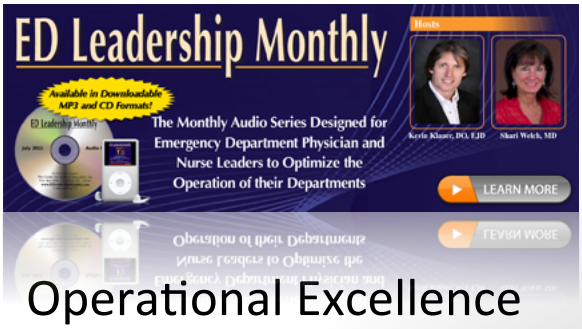


Operational Excellence

Top 10 Operational Pearls from 2013

Kevin M. Klauer, DO, EJD, FACEP
Chief Medical Officer, EMP, Ltd.
Editor-In-Chief, ACEP *Now*
ACEP Council Speaker

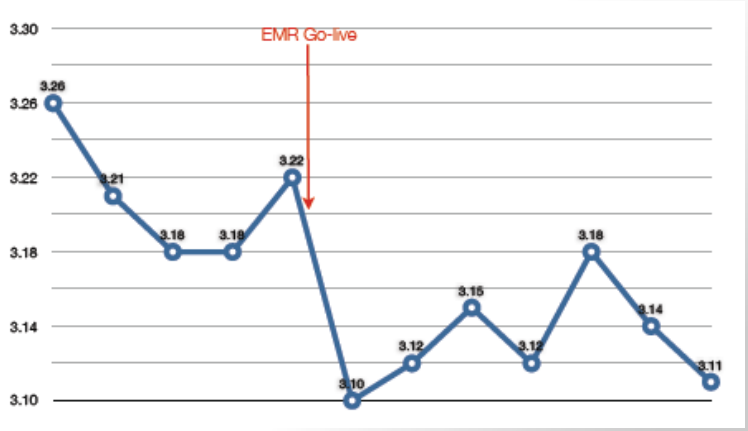
Healthcare Roundtable

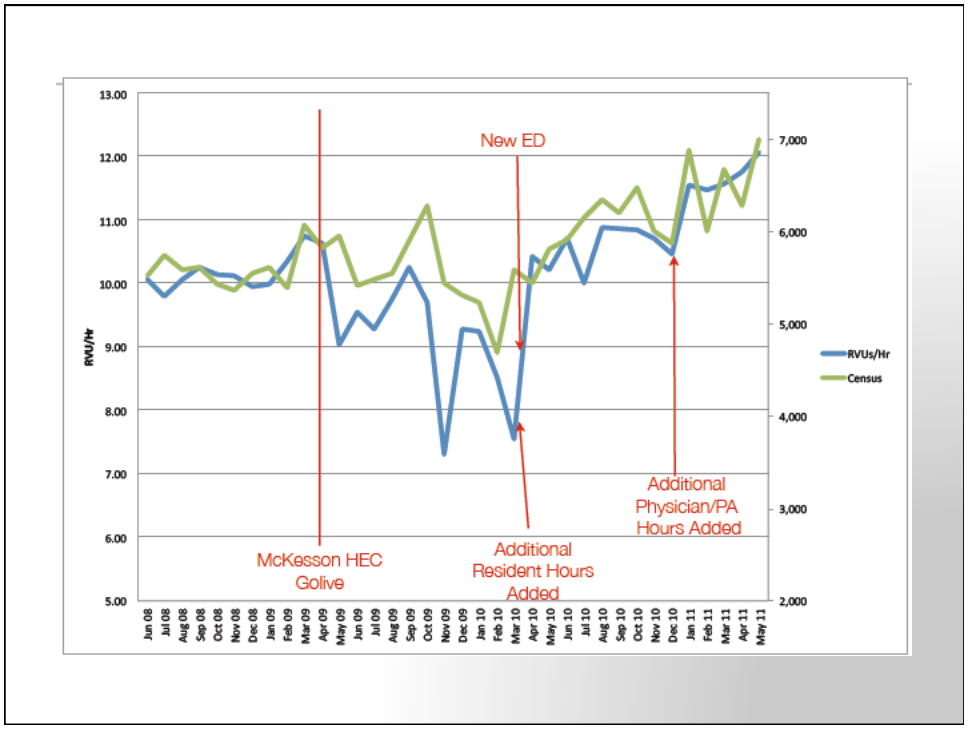
- EMRs and the Erosion of efficiency
- Documentation Demands
- Reimbursement Changes P4P
- ACA impact on reimbursement
- Choosing Wisely
- *PASTIES*
- Social Media
- Boarding = Death
- Maintenance of Certification
- Risk Management Patterns
- APPs Scope of Practice
- 2 Midnight Rule
- 3 Day rule
- CURB 65 (pneumonia score)
- Push the Plunger
- IV Acetaminophen

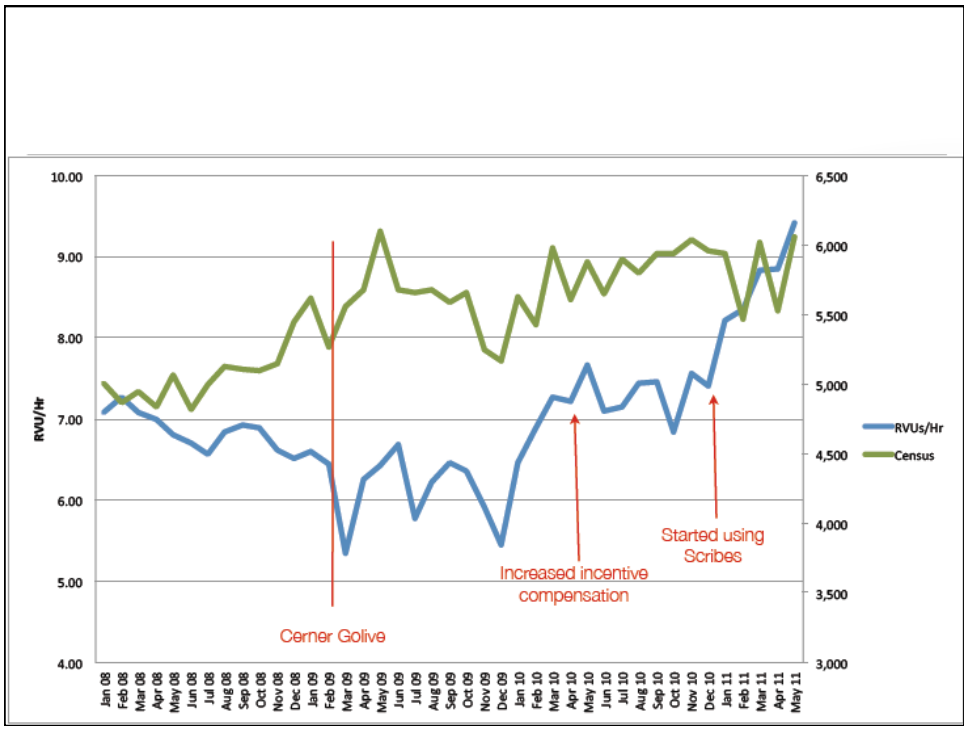
EMRs

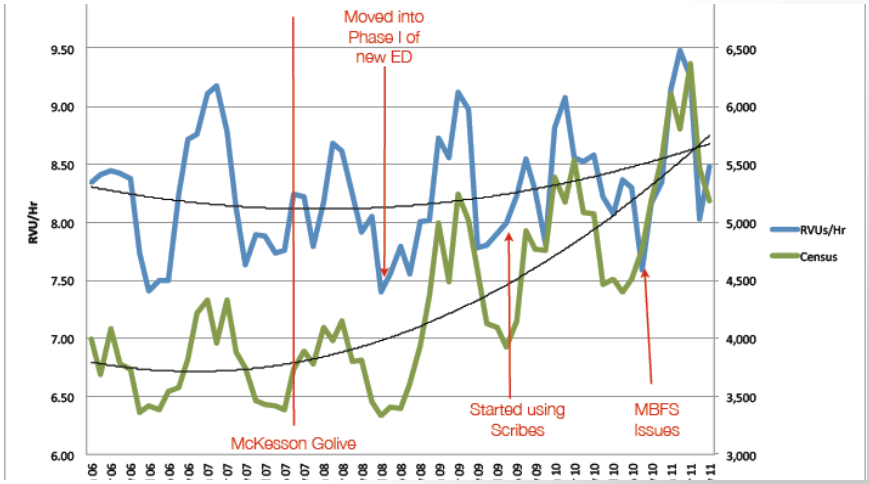
L. Poissant et al., "The Impact of Electronic Health Records on Time Efficiency of Physicians and Nurses: A Systematic Review," Journal of the American Medical Informatics Association 12, no. 5 (2005): 505–516.

- EHR: Increased documentation time by 17%
- CPOE: Increased documentation by 98%




New ED
McKesson HEC Golive
Additional Resident Hours Added
Additional Physician/PA Hours Added
RVU/Hr
RVUs/Hr
Census


Cerner Golive
Increased incentive compensation
Started using Scribes
RVU/Hr
RVUs/Hr
Census



A Success Story?

- The ED Length-Of-Stays decreased by 29%, from 6.69 to 4.75
- The ED LOS for admitted patients decreased 35%, from 12.22 hours to 7.96
- The LOS for discharged patients decreased 18%, from 4.61 hours to 3.78

- Chart completion improved from 63% in 2004 to 93% in 2006
- Charges per patient/total charges increased
- Collections per patient increased

EMRs & Liability

amednews.com
AMERICAN MEDICAL NEWS

BUSINESS

Make sure the way you use an EMR doesn't unwittingly look like fraud

Technically Speaking. By PAMELA LEWIS DOLAN, amednews staff. *Posted Nov. 21, 2011.*

www.medscape.com

Malpractice 'Discovery' Dangers in Your EHR

Leslie Kane, MA | Jul 16, 2012

Introduction

Picture this: You've been sued, and now the plaintiff attorney has the right to send in an expert to sit at your computer and examine information in your electronic health record (EHR). Besides any mistakes you might have made, system-wide bugs or design flaws that lead to data inconsistencies could be found and held against you in the discovery phase of a malpractice lawsuit.

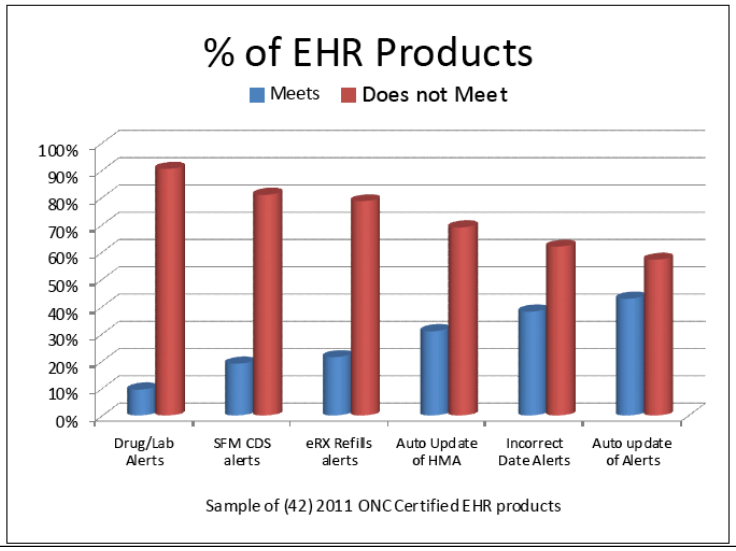
Doctors are becoming increasingly aware that EHRs can create certain malpractice risks. However, an expert in EHR and liability says there is a new category of malpractice risks in EHRs that most doctors have never considered. These include EHR system issues that you were never aware of and didn't cause.

"Every aspect of EHR selection, implementation, and use may be examined in the course of medical malpractice discovery to uncover the source of the incident, or undermine the records that are being presented in defense of the malpractice claim," says Ronald B. Sterling, CPA, MBA, national EHR expert, Silver Spring, Maryland, and author of *Keys to EMR Success* (Greenbranch Publishing; Phoenix, Maryland; second edition, 2010). "Anything could be a malpractice issue, from the product itself, the way it was set up, or how you've been using it."

For example, authorized software upgrades can unknowingly cause liability problems. Upgrades to the software can change

DO EHRs Increase Liability
Ozeran, L., Anderson, M. R., & FHIMSS, C. White Paper by.

Do EHRs Increase Liability?



Medical Malpractice Liability in the Age of Electronic Health Records. N Engl J Med 363;21. November 18, 2010

- Early
  - Inadequate training
  - Documentation gaps
  - EHR bugs and failures
- Mid
  - Metadata creates more discoverable events
  - Cut and paste histories
  - Information overload
  - Ignoring decision support
- Long term
  - Failure to use may = breach in SOC
  - Widespread decision support may result in false SOC

Case #2

CC: Passed out/fever

HPI: 33 year-old male, no previous medical history, c/o sudden-onset headache today.

- He has been having fevers as high as 100.
- He had 2 episodes of syncope today.
- No nausea or vomiting.
- He has had some chest congestion with cough.

MEDS: Percocet

ALL: Cephalosporins; Levaquin

SH: Smokes tobacco. Denies drugs. Occasional EtOH.

Physical Exam

GENERAL: Well-appearing male, appears to be in pain.

VS: T 98.1º, HR 81, BP 123/77, RR 14, SaO_2 97% on RA

HEENT: NC/AT. PERRL. EOMI. Mucous membranes moist.

NECK: Supple. No meningismus or meningeal signs.
No JVD, no LAN.

HEART: RRR, no murmurs

LUNGS: Clear to auscultation bilaterally.

ABD: Soft, nontender, nondistended. Normal active BS.

EXT: Thin, good peripheral pulses. No edema.

NEURO: Alert and oriented x3. No deficits on exam.

ED Timeline

- 11:13 Arrives by private vehicle
- 13:28 Seen by EM resident
- 13:59 Attending EM physician signs up on computerized tracking system
- 14:49 Ketorolac 30mg IV administered
- 16:24 LP completed
- 18:26 Morphine 5mg IV;
  Vancomycin 1gm IV administered (after LP results)

Diagnostics

- WBC 12.9, 84% neutrophils
- CT Head: Normal
- Lumbar puncture: CSF clear & colorless
  - Tube #1 - 26 WBC / 650 RBC
  - Tube #4 - 34 WBC / 41 RBC

ED Course

- 20:08 Ceftriaxone 2gm IV administered (ordered by EM attending)

  → RN calls EM physician (elsewhere in a large ED)

  → Reports patient c/o hand pruritis / flushed skin

  → Physician gives verbal order via cell phone to D/C ceftriaxone infusion

- 20:18 Benadryl 50mg IV

ED Course

RN calls EM physician a 2nd time due to pt c/o SOB

→ *Per RN, 'Pt gasping, audibly wheezing, drooling, with edema of face, lips, tongue, arms'*

ED Course

RN calls EM physician a 2nd time due to pt c/o SOB

→ *Per RN, 'Pt gasping, audibly wheezing, drooling, with edema of face, lips, tongue, arms'*

- Epinephrine 0.3mg 1:10,000 IV x2 doses
- Solumedrol 125mg IV
- Pepcid 20mg IV

ED Course

RN calls EM physician a 2nd time due to pt c/o SOB

→ *Per RN, 'Pt gasping, audibly wheezing, drooling, with edema of face, lips, tongue, arms'*

- Epinephrine 0.3mg 1:10,000 IV x2 doses
- Solumedrol 125mg IV
- Pepcid 20mg IV

- Pt intubated with adjunct use of bougie

An additional issue:

On subsequent review, it is discovered that the same physician ordered IV ceftriaxone for a pt with a cephalosporin allergy 6 months earlier

In a bizarre coincidence, it also happened to be the exact *same patient*, who had developed urticaria and mild wheezing during that previous encounter

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Documentation Demands

ICD-10

Differences

- October 1, 2014
- Much more detail
- Diagnostic code sets
  - 13,000 v. 68,000
- Procedure codes
  - 3,000 v. 87,000

Improvement in Coding Event Accuracy

- Hurt at the opera: Y92253
- Stabbed while crocheting: Y93D1
- Walked into a lamppost: W2202XA
- Walked into a lamppost, subsequent encounter: W2202XD
- Submersion due to falling or jumping from crushed water skis: V9037XA

- Z3754 Sextuplets, all liveborn
- W5922xS Struck by turtle, sequelae
- Z62891 Sibling rivalry
- Z631 Problems in relationship with in-laws
- V9107xD Burn due to water-skis on fire, subsequent encounter
- T505x6A Underdosing of appetite depressants, initial encounter
- V9733xD Sucked into jet engine, subsequent encounter
- T63442S Toxic effect of venom of bees, intentional self-harm, sequelae
- Z621 Parental overprotection

EM Specific

- Trimester of pregnancy
- AMI coding: Heart wall involved, Initial or subsequent, and STEMI or NSTEMI
- Asthma: Mild intermittent, mild persistent, moderate persistent, severe persistent, other specified then document if is uncomplicated, (acute) exacerbation, or status asthmaticus
- Decubitus ulcer: Anatomic site, Laterality when appropriate, Stage of pressure ulcer

EM Specific

- Dislocations: Anatomic site, laterality, type of injury-dislocation, subluxation sprain, episode of care A=initial, D=subsequent encounter, S=sequelae.
- Substance related disorders: need to know: substance, whether dependence or abuse, with or without current intoxication, associated psychotic disorder, status (in remission)
- Alzheimer's: early onset, late onset or other then note if it is with or without behavioral disturbance

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Reimbursement Changes

- IPPS
- OPPS
- PQRS
- Value Based Purchasing
- Value Based Payment Modifier

"Incentive Payment History"

2007 Physician Quality Reporting System – 1.5% subject to a cap

2008 Physician Quality Reporting System – 1.5%

2009 Physician Quality Reporting System – 2.0%

2010 Physician Quality Reporting System – 2.0%

"Incentive Payment History"

The Affordable Care Act authorized incentive payment through 2014;

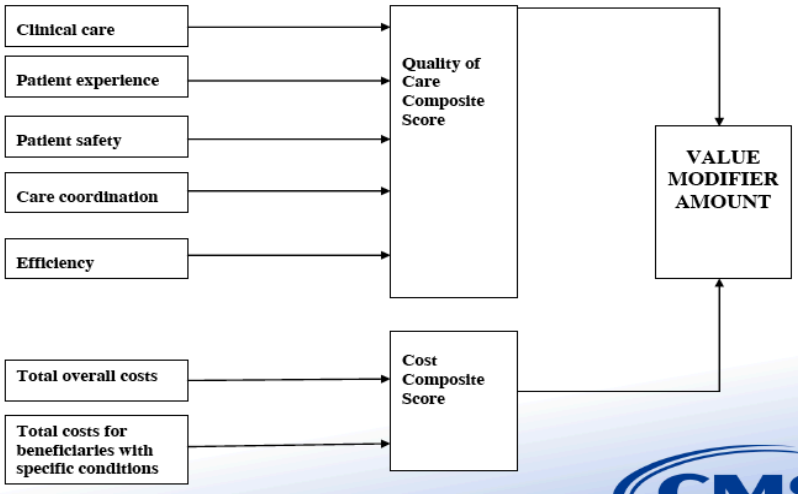
- 2011 Physician Quality Reporting System-1%
  Posting of those who successfully report
- 2012 Physician Quality Reporting System-0.5%
- 2013 Physician Quality Reporting System-0.5%
  Posting of individual provider performance
- 2014 Physician Quality Reporting System-0.5%

2015: 1.5% Penalty for not reporting

2016: 2% Penalty for not reporting

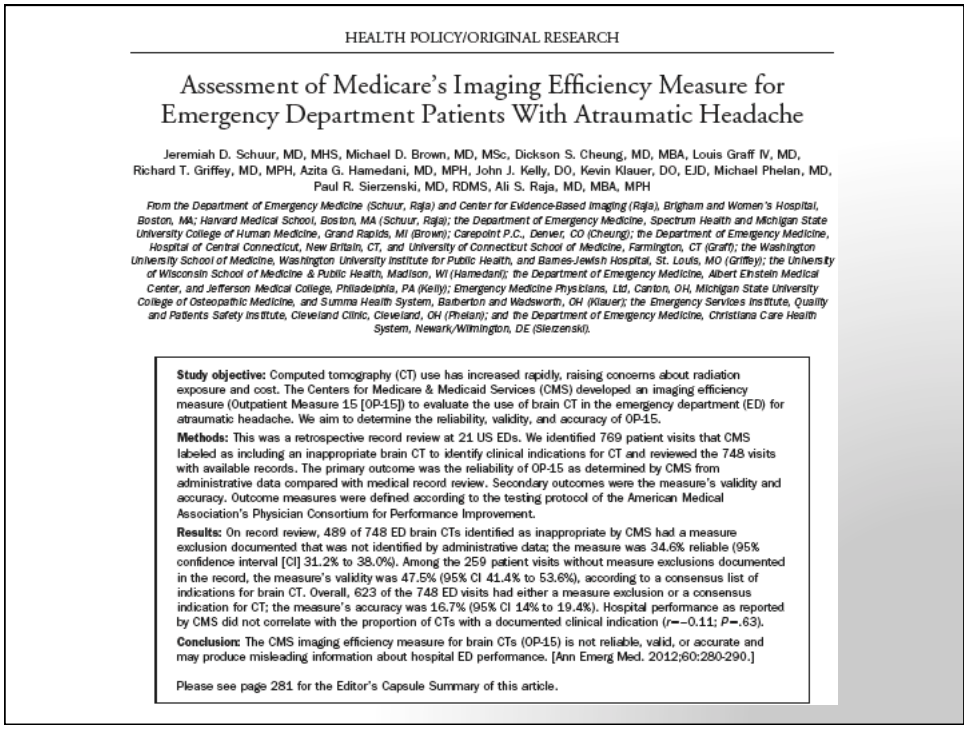
Value Modifier Scoring

Combine each quality measure into a quality composite and each cost measure into a cost composite using the following domains:



For 2013 There Are Four PQRS Programs:	Based on Reported 2013 Claims	Based on Reported 2014 Claims
1. Traditional PQRS Incentive	+0.5% payment in 2014	+0.5% payment in 2015
2. PQRS 3. Incentive	+0.5% payment in 2014	+0.5% payment in 2015
Total Potential PQRS Incentives	**+1.0% in 2014**	**+1.0% in 2015**
3. PQRS Penalties For Failure to Report	-1.5% in 2015	-2.0% in 2016
4. Value-Based Modifier (VBM)* For Failure to Report PQRS*	-1.0% in 2015	-1.0% in 2016
Total Potential PQRS Penalties	**-2.5% in 2015**	**-3.0% in 2016**

Stacie S. Jones, ACEP Director of Quality/Health IT



HEALTH POLICY/ORIGINAL RESEARCH

Assessment of Medicare's Imaging Efficiency Measure for Emergency Department Patients With Atraumatic Headache

Jeremiah D. Schuur, MD, MHS, Michael D. Brown, MD, MSc, Dickson S. Cheung, MD, MBA, Louis Graff IV, MD, Richard T. Griffey, MD, MPH, Azita G. Hamedani, MD, MPH, John J. Kelly, DO, Kevin Klauer, DO, EJD, Michael Phelan, MD, Paul R. Sierzenski, MD, RDMS, Ali S. Raja, MD, MBA, MPH

From the Department of Emergency Medicine (Schuur, Raja) and Center for Evidence-Based Imaging (Raja), Brigham and Women's Hospital, Boston, MA; Harvard Medical School, Boston, MA (Schuur, Raja); the Department of Emergency Medicine, Spectrum Health and Michigan State University College of Human Medicine, Grand Rapids, MI (Brown); Carepoint P.C., Denver, CO (Cheung); the Department of Emergency Medicine, Hospital of Central Connecticut, New Britain, CT, and University of Connecticut School of Medicine, Farmington, CT (Graff); the Washington University School of Medicine, Washington University Institute for Public Health, and Barnes-Jewish Hospital, St. Louis, MO (Griffey); the University of Wisconsin School of Medicine & Public Health, Madison, WI (Hamedani); the Department of Emergency Medicine, Albert Einstein Medical Center, and Jefferson Medical College, Philadelphia, PA (Kelly); Emergency Medicine Physicians, Ltd, Canton, OH, Michigan State University College of Osteopathic Medicine, and Summa Health System, Barberton and Wadsworth, OH (Klauer); the Emergency Services Institute, Quality and Patients Safety Institute, Cleveland Clinic, Cleveland, OH (Phelan); and the Department of Emergency Medicine, Christiana Care Health System, Newark/Wilmington, DE (Sierzenski).

Study objective: Computed tomography (CT) use has increased rapidly, raising concerns about radiation exposure and cost. The Centers for Medicare & Medicaid Services (CMS) developed an imaging efficiency measure (Outpatient Measure 15 [OP-15]) to evaluate the use of brain CT in the emergency department (ED) for atraumatic headache. We aim to determine the reliability, validity, and accuracy of OP-15.

Methods: This was a retrospective record review at 21 US EDs. We identified 769 patient visits that CMS labeled as including an inappropriate brain CT to identify clinical indications for CT and reviewed the 748 visits with available records. The primary outcome was the reliability of OP-15 as determined by CMS from administrative data compared with medical record review. Secondary outcomes were the measure's validity and accuracy. Outcome measures were defined according to the testing protocol of the American Medical Association's Physician Consortium for Performance Improvement.

Results: On record review, 489 of 748 ED brain CTs identified as inappropriate by CMS had a measure exclusion documented that was not identified by administrative data; the measure was 34.6% reliable (95% confidence interval [CI] 31.2% to 38.0%). Among the 259 patient visits without measure exclusions documented in the record, the measure's validity was 47.5% (95% CI 41.4% to 53.6%), according to a consensus list of indications for brain CT. Overall, 623 of the 748 ED visits had either a measure exclusion or a consensus indication for CT; the measure's accuracy was 16.7% (95% CI 14% to 19.4%). Hospital performance as reported by CMS did not correlate with the proportion of CTs with a documented clinical indication ($r=-0.11$; $P=.63$).

Conclusion: The CMS imaging efficiency measure for brain CTs (OP-15) is not reliable, valid, or accurate and may produce misleading information about hospital ED performance. [Ann Emerg Med. 2012;60:280-290.]

Please see page 281 for the Editor's Capsule Summary of this article.

OPPS M[illegible]sures i[illegible]etail

- ***OP-16 Troponi[illegible]r Emergency Department acut[illegible]rdial infarction (AMT) patients or[illegible]ain patients (with Probable Cardi[illegible]in) Received Within 60 minutes of[illegible]al***
- Outcomes?
- All Chest [illegible]atients?

OPPS Measures in Detail

- ***OP-19 Transition[illegible]rd with [illegible]ed Elements Received by Discharg[illegible]ient[illegible]***

- Major procedures and [illegible]rmed during ED visit, AND
- Principal diagnosis at di[illegible]OR chief complaint, AND
- Patient instructions, [illegible]
- Plan for follow-up [illegible]R s[illegible]nt that none required), including primary p[illegible], othe[illegible]hcare professional, or site designated fo[illegible]-up care, [illegible]
- List of new m[illegible]ons and changes to continued medications th[illegible]ents should take after ED discharge, with quantity prescr[illegible]and/or dispensed (OR intended duration) and instructions for each.

2014 IPPS Final Rule

(2016 Reimbursement)

- PN-3b: Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital has been removed from both the Hospital IQR and from the FY2016 Hospital VBP program, which ACEP supported
- AMI-8a: Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI) has been removed from the FY2016 Hospital VBP program. However, based on feedback from ACEP on this measure, CMS will continue to collect AMI-8a as part of the Hospital IQR Program for the FY2016 Payment Determination.
- ED-1: Median time from ED arrival to time of departure from the emergency room for patients admitted to the hospital; and
- ED-2: Median time from admit decision to time of departure from the ED for ED patients admitted to the inpatient status have been suspended for validation.
- The ED Throughput Measures are still finalized for the Hospital IQR Program Measures Adopted for the FY 2015 & FY 2016 Payment Determination and Subsequent Years.

CMS recognizes the importance of validating ED-1 and ED-2, and anticipates that their removal from validation will be temporary until they determine an appropriate

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- IV Acetaminophen

The Not So Affordable Care Act

- Premiums
- Deductibles
- Cancellations
- Medicaid Expansion
- $36 Million more insured
  - At what rate
- CMS Final Rule: 3% increased reimbursement
- Who's in the pool

Healthcare.gov
How's it Going?

- A Colossal Cluster
- First day: Reported millions signed up
  - Actual 6!
- November 6, 2013: 1,100 simultaneous users
- Silicone Valley Bail out
  - Estimated 5 million lines of code

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Maintenance of Certification

- Part I
- Part 2
- Part 3
- Part 4
  - PI and CP
  - PQRS Bonus 0.5%

ACEP-ABEM

CME for LLSA

Part 4

Part 2

ABEM

- 1. Complete at least one LLSA test in 2013 -- even if you have already met your current ABEM MOC requirements, meaning you didn't have to do one in 2013.
- 2. Attest to completing PI and CP activities on ABEM MOC Online by December 31, 2013 -- even if you have already met your current ABEM MOC requirements.
- 3. Apply for the PQRS MOC incentive through ABEM MOC Online by December 31, 2013. You will be charged a $25 fee by ABEM to prepare & submit your information to CMS.

AOBEM

Requirements for Participation in 2013 PQRS Incentive Program:

1. Maintain a valid unrestricted license in the United States.
2. Complete one of the following two options. (Do EITHER A or B)

1. **Exceed the CME requirement of 120 hours** in the three year cycle ending December 31, 2015. Documentation of 50 hours of CME **acquired during 2013** will satisfy this requirement. CMS requires these educational and self-assessment programs to have an assessment of what was learned.

OR

2. Successfully complete one COLA examination in 2013. Any COLA will satisfy this requirement.
3. Participate in and complete a Practice Performance Module as outlined in the AOBEM practice performance guidelines. Even if you achieve 100% on your initial evaluation, CMS requires a plan for improvement and a re-assessment after the improvement intervention is implemented.
4. Participate in and complete a Patient Experience of Care Survey. Information regarding this is available on this our web site. (You can use PG or PRC.)

Fill out the Attestation of completion form. **The AOBEM must receive this completed form by midnight Dec. 31, 2013.**

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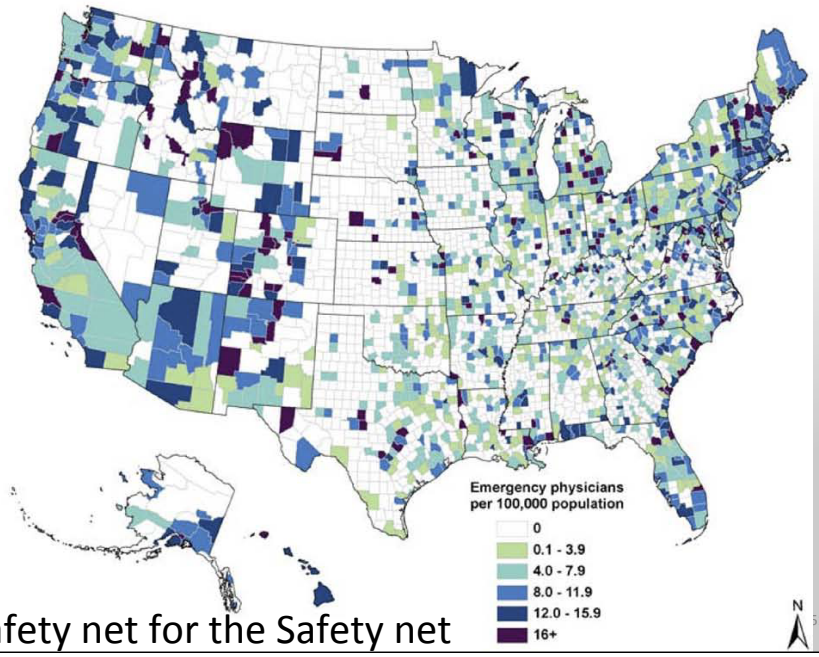
APPs & Scope of Practice

ED Workforce of the Future



Safety net for the Safety net

Clinical Advisor

Bryant Furlow

March 23, 2012

NP/PA roles set to expand with health care reform

On Monday, the U.S. Supreme Court will begin hearing arguments regarding the constitutionality of the Affordable Care Act and it's linchpin provision: the mandate that all adults secure health insurance policy. The Court may uphold the law in its entirety, strike down certain provisions, or repeal it entirely.

Midlevel provider's roles set to expand with health care reform

Passed in 2010, the Patient Protection and Affordable Care Act (ACA) aims to overhaul nearly every facet of the U.S. clinical health-care delivery system. In addition to securing health insurance coverage for 32 million previously uninsured Americans, the law places unprecedented emphasis on creating patient-centered medical teams through the development of personalized prevention plan services, pay-for-performance outcomes-based reimbursements, and financial incentives for clinicians to serve rural and low-income areas. These changes are expected to dramatically expand clinical roles for nurse practitioners and physician assistants.[1-3]

Define Who You Are

APP

Doctor

MLP

NPP

Physician Extenders

APC

- Cooperative approach between …?
  - SEMPA
  - ENA
  - AAPA
  - AANP

Scope of Practice

- Defined ….
- Level of Supervision
- Skill Competency
- Credentialing

Klauer K. Innovative staffing in emergency departments: the role of midlevel providers. CJEM. 2013 May 1;15(3):134-40.

Supervision

PAs compared to Nurse Practitioners?

- Autonomous
- Indirect Supervision
  - Consultation
  - No consultation
- Direct Supervision

AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

PROFESSIONAL ISSUES

ISSUE BRIEF

PHYSICIAN ASSISTANT SCOPE OF PRACTICE

October 2011

Scope of Practice

- Education and Experience
- State Law
- Facility Policies
- Physician Delegation

"The board does not recognize or bestow any level of competency upon a physician assistant to carry out a specific task**. Such recognition of skill is the responsibility of the supervising physician**. However, a physician assistant is expected to perform with similar skill and competency and to be evaluated by the same standards as the physician in the performance of assigned duties."

Wyoming Board of Medicine Rules and Regulations (2007). Chapter 5, Section 4d.

Credentialing

- Hospital Bylaws
- Delineation of Privileges
- Application
- Verification of training/competency

Credentialing

The Joint Commission

Those who provide "medical level of care" ***must use the medical staff process for credentialing and privileging***, making all [medical staff] standards applicable (including recommendation by the organized medical staff and approval by the governing body, OPPE, and FPPE).

APNs should request privileges only for those responsibilities involving medical level of care and not those responsibilities already allowed under the RN scope of practice.

APNs and PAs who provide "medical level of care" must be credentialed and privileged through the medical staff standards process

APNs and PAs who do not provide "medical level of care" utilize the human resources "equivalent" process detained in HR.01.02.05, EPs 10–15.

Coding Compliance

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Risk Management

The Current Malpractice Climate

2012 ASHRM Hospital Professional Liability Benchmark Analysis

- 1/25,000 ED visits
- Indemnity
  - 2002: $80,000
  - 2012: $158,000
  - 1 in 3
- CDC Ambulatory Care Study
  - 117 million ED visits in 2007
  - 94.9 million in 1997

Future claim severity expected to increase 4% annually
Loss Rate: $6.80 per visit

Bouncebacks?
30 Yrs
135,000 Pts
17

The Current Malpractice Climate High Risk Jurisdictions for 2012

State	% Exceeding $2 million
Wash, DC	11.4%
Fairfield, CT	10.3%
Philadelphia, PA	9.1%
South FL	8.6%
Cook County, IL	8.1%
New York City	4.8%
PA, excluding Phil	4.6%
Central FL	3.4%

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2 Midnight Rule

- Observation v. Full admission
- An admission lasting more than 2 midnights
- Reduce Obs admissions
  - Reduce burden on Medicare beneficiaries
- Long stay obs (>48 hrs)
  - 2006: 3% v. 2011: 8%
  - RAC (recovery audit contractor)
  - Review charts for verification of inpt admission
- Admitting Physician (?)

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3 Day Rule

- 2005: $2.6 Billion
- Patients & Families: $430 per day
- 1965: Implemented to avoid abuse of scarce outpatient beds (e.g. ECF)

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- 1. Avoid computed tomography (CT) scans of the head in emergency department patients with minor head injury who are at low risk based on validated decision rules. Minor head injury is a common reason for visiting an emergency department. The majority of minor head injuries do not lead to skull fractures or bleeding in the brain — which would need to be diagnosed by a CT scan.
- 2. Avoid placing indwelling urinary catheters in the emergency department for either urine output monitoring in stable patients who can urinate on their own, or for patient or staff convenience. These catheters are used to assist when patients cannot urinate, to monitor how much they urinate, or for patient comfort.
- 3. Don't delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit. This is medical care that provides comfort and relief for patients who have chronic or incurable diseases. Early referral from the emergency department to hospice or palliative care services can benefit patients, resulting in both improved quality and quantity of life.

ACEP's Choosing Wisely Submissions

- 4. Avoid antibiotics and wound cultures in emergency department patients with uncomplicated skin and soft tissue abscesses after successful incision and drainage and with adequate medical follow-up. Skin and soft tissue infections are a frequent reason for visiting an emergency department. Some infections, called abscesses, become walled off under the skin. Opening and draining the abscess is the appropriate treatment; antibiotics offer no benefit.
- 5. Avoid instituting intravenous IV fluids before doing a trail of oral rehydration therapy in uncomplicated emergency department cases of mild to moderate dehydration of children. Many children who come to the emergency department with dehydration require fluids. To avoid pain and potential complications, it's preferable to give these fluids by mouth instead of the use of an IV.

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BMJ open
accessible medical research

PAin SoluTions In the Emergency Setting (PASTIES); a protocol for two open-label randomised trials of patient-controlled analgesia (PCA) versus routine care in the emergency department

Jason E Smith,[1,2] Mark Rockett,[3] Rosalyn Squire,[1] Christopher J Hayward,[4] Siobhan Creanor,[5] Paul Ewings,[6] Andy Barton,[6] Colin Pritchard,[6] Jonathan Richard Benger[7]

EFFICACY OF PATIENT-CONTROLLED ANALGESIA FOR PATIENTS WITH ACUTE ABDOMINAL PAIN IN THE EMERGENCY DEPARTMENT: A RANDOMIZED TRIAL
Birnbaum, A., et al, Acad Emerg Med 19(4):370, April 2012

Physician-Initiated
>25%
4/67
0/70

- 206 Adults (18-65)
- Acute abdominal pain
- Randomized: MS regimen
  - 0.1mg/kg IV, then at discretion
  - PCA: 0.1mg/kg, then demand dose 1.0mg
  - PCA: 0.1mg/kg, then 1.5mg (6 minute lock out interval)
- 30 min: Decrease by 4; 30-120min: 0 &1.4

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CURB 65 Versus Pneumonia Severity Index

CURB-65, also known as the CURB criteria, is a clinical prediction rule that has been validated for predicting mortality in community-acquired pneumonia and infection of any site. The CURB-65 is based on the earlier CURB score and is recommended by the British Thoracic Society for the assessment of severity of pneumonia.

The score is an acronym for each of the risk factors measured. Each risk factor scores one point, for a maximum score of 5:

- **C**onfusion of new onset (defined as an AMT of 8 or less)
- **U**rea greater than 7 mmol/l (19 mg/dL)
- **R**espiratory rate of 30 breaths per minute or greater
- **B**lood pressure less than 90 mmHg systolic or diastolic blood pressure 60 mmHg or less
- age **65** or older

The risk of death at 30 days increases as the score increases:

- 0—0.7%
- 1—3.2%
- 2—3.0%
- 3—17.0%
- 4—41.5%
- 5—57.0%

Step 1: Stratify to Risk Class I vs. Risk Classes II-V	
Presence of:	
Over 50 years of age	Yes/No
Altered mental status	Yes/No
Pulse ≥125/minute	Yes/No
Respiratory rate >30/minute	Yes/No
Systolic blood pressure <90 mm Hg	Yes/No
Temperature <35°C or ≥40°C	Yes/No
History of:	
Neoplastic disease	Yes/No
Congestive heart failure	Yes/No
Cerebrovascular disease	Yes/No
Renal disease	Yes/No
Liver disease	Yes/No
If any "Yes", then proceed to Step 2	
If all "No" then assign to **Risk Class I**	
∑ <70 = **Risk Class II**	
∑ 71-90 = **Risk Class III**	
∑ 91-130 = **Risk Class IV**	
∑ >130 = **Risk Class V**	

Step 2: Stratify to Risk Class II vs III vs IV vs V	
Demographics	**Points Assigned**
If Male	+Age (yr)
If Female	+Age (yr) - 10
Nursing home resident	+10
Comorbidity	
Neoplastic disease	+30
Liver disease	+20
Congestive heart failure	+10
Cerebrovascular disease	+10
Renal disease	+10
Physical Exam Findings	
Altered mental status	+20
Pulse ≥125/minute	+20
Respiratory rate >30/minute	+20
Systolic blood pressure <90 mm Hg	+15
Temperature <35°C or ≥40°C	+10
Lab and Radiographic Findings	
Arterial pH <7.35	+30
Blood urea nitrogen ≥30 mg/dl (9 mmol/liter)	+20
Sodium <130 mmol/liter	+20
Glucose ≥250 mg/dl (14 mmol/liter)	+10
Hematocrit <30%	+10
Partial pressure of arterial O2 <60mmHg	+10
Pleural effusion	+10

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INTRAVENOUS ACETAMINOPHEN IN THE EMERGENCY DEPARTMENT.
Kwiatkowski, J.L., et al, J Emerg Nurs 39(1):92, January 2013

- FDA Approval 2010
- Avoids first-pass hepatic metabolism
  - Peak Concentrations: 15 min v. 1 hour
  - Max concentration 70% higher
- Comparable analgesic effects
  - Renal colic; Extremity injuries
- Contraindications: severe hepatic impairment or active liver disease
- Cost 1g: $10 v. $0.05

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Pushing the Plunger

- "The regulation you quoted has changed."
- "Our anesthesia regulation in 482.52 directs who may administer anesthesia. RN's or LPN's can never administer anesthesia (CRNA are allowed). Minimum and Moderated sedation is not anesthesia, therefore a trained RN can be a sedation nurse."
- "The professional who pushes the plunger on the syringe that contains a medication is the person who "administers" that medication. If that medication is for analgesia (minimal or moderate sedation) the medication may be administered by a trained RN under the personal supervision of the physician. However, if the medication is anesthesia, that medication can only be administered by a person qualified to administer anesthesia in accordance with 482.52 (in hospitals). Note that deep sedation is anesthesia."

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Social Media: Innocent fun?

- HIPAA-related Issues
  - Unauthorized disclosure of PHI
- Non-HIPAA-related Issues
  - Personal vs. Professional
- Friending your patients?
- ED Images
- ED Videos

Teaching Cases?

Potential Issues

- Login Used For Digital Radiography System
- All staff members are not created equal

Facebook case RI

- Dr. Alexandra Thran
- Posted recounts of patient encounters on FB
- No intentional disclosure of PHI
- The events were specific and allowed for 3rd party identification
- Medical Board
  - Unprofessional Conduct
  - $500 fine
  - Reprimand

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Boarding = Death

- Boarding *(Acad Emerg Med. 2011 Dec;18(12):1386-91)*
  A single Monday evening: 47% of 134 MI EDs
- Safety

THE ASSOCIATION BETWEEN EMERGENCY DEPARTMENT CROWDING AND ADVERSE CARDIOVASCULAR OUTCOMES IN PATIENTS WITH CHEST PAIN Pines, J.M., et al, Acad Emerg Med 16(7):617, July 2009

- 4,424 Adults possible ACS
- ACS: 18%
- Death, Cardiac Arrest, Delayed AMI, CHF, Dysrhythmias, HYN
  12% in ACS and 4% of others
- ED Crowding ACS Group: Lowest qrtile to Highest: OR (adverse event)
- Occupancy: 3.1; WR #: 3.7; Pt Care Hrs: 5.2

88

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Thank you !