

# THE Physicians Report

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DELIVERING  
HEALTH CARE TO

## PATIENTS IN CRISIS



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# Supporting the Delivery of Connection and Compassion

Patients in crisis present a unique set of challenges for the medical professional, as well as for the entire health-care system.

These patients can be quite complex medically, but even in those cases that are relatively straightforward, the amount of time and resources required to deliver the best possible care is substantial. These patients need not only delivery of quality medical care, but also referrals to and consultations with appropriate social workers, case managers, addiction programs, and mental-health services. One final thing they need is compassion and a human connection with their health-care provider.

This month's edition of *The Physicians Report* highlights the various important facets of care required for these challenging patients. This includes a detailed analysis of the opioid crisis facing our country, a review and recommendations on conversations with victims of domestic violence, a report on the integration of behavioral and physical health services, and discussions on treating addiction in inmates, the health benefits of housing for the homeless, and the positive impact that case workers have for patients in crisis in the ED.

As an emergency-department physician, I can speak from firsthand experience about the value of having case workers available to assist with the non-medical aspects of care that these patients require. The health system I work in has embedded care managers in the ED, and they are a vital member of my health-care team. While it costs the health system money to provide these services and have care

managers present in our ED, they actually create a net cost savings by helping to reduce bounce-backs and unnecessary admissions. They do that by getting patients the resources and referrals they need in a timely fashion.

We are currently expanding our care-management program to include some full-time care managers, who are doing outreach in the community with high ED utilizers to help ensure that these patients are getting access to the services and treatments they need. It has become increasingly apparent that in order to provide the best possible care, a team-oriented health system-integrated approach is needed.

As health-care providers, we are in a profound position, regardless of whether or not our specialty is focused on treating patients in health emergencies. We all see people at their best, their worst, and everything in between. While it's not always immediately obvious, we often see people who are in situations of crisis. It is an honor to support patients during these times. Having the right systems in place is what allows us to remain focused on showing up at our best for them.



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# WAKING TO A PUBLIC HEALTH NIGHTMARE

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"HE CURSES THE SPELLS WHICH CHAIN HIM DOWN FROM MOTION; HE WOULD LAY DOWN HIS LIFE IF HE MIGHT BUT GET UP AND WALK; BUT HE IS POWERLESS AS AN INFANT, AND CANNOT EVEN ATTEMPT TO RISE."

—Thomas De Quincy, *Confessions of an English Opium-Eater* (1821)



In every corner of the world, for thousands of years, people have been sipping, snorting, smoking, and topically applying the sap of *Papaver somniferum*, the opium poppy. In the 19th century, European chemists began isolating the pod's analgesic compounds, paving the way for the mass production of synthetic opioids.

Over the past two decades, the use of opioids, both synthetic and poppy-based, has blossomed into a full-scale public health crisis. According to the Centers for Disease Control and Prevention (CDC), roughly 1.9 million Americans currently struggle with an opioid use disorder. In 2015, 33,000 Americans died from opioid overdoses. Opioids are now responsible for more deaths in the United States than guns or car accidents.

### THE PATH TO AN EPIDEMIC

The most recent National Survey on Drug Use and Health revealed that approximately 10 percent of Americans aged 12 and older report recent illicit drug use, including misuse of prescription medications. Many of those surveyed are addicted to multiple substances. But while the types of addiction are many, misuse of prescription pain relievers and illegal opioids like heroin and fentanyl are by far the most deadly.

Attitudes toward the prescribing of opioids began to change in the late 1980s. As a series of recent investigative reports has revealed, that change stemmed in large part from an aggressive marketing campaign that Stamford, Connecticut-based Purdue Pharma orchestrated for its launch of OxyContin in 1986.

Purdue made several misleading claims about OxyContin, an extended-release formulation of oxycodone, lulling a generation of doctors into a false sense of security about its safety. OxyContin's supposed competitive advantage over other formulations was its 12-hour schedule, which Purdue insisted would provide patients with "smooth and sustained pain control all day and all night." Purdue also claimed that OxyContin's controlled-release design made it safer than immediate-release formulations. Fewer than 1 percent of patients taking OxyContin, Purdue's sales staff maintained, became addicted.

Physicians, health plans, and even some Purdue staff soon began to suspect that these claims were false. Many patients expecting 12-hour relief instead experienced intense withdrawal symptoms, craving their next doses after only six to eight hours. When physicians tried to help their patients by prescribing OxyContin on more frequent dosage schedules—three or four times per day—Purdue aggressively fought the practice, realizing health plans would stop paying a premium for the new drug. Purdue account managers persuaded physicians to increase dosages of OxyContin, and before long, physicians found themselves prescribing expensive 160mg OxyContin pills instead of more frequent

immediate-release formulations. Some patients ended up on 320 or more milligrams per day—more than three times what experts now consider a safe daily dosage.

The consequences were predictable. Rates of addiction and accidental deaths skyrocketed. Patients continued to experience withdrawal, and a steady flow of prescribed opioids into the community led to patterns of diversion and recreational use. As for the oft-mentioned clinical study showing that the rate of addiction from OxyContin was around 1 percent—that never existed.

Perhaps the most pernicious effect of Purdue's campaign was its success in persuading a generation of doctors to relax their caution about narcotic medications. Purdue's marketing team pushed the theory of "opiophobia," which held that concerns about prescribing opioid analgesics, particularly to patients with chronic pain, were exaggerated and unjustified. Purdue further argued that physicians had an ethical obligation to eliminate pain using the strongest tools at their disposal.

Despite the loss of more than 200,000 American lives to opioids since the release of OxyContin in the late 1990s, this legacy of beliefs and attitudes persists in the medical community to this day.

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## PATIENT-SATISFACTION SCORES, BASED IN PART ON HIGHLY SUBJECTIVE PAIN- SCALE RESULTS, EXACERBATE THE ISSUE BY GIVING DOCTORS AN INCENTIVE TO TRY TO ELIMINATE PAIN ALTOGETHER.

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### ONE COMMUNITY'S STRUGGLE WITH OPIOID ADDICTION

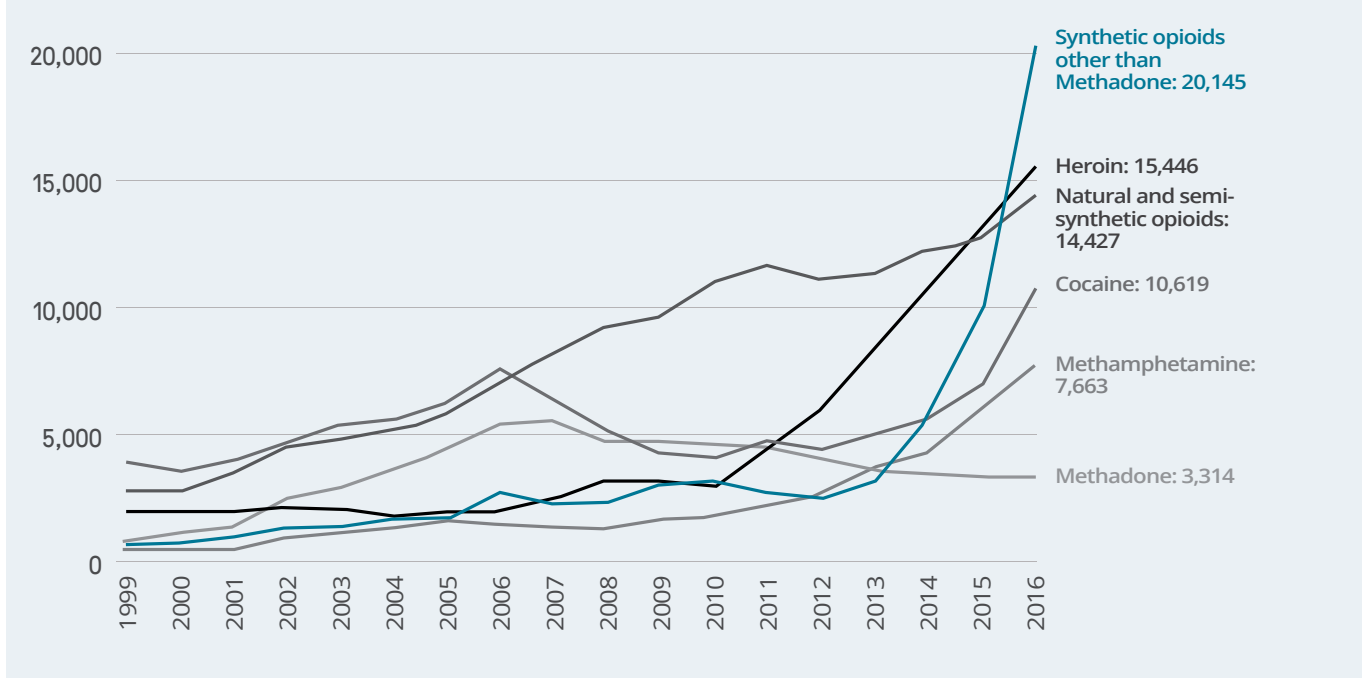
Dr. Jessica Bloom has been practicing family medicine in Bellingham, Washington, for more than a decade. Like many family-care physicians, she has been on the front lines of the opioid epidemic since launching her practice, Family Health Associates, with her husband in 2005.

Whatcom County began addressing opioid addiction during the early stages of the epidemic. "Ten years ago, we had a much more serious prescription-opiate issue than we do now," says Dr. Bloom. "The community came together, creating a task force that identified a handful of significant over-prescribers."

(Continued on page 6)



## Drugs Involved in U.S. Overdose Deaths, 2000–2016



*(Nightmare, continued from page 5)*

But though these pill-mill physicians no longer practice in Whatcom County, prescription opioid misuse persists. Even the most well-intentioned physicians, Dr. Bloom observes, find it challenging to prescribe opioids safely, particularly for chronic-pain patients. “The public expects medication to make pain go away completely,” she says. “Reducing pain is not enough. That’s part of the problem.” Patient-satisfaction scores, based in part on highly subjective pain-scale results, exacerbate the issue by giving doctors an incentive to try to eliminate pain altogether.

Meanwhile, limitations on how physicians prescribe certain medications, though intended to ensure safety, can instead drive physicians to write large prescriptions that patients may not need. “If a patient runs out of a prescription on a Saturday or Sunday, when my clinic isn’t open, she has to wait until Monday before I can write another,” says Dr. Bloom. “Sometimes it’s just easier for a physician to write a big prescription and be done with it.”

Most of these outsized prescriptions go partially unused, orphaned to medicine cabinets where adolescents discover and

use them for recreational ends. Many kids who misuse prescription opioids become opioid addicts and, unable to sustain their habits through prescriptions, turn to heroin. In 2016, the Whatcom County Medical Examiner reported 23 deaths related to drug use, 18 involving heroin and two involving prescription drugs.

The progression of the addict from prescription opioids to heroin represents a stark reversal from past decades, when heroin was the gateway to opioid abuse. Today most heroin users report that they tried prescription opioids first. One analysis of heroin users found that 75% were introduced to opioids through prescription drugs; of these, most turned to heroin because it was more accessible and less expensive.

Where do we start adjusting prescription practices to head off the epidemic? One answer is emergency rooms, where large prescriptions for OxyContin and Percocet are common and often lead to long-term opioid use. Another is surgeons, who frequently send patients home with large prescriptions to manage post-operative pain.

As Chair of Family Medicine at PeaceHealth St. Joseph Medical Center, Dr. Bloom facilitates regular conversations about post-operative prescribing practices. “We talk about the importance of limiting prescriptions to three days,” she says, “and emphasize that ongoing pain management naturally resides with primary-care physicians.”

Not that doctors need more to worry about—but most of Dr. Bloom’s primary-care colleagues agree that they are in a better position to help patients navigate post-operative pain safely. Regardless of which provider takes the driver’s seat, managing pain, whether acute or chronic, requires striking a delicate balance between comfort, convenience, and patient safety.

“Physicians must walk a fine line,” says Dr. Bloom. “I try to tell people that this isn’t to take their pain away, it’s to reduce it for now. You never want to harm patients by leaving them in pain, but you also don’t want to harm them by inadvertently driving them into the arms of addiction.”

### A MEASURED RESPONSE

In 2016, in an unprecedented step, the

*(Continued on page 28)*



# THE KEY ELEMENTS OF A PREAMBLE TO AN OPIOID AGREEMENT

BY MICHAEL SCHIESSER, MD

Prescription opioids are not the only controlled substance with a risk for abuse, misuse, and diversion, but they have a readily achievable threshold for lethal toxicity. They are the source of widespread patient-safety problems like addiction and overdose, excess resource utilization, and disability.

One of the keys to patient safety is communication. Providers who treat chronic illness with medications that are liable to be abused struggle to balance patient safety with issues of care-management efficiency. I find that if “it takes a village” to raise kids, it takes a well-aligned organization (not just one physician) to achieve outcomes of provider satisfaction, care efficiency, and patient safety. For many providers, communicating norms and expectations can be challenging. Additionally, communicating medication limits or agreements can result in patients feeling “singled out” or misinterpreting the purpose of the discussion. For this reason, I support universal delivery of pain agreements with companion video narration, so that key points can be meaningfully identified, efficiently delivered, and universally understood—assuming that the patient has an opportunity to ask questions.

Opioid agreements may differ significantly from practice to practice and across states. For the opioid agreement I use with patients (not included here), I use this six-point preamble to introduce important concepts:

- **Working together.** This agreement was created to keep your care safe and avoid confusion. Talk with your provider if you have questions before signing it. The medications you are prescribed are sometimes not used properly. This can cause serious problems. Pain medications

(“opioids”), anxiety medications, and medications for attention deficit disorder are all considered high-risk.

- **What problems could develop?**

Sometimes when patients use these medications for months or years, they find the medicine becomes less effective. Taking more than is instructed on the bottle can place you at risk for overdose and other problems. Dependence means having withdrawal symptoms if you stop taking the medication. If you can’t control how much you take, or if you are constantly thinking about the medication, you have an addiction. To avoid serious problems, never take more than the maximum daily dose in any 24-hour period. Also, pain medication can cause sleepiness, fractures, or death. Pain medications used over time can also lead to worse pain when you try to stop.

- **High risk!** Thousands of people die each year from prescription overdose. Combining pain medications with anxiety medications, sleeping pills, cold medicine, or alcohol increases the chance of death. Do not mix or use these drugs in any way not directed by your provider. These medications can also make driving more dangerous.

- **You must sign the form.** You need to follow this agreement to be a safe candidate for these medications. There may be other issues that lead your provider to recommend safer alternatives. Signing the form doesn’t mean the provider will necessarily prescribe you the medications. However, avoiding the agreement is not an option if you have been asked to sign in order to receive these medications. Your

provider may recommend weaning off of medications; if dependence is interfering with your care, your provider may also recommend treatments for dependence. Any violations of this agreement will impact your provider’s care plan.

- **We might share this agreement.**

By signing this, you are giving us permission to share this agreement with emergency departments, urgent-care centers, and other providers.

- **You might ask, “If my care changes as a result of this agreement, and I disagree with that, what do I do next?”**

If you feel you have been impacted by this agreement and would like reconsideration, we invite you to submit a written appeal explaining your circumstances. Any appeal will be reviewed by at least two staff members and may take three to seven days for a response.

These six elements fit nicely on one page, and I recommend placing them behind a plastic sheet protector, because the agreement itself fits on one double-sided page. When I show a short video presentation to my patients, the video prompts them to initial each of the main sections as they are explained, and then to sign the agreement.



*Dr. Michael Schiesser is an addiction specialist with Evergreen HealthCare, and serves on the quality committee for Evergreen Health Partners. He is an energetic advocate for sensible*

*strategies to support organizations and providers in prudent clinical care. To learn more about how physicians can make a difference in opioid addiction, visit <http://managingaddictions.com>.*

# INMATES, CONTINUITY, AND COMMUNITY

## EVOLVING TO DELIVER COMPASSIONATE CARE TO A VULNERABLE POPULATION

**Dr. Yong Ki Shin inhabits two worlds. It just so happens that these worlds coexist in a small rural town in southwestern Washington. Their close proximity makes it easy for Dr. Shin to pass from one into the other and back again, often several times in the same day.**

Dr. Shin launched his private practice in Montesano, Washington, in the late 1990s. About eight years ago, the county asked him if he would be willing to provide urgent care at the local jail. Grays Harbor County Jail's nurse practitioner—and only care provider—had decided to move on.

“My practice was across the street, so I figured it would be easy for me to go over and take care of the inmates,” says Dr. Shin. “That’s how I got started.”

But providing care to geriatric patients isn’t the same as providing care to the incarcerated. Dr. Shin admits he didn’t

know what he was getting himself into, and lacked the training to understand the standard of care in a correctional environment.

“The first three years, I was mostly providing urgent care,” says Dr. Shin. As he watched and learned more about the health needs of the inmates, he began taking steps to improve the quality of the jail’s care, especially in the way it treated inmates with addictions.

### **ADDICTION IN CORRECTIONAL SETTINGS**

Dr. Shin soon came to understand that practicing correctional medicine consists primarily of treating addiction.





Research from the National Center on Addiction and Substance Abuse (CASA) at Columbia University demonstrates an unmistakable link between drug and alcohol use and the rapid growth of the country's prison population. Of the more than 2.3 million people currently held in U.S. prisons and jails, two-thirds meet clinical criteria for substance abuse or addiction.

Many incorrectly assume that incarceration—time spent in a restrictive environment with limited access to substances to abuse—can help addicts kick their habits. On the contrary, long stints spent among other addicts under highly stressful circumstances, layering additional traumas onto already-fraught lives, make the odds of an addict relapsing after release extremely high.

Death from overdose is another significant danger, particularly when it comes to opioid addicts. A 2007 study of a population of more than 30,000 former inmates in Washington found that their risk of death from overdose after release was roughly 3.5 times higher than the general population's. The days immediately following a prisoner's release are the most dangerous. In the first two weeks, the study found, the risk of death by overdose was 12.7 times higher than it was for the average Washingtonian.

The most effective approach to mitigating these risks is to provide inmates with substance-use disorder treatment during incarceration, and to continue that treatment uninterrupted upon release. However, according to another CASA study, only 11% of inmates with substance-use disorders have access to treatment while incarcerated.

#### **CONFRONTING ADDICTION IN JAIL**

A lot can change in eight years. "Our community has changed. I have changed," says Dr. Shin. "Opiate addiction has become significantly worse."

Before accepting his new role at the Grays Harbor County Jail, Dr. Shin had only encountered patients with addictions in inpatient settings. His impressions were generally negative. "I hadn't been trained to treat addicts. I found them difficult and demanding, and I didn't know what to do with them," he recalls.

As Dr. Shin began caring for inmates, his views of addiction began to change. Gradually he stopped seeing it as an issue of self-control. When people put addictive substances before their freedom and health—and in the most extreme cases, before their lives—they are clearly no longer thinking rationally. "Once I started looking at it that way," says Dr. Shin, "I wanted to do whatever I could to take away that destructive craving."

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"Our community has changed. I have changed. Opiate addiction has become significantly worse."

DR. YONG KI SHIN

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That wasn't always the case. Christened by President Richard Nixon in 1971, the War on Drugs would become a decades-long crusade against the trade and use of certain controlled substances. Aggressive enforcement and harsh mandatory sentencing became commonplace for simple possession, taking precedence over prevention and treatment.

The federal government increased its budget for the control of illicit drugs eightfold during the 1980s. Over the same period, the frequency of arrests for drug offenses rose 126 percent. By 2013, nearly half a million people per year were being incarcerated for drug-related crimes.

Experiences with people visiting his clinic also influenced Dr. Shin's feelings toward addiction. Many of his elderly patients struggle not only with their own health issues, but also with raising grandchildren as the children's parents battle addiction—in many cases in the jail across the street.

*(Continued on page 32)*



# YOU DON'T NEED TO BE THE DOMESTIC- VIOLENCE EXPERT

## PUTTING THE PIECES IN PLACE TO SUPPORT PATIENTS IN CRISIS

Not long ago, quality providers approached potential victims of domestic violence with direct questions when they thought something might be wrong: *“How did you get these bruises?” “This is the third time I’ve seen you this year for this kind of injury. Is someone hurting you?”*

However, now we understand that patients don’t want to feel singled out or judged, but are looking to providers to offer support and connection.

### THE KEY COMPONENTS TO PUT IN PLACE

#### NORMALIZE THE “HEALTHY RELATIONSHIP” CONVERSATION

While providers were previously encouraged to question certain physical injuries or watch body language to screen for signs of domestic violence, recent approaches show that more traction can be made by talking to all patients about how their relationships impact their health. Patients who talk to their providers about abuse are four times more likely to use an intervention.



Patients who talk to their providers about abuse are **four times** more likely to use an intervention.

“We are moving away from disclosure-driven practice,” says Kate Vander Tuig, Senior Health Specialist at Futures Without Violence. “For years, we focused on ‘screening, screening, screening’ in order to be vigilant, and then offered a referral if a disclosure of domestic violence was made. However, we have learned that screening alone may not actually be helpful for survivors.”

“What is working? Brief, educational moments that make the connection between relationships and health,” continues Vander Tuig. “We want to make sure all patients have access to important information and resources, regardless of whether they choose to disclose or not. This shifts more power to the patient and creates the opportunity not only for the patient to access help on their own terms, but also to be able to help their friends and family, which studies show is very healing.”



On average, more than  
**3 WOMEN**  
 a day are  
**MURDERED**

by their partners  
 in the United States<sup>1</sup>

Approximately  
**1 in 3**  
**ADOLESCENT**  
**GIRLS**

in the United States is  
 a victim of physical,  
 emotional, or verbal

**ABUSE**  
 from a dating partner<sup>2</sup>

**1 in 4**  
**WOMEN**  
 in the U.S. experiences  
**VIOLENCE**

by a partner at some  
 point in her life<sup>3</sup>

## Connect to Resources

### FIND LOCAL PARTNERS

**The National Domestic Violence  
 HOTLINE** for patients and physicians

(800) 799-7233 | [www.thehotline.org](http://www.thehotline.org)

The National Domestic Violence HOTLINE offers highly trained advocates 24/7/365 to talk confidentially with anyone experiencing domestic violence, seeking resources or information, or questioning potentially unhealthy aspects of their relationship. Physicians can use this hotline to determine your local resources, and can share the number with their patients. (Note that computer behavior can be tracked; encourage your patients to access this resource by phone if they doubt that their computer is secure.)

### GET CLINIC MATERIALS

The National Health Resource Center on Domestic Violence, a project of Futures Without Violence, offers free materials to build health-care responses to domestic violence, such as clinic posters, patient-education tools, and guidelines for a range of populations.

Get all of these resources and a guide for addressing intimate partner violence in your clinic at [IPVhealth.org](http://IPVhealth.org).



In studies done in reproductive-health and adolescent-health settings, researchers found that survivors' health improved when clinicians utilized a universal education approach in which all patients were given information about how intimate-partner violence can affect their health, and where they can turn if they or friends of theirs need help.

Normalizing the conversation about healthy and unhealthy relationships is a proactive approach that is directly relevant to the health and wellbeing of your patient. Addressing the topic via a pragmatic,

health-focused dialogue helps reduce any shame, fear, or judgment the patient might feel. "There are many reasons why a patient might not feel safe disclosing violence: worries about mandatory reporting requirements, being judged, privacy issues, etc.," says Vander Tuig. "What we want to do is create an environment where survivors feel safe to talk about their relationships, but do not need to in order to get support from confidential resources like a domestic-violence advocate."

Plus, shifting the approach towards an educational conversation allows the patient

*(Continued on page 26)*



## EMERGENCY MEDICINE SUCCESS STORY

# Coordinate, Don't Lock the Gate



While legislators, industry consultants, business analysts, health-care insurers, and more have all struggled to “fix” what’s not working with health care, recent decades have seen the emergency room being used increasingly for primary care.

Not surprisingly, physicians have some very definite ideas about what is needed to improve their systems. If you ask those who are in the trenches day in and day out, they have a pretty good handle on the real issues. As a result, emergency-department physicians in Washington and Oregon have a success story to share.

In 2012, when the State of Washington was faced with a \$32 million budget deficit and “frequency of emergency-room visits” was identified as a place to look for savings, the Washington State chapter of the American College of Emergency Physicians (ACEP) rose to the occasion.

Washington State had just passed legislation that would mandate no payment for any more than three ER visits per patient for over 700 commonly-seen conditions—among them chest pain, abdominal pain, and miscarriage. Within six months the ACEP won a counter-lawsuit against the state, on the technicality that the law had been illegally passed. This legal win “hit the reset button” and gave the ACEP time to complete a plan that would reduce costs while also improving care.

ACEP leadership knew their profession could do a better job caring for patients AND save money at the same time. They had already been working towards that goal with a draft of *The Seven Best*

*Practices* (see page 23) in the works. However, with an expedited deadline of three months, the ACEP set out to finalize their best practices, line up the necessary components, and start rolling the new plan out across the state.

“We don’t need a moat in front of our EDs. We need a back door at discharge that actually leads somewhere.”

ALEX ROSENAU, DO, FACEP

### PROPER DIAGNOSIS

Emergency physicians knew that the ED was not the cause of high health-care costs. After all, the expensive part of health care is when patients are hospitalized. But what problems did ED best practices need to address in order to impact the state budget? Which component in the cascade of issues carried the most weight in affecting costs? Were they solving for:



**Frequency of visits?** First of all, it is not the most frequent visitor who is the most expensive visitor. “The homeless patients coming in from the cold for ‘three hots and a cot’ are not our most expensive patients,” explains Steve Anderson, MD, past president of the ACEP’s Washington State chapter.

Rather, he says, the patients with serious, chronic medical conditions who require lab work or radiology referrals represent the episodes that really ring up the costs. Data shows that the more expensive patients are in the five-to-15-visits-per-year range, not the most frequent visitors (those in the 16-plus-visits-per-year category). So frequency alone is not the right problem to solve.

**WASHINGTON STATE EMERGENCY ROOMS: FREQUENCY OF VISITS**

Washington State Medicaid Patients

Visits	Frequency
4-6	7262
7-10	2362
11-15	859
16-25	467
26-35	120
36-50	47
51+	23
<b>Total</b>	<b>11,140</b>

Source: Washington State

**Type of health condition?** Many visitors to the ED suffer from chronic conditions that can be managed but not cured, such as CHF, COPD/asthma, chronic pain conditions, mental-health problems, or substance-abuse disorders. “And when the care for these chronic conditions isn’t coordinated, we end up re-creating the wheel in the ED, repeating labs and scans that, unbeknownst to us, have recently been done by another provider,” explains Anderson.

**Glitches in care coordination?** In addition to those with chronic illnesses, many other visitors to the emergency room have been

seen by a doctor in recent years, if not recent months or weeks. Those doctors have likely done good work in identifying a treatment plan and next steps for their patients—yet when the same patients come into the ED during a medical crisis, those treatment plans are often unknowingly left by the wayside.

**Access to patient data?** Most EHRs have thousands of pages of data on file, which cannot be swiftly navigated and comprehended when treating an emergency-room patient. Providers need a fast and reliable way to access the most immediately helpful data when caring for their patients in an emergency situation.

**10%**  
DECLINE IN EMERGENCY-DEPARTMENT VISITS BY MEDICAID PATIENTS

**THE RIGHT DATA AT THE RIGHT TIME**

Historically, physicians in the ED setting in particular have not had the patient data they need to easily coordinate care. They all have access to their health system’s EHR, which could contain thousands of pages of information about a given patient. However, more data is not necessarily the answer.

Also, while obtaining information to aid their efforts, emergency-department physicians are exempt from HIPAA regulations during the initial evaluation phase of care. Beyond that time, the broad sharing of medical information could present a privacy issue. This means that for quality care, it is imperative that EDs be able to obtain critical health information swiftly and efficiently.

The right data, retrievable in a timely manner, was the missing tool the ACEP had needed.

Enter the EDIE, a software tool developed by Collective Medical and piloted through a program in Spokane. Thanks to an alliance with the ACEP, EDIE is now implemented in 100% of all Oregon and Washington EDs.

EDIE is not an EHR or a warehouse of data, but more of a data concierge that integrates with a range of leading EHRs and hospital admission, discharge, and transfer (ADT) feeds to pull out the data that has been deemed most urgent for ED providers to have at their fingertips. Drawing on multiple sources, EDIE filters the most relevant data and pushes the “only what you need” details to the surface for ED physicians.

By pulling up only the most necessary data, EDIE integrates with physicians’ workflow and eases access of information, eliminating the multiple login steps required to access separate technology systems. “For instance, taking three minutes per patient to see if they’re on a PDMP, at 30 patients per day—that 90 minutes is not a great use of any physician’s time,” says Anderson, referencing the disparate data resources that were previously being accessed. “It might just be three clicks, but I call it ‘three clicks to crazy,’” he jokes. “With EDIE, that critical PDMP information is being pushed to me, along with additional critical medical details, on a one-page, actionable fact sheet that takes one minute to read.”

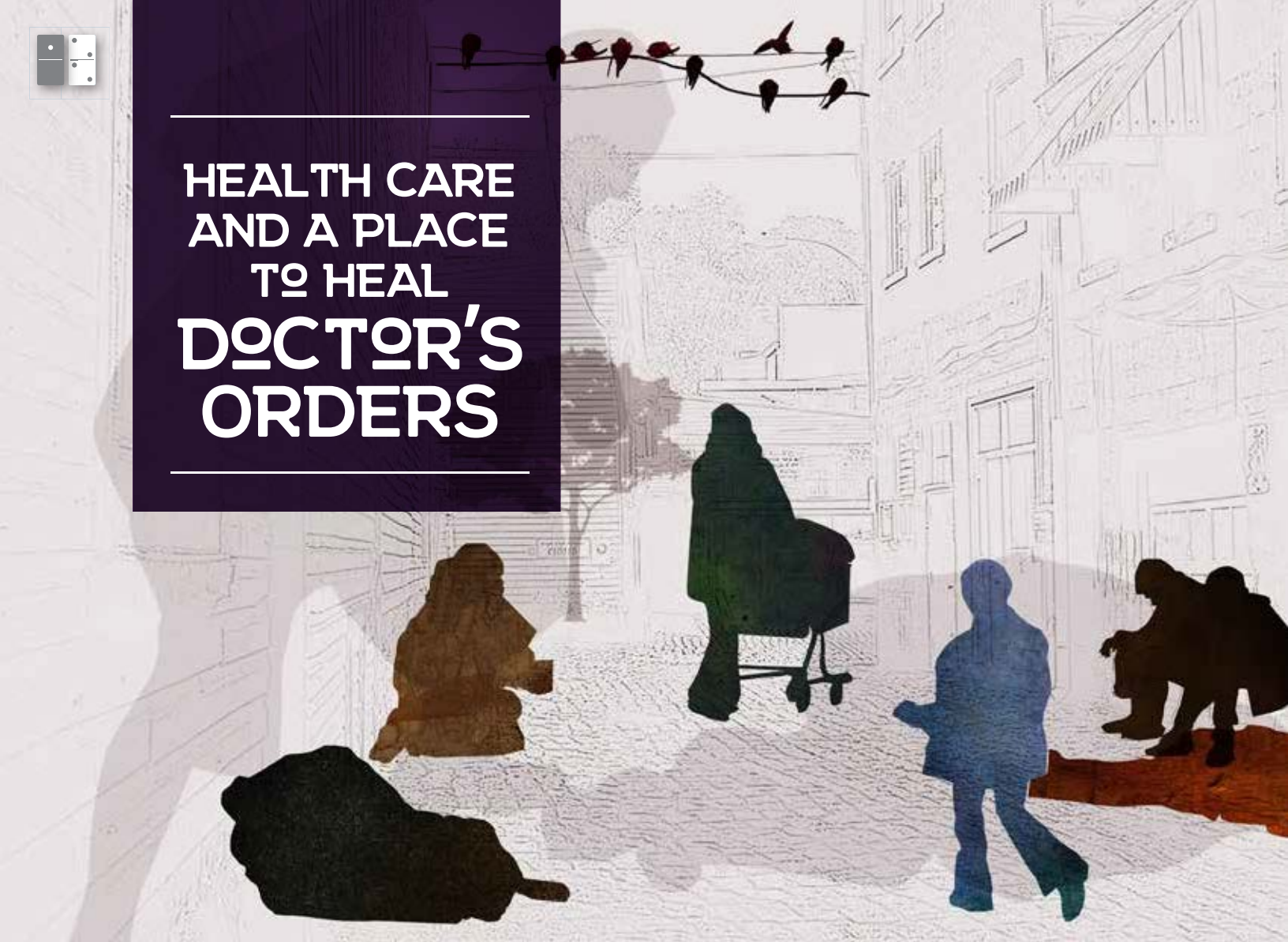
**11%**  
DECLINE IN VISITS FROM FREQUENT CLIENTS (5+ VISITS/YEAR)

The concise template shared across all participating EDs provides the following details about a given patient:

(Continued on page 22)



# HEALTH CARE AND A PLACE TO HEAL DOCTOR'S ORDERS



**Barbe West was a woman with a plan. A plan with a van. To be precise, her plan involved two vans.**

West serves as Executive Director of the Free Clinic in Vancouver, Washington, a city on the banks of the Columbia River just outside Portland, Oregon. Early last year, the clinic's leadership decided to take action to ensure that homeless people in Clark County could access the primary and urgent care they needed.

The Free Clinic has a long, proud history of delivering care to those who need but can't afford it. Its 500 volunteers treat approximately 8,000 uninsured Clark County residents per year, free of charge. Still, one group has continued to slip through the cracks.

"We've been very concerned that the homeless in Vancouver and its surrounding communities are not seeking care until it's too late," says West. "Most end up in an emergency room, and the ED is the wrong place to start receiving treatment."

For various reasons, the majority of the area's homeless had not been finding their way to the Free Clinic or similar services to nip looming health emergencies in the bud. So the Free Clinic decided to take a new approach. Instead of waiting for homeless patients to show up on their doorstep, they opted to take the show on the road, bringing the clinic to the places where homeless people spend the most time.

Last fall, a crack team of Free Clinic volunteers began making monthly visits to Share House, a community gathering space five miles from the clinic where Vancouver's homeless go for meals, showers, and beds. Here they began offering urgently needed medical and dental services from two vans.

The monthly convoys include physicians, nurses, dentists, and dental hygienists. A pharmacist goes along for the ride as well, dispensing essential medicines like antibiotics from a locked cabinet in one of the vans.

Both vans the Free Clinic uses were designed to provide mobile dental services. “We didn’t have a medical van,” says West. “When we broke the news to the care team, they said, ‘No problem. We can adapt. We’ll just lay the chairs down flat and, voila! They’ll become exam tables.’”

Indeed, necessity’s the mother of invention, and organizations like the Free Clinic trying to tackle the problem of delivering health care to homeless people need ingenuity in spades.

### HEALTH AND HOMELESSNESS

Homelessness exacerbates almost every condition that would make a patient high-risk anyway. People experiencing homelessness spend a lot of time outdoors, many of them struggling with mental-health and substance-use disorders that put them in constant danger. This naturally leads to high rates of illness, injury, and death.

For homeless people, access to preventive, primary, and urgent care services they can actually use is limited. Conditions that for most patients present temporary setbacks, such as minor wounds or common colds, often progress and become life-threatening among the homeless.

Data describing morbidity and mortality patterns among the homeless are incomplete. However, what data exists consistently shows that simply being homeless dramatically reduces life expectancy, often by half. A recent study in Vancouver, BC, for example, found that the city’s homeless tend to die between the ages of 40 and 49 years old. The life expectancy of the average person in British Columbia is 82.

For financial, practical, and social reasons, homeless people rarely visit community-based clinics for primary and urgent care.

“Many are uncomfortable in care settings where the rest of us feel at ease,” says Daniel Malone, Executive Director of Seattle-based DESC (formerly the Downtown Emergency Service Center). “Simple things like meeting a set appointment time or sitting in a waiting room—these can be quite challenging for our clients, even if the clinic is specifically geared to accommodate them.”

**“WE CAN'T EXPECT PEOPLE TO HEAL AND RECOVER PROPERLY IF THEY DON'T HAVE A SAFE PLACE TO GO AFTER DISCHARGE.”**

DANIEL MALONE  
EXECUTIVE DIRECTOR, DESC

Instead, people who are homeless hold out until they’re deathly ill, finding their way to emergency rooms when they can no longer go without help. Consequently, they tend to use emergency services and become hospitalized at much higher rates than the general population.

To make matters worse, the treatments homeless patients receive in acute-care

settings often have only a short-term benefit. “When a hospital discharges a patient back to the streets, the care the patient received often gets unwound,” says Malone. “We can’t expect people to heal and recover properly if they don’t have a safe place to go after discharge.”

### BRINGING URGENT CARE TO THE HOMELESS

While people experiencing homelessness may not seek treatment in community-based clinics, they do want care when they need it. “The most effective approach is to bring clinical services into environments where homeless people are already comfortable,” says Malone.

That’s where solutions like the Free Clinic’s two-van plan come in.

The Free Clinic is starting out by visiting the Share House one evening per month, hoping to see about 20 patients each time. If they encounter higher demand than that, they may increase the frequency of visits or try to expand the capacity of the mobile care team.

“Some patients will need follow-up care and won’t be able to wait a month,” says West. “We’ll be working with Share House to arrange transportation to our clinic in those cases.”

The other challenge West anticipates is ensuring continuity of care for patients who lack a permanent address, phone number, or other reliable means of contact. Two of the Free Clinic’s program managers will work closely with colleagues at the Share House to try to maintain the connection between the care team and its homeless patients.

In an entirely different urban landscape, DESC pursues similar strategies to bring health care to homeless people and prevent unnecessary trips to the hospital. All of its shelters, housing facilities, and daytime drop-in centers employ

*(Continued on page 27)*



# Mandated Suicide Training for Non-Specialists

## A Noble Step, but in the Right Direction?

In 2016, 1,141 people in the state of Washington died by suicide, putting Washington State above the national average. Acknowledging the work of suicide-prevention advocates in recent years, the Washington legislature recognized suicide as one of the public health crises that warranted action.

Effective January 1, 2016—with an extension of the Matt Adler Suicide Assessment, Treatment, and Management Act of 2012—all Washington physicians are required to receive training on suicide-risk assessment, treatment, and management. There are now more than 60 state-approved courses from which clinicians are required to choose (see page 17). Only five other states mandate similar training (Nevada, Kentucky, New Hampshire, Pennsylvania, and Utah)—limited, however, to social workers, drug-addiction counselors, and those in the field of mental health.<sup>1</sup>

Often due to stigma or problems accessing mental health care, patients are likely to have contact with a primary-care physician before a mental-health provider. According to one study, almost half of people who died by suicide saw a primary-care physician in the month before death.<sup>2</sup> Studies show that 59% of all psychotropic drugs are prescribed by non-mental health specialists.<sup>3</sup> These physicians in particular are critical gatekeepers for their patients' mental health care.

"In the scope of suicide care, most physicians," according to Dr. Jeffrey Sung, past president of the Washington State Psychiatric

Association (WSPA), "will be in the role of being a 'gatekeeper' of mental health care for a patient. I've trained hundreds of physicians on what they can do if they find themselves in the gatekeeper role, where you initially recognize signs of suicidality." Gatekeeper training provides skills in recognizing the warning signs of suicide, conducting brief screenings, and providing an emotional connection that can make a difference to a patient in crisis.

Yet Dr. Sung is one of the first to acknowledge that this is but a small step—and to question the current use of health-care resources in addressing the problem.

### TRAINING INDIVIDUALS VS. CHANGING SYSTEMS

"We need to ask ourselves," continues Sung, "does the health-care delivery system support the training in suicide? And what effects will it have to ask our colleagues to add up to 40 minutes of draining work to a seven-minute primary-care appointment, without changing their productivity requirements or payment, and the care coordination to follow? Every primary-care provider wishes they had more time. It's hard to feel good about this without addressing systemic issues."

Additionally, Sung cites delays in access, low availability of psychiatric hospital beds for those in crisis, and other systemic issues involved in delivering proactive mental health care that still need to be addressed. In other words, do we have the capacity to respond as we should? Is there greater efficacy with other





approaches? Suicide-risk assessment training might help to resolve the immediate risk of suicide, keeping patients alive in those critical moments when inaction is unconscionable. But there is only limited

One solution could be to integrate mental health care with primary care. That way, if a primary-care or other kind of doctor found themselves in an appointment with a patient who was noticeably distressed, they'd have the right resources down the hall, and could walk the patient directly to a mental-health specialist—just as a patient might go down the hall for a blood test or an X-ray. Better yet, a health-care consultant could be brought to the patient on the spot, so the patient wouldn't need to change rooms.

Making a comparison to the team-based approach to cancer care, Sung points to the routine screenings that are conducted with an eye towards prevention, in addition to the diverse, wrap-around services—oncology, radiology, nutrition counseling, plastic surgery, palliative care, pain management, financial planning, spiritual support, case management, and much more—that cancer patients receive as a matter of course during treatment. Embedding psychiatric care within primary care might well provide the integration that combines physical health with mental health.

According to one study, almost half of people who died by suicide saw a primary-care physician in the month before death.

evidence that supports physician training as a means to move the needle on such a critical health issue.

#### TRANSFORMING DELIVERY

While evidence in support of effective ways to prevent suicide is frustratingly limited, there are bright spots to pursue that go beyond crisis intervention and get more at transforming how care is delivered.

#### ZERO SUICIDE: IT CAN HAPPEN. IT ALREADY HAS.

Sung also cites the national movement taking shape around “Zero Suicide,” noting a recent case study from the Behavioral Health Services division of the Henry Ford Health System. To achieve a radical transformation over a course of 11 years, that organization focused on three key components:

## Suicide Prevention Training

### ALASKA / Alaska Department of Health and Social Services

Suicide Prevention Training with QPR Approach for Gatekeepers  
<https://bit.ly/2FrAcdF>

### IDAHO / Idaho Department of Health and Welfare

Suicide Prevention and Risk Assessment Training: May 21, 2018  
<https://bit.ly/2GfljY9>

### OREGON / Oregon Health Authority

Workforce Training for Behavioral and Physical Health-care Providers  
<https://bit.ly/2pMHJcn>

### WASHINGTON / Washington State Department of Health

Suicide Prevention Training for Health Professionals  
<https://bit.ly/2I6FYOJ>

### WYOMING / Wyoming Department of Health

Wyoming Suicide Prevention Trainings  
<https://bit.ly/2uq71CD>

**(800) 273-TALK**

#### One Number | Easy Access to Support

The National Suicide Prevention Lifeline is a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress, 24 hours a day, 7 days a week. Calls to this number access local resources, if available.

Learn more at  
[www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org).

(Continued on page 18)



# ARE YOU A MENTAL-HEALTH GATEKEEPER?

## What to Know About How You Can Help



Gatekeepers to care are urged to take all suicide threats and all suicide attempts seriously. A past history of suicide attempts is one of the strongest risk factors for death by suicide. The gatekeeper process includes these steps:

### 1. Ask directly

- “Are you thinking about killing yourself?”
- “Have you ever tried to hurt yourself before?”
- “Do you think you might try to hurt yourself today?”
- “Have you thought of ways that you might hurt yourself?”

This questioning won’t increase the person’s suicidal thoughts; it will give you information that indicates how seriously or frequently the person has thought about killing him- or herself. Studies suggest that acknowledging or talking about suicidal thoughts can reduce rather than increase the chances of a person’s following through on them. And the more you can learn, the better. As confirmed by a recent Mayo Clinic study, a non-fatal suicide attempt is a strong risk factor for subsequent suicide death.<sup>1</sup>

### 2. Show you care

- “I take what you’re saying seriously.”

Even if the a patient expresses a fleeting thought or comment, they need to know that someone is listening and can act in their interest to help.

### 3. Manage the means

- “Do you have pills or firearms in the house?”

Take steps towards reducing their access to firearms or harmful medications. You might need to enlist the support of the patient’s loved ones to assist in reducing such access. Not surprisingly, access to guns represents the deadliest risk.<sup>2</sup>

### 4. Act

- “I’m going to get you some help.”
- “Here are some therapists you can talk to right now.”

If you think someone might harm him- or herself, do not leave them alone. Here are some specific actions you can take:

- **In person:** Stay with your patient until they are with someone who is prepared to help them. If the resources are available, a physical handoff to a psychiatric professional is ideal. If not, connect them with the nearest appropriate mental-health resource. If you are their primary-care doctor, consider how you can coordinate with a mental-health specialist, and ensure that the necessary follow-up takes place beyond the crisis.
- **By phone:** If you do not have local resources immediately available, call the National Suicide Prevention Lifeline, available 24/7, at 1-800-273-TALK. You and/or your patient will be connected to the nearest available crisis center for more support in your area.

(Suicide Training, continued from page 17)

1. Improving access to care
2. Restricting access to lethal means of suicide
3. Instituting “Just Culture”

Their efforts resulted in an 80% (or more) reduction in suicides that was maintained over a 10-year period, including one year of zero suicides (2009).<sup>4</sup> The case study concludes that a goal of perfection is viable, given the right components and social transformations. The case study goes on to cite Just Culture as a lynchpin to the pursuit of perfection, and notes that effective suicide prevention requires systemic changes that go beyond a series of interventions.

### THE LONG, HOPEFUL ROAD

Few could argue with the intent behind physician training to create awareness for the signs of suicide and to save lives; in a sense, training might seem like the right thing to do simply because inaction during a crisis is not acceptable. But while the efficacy of broad-based suicide training is debated among some, and systemic improvements continue to be made across the spectrum of care delivery, the true successes in preventing suicide will be achieved by keeping a broad view.

“I appreciate the motivation around training, and hope it will be accompanied by the infrastructure to support the training,” Sung says.

For those in the field of creating hope, continued infrastructural improvements are the challenge that remains. [PR](#)

### Sources

<sup>1</sup> <http://afsp.org/wp-content/uploads/2016/04/Health-Professional-Training-Issue-Brief.pdf>

<sup>2</sup> <https://www.ncbi.nlm.nih.gov/pubmed/12042175>

<sup>3</sup> Mark, T.L., Levit, K.R., and Buck, J.A. “Datapoints: Psychotropic drug prescriptions by medical specialty.” *Psychiatric Services*, 60: 1167. 2009.

<sup>4</sup> <https://catalyst.nejm.org/dramatically-reduced-suicide/>

<sup>1</sup> <https://www.mayoclinic.org/medical-professionals/clinical-updates/psychiatry-psychology/deadliness-of-attempted-suicide-has-been-dramatically-underestimated>

<sup>2</sup> Ibid.

# Fighting the Opioid Epidemic

## One State's Approach

by Chris Baumgartner, Drug Systems Director, Washington State Department of Health



Drug overdose (mostly caused by opioids) now kills more people in Washington than traffic accidents do. Washington had nearly 700 opioid-related overdose deaths in 2016. This national and local trend has been branded a public health emergency and epidemic. While we've seen a decline for several years in prescription opioid-related deaths, the state has seen an increase in deaths caused by illegal opioids, primarily heroin.

The state of Washington has been working hard to address this epidemic for several years, and has stepped up activity to meet the complex challenges it presents. In October 2016, Governor Inslee issued an executive order to help bring attention and focus to addressing the epidemic. The order calls on many state agencies and our partners to work together to carry out the Opioid Interagency Working Plan. This plan has four main goals:

- **Prevent opioid misuse and abuse:**  
The key strategy for this goal is to try to improve opioid prescribing practices by using best practices and following new guidelines from both the Washington Agency Medical Directors Group and the Centers for Disease Control and Prevention.
- **Identify and treat opioid use disorder:**  
This goal's primary focus is to increase access to treatment for those with opioid use disorder. Recent federal funding to the Washington State Department of Social and Health Services is assisting in this work.
- **Prevent deaths from overdose:**  
Distribution of naloxone to those who use heroin or are at risk for overdose is

the primary strategy for this goal. The Center for Opioid Safety at the University of Washington's Alcohol and Drug Abuse Institute coordinates most of this work.

- **Use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions:** This goal seeks to improve our ability to monitor the epidemic through morbidity and mortality data we collect, as well as to improve access to and use of the Prescription Monitoring Program.

The Opioid Response Workgroup meets every quarter to continue this work. Subgroups for each goal meet more regularly to work on their strategies and activities. If you are interested in joining this work, or keeping updated on our progress, you can subscribe to get updates and notifications of activities at <https://public.govdelivery.com/accounts/WADOH/subscriber/new>.


A new Results Washington measurement tracks our progress on decreasing opioid overdose. Governor Inslee and his cabinet were given an update on this new measure in October; the video is available on TWV.

During the 2017 legislative session, an opioid bill (ESHB 1427) was passed and signed into law. The new law does several things to help address the opioid epidemic:

- It streamlines the licensing and citing of opioid treatment programs. The Department of Social and Health Services is implementing this project.
- It directs the Medical, Dental, and Nursing commissions, the Osteopathic Board, and the Podiatric Board to adopt

opioid prescribing rules. These rules will involve potential revisions of the current chronic, non-cancer pain rules, while establishing new rules for acute, sub-acute and perioperative prescribing of opioids. These rules must be adopted by January 2019.

- It makes several changes to the Prescription Monitoring Program. It provides new authority to use the system's data to provide overdose notifications to providers, looks to improve prescribing practices through quality-improvement work, and calls for other changes to make the program more effective. The Department of Health is working on these aspects of the issue as part of our effort to adopt opioid prescribing rules.

As you can see, Washington is hard at work to address the opioid epidemic. We look forward to seeing what comes from the recommendations made by the President's Commission on Combating Drug Addiction and the Opioid Crisis to assist us and other states in this work. We also look forward to continued work with our partners in this state to carry out the Opioid Interagency Working Plan. 



*Chris Baumgartner is currently involved with the Department of Health's Unintentional Poisonings Workgroup and the Agency Medical Director's Opioid Dosing Guideline, and was*

*previously the Prescription Monitoring Program's director. Throughout his tenure with public health, Mr. Baumgartner has played an active role in a variety of initiatives to promote patient safety and help prevent prescription-drug overdose and misuse.*





# Navos Mental Health Solutions

## Megan Kelly loves what she does for a living.

Her infectious humor, dogged optimism, and penchant for finding fun in one of the most challenging of clinical disciplines—caring for those with severe mental illness and substance-use disorders—have made her a hot commodity over the years. While Kelly takes her responsibilities seriously, she consistently finds rewards in challenges that others simply find daunting.

Kelly left Rochester, New York, where she'd been clinical director of a children's home for eight years, in 2008, uprooting herself for a new opportunity in Yakima, Washington. Comprehensive Healthcare, a large behavioral health organization in eastern Washington, had invited her out to help design and open a short-term residential evaluation and treatment center for youth in crisis.

"I loved that job," says Kelly. "I had the opportunity to develop a trauma-informed care program from the ground up."

Kelly's efforts achieved a milestone in crisis-treatment services for Washington youth. The center was the first of its kind in the state that did not include a seclusion and restraint room—a design decision reflecting Kelly's expertise in trauma-informed care.

People in the region began learning about her work. Among them was David Johnson, chief executive officer of Seattle-based Navos, the largest behavioral health-care provider in the state. Johnson met Kelly at a conference, liked what he heard, and extended an open invitation for her to move her talents farther west.

"After the facility in Yakima was up and running, I thought, 'Now what?'" Kelly remembers. "So I called David."

### CHAMPIONING TRAUMA-INFORMED CARE

Initially brought on board to implement trauma-informed care across the organization, Kelly has now served as Navos's chief clinical officer for the past two years.

Trauma-informed care recognizes and responds to the widespread impacts of traumatic experiences on patients' health. Such experiences range from domestic violence, sexual assault, and emotional abuse to growing up with a parent struggling with addiction.

Approaches to trauma-informed care emphasize partnering with patients in their recovery, promoting transparency and safety, and preventing further experiences that could inadvertently harm those who have already experienced trauma.



“Trauma-informed care involves setting up a system that accounts for the neurobiology of trauma and strives not to retraumatize individuals,” says Kelly.

Various efforts going back more than 40 years have contributed to the development of what we now call trauma-informed care, but Kelly maintains that the discipline’s principal catalyst was the Adverse Childhood Experiences (ACE) study conducted by the Centers for Disease Control and Prevention and Kaiser Permanente in the mid-1990s.

“The research team gave every employee at Kaiser Permanente a simple survey,” says Kelly. “They asked questions like, ‘Did you witness physical abuse?’ ‘Was there alcoholism in your family?’ ‘Were you sexually abused?’”

For each affirmative answer—that is, for each self-reported adverse childhood experience—the respondent received one point. Correlating the respondents’ total scores with their health histories, the researchers made an astounding discovery.

“They realized that, if you reported more than four adverse childhood experiences, you either were at risk for one of the major diseases, or already had one,” says Kelly. “Patients who reported zero ACEs were, for the most part, extremely healthy.”

Most people with severe mental-health or substance-use issues have experienced multiple traumatic events during their lifetime. Some of these events may have been inappropriate responses to their illnesses, such as incarceration or isolation within a behavioral health facility.

That’s why Kelly’s expertise is so vital to Navos. By implementing trauma-informed training and clinical practices, she’s making sure that the provider’s clients have a positive experience with mental health care and can make real headway on the road to recovery.



Clients can move freely throughout the Navos complex, essentially making their recovery experience a preview of the independent lives they’ll lead once they’re better.

### INTEGRATING BEHAVIORAL AND PHYSICAL HEALTH

With facilities throughout King County, Navos comprises a remarkable range of programs across the continuum of care, from psychiatric hospitalization, housing, and outpatient services to resources in schools and nursing homes. It even has an onsite cafe staffed by its clients in West Seattle.

Most of the people Navos serves struggle with multiple chronic conditions, the combination of which makes them not only highly vulnerable but also difficult to care for effectively. To streamline care and make necessary services easier to access, Navos created an integrated health clinic in partnership with King County Public Health, offering outpatient clients one-stop shopping for all of their behavioral and physical care needs.

The integrated health clinic emphasizes collaboration across disciplines, bringing generalists and specialists together to discuss and understand how a patient’s physical and mental health conditions interact. “Because you can’t separate the two, especially for folks who have serious mental illnesses,” says Kelly.

The approach has vastly improved care coordination, since virtually everyone

supporting a client is in the same building. If a physician diagnoses someone with asthma, for example, the clinic not only treats the asthma, but tries to identify stress factors that could be exacerbating the condition. Perhaps a client needs help with housing or food stamps, or needs to see a therapist to address underlying depression. Instead of having to make a new appointment, the client can simply walk down the hall.

People with severe mental illnesses and substance-use disorders typically have a hard time concentrating and processing information. Keeping track of several appointments in the same week can be extremely challenging for these patients, if not impossible. The convenience of having all the services they need in one place, possibly available in a single visit, makes a world of difference.

“If we can encourage a client to come in on a Tuesday and see a physician, therapist, and case manager in just a couple of hours, coordinating their needs while they’re onsite, we are providing excellent customer service,” says Kelly. “It’s highly effective, and one of my favorite programs at Navos.”

### A COMMUNITY OF RECOVERY

Recovery lies at the heart of Navos’s mission. It’s a matter not simply of managing the

*(Continued on page 35)*



*(Don't Lock the Gate, continued from page 13)*

- Demographic information
- Primary-care provider, if applicable
- Prescription Drug Monitoring Plan (PDMP) information, if applicable
- Security alerts (history of violence, attacks, etc.)
- Number of visits to the ED in Washington and Oregon in the last 12 months (where, when, and diagnoses encountered)
- Individualized care plans
- Advance directives

According to Benjamin Zaniello, MD, MPH, Chief Medical Officer of Collective Medical, “The technology is particularly powerful in complex markets, where multiple systems house the patient data that can benefit a health emergency.” As of now, the system includes a data push from various

**24%**  
 DECLINE IN NUMBER OF VISITS THAT RESULTED IN A PRESCRIPTION FOR CONTROLLED SUBSTANCES

prescription drug monitoring programs across the country. Anderson emphasizes that distinguishing “drug shoppers” from true pain patients is key to delivering the right care to these critical, but very different, high-use populations. Access to the details of a PDMP removes any chance of physician bias by providing the fact-based details of a plan already in place. “Patients with sickle-cell disease can be in a real pain crisis, and need to be cared for with appropriate meds—not treated like a potential addict,” he says. “And a possible addict needs completely different, but important, care from us.”

If a patient is under the care of a primary-care provider for an existing condition, the ED providers can now access those details instantly and begin exploring what has changed to bring them to the emergency room. If this is the patient’s fifth or more visit, the system will flag them as a possible super-utilizer, and physicians can look carefully at the dates and locations of their recent ED visits.

Patterns of ED visits can give clinicians additional clues as to what may be going on with patients. If there have been frequent visits in recent months, a new health issue or complication may be emerging. Recurring visits at the same time each month could mean the patient is running out of funds for necessary medications (e.g., insulin or pain medications). If the patient’s visits are all over the place, it might look a little more like they’re shopping for pain meds and covering their tracks by avoiding a pattern.

It is imperative to success, of course, that a majority of EDs in the region be on this system, sharing information in real time. Recognizing this, the leadership of the Washington chapter of the ACEP gained critical mass by working with Collective Medical to increase system adoption. Today, all emergency rooms in Oregon and Washington are participating in the data exchange, along with a majority of ERs in California and Alaska; the system will soon be fully operational in West Virginia, New Mexico, and Massachusetts as well. Active progress towards adoption is also currently being made in over a dozen more states, such as Illinois, Michigan, New York, and Florida. The next major step will be to use the data exchange to deepen coordination with primary-care providers.

**COORDINATE CARE AT BEGINNING, MIDDLE, AND END**

The ED is a critical axis point in care, where a patient either gets treatment and goes home with a plan, or—should their condition warrant it—is admitted to the

hospital. Considering that hospitalization is where health-care dollars really add up, it’s hard to overstate the importance of the ED’s role at that critical juncture.

“We have this concept of a case worker who assists with hospital discharge,” explains Anderson. “What if we had a case worker on the front end to help avoid hospitalization in the first place? How about we place this key role at a part of the process where it can impact costs the most?”

Many super-utilizers are simply patients who need their care better coordinated, or who have fallen off their already coordinated path. For example, 80% of super-utilizers have mental-health issues in their charts, and experience difficulty with carrying out their own care coordination. These patients, as well as those with chronic conditions, are greatly helped by consultations with case workers in the ED setting.

At the outset, a case worker can help a patient identify action items that have worked for them, plan the next steps to take, and determine specific obstacles to the coordination of their care. A concise paragraph giving an account of the ED episode is then entered into the EDIE

**14%**  
 DECREASE IN RATE OF VISITS FOR LESS-SERIOUS CONDITIONS

system, to instruct future case workers or physicians in the steps being taken for that patient. Additionally, after the patient exits the emergency room, case workers can use the system to follow up and make sure the patient remains on track with their plan.

Involving case workers in the process of ED care allows some high-use patients to get back on course with an existing


treatment, get home, and avoid future hospitalizations. A physician might be able to help with the immediate health crisis, but in some instances a case worker is just as important—or even more important—a contributor to the patient's future health. Moreover, adds Anderson, the payroll expense involved in adding case management to the front stage of the ED is an expense that pays for itself in no time.

## MAKE THE RIGHT CHOICE

### THE EASY CHOICE

By meeting the three-month deadline to implement best practices, and implementing tools to support them, Washington's emergency departments saved the state \$34 million towards the \$32 million deficit for 2013. Overall ED visits were cut by 10 percent from the year before, high utilizers were reduced by 11 percent, and non-emergency visits were reduced by 14 percent. And in the midst of the prescription-addiction crisis, narcotics prescribed by Washington EDs were reduced by 24 percent.

A key component of this effort was that the best practices were supported by tools that made the workflow easier on physicians. "We made the right choice the easy choice," says Anderson, reflecting on what it took to galvanize so many physicians towards this enormous success. The effort also incorporated a newly patient-centered view in evaluating what is best for supporting long-term care for difficult, chronic conditions.

With effort, organization, and an informed evaluation of the issues to solve, emergency physicians in Washington and Oregon saved their states money. Physicians got the tools they needed, and patients got better care instead of guarded care. It might have taken a state budget crisis to bring things to a head. But the way that crisis was tackled proved that we can't underestimate the leadership power of physicians in overcoming health care's challenges. And besides, we already knew physicians love solving tough problems. 



## Emergency Medicine The Seven Best Practices

The goal of the Seven Best Practices program adopted by Washington and Oregon is to redirect care to the most appropriate settings, reduce low acuity, and reduce preventable Medicaid emergency-room visits. The plan, which focuses on high users, attempts to address the root of the problem—chronic medical conditions, substance-abuse issues, and lack of primary-care access—by leveraging the following components for success.

- 1 **Electronic Health Information**—Adoption of an electronic emergency-department information system on a statewide basis in order to create and act on a common, integrated plan of care related to patients with high needs (those who have logged five or more visits in a rolling calendar year). The plan of care would be adopted by all emergency rooms, payors, and mental-health clinics, and sent to primary-care providers.
- 2 **Patient Education**—Dissemination of patient-education materials by hospitals and payors to help patients understand and utilize appropriate resources for care. This would include sharing information with patients and providers describing where patients can get off-hours coverage for primary or urgent care—including nurse call lines—and making this information easily available on provider web sites.
- 3 **Identification of Frequent Users of the Emergency Department and EMS**—Frequent ER or EMS users are defined as those patients seen by or transported to the ER five or more times within the past 12 months. Hospitals should identify these frequent ER users upon arrival to the emergency department, and develop and coordinate case management—including utilization of care plans—to address any core issues documented in the statewide information system.
- 4 **Patient Care Plans for Frequent ER Users**—A process to assist frequent ER users with their care plans through various means, such as contacting a patient's primary-care provider within 72 to 96 hours and/or notifying that provider of an ER visit if no follow-up is required. Payors will provide the information system with the name(s) of the primary-care provider(s) or group for Medicaid patients, along with provider fax number(s).
- 5 **Narcotics Guidelines**—Implementation of guidelines, incorporating existing Washington ACEP guidelines, to reduce drug-seeking and drug dispensation to frequent ER users.
- 6 **Prescription Monitoring**—Enrollment of ER physicians in the state's Prescription Monitoring Program (PMP). The PMP is an electronic online database used to collect data on patients who are prescribed controlled substances, ensuring coordination of prescription drug prescribing practices.
- 7 **Use of Feedback Information**—Designation of hospital emergency-department physicians and hospital staff who will be responsible for reviewing the reports of frequent ER users to ensure that interventions are working, including a process of reporting to executive leadership.

*Updated January 2015.*

# Is there a Doctor on Board?

## What to do when fellow travelers need a Good Samaritan

by David S. McClellan, MD, FACEP

Perhaps once a year while flying, I hear a flight attendant ask over the intercom, “Is there a doctor on the plane?” I always respond. I’ve helped people with small problems like nausea, and I’ve helped people with life-threatening conditions. On one flight I even asked the pilot to divert the plane.

### CASE HISTORY #1

An elderly man with COPD was experiencing shortness of breath. When a flight attendant asked for help, I approached the passenger and could tell the cause was simply COPD—he was not experiencing another kind of event. I knew the airline kit had an albuterol inhaler, which would be helpful, but he could use more. As luck would have it, I had prednisone with me, and knew that it could make a difference in his breathing. The flight attendant handed me a headset, and in a short time I was on a three-way call, via VHF radio, with in-flight medical control—an emergency-physician service in Denver that contracts with many U.S. airlines—and the pilot. I explained the passenger’s symptoms and described why I believed my personal prescription of prednisone would help. The Denver physician agreed that this would be a safe course of action, and the pilot listened to our conversation, asked questions, and granted me permission to administer the prednisone and put the passenger on oxygen. The passenger also took a few puffs of the albuterol inhaler from the airline kit, and in a short time, he was feeling good. I checked on him every half-hour or so, and his breathing stayed under control.

### CASE HISTORY #2

A hyperventilating man was experiencing malaise, dyspnea, and



light-headedness when a flight attendant requested medical assistance from other passengers. I pushed the call button to offer my assistance and was brought to the passenger’s seat, where he was sitting upright. A few questions about his condition revealed that his symptoms were the aftermath of a night of drinking; the conditions of air flight had exacerbated his hangover! I easily obtained two Tylenol for him and had him drink two bottles of water. With the flight attendant’s help, I repositioned the passenger across the floor of the galley to elevate his feet. During this episode, it was nice to see three other passengers offering to help—a nurse, a pediatrician, and a paramedic. Since I was able to quickly get a handle on the passenger’s more concerning symptoms, these three Good Samaritans returned to their seats. Within half an hour, the passenger’s breathing was normal, his light-headedness had abated, and he was also able to return to his seat.

### CASE HISTORY #3

My plane had departed from San Francisco on its way to Mexico. Not long after we passed Los Angeles, a passenger began experiencing chest pain, shortness of breath, and leg pain. After I answered the flight attendant’s request for assistance, I discovered through an interpreter that the Spanish-speaking passenger had recently undergone knee surgery, and had stopped taking his anticoagulants. A quick assessment convinced me that he had a potentially fatal condition and would benefit from a rapid evaluation on the ground. If we continued on course, he might not make it to Mexico.



To complicate things, the plane was not in a good situation for landing. The load was heavy, fuel would need to be dumped, and an unplanned landing in San Diego meant we'd hit a notoriously short runway—and we'd hit it hard, since, as all pilots know, a plane with a full tank can hit the ground with enough force to critically damage the plane. After such an emergency, an airline might need to spend tens of thousands of dollars on mandatory inspections and repairs.

Once again, I took the headset and told the pilot and the Denver physician—whom I had met personally at a medical conference, and with whom I had spoken just a few hours earlier—what was going on. The pilot expressed concern about the heavy plane, and I thought he was going to keep heading to Mexico, but he surprised me. He circled the San Diego airport, made the emergency call to the control tower, and landed the plane—really hard—on the runway. He'd called ahead for an ambulance, so shortly after landing, I escorted the passenger to the ambulance, talked to the EMT about his condition, and wished him well. I never found out if the passenger survived, but I knew I'd helped him have a shot.

### THE TYPICAL HEALTH CONDITIONS YOU'LL SEE

The usual events on a plane involve shortness of breath, nausea, dizziness, chest pain, palpitations, and headaches. Studies show that health-care providers provide assistance in 80 percent of medical events on a plane.<sup>1</sup> If you're a general physician, and you have a wide breadth of medical knowledge, you shouldn't be afraid to identify yourself and do something to help. If you're a specialist with a narrow scope of knowledge, you might not be able to give as much help; if you do identify yourself, though, assess the situation. If it's not serious, tell the flight attendant that this is out of your scope of practice and ask him or her to call for another volunteer. If it is serious, but you don't feel comfortable administering care, encourage the flight attendant to ask for anyone else with

“I can tell you that every time I've volunteered to help, I've always had a good experience.”

DAVID S. MCCLELLAN, MD, FACEP

medical training. There's almost always a willing paramedic, nurse, or Eagle Scout on a flight, ready to help. In fact, most flight attendants have training in first aid, CPR, and AED use, so you can let them use their training to care for the passenger while you encourage and assist them.

### THE TYPICAL MEDICAL SUPPLIES YOU'LL WORK WITH

All large U.S. commercial airlines should have a first-aid kit and an AED on board every flight. That means you'll most likely have basic first-aid supplies, plus a stethoscope, a blood-pressure cuff, a bag valve mask, aspirin, dextrose, atropine, lidocaine, saline, albuterol inhalers, injectable epinephrine, an oral antihistamine, an IV catheter, IV antihistamines, an IV drip set, and several syringes.<sup>2</sup> With regional planes, prop planes, and international planes, the supplies aboard can vary. If you decide to help on any plane, don't wait for a flight attendant to tell you about the supplies they have. Ask for the ones you need by name.

### DON'T LET THE FEAR OF A LAWSUIT STOP YOU

I've talked to colleagues about helping passengers, and they've sometimes expressed worry that with the lack of equipment, they might not be able to help the patient, and could get sued. But don't let this prevent you from doing all you can to help. In 1998 the Aviation Medical Assistance Act provided that state-qualified EMTs, paramedics, physicians, nurses, and physician assistants should not be liable for

negative results of medical help given to a passenger in good faith, provided there is no gross negligence or willful misconduct.<sup>3</sup>

### ADVICE FOR HEALTH-CARE PROVIDERS

Don't be afraid. It's humanitarian to help. People are supportive and appreciative—and you'll never be alone. If you know what you're doing with CPR, aspirin therapy, and an AED, the odds of something serious happening are very small. I can tell you that every time I've volunteered to help, I've always had a good experience. On one flight, when I dealt with two different emergencies, my wife said, “I'm never flying with you again”—but she wasn't serious.

Being a Good Samaritan means you don't get compensated, and often you'll get a quick “thank you” and that's it. An airline might give you a few thousand miles or a free drink, but it's not typical. After we arrived in Mexico, I walked into the hotel lounge and saw a few passengers from my flight. They pointed at me, giggled, and gave me a standing ovation. At that moment, in the lounge with my fellow passengers after a long, eventful flight, it was really nice to be there. 

### Resources

<sup>1</sup> Celine Grounder, “Medical Emergencies at 40,000 Feet.” *The Atlantic*, April 4, 2013. Accessed March 10, 2014, at <http://www.theatlantic.com/health/archive/2013/04/medical-emergencies-at-40-000-feet/274623/>.

<sup>2</sup> Mark Liao, “Handling In-Flight Emergencies.” *Patient Care, JEMS Emergency Medical Services*, June 3, 2010. Accessed March 10, 2014, at <http://www.jems.com/article/patient-care/handling-flight-medical-emerge>.

<sup>3</sup> U.S. House of Representatives, *Aviation Medical Assistance Act of 1998*, March 20, 1998. Accessed March 10, 2014, at <http://www.gpo.gov/fdsys/pkg/CRPT-105hrpt456/pdf/CRPT-105hrpt456.pdf>.



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*Heart Medical Center & Children's Hospital and has been in practice for 35 years.*



# Seven Meaningful Ways to Respond to Domestic Violence

by Jasmin Manolo

Survivors of domestic violence (DV),—across all lines of race, socio-economic status, gender, sexuality, and other factors—experience increased rates of many health issues, including hypertension, depression, asthma, and unplanned pregnancy. So where do we start in preventing and treating such a pervasive issue?

- **Educate patients about the connection between DV and health by talking about healthy relationships—and not-so-healthy relationships.**

Providers can help make the connection between DV and health by normalizing discussion about the intersections of healthy relationships. The benefit of such a universal-education approach is that patients are not required to disclose violence in order to get access to services and information, which increases safety and empowerment for DV survivors.

- **Use educational tools that make it easier to adopt an evidence-based approach.** Safety cards are a patient-education tool that's used to support this conversation while connecting patients with services. Check out the clinic materials offered by Futures Without Violence on page 11.

- **Bring a universal-education approach to health centers.** Set up specific training for all health workers, from the front desk to physicians. This promotes team-based care, an important component of success in sustaining a comprehensive response to DV.

- **Collaborate with DV advocates.** Many health-care providers partner with DV agencies to integrate health care and domestic-violence response systems.

These collaborative partnerships are a crucial step in supporting survivors with prevention and intervention strategies, as well as links to an extensive network of DV services that may not be provided in medical settings, such as emergency shelters or legal services.

- **Help patients get enrolled in insurance coverage that supports survivor health.**

Before the Affordable Care Act (ACA), some insurance companies considered medical treatment related to DV a pre-existing condition that would exclude survivors from getting insurance. As of now, DV screening and counseling are covered services under the ACA. To learn more, have patients visit [www.healthcare.gov](http://www.healthcare.gov) and [www.cuidadosalud.gov/es/](http://www.cuidadosalud.gov/es/).

- **Take care of yourself first.** Health workers are also affected by domestic and sexual violence, as well as by other forms of trauma—through both personal experiences and conversations with patients. A crucial step in addressing violence for your patients is to take care of yourself first, by examining your own relationship histories and thinking of ways you can support your own healing. The saying, “You can't pour from an empty cup” exists for a reason.

## THE BOTTOM LINE

Health professionals are uniquely positioned to serve an important role in addressing DV. By partnering with DV advocates, educating all patients about the health effects of violence, ensuring healthcare access for survivors, and taking care of yourself, you will be more effective in preventing violence and supporting survivors.

(Domestic Violence, continued from page 11)

to remain in control of his or her own situation. The simple offer of a wallet-sized patient-safety card is a discreet but powerful gesture that lets the patient take action when they are ready without increasing their risk level. To start this conversation, see Futures Without Violence's *Patient Education Resources* at [IPVhealth.org](http://IPVhealth.org).

## CONNECT WITH COMMUNITY PARTNERS

“Providers don't need to be the experts, but it's critical for them to partner with their local domestic-violence advocates,” says Vander Tuig.

The domestic-violence (DV) advocates in your area are a vital resource, because they know the unique risks your patients are up against, as well as the laws and services that will be the most protective of them given their situation. Providing more than just emergency shelter, advocates offer access to counseling, legal help, case management, family resources, 24-hour crisis support, and more.

Once a patient decides to make a move to get the resources they need, support from local advocates is vital. Don't wait

## Resources for Survivors

**National Domestic Violence Hotline**  
800-799-SAFE (7233)

**National Teen Dating Abuse Helpline**  
1.866.331.9474 ITTY:  
1.866.331.8453 | Text: loveis to 22522

**Strong Hearts Helpline for Native Americans**  
1-844-7NATIVE (1-844-762-8483)  
Monday through Friday from 9 a.m. to 5:30 p.m. CST

until you have a patient asking for help; physicians should be connected to local resources before a patient crisis occurs. In the swift moments during which a survivor is ready to take action, you don't want to be researching the "who, what, and where" of immediate, local support. Make this information available to all the providers at your clinic as a matter of course. And if a patient discloses violence, offer them a warm referral to a local advocate, using language like this: "Thank you so much for sharing that with me. A lot of patients in similar situations have found that it can be helpful to talk to an advocate over at [local domestic-violence agency] who can offer free and confidential support. If this is something you are interested in, I can connect you with them today, or just give you their information."

To locate the community DV experts in your area, simply call the National Domestic Violence HOTLINE at (800) 799-7233 and speak with a counselor.

Remember, there is no perfect plan, and there is no one-size-fits-all solution. Vander Tuig advises that it's important to go with whatever angle offers the most leverage as you meet with patients who may be in crisis. Any step you take with a domestic-violence survivor will provide needed help. The important thing is to not get overwhelmed with doing just the right thing. When you normalize the conversation around healthy, intimate relationships and are connected to local DV experts, you'll have the pieces in place to support your patients when the time comes. [PR](#)

### Sources

<sup>1</sup> Catalano, Shannan. "Intimate Partner Violence in the United States." U.S. Department of Justice, Bureau of Justice Statistics. 2007. Available at <http://www.ojp.usdoj.gov/bjs/intimate/ipv.htm>

<sup>2</sup> Davis, Antoinette, MPH. "Interpersonal and Physical Dating Violence among Teens." The National Council on Crime and Delinquency Focus. 2008. Available at [http://www.ocjs.ohio.gov/TDVMonth/Interpersonal\\_Teens.pdf](http://www.ocjs.ohio.gov/TDVMonth/Interpersonal_Teens.pdf)

<sup>3</sup> "Adverse Health Conditions and Health Risk Behaviors Associated with Intimate Partner Violence, Morbidity and Mortality Weekly Report." Centers for Disease Control and Prevention. February 2008. Available at <http://www.cdc.gov/mmwr/PDF/wk/mm5705.pdf>



*(Doctor's Orders, continued from page 15)*

clinical staff charged with identifying and addressing health issues as they arise. DESC also has a mobile crisis team that first responders can call on when someone on the street appears to be having a mental-health crisis.

### HOUSING AS HEALTH CARE

Poor health is both a symptom and a cause of homelessness. People frequently become homeless as a result of serious health issues, and those issues only worsen once they lose a permanent place to live. In a practical sense, stable housing and stable health are inextricably linked.

DESC's organizational philosophy emphasizes housing as an indispensable component of prevention, treatment, and recovery. Its nationally recognized Housing First program has successfully modeled how much more effective it is to provide homeless people with permanent housing first—and then give them the services they need to support their recovery.

In fact, many housing-first advocates have persuasively argued that providing permanent homes to homeless adults with addictions, untreated mental illnesses, and other chronic health issues can actually save human-services dollars in the long run. Allocating resources to supportive housing from public health funds, though perhaps not a viable political objective in most states, makes good financial sense.

In a 2009 study of the DESC Housing First program, researchers at the University of Washington found that

providing housing to 95 chronically homeless people with alcohol addiction saved Seattle taxpayers more than \$4 million in crisis-service costs in a single year—roughly half of what services for the same group had cost taxpayers the previous year.

Malone argues that one of the most important steps physicians can take to improve the health status of the homeless population is to support the development of stable housing options. "Doctors are highly respected, influential members of their communities. By advocating for policies that create more housing for people experiencing homelessness, they can have a tremendous impact on the problem."

Doctors can make their voices heard by reaching out to politicians and trade groups representing their interests. Over the past year, for example, the Washington State Hospital Association (WSHA) has been soliciting comments from its membership on the idea of extending Medicaid coverage to supportive housing. The Centers for Medicare & Medicaid Services (CMS), meanwhile, recently approved supportive-housing services as part of its Medicaid Transformation Demonstration project in Washington State.

No matter how many vans and volunteer doctors we deploy, our ability to improve the health of homeless people ultimately rests on the success of game-changing efforts like these. [PR](#)



*(Nightmare, continued from page 6)*

CDC issued an extensive non-binding guideline on opioid use for chronic pain. Among other things, the CDC guideline stipulates caps on daily dosages for chronic pain, limits on the length of prescriptions for acute pain, and preferential use of immediate-release formulations.

At the state level, departments of health, medical associations, and other groups have begun to ratify the guideline, amending as needed to reflect regional conditions. Almost everyone agrees that a concerted national response has been long overdue; even Purdue has come around to this point of view.

At the same time, experts warn that measures designed to combat the crisis could have unintended effects. People like Jeb Shepard, Associate Director of Policy and Regulatory Affairs for the Washington State Medical Association, argue that, while rampant opioid addiction warrants aggressive action, we need to remain attentive to the needs of patients, including those who have successfully managed their pain for years with opioid medications.

“We’re worried about the pendulum swinging from over-treatment to under-treatment,” Shepard says. “If the state decided to put in place blunt pill limits, they’d be very successful in reducing the amount of opioids prescribed. They’d also prevent some patients from accessing clinically appropriate treatments that enhance functioning and quality of life.”

The image of a swinging pendulum comes up often in conversations with public health experts. “People in the pain community fear doctors will stop treating patients who are legitimately in pain,” says Joy Conklin, Vice President of Practice Advocacy for the Oregon Medical Association.

Previous efforts to curb over-prescribing have had a freezing effect, just as experts had warned. So instead of enforcing hard-and-fast rules that chill the treatment of

“Research shows that 90% of patients who have a near-fatal overdose and live will fill a prescription for the same drug that almost killed them.”

IAN CORBRIDGE, POLICY DIRECTOR FOR PATIENT SAFETY, WASHINGTON STATE HOSPITAL ASSOCIATION

chronic pain, states have begun pursuing a multi-pronged approach that simultaneously addresses various facets of the problem. Introducing clinical guidelines and re-educating doctors and patients on the appropriate use of prescription opioids are both part of the equation. Another: putting information in the hands of doctors so they can mitigate risk at the point of care.

The point is not to penalize doctors for breaking rules, but to give them the information they need to ensure patient safety. To that end, most states have rolled out prescription drug monitoring programs, or PDMPs, that help doctors

evaluate their prescribing practices while identifying patients at high risk of abusing opioid medications.

“Research shows that 90% of patients who have a near-fatal overdose and live will fill a prescription for the same drug that almost killed them,” says Ian Corbridge, Policy Director for Patient Safety at the Washington State Hospital Association. “That’s largely because providers aren’t aware these events happened.”

Ongoing performance improvement and education are equally important. In 2018, prescribers in Washington will begin to receive reports indicating how their prescribing practices compare to those of their peers. “Our goal is to identify and provide feedback and education around prescribing guidelines to outliers so they can update their clinical practice,” says Shepard.

## ACCESS TO TREATMENT

Health experts are also acutely aware of the need to improve the accessibility of effective addiction treatment. Medication-assisted treatment (MAT), using such medicines as buprenorphine, methadone, and extended-release naltrexone in combination with counseling and behavioral therapy, has been shown to reduce opioid use, opioid-related overdose deaths, and infectious-disease transmission.

## FACT SHEET:

# CDC GUIDELINES FOR PRESCRIBING OPIOIDS

Learn more about the latest recommendations on opioid prescribing. Download these guidelines from the Centers for Disease Control and Prevention: <https://bit.ly/2GATDOo>

For additional regional information, visit your state’s Department of Health.

**GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN**

**IMPROVING PRACTICE THROUGH RECOMMENDATIONS**

CDC’s *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

**DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN**

- 1 Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
- 2 Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
- 3 Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy.

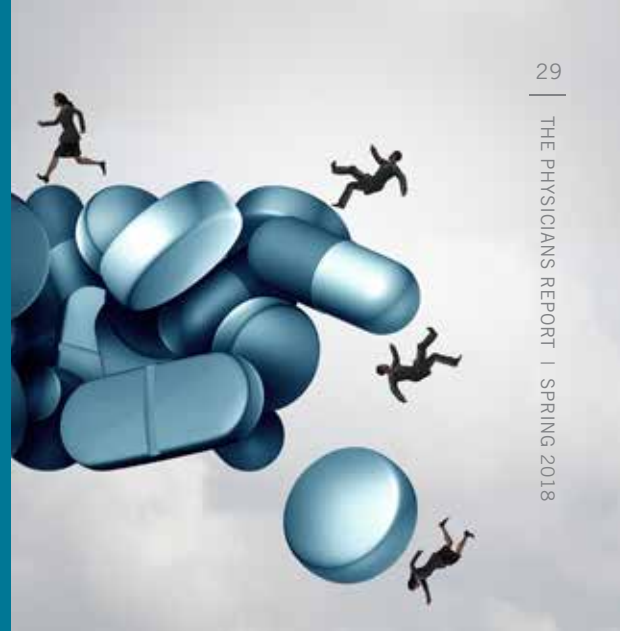
**CLINICAL REMINDERS**

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient



“We need doctors who acknowledge their fears, but manage to roll up their sleeves and learn how to care for these patients.”

DR. MICHAEL SCHIESSER,  
INTERNAL MEDICINE,  
ADDICTION SPECIALIST,  
EVERGREEN HEALTHCARE



The availability of MAT programs varies considerably. “Oregon is among the states with the least access to addiction treatment,” says Conklin. “If you’re outside urban areas, treatment resources are even more scarce.” And it’s not just Oregon. Rural areas in most states, often the hardest-hit by the opioid crisis, struggle with inadequate access to MAT resources.

The problem of accessibility extends to non-opioid therapies for chronic pain as well. Safer alternatives for chronic-pain management, like physical therapy, acupuncture, and cognitive-behavioral therapy, are often unavailable or not covered by patients’ insurance plans.

“It’s unfair to ask providers to use other strategies for chronic-pain management if the health system doesn’t enable that,” says Corbridge.

#### THE WAY FORWARD

Dr. Michael Schiesser, an internist who specializes in addiction, believes primary-care physicians should be prepared to engage patients who present with high-risk medication regimens. When a pain clinic closes, too often the wider medical community lacks the skills necessary to manage the patients orphaned by that closure, many of whom could benefit by transitioning to more conservative pain-management approaches. Fear of regulatory action often discourages physicians from obtaining the skills they need to treat these patients.

“No doctor wants to be scrutinized for their prescribing practices, whether it’s a civil or regulatory claim, charge, or investigation,” says Dr. Schiesser. Still, he says, managing pain medications is within the scope of primary care. “We need doctors who acknowledge their fears, but manage to roll up their sleeves and learn how to care for these patients.”

Many patients were first prescribed large doses of opioids years ago, when the medical community widely endorsed their long-term use, and most have never developed addictions. Ignoring these patients or aggressively tapering their opioid regimens introduces significant risks.


“The most recent sea change in opinion about the role of opioids in treating chronic pain has the potential to cause a lot of patient harm,” says Dr. Schiesser. “The adverse effects a patient may experience while tapering from a high opioid dose to little or no opioids are not trivial.”

When working with new patients who have experienced prolonged opioid exposure, doctors should carefully consider the benefits and risks of lowering dosages to comply with

prescribing guidelines. Ultimately the benefits may not outweigh the downside for the patient, even if it makes the doctor feel protected from scrutiny.

Doctors must also be able to distinguish between addiction and dependence. Not all patients who have received long-term opioid treatment for chronic pain are addicts. “Most patients with prolonged exposure to pain medications develop central nervous system adaptations that cause withdrawal symptoms when they don’t take those medications,” says Dr. Schiesser. Those withdrawal symptoms establish dependence, but the behavioral changes that accompany addiction are often absent.

Physicians who regularly use prescription drug monitoring databases, engage patients in weighing the risks, and thoroughly document clinical decisions in patients’ medical records have nothing to fear. Each patient presents a unique set of circumstances, and in some cases continuing the use of opioid medications may be reasonable.

“Physicians on the front lines need the acquired skills and training to engage opioid patients and facilitate good decision-making,” says Dr. Schiesser. “We want to help these patients achieve the healthiest long-term outcome possible.” 



# GOVERNMENT RELATIONS

## 2018 Session Update

### Successes in Washington State and Unprecedented Turnover in Oregon



#### FEDERAL

Nationally, we continue to support and work with the Physician Insurers Association of America (PIAA) and its push for national legislation to improve patient access to health-care services and to provide improved medical care by reducing the excessive burden that the liability system places on the health-care delivery system. Our in-house lobbyist Anne Bryant serves as the Chair of the PIAA Government Relations Committee.

On June 28, 2017, the U.S. House of Representatives passed the Protecting Access to Care Act (H.R. 1215), the first comprehensive medical-liability reform legislation to be passed by either chamber of Congress in more than five years, with a vote of 218–210. The House has passed similar legislation in previous years; the barrier to adoption thus far has been in the Senate. Unlike the previous legislation, H.R. 1215 is limited to claims involving expenditures of federal dollars.

We support the Good Samaritan Health Professionals Act and Crisis Standard of Care legislation that provides liability protection for health-care professionals and facilities providing uncompensated services to victims of federally declared disasters. We also promote the framework for legislation that addresses telemedicine-liability concerns, as telemedicine services continue to expand.

Learn more about:

- **H.R. 1215/Protecting Access to Care:** <https://bit.ly/2nAFgC6>
- **The Good Samaritan Health Professionals Act:** <https://bit.ly/2rFp44A>

#### WASHINGTON: SUCCESSES

Washington's 2018 legislative session convened on January 8, 2018, and adjourned on March 8, 2018, on time with no special session. This year's session saw an end to the historical environment of one Democrat crossing over to caucus with the Republicans for a new majority.

We defeated renewed efforts to expand liability in wrongful-death and survival claims to include other beneficiaries, as well as proposals to expand damages by inflating medical expenses in personal-injury medical claims. We also defeated the introduction of punitive damages in Washington. We supported shared decision-making proposals that did not alter informed-consent requirements, along with legislation that preserved liability protection for emergency-volunteer practitioners and the creation of a pilot program concerning telemedicine.

We work closely with our allies, including the Washington State Medical Association, the Washington State Hospital Association, and the Washington Liability Reform Coalition. We continue to





partner with the governor's Health Care Advisor to implement the Healthier Washington campaign in an effort to transform health-care delivery by promoting community health, improving quality of care, lowering health-care costs, and empowering patients.

Learn more on legislation about:

- **Wrongful death:** <https://bit.ly/2uLLYKY>
- **Punitive damages:** <https://bit.ly/2uQLGTP>
- **Emergency volunteers:** <https://bit.ly/2q452P9>
- **Telemedicine:** <https://bit.ly/2GATD0o>

#### **OREGON: UNPRECEDENTED TURNOVER**


Currently, there are two physician legislators in the Oregon Legislature: one Republican in the House and one Democrat in the Senate. There was an unprecedented amount of turnover in both the Senate and the House prior to session. The 2018 legislative session

convened on February 5, 2018, and adjourned on March 4, 2018, eight days before the constitutional deadline.

Prior to session, we defeated proposals to increase the \$500,000 cap on non-economic damages recoverable in wrongful-death and bodily-injury actions, proposals to add insurance to the Unlawful Trade Practices Act, and proposals to expand the types of lawsuits that can be brought against insurance companies. We supported comprehensive legislation that improves the liability system and provides for meaningful patient-safety initiatives, including a proposal that allows for a sliding scale on attorney contingency fees. No such initiatives were filed during the 2018 legislative session.

As in Washington, we work closely with our Oregon allies, including the Oregon Medical Association and the Oregon Liability Reform Coalition. We continue to promote further improvement to the health-care delivery system through a partnership with the Oregon Patient Safety Commission to implement a patient-empowerment program, and our in-house lobbyist serves on the Oregon Collaborative on Communication & Resolution Program Advisory Council. We also participate in the Oregon Rural MPL premium subsidy plan, which pays part of the premium by reimbursing participating providers.

#### **IDAHO AND WYOMING: BUSINESS AS USUAL**

In Idaho, the 2018 legislative session convened on January 8, 2018, and adjourned on March 26, 2018. In Wyoming, the 2018 legislative budget session convened on February 12, 2018, and adjourned on March 15, 2018. Both states' sessions were relatively quiet, and did not present any significant professional-liability challenges. 



As the only Northwest-based medical-professional liability carrier with a registered in-house lobbyist, we provide advocacy on challenges to the professional-liability industry that:

- Create new causes of action against health-care professionals
- Adversely alter the standard of care for physicians
- Create strict liability for performing or not performing care
- Impose onerous or unnecessary duties on its insureds

To learn more about our Government Relations Program, contact:



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*(Inmates, continued from page 9)*

A couple of years ago, local leaders came together to develop a community-based strategy for coping with the problem. Public health officials, the sheriff's department, and the prosecutor's office all contributed to the conversation. Among the highest priorities they identified was bringing treatment services into the jail to reduce criminal recidivism and improve the odds of recovery.

To that end, the county formed a partnership with Evergreen Treatment Services (ETS), a nonprofit that has provided substance-use disorder services in Western Washington since 1973. ETS has since taken on multiple roles in treating the jail's addicts. As a first step, the county had ETS addiction specialists come to the jail on a daily basis to provide methadone to patients who had been using it successfully before their incarceration.

ETS has also helped Dr. Shin identify suitable candidates for treatment with Suboxone, a highly effective medication-assisted therapy combining buprenorphine and naloxone. Dr. Shin sought training and obtained the necessary certification to provide Suboxone to prisoners himself, which he has been doing for nearly two years. However, funding for addiction treatment has been limited: while Medicaid does pay for Suboxone therapy, that coverage ends when a Medicaid recipient becomes incarcerated.

Upon releasing these inmates back into the community, the jail does a warm handoff, driving them to the local ETS center where they can begin the process of continuing their care outside of the

penal system. "We wanted to remove some of the obstacles these patients have to establishing long-term addiction treatment, and reduce the incidence of overdoses," says Dr. Shin.

#### TRAINING A NEW GENERATION

Dr. Shin has no illusions that efforts like his will solve the problem of addiction in rural communities like Montesano. Incarcerated addicts, often at the lowest point in their lives, present the poorest odds of recovery of any addicted group. Still, when communities fail to address these needs among the incarcerated, it reveals the troubling yet common conviction that addiction is a personal failure rather than a public health


crisis—an attitude that undermines efforts to prevent and treat addiction in the first place.

"Many doctors have done much more than I have to treat inmates with addiction problems," says Dr. Shin. "I wasn't trained to treat addiction, but I saw a need in my community and evolved."

Other physicians need to evolve as well, Dr. Shin maintains. The problem is not that we lack the knowledge and tools to prevent and treat addiction, but that there are not enough doctors willing and able to work with addicted patients, regardless of whether they're incarcerated.

"We've reached a point where we can no longer rely on addiction specialists to deal with the problem," says Dr. Shin. "Our program would not have been possible had ETS not been providing services in the community." In other words, overdependence on organizations like ETS is a real obstacle to communities' ability to fight addiction effectively.

Medical schools have begun incorporating addiction and correctional medicine into their curricula, so there is hope that the next generation of doctors will be better equipped. Dr. Shin, who serves on the faculty of the School of Medicine at the University of Washington, enjoys teaching students and residents about correctional medicine and the use of Suboxone.

"I'm just so heartened when doctors-in-training, both students and residents, show interest in learning how to care for the incarcerated." 



"We've reached a point where we can no longer rely on addiction specialists to deal with the problem."

DR. YONG KI SHIN

## ONLINE CME

### Intimate Partner Violence/Domestic Violence

*Suited for providers and staff involved in direct patient care*

The first professional contact for people who experience relationship violence is likely to be a physician or other health-care provider. Studies report that abused women seek medical attention more frequently than non-abused women, even if they tend to hide that they are being harmed. Using a process of validation, safety assessment, and referral, a physician may be able to help a victim improve his/her situation. This activity has been approved for *AMA PRA Category 1 Credit™*.

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### Transitioning Care in the Face of Painkiller Addiction or Abuse

*Suited for physicians of all specialties and affiliated providers involved in direct patient care*

Every touch point with a patient is an opportunity to consider risks of opioid therapy and to realign management towards the best health outcomes. This one-hour webinar offers an ethical framework for evaluation, and you'll hear examples of dialogue that squarely addresses high-risk situations and options for tapering or alternative treatment. This activity has been approved for *AMA PRA Category 1 Credit™*.

[www.phyins.com/transitioningcare](http://www.phyins.com/transitioningcare)

### Sexual-Abuse Claims Against Medical Providers: A Malpractice Defense Attorney's Perspective

*Suited for MDs, nurses, MAs, and other clinical staff*

Physical touch is not only essential to medical care, it humanizes the physician-patient relationship. It is also an aspect of care that is ripe for misunderstanding and misperception. Abuse can easily happen under the guise of therapeutic touch. Indeed, allegations of sexual misconduct are on the rise.

This one-hour presentation by defense attorney Peter Eidenburg will discuss best practices to prevent allegations of sexual wrongdoing and what to do if a patient makes a complaint. Peter will bring his insights from the courtroom to help you better understand how these situations arise, how plaintiff attorneys build cases, and the unique challenges to litigating sexual-misconduct claims. You will not want to miss this opportunity to empower both yourself and your patients through better awareness of these issues. This activity has been approved for *AMA PRA Category 1 Credit™*.

[www.phyins.com/sexualabuseclaims](http://www.phyins.com/sexualabuseclaims)

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## TOOLS

### HR Tools: New Human-Resources Help

Physicians Insurance now offers all members a collection of go-to functions for human-resources needs, offered in partnership with Business Legal Resources (BLR), a company that has been providing solutions to daily workplace needs and problems for more than 40 years. HR Tools includes resources such as:

- **Ask the experts**—Quick and direct consults with legal experts.
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- **Salary data**—Salary data for over 2,900 job titles at national, state, and local levels, compensation metrics calculators, plus guidance on complex state and federal wage laws.
- **Time-savers**—Hundreds of downloadable samples, ADA policies, white papers, PowerPoint presentations, checklists, record-keeping tools, and training meetings.
- **Job description manager**—Thousands of searchable, prewritten, and legally reviewed job descriptions, including suggested grade and salary levels by state.
- **Leave and Disability Resource Center**—Guidance, e-books, videos, posters, news, forms, white papers, and more.
- **FLSA Resources Center**—An advice-rich resource center with information, manuals, and guidebooks to help you handle the rules and requirements of the FLSA.

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# GUIDANCE ON NEW DUTY TO WARN OR PROTECT STANDARDS

*Issued jointly by Physicians Insurance, the Washington State Hospital Association,  
and the Washington State Medical Association*

Physicians Insurance is committed to providing the most current and prudent medical liability guidance to our members so that they can continue to care for their patients with confidence. When milestone legal decisions are made in the courts, such as with *Volk v. DeMeerleer*, we make every effort to broadly share the news and its implications on future litigation. The following guidance is authored and offered as a collaboration by the Washington State Hospital Association (WSHA), Washington State Medical Association (WSMA), and Physicians Insurance."

May 2017: The Washington Supreme Court decision in *Volk v. DeMeerleer*, 386 P.3d 254, 187 Wn.2d 241 (2016), alters the scope of the "duty to warn or protect" in at least three critical ways:

1. It brings into question the groups of health-care professionals who are subject to the duty to warn or protect in the voluntary inpatient and outpatient setting.
2. The duty now clearly applies in the voluntary inpatient and outpatient setting.
3. Most importantly, outside of the context of an involuntary commitment proceeding,

the scope of persons to warn or protect now includes those who are "foreseeable" victims, not reasonably identifiable victims subject to an actual threat.

Facts of the case: The *Volk* decision involved circumstances in which a psychiatrist was treating a patient who had expressed suicidal and homicidal thoughts in the past. Many years later, and about four months after being last seen by the psychiatrist, the patient killed two individuals known to the patient. The patient had not voiced any thoughts to harm them. Representatives of the deceased filed a lawsuit against the psychiatrist for failing to protect them from the patient's violent actions. That lawsuit is still pending at the trial court, but the Supreme Court's decision established a new standard that is now binding on treatment providers.

In *Volk*, the Supreme Court held that, in the outpatient and voluntary inpatient treatment setting, the duty of health-care providers to warn or protect potential victims of violence extends to all individuals who may be "foreseeably" endangered by a patient, even if no specific target was identified.

The WSMA, Physicians Insurance, and the Washington State Hospital Association recommend that physicians and providers who treat patients with violent tendencies or ideations consider implementing the following guidelines (these guidelines are intended to be general guidance and not legal advice):

- Continue to use reasonable care to act consistent with the standards of your profession.
- Complete and update suicide and violence risk assessments with findings documented in the patient's medical record.
- Develop a policy and procedure to assess whether a patient has dangerous propensities, and use it consistently.
- Document in the patient's medical record how you reached your clinical decision and the measures you have recommended to mitigate potential risk, even when you are assessing a patient who has violent tendencies or ideations and do not believe the patient will harm others.



- In all cases, carefully consider and document in the patient's medical record the measures taken to mitigate risk. Measures will fall into two categories: measures to treat the patient and measures to warn potential victims. Measures to treat the patient may include, but are not limited to: seeking to hospitalize the patient; seeking to initiate involuntary commitment proceedings; scheduling more frequent visits or contacts with the clinic; starting injectable medication, etc. Measures to warn potential victims may include notifying law enforcement and notifying "foreseeable" victims.
- When you decide to issue a warning, notify law enforcement before contacting potential victims. Document in the patient's medical record your notification efforts and the individuals or groups notified.
- In *Volk*, the Supreme Court held that it is a jury's responsibility to determine who may be a foreseeable victim. We cannot, therefore, provide firm guidance on how to identify a foreseeable victim. In assessing the

scope of foreseeable victims, consider people close to the patient, such as family members, work colleagues and others within the person's social circle. Depending on your assessment, notification of a broader group could be required. In that case, coordination with law enforcement may be necessary. You must assess every case individually.

- For any action taken, document in the patient's medical record the reasons the action is necessary to warn or protect foreseeable victims, and, if applicable, to prevent or lessen a serious and imminent threat to a person's or the public's health or safety, as described above.

Finally, we recommend that you consider these points in a clinical context, act in good faith and document in the patient's medical record your thought process in sufficient detail to justify any course of action you decide to take, even if you feel that a patient has not triggered the duty to warn or protect potential victims.

#### QUESTIONS?

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**WSMA, Physicians Insurance, and the Washington State Hospital Association**

will continue to pursue legislative, regulatory, and judicial options to address the results of the *Volk* decision. Currently, the legislative efforts to fund a study of the decision on the state's mental health treatment system are underway. Additional details on those options will be forthcoming.

*(Navos, continued from page 21)*

symptoms of chronic mental-health issues, but of doing what it takes to restore hope and help clients reclaim their lives.


"Navos really believes in recovery," says Kelly. "We live it and breathe it. We believe people can get well and have jobs and live on their own, and we make that happen."

Integrating case management with mental and physical health care has been a vital component of Navos's trauma-informed strategy. Supporting recovery means understanding how all of the different aspects of a person's life influence health—behavioral and physical conditions as well as social determinants like housing, food, transportation, and access to a support network outside care settings.

Equally important is making sure clients understand that they're not second-class citizens in the Navos community. "We are a community of healing," says Kelly. "We don't separate. It's not us against them."

For example, Navos offers what Kelly calls a "hospital without walls" program, where clients live in townhomes adjacent to the administration building. Every day, nurses pay visits to these clients in their homes to give them their medications. Clients can also move freely throughout the Navos complex, essentially making their recovery experience a preview of the independent lives they'll lead once they're better.

It's a remarkably compassionate and humanizing medical-home model—one that fosters trust, safety, and patient empowerment. While it can be intimidating at first for providers used to swimming in their own lanes, it's the right thing to do for patients.

And if you asked Megan Kelly, she'd also likely tell you it's fun. 



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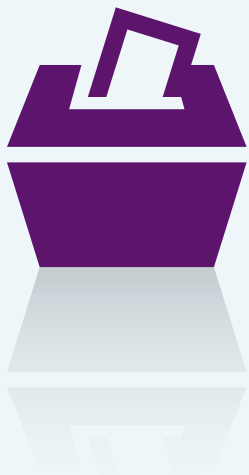
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## ANNUAL MEETING AND PROXY VOTE

The annual meeting of the members of Physicians Insurance A Mutual Company will be held on Monday, April 30, 2018, at 1:00 p.m. at 1301 Second Avenue, Suite 2700, Seattle, Washington. The purposes of this meeting are to elect directors, to amend the bylaws, and to act on any other matter coming before the meeting.

Visit [www.phyins.com/proxyvote2018](http://www.phyins.com/proxyvote2018) to learn more, and to complete and return your proxy for the meeting.