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INSIDE

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Editor's Note: This month's cover story on the opioid epidemic is the latest in an ongoing series across multiple AHC Media publications. To read more about opioids, please visit AHCMedia.com.

Innovative Program Targets Five Common Pain Syndromes With Non-opioid Alternatives

To prevent chronic acute pain from becoming chronic, administrators say the heart of the ALTO program is in the ED, but that other departments must be brought into the loop as well

With the prescription opioid crisis a growing concern across the country, providers are feeling the squeeze — caught between calls to limit prescribing powerful painkillers and patient complaints that treatment for pain is suboptimal. No one is feeling the heat more than frontline emergency providers who must contend daily with patients who present with fractures, injuries, and other instances of acute or chronic pain. How do physicians and nurses meet patient expectations for pain relief without exacerbating the opioid abuse problem?

One potential solution that is attracting considerable attention is the Alternatives to Opiates (ALTO) program developed by the St. Joseph's Healthcare System in Paterson, NJ. While the program has only been formally in place in the ED at St. Joseph's Regional Medical Center (SJRMC) since January, developers note that they have successfully treated more than 300 patients with non-opioid alternatives thus far, and other hospitals in New Jersey and around the country are eager to hear how they might implement a similar program.

Focus on Pain Receptor Sites

Mark Rosenberg, DO, MBA, FACEP, the chairman of emergency medicine and medical director for population health in the St. Joseph's Healthcare System, said the road to the ALTO program began about two years ago when he first searched for a way to improve pain management in the ED while also moving the focus away from the use of opioid medications.

"I worked with New York Medical College [in Valhalla, NY] to develop an acute pain fellowship for emergency medicine, and my first fellow was

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Alexis LaPietra, DO," Rosenberg explains, noting that LaPietra is now the medical director of pain management in the ED at SJRMC. "She took this pain fellowship and brought back the ALTO program."

While the primary aim of the program is to use alternatives to opioids whenever possible, there is also another important underlying goal.

"Many patients who come to the ED with acute pain will go on to have chronic pain, so if we can stop the acute pain from becoming chronic, that would be helpful," Rosenberg notes. "Also, if we don't have to give opioids, then no one will get addicted to opioids."

Rosenberg explains that the protocols that make up the ALTO program are focused on five key diagnoses that emergency providers see regularly:

- renal colic or kidney stones;
- lumbar radiculopathy or sciatica;
- acute headache, including migraine and cluster headaches;
- musculoskeletal pain, such as back pain and shoulder pain;
- extremity fractures and joint dislocations.

Under the ALTO program, instead of using opioids for these diagnoses, providers use a host of different therapies, but the focus of these therapies is very different, Rosenberg stresses.

"This is not just giving a different pain medication," he says. "The pain medications are specifically chosen because of how they affect the pain receptor sites for each of the different pain syndromes."

Rosenberg adds that it is not a matter of giving a patient acetaminophen instead of opioids.

"That is not how this works," he explains. "All pain is mediated by receptors, so we are just addressing the receptor sites."

Among the alternative therapies called for in the ALTO program are trigger point injections, nitrous oxide, and ultrasound-guided nerve blocks, to name a few. But are physicians receptive to using such therapies?

"Once [physicians] hear the protocols, they understand how it is really [about] receptor management, and when they hear our success rate, everyone is willing to jump on board," Rosenberg says. "Physicians are well-meaning and don't want to contribute to the opioid problem if they have another option."

In many cases, the ALTO therapies actually work better than opioids, Rosenberg observes.

"We see this over and over again — more complete pain relief," he says. "Rather than covering up the pain with an opioid, we are actually stopping the pain at the receptor site."

Provide Education, Psychosocial Support

The ALTO program is not just about prescribing; it also focuses on providing psychosocial support and education to patients, Rosenberg notes.

"The majority of patients do not want to get dependent on opioids, and they would rather stay away from them. What they want is pain relief, and I can give them comparable or better pain relief without using opioids," he says. "Patients are excited about this, and it is not experimental treatment. It is just using different treatments rather than going to opioids."

For follow-up, the ALTO program reaches into outpatient centers that understand the approach.

"This is a comprehensive, multidisciplinary program that utilizes family medicine as part of our referral practice, and they know the patients in the ALTO protocol are trying to not use opioids," Rosenberg says. In some of the more difficult cases, physical therapy and other non-opioid techniques may be used to help patients effectively manage their pain, he says.

Rosenberg acknowledges that some patients who have been on opioids before and want to receive opioids again for a variety of different pain relief reasons likely will not be satisfied with the ALTO approach. He adds that patients with dependency issues — especially those patients who have overdosed on oxycodone or heroin — will be referred to recovery programs.

While the aim of ALTO is to minimize the use of opioids, there is a major place for the powerful painkillers when they are, in fact, needed, Rosenberg stresses.

"We use opioids, but we try alternatives first," he says. "The results have been phenomenal."

Take More Time With Patients

The ALTO approach takes a bit more of a provider's time to deliver for a variety of reasons, LaPietra acknowledges.

"Patients deserve to get a little bit more education than maybe we have classically given them," she explains. "When we first prescribed something like a tablet of Percocet, we [would] say, 'here you are getting a strong pain medication and you might get a little nauseous, and you might feel a craving for it, so be careful.' [There was] very minimal instruction when they were getting one tablet."

EXECUTIVE SUMMARY

To combat the prescription opioid problem, St. Joseph's Healthcare System in Paterson, NJ, has developed a new program that gives providers options they can use to effectively alleviate pain without resorting to highly addictive medication. Launched in January 2016 in the ED at St. Joseph's Regional Medical Center (SJRMC), the Alternatives to Opioids (ALTO) program utilizes protocols that primarily target five common conditions: renal colic, sciatica, headaches, musculoskeletal pain, and extremity fractures. Administrators say they have successfully treated more than 300 patients under the new program, and they see ALTO as a model other hospitals can duplicate.

- Among the alternative therapies called for in the ALTO program are trigger point injections, nitrous oxide, and ultrasound-guided nerve blocks.
- ALTO medications are specifically chosen because of how they affect the pain receptor sites for each different pain syndrome.
- While the primary goal of the program is to use alternatives to opioids whenever possible, another important underlying goal is to stop acute pain from becoming chronic.
- While ALTO therapies typically take a bit longer to deliver than prescribing opioids, administrators note that this has not adversely affected patient flow in the ED.

With the ALTO program, patient education is a high-priority task that applies not only to explaining the opiate alternatives that are available, but also to explaining the risks of opiates when they must be used.

"We do take a little bit more time than we did before, but that is a population health benefit overall," she says. "It makes our patients feel involved in the conversation, and it helps them feel confident when we take the time to talk to them."

LaPietra adds that the extra time with patients helps ease their anxieties, and probably also helps them feel better.

"They know that they are going to be treated and that we care about what is going on," she says.

Also, some of the ALTO treatments, such as trigger point injections, take more time to deliver than prescribing a tablet, but they are also better medicine, LaPietra contends.

"It is a good investment. It is what medicine is about: involving the patient, caring for the patient, and taking some time with the patient," she says.

On average, LaPietra estimates that the ALTO approach requires an extra one to two minutes — not enough of a change to adversely affect patient flow.

"In our 12-hour day, adding a minute or two to each patient shouldn't inhibit our ability to discharge and see more patients," she says. "The patients are very satisfied, so it is worth investing the time because they will leave the department feeling better about their experience."

In fact, improved patient satisfaction has encouraged providers to spend extra time with patients because they get to see the positive patient response, LaPietra notes.

Rosenberg notes that the extra time providers spend with pain patients has not adversely affected the

ACEP Takes Issue With Pain Questions

The American College of Emergency Physicians (ACEP) urges the Department of Health and Human Services (HHS) to remove questions about pain from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), the survey HHS uses to assess patient satisfaction among discharged patients. In a letter to HHS Secretary **Sylvia Burwell**, ACEP President **Jay Kaplan**, MD, said the questions regarding pain have resulted in unintended consequences.

Specifically, Kaplan noted that in pursuit of higher patient satisfaction scores, providers may honor patient requests for powerful painkillers, even when such medications are unnecessary or even harmful.

"Any questions that provide an opportunity for patients to express dissatisfaction because they didn't get the drugs they sought provide disincentives for physicians to prescribe non-opioid analgesics, which will negatively affect their scores," Kaplan said.

The 32-item HCAHPS survey includes two questions about pain:

- During this hospital stay, how often was your pain well-controlled?
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

Beginning in 2016, less than satisfactory answers to these questions adversely affect hospital DRG payments, Kaplan explained. He also noted that similar questions are included in the third draft version of the Emergency Department Patient Experience of Care (EDPEC) survey, which has undergone pilot testing. After some earlier input from ACEP, those questions now read as follows:

- During this ED visit did you have pain?
- Did the doctors and nurses try to help reduce your pain?
- Did you get medicine for pain?

Kaplan noted that similar questions have been a problem for years on other types of patient satisfaction surveys and that they are counterproductive to efforts to combat the opioid crisis.

"We are concerned that the current evaluation system may inappropriately penalize hospitals and physicians who, in the exercise of medical judgment, opt to limit opioid pain relievers to certain patients and instead reward those who prescribe opioids more frequently," he said.

Kaplan concluded his letter by urging HHS to remove any questions regarding pain at least until there is a thorough examination of whether there is a connection between the pain questions and any inappropriate prescribing.

Mark Rosenberg, DO, MBA, FACEP, supports the ACEP missive, noting that emergency providers should not be judged specifically on patient satisfaction of their pain management.

"They should be judged on the care that they give their patients and how satisfied patients are with their care," he says. "A significant number of patients who are dependent on opioids and come to the ED to doctor shop are also filling out those surveys, and they are not satisfied unless they get a prescription for opioids." ■

total amount of time patients spend in the ED.

"When I am looking at discharged patients, which most of [the ALTO] patients are, the cycle time after they have been seen by a physician has actually decreased," he says. "On the global picture, I am not seeing any effect by implementing this pain management program on discharged patients."

Consider Payer Response

How do program administrators know the program is working? Rosenberg observes that many of the patients receive immediate and complete relief from their pain. The approach has worked particularly well for patients who present with renal colic, he says. For instance, Rosenberg recalls one patient who had received hydromorphone, but achieved only partial pain relief.

"At that point we got a pain consult with our team and the decision was made to use the ALTO protocols. The patient got some IV lidocaine and had complete relief of his pain," he explains.

Providers also are achieving good results from patients who present with severe back pain, many of whom are in such pain that they are unable to walk when they first arrive, Rosenberg says.

"We find the site of where the pain is coming from or where the trigger is," he says. "That is where you have a focal area — a spasm of inflammation, whether it is in the neck or upper or lower back."

Typically, these patients receive trigger point injections with lidocaine-type medications, and they feel much better very quickly, Rosenberg explains.

"We refer these patients into physical therapy or start them on physical therapy while they are still in the ED, and they are followed up with our family medicine program," he explains. "We have not gotten any patients back in need of [repeat] trigger point injections. Most of the time the cycle is broken and patients are doing extremely well."

The ALTO program is so new that it is not yet entirely clear how payers will view the treatments, Rosenberg notes.

"We have not had any issues," he says. "We have been doing regional nerve blocks for a long time, so I would anticipate that these are billable procedures ... and that insurance companies would be paying for them."

Decline Refill Requests for Opioid Prescriptions

Thus far, there is little evidence that the program has discouraged "doctor shopping" patients from presenting to the ED — at least not yet.

"The feedback I have gotten is that the patients are still coming, but they are asking questions and they are [mentioning] the program by name," LaPietra says. "They are saying that they have some chronic pain or that they have come here before for a painful condition, and that they understand that we will not be giving them pain medication anymore."

The nursing staff report they spend a lot of time bedside with these patients, educating them about what ALTO really is, and pointing out that they will receive treatment for their pain; however, nurses also stress patients will undergo a risk assessment, and that providers will try to be appropriate and responsible in what they prescribe, LaPietra explains.

"For some of these patients who have chronic pain and longstanding prescriptions from their physicians, we are able to look them up in our prescription database, and if they have a history of opioid prescriptions from their physicians, that is good and it leads me to believe that they are receiving good care in the community," LaPietra says. "But we will not refill those chronic pain medications. That is a part of ALTO that we have tried to push our physicians to educate our patients about."

Emergency providers will take care of an acute pain episode in the ED, and they will turn to opioid alternatives first, but patients must understand that emergency providers will not be refilling any high-milligram prescriptions for pain medications, and that is for patient safety, LaPietra stresses.

"If patients are on a lot of strong opiates that have side-effects, then they need to be followed up regularly with the physician who did the extensive evaluation before giving out those kinds of medications," she says. "We don't have that kind of time with our patients."

LaPietra agrees these types of patients might eventually seek treatment elsewhere, but she is also hopeful that with some education and understanding of the risks, patients will follow up with a primary care practitioner.

"That is the most appropriate place to go rather than utilizing the ED for prescription refills," she says.

Make the Required Investments

Clinicians and administrators interested in establishing a program similar to ALTO in their own hospitals must allow time for providers to learn the new protocols and become comfortable with the approach, LaPietra notes. This required four to five months of intense training in the ED at SJRMC, but it is a very large department with 50 to 60 attending physicians, 24 residents, a few mid-level providers, and more than 100 nurses, she explains.

However, the hardest work, and what takes the longest amount of time to accomplish, is involving other departments, LaPietra says.

"In the ED, you are a closed unit, so word travels quickly and the dissemination of information can happen pretty easily," she explains. "But when you are talking about getting the support of other departments, that calls for meetings, and then after the meetings there is reflection, and then discussion with colleagues."

Engaging other departments requires effort and resources, but it is worth the investment, LaPietra stresses. "If the hospital system wants to adopt this protocol, the ED is the heart and soul of it, but really the benefit of this program is in the community where there will be a strong downstream effect," she says.

Further, LaPietra states that clinicians from many different disciplines have been receptive to the ALTO approach.

"Everyone is very aware of what is going on right now with prescription opiates, and what I am finding is that everyone is trying to do a little better," she says. "[The other departments at SJRMC] were very open to adopting something that we already had for them."

Implementation does not necessarily have to take a full year, but administrators should appreciate the amount of outreach and training that must take place, LaPietra stresses.

"The long-term effects of all this investment are going to be huge," she says. "This is going to continue to improve patient lives and patient safety."

Be Proactive

Both LaPietra and Rosenberg say they are happy to share their protocols and research, and they are willing to collaborate with others interested in implementing an ALTO-type program.

"If we are the only ones doing this, then it is not helping everybody," LaPietra explains. "We want to be a model. We want to show people what we are doing and how we have made it successful ... so that we can start a paradigm shift away from only using opiates and [having providers realize] that there is a lot more out there."

LaPietra adds that the ALTO program is about reform and the recognition that things need to change.

"Not only do we need to make change in terms of available treatment for people who have an addiction, but we also need to promote a proactive approach to prevent people from getting hooked on prescription opiates, which are really a gateway drug into heroin," she says.

> BY TAKING A PROACTIVE APPROACH TO THE PROBLEM, THERE IS NO NEED FOR THE GOVERNMENT TO ISSUE MORE REGULATIONS.

Also, by taking a proactive approach to the problem, there is no need for the government to issue more regulations, LaPietra observes.

"We don't need the government to limit our opiate prescribing. We want to be able to prescribe these medications. They are very important, especially for end-of-life pain," she says. "We are already regulating ourselves by [implementing] an innovative, proactive program that can contribute to dampening this epidemic." ■

SOURCES

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New Tool Improves Processes, Streamlines Operations

A one-page aid facilitates shared decision-making, improves patient knowledge, and leads to more efficient use of resources in low-risk chest pain patients

An intriguing new tool that encourages shared decision-making between emergency providers and patients who present with low-risk chest pain shows promise toward improving care as well as patient knowledge. Evidence suggests the new tool ultimately leads to the more efficient use of resources. This is based on research presented at the American College of Cardiology's 65th Annual Scientific Session held on April 2-5 in Chicago.

The tool, called Chest Pain Choice, was developed by researchers at the Mayo Clinic in Rochester, MN. It is designed to facilitate a discussion of whether the patient should be admitted to an ED observation unit for cardiac stress testing or to follow up with a clinician in 24-72 hours.

"When we designed it, we intentionally engaged with major stakeholders, recognizing that it really needed to work for all the parties involved," explains **Erik Hess**, MD, an emergency physician and health services researcher at the Mayo Clinic. "We incorporated patient representatives initially, as well as designers, investigators, emergency physicians, and cardiologists in developing the prototype."

For instance, one of the biggest concerns of providers was the effect the tool would have on workflow in the emergency setting.

"Prior research in the area of shared decision-making has usually been conducted in the outpatient setting in the context of having more time to make decisions," Hess notes. "It presumed the patient would have the opportunity to grapple with

their decision outside of the context of the clinical encounter, and so there would be videos developed or extensive pamphlets [to review]. Our clinicians essentially said there was no way they would use the tool if it was more than a page."

Providers also voiced concern about the degree of understanding patients have regarding their risks when discussing various treatment options.

"Clinicians tend to feel that it is up to them to keep their patients safe, and they are not [always] confident at baseline when they are counseling patients that what they say connects, is processed, and could be recited back to them," Hess observes. "The risk element is what physicians care about quite a bit."

To meet these concerns, designers constructed a brief, one-page, patient-oriented tool that provides descriptions and graphics that illustrate a patient's risk of experiencing a cardiac event in the next 45 days. The risk is depicted in three different formats that are considered best practices by health literacy experts, Hess explains.

"Some people might like pictures, some might like numbers, and others might like words," he says.

Consequently, the tool illustrates risk through pictograms, showing, for example, that one out of 100 characters is at risk for having a cardiac event. Simultaneously, the tool describes this risk in numbers as well as in words.

"Whenever you communicate data to patients, it always has to have the same denominator," Hess observes. "So [in all three forms of communication] we are always staying with the same denominator. We are not switching it around."

EXECUTIVE SUMMARY

A one-page tool has shown promise for facilitating shared decision-making between clinicians and patients who present to the ED with low-risk chest pain. The tool, dubbed Chest Pain Choice, was developed by researchers at the Mayo Clinic. It is designed to more effectively communicate risk to patients so that they can make more informed decisions with their providers regarding treatment options.

- Investigators devised a study involving 898 low-risk chest pain patients in six EDs in five states. Half the patients were randomized to standard physician consultations and half received consultations facilitated by the Chest Pain Choice tool.
- A post-clinical encounter questionnaire testing patient knowledge showed that patients in the intervention group answered 53% of the questions correctly vs. 44.9% in the group receiving standard physician consultations.
- When asked to evaluate their experience of discussing their care with the physician, 68.9% of patients who experienced the decision aid said they would recommend the method used during their discussions, while 61.2% of the patients receiving standard consultations recommended the method used in their cases.
- Researchers noted that patients who discussed their risks using the decision aid tool were substantially less inclined to opt for admission to an ED observation unit for stress testing than patients who received standard physician consultations.

Target a Subgroup of Chest Pain Patients

To examine the tool in practice, investigators designed a study involving 898 low-risk chest pain patients in six EDs in five states. Half the patients were randomized to receive a standard physician consultation and half underwent discussions with their physicians using the Chest Pain Choice tool.

To test their knowledge about their risks and options, all the patients in both groups filled out a questionnaire following their ED encounters.

The results showed that patients who discussed their risks with the physician using the decision aid answered 53% of the questions correctly, while patients randomized to standard consultations answered 44.6% of the questions correctly.

When asked to evaluate their experience of discussing their care with a physician, 68.9% of the patients who experienced the decision aid said they would recommend the method used during their discussions, while 61.2% of the patients receiving standard consultations recommended the method used in their cases.

Further, patients who discussed their risks using the decision tool were substantially less inclined to opt for admission to an ED observation unit for stress testing than patients who received standard physician consultations. Researchers report that there were no adverse heart events associated with use of the decision aid.

Hess stresses that the tool is not

designed for patients who are so low risk that a physician is confident that those patients need no further workup; those patients were not even included in the study.

"The [study participants] were patients that the clinician was worried about enough to consider admitting them to observation for further testing, and at the time they were making the decision for further testing, they were unaware on average of the patients' objective risks," Hess explains. "Based on the physician exam and initial vital signs, these were the patients that the physicians were concerned enough about that they didn't think they should necessarily go home immediately."

Use More Inclusive Language

In the study, Hess notes the physicians in the intervention arm only ended up spending a little more than one minute longer to use the tool to engage in a discussion with patients about their options than those physicians engaging in traditional consultations. This proved to be less of a time limitation than what some physicians feared when they engaged in the study, Hess observes.

Further, use of tool has had a larger effect on the way some physicians communicate with patients.

"When you start using the tool, your approach to communicating with patients starts to change," Hess notes. "Physicians often start to use more inclusive language."

For example, when considering options for care, a physician will suggest that he or she and the patient look at the situation together, Hess explains.

"Communication styles have started to correlate with the use of the tool. There are definitely physicians who have actually started to change the way they interact with patients, and they want to use the tool in practice," he says.

CLINICIANS AT OTHER SITES AROUND THE COUNTRY ARE EXPERIMENTING WITH THE DECISION TOOL AND, IN SOME CASES, MODIFYING IT TO BE AS CONTEXTUALLY SPECIFIC AS POSSIBLE.

"There are super-users and people who are excited about it, but not everyone is a super-user," Hess acknowledges. "Some physicians who have been caring for patients for years — their pattern of interaction is so ingrained that they just don't seem to be as open to interacting with patients in a different way."

Incorporate Into Workflow

Despite such challenges, based on the results of the study and clinician and patient feedback, efforts are under way locally to implement the tool, Hess explains.

"We are in the process of revising our observation unit protocols to systematize that patients are exposed to this decision aid, and that the physician has the conversation with them," he says. "In every section of our ED, when [clinicians] are considering admitting a patient to the observation unit with an indication of chest pain, we are working through ways to incorporate [the tool] as part of the usual flow of care."

In addition, investigators are exploring ways to make the tool available as an online application so that any clinician in the Mayo network will have access to the tool as a recommended decision aid for certain groups of chest pain patients. Further, once more sites have implemented the tool, Hess is hoping to design a study to measure its effect.

In addition to work with the tool at Mayo, Hess notes that clinicians at other sites around the country are experimenting with the decision tool, and in some cases, modifying it to be as contextually specific as possible. He expects more data on these efforts to be shared in the coming months.

"People are already simultaneously and dynamically working with me and sometimes independently, figuring out ways to use this in their own settings," he says. ■

SOURCE

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Advance Care Planning With and Without an Annual Wellness Visit

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

An elderly obtunded patient presents via EMS from a nursing home to the ED with decreased blood pressure, increased pulse, labored breathing, and bradycardia. The patient has multiple chronic problems. The family says their mother's quality of life is poor. The nursing home advised the paramedics that the patient does not have an advance directive. The emergency provider speaks with the family to determine whether extreme measures are desired to prolong life in the event of life-threatening medical emergency. The family states they would like to initiate an advance directive.

This is a common scenario in an ED. If performed and documented appropriately, advance care planning (ACP) can now be billed by the emergency provider in addition to an evaluation and management level. For example, the patient described above might have received a comprehensive evaluation and management level 99285 by the emergency provider as well as discussion with the family of advance directives for a period of 20 minutes.

The advance directives discussion is identified by Current Procedural Terminology (CPT) as: CPT code 99497 (ACP, including the explanation and discussion of advance directives such as standard forms [with completion of such forms, when performed], by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate; and an add-on CPT code 99498 (ACP, including the explanation and discussion of advance directives such as standard forms [with completion of such forms, when performed], by the physician or other qualified health professional; each additional 30 minutes [list separately in addition to code for primary procedure]).

The Centers for Medicare & Medicaid Services (CMS) made the CPT codes for ACP separately payable by Medicare. The change in policy was implemented through the annual Medicare Physician Fee Schedule Database (MPFSDB) update.

A unit of time for ACP is attained when the midpoint of the 30-minute service is passed or 16 minutes, according to CMS. CPT 99497 and 99498 are separately payable under the Medicare Physician Fee Schedule (MPFS). The national Medicare reimbursement amount for 99497 is $79.50 and 99498 is $74.47. Note that this service cannot be billed in addition to critical care, because it is also a time-based code.

In addition, CMS also is including voluntary ACP as an optional element of the annual wellness visit (AWV). ACP services furnished on the same day and by the same provider as an AWV are considered a preventive service. Therefore, the deductible and coinsurance are not applied to the codes used to report ACP services when performed as part of an AWV.

Voluntary ACP means the face-to-face service between a physician (or other qualified healthcare professional) and the patient discussing advance directives with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his or her medical treatment at a future time should he or she lack decisional capacity at that time. When voluntary ACP services are furnished as part of an AWV, coinsurance and deductible would not be applied for ACP. Both the ACP and AWV also must be billed together on the same claim form. To have the deductible and coinsurance waived, modifier 33 (preventive services) must be billed.

The laws governing advance directives vary from state to state, so it is important patients complete and sign advance directives that comply with state law. Also, advance directives can contain different titles depending on the state. Some examples of advance directives include:

- healthcare proxy;
- durable power of attorney for healthcare;
- living will;
- Medical Orders for Life-Sustaining Treatment (MOLST).

These are time-based codes, with 99497 to be billed for the first 30 minutes, and 99498 for each additional 30 minutes. Because the purpose of the visit is the discussion, no active management of the patient's problem(s) has to be performed during the time of these visits.

Additionally, these code(s) can be billed with the ACP services, if applicable, for the following services:

• new and established patient office visits (99201-99215);

• observation initial, subsequent, and discharge care codes (99217-99220, 99224-99226);

• initial, subsequent, and discharge hospital service codes (99221-99233, 99238-99239);

• observation or inpatient admit and discharge on the same date (99234-99236);

• outpatient and inpatient consultations (99241-99255);

• ED visit codes (99281-99285);

• initial, subsequent, and discharge nursing facility care codes (99304-99316);

• annual nursing facility assessment code (99318),

• new, established, and discharge domiciliary or rest home visit codes (99234-99337),

• new and established patient home visit codes (99341-99350);

• initial and periodic preventive medicine codes (99381-99397);

• Transitional Care Management Service codes (99495-99496).

However, these codes cannot be billed with:

• critical care codes, as they are also time-based codes (99291, 99292);

• inpatient neonatal and pediatric critical care codes (99468-99476);

• initial and continuing intensive care services (99477-99480).

Although the ED does not generally provide the AWV, the initial AWV with personalized prevention plan of service (PPPS) provides for the following services to an eligible beneficiary by a health professional:

• establishment of an individual's medical/family history;

• establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual;

• measurement of an individual's height, weight, body mass index (BMI) (or waist circumference, if appropriate), blood pressure (BP), and other routine measurements as deemed appropriate, based on the beneficiary's medical/family history;

• detection of any cognitive impairment that the individual may have as defined in this section;

• review of the individual's potential risk factors for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations;

• review of the individual's functional ability and level of safety based on direct observation, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations;

• establishment of a written screening schedule for the individual, such as a checklist for the next five to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual's health status, screening history, and age-appropriate preventive services covered by Medicare;

• establishment of a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are under way for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (IPPE), and a list of treatment options and their associated risks and benefits;

• furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition;

• any other element(s) determined appropriate by the secretary of Health and Human Services through the National Coverage Determination (NCD) process.

The AWV will include:

• establishment of, or update to, the individual's medical and family history;

• measurement of his or her height, weight, BMI (or waist circumference);

• BP measurement.

The goal of the service is to assure health promotion and disease detection and to foster the coordination of the screening and preventive services that already may be covered and paid for under Medicare Part B.

Effective Jan. 1, 2016, when ACP services are provided as part of an AWV, providers would report as applicable the following:

• G0438 AWV, including a PPPS, first visit;

• G0439 AWV, subsequent AWV;

• 99497: First 30 minutes is used to report face-to-face service between a provider and a patient, family member, or surrogate in counseling and

discussing advance directives — with or without completing relevant legal forms;

• 99498 (for each additional 30 minutes, as applicable).

HCPCA G0438 and G0439 PPPS require that the initial AWV providing PPPS provides for the following services to an eligible beneficiary by a health professional:

• establishment of an individual's medical/family history;

• establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual;

• measurement of an individual's height, weight, BMI (or waist circumference, if appropriate), BP, and other routine measurements as deemed appropriate, based on the beneficiary's medical/family history;

• detection of any cognitive impairment that the individual may have as defined in this section;

• review of the individual's potential risk factors for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for patients without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and that are recognized by national medical professional organizations;

• review of the individual's functional ability and level of safety based on direct observation, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and that are recognized by national professional medical organizations;

• establishment of a written screening schedule for the individual, such as a checklist for the next five to 10 years, as appropriate, based on recommendations of the USPSTF and ACIP, as well as the individual's health status, screening history, and age-appropriate preventive services covered by Medicare;

• establishment of a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are under way for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits;

• furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition;

• any other element(s) determined appropriate by the secretary of Health and Human Services through the National Coverage Determination (NCD) process.

The AWV will include:

• establishment of, or update to, the individual's medical and family history;

• measurement of his or her height, weight, BMI (or waist circumference);

• BP measurement.

The goal of the service is to assure health promotion and disease detection and fostering the coordination of the screening and preventive services that already may be covered and paid for under Medicare Part B.

Critical Access Hospitals (CAHs) also may bill for these professional services using bill type 85X with revenue codes 96X, 97X, and 98X. Method II payment will be based on the lesser of the actual charge or the facility-specific MPFS.

Of note to providers, the deductible and coinsurance does not apply when ACP is not furnished as part of a covered AWV. ■

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Apply new information about various approaches to ED management;
2. Discuss how developments in the regulatory arena apply to the ED setting; and
3. Implement managerial procedures suggested by your peers in the publication.

COMING IN FUTURE MONTHS

- A team approach to identifying elder abuse in the ED
- Using ED-based motivational interviewing to slash opioid abuse
- Rating the way patients are assigned to emergency providers
- A specialized unit for critically ill patients who present to the ED

ED MANAGEMENT®

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right, or log onto **AHCMedia.com** and click on My Account. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CME/CE QUESTIONS

1. **While the primary aim of the Alternatives to Opioids (ALTO) program at St. Joseph's Regional Medical Center is to use alternatives to opioids whenever possible, another important, underlying goal is to:**

   a. reduce the likelihood acute pain becoming chronic.
   b. speed treatment to patients presenting with pain.
   c. train residents and medical students in new pain relief techniques.
   d. discourage doctor-shopping patients.

2. **Under the ALTO program, pain medications are specifically chosen because of:**

   a. the speed with which they can deliver pain relief.
   b. their ability to mask pain.
   c. their wide availability and safety profile.
   d. how they affect the pain receptor sites.

3. **The hardest work, and what takes the longest amount of time to accomplish, when implementing an ALTO-type program is:**

   a. training and education.
   b. getting buy-in from clinicians.
   c. involving other departments.
   d. documenting outcomes.

4. **When gathering input on the design of a decision tool to facilitate shared decision-making between providers and patients who present to the ED with low-risk chest pain, one of the biggest concerns of providers was the effect that use of the tool would have on:**

   a. patient treatment choices.
   b. workflow.
   c. teamwork.
   d. nurse responsibilities.

ED ACCREDITATION UPDATE
COVERING COMPLIANCE WITH JOINT COMMISSION STANDARDS

Tackling Disrespectful, Unprofessional Provider Behaviors

A systematic approach requires careful planning, the ability to track and measure outcomes, and high-level support.

If one accepts the notion that effective teamwork is a necessary element to the delivery of safe care in the complex hospital environment, then it's clear that behaviors that diminish or threaten teamwork can compromise patient safety. However, how can an organization systemically identify such behaviors when they occur, and intervene in a way that can be sustained?

Physician leaders at Vanderbilt University Medical Center (VUMC) in Nashville, TN, decided to take on this problem with the development of what they call the Coworker Observation Reporting System (CORS). Three years into the implementation of CORS, investigators found that when effective safeguards are in place, not only are staff members willing to report unprofessional or disrespectful behaviors among providers, but when these behaviors are pointed out to the individuals involved, they self-correct their behaviors in the vast majority of cases.[1]

Program developers acknowledge that putting such a system in place requires high-level support and commitment, but they suggest it is a system that can improve culture and patient safety.

Establish Safeguards for Staff Reporting

The idea for CORS grew out of earlier work at VUMC that focused on identifying physicians at risk for medical malpractice.

"We found that a small number of physicians accounted for more than their fair share of patient complaints, which we know increases the risk for malpractice, so we set out to see if there might be parallel differences in physicians who generate more than their fair share of staff concerns," explains **William Cooper**, MD, MPH, director of Vanderbilt's Center for Patient and Professional Advocacy, and vice chair of the department of pediatrics. "It turns out that 3% of our physicians accounted for a large proportion of our staff concerns, and we know if we intervene with physicians to reduce patient complaints, we can be effective. We wanted to set out to see if a similar approach would be effective for staff complaints."

How are staff complaints about a provider's behavior relevant to patient safety? Cooper explains that when providers fail to model respect or effective teamwork, it threatens the right thing from happening for the patient.

"If a staff nurse is more worried about how a physician is going to behave when he or she enters the ICU, he or she may fail to attend to the tasks at hand," he says. "We know that those slips and lapses are among the common sources of medical errors."

Similarly, disrespect can manifest in providers failing to adhere to accepted best practices, safety checklists, and other issues that can directly affect patient care.

However, training hospital staff to report behavioral concerns about providers is challenging, Cooper acknowledges. "What we have found over the years is that a couple of things have to be present to encourage the sharing of these observations," he says. "One is that the [reporting] individuals have to trust that the organization is going to respond, and they also have to feel that they

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have a certain element of psychological safety."

For example, Cooper notes that if a nurse or tech enters a concern about a provider's behavior into VUMC's online occurrence reporting system, that person has to feel that it is going to be worth their time, that someone is actually going to do something with the information, and that there will be no retribution for entering the report.

Always Provide Feedback

To address these issues, staff members who enter reports always receive feedback from the CORS program.

"We don't tell them the specifics, but we just let them know that we appreciate their willingness to share their concerns, and that we are committed to sharing their observations with the involved professionals, with the intent of giving them the opportunity to self-reflect on how their behavior wasn't consistent with our culture," Cooper explains.

Also, the "messengers" who are trained to deliver the information to the providers in question make it clear that any sort of retribution is out of the question.

"We include in [the messenger] training specific messages just to remind the team member receiving the report that if they were to have any conversation that could be interpreted as retaliation, that would require us to escalate, because in a safety culture you can't tolerate retaliation against safety reporters," Cooper says.

Providers who serve as messengers are most often nominated by their department chairs or their divisional leaders to serve in the role, Cooper notes.

"We generally look for messengers who are respected physicians who are committed to discretion and confidentiality, and who are themselves models of professionalism," he says. "They undergo training in how to have these conversations in a non-judgmental way that increases the likelihood that the individual receiving the report will reflect and then hopefully modify [his or her] behavior when put in the same situation again."

Weed Out Petty Concerns

The initial interactions between a messenger and a provider who has received a negative report from a staff member are referred to as single-report sharing.

"We make people aware that their behavior or something that they have done or said has upset another member of the team, and this is presented as an observation that they can react to and internalize," explains **Roger Dmochowski**, MD, the physician leader of CORS, a professor of urology, and associate director of risk prevention in the Vanderbilt Health System.

Dmochowski allows that perceptions often differ between the two sides.

"It may be that the provider has a very reasonable, in their mind, explanation of what occurred and would like that heard, and we provide that venue," he says. "You have to have a willingness to understand that these are the perceptions of one human about the interactions with another human or an interaction with humans as a group, so there is some necessity to realize that there may be alternative explanations, which allow the individual to at least in their own mind explain what is perceived."

Also, if a report is deemed to be petty or not substantial, a supervisor has the option not to deliver the message, Dmochowski observes.

"There is that necessity to be aware of pettiness, and there are some individuals who rather than directly addressing an issue will actually revert to writing something or

EXECUTIVE SUMMARY

To address problematic provider behaviors that can affect patient safety, physician leaders at Vanderbilt University Medical Center (VUMC) developed the Coworker Observation Reporting System (CORS), a systematized approach for retrieving and addressing concerns about providers reported by staff.

- To encourage staff members to report concerns, they have to trust that the organization is going to respond, and they also have to feel that they have a certain element of psychological safety.
- Selected peer messengers share staff complaints with providers, enabling them to offer their perspectives on the issues or events in question.
- Three years into the implementation of CORS, investigators found that the majority of providers self-correct their behaviors when reports about staff concerns are shared.
- Additional level 1, level 2, and level 3 interventions are built into the CORS system for providers who fail to self-correct after one or two reports.

using innuendo," he explains.

However, Dmochowski notes that in many instances, the reports are actually consistent with other issues that have arisen involving individual providers, and the staff reports help to guide interventions that may be necessary, such as coaching or anger management, for example.

Cooper concurs, noting that some providers who have been reported have been known for years to treat members with disrespect, but once they hear about their behaviors from a messenger, the complaints often cease. Through the CORS program, VUMC now has data to back up this claim.

"So far, we are seeing that 70% [of the providers] get no subsequent complaints in a one-year follow-up period," he says.

A process is in place in CORS for what is called level 1 "awareness" interventions, level 2 "guided" interventions, and level 3 "disciplinary" interventions if providers continue to receive reports about their behavior after one or two single-report sharing episodes.

Flatten the Hierarchy

As far as effect on culture is concerned, Cooper notes there are anecdotal reports that certain provider behaviors that have been consistently problematic for a long time have improved since implementation of the CORS program. He stresses that the CORS reports, as well as the messenger awareness sessions, are confidential. As a result, staff do not necessarily attribute such improvements to the CORS program, but they have noticed a change.

Would it be better if team members simply reported their concerns directly to the providers they have issues with? Perhaps, but that isn't always realistic in the current healthcare environment, Dmochowski observes.

"One of the things we have still in modern medicine is a relative hierarchy such that there is a perception of hierarchal dominance, and people are hesitant to go around the hierarchy," he says. "This allows that flattening of hierarchy."

SOME PROVIDERS WHO HAVE BEEN REPORTED HAVE BEEN KNOWN FOR YEARS TO TREAT MEMBERS WITH DISRESPECT, BUT ONCE THEY HEAR ABOUT THEIR BEHAVIORS FROM A MESSENGER, THE COMPLAINTS OFTEN CEASE.

Currently, the CORS program is designed exclusively for reports regarding physicians, advance practice nurses, and physician assistants. However, administrators are working with VUMC's human resources team to see whether there are appropriate parallel processes that could be used to address the behaviors of other team members, Cooper explains.

In addition, VUMC is expanding its work to include several other sites around the country that have expressed an interest in adapting the CORS program to their own settings.

"That will give us a national comparison database so we can not only show a physician how [he or she] compares locally, but also nationally to several partner organizations," Cooper says.

Get Support From Top Brass

While he is a big believer in CORS, Dmochowski explains there are several pieces that must be in place for the system to work.

"First and foremost, you have to have leadership commitment to this," he explains. "You can't do it without the very top, c-suite leadership saying, 'yes, [we] believe in this, and [we] want to try to remediate bad behavioral patterns.' That is key."

Second, Dmochowski says the system requires a stable process that will allow reporting, the aggregation of data, and the delivery of data in a manner that is repetitive and reproducible.

"Third, you've got to have trained peers who are willing to basically sit down with their colleagues ... and have discussions regarding whatever has been reported, realizing that it is by and large an awareness intervention," Dmochowski explains. "It is just a very small group of people who have repetitive sorts of behavioral issues, but repetitive behavioral patterns then point to other issues."

For example, VUMC has discovered issues with physicians or providers who have experienced cognitive declines, and others who have been under the influence of various exogenous agents that have affected their behaviors at work, Dmochowski notes.

"This has allowed us to have direct intervention in a very timely fashion, which obviously serves patient safety," he says.

Cooper advises hospitals interest-

ed in taking on the issue of unprofessional behaviors to plan carefully and assess whether they have the infrastructure in place to launch an effective program.

"You have to have the right people in place, you have to have the right process, and you have to have the right data systems," he says. "Really be thoughtful and careful in ensuring that you are able to measure whether physicians have been associated with more than their fair share of reports."

Cooper adds that leaders must be committed to treating everyone the same and making sure everyone receives interventions regardless of their positions within the organization.

"At the end of the day, this is about culture change, so if you are going to have culture change, you have to be intentional about it," he says. "You have to ensure that [the program] aligns with your values and that you are willing to step up to the plate when you want to make a change." ■

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1. **William Cooper**, MD, MPH, Director, Center for Patient and Professional Advocacy; Vice Chair, Department of Pediatrics, Vanderbilt University School of Medicine, Nashville, TN. Email: william.cooper@vanderbilt.edu.
2. **Roger Dmochowski**, MD, Professor of Urology, Associate Director of Risk Prevention, Vanderbilt Health System, Nashville, TN. Email: roger.dmochowski@vanderbilt.edu.

Top Patient Safety Risks Include Health IT Issues, Patient ID Errors

Failure to embrace a safety culture is listed as number 10 on this year's list of the top 10 patient safety concerns for healthcare organizations, as determined by the ECRI Institute, an organization that specializes in work involving patient safety, adverse event reporting and analysis, and the development of recommendations for hospitals and other healthcare providers.

The other problem areas included on the list are:

1. Health IT configurations and workflow that do not support each other;
2. Patient ID errors;
3. Inadequate management of behavioral health issues in non-behavioral health settings;
4. Inadequate cleaning and disinfection of flexible endoscopes;
5. Inadequate test-result reporting and follow-up;
6. Inadequate monitoring for respiratory depression in patients prescribed opioids;
7. Medication errors related to pounds and kilograms;
8. Unintentionally retained objects despite correct count;
9. Inadequate antimicrobial stewardship.

> ALL STAFF MEMBERS MUST BE TRAINED TO WORK WITH PATIENTS WHO HAVE BEHAVIORAL HEALTH NEEDS, AND PARTICIPATE IN FREQUENT DRILLS.

Highlighting the top problem on the list, ECRI noted that when IT systems are implemented, too often the proper adjustments are not made so that the IT configurations and workflows work in concert effectively, resulting in suboptimal communication.

The institute also noted that in its reviews of patient safety organization events, patient ID errors were both frequent and serious.

The management of behavioral health issues in non-behavioral settings emerged as a top concern because hospitalized patients with psychiatric issues may pose added risks when not under specialized psychiatric care, ECRI noted. The institute added that all staff members must be trained to work with patients who have behavioral health needs, and participate in frequent drills.

The ECRI Institute's brief on the top 10 safety concerns is available at: http://bit.ly/1Z7MqHC. ■