A large, light gray outline of a briefcase with a handle and a latch, serving as a background for the title text.

**EDIE/PreManage
Information Sharing
Resource Guide
for Oregon Users**

Table of Contents

Overview	3
Definition of Features	3
Key Recommendations	4
Organizational Roles	5
Care Team	6
Care Team Assignments.....	6
Editing and Updating Provider Entries	7
Care History	8
Care History Suggested Content	8
Care Guidelines	9
Care Guidelines Suggested Content.....	10
Behavioral Health Information Sharing	11
Security and Safety	12
Appendix	13
Oregon Statewide Criteria for Hospital EDIE Notifications	13
EDIE Notification Headers and Format	14
Care History and Care Guidelines Examples	15

Overview

EDIE/PreManage are tools developed by Collective Medical (CM) which provide powerful, real-time information to users about ED utilization activity. Users with access to EDIE/PreManage can view the information on demand for patients in their care.

In addition, EDIE/PreManage provide a place where users can contribute critical information about high risk patients to assist ED providers in patient care and treatment.

The purpose of this Resource Guide is to provide information that promotes the consistent use of specific EDIE/PreManage features (Care Team, Care History, Care Guidelines, Security and Safety) to facilitate improved communication and cross organizational care coordination in Oregon.

Some state and federal laws provide special protections for certain categories of patient information. Psychotherapy notes and information from providers that hold themselves out as Alcohol and Drug treatment programs may not be uploaded into PreManage except in an emergency or with specific patient consent.

Additional privacy and security resources are available from CM at the following links:

<https://www.collectivemedicaltech.com/privacy-security/>

<https://www.collectivemedicaltech.com/about-us/CMT-policies/>

Definition of Features

CM Note: *In Fall 2018, CM added new terminology on the patient detail view. The term “Insights” was added as a section header for both the “Care History” and “Care Guidelines” features. Users may still hear these sections referred to as “Care History” and “Care Guidelines” but we’ve included the term “Insights” below to keep consistent with the new view in the PreManage portal.*

Care Team: Section where information about the care team is located, including providers, care managers, etc. Information in this section comes from four different sources: (1) hospitals at time of admission (2) primary care or behavioral health provider clinics from most recent patient roster (3) health plans from current membership files and (4) care coordinators based on their active caseload of patients. When patients admit at a hospital and an EDIE notification is triggered, the patient’s current list of providers will be included in the notification. (See appendix for Oregon statewide criteria for triggering EDIE notifications.)

Insights—Care History: Section where objective information related to the patient’s history can be collaboratively entered by multiple care managers/coordinators from various organizations. If there is information in any tab in this section it will be sent in the EDIE notification to hospitals with or without a care guideline.

Insights—Care Guideline: Section where brief information that is relevant to a patient’s treatment in an ED setting is entered, including care considerations, care coordination details, pain management information, suggested ED-based interventions, and any other information that is considered relevant. Care guidelines are entered and maintained by one user with input from the patient’s entire care team, if possible. EDIE notifications sent to hospitals include the most recent care guideline for the patient (regardless of author) and will include a second care guideline if one is authored by the hospital receiving the EDIE notification.

Security and Safety: Section where important information about security and safety risks associated with a patient can be documented. When information is added to this section, it will trigger an EDIE notification to the hospital at the time of the patient visit.

Key Recommendations

What to Do:

- Provide Information that is brief, patient specific and relevant in an ED setting
- Put information about your organization’s care team members (care managers, social workers, etc.) in the Care Team section
- Include factual, objective information in the Care History section
- Create a single Care Guideline that includes succinct, patient specific care considerations—use bullet points—no more than 5-6
- Add Security and Safety Events in that section and NOT in Care Guidelines

What NOT to Do

- Use generic information or phrases (e.g., “Don’t give narcotics”)
- Copy and paste large care plans
- Create duplicate care guidelines
- Include unnecessary information
- Include psychotherapy notes
- Include information about current substance abuse treatment programs
- Include acronyms
- Add or edit other organization’s information in the Care Team box

Organizational Roles

EDIE and PreManage users often ask—"how do we determine which organization does what?" This will often depend on the community and which organizations are involved in managing high risk, high needs populations. The following roles are suggested as a default—acknowledging that the best results will be realized from organizations defining together what their respective roles should be in each community or region.

Emergency Department:

- Contributes relevant information to the Care History Section (shared space for information from various users)
- May create a care guideline if the patient is not established with a primary care provider, or the primary care provider does not have access to PreManage
- When creating care guidelines, they should be done whenever possible in collaboration with any other known care providers (primary care, behavioral health, health plan)
- EDIE notifications sent to hospitals for patients who seek care at their facility will include the most recent care guideline regardless of author

Primary Care:

- Contributes relevant information to the Care Team and Care History sections
- Usually takes the lead on the development of the care guideline for established patients in collaboration with other known care providers (including ED(s) where patient has most often been seen)

Behavioral Health:

- Contributes relevant patient information in the Care Team and Care History sections (on topics such as Behavioral Health, Substance Use History)
- Contacts care providers who have developed care guidelines to contribute information and updates on patients in their care
- May take the lead on developing care guidelines for patients where they have the primary relationship

Other Providers (SNF, AAA/APD, EMS, etc.):

- Contributes relevant information to the Care Team and Care History sections
- Generally, does not create care guidelines. Contacts primary care provider to contribute information and updates on patients in their care

Health Plan:

- Contributes relevant information to the Care Team and Care History sections
- Generally, does not create care guidelines, but may initiate care conference with others involved in the care of the patient to agree on information to be included in a coordinated care guideline
- May enter care guidelines on behalf of other organizations

Care Team

The Care Team is the place to document members of the patient care team including primary care provider, behavioral health providers, care coordinators, social workers, etc.

The Care Team displays individuals (providers, care managers) and organizations with associations to patients. Four different sources of information can populate the Care Team (1) hospitals at time of admission (2) primary care or behavioral health provider clinics from most recent patient roster (3) health plans from current membership files (4) care coordinators based on their active caseload of patients. At a minimum, each entry contains the associated provider’s primary specialty and typically contains contact details such as phone number, fax number, and/or email.

Having this information available and in a consistent place is highly valued by all care team members. When patients admit at a hospital and an EDIE notification is triggered, the patient’s current list of providers will be included in the notification to assist ED providers with care coordination needs.

Care Team Assignments

Care Team information from any source can be contributed in two ways:

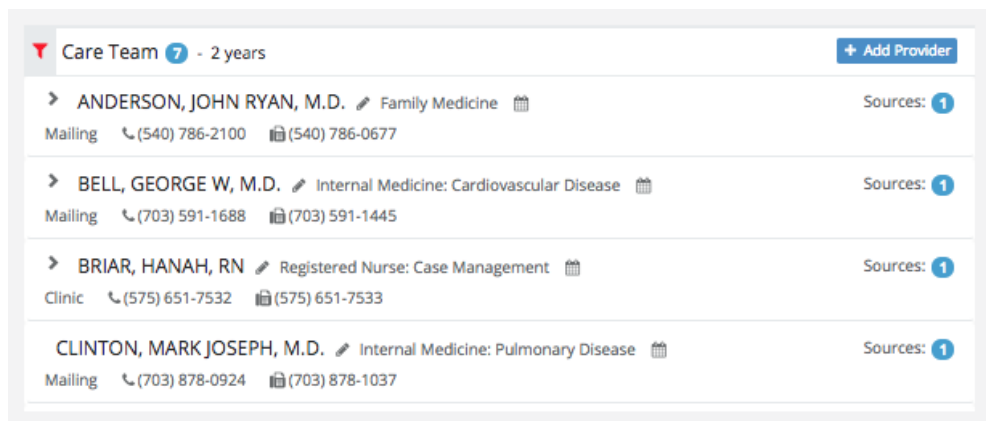
- Automated entries through eligibility files or data feeds
- Manual entries through the web portal

Automated entries are managed by organization IT staff/departments on an ongoing basis. Ongoing provider-patient assignments, such as primary care provider relationships, should be loaded through automated processes.

However, individual users with access to PreManage can contribute information through manual entries. This is especially helpful for users such as care managers who are actively managing patients seeking care routinely in the ED setting.

Adding Providers via Manual Web Portal Entries

To add a provider to the **Care Team** via the web portal, select the blue “Add Provider” button from the Care Team module of the desired patient and complete the information in the dialog box:



The screenshot shows a web portal interface for a patient's Care Team. At the top, it says "Care Team 7 - 2 years" and has a blue "+ Add Provider" button. Below this is a list of four providers, each with a right-pointing chevron icon, their name, specialty, and contact information. Each provider entry also has a "Sources: 1" indicator. A blue arrow points to the "+ Add Provider" button.

Provider Name	Specialty	Contact Information	Sources
ANDERSON, JOHN RYAN, M.D.	Family Medicine	Mailing (540) 786-2100 (540) 786-0677	1
BELL, GEORGE W, M.D.	Internal Medicine: Cardiovascular Disease	Mailing (703) 591-1688 (703) 591-1445	1
BRIAR, HANAH, RN	Registered Nurse: Case Management	Clinic (575) 651-7532 (575) 651-7533	1
CLINTON, MARK JOSEPH, M.D.	Internal Medicine: Pulmonary Disease	Mailing (703) 878-0924 (703) 878-1037	1

Note: Users should only add or edit information about providers they have firsthand knowledge about— such as yourself, someone on your care team, or someone from your organization’s care team. Do not add or edit information you are unsure about—such as information about providers from other organizations. If you see something that is incorrect, contact the organization who added the information and ask them to edit it through their own access to PreManage.

Note: Providers with NPIs (National Provider Identifier) should be entered using their CMS issued 10-digit NPI number. To search for provider NPIs visit: <https://npiregistry.cms.hhs.gov/>

For providers who do not have NPIs, such as care or case managers and care coordinators, use the CMS Health Care Provider Taxonomy Codes to enter the information in a standardized way:

- Code: 171M00000X
- Grouping: Other Service Providers
- Classification: Case Manager/Care Coordinator

For full provider code list see: <http://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/code-lookup-mainmenu-50>

Editing and Updating Provider Entries

Any providers added manually through the web portal should be maintained by the user who entered the information so that the ED providers have the most current information on care managers or care coordinators working with the patient.

Users can enter dates in the Assignment Range boxes when adding a provider so that the provider assignment is automatically removed after a future end date (e.g., 6 months from engagement with a patient). Users can also edit provider information at any time by doing the following:

- Click the pencil edit icon next to the provider’s name
- Update desired provider information
- Click “Update”

To immediately remove a provider from the Care Team, complete the following steps:

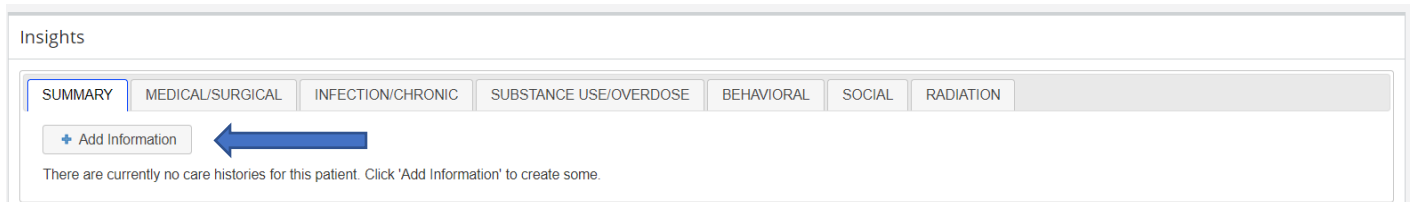
- From the Care Team module of the desired provider, select the pencil edit icon
- Enter an Assignment Range end date that is older than the current date for immediate inactivation, or a future date that will expire the relationship in the future
- Click “Update”

Care History

The Care History section is for **objective** information (“just the facts”) related to the patient’s history. Information to incorporate in this section includes medical diagnoses, previous surgeries, and allergies. Any EDIE/PreManage user with access to a patient record can add information in this section and can contribute to a shared understanding of the patient’s background. This means multiple care managers/coordinators across organizations can contribute information to this section rather than creating a duplicate care guideline.

NOTE: There are six tabs that allow you to organize the type of information you’d like to include. Even if only one of the six tabs is completed, this will trigger the delivery of the Care History to the ED. Therefore, you don’t need to complete all the sections for the information to be sent.

To add a **Care History**, click on the “Add Information” button and fill in the tabs as appropriate:



Care History Suggested Content

Recommended Tab	Example Entry
Medical/Surgical	<ul style="list-style-type: none"> • Patient has a history of kidney stones, diabetes and asthma
Infection/Chronic	<ul style="list-style-type: none"> • Patient has MRSA • Patient has chronic back pain
Substance Use/Overdose	<ul style="list-style-type: none"> • Alcohol Dependence • Patient with history of intermittent sobriety. • Multiple prior detox episodes. • Patient is not currently engaging in an identified Chemical Dependency treatment plan.
Behavioral	<ul style="list-style-type: none"> • Patient often presents with various pain complaints, including presenting after having been assaulted and requesting pain medicine for this.
Social (community services used by, or available to, the patient)	<ul style="list-style-type: none"> • Patient has transportation through Tri-Met lift. • Patient should be strongly encouraged to meet with his Parole Officer who is trying to help patient get access to housing and treatment.
Radiation	<ul style="list-style-type: none"> • Has received multiple negative imaging studies for abdominal pain

Care Guidelines

Care Guidelines are a powerful part of PreManage intended to deliver brief, critical information to ED providers at the point of care (i.e., information delivered in a hallway conversation). Information should be entered in succinct, bullet point format with no more than 5-6 bullet points per tab. When information is entered in this section it will automatically be sent to the ED once the patient presents.

There are five tabs that allow you to organize the type of information you'd like to include:

- **Care Recommendation:** A guideline for how a condition should be treated or has been successfully treated in the past
- **Care Coordination:** An explanation of the coordinated efforts in regard to this patient's care
- **Pain Management:** A guideline for how the patient's pain should be managed, including pain contracts, authorized pain prescriber, etc.
- **Helpful ED-Based Interventions to Try:** A list of helpful interventions that have been successful in prior ED visits
- **Other Information:** This tab should be used with caution as the most relevant patient information can likely fit into one of the other tabs above or in the Care History section.

NOTE: Even if only one of the five tabs is completed, this will trigger the delivery of the Care Guideline to the ED. Therefore, you don't need to complete all the tabs for the information to be sent.

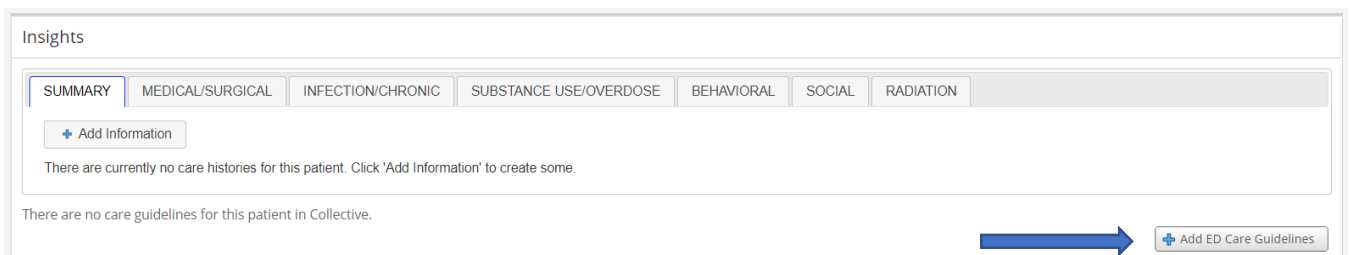
Ideally there should be one care guideline for each patient, developed by the individual who has the most first-hand knowledge of the patient in collaboration with others who are involved in their care.

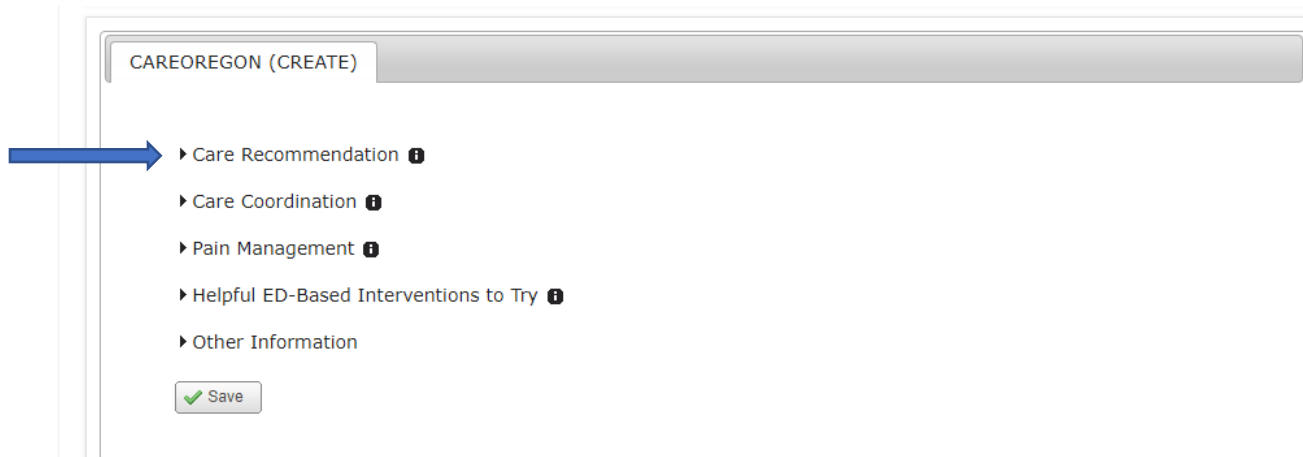
Care Guideline authors are encouraged to keep the guidelines up to date (e.g., review and update guidelines *every 3-6 months*) in collaboration with a patient's care team.

NOTE: Users can view a list of Care Guidelines in need of updates on the PreManage Groups page in the portal (see Groups page, "Patients with Due or Inactive Guideline").

Care Guidelines remain viewable in a patient record for 18 months without updates. After that time, they are no longer sent to the ED but remain attached to the patient's record and are viewable in PreManage for further editing or deletion.

To add a **Care Guideline**, click on the **"Add ED Care Guideline"** button and fill in the tabs as appropriate:





Care Guidelines Suggested Content

Recommended Content	Example
Goals for patient care	<ul style="list-style-type: none"> • PCP recommends hospice, but family is hesitant
Specific treatment protocols/guidelines	<ul style="list-style-type: none"> • Low dose haloperidol effective for acute agitation
Outpatient care patient is currently receiving so ED can redirect patient back to appropriate care	<ul style="list-style-type: none"> • Pt requires paracentesis weekly for cirrhosis, f/u with Dr. Jones every Wednesday
Presence of a pain contract	<ul style="list-style-type: none"> • <i>Note who the prescriber is and a brief description:</i> • Patient has a pain contract with PCP, Dr Jones • Receives 10mg Norco bid for chronic back pain • Patient has agreed not to receive pain medications from any other source unless a new acute issue, or will be in violation of pain contract
Baseline presentation	<ul style="list-style-type: none"> • At baseline patient lists to the left, has shuffling gait, poor short-term memory
Tips/strategies for engaging with the patient	<ul style="list-style-type: none"> • Patient calmer when mother present, music helps alleviate anxiety
Engagement in primary care	<ul style="list-style-type: none"> • Patient has not seen PCP in over 1 yr. despite repeated outreach. • Please attempt to schedule if patient presents to ED
Availability of Care Team member to intercept ED visit	<ul style="list-style-type: none"> • ACT team available to attend ED visit, please call phone# in Care Team as soon as patient presents to ED
Successful interventions to redirect ED over utilization	<ul style="list-style-type: none"> • Set clear limits, patient will be inappropriate or aggressive, will use manipulation maneuver to get what she wants. • Limit comfort measures

Behavioral Health Information Sharing

Some state and federal laws provide special protections for certain categories of patient information. However, other patient information can be shared to help coordinate care for patients with behavioral health history.

Sharing Behavioral Health information

What Can be Shared:

- Mental health/behavioral health information for health care or care coordination purposes
- Substance use history and treatment (unless CFR 42 Part 2 Provider)

What Cannot be Shared:

- Psychotherapy Notes
- Substance use disorder treatment (CFR 42 Part 2 providers)

Helpful information for ED Providers:

- Patient's usual presentation
- Hx of suicidal ideation
- Hx of substance use, treatment (unless CFR 42 Part 2 provider)
- Relevant IP psychiatric admissions
- Complex psychiatric medications
- Enrollment in special programs (e.g. ACT), particularly if they receive real time notifications and could potentially respond by phone or in-person to the ED

Information not helpful in an ED setting:

- Names for specific care providers/case managers- should be documented in the Care team
- Extensive social history

Security and Safety

The Security and Safety section in PreManage should be used to alert ED providers about patients who may pose a threat to themselves or to providers and others in the ED setting. Security Events should NOT be completed for every patient but used only for those patients who have a history of violence to others, self-harm, elopement, etc. Some organizations have also used to Security and Safety Events to inform the ED of serious medication allergies and alerts. In all cases, Security Events should be added with agreement from the patient’s care team, including primary care providers, case managers and others. High risk huddles and care conferences are a great place to discuss the need for and agree upon Security Events.

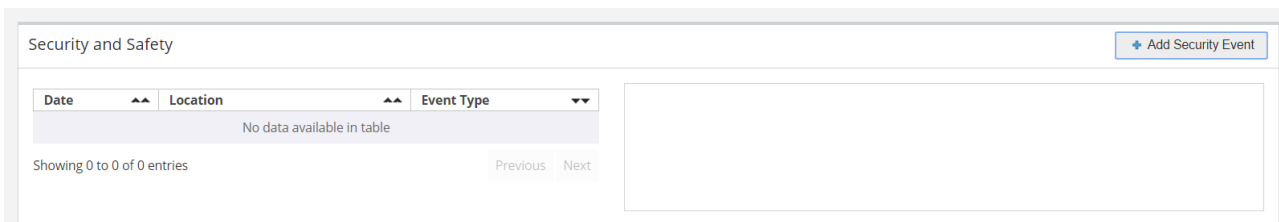
Note: This type of critical information should be entered as a Security and Safety alert and NOT in the Care Guideline section where it can be potentially overlooked among the other information in that section.

When Security Events are added to a patient record, they will trigger an EDIE notification to the hospital when the patient admits. Security Events are also visible in the PreManage portal by a yellow banner which appears at the top of the patient record.

How to Add a Security Event

Consistent with the guidance around entering Care Guidelines, Security Events should be added in the context of a high-risk huddle or interdisciplinary care team managing the patient’s care. In most cases, this will include the patient’s primary care provider if they are established with primary care. In other cases, the member of the care team with the most knowledge and deepest relationship with the patient may enter the Security Event. Any PreManage user with access to enter/edit care guidelines can also enter security events. As with Care Guidelines, users are strongly encouraged to keep these Security Events updated and remove them when they no longer apply to the patient. This is best achieved in the context of the high-risk huddles when patient cases are reviewed and information in PreManage can be updated to match the current state of the patient.

Security Events are located below the Care Guidelines section in the PreManage portal. To add a **Security Event**, click on the “Add Security Event” button and complete the fields in the dialog box:



Appendix

Oregon Statewide Criteria for Hospital EDIE Notifications

The information shared by PreManage users in the Care Team, Care History, Care Guidelines, and Security and Safety sections is included in EDIE notifications to hospitals at the time of patient admission.

EDIE notifications are not sent to hospitals for every patient admitting, but are triggered based on agreed-upon statewide criteria (and any additional hospital-specific criteria as requested by a hospital):

- Patient has Care Guidelines
- Patient has Care History
- Travelling patients: ED visits at 3 different hospitals in 60 or 90 days
- 5 ED visits in 12 months
- Security Event
- PDMP (for those hospitals that have been credentialed for PDMP)*;

*PDMP (Prescription Drug Monitoring Program): There are six unique criteria that were originally developed by the State of Washington and have been adopted by the Oregon College of Emergency Physicians (OCEP) for application across all PDMP connections to EDIE in the state. The following criteria will trigger a PDMP report through an EDIE Notification:

1. Three (3) or more prescribers within 12 months;
2. Four (4) or more controlled substance II-V prescriptions within 12 months;
3. Two (2) or more controlled substance II-V prescriptions within last 40 days;
4. Any prescription for Methadone, Suboxone, fentanyl transdermal, LA morphine, and LA oxycontin within last 6 months;
5. Any overlapping prescriptions for narcotics (controlled substance II-V) and benzodiazepines within last 6 months;
6. More than 90 average MED (morphine equivalents)/day prescribed within the last 15 days

The PDMP report is triggered for a patient who meets one or more of the above 6 criteria. The PDMP report then populates as a distinct segment of the EDIE notification and includes a 6 month look back on that patient's prescription history.

Hospital EDIE Notification Headers and Format

Note: Collective Medical is currently standardizing the format of hospital EDIE notifications to better support care coordination. Below is the list of notification subject headers that will be included in EDIE notifications statewide, in expected order and format. However, Collective Medical may adjust the final order of headers per customer input.

Header

- Patient name
- MRN
- Date

Criteria Met

Security Event(s)

- Security type
- Date
- Notes

Care Guideline

- Most Recent Guideline from another facility
- My Facility Care Guideline (unless it's the most recent)

Care Hx

Notable Program Enrollment and Groups ED Encounter Count

- 12 month visit history by facility

ED Encounter Summary

- Most recent 10 (5 Stretch Goal) ED Visits in the last 12 months
- ED Name
- City
- State
- Diagnosis or Chief Complaint

IP Encounter List

- All IP visits in the last 3 months
- Admit date
- Hospital name
- City
- State
- Diagnosis or Chief Complaint

PDMP (Displays only when available)

- 6 month medication history
- Drug name, dose, route
- Dispensed date
- Prescribing provider
- Quantity dispensed

Recent Anticoagulant

- Timeframe alert is 200% of days supplied
- Drug name, dose, route
- Dispense date
- Provider
- Days supplied

Care Team

- Name
- Specialty and role
- Phone, fax, email

More info portal URL

POLST/Advance Directive

Footer

Care History and Care Guidelines Examples

Below are user-provided examples of Care History and Care Guidelines. We've provided some "Good Examples" first to provide users with ideas about what to include in these sections in PreManage. We've also provided some "Bad Examples" to give users an idea of what is NOT helpful—primarily because the information is too generic to be useful for ED providers in caring for high risk patients.

Good Examples of Information to Include

Example 1: PATIENT ESTABLISHED WITH PRIMARY CARE

CARE GUIDELINE:

Care Recommendation:

- Pt established with Family Practice—see Care Team contact info.
- Pt has standing order for paracentesis with interventional radiology.
- Pt now established with GI.

Care Coordination:

- Pt offered that he has veterans status yet declined any desire for association with VA for benefits/services.

Pain Management:

- Chronic Pain Agreement 09/20/2017 - Oxycodone CR and Gabapentin. Osteoarthritis: Chronic low back pain, right hip pain s/p replacement now with leg length discrepancy, bilateral knee pain.

Example 2: PATIENT ESTABLISHED WITH PRIMARY CARE

CARE HISTORY:

Substance Use:

- Hx of IVDU (heroin), per pt, last use was 3 months ago

Pain Management:

- Chronic pain, on methadone prescribed by PCP

Medical/ Surgical:

- Hx of abdominal wall abscesses, chronic pain, diabetes mellitus, cystitis, Hep C

Behavioral:

- Pt is eligible for Forensic ACT Team due to frequent incarceration and dxs of bipolar d/o with psychotic features

December 2018

- EMS will request FACT referral be initiated at next incarceration - although it appears that client might not be very open to a Mental health referral
- EMS has been working with client, who is homeless and very vulnerable on the streets, often victimized. Client is using ETOH and is very disorganized, unable to hold on to a phone - difficult to coordinate care and services for client

Example 3: Patient with Behavioral Health Needs

CARE GUIDELINE:

Care Recommendation:

- At baseline presents with good grooming/hygiene, with euthymic (if irritable) mood and congruent affect. Tends to be suspicious and guarded upon approach and reports distrust of systems due to mistreatment/neglect in the past.

Care Coordination:

- Mental health provider: See contact info in Care Team
- Housing: Home Forward 2 bdrm apartment

Example 4: Patient with Behavioral Health Needs

CARE GUIDELINE:

Care Recommendation:

- Maintaining at baseline with breakthrough symptoms since 2008 (last hospitalization in 2005 due to inability to care).
- At baseline reports she calls "songs" that play on her anxiety and paranoia. The songs inform her that she is at risk of losing her housing, her SSI benefits, or her services. They will also tell her that she needs to move back to ID to live in a group home, or that she is "not doing enough" to manage her mental health.
- She maintains stability by rigidly adhering to her "relapse prevention plan", which includes community volunteer work, arts and crafts events, weekly check-ins with her "Mom" and "Auntie", art journaling, weekly med pickup and counseling appt with clinician.

Helpful ED-Based Interventions to Try:

- Remind her that her "songs" are often critical and not always representative of reality.
- Remind her that her housing is not at risk, she has lived there successfully for many years; as well, she is not at risk of losing her benefits. Encourage her to identify her relapse prevention plan and how she is adhering to it.
- Remind her to f/u with her Care team for add'l support and reality testing

December 2018

Care Coordination:

- When patient presents to the ED, contact the Care Team listed in box
- Housing: subsidized one-bdrm building- Waterfall Court (000-000-0000)

Example 5: Complex Behavioral Health Patient Managed by Interdisciplinary Care Team:

CARE HISTORIES

Medical/Surgical:

- Patient has had multiple ultrasounds/labs for abdominal pain—no abnormal findings. PCP attributes pain to anxiety and poor diet.
- PCP willing to provide quick access to face to face/phone appointments—sees patient frequently – 18 times in the past year.
- Patient appears to be overly focused on medication as the solution to her problems – frequently asking for new medications without tolerating a trial period of current ones.

Behavioral:

- Patient is enrolled in 5 therapy groups weekly, attending on Monday, Wednesday and Friday. See providers in Care Team box
- Behavior plan has been created for her adult foster home.
- Patient has a history of agitation with aggression toward her facility care staff, mother, EMTs and police, resulting at times to being put in 4-point restraints.
- Patient has a history of self-harm. She has jumped in front of cars, tried to exit moving vehicles, repeatedly pounded her forehead against the sharp corner of a car door, and eaten coffee grounds in an attempt to mimic a GI bleed.

Social:

- Patient has been evicted from or left several adult foster homes. She often says that she wants to move. Please refer her to her Multnomah County DD caseworker—see Care Team box
- Patient’s anxiety and health symptoms are often triggered by her boyfriend not responding to her texts or phone calls, or visiting her when promised.

CARE GUIDELINE

- Do not change or add medications. Refer Patient to PCP or psychiatrist for medication prescribing.
- Patient would benefit from a rapid assessment and discharge from the ED as appropriate.
- Remind Patient of the mindfulness skills she identified as helpful: Notice what's in the room: 5 things you can see, 4 things you can touch, 3 things you can smell, 2 things you can hear and 1 thing you can taste.

Bad Examples of Information NOT to Include

CARE GUIDELINE

Care Recommendation:

- Administer no opiates or benzodiazepines in the ED for chronic conditions or for non-emergencies, only for obvious trauma or severe medical issues.
- ED Providers should immediately check the Washington State Prescription Review database for prescriptions filled.
- DO NOT BED AND GOWN UNLESS THERE IS EVIDENCE OF A MEDICAL EMERGENCY. (RME is preferable.)
- Limit comfort/convenience items unless medically indicated.
- Provide appropriate but directed workup and disposition.

Care Coordination:

- Please ask care coordinator or social work to contact their Main Point of Contact if pt presents to the ED during business hours.

Pain Management:

- Not on an opiate therapy plan.