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Secondary 'over-triage' attacked but causes make change difficult

Evidence-based practices can help address the challenge

The term "over-triage" certainly sounds ominous and wasteful, but as researchers at the University of California, San Diego (UCSD) School of Medicine note in their recent paper in *The Journal of Trauma, Injury, Infection, and Critical Care,*[1] it is anything but simple.

The authors note that, not unlike the challenge of call panels, over-triage involves several dynamics outside the immediate control of ED managers, such as a shortage of available specialists and the potential threat of lawsuits. They add, however, that some strategies, such as practicing evidence-based medicine, can help reduce the incidence of over-triage.

They also differentiate between "primary over-triage," which refers to the transport of patients from the field to hospitals, and "secondary over-triage," which refers to the transport of patients between hospitals — thus involving the decision-making of hospital-based providers. The average cost of a patient who faces secondary over-triage is $5,917, they say.

If patients are discharged within 24 hours, it is unlikely they needed to be transferred in the first place, says **David Chang,** PhD, MPH, MBA, director of the UCSD Center for Surgical Systems and Public Health and one of the paper's authors.

"We're not saying these patients should not be evaluated," Chang explains. "We are saying that if they could be discharged so quickly, they

EXECUTIVE SUMMARY

While secondary over-triage is the result of a number of systemic problems, experts agree that there are some strategies ED managers can use to help reduce the frequency of such incidents.

- Use evidence-based medicine to determine best practices and develop protocols.
- Seek out members of your team with EMS experience to interface with local agencies.
- Pursue education and outreach with paramedics, and involve them in the development of protocols.

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probably could have just been given a follow-up examination shortly thereafter."

Kevin Corrigan, DO, medical director of the ED at Lexington (NC) Memorial Hospital, says, "My initial reaction to the paper was that a lot of times we transfer people out because we do not have the capability to care for them in case they 'go south.' We try to put them in a facility that could take care of them in case of an adverse outcome rather than coordinating an emergency transfer in the middle of the night, where the transfer time could be beyond the 'golden hour.'"

So, for example, if a pregnant patient who had recently received dialysis was the victim of blunt abdominal trauma, she would be transferred, notes Corrigan.

"It's possible that she would be discharged from that facility within 24 hours if she did not need dialysis, but the fear is for whatever reason that she would need emergent dialysis or need emergent surgery, and we do not have the facilities to do that," he explains.

Such situations often arise with rural facilities, note ED managers, who add that fear of lawsuits is a significant factor in this cautious approach. Hayley Osen, research analyst in the Department of Surgery at the UCSD Center for Surgical Systems and Public Health and lead author of the paper, says, "I would agree with that. I also want to highlight that we are not blaming the physicians or trauma teams. It's really a systems level issue."

Specialty coverage is an over-triage issue at Samaritan Hospital in Troy, NY, according to **John Janikas**, MD, director of emergency medicine. "In my hospital we have no neurosurgeons, orthopedists, or even plastic surgeons. If we receive a pediatric trauma victim, I do not have anyone I can talk to," he says. A child with a small head bleed might be discharged within 24 hours from a trauma center, but Janikas says he doesn't have specialists in the facility with whom he feels comfortable discussing such a situation.

Use evidence-based medicine

Despite these challenges, the researchers say secondary over-triage can be reduced through the use of evidence-based medicine.

Chang says, "We need to have more decisions based on the literature."

Osen suggests, "Review comparative effectiveness in the research, and create a culture of evidence-based medicine where providers can be more confident in their decision-making."

Their position received qualified support from ED managers including Janikas. "That's a great way to practice," he says. "The problem is that while you can use research to come up with best practice guidelines, there's a disconnect between what is considered a best practice because one journal said so and the time it takes to filter through and become standard of care." (*Janikas*

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offers several other strategies for reducing over-triage, below.)

Tim Hall, MD, FACEP, medical director of the ED at Carolinas Medical Center — University in Charlotte, NC, says, "Without specifics that's hard to comment on. You can take situation 'X' and say you have 'Z' risk of adverse outcome, but what constitutes an acceptable risk is hard to know."

Corrigan says, "It comes to the point you get down to the art of medicine; having protocols for every situation is pretty impractical." For example, he notes, from a potential jury standpoint, children who are trauma victims are a high-risk population. "The risk tolerance is pretty close to zero there," he notes.

REFERENCE

1. Osen H, Bass RR, Abdullah F, et al. Rapid discharge after transfer: risk factors, incidence, and implications for trauma systems. *J Trauma Injury Inf Cric Care* 2010; 69:602-606. ■

Over-triage can be curbed

While secondary over-triage presents a significant challenge, **John Janikas**, MD, director of emergency medicine at Samaritan Hospital in Troy, NY, says there are several ways to reduce such incidents.

For example, your local EMS can serve a significant triage function, he says. "We have a very strong regional EMS organization here, and they have lots of protocols," says Janikas. "For example, they know that if there are multiple traumas, they are to triage ahead of time and go straight to regional trauma centers." Such situations occur often in his area, he says.

Janikas says that he has a couple of physicians on his staff who work well with EMS and had previously worked with several agencies, and that ED managers should identify such physicians. "The biggest thing is to get involved," he says. "Get an ED director or someone on their staff that has an interest in EMS to really get involved with re-education and outreach, and to help develop protocols and educate paramedics so everyone is on the same page." By taking this action, everyone will know ahead of time what will be done in certain situations, he says.

"Developing your team is a part of any good leader's role, and finding those people on your team who are interested in EMS is critical," he emphasizes. "At my site, we have one doctor with decades of EMS experience, and he manages the program and our meetings." The more invested the ED can become with education, outreach, and protocol development, the better your triage process is going to be over time, says Janikas. ■

SOURCES

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Management Tip

Know what your ED can handle

When making the medical decision concerning whether a patient should be transferred, you have to know what your facility can do and what it can't handle, says **Kevin Corrigan**, DO, medical director of the ED at Lexington (NC) Memorial Hospital.

"As soon as you know you have a patient your facility can't handle, the sooner you transfer the better," Corrigan says. "They should not be at your facility any longer than necessary."

So, for example, if you have a 400-pound man with appendicitis and your tables cannot accommodate him, he should be transferred as soon as possible. "As soon you realize that, there's no reason to do any more testing," Corrigan says. "Rapid transport is the best option." ■

Gold Star
AWARD

New guidelines create an 'Oxy-free' ED

Aim is reduced deaths from prescription narcotics

[Editor's note: In this month's issue, we honor our second "gold star" winner. ED Management *gives this award to ED teams that go above and beyond the expected to dramatically improve performance through unique and creative approaches. Would you like to nominate your ED or another facility for a Gold Star? If so, contact Steve Lewis, editor, at steve@wordmaninc.com.]*

The EDs at several Swedish Medical Center hospitals in the Seattle area have adopted guidelines aimed at significantly restricting the dispensing of Schedule II narcotics such as oxycodone, dilaudid, morphine, methadone, and fentanyl in an effort to combat the dramatic rise in abuse and overdose deaths associated with those drugs.

"For most ED doctors there's a kind of battle with people who are seeking opiates," notes **Russell Carlisle**, MD, director of the ED at Swedish Medical Center/Cherry Hill.

While noting that such medications are certainly needed for treating acute pain, and that they might be required on occasion for chronic pain, although the cause is often multi-factorial, "it usually is not," says Carlisle. Therefore, he notes, you have to be careful with who gets these addictive and dangerous drugs.

EXECUTIVE SUMMARY

In the face of recent increases in prescription medication addiction, overdose, and deaths, the EDs at several Swedish Medical Center hospitals in the Seattle area have severely restricted the dispensation of Schedule II narcotics.

- ED physicians are cautious about which patients receive addictive and dangerous drugs.
- Guidelines are applied not only to abusers, but to all patients across the board.
- When patients are prescribed Schedule II medications, they receive a limited number of doses.

"Our guidelines actually came from the Washington ED Opioid Abuse Workgroup, which was started by **Darren Neven**, an ED doctor from Spokane," Carlisle says. While Neven's guidelines were directed more toward the opioid abuse group of patients, "we applied it to not only abusers, but across the spectrum," Carlisle says. (*A copy of the guidelines can be found on p. 138.*)

Patients are tiered into two separate groups: "opiate tolerant," who are people who have had opiates before, and "opiate naive." "So if I go into an ED and I am opiate naïve, I do not need to be knocked over with the strongest opiate. A mild drug would probably be OK for me, even with strong pain," says Carlisle. "And, I do not need 30 pills. Maybe five would be more appropriate."

For such patients, evidence-based medicine is used to explain why they're not getting a stronger drug. "Studies show if you have these drugs for more than a week, the risk of disability is doubled. If you get more than 150 morphine doses, your risk of disability is doubled," Carlisle explains. In addition, he notes, 30% of people have a predilection for addition and 15% have "a very strong one."

These are guidelines, not rules, he emphasizes. "There are clear exceptions written in them," he notes. "If you think pain is exceptional, you can use the drug. If you come in with a severe injury, you get IV morphine." For patients who are opiate tolerant, however, the only exception would be a chronic pain patient on a protocol, he notes. "It's generally the wrong thing to do, because it tends to increase the risk of addiction and reward your coming to the ED," he explains. "These patients generally do worse on narcotics." (*Carlisle says sharing data with his physicians helped ensure compliance. See the story on p. 137.*)

Laurie Kates, MD, an ED staff physician at Swedish Cherry Hill, says that because "nothing is set in stone" the doctor's evaluation plays a key role in whether patients receive these drugs. "If it's something objective like a broken bone, that makes it easier," Kates says. "There's nothing wrong with narcotic medications for certain indications, but having a policy that we will not refill them or treat chronic pain conditions does make it simpler."

To help ensure clear communications with patients, signs in the ED explain to patients that due to the recent increase in nationwide deaths

SOURCE

For more information on rolling narcotics policies, contact:

• **Russell Carlisle**, MD, ED Director, Laurie Kates, MD, ED Staff Physician, Swedish Medical Center/Cherry Hill, Seattle. Phone: (206) 320-2000.

related to abuse of narcotics, the Swedish doctors are following guidelines designed to significantly limit prescriptions for narcotics. The explanation also is printed on a sheet of paper, and when patients come in, the doctors review it with them. Carlisle says, "We ask them to read it while we do our assessment. That actually sets a platform or boundary." (*For more on the value of this boundary, see the story on p. 139.*)

Although the program does help staff deal with those patients who are seeking drugs, "It's not really directed at them, but at everyone," says Carlisle.

Still, says Kates, she appreciates the fact that the guidelines take away any potential conflict. "If you think a patient is drug-seeking, it's easier just to say this is our policy. It really reduces any confrontation that may have come up in the past," she says. "More importantly, people understand we're trying to reduce the overall amount of narcotics leaving the ED. It's not meant to be punitive to any one individual, and I don't feel people take it that way, either." (*To help ensure this program's success, ED nurses received inservices. See the story below.*) ■

Inservice helps prepare nurses

Nurses played a "minimal" role in the implementation of new guidelines restricting use of Schedule II narcotics in the EDs at several Swedish Medical Center hospitals in the Seattle area, says **Melody Schlaman**, RN, nurse manager for the ED at Swedish Cherry Hill. However, inservices for nurses played an important role in preparing them for the new process, Schlaman says.

"It was a verbal inservice, telling them that our doctors, based on trends both nationally and statewide with deaths related to oxycodone, decided to take a chance and no longer prescribe these medications to take home," Schlaman says. "We showed them the reasons why and gave them access to the supporting documentation."

This education was important, she says, because "sometimes as nurses we need something to back up what we tell patients. If you have a drug-seeking patient and realize this is a physician practice decision, you need to share that with patients." If the patients start escalating, says Schlaman, "all our staff has very strong de-escalation training and can partner that with the Schedule II training they received." ■

SOURCE

For more information on nursing inservices, contact:

• **Melody Schlaman**, RN, ED Nurse Manager, Swedish Medical Center/Cherry Hill, Seattle. Phone: (206) 320-2000.

Management Tip

Show docs data to achieve buy-in

Data can be a powerful tool for gaining physician buy-in, says **Russell Carlisle**, MD, director of the ED at Swedish Medical Center/Cherry Hill in the Seattle area. Carlisle used such an approach quite effectively recently when implementing guidelines that severely restricted the use of Schedule II narcotics in the ED.

"We have an EMR, and we share data with the doctors," he explains. "For each doctor we track the number of prescriptions per month and the number of pills per prescription."

While the physicians' names do not appear on the reports, their numbers do, and every physician knows his or her number. With this system, they can glance at the report and see how their performance matches up against that of their colleagues. "No one wants to be an outlier," Carlisle says.

He knows from experience that this approach works. "I used it for length of stay," he recalls. "The slower doctors got faster." ■

Due to Recent Increase in Prescription Medication Addiction, Overdose and Deaths the Cherry Hill, First Hill, Ballard and Issaquah Emergency Departments Follow These Guidelines to Reduce Prescription Drug Abuse **

1. **One provider should provide all opioids to treat a patient's chronic pain:** *We do not prescribe additional narcotic pain medications after the first visit or when you are already receiving or have received medications from another doctor or ED. Any exception will be done only after a urine tox screen and direct contact with your regular doctor.*
2. **The administration of intravenous and intramuscular opioids in the emergency department for the relief of acute exacerbations of chronic pain is discouraged:** *We do not give pain medication shots (injections) for exacerbations of chronic pain.*
3. **Prescriptions for controlled substances from the emergency department should state the patient is required to provide a government issued picture identification (ID) to the pharmacy filling the prescription:** *You will be asked to show a state ID (Drivers License or similar) when you get a narcotic prescription from our ED filled at the pharmacy.*
4. **Emergency departments should photograph patients who present for pain related complaints without a government issued ID:** *If you do not have photo ID and are requesting or prescribed narcotic pain medication we will take your photograph for the medical record.*
5. **Emergency medical providers should abstain from providing replacement prescriptions for controlled substances that were lost, destroyed or stolen:** *We do not refill stolen or lost prescriptions for narcotics or controlled substances.*
6. **Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program who have missed a dose:** *We do not provide missed methadone doses.*
7. **Long acting or controlled release opioids (such as OxyContin, fentanyl patches and methadone) should not be prescribed for acute pain:** *we do not prescribe long acting or controlled release opioids (OxyContin, MSContin, fentanyl, Duragesic, methadone . .)*
8. **Emergency departments should share the ED visit history of a patient with other emergency physicians who are treating a patient:** *Health care laws allow us to share and request your medical record and visits with other doctors.*
9. **Emergency departments should coordinate the care of patients who frequently visit the ED using an ED coordination program:** *Frequent users of the ED will often have care plans made to facilitate and optimize their care including avoidance of use of medications associated with abuse or addiction.*
10. **The Swedish Ballard, Cherry Hill, Issaquah, and First Hill Emergency Physicians do not prescribe Schedule 2 Controlled Substances -- those most associated with abuse or addiction -- including oxycodone or oxycodone containing medications (Percocet, OxyContin), Dilaudid (hydromorphone), Morphine (MSContin), fentanyl (Duragesic) and others.**

Source: Swedish Cherry Hill Medical Center, Seattle.

Management Tip

'Platform' helps avoid conflicts

When dealing with chronic pain patients, it's important to initially set a platform or boundary in the discussion, says **Laurie Kates**, MD, staff physician in the ED at Swedish Medical Center/Cherry Hill in the Seattle area.

"You establish right off that you have a program and it has guidelines based on what's best for patients and the community and that you probably will not be able to deviate from those guidelines," says Kates. "Otherwise, you'll be in a fight, and you want to avoid a fight."

It's good to show any of your chronic pain patients — not just drug-seekers — these guidelines because it increases their awareness of the problem, she says. "These medications that they may go home with are in fact quite dangerous. The worst thing to have happen would be for some of your teen-age children's friends to discover them in your medicine cabinet during a party, and pretty soon one or two of those kids who have a tendency to have an addiction take some." ■

ED Coding Update

Preparing for 2011: Revenue boosters

*[This column is written by **Caral Edelberg**, CPC, CCS-P, CHC, president of Edelberg Compliance Associates, Baton Rouge, LA.]*

A new year is fast approaching, and with it comes unusual challenges for ED compliance. As recovery audit contractors (RAC) step up audit activities, many hospitals and ED practice groups are taking a second look at appropriate ways to ensure compliance without sacrificing revenue.

By now most providers understand the complex rules for documenting records to comply with 1995 *Medicare Documentation Guidelines*. However, a quick record review might indicate problems with isolated elements that compromise compliance and revenue. Ensure physicians understand how to document the following, particularly on moderate to high acuity cases:

• **History.** It should also include a review of the system with the statement "All other systems negative to my review" when it applies.

• **Physical exam.** Address all body areas and organ systems that are relevant with a brief statement on those with negative findings. Use an organized approach to documenting that identifies each body area/organ system so coders can differentiate.

continued on page 140

EMRs create new challenges

By **Caral Edelberg**, CPC, CCS-P, CHC
President
Edelberg Compliance Associates
Baton Rouge, LA

The emergence of electronic medical records (EMRs) has created numerous problems for coding and audit staff. In addition to learning new formats and reviewing longer records, entries can often be confusing and conflicting.

Here are some problems from recent audits:

• See PMD in 24 hours (formatted discharge order). See specialist in 3-4 days (physician documentation). See PMD if problem worsens (nursing notes).

The need for urgent follow-up v. follow-up only if problem worsens indicates a significant difference in the possible acuity of the patient, the level of problem being managed, and the risk to the patient who might not follow the ED's recommendation to be seen immediately.

• Orders for high level diagnostic studies (CT scans, MRIs, Doppler, etc.) that are added, removed, and added again without the physicians indicating the orders in their narratives.

The need for these tests indicates a higher complexity of service only if they are performed. Until everyone in your ED is on board with the EMR, you'll want to cover as many bases as possible in the ED and nursing narratives.

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• **Medical decision-making.** Provide a detailed description of the patient's symptoms, problems, and relevant history to support interventions and medical necessity. Medical necessity will be a major RAC focus for hospitals in 2011, and failure to provide necessary information for the ED visit may limit hospital revenue. In addition, be sure to:

— Clearly document all orders-the facility won't bill for a service/intervention without a documented order.

— Document your treatment plan for the ED course.

— Document the rationale for interventions and any discharge instructions for follow-up. For example, "I believe the patient's condition requires hydration," or, "See internist in two to three days for follow-up testing, med reconciliation.

— Provide differential diagnoses to support medical decision-making.

— List diagnoses in order of importance. (No one group — coders, physicians, or ED nurses — should work in a vacuum. *See the story, right.*)

Although coding rules are vastly different for ED professional and facility coding, Aetna, one of America's largest health insurers covering an estimated 40 million enrollees, has announced plans to start basing its payment for the facility portion of ED services on the physician's E&M code. This payment strategy runs counter to CPT and Medicare directives. Numerous organizations, including the American College of Emergency Physicians and Emergency Department Practice Management Association, have raised concerns about the inappropriateness of this modification to established coding policy.

In its June 2010 *Office Link Updates*, Aetna announced, "Effective Nov. 15, 2010, payment for facility emergency department services will be based on the level of severity determined by the treating emergency physician. The emergency service evaluation and management code billed by the physician will be applied to the corresponding facility bill to determine the appropriate level of payment. Emergency department service evaluation and management codes are represented by the code range of 99281-99285. This policy will not apply to emergency room services which result in inpatient admissions." Until overturned, this means deficient documentation that results in down-coding of the physician level will impact the facility level as well for this payer, bringing additional focus on ED physician documentation.

In addition, Aetna has published a focus on reducing ED visits by taking a "multi-faceted approach to decreasing emergency room (ER) use by Aetna members when urgent care (UC) services would be an appropriate option instead. To address this issue, we are asking employers to educate their employees on urgencies, out-of-pocket expenses, and appropriate use of the ER vs. UC; in providing case management services to members who frequent the ER for non-ER services; in directing members to find the appropriate urgent care center in DocFind, our online provider directory, and through Informed Health Line, Aetna's

Who should chart audits?

By **Carol Edelberg,** CPC, CCS-P, CHC
President
Edelberg Compliance Associates
Baton Rouge, LA

Never have checks and balances been more critical to your practice and the hospital compliance program and revenue picture. Resubmitting records to dispute payment denials and audit findings has become today's norm. ED compliance relies on a complex system that demands checks and balances to ensure everyone understands the financial and legal repercussions of anything less than a well-managed system.

Coders should not audit themselves. Physicians should not determine documentation guidelines themselves. Nurses should not develop facility assessment criteria (E&M levels) by themselves. All should be collaboratively involved in assessing and developing compliance and revenue processes and outcomes. What makes sense for clinical documentation might not tell the full story to support code choices. Interpreting documentation and applying it to coding policies might require physician or nursing input from time to time to clarify complicated clinical issues.

Coding rules change constantly due to regional and national clarifications provided by Medicare, Medicaid, and private payers. Unfortunately, many gray areas still exist, and a collaborative effort between physicians, nurses, and coding staff might be essential to ensuring a best practices solution to today's growing revenue and compliance problems.

24-hour nurse line."

Aetna further directs employers to "help consider modifying your outgoing phone message to offer options, including `911,' urgent care, or speaking with the on-call doctor. We also hope that you will take some time to talk with your patients about the advantages of using UC centers and walk-in clinics for non-emergent care." Unfortunately, there is no information to help employers and their covered employees differentiate between a bona-fide emergency and a problem that is not. Shortly before this issue of EDM went to press, members of the Multi-State Managed Care Coalition met with Aetna. Aetna agreed to the following:

- The coalition will prepare questions regarding Aetna's new ED E&M Reimbursement Policy, to which Aetna will respond, so that a list of frequently asked questions may be developed for hospitals.
- The coalition will consider formulating an alternative approach to Aetna's new policy that would be responsive to the concerns Aetna has raised.
- Effective Nov. 15, 2010, Aetna will implement its new ED E&M Reimbursement Policy in monitor mode only, which will enable it to record all claims in which hospitals bill at a different level of severity from the treating physician without any change or reduction of reimbursement. After about 45 days, Aetna will evaluate the results and, if appropriate, re-visit the policy. The coalition expects to meet with Aetna then. ■

Intervention reduces chronic pain visits

Consultation of 15-30 minutes redirects patients

A simple behavioral health consultation of 15-30 minutes has helped reduce the number of chronic pain patients who use the ED at Providence Newberg Medical Center in Newberg, OR, as their primary source of medical care.

"We now have three years of data," says **Mary Peterson**, PhD, director of clinical training in the Graduate Department of Clinical Psychology at George Fox University, also in Newberg.

Peterson, along with several graduate students, tracked 90 high utilizers of the ED for three years. "The first year, the average number of visits per patient was 6.8. The second year it was 3.5, and the third year it was 2.3," she reports. High utilizers were patients who had had more than six visits in the previous six months or more than three visits in the previous three, she explains.

Jonathan Woodhouse, PsyD, a neuropsychology postdoctoral fellow in psychiatry and behavioral sciences at the University of Oklahoma Health Sciences Center in Norman, used this intervention for his doctoral dissertation while at George Fox. Woodhouse says, "We originally had a behavioral health consultation team embedded in the ED to address suicidal behaviors. We piggybacked on that team and developed another service."

The intervention worked like this: Grad students would meet patients at the bedside and introduce the "bio-psychosocial model," which, Woodhouse explains, is a way of validating the patient's physical pain while introducing the concept that there are other treatment options besides opioids.

"Often there is a level of resistance because patients do not want to hear that depression is the cause of their pain," says Woodhouse. "So we approach it from a position of empathy." The students explained to the patient that while anxiety and depression play a role, pain can exacerbate them and pain meds won't help.

The second part of the intervention involves explaining to the patient that while they in fact might require pain medications, the ED is not the best place to receive them. "We tell them that if they have a primary care provider, that is the best place for them," says Woodhouse. "Many people do not have one, so we were able to set up a contract with primary care providers in the community who were willing to take on these patients on

EXECUTIVE SUMMARY

It's hard to believe that something as simple as a 15-30 minute consultation can have an impact on chronic pain patients using the ED as their venue of choice for medical care; however, that's just what happened in the ED at Providence Newberg Medical Center in Newberg, OR. The average number of visits per patient per year dropped from 6.8 to 2.3 in just three years.

- Grad students met patients at the bedside, validating their physical pain while introducing the concept that there are other treatment options besides opioids.
- A series of letters went to patients after discharge to reinforce follow-up recommendations.
- Local primary care providers were enlisted to treat patients who had no "medical home."

SOURCES

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a rotating basis."

When patients left the ED, they received information on chronic pain and materials on the psychological management of pain and letters saying they should go to primary care providers. These patients were tracked, and if they continued as "frequent flyers," they would get a second letter stating more strictly that they needed to go to a primary care provider and that the hospital reserved the right to not continue opioids. A third letter, if necessary, stated that they would not receive opioids at the hospital.

"This is a confounding variable and had a powerful effect," says Woodhouse.

Jeff Hanson, RN, the manager of emergency services, says, "We had a great resource in this tool, and it was strengthened when we were able to take it to adjoining clinics and follow up on the outpatient side." For many of these patients, he points out, the ED previously was their treatment venue. "When the students were able expand their reach/consultation practice and do it immediately in the ED and also have follow-up availability in clinics working in association with local primary care providers, that had a huge impact," Hanson says. (Hanson, who joined the team well into the intervention, says it was also strengthened by a new policy adopted by the ED physicians. *See the story below.*) ■

New policy aids program

While a behavioral health program has three years of results to show it successfully helped reduce ED visits by patients seeking painkillers, the ED manager believes it was strengthened by a new policy adopted by the physicians.

"It was up to the ED doctors and nursing staff to really buy into it and present it and use the tool that was there," says **Jeff Hanson**, RN, the manager of emergency services at Providence Newberg Medical Center in Newberg, OR. "Once you got everyone working together and essentially enforcing and putting into practice what was there for us to utilize, it really worked."

The program included a policy that said the ED would be Demerol-free and that it would not ever give methadone. "Our group at a prior hospital had a similar protocol, but it only had limited success because our manager would undo what we attempted," says **Russ Griggs**, MD, medical director of the ED. "When we came out here, since we started a new group, the four of us were all aligned."

Primary care providers, who "used to send these patients to the ED and never heard from them again," soon were bombarded with calls from their patients, says Griggs. "I ended up sitting down one on one with them to explain why it was better for them and the patient," he recalls. "We went through a rough patch, and then it got better." ■

SOURCE

For more information on protocols for the use of opioids, contact:

• **Russ Griggs**, MD, ED Medical Director, Providence Newberg Medical Center, Newberg, OR. Phone: (503) 544-1990.

CLINICAL TIP

ED staff should take holistic view of pain

When treating a patient for chronic pain, you must take into account and care for the whole patient, says **Jeff Hanson**, RN, the manager of emergency services at Providence Newberg Medical Center in Newberg, OR.

"Many studies have documented why patients may present to the ED for chronic pain

complaints, and not all of them are truly based in pain," he says. "There are depression issues, anxiety issues, and lack of coping skills. As you get providers to look at the whole of the patient and put non-pharmaceutical treatment options in place, you're looking at reducing ED visits." ■

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/ CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this activity with the March issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a letter of credit. When your evaluation is received, a letter will be mailed to you. ■

CNE/CME OBJECTIVES

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

COMING IN FUTURE MONTHS

■ ED policy of "extra fast, extra easy, extra great" care

■ How to address rash of concussions among young athletes

■ Program offers comfort, control for patients at end of life

■ Coordinating predictable admissions reduces wait times

CNE/CME QUESTIONS

13. According to John Janikas, MD, director of emergency medicine at Samaritan Hospital in Troy, NY, by working closely with their local emergency management services (EMS) , managers of emergency departments can help reduce incidents of secondary over-triage. What are the functions that are most important in this interface?
A. Outreach to the agencies
B. Education of paramedics
C. Development of protocols
D. All of the above

14. According to Russell Carlisle, MD, director of the Swedish Medical Cherry Hill campus in Seattle, how many doses of morphine double a patient's risk of disability?
A. 150
B. 125
C. 100
D. 75

15. Caral Edelberg, CPC, CCS-P, CHC, president of Edelberg Compliance Associates in Baton Route, LA, , says you must be sure your physicians understand how to document in three key areas. Which of the following is not among them?
A. History
B. Outcome
C. Physical examination
D. Medical decision-making

16. According to Edelberg, the aspect(s) of electronic medical records that has/have created problems for coding and audit staff include:
A. See PMD in 24 hours (formatted discharge order)
B. See specialist in 3-4 days (physician documentation)
C. See PMD if problem worsens (nursing notes)
D. All of the above

17. According to Jonathan Woodhouse, PsyD, a neuropsychology postdoctoral fellow in psychiatry and behavioral sciences at the University of Oklahoma Health Sciences Center in Norman, a chronic pain intervention program he implemented at Providence Newberg Medical Center in Newberg, OR, included several approaches. Which of the following was not among them?
A. Approaching the patient from a position of empathy.
B. Explaining to the patients that the ED is not the best place to receive pain meds.
C. Recommending pain medications if the patient threatens violence.
D. Establishing contact with primary care providers for patients who did not have one.

18. According to Jeff Hanson, RN, the manager of emergency services at Providence Newberg Medical Center, not all chronic pain complaints are truly based in pain. What are some other causes?
A. Anxiety issues.
B. Depression issue.
C. Lack of coping skills.
D. All of the above

OPPS rule impacts obs, adds quality measures

Hospitals to get 2.35% pay rate increase

The Centers for Medicare & Medicaid Services (CMS) has issued a final rule for hospital outpatient departments (HOPDs) for calendar year (CY) 2011 with a payment rate increase of 2.35%.

The Affordable Care Act requires CMS to reduce the HOPD fee schedule increase factor (often referred to as the hospital operating market basket increase factor) for the CY 2011 Outpatient Prospective Payment System (OPPS) payment by 0.25%. Accordingly, CMS has calculated the CY 2011 OPPS payment rates to reflect a hospital operating market basket increase factor of 2.35%, which is the market basket of 2.6% minus the 0.25% reduction.

Among the changes that could impact EDs in the next fiscal year include modification of several supervision requirements for outpatient therapeutic services, including:

• Requiring direct physician supervision for only the initiation of certain services and allowing general supervision once the treating practitioner deems the patient medically stable. This two-tiered approach to supervision applies to a limited set of non-surgical extended duration services, including observation services.

• Redefining direct supervision for all hospital outpatient services to require "immediate availability" without reference to the boundaries of a physical location.

A more direct impact will be felt in the fiscal years of 2012 and 2013, with the addition of eight quality measures for payment determination. Six of these are chart-abstracted measures of timeliness and appropriate care in the ED, including time to pain management for long bone fracture; door to diagnostic evaluation by a qualified medical professional; head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival; patient left without being seen; median time from ED arrival to ED departure for discharged ED patients; and transition record with specified elements received by discharged patients.

The complete OPPS rule can be found at www.cms.gov/HospitalOutpatientPPS. ■

CNE/CME ANSWERS

13. D; 14. A; 15. B; 16. D. 17. C; 18. D;

Due to Recent Increase in Prescription Medication Addiction, Overdose and Deaths the Cherry Hill, First Hill, Ballard and Issaquah Emergency Departments Follow These Guidelines to Reduce Prescription Drug Abuse **

1. **One provider should provide all opioids to treat a patient's chronic pain:** *We do not prescribe additional narcotic pain medications after the first visit or when you are already receiving or have received medications from another doctor or ED. Any exception will be done only after a urine tox screen and direct contact with your regular doctor.*
2. **The administration of intravenous and intramuscular opioids in the emergency department for the relief of acute exacerbations of chronic pain is discouraged:** *We do not give pain medication shots (injections) for exacerbations of chronic pain.*
3. **Prescriptions for controlled substances from the emergency department should state the patient is required to provide a government issued picture identification (ID) to the pharmacy filling the prescription:** *You will be asked to show a state ID (Drivers License or similar) when you get a narcotic prescription from our ED filled at the pharmacy.*
4. **Emergency departments should photograph patients who present for pain related complaints without a government issued ID:** *If you do not have photo ID and are requesting or prescribed narcotic pain medication we will take your photograph for the medical record.*
5. **Emergency medical providers should abstain from providing replacement prescriptions for controlled substances that were lost, destroyed or stolen:** *We do not refill stolen or lost prescriptions for narcotics or controlled substances.*
6. **Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program who have missed a dose:** *We do not provide missed methadone doses.*
7. **Long acting or controlled release opioids (such as OxyContin, fentanyl patches and methadone) should not be prescribed for acute pain:** *we do not prescribe long acting or controlled release opioids (OxyContin, MSContin, fentanyl, Duragesic, methadone . .)*
8. **Emergency departments should share the ED visit history of a patient with other emergency physicians who are treating a patient:** *Health care laws allow us to share and request your medical record and visits with other doctors.*
9. **Emergency departments should coordinate the care of patients who frequently visit the ED using an ED coordination program:** *Frequent users of the ED will often have care plans made to facilitate and optimize their care including avoidance of use of medications associated with abuse or addiction.*
10. **The Swedish Ballard, Cherry Hill, Issaquah, and First Hill Emergency Physicians do not prescribe Schedule 2 Controlled Substances -- those most associated with abuse or addiction -- including oxycodone or oxycodone containing medications (Percocet, OxyContin), Dilaudid (hydromorphone), Morphine (MSContin), fentanyl (Duragesic) and others.**

Source: Swedish Cherry Hill Medical Center, Seattle.

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When looking for information on a specific topic, back issues of *ED Management* may be useful. If you haven't activated your online subscription yet so that you can view back issues, go to www.ahcmedia.com. On the left side of the page, click on "activate your subscription." You will need your subscriber number from your mailing label. Or contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-5476. Fax: (800) 284-3291 or (404) 262-5560. E-mail: customerservice@ahcmedia.com.