

# Emergency Department Visits

## TOOLKIT

### Overview

An increasing number of people are using hospital emergency departments (ED) for non-urgent care and for conditions that could have been treated in a primary care or urgent care setting. Reducing this trend improves quality and lowers costs in health care and appropriately channels patient care to primary care settings.

This toolkit can help clinics implement systems and processes that support patient care outside of the ED when appropriate. This toolkit also includes follow-up actions to take within 7 days of an ED visit to help the patient transition from the ED to the community. Providing excellent care coordination reduces risk for medication error, repeat ED visits, hospitalization, nursing home admission and death.

The bookmarks below navigate to specific checklists that impact utilization.

- **Preventing avoidable ED visits** (Diagnosis Code Source: *Oregon Health Authority*)
  - Access
  - Data
  - Care Coordination
  - Patient Education
  - Practitioner/staff education
  - Other office systems
- Follow-up after an ED visit



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## Access [back to top](#)

- ☐ Meets Legacy Health Partners [access standards](#) (*login required to open*)
- ☐ Tracks/utilizes third next available data or some other measure of access
- ☐ Offers extended hours (early morning, evenings, and/or weekends)
- ☐ Reserves same-day or next-day appointments for acute needs
- ☐ Offers virtual follow-up visits for patients discharged from the ED
- ☐ Offers alternative communication/delivery of care, for example: online communication or group visit
- ☐ Has access to care policies in place that address:
  - ☐ How quickly phones are answered
  - ☐ Triage/clinical advice
  - ☐ Handling of post-ED/urgent care notifications (electronic/fax)

## Data [back to top](#)

- ☐ Identifies where a majority of practice's patients present to the ED: \_\_\_\_\_

## Care Coordination [back to top](#)

- ☐ Shares pain contracts and acute care plans with above facilities
- ☐ Calls ED to notify them the patient is coming in and sends conversation/notes before patient arrives
- ☐ Routinely receives electronic/fax notification for ED/hospital visits from local hospitals

## Patient Education [back to top](#)

- ☐ Provides a welcome letter or onboarding process for patients to explain emergent/urgent/non-urgent care and how/when to access each
- ☐ Uses variety of patient education opportunities like hold messages, signage or messages on statements
- ☐ Uses action plans for chronic disease
- ☐ Uses teach-back methods to confirm patient understanding

### ***SIGN EXAMPLE***

#### **Call us first!**

Use the 24-hour care line when you:

- Are sick or hurt
- Can't decide whether to go to the doctor or the emergency room
- Need advice on an urgent health need

**CALL THE CLINIC NUMBER  
(XXX) XXX-XXXX**

## Practitioner/staff education [back to top](#)

- ☐ Roles and expectations around ED referral and follow-up. Non-clinical staff should never be allowed to direct a patient to the ED.
- ☐ Policies for timely follow-up to after-hours patient needs
- ☐ Policies/procedures to identify high utilizers and refer them to behavioral health, health partner, or appropriate internal/external resources
- ☐ Staff use standardized scripting for post-ED outreach
- ☐ Uses standardized post-ED outreach documentation

## Other office systems [back to top](#)

- ☐ Appropriate recall systems in place for chronic disease
- ☐ Standing orders for flu/pneumonia vaccines
- ☐ Policies/procedures for routine depression/drug/alcohol screening
- ☐ Policies/procedures for fall risk screening/prevention
- ☐ Policies/procedures for patients with chronic pain

## Follow-up after an ED visit [back to top](#)

Patients should have a follow-up or service **within seven days** of their ED visit to support their transition and coordination of care.

- ☐ Establish relationship with area hospitals and emergency rooms to develop a notification process of visits
- ☐ Review all ED discharge notices daily, and outreach within three to five days to schedule the patient within seven days following an ED visit (visits can be via telehealth, E-visit, or virtual check-in)
- ☐ Contact patient as soon as ED discharge notification is received and a) schedule follow-up visit as soon as possible or b) ensure patient has follow-up visit scheduled with appropriate specialist.
- ☐ Educate patients on the importance of follow-up and adherence to treatment recommendations.
- ☐ Reschedule cancelled appointments.
- ☐ Coordinate care with behavioral health practitioners by sharing progress notes and updates.
- ☐ Consider telemedicine visit when appropriate

## For people with multiple high-risk chronic conditions

For patients with multiple chronic conditions\* there are specific actions and coding needed for measure compliance within seven days of their ED visit.

### Actions needed for compliance:

Patients must have a follow-up visit or service within seven days of the emergency visit:

- Outpatient or telephone visit (with or without telehealth modifier)
  - There must be meaningful dialogue between the staff and patient demonstrating review and education has been completed about the reason for the ED visit.
  - A telephone visit can be conducted by the following to satisfy the measure: Physician, Physician Assistant, Registered Nurse, Licensed Practical Nurse, or Medical Assistant. Anyone the provider office delegates this task to.
- Behavioral health visit/phone or face-to-face visit
- Community mental health center visit
- Transitional care management services
- Case management visits or complex care management
  - Requires face-to-face services.
- An intensive outpatient encounter or partial hospitalization
- Electroconvulsive therapy with POS code 24, 52 or 53
- E-visit or virtual check-in
  - Must be initiated by the patient, conducted via patient portal and meet duration of code requirement.
- Substance use disorder (SUD) or SUD counseling/surveillance
- Documentation that the patient refused follow-up (as long as the documentation refers to the ED follow-up)

### \*Eligible chronic conditions:

- COPD/ Asthma/ unspecified bronchitis
- Alzheimer's disease and related disorders
- Chronic kidney disease
- Major depression/ dysthymic disorder
- Heart failure/ cardiomyopathy
- Acute myocardial infarction
- Atrial fibrillation
- Stroke/ transient ischemic attack

### Additional best practices for these patients:

- ☐ Identify patients with chronic conditions by scheduling an Annual Wellness Visit (AWV)
- ☐ Educate patients about emergency care and the need to follow up immediately following an Emergency Department (ED) visit
- ☐ Develop standard policies around managing chronic condition patients (PCP checkups, provide written guidelines as to when to follow up and where to seek care)
- ☐ Plan other outreach activity to notify patients with qualifying conditions and events (phone call, email, letter, reminder at every visit)

### Commonly used claim codes to close gap

*\*Not a comprehensive list of codes*

*If appropriate codes are used, copies of medical records may not need to be submitted.*

|                                                  |                                          |
|--------------------------------------------------|------------------------------------------|
| Outpatient ED, telehealth and nonacute inpatient | <b>98966</b>                             |
| Care management                                  | <b>99489</b>                             |
| Case management                                  | <b>99366</b>                             |
| Transitional care                                | <b>99496</b>                             |
| Behavioral outpatient                            | <b>99078</b>                             |
| <b>Exclusions:</b>                               |                                          |
| Inpatient stay:                                  | <b>0100, 0101</b>                        |
| Acute inpatient:                                 | <b>99221, 99222, 99234, 99235, 99255</b> |

### Use documentation within the medical record to close gap

Include follow-ups through:

- Explanations of medical decision or care coordination
- Involvement/inclusion of provider(s)
- Counseling
- Patient education
- Ordered diagnostics or labs
- New or changed treatments and orders

## Template of Medical record components

This template outlines medical record documentation elements for following-up with patients after an Emergency Department Visit. Documentation must be dated within the seven-day timeframe or on day of discharge from ED visit:

|                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient Name                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Patient Date of Birth                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Provider/practice identifier             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Date of service                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Reason for encounter                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Type of encounter                        | <input type="checkbox"/> Telephone visit<br><input type="checkbox"/> Transitional care management<br><input type="checkbox"/> Care management<br><input type="checkbox"/> Non-face-to-face encounter with non-physician personnel                                                                                                                                                                                                                                  |
| Emergency department details             | <input type="checkbox"/> Admission date<br><input type="checkbox"/> Discharge date<br><input type="checkbox"/> Discharge disposition<br><input type="checkbox"/> Services rendered in ED (i.e., labs, tests, results, care provided, date collected)                                                                                                                                                                                                               |
| Discharge instructions and plan reviewed | Identify medication(s)<br><input type="checkbox"/> New medication with reason including dose/frequency<br><input type="checkbox"/> Changes in doses (include change and reason)<br><input type="checkbox"/> Stopped (include what medication stopped or held and reason)<br><input type="checkbox"/> No changes noted (continue taking all current medication as prescribed; no changes made in ED)<br><br>Document review of discharge instructions and education |
| Ability to manage medications            | Assess and document patient or caregiver's ability to manage medications                                                                                                                                                                                                                                                                                                                                                                                           |
| Red flag symptoms                        | Assess patient or caregiver's knowledge of worsening condition, what to do, or who to contact                                                                                                                                                                                                                                                                                                                                                                      |
| Provider/nurse counseling                | Document counseling could include details reviewed with the patient:<br><input type="checkbox"/> Patient education<br><input type="checkbox"/> Changes in treatment provided at time of outreach<br><input type="checkbox"/> New orders<br><input type="checkbox"/> Additional counseling                                                                                                                                                                          |

**Legacy Health Partners**

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