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Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health

Title

Comprehensive Approach to Sustainable Reduction in Emergency Department Opioid Prescribing

Permalink

<https://escholarship.org/uc/item/85b0p788>

Journal

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 20(5.1)

ISSN

1936-900X

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Publication Date

2019

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0.617±0.13 and for the ED was 0.623±0.13. The Youden's index for these tests was 0.33 for physicians' scores and 0.22 for EMS scores.

Conclusion: Although this work is based on a small sample, the findings suggest that FAST-ED scores assessed by prehospital personnel were not different from those obtained by physicians at the ED. The FAST-ED score between the two groups had a comparable sensitivity, specificity and accuracy for predicting LVOS.

19 Comprehensive Approach to Sustainable Reduction in Emergency Department Opioid Prescribing

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Objective: Despite the strict regulation of opioids, the majority of individuals who develop opioid use disorder are introduced to opioids through prescription pain medication. While emergency physicians contribute minimally to the overall number of opioid prescriptions, they treat a high volume of patients with painful conditions and are often at least the initial prescriber of opioids for such patients. The present quality improvement (QI) project aimed to decrease the rate of opioids administered in the emergency department (ED) and prescribed at discharge.

Design and Method: The QI project consisted of three distinct interventions: 1) monthly non-anonymous feedback to all providers regarding their opioid prescription patterns compared to the provider group; 2) removal of hydromorphone from the decentralized, automated, medication dispensing system; and 3) addition of an "Alternative to Opioids" order set to the computer provider order-entry system. The intervention spanned a four-month period from October 2018 to January 2019 in a 27-bed community hospital ED that sees about 50,000 patients annually. We compared opioid administration and prescription to the same months in the preceding year to account for seasonal variation.

Results: There were 12,897 patient-visits in the pre-intervention period compared to 12,372 in the post-intervention period. The normalized morphine milligram equivalents (MME) administered and prescribed per patient decreased 32.3% from 10.2 to 6.9. The average MME of opioids administered before and after the intervention (12.6 vs 12.9, $p = 0.33$) or prescribed for outpatient therapy (72.6 vs 69.1, $p = 0.11$) did not differ. The exposure of our

community to opioids was reduced by 45,800 MME over the study period.

Conclusion: The intervention produced a significant and sustained reduction in the administration and prescription of opioids. The average dose administered did not differ, suggesting that patients who required opioid pain control were not undertreated. Fewer individual patients were exposed to opioids as part of their treatment, theoretically decreasing the risk of dependence, abuse, and addiction. The intervention required minimal resources to implement and is easily scalable to a variety of settings.

20 Telephone Follow-Up After Pediatric Emergency Department Discharge – Does It Impact the Likelihood of Return Visits?

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Background: Successful transitions of care from the pediatric emergency department (ED) to home can be impacted by comprehension of discharge instructions, medication adherence, and primary care follow-up. Post-discharge communication has been used to identify barriers to ongoing care after discharge. While follow-up calls after ED discharge have been associated with improved adherence and primary care follow-up, some research suggests a higher likelihood of return visits for patients called. In this study, we analyzed predictors of nurse-directed telephone follow-up after discharge from a pediatric ED and the rate of return visits.

Methods: We performed a retrospective cohort study of patients <19 years old discharged from an academic pediatric ED between 3/1/2015-8/31/2016. Staff nurses called discharged patients within 72 hours with a standardized survey to assess follow-up and symptoms. We used multivariate logistic regressions to evaluate relationships between patients called, those reached, and those not called, and 72-hour and seven-day return visits. These data were controlled for by age, insurance type, and race.

Results: Of the 25,152 patients discharged from the pediatric ED during this time period, 7378 (29%) had calls attempted; 4110 (16.3%) were reached and completed the survey. Patients reached were less likely to return in 72 hours compared to those not reached (2.6% vs 5.4%; adjusted odds ratio [aOR] 0.5; 95% confidence interval [CI], 0.40-0.59). Similarly, patients reached were less likely to return within seven days (6.0% vs 8.2%; aOR 0.71; 95% CI, 0.62-0.82) (Table 1). Few patients needed clarification on instructions