ED MANAGEMENT®

BEST PRACTICES, PATIENT FLOW, FEDERAL REGULATIONS, COST SAVINGS, ACCREDITATION

AUGUST 2017 Vol. 29, No. 8; p. 85-96

INSIDE

AHC Media
A RELIAS LEARNING COMPANY

Initiating Medication-assisted Treatment for Patients Presenting With Opioid Withdrawal

Critical to success: partnering with a reliable provider who can take over care of patients after they have been discharged from the ED

With a new report showing dramatic surges in both ED visits and hospital admissions because of problems related to opioid misuse, it's clear that current approaches to the problem are not sufficient.

The report, published by the Agency for Healthcare Research and Quality, indicates that in 2014, ED visits prompted by problems related to opioid use were double what they were a decade earlier, and opioid-related inpatient stays were up by 64%.[1]

While many emergency providers have long resisted getting involved with the treatment of addiction, the scope of the problem has prompted some EDs to reexamine their role in potentially connecting patients with treatment at a time when they are highly motivated to make a change. For instance, following a two-month research period last summer, the ED at Providence Sacred Heart Medical Center in Spokane, WA, began initiating medication-assisted treatment (MAT) to presenting patients with opioid use disorders, and then immediately connecting them to a MAT provider for continuing care.

There were initial concerns about potential provider resistance as well as spikes in volume, but these issues did not materialize. In fact, while these are still early days with the new approach, providers report that the program is working well, and that they are taking calls from colleagues who are interested in spearheading similar approaches.

Identify Appropriate Patients

The decision to consider initiating MAT in the ED was driven, in part, by a sense of frustration with the available treatment options for patients who present with symptoms of opioid withdrawal.

"There is a perception that there is a

Financial Disclosure: Physician Editor **Robert Bitterman**, Author **Dorothy Brooks**, Editor **Jonathan Springston**, Nurse Planner **Diana S. Contino**, Executive Editor **Shelly Morrow Mark,** and AHC Media Editorial Group Manager **Terrey L. Hatcher** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

ED MANAGEMENT®

ED Management®,
ISSN 1044-9167, is published monthly by
AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
AHC Media, LLC
PO Box 74008694
Chicago, IL 60674-8694

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421
Customer.Service@AHCMedia.com
AHCMedia.com

EDITORIAL EMAIL ADDRESS:
jspringston@reliaslearning.com

SUBSCRIPTION PRICES:
Print: U.S.A., 1 year with free *AMA PRA Category 1 Credits™*: $519. Add $19.99 for shipping & handling.
Online only: 1 year (Single user) with free *AMA PRA Category 1 Credits™*: $469
Outside U.S., add $30 per year, total prepaid in U.S. funds

Back issues: $82. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date. GST Registration Number: R128870672.

ACCREDITATION: Relias Learning LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.25] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

Relias Learning is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Relias Learning designates this enduring material for 1.25 *AMA PRA Category 1 Credits™* per issue and a maximum of 15 *AMA PRA Category 1 Credits™* annually.

Physicians should claim only credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for a maximum of 15.00 hour(s) of ACEP Category I credit.

This activity is intended for emergency physicians, ED nurses, and other clinicians. It is in effect for 36 months from the date of the publication.

Opinions expressed are not necessarily those of this publication, the executive editor, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

AUTHOR: Dorothy Brooks
EDITOR: Jonathan Springston
EXECUTIVE EDITOR: Shelly Morrow Mark
AHC MEDIA EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

lot of medicine that is really effective at combating withdrawal symptoms, which are diarrhea, abdominal pain, sweatiness, agitation, and anxiety, but there is not a lot that we can do," explains **Darin Neven**, MD, an emergency physician at Providence Sacred Heart Medical Center. "There are some addictive substances we can use to treat symptoms, but obviously that is not what we want to do in someone we are treating with addiction, so a lot of times we would give them over-the-counter medicines, and they would have to tough it out."

For example, patients would be given antihistamines, acetaminophen, or ibuprofen, Neven explains. "We tried to stay away from benzodiazepines, but generally it wasn't a rewarding experience," he says. "Patients would often stay in a sobering center where they were often sent for just a short period of time, and then they would relapse."

Neven knew that unless patients were given treatment that could alleviate their physiologic cravings, the prospects for recovery were dim, so he took part as the principal investigator on a two-month study, testing an approach whereby appropriate patients would be given their first dose of Suboxone (a combination of buprenorphine and naloxone) in the ED, and then immediately would be connected with a MAT provider who would pick up their care from that point.

"This was actually a medicine that completely removed [the patient's] withdrawal symptoms, took away all of their physiologic cravings, and then set them up for long-term stability if they could follow through the next day and subsequent days with the Suboxone treatment," Neven observes.

Ariana Kamaliazad, a medical student at the University of Washington School of Medicine in Seattle who served as an investigator on the study, concurs that the Suboxone essentially enabled patients to make it to their follow-up appointments with a MAT provider.

"Before, if you saw someone in the ED who was interested in a MAT program ... you could give them the information on how to do that, but it would be difficult for them to follow up because they would be feeling these withdrawal symptoms so much," she explains. "Usually, these people would just be enticed to just use [opiate drugs] when they got out of the hospital rather than follow up with a treatment program."

During the two-month study period in the summer of 2016, Kamaliazad would be contacted by phone or text message by the emergency provider whenever a patient presented to the ED with symptoms of acute withdrawal and he or she was interested in treatment for their addiction.

"I would respond to the ED in person and go in and meet the patient to determine their eligibility for the program," she explains.

For instance, the patients would need to be able to get to the Spokane Regional Health District every day for daily dosing of Suboxone, and they couldn't have other addictions or comorbidities.

Kamaliazad notes that another critical piece of information involved determining when the patient last used opiate medications because if they were still feeling the effects of the opioids, Suboxone actuually could send them into withdrawal rather than ease their symptoms. Also, Kamaliazad would use a clinical opiate withdrawal scale (COWS) to assess the severity of withdrawal

that the patient was experiencing.

"Then, I would give the emergency provider the information that I had gathered, and we would both come up with an assessment of whether or not we thought it was appropriate for this patient to receive Suboxone,"she says. "If it was appropriate, we would administer [the pill], watch the patient take it, and I would set the patient up with an appointment the following morning at the MAT program where they would go in and enroll."

Kamaliazad would keep tabs on whether the patient kept the follow-up appointment the next day. "As the patient is feeling better, he or she is more likely to make it to that appointment rather than go out and find more drugs," she says.

After 30 days, 71.4% of the patients who received a dose of Suboxone in the ED were still enrolled in MAT at the Spokane Regional Health District, and 28.6% were no longer participating, according to data provided by Kamaliazad. Among the 25 patients still in treatment, six patients had switched from taking daily doses of Suboxone to daily doses of methadone.

At 60 days, 51.4% of the patients were still in treatment at the health district, and three additional patients left to seek MAT at a program that offered weekly rather than daily dosing, although these patients were lost to follow-up by investigators at this point.

Ensure Prompt Follow-up Care

There were some limitations during the two-month study period. For example, with the available funding for the project, the health district could accommodate only two patient enrollments in MAT per day. "During the research, when we had a third person who wanted to be enrolled for that day and we couldn't fit him in, we had to turn that person down," Kamaliazad notes.

Also, under the Drug Addiction Treatment Act of 2000, providers who have not received a Drug Enforcement Administration (DEA) waiver to prescribe Suboxone can administer only one dose, and only if the patient is connected to a MAT provider who can continue with the treatment. "Under that law, we couldn't give people treatment if they weren't going to be able to follow up the next day in a clinic," Kamaliazad notes. Because the health district was open to provide MAT services only from Monday through Thursday, emergency providers were limited to enrolling patients in the program from Sunday through Wednesday. "The law says [providers without DEA waivers] can't prescribe Suboxone; we have to physically administer it, so we can't give patients three days of the drug," Neven observes. "We were only treating patients in the ED when we knew we could get them into a clinic the next day, which was Sunday through Wednesday."

Despite these limitations, the results of the study convinced the hospital to continue offering the approach, although there have been some logistical changes. For instance, now nurses from ED case management fulfill the role that

EXECUTIVE SUMMARY

With new data showing big increases in ED and inpatient use related to opioid abuse, providers are looking for new solutions to the opioid crisis. While emergency providers have been traditionally resistant to getting involved with addiction treatment, some are taking a fresh look at an approach that involves initiating medication-assisted treatment (MAT) in the ED, and then referring patients to a MAT provider for continuing care. Providers with experience in this approach note that it gives them something to offer patients who present to the ED with symptoms of opiate withdrawal, and the evidence suggests it is far more likely than non-medication-based approaches to keep patients in treatment.

- In a two-month study involving the initiation of MAT in the ED, providers at Providence Sacred Heart Medical Center in Spokane, WA, found that when patients deemed appropriate for MAT were initiated into treatment with a single dose of Suboxone while in the ED, more than 70% of patients were still engaged in treatment at 30 days.
- Following the study, the ED continued to provide the MAT program, partnering with a Suboxone provider for continued care of the patients following their ED visit.
- Although there were concerns that offering MAT in the ED would result in volume spikes, that has not materialized, according to providers. They estimate that the ED treats and refers about four patients per week to the MAT provider.
- Program administrators emphasize that the ED may offer the best opportunity to capture patients who are ready and motivated to engage in treatment for their opioid use disorder.

Kamaliazad handled during the study. This involves determining when patients qualify for MAT, working with emergency physicians to initiate the Suboxone treatment, and arranging for follow-up. Also, instead of working with the health district to connect patients with ongoing MAT, the ED has partnered with a large Suboxone provider.

Although the program still is limited to patients who present to the ED from Sunday through Wednesday, Neven notes that it is nonetheless a big plus for the ED to have a referral resource for patients in need of MAT. "That is a major barrier [for many EDs]," he says. "There is a shortage of clinics that will take these patients, and [the approach] definitely requires a cooperative clinic to provide MAT."

Rely on Evidence

There is often a concern among emergency providers that if they begin inducting patients into MAT, the ED will be overwhelmed with patients wanting this service, potentially leading to crowding, boarding, and other volume-related issues. Neven acknowledges that he had concerns along these lines as well, but, in fact, demand for MAT has been modest and manageable.

"We estimated that, at most, we would refer five patients per day to the Suboxone provider, and we haven't hit that yet," Neven reports. "We are treating what feels like about four patients per week in an ED that sees 60,000 adults and 30,000 pediatric patients a year."

Kamaliazad acknowledges that the study conducted last summer had a bigger impact on ED volume. "It did attract more people to the ED because they had heard about [the MAT] program and wanted to get into treatment," she says. "We were referring patients to the health district, and that was the only program at that time that was accepting Suboxone patients or any type of MAT patients."

However, Kamaliazad notes that now patients don't need to come to the ED to access MAT treatment; they can go straight to the MAT treatment provider.

ALTHOUGH MANY EMERGENCY PROVIDERS HAVE BEEN HESITANT TO GET INVOLVED IN THE TREATMENT OF ADDICTION, THE OPIOID CRISIS HAS GOTTEN SO SEVERE THAT MORE PHYSICIANS ARE WILLING TO ENGAGE ON THIS ISSUE, NEVEN OBSERVES.

Still, Neven acknowledges that he was worried that the program could cause volume to spike. "There are so many patients who come to the ED with an agenda to get prescription opioids," he says. "I have been really surprised that we have not been overrun with people who want to get Suboxone." While Neven is supportive of offering Suboxone in the ED, he used the study period to determine whether the rest of the emergency providers would buy into the concept as well. "That was one of the major things we were testing," he says. "There were vocal physicians that I knew of who felt that methadone programs are misplaced and misguided ... and that they are a waste of money."

However, all the physicians ultimately agreed to participate in the program and offer Suboxone to the patients they determined were appropriate for the treatment, Neven explains.

Although many emergency providers have been hesitant to get involved in the treatment of addiction, the opioid crisis has gotten so severe that more physicians are willing to engage on this issue, Neven observes. He also has a ready comeback for physicians who question whether MAT is the right approach. "My main answer to that is to look at the data on what is most effective for treating opioid addiction. It is not abstinence-based therapy. It is not tough love. And it is not a 12-step program," he says. "These things do not work for opioid addiction, and it is very clear in the literature that they do not work."

People relapse at rates topping 90% when those approaches are used, and outcomes are much better when opioid substitution therapy or MAT is used, Neven adds.

"We are slowly educating physicians that this is the best, evidence-based approach, and it is also a harm reduction method," he says. "Every dose of Suboxone is one less dose of heroin, which is one less dose of harm, so we should do everything we can to reduce harm. We shouldn't go for a lifetime of sobriety because that is not realistic.

Kamaliazad adds that the ED may offer the best opportunity to connect with patients who have opioid addictions. "A lot of these patients have other social factors that are going to predispose them to not make regular appointments with doctors, so whether or not people in the ED want to treat people with addictions, it might be that the healthcare system is only able to capture these patients when they are in an acute setting because they tend not to follow up with regular physicians," she says.

How might emergency medicine clinicians move forward with a similar program to what Neven and colleagues are doing in Spokane? One easy first step is to take the Suboxone course that will enable providers to obtain a DEA waiver to prescribe the drug, Neven advises. "It is four hours of a webinar online and then four hours in front of a computer doing online learning," he says. "You will learn a comprehensive approach for giving Suboxone ... and obtain your DEA number."

While the approach offered at Providence Sacred Heart does not require providers to prescribe Suboxone or to obtain a DEA number, it does give physician leaders added flexibility, Neven explains. He also advises providers who are interested in initiating MAT in the ED to spend a day or two in a Suboxone clinic.

"You will get an idea of how a clinic works and how you get someone inducted," he says. "I worked in a Suboxone clinic for several months, and that is how I learned [the approach]."

Kamaliazad adds that when implementing the program it is helpful to employ a community health worker or some type of healthcare professional who has taken the Suboxone course, can consult on some of the more difficult cases, and facilitate the transition of patients to a MAT program.

"It is difficult for every physician in the ED to learn about all the options people have for MAT, so if one person knows about all the available programs, and he or she can be called and consulted, it makes it a lot easier," she says.

KAMALIAZAD ADDS THAT THE ED MAY OFFER THE BEST OPPORTUNITY TO CONNECT WITH PATIENTS WHO SUFFER FROM OPIOID ADDICTIONS.

Other emergency providers are taking an interest in developing MAT programs similar to the approach used at Providence Sacred Heart. Neven has fielded calls from colleagues on the subject, and he is looking at opportunities to expand the approach to other EDs.

Meanwhile, **Lauren Whiteside**, MD, MS, an emergency physician at Harborview Medical Center in Seattle, says she is one of the principal investigators for a large, multisite trial that will be evaluating the effectiveness and implementation of ED-initiated buprenorphine/naloxone for patients with opioid use disorder. The study includes sites in New York City, Cincinnati, and Baltimore, in addition to Seattle, and researchers anticipate recruiting 2,000 patients to participate in the investigation. *(For more information about this trial, please visit: http://bit.ly/2ueJrnq.)*

Investigators will be looking to see if outcomes confirm earlier findings from a randomized, controlled trial conducted by the Yale School of Medicine from 2009-2013. In that study, researchers found that providing patients with Suboxone and a referral to treatment in the ED made them more likely to remain in treatment for an opioid use disorder for at least 30 days than patients who only received a referral to treatment. The findings showed that 78% of the patients given Suboxone were still in treatment at 30 days, while just 37% of the patients who only received referrals to treatment were still engaged in treatment.[2] ■

REFERENCES

1. Agency for Healthcare Research and Quality. Patient Characteristics of Opioid-Related Inpatient Stays and Emergency Department Visits Nationally and by State, 2014. Available at: http://bit.ly/2tL4Ggi. Accessed June 28, 2017.
2. D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: A randomized clinical trial. *JAMA* 2015;313:1636-1644.

SOURCES

- **Ariana Kamaliazad**, Medical Student, University of Washington School of Medicine, Seattle. Email: arikamal@uw.edu.
- **Darin Neven**, MD, Emergency Physician, Providence Sacred Heart Medical Center, Spokane, WA. Email: darin@consistentcare.org.
- **Lauren Whiteside**, MD, MS, Emergency Physician, Harborview Medical Center, Seattle. Email: laurenkw@u.washington.edu.

EPs Value Observation Care, Remain Wary About Tighter Restrictions

Even with MOON notice requirements, patient misconceptions regarding the costs associated with observation stays linger

For years, the use of observation has been under constant assault by critics. While some charge that observation is just a cost-shifting mechanism that disadvantages patients, others gripe it is another layer of needless bureaucracy. Of course, it doesn't help that the rules governing payment for observation seem to be constantly in flux, with the latest requirement (effective in March 2017) concerning providing Medicare Outpatient Observation Notices (MOON) to Medicare patients who remain in observation beyond 24 hours.

However, despite this friction, the use of observation has increased steadily, and there always has been plenty of evidence that emergency providers truly value the service as a needed middle ground, such as when testing has not yet been completed on a patient or when providers need a bit more time to ascertain whether a patient is safe to be discharged.

For instance, a recent study that gauged emergency physician views on the use of observation status found that providers in the United States and in the United Kingdom value the service because of the potential benefits it offers in terms of patient safety and quality care. This is despite the different regulatory frameworks and payment systems that exist in the two countries.[1]

However, despite the benefits that observation offers, clinicians who oversee observation units in the United States lament what they view as misinformation about why observation is used and the financial effect of an observation stay on patients. Further, some experts voice concerns that any further tightening of the restrictions around observation could affect care and outcomes negatively.

Clear up Misconceptions

In the study gauging emergency physician views on the use of observation, investigators consulted 10 emergency physicians from a university healthcare system in the Midwest and 14 emergency physicians from two hospitals in the United Kingdom.

Even though the payment rules governing the use of observation in the two countries are entirely different, the reasons given for the increasing use of observation in both countries were quite similar. In particular, participants from both countries believe in the importance of preserving inpatient resources, although this view was more evident among the physicians in the United Kingdom. Further, all the participants emphasized that clinical needs take precedence over administrative or financial factors in their decisions on whether to place patients on observation.

Physicians from both countries viewed observation as particularly

EXECUTIVE SUMMARY

A new study suggests that emergency physicians in the United States and the United Kingdom value the benefits of observation care, viewing it as an important middle ground when a diagnosis is not yet clear or when more testing is needed, and they generally are wary about any further tightening of the restrictions governing its use. Although it is a challenge staying up to date on regulatory requirements, some physicians in the United States are most concerned about common patient misconceptions about the costs of observation vs. inpatient care — misconceptions that linger despite the new requirement that Medicare Outpatient Observation Notices (MOON) be delivered to patients who remain in observation beyond 24 hours.

- Delivering MOON forms has created logistical hurdles for some hospitals, especially during weekends when staffing is not as robust.
- Atlanta-based Emory Healthcare ensures that appropriate observation patients receive the MOON form by distributing it to patients at the same time every morning. Emory also has set up a MOON hotline for patients who have questions or concerns about their observation status or payment.
- Noting that the literature shows that patients who succeed in observation do so in an average of 15-18 hours, Emory aims to capture 85% of observation patients in an observation unit, and for 85% of those patients to go home within 24 hours.

valuable when there are clearly defined protocols or treatment pathways that can be completed within 24 hours. For example, it is common practice in both countries to refer patients with chest pain to observation while testing is completed to rule out an acute coronary syndrome. However, U.K. and U.S. physicians agreed that observation can be misused when it serves as a holding place for patients who do not have any clear diagnosis. Nonetheless, both U.K. and U.S. physicians agreed that there are times they need more time to ascertain a correct diagnosis, and that observation plays a useful role in providing a safe space in cases in which patients do not meet inpatient criteria.

Although physicians on both sides of the Atlantic recognized a potential for abuse in the growth of observation, the investigators reported that the physicians also voiced concerns about tighter regulatory reforms that could further restrict a provider's ability to use the service.

"A lot of the alarming or conspiratorial types of suggestions for why we are seeing an increase in the use of observation have not really been borne out upon further study," explains **Brad Wright**, PhD, a co-author of the study and an assistant professor in the department of health management and policy at the University of Iowa in Iowa City, IA. "This is a type of care that seems to serve a lot of valuable roles and purposes, but at the same time there are criticisms and concerns. I think we need to know more before [implementing] a stricter definition of how observation is to be used. There are so many good things that it does."

Michael Ross, MD, FACEP, FACC, the chief of service for observation medicine at Emory Healthcare and a professor of emergency medicine at Emory University School of Medicine in Atlanta, agrees with these sentiments. However, he notes that patients often believe misconceptions about the costs associated with observation care. "I have heard more and more patients saying they don't want to be observed because [they believe] Medicare doesn't pay for observation," he says.

In fact, such comments stem from a misunderstanding of what happens to a small number of patients who are observed and then transferred to a skilled nursing facility (SNF), Ross explains. "If they didn't have the three [required] inpatient qualifying days, then Medicare doesn't pay for the SNF as a benefit," he says. "It turns out that this group represents 0.7% of all Medicare observation patients. It is extremely rare."

"THIS IS A TYPE OF CARE THAT SEEMS TO SERVE A LOT OF VALUABLE ROLES AND PURPOSES, BUT AT THE SAME TIME THERE ARE CRITICISMS AND CONCERNS."

Ross notes that another common misperception is that patients in observation will pay more out-of-pocket costs than if they are admitted to the hospital. In fact, a report from the Office of the Inspector General (OIG) has found that in the vast majority of cases, the opposite is true. The OIG reports that on average, beneficiaries pay twice as much for a short inpatient stay as for an outpatient visit that includes observation.[2]

Consider Logistical Hurdles

The new Centers for Medicare & Medicaid Services (CMS) requirement that hospitals provide patients who have been in observation for more than 24 hours with a MOON form does not necessarily clear up all the misconceptions regarding observation vs. inpatient costs, but it is intended to clarify to patients in written and oral form that they are observation patients, not inpatients, and what the cost-sharing implications of this status are, Ross explains.

With the approval of CMS, Emory has added some verbiage to the MOON form to provide patients with more information about why they are in observation. This consists of a series of check-off boxes that give providers a range of reasons as to why the patient is in observation so that the clinician can simply check the box or boxes that apply. The options on the Emory MOON form include:

- Your diagnostic testing is not yet complete;
- Further treatments of your condition are needed;
- Consultation needs to be completed;
- Ongoing evaluation and management of your condition is needed;
- You require more care after your surgery but should be able to be discharged within 48 hours;
- Your Medicare Advantage plan has told your doctor to place you in observation;
- Other.

Coming up with a way to reliably ensure that the MOON notice

requirement is met for all patients who remain in observation beyond 24 hours presented some hurdles at Emory Healthcare's five hospitals with observation units, Ross explains.

"There are really three ways you can do it. You can wait until the patient hits 24 hours [in observation] and then give [the MOON form] to him, but then the patient could hit 24 hours at [5 a.m.] and then be discharged at [7 a.m.] before the nurse comes by to give it to that patient. We thought that was problematic," Ross observes.

Another option that Ross considered was simply to give the MOON form to every observation patient. That is permitted by CMS, but Ross nixed that idea because it involved giving the form to patients who didn't need it. Instead, Ross explains that Emory arrived at a "happy medium" between these two options.

"We know that by [10 a.m.], the rounds have occurred ... so what we do is have the nurse give [the MOON form] to every observation patient at that time, whether they have crossed the 24 hours in observation or not," he says. "We know that if we do this consistently, we will always [supply the form] to patients before they are discharged. What is also nice is that if somebody comes and goes from observation between [the times when the form is given], then that patient hasn't been in observation for 24 hours, so there is no concern about missing the patient."

By using this approach, Emory can fulfill the MOON requirement in a systematic way that ensures reliability. "It allows us to consolidate our staff and workflow," Ross offers. However, he acknowledges that it has been more challenging to cover the weekends when staffing is not as robust. "There are all kinds of logistical things that have popped up," Ross observes, noting that, regardless, the MOON forms are given to appropriate patients.

How does Ross ensure that providers are kept informed about all the regulatory changes affecting observation care, such as the MOON form requirement? "I think you just hard-coat what is needed into the workflow," Ross says. In addition, Ross regularly disseminates written information about any regulatory changes to the physicians, and he will make liberal use of phone contact, too. "We have a monthly meeting for our CDUs [clinical decision units] where we discuss all issues, and I attend the care coordination meetings monthly where nurses that deliver the MOON forms discuss it," he explains. "They have said that, by and large, most patients sign the forms, and some people will ask questions ... but it really hasn't changed very much of what we do."

WHILE THERE HAVE BEEN SEVERAL SIGNIFICANT REGULATORY CHANGES TO OBSERVATION IN RECENT YEARS, ROSS ... BELIEVES MEDICARE IS GETTING CLOSER TO A WELL-DEFINED SERVICE.

Emory also has established a MOON hotline for observation patients who ask questions about their status or payment issues, although thus far there have not been too many takers, Ross reports. "Every hospital comes up with a different way to [handle the MOON form requirement]," he says. "Some places are using registration clerks, and some are using [electronic tablets] instead of paper documents where the patients sign their names electronically."

When Medicare budgeted for the MOON process change, the agency understood hospitals were going to need added resources, Ross recalls. "They estimated [the process] would take five or 10 minutes of time [per patient], so they increased payment for that."

Push for Regulatory Tweaks

While there have been several significant regulatory changes to observation in recent years, Ross, who served on an ambulatory payment classification (APC) advisory committee to CMS, believes Medicare is getting closer to a well-defined service. "The comprehensive APC for observation packages everything into a single payment," he explains. "The emergency visit and the observation visit are combined."

That means for a chest pain patient, for example, the stress test, MRI, echocardiogram, and everything the patient gets during an observation visit are combined. Medicare would cover the visit, with patients paying a 20% copay, Ross explains.

"That is almost always going to be less than what an inpatient deductible would be for the patient," he adds.

The only two things that are not covered by Medicare are self-administered drugs and the SNF benefit when inpatient requirements are not met, but the American College of Emergency Physicians is advocating that those issues be addressed, Ross explains.

In particular, Ross would like to see a change to the requirement that patients spend three days as inpatients to be eligible for the SNF benefit. "It is clear that observation is at least comparable to inpatient level care, if not higher in many cases with type 1 observation units," he says. "I think Medicare needs to do what Medicare part C plans do and either drop the three-day rule or include time in observation toward the three-day rule."

For example, if a patient is observed and gets admitted, start the clock with observation rather than when the patient was admitted, Ross advises. "Such a change would go far with patients," he says.

Regarding self-administered drugs, Ross understands that some of these drugs are very expensive, and that Medicare is reluctant to cover such costs, but he believes this problem could be addressed by simply placing a cap on the amount that Medicare will pay for these medications.

"If a patient is in observation for a GI bleed, you don't want him to take aspirin or Coumadin, so really for quality and safety reasons, hospitals are going to want to [be in charge of administering] those medications," he says.

Much of the handwringing over observation stems from the decision by Medicare officials to adopt the diagnosis related groups (DRG) system decades ago, Ross shares. "They created a dichotomous world where everything was inpatient or outpatient, and they didn't realize at the time that this was like saying that everyone can fit into a small T-shirt or a large T-shirt, and there was no such thing as a medium T-shirt," Ross explains. "Observation patients are really neither inpatient nor emergency patients. They truly are a separate, distinct, middle category."

The intent of observation is to see if someone must be admitted, but such patients really fall between inpatient and outpatient, Ross notes. "If you don't have that option, you are going to admit people who don't need to be admitted, or you are going to send home people who should have been admitted," he says.

Over the years, it has become clear in the literature that patients who succeed in observation do so in an average of 15-18 hours, Ross advises. "If you hit 15 to 18 hours, and you are still spinning your wheels, you have reached a point of diminishing return, and keeping the patient additional hours [in observation] is probably not going to make a difference unless there is something missing, like a stress test," he says.

Otherwise, Ross notes that it is probably better to admit the patient at that point. "Our goal is to capture 85% of observation patients in an observation unit, and for 85% of those patients to go home within 24 hours," he says. ■

REFERENCES

1. Martin G, Wright B, Ahmed A, et al. Use or abuse? A qualitative study of emergency physicians' views on use of observation stays at three hospitals in the United States and England. *Ann Emerg Med* 2017;69: 284-292.
2. Department of Health and Human Services, Office of Inspector General. Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy. Available at: http://bit.ly/2if88Ky. Accessed June 27, 2017.

SOURCES

- **Michael Ross**, MD, FACEP, FACC, Chief of Service, Observation Medicine, Emory Healthcare; Professor of Emergency Medicine, Emory University School of Medicine, Atlanta. Email: mross@emory.edu.
- **Brad Wright**, PhD, Assistant Professor, Department of Health Management and Policy, University of Iowa, Iowa City, IA. Email: brad-wright@uiowa.edu.

Diagnosing, Treating Benign Paroxysmal Positional Vertigo

New guidelines offer tips for handling vague symptoms of dizziness associated with this disease

Every year, vague symptoms of intense dizziness drive millions of Americans to EDs and other frontline providers, and a large percentage of these cases (17-42%) are the result of benign paroxysmal positional vertigo (BPPV). Although the inner-ear problem itself is not generally serious, delays in diagnosis can affect quality of life negatively and lead to the loss of work, falls, and even depression in some patients. Since BPPV becomes more prevalent as people age, the effect on seniors is more pronounced.

However, updated guidelines from the American Academy of Otolaryngology – Head and Neck Surgery highlight advances in the diagnosis and treatment of BPPV that can help providers quickly arrive at a correct diagnosis and immediately apply treatment, generally leading to a quick resolution of symptoms without resorting to expensive imaging studies or potentially harmful medications.[1]

Although the dizziness associated with BPPV is episodic, it can be very intense and it is quite daunting, notes **Neil Bhattacharyya**, MD, FACS, chair of the guideline update group and associate chief of the division of otolaryngology at Brigham and Women's Hospital in Boston. "A lot of patients will think they are having a stroke, or that something much more serious is going on," he says. "It can be paralyzing because if you don't know what is causing the dizziness, you don't want to move around. You just kind of sit there in bed, hoping it is going to go away."

Sometimes, physicians will adopt a wait-and-see approach toward complaints of dizziness; meanwhile, the intense spinning sensation that goes along with BPPV may keep patients from driving or going to work. The dizziness may be accompanied by nausea, vomiting, or an intense feeling of disorientation or instability. "Many physicians will prescribe medications such as Valium or other agents to try to suppress the dizziness, but that is not the best treatment for BPPV," Bhattacharyya stresses.

However, the new guidelines make clear that opting for expensive imaging studies generally is unnecessary and ill-advised as well. "We were able to strengthen some of the statements about the diagnosis of BPPV, bringing it to the forefront so that it is more at the top of the tongue for a differential diagnosis of dizziness for patients and for physicians, Bhattacharyya says. "We also strengthened the treatment recommendations so that if the provider is aware of the diagnosis, it can become a relatively straightforward treatment, skipping all the bells and whistles of MRIs and hearing tests and things like that, and going right to the treatment, all in that one visit."

Further, the evidence-based guidelines are an attempt to address the fact that providers use a wide variety of diagnostic and therapeutic interventions for BPPV, some of which are ineffective, expensive, and needlessly time-consuming. However, Bhattacharyya acknowledges that getting to the root cause of dizziness can be especially challenging for providers.

"It is one of those symptoms where the patient will come in and complain that they are dizzy, but when you look at them, they are walking normally and talking normally, and they are obviously not having a stroke," he says. "They may say that

EXECUTIVE SUMMARY

Updated guidelines on the diagnosis and treatment of benign paroxysmal positional vertigo (BPPV) suggest a series of in-office maneuvers, rather than expensive imaging tests or medications, offer a faster route to diagnosis and cure.

- Typically, patients with BPPV present with symptoms of intense dizziness that may be accompanied by nausea, vomiting, or an intense feeling of disorientation or instability.
- A very specific diagnostic step called the Dix-Hallpike maneuver can enable physicians to quickly spot the signs of BPPV.
- When the diagnosis is positive for BPPV, canalith repositioning maneuvers typically can resolve the symptoms.
- When BPPV is suspected, guideline authors urged providers to stay away from vestibular suppressive medications, which produce a host of side effects and can contribute to a delay in diagnosis.

they felt dizzy last night or yesterday or a few days ago, but they are not dizzy now."

However, if the cause of the dizziness is BPPV, there is now strong evidence that physicians can make the diagnosis in the ED or in an office setting with a five- to 10-minute history and physical exam, using a very specific diagnostic step called the Dix-Hallpike maneuver, Bhattacharyya explains.

The maneuver involves moving the patient from an upright to a supine position, with the head turned 45 degrees to one side and the neck extended roughly 20 degrees with one ear facing down. The procedure can be repeated with the opposite ear facing down.

"If you do this maneuver, you can elicit the same dizziness symptomatology and make the diagnosis," Bhattacharyya says. In particular, in cases of BPPV, the clinician will observe rapid eye movements or nystagmus. "Once you make the diagnosis [of BPPV], there is very compelling evidence that you can do a particle repositioning maneuver, and roughly 80% of the time, cure the patient in that same visit," he says.

This second maneuver involves a series of head movements that are designed to move the small crystals of calcium carbonate or canaliths that have collected in the ear canal, which essentially cause the dizziness.

The updated guidelines stress the importance of completing these maneuvers when BPPV is suspected. "That is one of the very key points here rather than just saying, 'well, I guess the patient was dizzy three days ago; we ought to rule out the bad stuff. Let's get an MRI and follow up with neurology in a month,'" Bhattacharyya notes. "By then, you have missed the boat." While the maneuvers used to diagnose and treat BPPV are not new, the evidence behind them is much stronger than it was seven years ago when the last guidelines were published. "Almost all of the multidisciplinary panel members were familiar with the maneuvers, but they weren't quite as familiar with how effective they are because there is relatively new data in the literature," Bhattacharyya explains. "We would like to see 100% penetration of these diagnostic and therapeutic maneuvers, particularly when patients come in with a vague complaint of dizziness."

As a result of the new evidence, the guidelines stress two very strong negative recommendations or things the expert panel advises providers not to do. "You don't have to get an MRI or a CT scan, which saves the patient anxiety, saves the system money, and saves you time," Bhattacharyya notes. "Also, we really want to steer clinicians away from vestibular suppressive medications, which have a host of side effects and contribute to both a delay in diagnosis and time out of work because the patient generally can't drive or go to work on Valium or other similar medications."

The guideline authors suggested there is ample room for improvement in the way BPPV is addressed. They estimated that it costs about $2,000 to diagnose BPPV, and that more than 65% of patients with BPPV will undergo potentially unnecessary diagnostic testing and interventions. In fact, the authors noted that healthcare costs associated with the diagnosis of BPPV top $2 billion per year.

To partially address these cost implications, a consumer advocate was added to the guideline development group for this most recent update. Bhattacharyya explains that this step was taken because of the growth of shared cost models in medicine. "A lot of patients have insurance plans where they have a high deductible, or they have a 20% copay ... so, increasingly, we are seeing patients who are not only concerned about their body, but their pocketbook as well," he says.

For example, if a patient is going to undergo an MRI, he wants to know if that is cost-effective because it may not be a covered service under his health plan, Bhattacharyya observes. "We felt it was important to include the consumer side of the equation, because patient-centered decision-making is so important," he says. ■

REFERENCE

1. Bhattacharyya N, Gubbels SP, Schwartz SR, et al. Clinical practice guideline: Benign paroxysmal positional vertigo (update) executive summary. *Otolaryngol Head Neck Surg* 2017;156:403-416.

SOURCE

- **Neil Bhattacharyya**, MD, FACS, Associate Chief, Division of Otolaryngology, Brigham and Women's Hospital, Boston. Phone: (617) 525-6540.

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

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

ED MANAGEMENT®

CME/CE INSTRUCTIONS

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

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

2. Log on to **AHCMedia.com** and click on My Account. First-time users must register on the site using the eight-digit subscriber number printed on their mailing label, invoice, or renewal notice.

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

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

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

CME/CE QUESTIONS

1. **In 2014, what was the rate of ED visits prompted by problems related to opioid use compared to what they were a decade earlier?**

   a. Half
   b. About the same
   c. Double
   d. Triple

2. **Under the Drug Addiction Treatment Act of 2000, providers who have not received a Drug Enforcement Administration waiver to prescribe Suboxone can administer only one dose, and only if:**

   a. the provider is supervised by an addiction specialist.
   b. the patient is connected to a medication-assisted treatment provider who can continue with the treatment.
   c. the patient is admitted to the hospital.
   d. the patient can demonstrate that he or she has adequate social support.

3. **In a new study, emergency physicians in both the United States and the United Kingdom recognized a potential for abuse in the growth of observation, but they also voiced concerns about:**

   a. residency training programs.
   b. not having enough beds in observation units.
   c. limited budgets.
   d. tighter regulatory reforms that could restrict a provider's ability to use observation.

4. **Patients commonly have misconceptions about which of the following aspects of observation care?**

   a. The costs
   b. The treatments
   c. The staff
   d. All of the above