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INSIDE

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Underpayment Is Major Concern for EDs with New Surprise Billing Law

The No Surprises Act, which took effect on Jan. 1, 2022, establishes new federal protections for patients against out-of-network providers "balance billing" for the difference between the provider's billed charge and the amount paid by insurance.[1] "Patients will now be protected from nearly all surprise billing scenarios," says **Ben Chartock**, an associate fellow at the University of Pennsylvania Leonard Davis Institute of Health Economics.

According to a recent analysis, 27% of privately insured patients with heart attacks were at a risk of receiving a surprise medical bill.[2] Patients with surprise out-of-network bills for ED visits paid physicians more than 10 times as much as other ED patients, on average, according to the authors another study.[3] "Financial costs to patients from surprise bills often represent a 'second emergency,'" Chartock notes.

The No Surprises Act does not stop all patients from receiving large bills for ED visits. "In 2022, out-of-pocket maximums can exceed $8,000," says **Krutika Amin**, PhD, an associate director of the Peterson-Kaiser Family Foundation Health System Tracker in San Francisco.

Many ED patients still have to pay high deductibles and coinsurance premiums. What has changed is ED patients can no longer be billed by out-of-network providers for any amounts over what they would have paid for in-network care. "Before the No Surprises Act protections, the patient would have had to pay their deductibles or coinsurance under their insurance plan, plus any surprise or balance bills," Amin explains.

Now, the patient will be held harmless for those amounts. "If patients are avoiding EDs from the fear of getting these bills, this will protect them," Amin says. "For ED visits, the law is clear. They're not allowed to surprise bill patients." ED leaders should consider these other implications.

• **Billing practices for ED visits will be affected significantly.** ED providers will have to bill the patient's insurance, even if it is not in network, and wait to hear a response before billing the

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patient. The health plan must respond with a denial or payment in 30 days. The plan will decide how much they are willing to pay and the acceptable dollar amount the provider can charge the patient.

"The law says that providers can't bill for any balance beyond that amount, even if they don't feel like they've gotten an adequate payment from the insurer," says **Jack Hoadley**, PhD, research professor emeritus in the Health Policy Institute at the Georgetown University McCourt School of Public Policy.

• There is controversy over the qualified payment amount (QPA), which is based on the median payment insurers pay in that market and region. According to the interim final rule (IFR), arbiters must begin with the premise that the QPA is an appropriate amount of reimbursement. This "would have arbiters give unequal weight to the QPA, the insurer's artificially low median in-network rate for reimbursement, rather than a balanced mix of other factors in the process," according to an American College of Emergency Physicians (ACEP) statement.[4]

The American Hospital Association and the American Medical Association jointly filed a lawsuit alleging the independent dispute resolution process unfairly benefits the health plans.[5] Another lawsuit, filed by ACEP, the American College of Radiology, and the American Society of Anesthesiologists, argues the IFR on surprise medical billing will harm patients and access to care.[6]

"Regardless of how the litigation plays out, there will still be a dispute resolution process," Hoadley says. "What the litigation is disputing is the presumption that the in-network rate is the default."

Surprise out-of-network bills affected about 14% of ED visits overall, and 20% of ED visits that resulted in a hospital admission, according to the authors of a study.[7] To the extent arbiters rely on the QPA in making determinations, in-network EDs and hospitals may see their negotiated rates converge to the QPA, says **Christopher Garmon**, PhD, assistant professor of health administration at the University of Missouri-Kansas City. Since the QPA is the median in-network rate, some EDs presumably will see more revenue, while others will see a reduction. "It's too soon to tell what the overall effect will be for EDs and hospitals," Garmon says.

Underpayment for ED visits (based on the QPA) is a valid concern under the No Surprises Act, according to **Leslie Howard**, Esq., founder and managing partner at Tinton Falls, NJ-based Cohen Howard LLP. "For the out-of-network ED groups, for those doctors, the consequences are much greater," Howard cautions. "I think it could be very unfavorable to certain doctors providing routine ER care."

• Emergency physicians (EPs) receiving less reimbursement is likely to trigger additional problems with access to care. The QPA is less reimbursement than many out-of-network EPs are used to. "You may have doctors, ER specialist doctors, that may just cease covering the ER. We have begun to see that as an option for many of our clients," Howard reports. Consultants such as plastic surgeons who are used to receiving a handsome sum for showing up in the middle of the night to consult on ED cases may now have no incentive to arrive. "Many EPs are just saying they're not going to show up anymore because it's not going to be worth their time," Howard says.

• EPs likely will go through arbitration, frequently seeking additional reimbursement, but face an uphill battle to prevail. The QPA is the rate the arbitrators have to fall back on for out-of-network EPs "unless the doctors can show really almost extraordinary reasons why they should be paid more," Howard says.

Justifying extra reimbursement for a routine laceration repair is going to be more difficult than if it is a complicated severe trauma case. To succeed in arbitration, the EP must show the case involved unique circumstances, the EP was more highly qualified in some way, prior payments were higher for similar cases, or other similar reasons.

"There is no incentive, right now, for the insurance companies to provide fair reimbursement," Howard says. "Many providers out there just accept what they get because they don't have the bandwidth to fight."

The insurer hopes the EP will give up trying to fight the low reimbursement, given the arbitration is highly likely to go in the insurer's favor.

"The EPs, as doctors who do more general procedures and not extraordinary procedures, are not going to have incentive to fight," Howard says. "It will be very hard to overcome the presumption that the payment is too low."

• It is unlikely there will be any significant enforcement in the first part of 2022 as facilities, practices, payors, and regulators work through the nuances of the law. Violations of the No Surprises Act can result in penalties up to $10,000 per violation.

"But there is a lot of confusion related to the implementation of the No Surprises Act. Both the statute and regulations are incredibly complex, and there are more unanswered questions than answers at this point," says **Danielle Sloane**, JD, an attorney in the Nashville office of Bass, Berry & Sims.

Nonetheless, EDs should be making good faith efforts to prevent patients from receiving surprise bills. "In the short term, ED practices should update their website to include a surprise billing disclosure," Sloane offers.

• Some ED practices that are in network with payors are receiving letters from payors demanding a reduction in their rates. Payers are threatening to terminate their contracts if ED groups do not accept the lowballed rates. "This is a growing unintended consequence of the No Surprises Act," Sloane observes.

Health plans are taking the position that the government has set the rate, and they are not going to pay any more than that set rate. Some insurers have terminated ED groups that are in network because the QPA rate is lower than their current in-network rate.

"Insurance companies will continue to narrow their networks and kick out in-network doctors. It will be more advantageous to them to do that, since the QPA rate is artificially low," Howard predicts.

• More states could enact their own laws that meet the standards of the No Surprises Act, but also provide protection for providers to receive fair reimbursement. "Everyone agrees that balance bills have to stop," Howard says. "But providers are always painted as the overcharger when, in reality, the insurance companies are making billions of dollars and their CEOs are paid millions of dollars."

Ideally, there would be a good faith negotiation between providers and insurers to result in fair payment. In some cases, New Jersey providers ended up satisfied with reimbursement after the state passed its surprise billing legislation, according to Howard. In terms of overall reimbursement for ED groups and hospitals for ED care, "it's not necessarily all doom and gloom," Howard adds. "One positive is that cash flow would improve."

• The No Surprises Act also carries implications during the "post-stabilization" period, for care provided to patients after they are stabilized in the ED. Under EMTALA, required emergency services include a medical screening exam to determine whether an emergency medical condition exists as well as further treatment necessary to stabilize the patient.

"Under the No Surprises Act, 'emergency services' subject to the law's protections include any additional services rendered after a patient is stabilized that are related to the emergency visit," says **Stephanie Hoffmann**, JD, a healthcare attorney in the Nashville office of Bradley.

Health plans are going to want to see out-of-network patients shifted to an in-network facility for additional hospitalization or follow-up treatment. What has changed is the ED patient has to consent to this.

"The law makes sure the patient has a say in it. If the patient wants to stay in the out-of-network facility, then some of these balance billing protections are going to continue," Hoadley says.

• EDs could face an uptick in patient complaints about "surprise" bills, even if everything was handled above board. "Patients are going to be very easily able to submit their concerns," Hoffmann says.

ED providers must show a good faith effort to notify patients about out-of-pocket costs and withdraw any

inadvertent bills (e.g., the ED entered the wrong insurance information). "The law does have a sort of escape valve, where if you did not know you were violating the law and you withdraw the bill within 30 days, that instance is not going to be penalized," Hoffmann explains.

Ideally, ED staff educate patients on what to expect from their bill, but this usually is not reality in busy EDs.

"There's not much time for administrative work on the front end in an emergency," Hoffmann says. "That's going to remain a challenge." ■

REFERENCES

1. Pollitz K. No Surprises Act implementation: What to expect in 2022. KFF Issue Brief. Dec. 10, 2021. https://bit.ly/3qs5xll
2. Pollitz K, Rae M, Cox C, et al. Surprise bills vary by diagnosis and type of admission. Peterson-KFF Health System Tracker. Dec. 9, 2019. https://bit.ly/3FEwWqE
3. Biener AI, Chartock BL, Garmon C, Trish E. Emergency physicians recover a higher share of charges from out-of-network care than from in-network care. *Health Aff (Millwood)* 2021;40:622-628.
4. American College of Emergency Physicians. ACEP statement on new interim final rule to implement surprise billing legislation. Oct. 1, 2021. https://bit.ly/32DqSQm
5. American Hospital Association. Hospital and physician groups file lawsuit over No Surprises Act final rules that jeopardize patient access to care. Dec. 9, 2021. https://bit.ly/3pv8zFU
6. American College of Emergency Physicians. American College of Emergency Physicians, American College of Radiology, and American Society of Anesthesiologists file lawsuit against the federal government's implementation rules for 'No Surprises Act.' Dec. 22, 2021. https://bit.ly/3HeWkDv
7. Garmon C, Chartock B. One in five inpatient emergency department cases may lead to surprise bills. *Health Aff (Millwood)* 2017;36: 177-181.

ED Visits for Alcohol and Substance Use Disorders Surging Nationally

One in 11 ED visits were made by adults with alcohol use disorder (AUD) or substance use disorder (SUD), according to the results of a recent study.[1] "As clinicians, we had been experiencing a rising number of ED visits and hospitalizations among individuals with alcohol and other substance use disorders in recent years," reports **Leslie Suen**, MD, MAS, the study's lead author.

Suen and colleagues wanted to learn whether what they were seeing reflected national trends. They analyzed ED visits recorded from 2014 to 2018 using the National Hospital Ambulatory Medical Care Survey. They found that on average, 9.4% of ED visits annually involved AUD or SUD. The percentage of visits increased steadily over time. "When we examined visits by individuals with alcohol and other substance use disorders visiting safety net vs. non-safety net hospitals, we found populations were similar," says Suen, a fellow in the National Clinician Scholars Program at the University of California, San Francisco Philip R. Lee Institute for Health Policy.

Suen and colleagues expected patients who visited safety net hospitals would be sicker, but this was not the case. "This fact only highlights for us how this issue affects all hospitals, not only those seeing predominantly disadvantaged populations," Suen says.

ED patients with AUD or SUD were more likely to present with Medicaid coverage, to be experiencing homelessness, to have undergone mental health treatment previously, and to present with trauma and injury. The paper suggests systematically screening people who present with trauma for AUD/SUD.

In another analysis, the authors reported SUDs are just as deadly as heart attacks.[2] "Yet so many EDs are still not offering any form of standard of care substance use treatment, potentially making them vulnerable to facing liability and lawsuits due to violation of EMTALA," Suen says.

According to a recent report, EDs could be liable for disparate treatment and/or disparate impact discrimination if the EDs do not use evidence-based practices for substance use-related emergencies.[3] "There is a moral and ethical obligation to offer standard of care for these conditions," Suen concludes.

Patients with AUD and SUD "are among the most vexing and risky subcategory of patients who present to the emergency department," according to **Andrew P. Garlisi**, MD, MPH, MBA, VAQSF, EMS medical director at Cleveland-based University Hospitals EMS Training & Disaster Preparedness Institute.

Presentations often are "bundled" with a host of comorbid conditions and chronic or acute traumatic events. "They range from the acutely

intoxicated to patients suffering from potentially life-threatening withdrawal syndromes," Garlisi says.

The group includes preteens experimenting with alcohol or recreational drugs and elderly patients who overdose on anxiolytic or narcotic prescription medications.

Garlisi says ED providers must consider many possibilities, including methamphetamine or cocaine abusers who present with uncontrolled hypertension and chest pain, chronic alcoholics in withdrawal experiencing seizures or arrhythmias, and auto-anticoagulated chronic alcoholics who collapse due to serious anemia from GI bleeding.

Providers also should consider intoxicated patients with multiple trauma, geriatric patients on chronic narcotics with subdural hematoma caused by frequent falls, intoxicated patients who intentionally overdose, and heroin overdose patients who were unresponsive at the scene but were revived with multiple doses of naloxone.

Providers should "suspect and expect an underlying potentially serious coexisting medical complication in each patient encountered until proven otherwise," Garlisi stresses.

For example, chronic alcoholism is associated with a plethora of medical complications: liver disease, coagulopathy with bleeding complications, electrolyte imbalance, cardiac complications, hypoglycemia, and malnourishment.

"Traumatic injuries are common among this patient population and are often subtle," Garlisi warns. "Added to the high risk is the stigma of the abuse disorder."

This could negatively affect the judgment of ED staff who dismiss the patient as a "druggie" or a "frequent flyer."

"Disparaging comments and judgmental statements should never be entered into the medical record," Garlisi cautions.

The plaintiff attorney could argue the provider's medical judgment was affected by bias or prejudice against the plaintiff. Unkind comments could be highlighted and magnified on a large screen for the jury to view. "Several of the jurors might have family members or close acquaintances who suffer from addiction, and the verdict [could be] impacted accordingly," Garlisi says.

AUDs and SUDs can cloud the evaluation of other issues, such as trauma. "Primary emergent toxic effects of alcohol can present as bleeding from the GI tract, pancreatitis, alcoholic ketoacidosis, obtundation, arrhythmias, cardiomyopathy, and liver damage," says **Kenneth Alan Totz**, DO, JD, FACEP, a Houston-based attorney and practicing EP.

Totz says the ED evaluation of an acutely intoxicated patient should include analysis of airway, breathing, and circulation; decision-making capacity; and serious consideration to ruling out coexistent trauma accounting for any pain or altered mental status. "The malpractice literature is littered with cases of missed subdural hematomas and [cervical] spine injuries that were blamed on alcohol intoxication," Totz warns.

ED providers also should document the placement of a cervical collar until a cervical spine injury is eliminated from the differential diagnosis. If the provider elects not to place a cervical collar, documenting a reasonable rationale is important. "Your documentation will be helpful in case a patient removes their own collar and injures themselves or elopes from the ED," Totz says.

The chart should reflect that cervical spine or head injury was considered, but ruled out using clinical decision rules, history, or physical exam.

"The medical record should be crystal clear that we considered the injuries, but that the patient was not injured at the time and place we evaluated them," Totz says. ■

REFERENCES

1. Suen LW, Makam AN, Snyder HR, et al. National prevalence of alcohol and other substance use disorders among emergency department visits and hospitalizations: NHAMCS 2014-2018. *J Gen Intern Med* 2021;Sep 13:1-9.
2. King C, Cook R, Korthuis PT, et al. Causes of death in the 12 months after hospital discharge among patients with opioid use disorder. *J Addict Med* 2021; Sep 10. doi: 10.1097/ADM.0000000000000915. [Online ahead of print].
3. Yeboah-Sampong S, Weber E, Friedman S. *Emergency: Hospitals are Violating Federal Law by Denying Required Care for Substance Use Disorders in Emergency Departments*. Legal Action Center, 2021. https://bit.ly/3JkHz3W

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Few EDs Screen Patients for Excessive Alcohol Use

Just one in six EPs consistently screened patients for excessive drinking, according to the results of a recently published investigation.[1]

"The problem of excessive alcohol use occurs frequently in ED patients. We wanted to find out what practicing emergency physicians were doing to identify patients with excessive drinking and help guide them toward treatment," says **David P. Sklar**, MD, one of the study's authors.

Sklar and colleagues used the American College of Emergency Physicians Emergency Medicine Practice Research Network to survey a national sample of 347 EPs. Of those surveyed, 16% reported "always/usually," 70% reported "sometimes," and 14% reported "never" screening adult ED patients for excessive alcohol use. Of the respondents who did screen patients, only 10.5% received an electronic health record reminder to do so.

"Previous surveys involved administrative personnel from the ED, who may not have been representative of practicing emergency physicians," notes Sklar, a professor of medicine at Arizona State University.

Sklar and colleagues sought data on the barriers to interventions by EPs, who routinely care for patients hurt or killed by motor vehicle crashes or gun violence episodes where alcohol was a factor. "Many times, I have wondered if we might have been able to prevent these tragedies if we had recognized the problem drinking behaviors earlier," Sklar laments.

Alcohol screening and brief interventions in the ED can be effective to guide patients into treatment.[2] In their work, Sklar and colleagues wanted to find out where EDs were nationally in using this proven approach. Because of the relatively small percentage of EPs who never screened, "that made me think that we could work with those who admitted to sometimes screening, since at least they did not seem opposed to the idea," Sklar says.

EPs reported limited time and lack of treatment options as barriers to screening more often. "We spend so much time documenting useless information in the medical record. Yet we have no time to have a conversation about a potentially lethal substance abuse problem," Sklar observes. "It makes me very sad when a patient recognizes a problem with alcohol use, but we have no availability for treatment in the community at the time that the patient is ready to commit to it."

It would be hard to argue that screening for excessive alcohol use constitutes the legal standard of care in emergency medicine, considering the inconsistent patterns reported among providers. "But I don't think that gets us off the hook. Prevention should be as much a part of our practice as intervening during an acute illness or injury," Sklar argues.

Community treatment systems are needed to facilitate the next steps after the ED screening. "The ED is where people often go during their most vulnerable times," Sklar says. "We have an opportunity to help them prevent a future crisis if we can show them that help is available and how to access it." ■

REFERENCES

1. Uong S, Tomedi LE, Gloppen KM, et al. Screening for excessive alcohol consumption in emergency departments: A nationwide assessment of emergency department physicians. *J Public Health Manag Pract* 2022;28:E162-E169.
2. D'Onofrio G, Degutis LC. Preventive care in the emergency department: Screening and brief intervention for alcohol problems in the emergency department: A systematic review. *Acad Emerg Med* 2002;9:627-638.

Ransomware Attacks Pose Unique Danger to ED Patients

For EDs, ransomware attacks pose concerning patient safety and liability risks. "There aren't rare events anymore," says **Eric Perakslis**, PhD, chief science and digital officer at the Duke Clinical Research Institute.

Experts agree EDs should assume they will be attacked at some point. "Preparing for the attack will give the ED a better chance to recover quickly," says **Linn F. Freedman**, JD, CIPP/US, a partner at Providence, RI-based Robinson & Cole where she serves as chair of its data privacy and cybersecurity team.

How staff react to the ransomware attack is crucial. "Not knowing what's going on in a ransomware attack can

be very confusing. People have to make quick decisions about what they can do," Perakslis says.

Ransomware often is accompanied by other simultaneous attacks. Multiple attacks could be made by the same entity or by others aware the hospital systems are now vulnerable. "Any given attack could be one dimension of a multidimensional attack," Perakslis notes. "This has happened in several hospital attacks."

For example, a department might be hit by a ransomware attack, and staff immediately receive phishing emails claiming to be a patch for the attack. In a panic, staff start opening these messages. "Next thing you know, all the well-meaning people are now circulating viruses throughout the whole system," Perakslis says.

If an attack is happening, is it not always apparent which systems are affected. In the moment, staff should start by identifying what seems to be working right and what is not. It all depends on how the attack originated.

Certain outlets in the ED include emergency power and are on a generator in case of power outages or natural disasters. "If the lights go off, everybody knows you can plug into the red outlet to get power. Likewise, people should have a sense of which systems are likely to be more protected than others if systems are compromised," Perakslis says.

If there are multiple networks in a hospital and one goes down, the other networks should be OK. EDs can best prepare for a ransomware attack by practicing "basic hygiene in IT," as Perakslis describes it. "The more redundant your systems are, the less vulnerable you are," he adds.

When an attack happens, leaders will have to decide whether the ED can continue to care for patients. Can patients be transferred to another area on the campus? Will patients need to be moved to a facility across town? Should everybody keep working as usual? A ransomware attack does not necessarily mean the ED has to go on diversion.

"Every ED is a little bit different," Perakslis observes. "What if you were stopped from getting into the EHR? Does that mean you have to close your ED?"

If an ED has to divert patients because of ransomware, the liability implications would be no different than any other circumstance resulting in diversion. "Claimants would have to show facts that prove legal elements of their claims. These include whether the ED was negligent in causing any harm or damages to the claimant, whether the ED took appropriate preventive measures to prevent the attack, and how the ED responded to the attack," Freedman explains.

Scheduling and other parts of the EHR might be prime targets for ransomware, but medical devices might be affected, too, notes **Melissa L. Markey**, JD, CISSP, co-leader of the Hall Render life sciences team in Denver.

For example, the WannaCry ransomware attack in 2017 locked certain devices that monitored contrast agents used in medical imaging. Other bad actors might target infusion pumps, which can put lives in immediate danger. Elsewhere, automated medication dispensing machines might malfunction or start providing unreliable data.

Typically, EDs react to a ransomware attack by taking vulnerable devices offline. "This is a protective action. But it has the effect of decreasing the data that is available to care for patients," Markey says.

If imaging is taken off the hospital's network, it remains possible

to obtain a CT scan, but the scan is read from a single dedicated monitor instead of radiologists connected to the network. Still, even though providers might be able to see a test somewhere, results can be delayed.

Organized criminal groups behind ransomware attacks see the potential to make big money because of the healthcare industry's reliance on networked systems, says **Rob D'Ovidio**, PhD, associate professor of criminology and justice studies at Drexel University. "But they also recognize that the potential harm and loss of life to patients means increased scrutiny by the law enforcement community when compared to criminals launching ransomware attacks where losses are limited to money paid out by victims to bring networks back online," D'Ovidio says.

Solid business continuity plans make it possible for EDs to continue patient care if networks are shut down. "The potential to cause harm to patients is only going to increase as more medical devices are connected to networks," D'Ovidio warns. "In the case of networks in EDs, restoring your network can literally be the difference between life and death."

Harm also can result when computing devices supporting administrative tasks are taken offline, as EDs increasingly rely on network communications to monitor vital signs, administer medications, and aid clinical decision-making. "This reliance on computers has the potential to be disastrous if the devices are taken offline without notice," D'Ovidio says.

One important way EDs can mitigate risks is by reducing vulnerability of internet-connected systems. "We should be smarter about what we connect to the internet and make vulnerable in the first place," Perakslis argues.

The ability to run medical equipment offline is important. "In lower-resource settings, it is better to stay lower tech, as a general rule," Perakslis suggests. "If an ED is heavily networked, it should have critical redundancies. If those redundancies are not possible, the systems approach should be lower tech."

Intent is an important distinction. Are bad actors looking for money, seeking to inflict reputational harm, or trying to intentionally disrupt care? "I do think that medicine needs to consider setting the default switch to the internet to 'off,'" Perakslis says. "Just because we are getting all these great devices connected to the internet doesn't mean we should."

If an ED is attacked, it will take time to migrate to backup systems. "The time it takes to become operational will usually take much longer than if the ED lost electricity and had to get a backup generator working," Freedman notes.

Administrators also should prepare for attacks that could involve third parties the facility relies on to function. EDs should be practicing responses to this scenario. "Ransomware gangs are using a 'one-stop-shopping' approach for maximum disruption, which leads to an increased chance of getting an organization to pay the ransom," Freedman says.

Ransomware attacks can inflict long-term damage. The authors of one study suggested hospitals that sustained cybersecurity events experienced safety problems for up to two years following a breach.[1] "ED patients, particularly those who are presenting with critical illnesses, are at risk of less optimal outcomes due to delays in care ... and possible lack of access to some advanced technologies," Markey notes.

To stay ahead of this risk, leaders can create packets with all documents needed to convert to non-digital care on short notice. Staff can switch to manual processes for ordering labs and imaging, following care protocols, and calculating drug dosages.

"Integrate ransomware response training with emergency preparedness training, or have a separate training that focuses on operating the ED without all the electronics," Markey suggests. ■

REFERENCE

1. Choi SJ, Johnson ME, Lehmann CU. Data breach remediation efforts and their implications for hospital quality. *Health Serv Res* 2019;54:971-980.

Unexpected Gaps in Opioid Overdose Treatments

Opioid overdoses and related mortality remain a serious problem, which means "it's important for clinicians to take advantage of every opportunity to prescribe lifesaving medications like naloxone and buprenorphine," says **Kao-Ping Chua**, MD, PhD, an assistant professor of pediatrics and health services researcher with the Susan B. Meister Child Health Evaluation and Research Center at the University of Michigan. Naloxone and buprenorphine can avert disasters, but "most EDs are not prescribing these medications to patients presenting with opioid overdose, potentially owing to factors such as stigma, lack of time,

[and] lack of awareness of the importance of these medications," Chua notes.

Chua and colleagues analyzed 148,966 ED visits for opioid overdose that occurred between 2019 and 2021.[1] Only one in 13 patients received a naloxone prescription within 30 days of the ED visit for opioid overdose. "In contrast, almost half of patients with an ED visit for anaphylaxis received a prescription for epinephrine, another lifesaving rescue medication," Chua notes.

Additionally, only one in 12 patients received a buprenorphine prescription within 30 days. "These low rates of prescribing occurred against a backdrop of rapidly escalating numbers of opioid overdose deaths," Chua laments.

Patients presenting to EDs for opioid overdose should go home with a naloxone prescription or a naloxone take-home kit. Alternatively, these patients could start buprenorphine when it is clinically feasible, or they could be connected directly to outpatient treatment for opioid use disorder.

These findings are consistent with the work of previous researchers who found low rates of naloxone and buprenorphine dispensing after ED visits for opioid overdose among privately insured patients.[2,3] "In that sense, the findings are not particularly surprising, but they are still sobering," Chua adds.

Elsewhere, a group of investigators analyzed 15 randomized, controlled trials that included 3,852 participants and 36 observational cohort studies that included 749,634 patients. They noted generally lower rates of all-cause mortality, drug-related deaths, and suicide among patients who were on opioid agonist treatment.[4]

In a New Jersey-centric investigation of opioid overdoses that occurred between 2014 and 2019, lead author **Stephen Crystal**, MA, PhD, was alarmed by the shift from overdoses of prescription opioid analgesics to overdoses involving fentanyl-adulterated street drugs. Further, he was struck by the complex patterns of mental health and non-opioid substance use disorder, which are increasingly typical of patients who present with opioid overdose.[5]

"This highlights the urgent need for ED to develop strategies for managing and referring patients who present with opioid overdose that immediately engage them in treatment," says Crystal, director of the Rutgers University Center for Health Services Research.

Crystal suggests providers initiate buprenorphine during the ED visit, with patients leaving the department with a prescription to bridge them to a follow-up outpatient visit. Arrange consultations with addiction psychiatry specialists during the visit. Importantly, give patients a "warm handoff" for follow-up care — ideally, with an appointment for a provider he or she already "met" via phone or video call while in the facility.

"Given the rapid spread of fentanyl in street drugs, the ED needs to connect with partner organizations to expand its public health role, from simply providing acute treatment to becoming a bridge for recovery," Crystal says. ■

REFERENCES

1. Chua KP, Dahlem CHY, Nguyen TD, et al. Naloxone and buprenorphine prescribing following US emergency department visits for suspected opioid overdose: August 2019 to April 2021. *Ann Emerg Med* 2021 Nov 18;S0196-0644(21)01349-4. doi: 10.1016/j.annemergmed.2021.10.005. [Online ahead of print].
2. Kilaru AS, Liu M, Gupta R, et al. Naloxone prescriptions following emergency department encounters for opioid use disorder, overdose, or withdrawal. *Am J Emerg Med* 2021;47:154-157.
3. Kilaru AS, Xiong A, Lowenstein M, et al. Incidence of treatment for opioid use disorder following nonfatal overdose in commercially insured patients. *JAMA Netw Open* 2020;3:e205852.
4. Santo T Jr, Clark B, Hickman M, et al. Association of opioid agonist treatment with all-cause mortality and specific causes of death among people with opioid dependence: A

systematic review and meta-analysis. *JAMA Psychiatry* 2021;78:979-993.
5. Crystal S, Nowels M, Olfson M, et al. Medically treated opioid overdoses among New Jersey Medicaid beneficiaries: Rapid growth and complex comorbidity amid growing fentanyl penetration. *J Subst Abuse Treat* 2021;131:108546.

Stroke Patients Visit EDs Often After Discharge from Hospital

About half of patients discharged from the hospital with a stroke diagnosis are sent straight home.[1] Managing the care of stroke patients after discharge to home can be a daunting challenge for all concerned parties.

"Many of the post-discharge events that occur once a stroke patient is sent home may not require hospitalization," says **Wayne Rosamond**, PhD, a professor of epidemiology at the University of North Carolina Gillings School of Global Public Health.

Rosamond wanted to know what happens when these patients present to EDs, how often they presented, and their condition at arrival. In 2017, Rosamond and colleagues published the results of the COMprehensive Post-Acute Stroke Services (COMPASS) study, which was an examination of post-acute stroke care models.[2] More recently, working with a different research group, Rosamond and colleagues used COMPASS data to examine ED visits.[3]

More than 20% of stroke patients recorded three or more ED visits in the first year after they were discharged home from the hospital. Notably, about half of these frequent ED visits were not directly related to stroke. "Patients were about as likely to present with an injury, such as a fall, or with non-specific signs or symptoms as they were to present with a stroke event," Rosamond reports.

For ED clinicians, it is important to be aware that repeat visits to the ED are quite common, even for patients who experienced mild or moderate strokes and are managing their conditions at home. "This suggests that home care models for these complex patients are important to evaluate and modify, if needed, to improve long-term care outcomes," Rosamond says. ■

REFERENCES

1. Jackson G, Chari K. National Hospital Care Survey demonstration projects: Stroke inpatient hospitalizations. National Health Statistics Reports. No.132, Nov. 13, 2019. https://bit.ly/3z6NdSv
2. Duncan PW, Bushnell CD, Rosamond WD, et al. The Comprehensive Post-Acute Stroke Services (COMPASS) study: Design and methods for a cluster-randomized pragmatic trial. *BMC Neurol* 2017;17:133.
3. Rosamond WD, Kucharska-Newton AM, Jones SB, et al. Emergency department utilization after hospitalization discharge for acute stroke: The COMprehensive Post-Acute Stroke Services (COMPASS) study. *Acad Emerg Med* 2021; Oct 17. doi: 10.1111/acem.14401. [Online ahead of print].

CT Scans Rarely Change Management of Acute Pancreatitis

At Stony Brook (NY) University Medical Center, some EPs believed they were overordering abdominal CT scans for patients admitted to the floors with acute pancreatitis. A group of researchers set out to find out if the early CT imaging that was happening in the ED changed the patient's diagnosis or management, above and beyond the abdominal ultrasound.[1]

Researchers reviewed charts of 174 patients with acute pancreatitis who came to the ED and underwent CT scans from 2013 to 2015. Of this group, 145 patients underwent abdominal CTs during their hospital stay (86% of the time, the scans were performed in the ED). Of the patients who underwent abdominal CT, 39% showed evidence of acute pancreatitis. CT led to the correct diagnosis or a change in management in only 14.5% of patients.

"That CT scans rarely add information or lead to changes in management, and that most information can be obtained from right upper quadrant ultrasounds, was not surprising," says **Adam J. Singer**, MD, a study author and vice chairman for research in the department of emergency medicine at

the Renaissance School of Medicine at Stony Brook University. "Our findings suggest that when an ED physician admits a patient for acute pancreatitis — unless there is doubt regarding the diagnosis, an ultrasound study would suffice"

David Sumner, JD, has seen several malpractice cases where it became apparent the EP defendants were unfamiliar with evidence-based guidelines for management of acute pancreatitis.

"I have yet to see acute pancreatitis managed consistently with national guidelines in a community hospital setting," says Sumner, a Tucson, AZ-based medical negligence specialist with a multistate trial practice.

Sumner stresses the importance of becoming familiar with current guidelines, "rather than stumble through early disease mismanagement to the great jeopardy and peril of acute pancreatitis patients."

Long wait times without reassessment also are contributing factors in acute pancreatitis lawsuits. It is one thing if the ED is resource-challenged because of COVID-19 pandemic patient surges.

"But I have seen patients languish for too many hours with urgent conditions because the ER is understaffed, or the ED is poorly managed — unrelated to unpredictable patient surges," Sumner reports.

A patient who is legitimately triaged as level 4 or 5 is unlikely to deteriorate to an immediate life-threatening scenario despite an hours-long wait. "Their head may explode from frustration and impatience. But these are not the patients generating meritorious ER claims," Sumner explains.

EDs need an effective triage system to prevent malpractice lawsuits involving acute pancreatitis patients. "There are serious conditions besides stroke and heart attack that require early intervention. But protocols are not in place to effectively identify those patients who are not fitting the acute stroke or MI scenario," Sumner says.

It is a problem if an acute pancreatitis patient is left to wait for hours without any intervention. "You do not let acute pancreatitis patients sit six hours without IV fluid hydration just because they did not fire a SIRS [systemic inflammatory response syndrome] alert at first presentation," Sumner says.

One hospital's EMR would not give a SIRS alert until an ED patient was brought to a treatment room. "That clearly does not work well when wait times are several hours before a patient is officially roomed in the ED," Sumner says.

Cases like that could meet the gross negligence standard, which is required in some states with partial immunity statutes for ED care. "That burden of proof is insurmountable, in most cases," Sumner reports. "But an inaccurate nurse triage designation, followed by no reassessments while waiting — plus an extraordinary wait time — will help a plaintiff's lawyer develop that rare meritorious gross negligence case."

For acute pancreatitis patients, Sumner stresses that "efficient and clinically accurate triage is the singular most vital function to help eliminate potential claims — but more importantly, to provide safe and effective treatment to ER patients." ■

REFERENCE

1. Lohse MR, Ullah K, Seda J, et al. The role of emergency department computed tomography in early acute pancreatitis. *Am J Emerg Med* 2021;48:92-95.

Older Adults with Abdominal Pain Risk Mistriage, Inadequate Diagnostic Tests

Abdominal pain in older adults presenting to EDs is triaged as "emergent" acuity half as often as other similarly acute conditions, according to the authors of a recent analysis.[1]

Investigators compared adults age 65 years and older with a chief complaint of abdominal pain during 81,509 visits to 1,211 EDs from 2013 to 2017 to those who had no complaint of abdominal pain. Of adults age 65 years and older, 7% of the ED visits were for abdominal pain. These patients were less likely to be triaged to Emergency Severity Index level 2 (emergent) acuity.

However, abdominal pain patients were more likely to be admitted directly to the OR than older adults without abdominal pain. "Our finding does raise the concern that even within older adults, there may be under-recognition of the severity of abdominal pain at the time of triage, despite outcomes that are as bad or worse as non-abdominal pain chief complaints," says **Ari B. Friedman**, MD, PhD, the study's lead author and an assistant professor of emergency medicine at the University of Pennsylvania.

Friedman and colleagues wanted to know who receives effective testing, when clinicians use potentially ineffective or outdated testing (e.g., abdominal X-ray), and how many patients were screened for "curveballs" (e.g., ordering an ECG for the possibility the patient's abdominal pain is caused by an inferior MI).

• One in six patients received an X-ray but not a CT or ultrasound.

"While we can't entirely rule out that some of these were chest X-rays looking for a pneumonia, most of them were probably abdominal plain films — X-rays. These have been shown to be misleading in a lot of cases," Friedman explains.

• Most patients (60%) did not get an ECG.

This is "a simple test that can help diagnose heart attacks, as well as arrythmias that can suggest the need for a CT angiogram to look for mesenteric ischemia, and also help avoid complications of nausea medicines," Friedman reports.

• 40% of patients did not undergo CT or ultrasound imaging of their abdomen.

"By contrast, 93% of 30-39-year-olds get an EKG for a chest pain chief complaint," Friedman notes.

ED providers should not think of abdominal pain in older adults as "the same entity" as abdominal pain in younger patients. At the department level, Friedman says EDs should consider adding abdominal pain in older patients to the list of automatic ECG criteria.

"Review the patterns of prioritization of the CT scan to ensure that low-risk stroke and trauma patients aren't unduly prioritized over older adults with abdominal pain," Friedman advises.

Many changes related to aging can lead to "subtle presentations of insidious intra-abdominal pathology, leading to delay in diagnosis, missed diagnosis, and high morbidity and mortality," says **Bryan Baskin**, DO, FACEP, quality improvement officer at the Cleveland Clinic Emergency Services Institute.

Exams can be less reliable without "classical" presentations due to less pain perception, febrile response, or muscular response to infection or inflammation.

"Of note, abdominal X-ray has limited utility in most cases to rule out insidious pathology. Abdominal X-rays in older adults have high positive predictive value but low negative predictive value and low sensitivity for most etiologies, including free air," Baskin explains.

Thus, a "negative" abdominal X-ray is not as reassuring as it seems. Histories also might be unreliable due to cognitive changes. "Emergency medicine providers must keep a high index of suspicion for insidious etiology when seeing older patients with abdominal complaints," Baskin concludes.

Elderly patients with abdominal pain represent a high-risk patient population, according to **Chadd K. Kraus**, DO, DrPH, FACEP, CPE, director of emergency medicine research and a practicing EP at Geisinger Emergency Medicine in Danville, PA.

One reason is these patients often present with multiple comorbid conditions, resulting in initial subtle or atypical symptoms. For example, patients might report just some mild nausea or vomiting, fever, or general malaise. Those might be the only clues to an intra-abdominal process, such as small bowel obstruction or infection.

"These subtle and nonclassic presentations can increase medico-legal risks because they frequently cause diagnostic errors or delays," Kraus explains.

Failure to diagnose and treat a serious condition in an elderly patient in a timely manner can result in a malpractice claim, Kraus warns. Adding to the legal risks is the fact elderly patients with abdominal pain frequently present with conditions that require time-sensitive interventions.

Elderly patients also record high morbidity and mortality rates related to intra-abdominal processes. For EDs, "a broad diagnostic approach that considers worst-case scenarios can reduce the clinical and medico-legal risks in elderly patients with abdominal pain," Kraus offers.

If the patient is to be discharged, clear and thorough return instructions are necessary. "Discussion with the patient, and documentation of a close follow-up plan within an established time frame, should be a part of the discharge for any elderly patient with abdominal pain," Kraus says.

Discharged older patients with abdominal pain should be informed of new or worsening symptoms that warrant immediate return to the ED (including, but not limited to, symptoms such as fever, vomiting, or increasing pain).

"It is also important to document a clear, time-dependent follow-up — for example: 'See your family doctor in the next 24-48 hours,'" Kraus recommends. ■

REFERENCE

1. Friedman AB, Chen AT, Wu R, et al. Evaluation and disposition of older adults presenting to the emergency department with abdominal pain. *J Am Geriatr Soc* 2021; Oct 10. doi: 10.1111/jgs.17503. [Online ahead of print].

Damages, Causation Are Obstacles in Abdominal Pain Med/Mal Cases

When deciding whether to pursue these claims, there are important considerations

Abdominal pain can be indicative of a host of medical issues. Heart attack, appendicitis, diverticulitis, and gallbladder inflammation are just some of the possible diagnoses that could be missed in the ED. That does not mean a malpractice lawsuit will be successful.

"Counsel must weigh not only the liability and causation issues, but also the value of the case," explains **Timothy L. Barnes**, Esq, an attorney with Morristown, NJ-based Porzio, Bromberg & Newman.

If plaintiff attorneys are deciding whether to pursue an abdominal pain claim, Barnes says there are important considerations:

• Did staff carefully review the patient's history?

"Were comorbidities part of the intake? Was a family history considered? Were the patient's medications part of the inquiry?" Barnes asks.

• Did staff order, interpret, and act on the appropriate tests and radiographs?

"Chest pains should lead to an ECG, abdominal pain to a CT scan, and pelvic pain perhaps should lead to an ultrasound," Barnes says.

• Did an expert need to review or interpret test results?

ED providers often are dependent on a radiologist to interpret X-rays. Sometimes, staff conducts its own preliminary review. "The interpretation and decision to act thereafter, to admit or discharge, or to seek a consult, would all depend on the reading of the films," Barnes explains.

• Can a plaintiff attorney prove causation?

"Causation is, and should always be, in the forefront of the lawyer's mind," Barnes says.

The pertinent question with misdiagnosed abdominal pain is: If the patient was properly treated, would the ultimate outcome have been substantially different? In other words, the plaintiff has to determine what injuries arose from the alleged malpractice that otherwise would not have occurred.

"Proximate cause can be a viable defense at trial, and should be addressed by counsel in the workup," Barnes asserts.

> "COUNSEL SHOULD LOOK LONG AND HARD IN CONSIDERING THESE CASES. THERE ARE MANY REASONS NOT TO PURSUE THEM."

Plaintiff attorneys may discover that, in fact, malpractice occurred, but the abdominal pain patient's poor outcome would have happened anyway. This was the situation in a recent case Barnes reviewed that involved missed myocardial infarction (MI). The potential plaintiff was a man who was angry an EP had misread the ECG and sent him home, only for the patient to be readmitted the next day with a full-blown MI, leading to bypass surgery. The EP did misread the ECG. The issue was that if the ECG had been read correctly, it would not have made any difference in the outcome.

"[The patient] would have had some muscle damage and would have still needed a coronary artery bypass graft," Barnes reports. "We declined the case."

• What is the value of the case?

"The patient's limited life expectancy is always a hurdle to overcome," Barnes says.

Many older ED patients are living with a host of pre-existing conditions, which, coupled with the patient's age, argue against investing the needed time and money to pursue a malpractice claim. Even if there is clear liability and causation, the case of misdiagnosed abdominal pain still might not be worth pursuing from a financial standpoint. "Expert fees are significant everywhere. Multiple experts are usually needed," Barnes says.

Multiple depositions also are necessary. "Expenditures of $15,000 presuit are not unusual. Coupled with the potential trial costs, spending $50,000 for a completed case would be routine," Barnes observes.

Additionally, in some states, there is a delay of several years from filing the malpractice lawsuit to actually going to trial, since the COVID-19 pandemic has delayed all aspects of trial work.

"Counsel should look long and hard in considering these cases," Barnes says. "There are many reasons not to pursue them." ■

Rapid-Access Psychiatry Encounter Might Reduce ED Use Rate

Rapid-access ambulatory psychiatry care, administered through an urgent care psychiatry clinic taking walk-ins only, may lower future ED use rates.[1] "We were trying to demonstrate the value of providing outpatient psychiatric care to patients in a rapid access model," reports **David Kroll**, MD, the study's lead author and associate vice chair in the department of psychiatry at Brigham and Women's Hospital in Boston.

Kroll and colleagues found that for 88 patients who had not received ambulatory psychiatric care, ED use decreased from 0.68 visits per patient to 0.36 in the six months after the encounter. "We are increasingly understanding that the benefits of providing psychiatric care are not limited to the relief of psychiatric symptoms alone," Kroll notes.

Mental and physical health intersect, and psychiatric care can improve the outcomes of many other general health conditions. The reverse also is true: Psychiatric disorders often lead to worse outcomes from physical health conditions. "This is why we hypothesized that providing rapid access to psychiatric care might be associated with a decreased frequency of physical health emergencies," Kroll says.

> "THE BENEFITS OF PROVIDING PSYCHIATRIC CARE ARE NOT LIMITED TO THE RELIEF OF PSYCHIATRIC SYMPTOMS ALONE."

There was a stronger link to reduction in physical health emergencies than there was for psychiatric emergencies. This does not necessarily mean providing psychiatric care is more effective for physical health emergencies than psychiatric emergencies. "Our data were likely affected by a relatively small number of psychiatric emergencies overall," Kroll explains.

For ED clinicians, an important consideration is that lack of access to outpatient psychiatric care could contribute to the medical emergencies they see. Most EPs are well aware of the shortage of available mental healthcare providers in both inpatient and outpatient settings.

"But having adequate outpatient psychiatry resources in a hospital or healthcare system affects their work, perhaps more than they already realize," Kroll says. ■

REFERENCE

1. Kroll DS, Wrenn K, Grimaldi JA, et al. Impact of a rapid-access ambulatory psychiatry encounter on subsequent emergency department utilization. *Community Ment Health J* 2021;57:973-978.

ED Is Focus of Reduction in Sepsis-Related Mortality

At Allegheny Health Network, the primary goal was to reduce sepsis-related mortality.[1]

"With the understanding that most sepsis cases present through the ED, we sought to identify opportunities to improve early recognition and treatment, and ultimately reduce sepsis-related mortality," says **Kathleen M. Latouf**, DO, MPM, Allegheny Health Network Emergency Medicine Institute quality officer and medical director of the department of emergency medicine at AHN Wexford Hospital.

Latouf and colleagues formed the ED Sepsis Performance Improvement Team, with a goal of implementing a standardized, systemwide sepsis alert. Since Allegheny spans a large footprint in western Pennsylvania, with a mix of academic, community, and rural hospitals, the sepsis alert had to be personalized for each ED.

"This was accomplished through engagement with the frontline clinicians and nurses at those respective sites. The awareness that local solutions were sometimes best helped with the implementation of this process at other sites," Latouf says.

One of the biggest lessons learned was complex issues required input from a large multidisciplinary team: Frontline clinicians, nurses, infectious disease specialists, EMS, pharmacy, laboratory director, informatics, data analytics, and an operational excellence coach.

"Our preliminary results suggest that the use of a sepsis alert, in conjunction with nursing protocols and physician order set usage, can improve core measure compliance and improve sepsis-related mortality," Latouf reports. ■

REFERENCE

1. Laux L, Campbell T, Latouf KM, et al. Emergency department initiative to improve sepsis core measure compliance: A hospital network approach. *Crit Care Nurs Q* 2022; 45:25-34.

CME/CE INSTRUCTIONS

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CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Apply new information about various approaches to ED management;
2. Identify and explain the legal and regulatory issues related to the delivery of emergency services;
3. Implement effective operational procedures and risk management into daily practice.

CME/CE QUESTIONS

1. **Which did a study reveal regarding ED visits for alcohol use disorder (AUD) and substance use disorder (SUD)?**

   a. Individuals with AUD and SUD visiting safety net hospitals were much sicker than those who visited non-safety net hospitals.
   b. Risks of systemic screening for AUD/SUD turned out to outweigh the benefits.
   c. SUD affected mainly disadvantaged populations.
   d. Annual ED visits involving AUD or SUD have increased steadily over time.

2. **ED patients with AUD or SUD were more likely than other ED patients to:**

   a. be privately insured.
   b. have never received mental health treatment.

c. be experiencing homelessness.
d. present without co-existing medical complications.

3. Which did a recent study show regarding screening for excessive alcohol use?

a. Most emergency physicians (EPs) never screen adult ED patients for excessive alcohol use.
b. The EPs who did screen received an electronic reminder to do so.
c. Most EPs were strongly opposed to the idea of screening.
d. EPs identified limited time and lack of treatment options as barriers to screening.

4. Which is true regarding ED billing practices under the No Surprises Act?

a. Out-of-network providers are prohibited from "balance billing" for the difference between the provider's billed charge and the amount paid by insurance.
b. EDs must limit billing for out-of-pocket maximums to $1,000 or less per visit.
c. Patients still can be billed by out-of-network providers for any amounts over what they would have paid for in-network care.
d. For complex ED cases, insurers are required to pay significantly higher rates than the median in-network reimbursement rates.

5. Which did a study reveal regarding opioid overdose-related ED visits?

a. Most patients received a naloxone prescription within 30 days of the ED visit.
b. Few patients with anaphylaxis received a prescription for epinephrine.
c. Few patients received a buprenorphine prescription within 30 days.
d. Most privately insured patients received both naloxone and buprenorphine prescriptions.

6. Which is true regarding stroke patients presenting to EDs after hospital discharge?

a. About one-fifth of stroke patients logged three or more ED visits in the first year after they were discharged home.
b. Almost all the ED visits were directly related to stroke.
c. Stroke patients were unlikely to present to EDs with any type of injury.
d. Repeat visits to the ED happened mainly for patients who had suffered a severe stroke.

7. Which did a recent study reveal regarding ED visits for abdominal pain?

a. Most adults age 65 years and older reported a chief complaint of abdominal pain.
b. Older abdominal pain patients were less likely to be admitted directly to the OR than patients without abdominal pain.
c. Older adults with abdominal pain were triaged as "emergent" acuity half as often as other similarly acute conditions.
d. The severity of abdominal pain was overestimated at the time of triage.