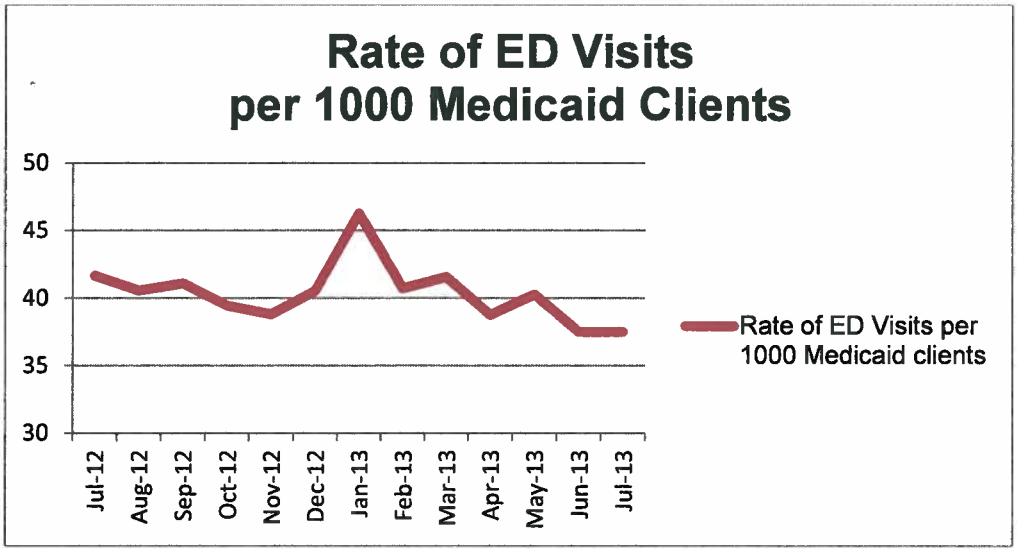
Beyond the collective efforts of the workgroup, the issue of reducing inappropriate emergency room use has become an area of focus statewide. Individual hospitals and clinics are taking innovative approaches to care coordination. For example:

- Newport Hospital has secured funding to improve access to mental health services within the primary care setting and reduce crises that result in an ED visit. The pilot is focused on high risk patients who are frequent utilizers of the ED.
- PMH Medical Center in Prosser has implemented a community based paramedic programs to provide in-home visits to high risk patients with 24 to 48 hours of discharge. These visits include review of discharge instructions, physical evaluation, and making sure the patient has their medication and a follow-up appointment. While the project is still in the early phases, anecdotal evidence points to a reduction in visits by frequent utilizers. With nearly a year's worth of post-implementation data available, there are continued signs of improvement to quality and coordination of care.
- With grant funding from Center for Medicare and Medicaid Innovation, Kitsap Community Mental Health Center has developed an enhanced system of communication with the local ED enabling better coordination of care.

Claims data from both fee-for-service and managed care Medicaid clients' emergency department utilization was analyzed to examine ED utilization, frequent client utilization, visits resulting in a scheduled drug prescription, and visits with a low acuity diagnosis[ii]. Between the formal implementation of the best practices (June 2012) and the most current available month of data (June 2013), all metrics show measurable improvement.

- Rate of emergency department visits[iii] declined by 9.9%;
- Rate of visits by frequent clients (who visited five or more times annually) decreased by 10.7%;
- Rate of visits resulting in a scheduled drug prescription decreased by 24.0%; and
- Rate of visits with a low acuity diagnosis decreased by 14.2%

Although encouraging trends are concurrent of the implementation of the Seven Best Practices, other factors may also play a role, such as the recent transition of clients from the fee-for-service model to managed care organizations. The Health Care Authority will continue to monitor these trends in collaboration with the ED workgroup.


Rate of ED Visits
per 1000 Medicaid Clients
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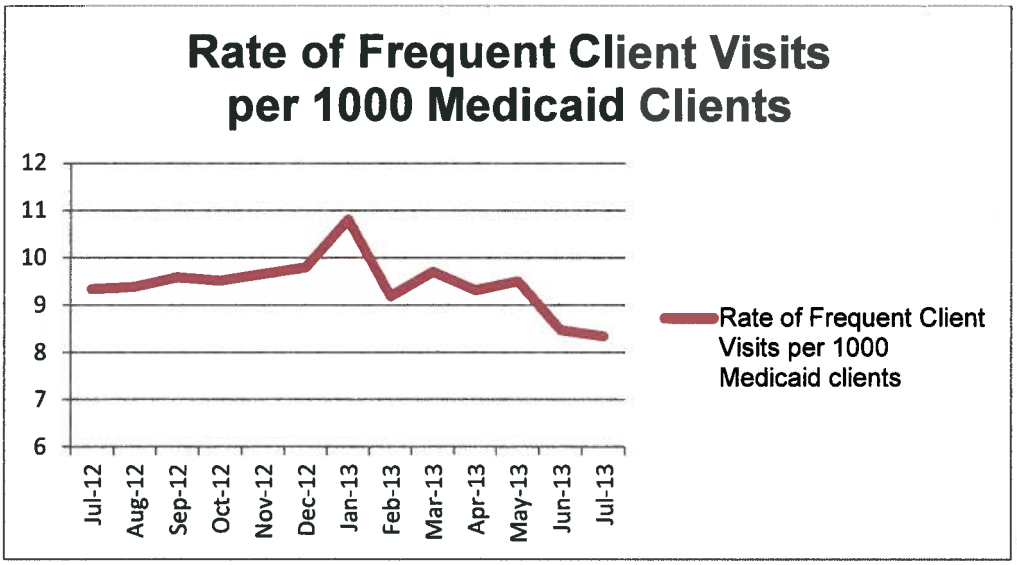
May-13
Jun-13
Jul-13
Rate of ED Visits per 1000 Medicaid clients
iv


Rate of Frequent Client Visits
per 1000 Medicaid Clients
12
11
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Jul-12
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Oct-12
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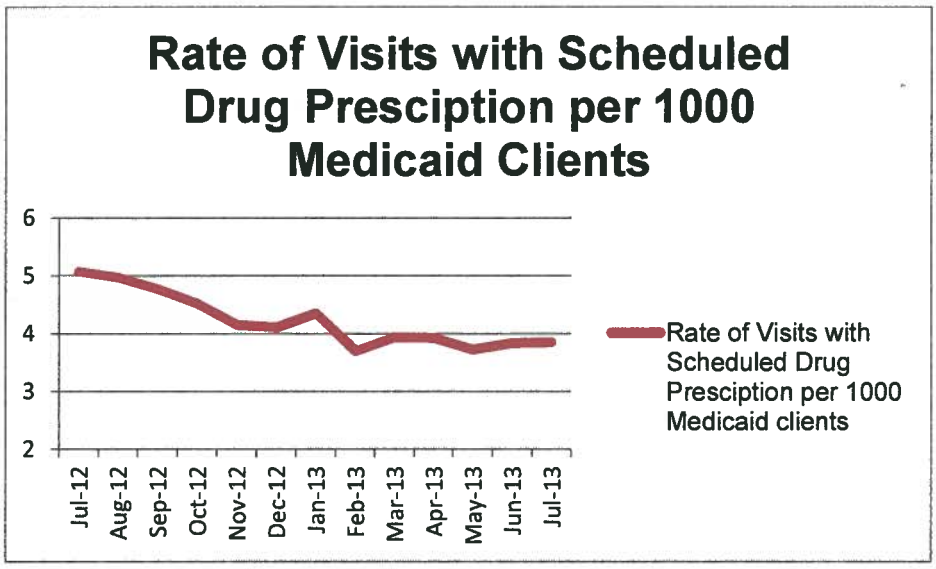
Jul-13
Rate of Frequent Client Visits per 1000 Medicaid clients
v



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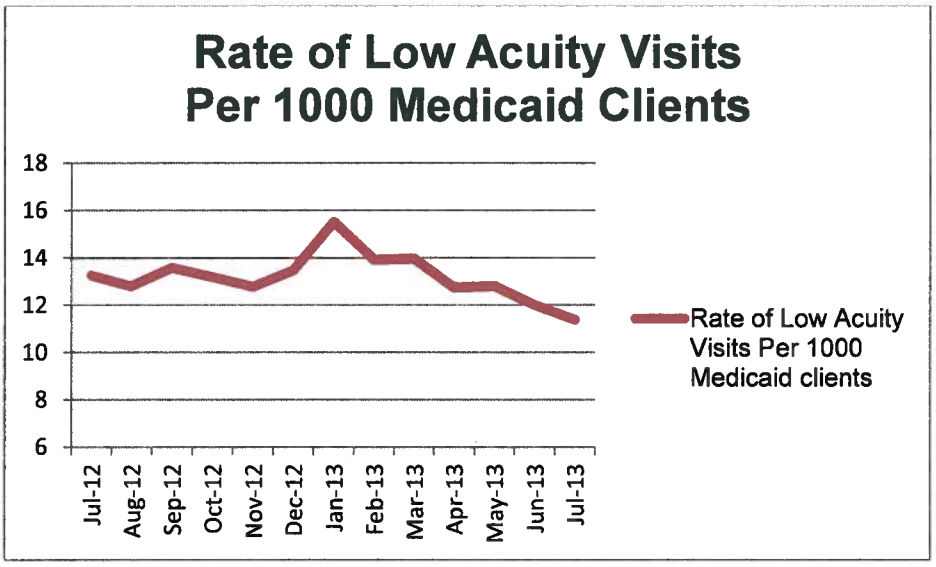

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Fiscal Impact

Savings were achieved through reductions to the Health Care Authority budget, with an estimated annual savings for state fiscal year 2013 of $33,650,000. The savings from managed care health plans were built directly into the premiums from the preliminary assumption of savings identified in the Third Engrossed Substitute House Bill 2127 of 2012. The total savings cannot be definitively attributed to the Seven Best Practices and may be related to other factors, including the previously mentioned transitioning of Medicaid fee-for-service clients into Medicaid managed care health plans during the same time period.

Next Steps

We anticipate upcoming changes to health policy and delivery will also positively impact ED utilization. In particular, the statewide roll out of medical health homes will help provide more comprehensive care management for clients with chronic health conditions. The restoration of a dental care benefit for adult Medicaid patients effective January 1, 2014, will very likely reduce ED utilization for Medicaid clients with non-emergent dental disease and pain. Moreover, given the apparent success of the Seven Best Practices in reducing ED utilization and the rate of ED-related scheduled drug prescribing, HCA will work with hospitals and health plans to sustain these efforts. In addition, the Health Care Authority will continue to identify and disseminate innovative practices that reduce utilization while improving client health outcomes. Specific next steps include the following:

- Encourage more robust information exchange by exploring new data linkages, such as January 2014 incorporation of Prescription Monitoring Program into hospitals' electronic information exchange system;
- Widen the conversation to address the roles of community mental health clinics, chemical dependency treatment providers, and primary care providers;
- Prepare for the impact of increased Medicaid population that began January 2014 on emergency department use by working with Medicaid managed care health plans to assure that Medicaid clients are educated about appropriate ED use;
- Work with local Emergency Medical Services (EMS) systems to identify alternative sites of care for patients who access EMS via 911, but do not need care in an emergency department; and
- Promote the electronic client care plans throughout the Medicaid Health Information Technology (HIT) solutions with primary care provider integration, medical home use, multi-payer use, and improvement on the return on investment for meaningful use.

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[i] Data Source: Collective Medical Technologies LLC, Emergency Department Information Exchange, and Inland Northwest Health Services.

[ii] Data was analyzed from July 2012 forward, as data required for the metric development from previously contracted Medicaid health plans (before July 2012) was not available.

[iii] For these measures, an emergency department visit is defined by an outpatient claim identified as an emergency department visit, without either a transfer to an inpatient facility patient status, surgical procedure, or death of the patient.

[iv] For these measures, an emergency department visit is defined by an outpatient claim identified as an emergency department visit, without either a transfer to an inpatient facility patient status, surgical procedure, or death of the patient.

[v] Frequent client visits are defined as Medicaid clients who have visited an emergency department five or more times in the past 12 months.

[vi] Measure is defined by an emergency department visit (as defined above) that results in a scheduled drug (2-5) prescription.

[vii] Measure is defined by an emergency department visit (as defined above) that has a primary diagnosis which is included in the 527 low acuity list. Contact Health Care Authority for diagnostic details.

SR 29 AND SCR 47 of the 2014 Regular Legislative Session

Enclosure (3)

Behavioral Health Use of Louisiana Hospital Emergency Departments in SFY 14

Behavioral Health Use of Hospital Emergency Departments		
Month of Service	**Visits**	**Payments**
July 2013	2,185	$ 714,160
August 2013	2,381	$ 843,079
September 2013	2,395	$ 817,629
October 2013	2,210	$ 735,762
November 2013	1,917	$ 609,425
December 2013	1,897	$ 641,250
January 2014	1,858	$ 584,998
February 2014	2,005	$ 604,969
March 2014	2,285	$ 843,916
April 2014	2,625	$ 871,546
May 2014	2,185	$ 687,044
June 2014	1,898	$ 562,445
State Fiscal Year 2013-2014 Total	25,841	$ 8,516,223

Source: DHH MARS Data Warehouse, State Fiscal Year 2014 Medicaid Fee For Service claims, Bayou Health Shared Savings plan claims, Louisiana Behavioral Health Partnership and Bayou Health Prepaid plan encounters.

Specifications: ED visit is defined as Revenue Codes 450, 459, and 981. Behavioral health is defined by Diagnosis Code as in Bayou Health Informational Bulletin 12-18 http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB12-18.pdf Available data cannot identify individuals visiting an ED in a suicidal state.

SR 29 AND SCR 47 of the 2014 Regular Legislative Session

Enclosure (4)

Louisiana Emergency Department Visit Registry Brief

DEPARTMENT OF HEALTH
AND HOSPITALS

Emergency Department Registry Brief

Louisiana Medicaid

A. Background

In 2013, DHH released a Notice of Intent to establish a triage fee for outpatient services rendered by hospital emergency departments when it is determined that the services provided were for treatment of non-emergent conditions. This was expected to reduce the high cost associated with the treatment of non-emergent conditions and also reduce the inappropriate use of the hospital emergency departments. This triage fee consisted of an established flat rate of $50 which covers the facility fee and any testing and/or supplies that are associated with the non-emergent visit. To determine if a visit to an emergency room was appropriate as a result of an emergent medical condition, DHH proposed to use the "prudent layperson standard." DHH received a list of non-emergent codes (used by another state's MCO) and ran data to determine the savings.

To help with the review of the non-emergent codes, DHH requested that the Medicaid Quality Committee review the list of non-emergent codes. Committee members had concerns relative to the list and the Notice of Intent that was published regarding the ER Triage Fee. The following are some of the concerns listed by the Quality Committee: shortage of primary care and specialty care in many areas; many visits to the ED occur outside of business hours; and reducing payment for ED will ultimately constrain hospital resources, compounding an already recognized access problem for patients who have no other alternative. Quality committee members cited the CMS Informational Bulletin dated January 16, 2014 titled "Reducing Nonurgent Use of Emergency Department and Improving Appropriate Care in Appropriate Settings" to support their concerns. In this letter CMS strongly encourages states to consider alternatives and lists several other approaches that have produced cost savings without jeopardizing access to care as well as demonstrate sufficient access to services outside of the ED. Reviewing the concerns and issues, DHH chose to abandon the triage fee and focus on the development of a holistic alternative approach.

In particular, DHH adopted the collaborative approach taken by the state Medicaid program and a coalition of doctors, hospitals, and Medicaid health plans in Washington State that has shown

approximately $34 million in savings. Washington State uses the goal of the Seven Best Practices program to redirect care to the most appropriate setting, reduce low acuity, and reduce preventable Medicaid emergency room visits. Below are the seven practices.

1. Track emergency department visits to reduce "ED shopping";
2. Implement patient education efforts to re-direct care to the most appropriate setting;
3. Institute an extensive case management program to reduce inappropriate emergency department utilization by frequent users;
4. Reduce inappropriate ED visits by collaborative use of prompt (72 hour) visits to primary care physicians and improving access to care;
5. Implement narcotic guidelines that will discourage narcotic-seeking behavior;
6. Track data on patients prescribed controlled substances by widespread participation in the state's Prescription Monitoring Program (PMP); and
7. Track progress of the plan to make sure steps are working.

Louisiana Medicaid paid an average of $189 for each of the top five ER diagnoses in SFY 14 while the average cost for the same diagnoses with a primary care physician was $72. If 25% of ED visits could be "avoided" with the Medicaid recipient opting for the more appropriate primary care visit, taxpayers could realize an estimated savings of $1.6 million annually. This estimate is a conservative projection based upon savings realized from other states that have implemented initiatives to curb ED utilization.

Senate Resolution 29 of the 2014 Louisiana Legislature Regular Session

The early work of the voluntary committee was officially adopted by the legislatively created workgroup as a result of the passage of SR29. Central to realizing the goals of SR29 was the development and implementation of an "Emergency Department Health Information Exchange."

As a result of discussions earlier this year between DHH and stakeholders about ways to potentially reduce the rate of Medicaid enrollees utilizing emergency room resources when other

settings of care may be more appropriate, DHH wishes to launch a data-sharing initiative aimed at identifying opportunities for health plan outreach, education, and intervention.

The Medicaid Managed Care plans are required to provide access to viable alternatives to the emergency room for conditions that are non-emergent in nature. It is the DHH's goal to positively impact Medicaid enrollees through increased health plan outreach, identification of enrollees who may benefit from case management, and the identification of frequent utilizers of the emergency room in a timelier manner. Through the identification of these members shortly after receiving services, DHH believes that health plan intervention, when appropriate, can assist in educating members regarding appropriate venues of treatment, identifying patients that might benefit from case management, and provide the plans an opportunity to more closely coordinate care for those that may already be in case management.

In addition to establishing a legislatively-mandated ER Reform Work Group, Louisiana has implemented a number of initiatives and measures to help curb excessive ED utilization, such as its HITECH funded Patient Centered Medical Home Initiative, inclusion of urgent-care facilities as providers of service, and the use of managed care organizations that link Medicaid recipients to a single primary care physician. Despite these efforts, in 2013, taxpayers spent $73 million on ED care that was identified as "non-emergent."

B. Need

Louisiana's five managed care organizations (MCOs) are charged with coordinating the care of Medicaid patients, improving health outcomes, and controlling costs. Access to timely information Medicaid ED visits is critical to successful care coordination and the reduction of avoidable ED utilization. However, at present, information on ED visits is extrapolated from hospital claims data. Hospitals and other providers of care have up to a year to submit a claim for payment, making reliance on claims data valueless in the coordination of care.

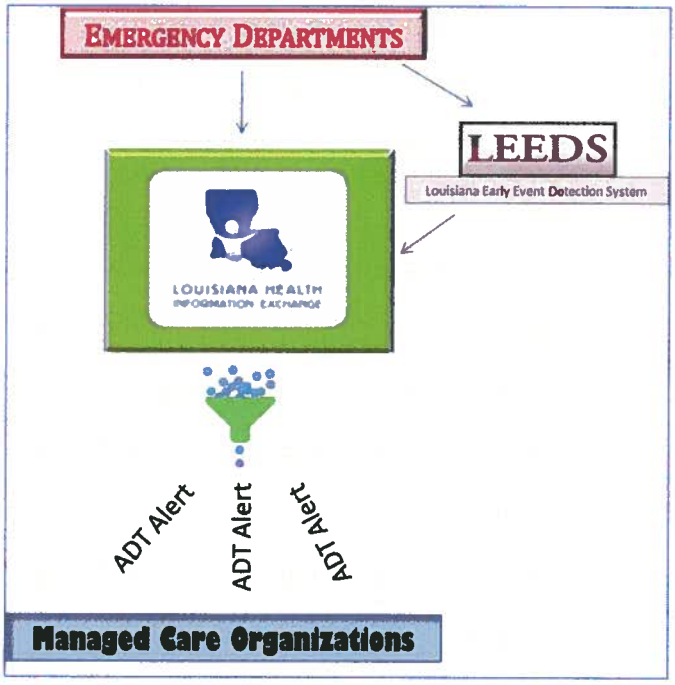
C. Proposal – Emergency Department (ED) Registry

Louisiana Medicaid will partner with the Louisiana Health Care Quality Forum, the administrator of LaHIE, Louisiana's state designated health information exchange, to create an Emergency Department (ED) Registry. The Registry will serve as a repository for data and will

have reporting and notification functions. Emergency departments throughout Louisiana will transmit ED utilization data to LaHIE which will use the data to populate the Registry.

With use of the ED Registry, Louisiana Medicaid anticipates a 25% reduction in ED utilization and a corresponding increase in more economical primary care utilization. The shift from ED to PCP is expected to generate an estimated savings of $1.6 million annually.

1. **Emergency Department Participation** Louisiana Medicaid recognizes that the success of the Registry is dependent upon robust participation by EDs. There are a total of 114 emergency departments in Louisiana. At present, 48 or approximately 40% of them participate in LaHIE. However, a significant increase in hospital participation in LaHIE is expected in 2015 as Louisiana Medicaid begins requiring its MCOs to contract with only those acute care hospitals that participate in LaHIE. Until then, for those hospitals not yet participating, an alternate means of transmitting data for the Registry has been established through Louisiana's Office of Public Health (OPH). ED and urgent care facilities are required to submit syndromic surveillance data to OPH. Data is transmitted via HL-7 formatted files using secure file transfer protocol (SFTP) through Louisiana's Event Detection System (LEEDS). EDs not yet participating in LaHIE will utilize these existing interfaces to submit the data needed to populate the Registry. OPH will forward the ED utilization data to LaHIE on a daily basis.



2. **ADT Alerts** LaHIE will create Admission, Discharge, Transfer (ADT) messages from the ED utilization data it receives on a daily basis. The ADT message will include the patient's name, basic demographics, name of facility, attending physician, patient's chief complaint, and preliminary diagnosis code (if any). Using member lists provided by each MCO, LaHIE will

match the ADT message with the patient/member and forward the message to the appropriate MCO. MCOs will be provided the option to subscribe to additional reports and/or dashboards that breakdown non-emergent use of emergency rooms by Parish, Zip Code, PCP, Hospital, and Diagnosis.

ADT alerts provided by the Registry will provide Louisiana's MCOs the real-time patient data needed to coordinate care and ultimately to reduce the non-emergent use of the ED. As noted in ONC's HealthITBuzz, the state of Maryland has experienced positive outcomes from use of ADT alerts. Maryland's Chesapeake Regional Information System for Our Patients (CRISP) reported improved coordination of care, facilitation of geospatial mapping, reduction in ED frequent flyers, and reduction in health disparities.[1] Although the primary purpose of Louisiana's ED Registry is to reduce the incidence of non-urgent ED utilization through coordination of care, other states have also shown a reduction in laboratory test ordering and hospital admissions and readmissions with the use of HIE in ED settings. [2]

A poll was taken of Louisiana Medicaid MCOs to determine how each would utilize the ED Registry and its alerts. Some of the planned uses reported by Louisiana MCOs include:

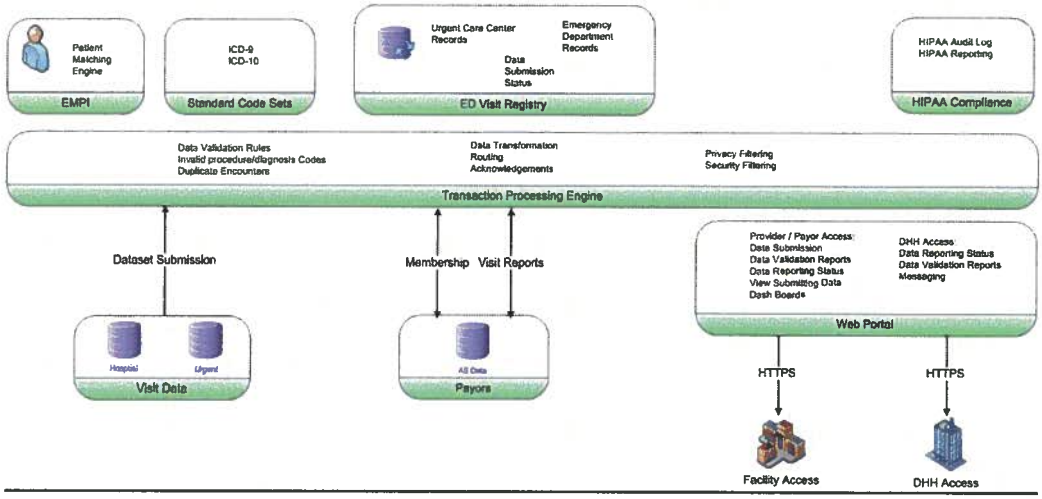
- Dedicated disease management categorized by age and number of visits
- Post ER visit contact with member
- Access to behavioral health codes for proactive case management
- Notification to PCP of ER visit
- Targeted educational material to member
- Creation of member list for frequent ER users for education and outreach

3. **Data-Driven Decision-Making** Louisiana Medicaid will be provided a series of reports, via the Registry's online portal, developed by LHCQF to support the analysis of ED utilization. Each participating MCO will have access to a version of these reports, specific to its enrolled members. This statewide data may be utilized as a basis of discussion among Louisiana's ED Reform Workgroup to drive discussions around interventions, educational messaging, and policy decisions. These reports will be provided periodically to Louisiana Medicaid and MCOs as

agreed upon by all parties. This data will provide actionable information to drive future MCO negotiations, policy recommendations, and legislative actions.

4. ED Visit Registry Solution Architecture

Louisiana ED Visit Registry Architecture



Clinical Data Repository / ED Visit Registry

The Clinical Data Repository Warehouse is used to store all encounter information contributed to the ED Visit Registry for the purpose of making it available within the Web Portal and external report generation tools. It is a dynamic repository capable of storing user-defined models.

Transaction Processing Engine (TPE)

Transaction Processing Engine is the central transaction hub, communicating over TCP/IP, Web Services or SFTP with participating facilities by receiving, processing and sending transactions as required.

TPE is used to feed the Clinical Data Repository on a real time basis, and is made up of three major components: (1) A Java based Engine, which performs the transaction processing, including rules processing; (2) The client side Administrator, which is the Windows application used to configure the engine; (3) A web based Web Monitoring Tool used to track the status of the engine and the message processing.

EMPI and Provider Index

EMPI is be used to provide the Master Patient/Provider Index (MPI) which is required to reconcile patient, provider and/or payor information from multiple sources. When a patient or provider is added to the EMPI, an Enterprise Identifier (EID) is assigned, which is used as the Primary Patient/Provider identifier in the reporting system solution. The Web Portal and report generation engine retrieves data from the EMPI via web services when querying for patient/provider demographics.

HIPAA Compliance Tracking Module

HIPAA compliance is of the utmost importance at the Quality Forum. The Quality Forum regularly trains its employees on HIPAA privacy obligations. An internal committee, along with the Quality Forum's Health Information Technology Advisory Council, reviews privacy and security protocols and recommends and approves changes in policies and procedures. The Quality Forum plans to utilize the Idera SQL compliance tool to monitor, log and report all access to records (both PHI and Non-PHI) in its database. This solution will enable the Quality Forum, Louisiana DHH and Facility privacy officers to review user access to their datasets.

Web Portal

The LaHIE Web Portal is being expanded to accommodate on-line query access to the ED Visit Registry.

D. Cost Savings

Significant reductions in health care costs have been attributed to the use of health information exchange technology in ED settings. A pilot test, conducted by the Agency for Healthcare Research and Quality in 2009, found that ADT alerts generated by the Indiana Health Information Exchange led to a 53% reduction in non-urgent ED visits with a simultaneous increase of 68% in primary care visits. A $2 to $4 million savings over the 6-month pilot period was reported.[3] In SFY 13 with use of Emergency Department Information Exchange (EDIE), the Washington State Health Care Authority reported savings of more than $30 million; a 10% decline in emergency department visits; an 11% drop in the rate of "frequent visitors"; and a 14% decrease in the rate of less serious visits.[4]

With use of the ED Registry and ADT alerts, Louisiana Medicaid anticipates a 25% reduction in ED utilization and a corresponding increase in more economical primary care utilization. A 25% reduction is a conservative projection based on results realized by other states. The shift from ED to PCP will generate an estimated savings of $1.6 million annually.

	Emergency Department			Primary Care		
Top Five ED Diagnoses	Number of Visits	Total Cost	Average Cost per Visit	Number of Visits	Total Cost	Average Cost per Visit
URIN TRACT INFECTION NOS	14,507	$2,368,086	$163	50,879	$3,227,459	$63
OTH CURR COND-ANTEPARTUM	10,054	1,771,933	$176	5,356	357,420	$67
LUMBAGO	6,409	1,101,163	$172	31,793	2,727,148	$86
HEADACHE	10,798	2,403,890	$223	44,425	3,661,221	$82
ABDOMINAL PAIN UNSPECIFIED SITE	11,545	2,453,047	$212	71,137	4,438,527	$62
TOTAL/AVERAGE	53,313	$10,098,119	$189	203,590	$14,411,774	$72

Cost Savings Calculation	25% Decrease in ED Visits	Shift to PCP Vists
	(13,328) Visits*$189	13,328 Visits*$72
	($2,519,039) Cost Savings	$959,616 Cost Increase

Total Cost Savings
($1,559,423)

F. Performance Measures

The performance measures established for the Registry will be used to assess the effectiveness of MCOs and the Louisiana Health Care Quality Forum (LHCQF) in the implementation of the Registry and subsequent coordination of care and reduction in non-urgent ED utilization. The measures will be included as deliverables in contracts between Louisiana Medicaid and the MCOs and LHCQF. Monitors will track contractor performance to ensure established targets have been met. See Appendix A for details on each measure.

Performance Measure	Objective
ED Registry Participation	Participation by emergency departments
Reporting Proficiency	Completeness of ED utilization data
Member Identification	Accuracy of record locator service in matching MCO members with ED data
PCP Engagement Rate	% ED visits that are "out of care" MCO members
Member follow-up rate	Follow-up rate for members with chronic certain chronic diseases
ED Visits per 1000 Member Months	ED utilization
MCO-Patient Follow-Up Rate	Member follow-up and contact rate
Super-utilizer of ED services	Identify super-utilizers

G. Implementation Work Plan

The Registry will be implemented by the Louisiana Health Care Quality Forum (LHCQF), the administrator of LaHIE. Deliverables and task descriptions are as follows:

Task Descriptions

Finalize Data Standards:

One of the main challenges in developing a registry is ensuring that data from all participating organizations is collected in a consistent standardized manor. LHCQF team expects to work closely with all stakeholders to understand what data is available from contributing organizations, and then develop a standard data format that will ensure adequate information is

collected. The agreed upon standards will be fully documented, and delivered to DHH for final approval. Once approved, the specification document will be made available to providers.

Retrieve Test Data From DHH:

After data standard has been approved, LHCQF team will work with DHH team to establish group of pilot organizations to contribute data to the ED Visit registry. Our team will work closely with each participant organization, and their EMR vendor, to identity the appropriate data source(s) within their organizations. The LaHIE team will then work with each pilot organization to extract the data, and transmit it to DHH for incorporation into the ED Visit Registry. LHCQF team will setup and configure LaHIE environment to facilitate connecting to DHH SFTP server for the import of data into the registry. LHCQF Team will provide DHH a summary report of the actions completed, and documented verification that test files have been successfully transmitted to the ED Visit Registry.

Validate Test Data:

Once the data files from each of the pilot organizations have been collected, LHCQF team will closely analyze each submission for accuracy and completeness. The data submission standard will be reviewed and adjusted based on evaluation of data submission(s). Any changes necessary will be coordinated with each pilot organization. The process will be repeated until all pilot organizations have successfully submitted files that match the final standard.

Develop ED Visit Registry Layout:

This task is focused on designing the process of how information will be shared via the ED Visit Registry, how providers and payors will interact with the registry, and back-end data structures. The process of interacting with the ED Visit registry ensures alignment with established goals and objectives. LHCQF Solution Architects will leverage the documented process and use cases, to design changes necessary the LaHIE to enable hospitals and urgent care centers to submit data to the registry, permit authorized providers to view a patient's ED visit history. New modules will be designed to notify payors when a plan member has been discharged from either of these care settings. LHCQF team will present to DHH the process flow, design specifications, including mock-up of the provider user interface, for approval.

Develop Data Export Layout:

Health plans requested the ability to incorporate ED Visit Registry data into their case management systems. The project team will work with MCO's to develop a standard data extract. Upon completion of this task, LHCQF will present to DHH a documented standard for review and approval.

Establish Registry:

Payor Access – Based on approved design, LHCQF will setup and configure a new module that will allow registered users to view an ED registry for their specified plan. Standard registry filters will be available to allow users to filter on date ranges and export this information into their Case Management system

Provider Access – Based on approved design, LHCQF will setup and configure a new feature within LaHIE that will allow registered users to view an ED registry for their patient panel. Standard registry filters will be available to allow users to filter on date ranges and an option export this information into their EHR

User Acceptance Testing:

User Acceptance Testing involves significant participation from our Pilot Organizations, and is based on requirements established at the start of the project. This deliverable validates end-to-end business process, system transactions and user access, and confirms the registry functionally fit for use and behaves as expected. LHCQF recognizes that the specific focus during UAT should be in terms of the exact real world usage of the application. Our UAT testing will be done in an environment that simulates the real world or production environment. The test cases are written using real world scenarios for the application. The test team develops test scenarios, and scenario-based testing is used to conduct User Acceptance Testing.

LaHIE team will work with DHH and pilot group to develop a test plan, including specific User Acceptance Test cases. During UAT, a log of all the test cases executed and the actual results will be maintained. A copy of the log will be presented to DHH for final User Sign Off

Conduct User Training:

LHCQF Team will develop role based training materials on how to utilized the ED Visit Registry. LHCQF will provide webinars and in-person group training to Providers how to get access, and utilize the ED Visit registry. All training materials, along with a proposed training schedule, will be provided to DHH for review and approval prior to the start of the first training session. After training has been completed, LHCQF will provide DHH with documentation of each session was taught, and attendee list for review.

Implementation:

Implementation task is focused on three areas: (1) Production Startup of ED Visit Registry; (2) Assisting Hospitals, Urgent Care Centers and Payors with establishing data submissions to the Registry; and (3) Promotion of the Registry across Louisiana.

Upon successful completion of User Acceptance Testing, LHCQF Technology team will transition the Registry from its test environment into LaHIE Production environment. This is an

intensive process, and includes transferring all of the newly developed user interfaces modules on to the appropriate servers, updating all pro-active maintenance procedures, automated system monitors, etc.... Once completed, the Pilot group will be asked to validate the registry functioning as expected.

LHCQF LaHIE Implementation Team will work with Hospitals and Urgent Care Centers to sign-up for Participation in ED Visit Registry. This includes reviewing the data file submission specification, assisting in validation that the submission file is properly formatted, connection to SFTP server for data submission, and registering authorized providers to access the information contained in the Registry. This Implementation Team will also work with MCOs to begin providing Membership rosters, and notifications from The ED Visit Registry.

LHCQF will work with ED Workgroup Marketing sub-committee to develop and execute marketing plan to promote and educate the Health Care community on the benefits of utilizing the registry.

References

[1]Galvez, Erica. "HIE Bright Spots: How ADT Messages Support Care Coordination,." *HealthITBuzz*. ONC. 26 Mar. 2013. Web. http://www.healthit.gov/buzz-blog/state-hie/hie-bright-spots-adt-messages-support-care-coordination-part-ii/

[2] "The Financial Impact of Health Information Exchange on Emergency Department Care." *J Am Med Inform Assoc*. 2012. Web. http://jamia.bmj.com/content/early/2011/11/03/amiajnl-2011-000394.full.html

[3]"Statewide Health Information Exchange Provides Daily Alerts about Emergency Department and Inpatient Visits Helping Health Plans and Accountable Care Organizations Reduce Utilization and Costs." *Agency for Healthcare Research and Quality*. 12 Jan 2014. Web

[4]"ER is for Emergencies Results in Better Care Coordination and Cost Savings." *Washington State Hospital Association*. March 2014. Web. http://www.wsha.org/eremergencies.cfm

Appendix A

	Performance Measures				
	Measure	Objective	Numerator	Denominator	Baseline
1.	ED Registry Participation	Measure the participation of eligible hospitals in the submission of a daily batch file to DHH for the purposes of timely reporting of ED utilization by Medicaid members to Bayou Health plans.	Number of distinct eligible hospitals (by NPI) that successfully submit batch file to the DHH sFTP for all Medicaid member visits occurring on a specific date	All eligible hospitals	
2.	Reporting Proficiency	Measure the completeness of ED visits being reported to the ED Visit Registry	Number of ED discharges (unique events) found in the ED registry for any date of service for any eligible hospital	Number of claims and encounters specific to any eligible hospital for any date of service	
3.	Member Identification	Measure the accuracy of the record locator service vendor for matching Medicaid ED members with their linked health plan	Number of matched records	Number of unique events	
4.	PCP Engagement Rate	Determine the percentage of ED visit members that are "out of care" with his/her PCP or OB/GYN	Number of ED Registry visits with a Primary Care Provider (PCP) visit in 365 days prior to Date of Service (DOS).	Number of ED Registry discharges (unduplicated visits; member may be duplicated	531,200/689,950 Rate: 76.99%

	Performance Measures				
	Measure	Objective	Numerator	Denominator	Baseline
5.	Member follow-up rate	Determine the follow-up rate for members with select chronic diseases within 30 days of an ED Visit	Number of office visits for ED claims/encounters on the selected date of service with a diagnosis code pertaining to the selected diseases (see definitions) in the diagnosis history of the unique patient within 30 calendars of the date of service of the ED visit	Number of ED Registry visits for select chronic diseases	Congestive Heart Failure 579/1,507=38% COPD 6,729/21,417=31% Diabetes 70/245=29% Sickle Cell 2,143/5,437=39%
6.	HEDIS Ambulatory Care: ED Visits per 1000 Member Months	Measure the utilization of ED services for members of a selected plan	ED Visits	Member months	
7.	MCO-Patient Follow-Up Rate	Measure MCO-Patient follow up and contact rate after ED visits	Number of unique patient live contacts within 14 calendar days of receipt of ED visit notification	Number of ED visit notifications received on any given date of service	
8.	Super-utilizer of ED services	Identify super-utilizers	Number of distinct Medicaid Members who have three or more ED Visits within 90 calendar days	Member Months * 1,000	42,128/15,121=2.79

SR 29 AND SCR 47 of the 2014 Regular Legislative Session

Enclosure (5)

DHH Emergency Department Utilization Communications Plan

Emergency Room Utilization Workgroup – Communications Plan

January 2014

Drafted by the Louisiana Department of Health and Hospitals

Emergency Room Utilization Workgroup – Communications Plan

January 2014

Objective

Addressing inappropriate use of emergency rooms is a national challenge that has only become more pressing in recent years. In Louisiana, the transition from the charity hospital system run by Louisiana State University to the public-private partnerships has increased our need for ongoing communication about when it's the right time to use the emergency room. This messaging is critical because inappropriate use of the ER leads to higher costs for hospitals, communities and the State of Louisiana. Those costs are born by all Louisiana taxpayers.

The Emergency Room Utilization Workgroup Communications Plan should lay out a basic structure and set of key messages that should be utilized by all Workgroup members. Implementation of the plan is heavily dependent upon Workgroup adoption and implementation of these strategies and messages. This plan should accomplish three key things:

1. Educate residents on when it's the right time to use the emergency room.
2. Educate residents on where they can access care, at all levels for most circumstances based on four factors:
    a. The type of care needed;
    b. Whether they are insured, uninsured, have Medicaid or Medicare;
    c. Where they are located; and
    d. At what time they are seeking the care.

ER Workgroup Members

3. Empower residents, health care workers and community leaders with the tools to continue messaging on where to get the right care at the right time.

Given that specific components of the communications plan may take substantially more time and resources to complete, it is recommended that there be three phases of the rollout that should build upon earlier phases. The rollout is included in the schedule on page 5.

Tactics

Interim Education and Resource Website

With the understanding that a large-scale health care directory will take time to design and implement, the Department, along with the workgroup, shall develop a simple website that shares the unified messages (referenced in the section below). This site, which could be called RightCareLa.org, would provide simple education about how to know when it is the right time to use the emergency room and will provide a resource list to other options.

This site will be hosted and maintained by the Department of Health and Hospitals. Workgroup stakeholders would be encouraged to link to this website on their sites, social media pages and provide links to it in education materials.

Unified Messaging

Essential to implementing a campaign based on educating all consumers on when it's the right time to use the emergency room, is unified messaging across the health care industry, providers, stakeholders at the Department of Health and Hospitals.

DHH will develop key messages about picking the right place to find the right care at the right time. This messaging will be clear and simple. It will be written specifically to be accessible to most consumers and should be translated into (at a minimum) Spanish and Vietnamese.

The information about how to know where to go will be based on best practices identified and outlined in Washington State's "ER is for Emergencies" campaign: http://wsma.org/wcm/For_Patients/Know_Your_Choices/ER_is_for_Emergencies_for_Patients/wcm/Patients/Know_Your_Choices/ER_is_for_Emergencies.aspx?hkey=d000ad1d-e240-4baf-8ada-3ba4a189979f.

ER Signage and Push Cards

DHH will develop, along with the smaller workgroup, communications materials to be made available for us in emergency departments, such as:

- waiting room signage,
- talking points for health care workers about appropriate ER usage, and

- a push card/brochure with a perforated business card-size reference card that has key resource phone numbers and websites available.

The Department will provide final artwork for the materials listed above that may be printed and utilized by hospitals statewide.

Billboards and PSAs

The Department, along with the workgroup, will develop final artwork for billboards and bus stop benches that educate consumers on the right time to use the emergency room. It will also direct users to the education and resource page for more information. DHH will also provide these final files to the Bayou Health MCOs for use for their members.

The Department will also work with the workgroup to draft scripts for radio and TV public service announcements regarding the right time to use the ER and referencing the education and resource website. DHH will seek partners for the production and distribution of these PSAs.

Social Media Messaging

The Department, along with the workgroup, will develop a key set of social media messages and infographics that can be used on Facebook, Twitter and Instagram aimed at educating the public on the right time to use the ER. These messages and digital materials will be available for all workgroup members and available for download online for use by other stakeholder agencies.

Empowering Community Leaders

Key to an effective education campaign is the utilization of existing networks, communities and organizations already messaging and serving Louisiana residents. The smaller workgroup will seek to identify partner non-profits, faith leaders, education leaders and community organizers. The workgroup should also develop materials specific to health care workers that can be distributed by employers using existing communications mechanisms such as internal email listserves.

Engaging the Non-Profit Community

Numerous non-profit organizations have made health care access key issues of their work in recent years. The Department, along with the workgroup, will draft key messaging points for these non-profits. The Department and workgroup members should then seek the involvement of these non-profits in sharing information about appropriate emergency room use and where access to the right care may be found.

The Department and workgroup should provide any of the education materials and resources to these organizations for use with their membership target audiences.

Engaging Faith Leaders

Given the critical leadership role faith leaders play in Louisiana, the Department and workgroup should seek the partnership and participation of faith communities in the effort to share materials produced by the workgroup.

The Department and workgroup should also seek to meet with the faith-based collaborative groups that have engaged in health care messaging in recent years to seek their participation in sharing information with their constituents.

Engaging Health Care Workers

The Department, along with the workgroup, will develop messaging that may be sent to health care workers via their employers and representative organizations regarding the right time to use the ER, along with key talking points for how to help health care consumers find the right place to access care.

Cross-Agency Messaging

Given the Department of Health and Hospitals working relationships with state agencies that have direct interaction with Louisiana residents, the Department should fully utilize the points of contact these agencies have with residents to share information regarding the right time to use the ER and the education and resource website (and the health care directory once developed). These materials and messages could be added to existing mechanisms for communicating. Below is a list of possible agencies and points of contact.

- Department of Children and Family Services
  - At SNAP clinics.
  - Through TANF programs.
  - In foster parent materials.
- Department of Education
  - In materials provided to Louisiana schools for teachers, students and parents.
  - Possible lesson plan development for health classes.
- Department of Corrections
  - Through inmate release communications and materials.
- Department of Insurance
  - In call-center and website materials.
- Department of Revenue
  - In materials provided to individuals when taxes are filed.
- Department of Wildlife and Fisheries
  - Through materials that can be posted at fisheries landing docks, processors and in other venues.

Timeline

Phase One

The first phase of the communications plan will focus primarily on the following items:

1. Formation of the sub-workgroup, which should include communications staffers from the Workgroup members;
2. Discussion and identification of funding resources for creation of materials and the distribution of those statewide;
3. Development and workgroup approval of the unified messages; and
4. Development and launch of a simple education and resource website.

Phase Two

The second phase should focus on the development of the collateral marketing and education materials for distribution to the Workgroup members and stakeholders. Development of the health care directory should be ongoing.

This should also be the time during which the smaller workgroup seeks to partner with other organizations, faith leaders and to communication with health care workers.

Phase Three

Consideration of the development of a health care directory and large-scale push of the right care at the right time messaging.

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SR 29 AND SCR 47 of the 2014 Regular Legislative Session

Enclosure (6)

Louisiana Emergency Department Opioid Prescribing Recommendations and Background

Louisiana Opioid Prescribing Recommendations

1. The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.

2. Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.

3. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.

4. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED.

5. EDs are encouraged to assist in the coordination of care of patients who frequently visit the ED seeking controlled substances by contacting the patient's health plan to refer the patient for case management.

6. The law does not require the use of opioids for the treatment of pain.

7. Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed 30 pills.

8. EDs are encouraged to use an appropriate screening tool prior to prescribing opioid medication for acute pain. Patients whose behavior raises the provider's concern for addiction should be encouraged to seek detoxification assistance, and emergency department staff should provide information to assist in the process.

9. The administration of Demerol® (Meperidine) in the ED is discouraged.

10. For exacerbations of chronic pain, the emergency medical provider is strongly encouraged to access information from the Prescription Monitoring Program (PMP) and if necessary attempt to contact the patient's primary opioid prescriber or patient's pharmacy. Emergency medical providers should only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.

Disclaimer*: *This document should not be used to establish any standard of care. *No legal proceeding, including medical malpractice proceedings or disciplinary hearings, should reference a deviation from any part of this document as constituting a breach of professional conduct. These recommendations are only an educational tool. Clinicians should use their own clinical judgment and not base clinical decisions solely on this document. The recommendations are not founded in evidence-based research but are based on promising interventions and expert opinion. Additional research is needed to understand the impact of these interventions on decreasing unintentional drug poisoning and on health care costs. All of the following recommendations should be implemented in concert and collaboration with public health entities and other relevant stakeholders.*

Louisiana Emergency Department Opioid Prescribing Recommendation

BACKGROUND

The emergency department (ED) is the largest ambulatory source for opioid analgesics with 39% of all opioids prescribed, administered, or continued coming from emergency departments.[1] According to the Drug Abuse Warning Network (DAWN), the estimated number of ED visits for nonmedical use of opioid analgesics more than doubled from 2004 to 2008 (from 144,600 to 305,900 visits).[2] As the use of prescription opioids for chronic non-cancer pain has increased, so have unintended consequences related to opioids, such as unintentional poisoning deaths, poisoning hospitalizations involving prescription opioids and substance abuse treatment admissions.

These recommendations are intended to help EDs reduce the inappropriate use of opioid analgesics while preserving the vital role of the ED to treat patients with emergent medical conditions. These recommendations were developed by the Senate Resolution 29 Workgroup of the Louisiana Department of Health and Hospitals (DHH). This work group is composed of members representing:

- Louisiana Department of Health and Hospitals
- Louisiana Board of Pharmacy
- Louisiana Hospital Association
- American College of Emergency Physicians – Louisiana Chapter
- Louisiana Emergency Nurses Association
- Bayou Health Health Plans

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1. **The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.** Parenteral opioids should be avoided for the treatment of chronic pain in the ED because of their short duration and potential for addictive euphoria. Generally, oral opioids are superior to parenteral opioids in duration of action and provide a gradual decrease in the level of pain control. When there is evidence or reasonable suspicion of an acute pathological process causing the acute exacerbation of chronic pain then parenteral opioids may be appropriate. Under special circumstances some patients may receive intravenous or intramuscular opioids in the ED.

2. Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed, or stolen.
Patients misusing controlled substances frequently report their prescriptions were lost or have been stolen. Pain specialists routinely stipulate in pain agreements with patients that lost or stolen controlled substances will not be replaced. Most pain agreements between chronic pain patients and physicians, including the HRSA toolkit sample pain agreement[3], state that prescriptions will not be replaced. EDs should institute a policy not to replace prescriptions that are requested on the basis of being lost, stolen, or destroyed.

3. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.
Methadone should not be prescribed or administered as opioid substitution therapy from the ED. Methadone has a long half-life and patients who are part of a daily methadone treatment program that miss a single dose will not go into opioid withdrawal for 48 hours. Opioid withdrawal is not an emergency medical condition. The emergency medical provider should consider that the patient may have been discharged from a methadone treatment program for noncompliance or is not enrolled.

4. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED.
Long acting opioids should not be prescribed from the ED because this treatment requires monitoring which the emergency medical provider cannot provide. Methadone and oxycodone are involved in more unintentional opioid overdose deaths than any other prescription opioid.[4]

5. EDs are encouraged to assist in the coordination of care of patients who frequently visit the ED seeking controlled substances by contacting the patient's health plan to refer the patient for case management.
Health plans should provide hospitals with information on the referral process.

6. The law does not require the use of opioids for the treatment of pain.

7. Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed 30 pills.
Patients should receive only enough opioid medication prescribed from the ED to last them until they see a physician for follow-up. For acute injuries with objective findings such as fractured bones, the emergency medical provider should not prescribe more than 30 pills. Large prescriptions promote a longer period of time to elapse before the patient's pain control and function can be re-evaluated by a physician. Large prescriptions also increase the potential for diversion and abuse. Some fractures, such as a fractured rib or a fractured clavicle, often heal within 30 days without further medical evaluation. The patient should have a medical evaluation if they require opioid therapy beyond 30 pills. Infrequently and in exceptional cases, it may be necessary to prescribe more than 30 opioid pills. Opioid medications should be used only after determining that alternative therapies do not deliver adequate pain relief. The lowest dose of opioids that is shown to be effective should be used.[5]

8. EDs are encouraged to use an appropriate screening tool prior to prescribing opioid medication for acute pain. Patients whose behavior raises the provider's concern for addiction should be encouraged to seek detoxification assistance, and emergency department staff should provide information to assist in the process.

Patients with a history of or current substance abuse are at increased risk of developing opioid addiction when prescribed opioids for acute pain.[6,7] Emergency medical providers should ask the patient about a history of or current substance abuse prior to prescribing opioid medication for the treatment of acute pain. A non-opioid regime should be offered to ED patients with acute pain and a history of or current substance abuse. A history of or current substance abuse should not exclude an ED patient from being prescribed opioids for acute pain but it should prompt a discussion with the patient about the potential for addiction. Consideration should be given to prescribing a smaller quantity of opioid medication, with follow up opioid monitoring in patients with a history of or current substance abuse.

Patients often find themselves in the ED after their dependence or addiction has led them to a turning point in their lives, such as a traumatic event or hitting rock bottom. Without immediate intervention the patient can easily fall back into addiction. Patients should be referred to an appropriate treatment facility. See http://nationalsubstanceabuseindex.org

9. The administration of Demerol® (Meperidine) in the ED is discouraged.

Demerol® use has been shown to induce seizures through the accumulation of a toxic metabolite with a long half-life that is excreted by the kidney. Demerol® has the lowest safety margin for inducing seizures of any opioid. Numerous reviews of meperidine's pharmacodynamic properties have failed to demonstrate any benefit to using meperidine in the treatment of common pain problems.[8,9]

10. For exacerbations of chronic pain, the emergency medical provider is strongly encouraged to access information from the Prescription Monitoring Program (PMP) and if necessary attempt to contact the patient's primary opioid prescriber or patient's pharmacy. Emergency medical providers should only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.

Opioid prescriptions for exacerbations of chronic pain from the ED are discouraged. Chronic pain patients should obtain opioid prescriptions from a single opioid prescriber that monitors the patient's pain relief and functioning. Prescribing pain medicine from the ED for chronic pain is a form of unmonitored opioid therapy which is not safe. In exceptional circumstances, if the emergency medical provider deems opioid medication is appropriate for acute exacerbations of chronic pain, the following safeguards should be considered:

- Prescribe enough opioid pain medication to last until the patient can contact their primary prescriber, with a maximum of a 3-5 day supply of opioid (rather than a quantity sufficient to last until the patient's next scheduled appointment).
- The Prescription Monitoring Program should be utilized to identify all current controlled drug prescriptions. The ED physician should confirm that recent opioid prescriptions reported by the pharmacy match what the patient reports. No opioids should be prescribed if the patient misrepresents historic opioid prescriptions. Providing false information in an effort to obtain prescription opioids is an aberrant medication taking behavior that can signal an addiction problem.

- If deemed necessary, the emergency medical provider should attempt to contact the primary opioid prescriber prior to prescribing any opioids. If the patient's primary opioid provider feels further opioid pain medicine is appropriate, it can be prescribed by that provider, during office hours.

[1]National Center for Health Statistics. Medication therapy in ambulatory medical care: United States, 2003-04. Vital and Health Statistics, Series 13, number 163, December, 2006. Accessed on 10/16/09 at http://www.cdc.gov/nchs/data/series/sr_13/sr13_163.pdf#page=26#page=26

[2]Cai R, Crane E, Poneleit K, Paulozzi L. Emergency Department Visits Involving Nonmedical Use of Selected Prescription Drugs --- United States, 2004—2008. *MMWR Morb Mortal Wkly Rep* 2010; 59(23); 705-709.

Accessed on 5/24/11 at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5923a1.htm?s_cid=mm5923a1_w.

[3]HRSA Toolkit accessed on 10/23/2009 at: http://hrsa.dshs.wa.gov/pharmacy/ChronicPainAgreement.pdf

[4]CDC - Injury - Poisoning in the United States - Issue Brief. Accessed on March 22, 2010 at: http://www.cdc.gov/HomeandRecreationalSafety/Poisoning/brief.htm.

[5]Unintentional Drug Poisoning in the United States, CDC Issue Brief, July 2010, accessed May 27, 2011 at http://www.cdc.gov/HomeandRecreationalSafety/pdf/poison-issue-brief.pdf

[6]Braden J, Russo J, Fan M, Edlund M, Martin B, DeVries A, Sullivan MD. Emergency department visits among recipients of chronic opioid therapy. Arch Intern Med *in press*.

[7]Edlund MJ, Fan M, DeVries A, Braden J, Martin B, Sullivan MD. Trends in use of opioids for chronic non-cancer pain among individuals with mental health and substance use disorders: the TROUP study. Clin J Pain 2010; 26:1-8.

[8]Chalverus, CA. Clinically significant meperidine toxicities. *J Pharm Care in Pain & Symptom Control* 2001; 9(3):37-55.

[9]Latta, KA, Ginsberg, B, Barkin, RL. Meperidine: A critical review. *Am J Therapeutics*, 2002, 9:53-68.

SR 29 AND SCR 47 of the 2014 Regular Legislative Session

Enclosure (7)

Measures and Baselines for Quarterly Reporting on the Progress of SR 29 Strategies

SR29 Progress Measure Specifications

1) Eligible Hospital Participation in ED Visit Registry

Objective: Measure the participation of all eligible hospitals that submit a daily batch file to DHH for the purposes of reporting and tracking ED utilization among Medicaid members.

Numerator: Number of distinct eligible hospitals (by NPI) that successfully submit batch file to the DHH sFTP for all Medicaid member visits occurring on a specific date. A Medicaid member is defined as any Medicaid recipient (Title XIX or Title XXI) that is also an enrollee in one of the Bayou Health Managed Care Organizations. Data source: ED visit registry data

Denominator: All eligible hospitals. An eligible hospital is defined as any Medicaid hospital provider (type 60) that operates a fully-staffed emergency department. Data source: DHH MDW. See description on page 2.

2) Completeness of Data Reported to ED Visit Registry

Objective: Measure the completeness of ED visits being reported to the ED Visit Registry

Numerator: Number of ED discharges (unique events) found in the ED registry for any date of service for any eligible hospital. Source: ED Visit Registry

Denominator: Number of claims and encounters specific to any eligible hospital for any date of service. Source: DHH MDW

3) Accuracy of Medicaid Member Identification from ED Visit Registry

Objective: Measure the accuracy of the record locator service vendor for matching Medicaid ED members with their linked health plan.

Numerator: Number of matched records. A record is considered matched if the RLS engine is able to match the unique patient ID to an eligibility record and health plan enrollment record. Source: DHH MDW.

Denominator: Number of unique events. Source: ED Visit Registry.

4) Pre-ED Visit Primary Care Provider Contact Rate

Objective: Determine the percentage of ED visit members in recent contact with his/her PCP or OB/GYN.

Numerator: Number of ED Registry visits with a Primary Care Provider (PCP) visit in 365 days prior to Date of Service (DOS). Source: DHH MDW

Denominator: Number of ED Registry discharges (unduplicated visits; member may be duplicated). Source: ED Visit Registry

Definition of PCP:

- Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics/gynecology.
- Certified nurse midwives and nurse practitioners who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider).
- Primary care practitioner. A physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.

5) Post-ED Visit Physician Follow Up Rate

Objective: Determine the follow-up rate for members with select chronic diseases within 30 days of an ED Visit

Numerator: Number of office visits for ED claims/encounters on the selected date of service with a diagnosis code pertaining to the selected diseases (see definitions) in the diagnosis history of the unique patient within 30 calendars of the date of service of the ED visit. Source: DHH MDW

Denominator: Number of ED Registry visits for select chronic diseases. Source: ED Visit Registry

6) ED Visits per 1,000 Member Month

Objective: Measure the utilization of ED services for members of a selected plan

Numerator: ED Visits (see HEDIS Ambulatory Care specifications)

Denominator: Member months (see HEDIS Ambulatory Care specifications)

SR29 Progress Measure Specifications

Data Source: The LMMIS MARS Data Warehouse (MDW) is a client/server computing platform developed to house a minimum of five full fiscal years (state and federal) of LMMIS claims and encounters, eligibility, provider, and reference information. The purpose of the MDW is to provide an independent, isolated computing platform that will be used to generate CMS and State MARS reports. It also supports the data mining efforts required by DHH to manage the Medicaid program.

Measure #5 – Post-ED Physician Follow Up Rate Specifications

Office Visits: A claim with CPT 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429, 99499

Sickle Cell Disease:

28241	THLASEMA HB-S W/O CRISIS	28242	THLASSEMIA HB-S W CRISIS
28260	SICKLE CELL DISEASE NOS	28261	HB-SS DISEASE W/O CRISIS
28262	HB-SS DISEASE W CRISIS	28263	HB-SS/HB-C DIS W/O CRSIS
28264	HB-S/HB-C DIS W CRISIS	28268	HB-S DIS W/O CRISIS NEC
28269	HB-SS DIS NEC W CRISIS		

Congestive Heart Failure:

39891	RHEUMATIC HEART FAILURE	42832	CHR DIASTOLIC HRT FAIL OCT02-
42831	AC DIASTOLIC HRT FAILURE OCT02	4281	LEFT HEART FAILURE
4280	CONGESTIVE HEART FAILURE	42833	AC ON CHR DIAST HRT FAIL OCT02-
42820	SYSTOLIC HRT FAILURE NOS OCT02-	42840	SYST/DIAST HRT FAIL NOS OCT02-
42821	AC SYSTOLIC HRT FAILURE OCT02-	42841	AC SYST/DIASTOL HRT FAIL OCT02-
42822	CHR SYSTOLIC HRT FAILURE OCT02-	42842	CHR SYST/DIASTL HRT FAIL OCT02-
42823	AC ON CHR SYST HRT FAIL OCT02-	42843	AC/CHR SYST/DIA HRT FAIL OCT02-
42830	DIASTOLC HRT FAILURE NOS OCT02-	4289	HEART FAILURE NOS

COPD:

4660	AC BRONCHITIS*	4919	CHRONIC BRONCHITIS NOS
490	BRONCHITIS NOS*	4920	EMPHYSEMATOUS BLEB
4910	SIMPLE CHR BRONCHITIS	4928	EMPHYSEMA NEC
4911	MUCOPURUL CHR BRONCHITIS	494	BRONCHIECTASIS OCT00-
49120	OBS CHR BRNC W/O ACT EXA	4940	BRONCHIECTAS W/O AC EXAC OCT00-
49121	OBS CHR BRNC W ACT EXA	4941	BRONCHIECTASIS W AC EXAC OCT00-
4918	CHRONIC BRONCHITIS NEC	496	CHR AIRWAY OBSTRUCT NEC *Qualifies only if accompanied by secondary diagnosis of 491.xx, 492.x, 494.x or 496 (i.e., any other code on this list).

Diabetes:

25010	DMII KETO NT ST UNCNTRLD	25011	DMI KETO NT ST UNCNTRLD
25012	DMII KETOACD UNCONTROLD	25013	DMI KETOACD UNCONTROLD
25020	DMII HPRSM NT ST UNCNTRL	25021	DMI HPRSM NT ST UNCNTRLD
25022	DMII HPROSMLR UNCONTROLD	25023	DMI HPROSMLR UNCONTROLD
25030	DMII O CM NT ST UNCNTRLD	25031	DMI O CM NT ST UNCNTRLD
25032	DMII OTH COMA UNCONTROLD	25033	DMI OTH COMA UNCONTROLD