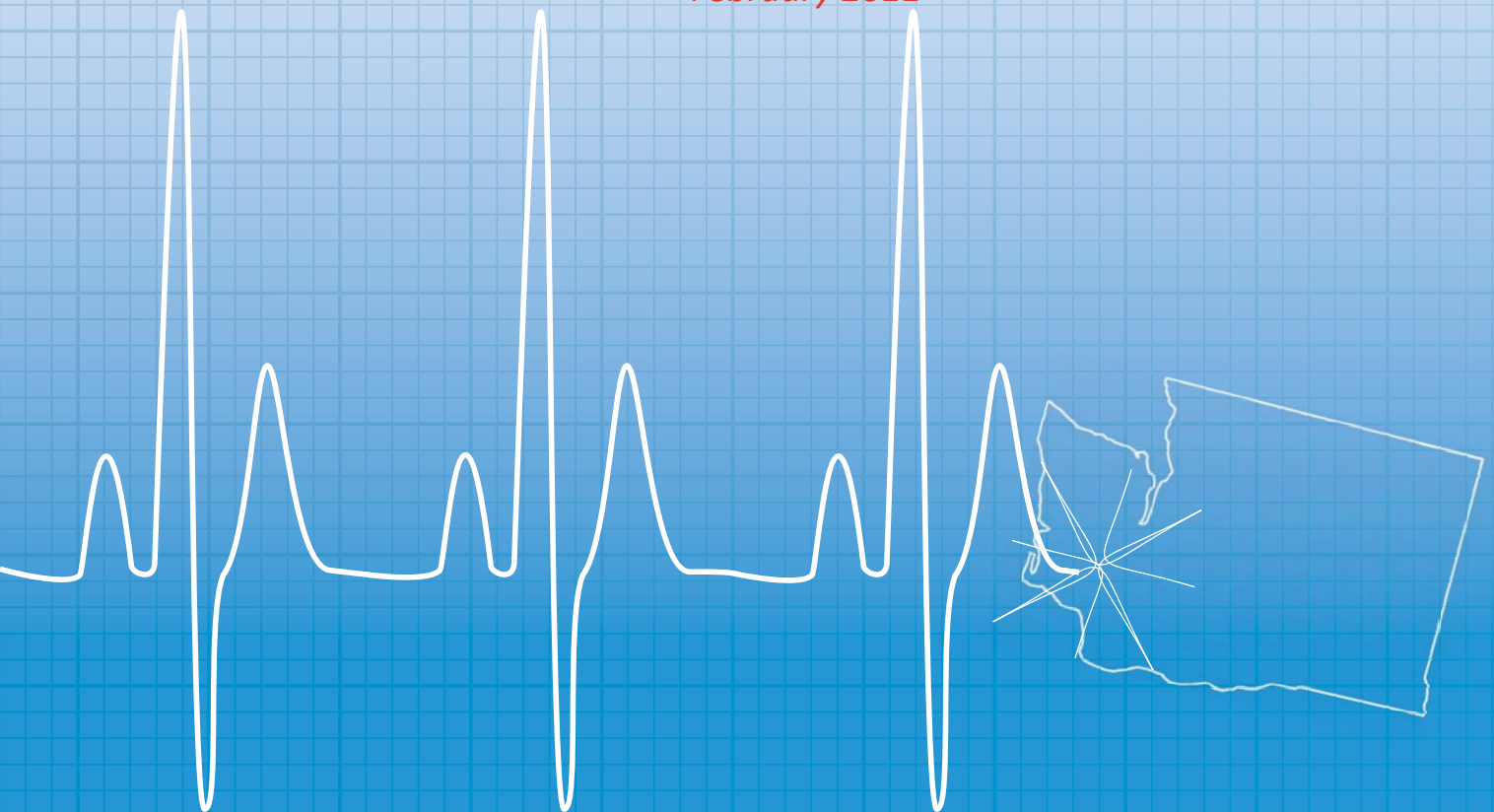


Potentially Avoidable Emergency Room Use

*Developed by WSHA's Health Information Program
February 2011*



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Cascade Valley Hospital & Clinics
Central Washington Hospital
Dayton General Hospital
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Harrison Medical Center
Island Hospital
Kadlec Medical Center
Kennewick General Hospital
Lake Chelan Community Hospital
Legacy Salmon Creek Medical Center
Lincoln Hospital
Mason General Hospital
Mid-Valley Hospital
MultiCare Allenmore Hospital
MultiCare Good Samaritan Hospital
MultiCare Mary Bridge Children's
Hospital & Health Center
MultiCare Tacoma General Hospital
Newport Hospital & Health Services
UW Medicine/Northwest Hospital &
Medical Center
Othello Community Hospital
Overlake Hospital Medical Center
PeaceHealth St. John Medical Center
PeaceHealth St. Joseph Hospital
Providence Centralia Hospital
Providence Holy Family Hospital

Providence Mount Carmel Hospital
Providence Regional Medical
Center Everett
Providence Sacred Heart Medical Center &
Children's Hospital
Providence St. Mary Medical Center
Providence St. Peter Hospital
Pullman Regional Hospital
St. Anthony Hospital
St. Clare Hospital
St. Francis Hospital
St. Joseph Medical Center
Providence St. Joseph's Hospital Chewelah
Seattle Children's
Skagit Valley Hospital
PeaceHealth Southwest Medical Center
Swedish/Edmonds
Sunnyside Community Hospital
Swedish Medical Center - Ballard
Swedish Medical Center - Cherry Hill
Swedish Medical Center - First Hill
Swedish Medical Center - Issaquah
Tri-State Memorial Hospital
University of Washington
Medical Center
Valley General Hospital
Walla Walla General Hospital
Whitman Hospital & Medical Center
Yakima Valley Memorial Hospital

Washington State Hospital Association **Potentially Avoidable Emergency Room Use**

Developed by WSHA's Health Information Program

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Introduction

Emergency room (ER) use is a topic of ongoing interest for policy makers and health care regulators. This is especially true in an era of shrinking budgets and an increasing desire to better control health care costs.

The cost of providing care in the ER is high. A study featured in the September 2010 issue of *Health Affairs* found that many people seek care in the emergency room for ailments that are not emergencies and that inappropriate ER use could be attributed, in part, to a lack of access to primary care services.¹ In a recent survey by the Healthcare Intelligence Network, 95 percent of responding hospitals stated that avoidable ER visits were a problem.²

Information on ER use is critical to develop true understanding of the issues and to ensure that new policies around emergency services are grounded in reality rather than perception. To provide this vital information, the Washington State Hospital Association (WSHA) asked its members to share visit level data on ER use. This report analyzes that data to provide information for public policy advocacy and hospital planning. Member response was excellent, with data submitted by 53 emergency facilities in all urban and many rural areas of the state.



An initial report analyzing overall use patterns for emergency services in Washington State was released in October 2010. (<http://www.wsha.org/files/127/ERreport.pdf>) This second report focuses on potentially avoidable use of the ER and addresses three key questions:

- How many ER visits are potentially avoidable?
- What are the characteristics of these visits?
- What are solutions to ensure patients receive care in an appropriate setting?

¹ Pitts, S.R., et al. Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. *Health Affairs*. September 2010.
² 2010 Performance Benchmarks in Reducing Avoidable ER Visits. The Healthcare Intelligence Network. 2010.

Where did the data come from?

The analysis in this report is based on data supplied voluntarily by 53 hospitals. As the map shows, participating hospitals represent a broad spectrum of both rural and urban communities. (For a list of participating hospitals, see the inside front cover.) The data are robust, with 2.6 million visit records collected for 18 months (January 2008 to June 2009) — representing about two-thirds of all ER visits in the state for this period. Hospitals were asked to submit data on patient age, gender, time and date of service, diagnosis code, payer, and charges. Data on ER costs or payment were not available.



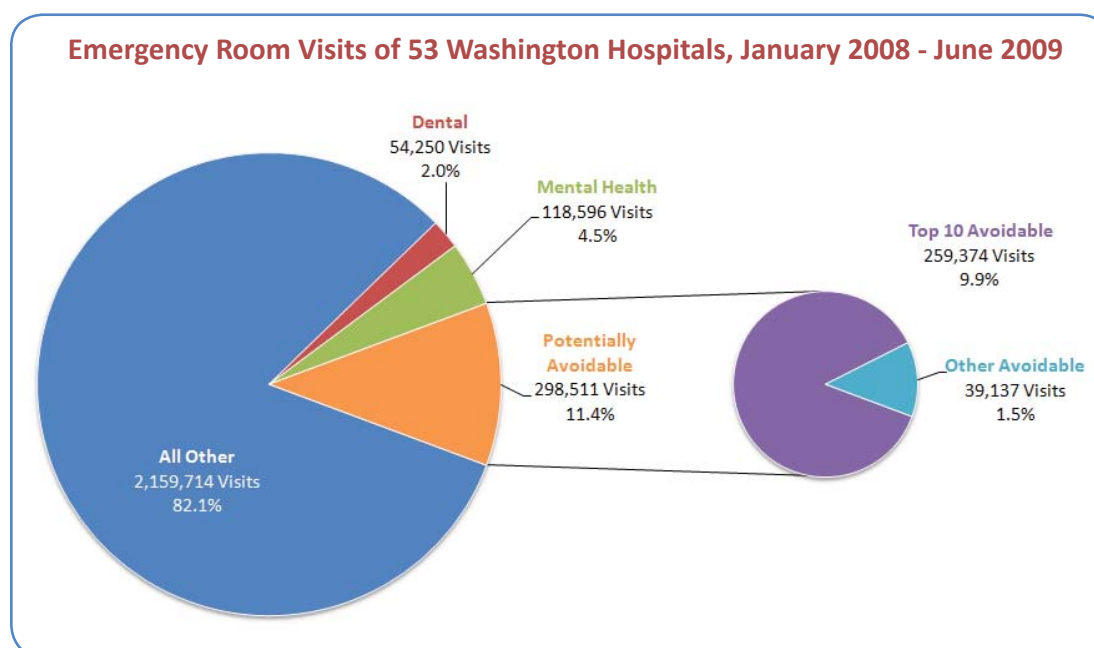
Although a large number of hospitals participated in this study, the data set has some limitations. First, because of the missing hospitals, the data may contain some biases. Second, this was the first time hospitals prepared record extracts for emergency services for a standard analysis. Some data elements are missing for the hospitals that chose to participate. For example, some hospitals do not record time of visit. Third, the data set is abstracted from initial billing records. Payer status often changes over time, especially for ER services, as hospitals obtain more accurate information.

The data are sufficient for certain analyses of patient characteristics. Because of the absence of data from some hospitals, however, accurate calculations of utilization rates by payer cannot be made.

What is a potentially avoidable ER visit?

Potentially avoidable ER visits are defined as those which could have been appropriately treated in another setting at the time the visit occurred. The list of avoidable conditions in this report uses the same primary diagnosis codes (ICD-9 codes) as used by the California Emergency Room Coalition, an advisory committee working on cost containment in the Medi-Cal program. The Medi-Cal approach attempts to define diagnosis codes where the patient could have been treated in an alternative setting. (See Appendix 1 for the list of Medi-Cal avoidable diagnoses).

The Medi-Cal approach, while not perfect, provides the best available tool to examine potentially avoidable ER visits.³



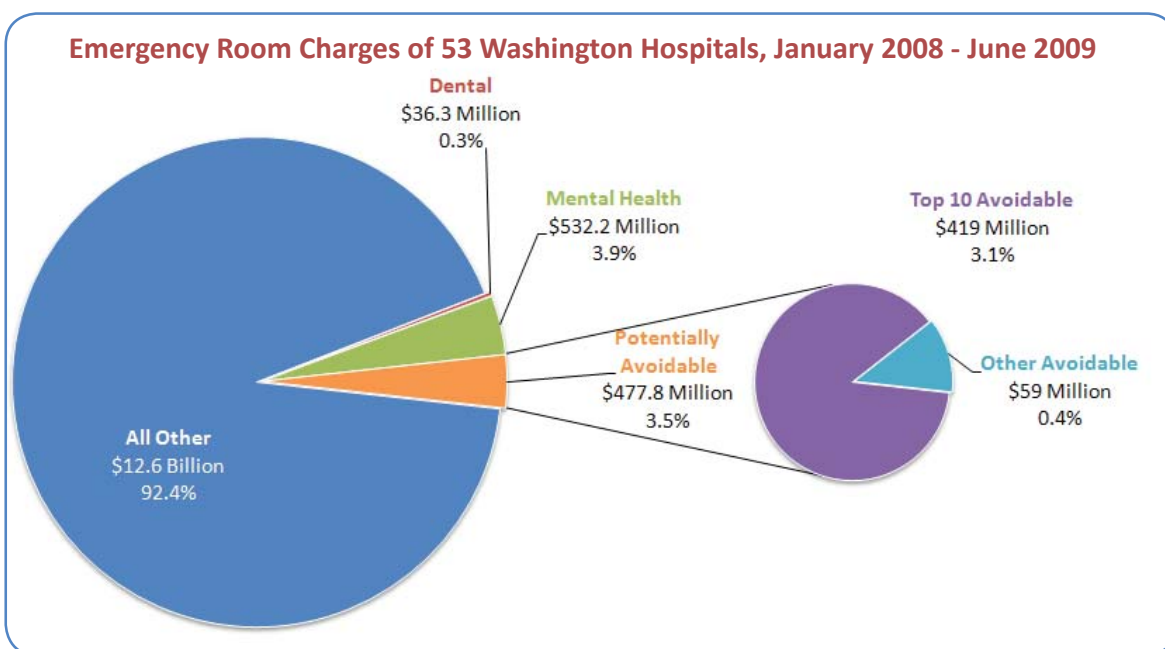
While emergency room visits for dental care and certain visits for mental health services for psychiatric care and substance abuse are not considered avoidable, both are topics of concern in discussions of emergency care. For this reason, these visits are also examined in this report, separately from the potentially avoidable visits. For the purposes of this report, dental diagnosis codes were used identifying conditions that would normally be treated in a dentist's office. Appendix 2 contains a list of dental and mental health codes examined in this report.

³ Other reports have used a classification system first introduced in a New York University study. Under this approach, visits are classified as avoidable if they could have been prevented by providing more up-front care to keep the patient healthy. While this may represent what can be saved by a revision of the health care system, many different organizations need to be involved in order to prevent these visits. At the time of the visit, they were not necessarily avoidable. For this reason, the methodology was rejected for this project. A more detailed discussion of this model is available at http://www.wsha.org/files/127/Brief_NYU_model_final.doc.

Frequency and cost

When the 2.6 million visits in the study data set were reviewed for all potentially avoidable conditions classified under the Medi-Cal approach, avoidable visits accounted for 11.4 percent of the visits and 3.5 percent of charges (\$477.8 million). Potentially avoidable conditions are largely of low clinical severity with a relatively low average charge for these visits – roughly \$1,600 compared with the \$5,363 average for all visits in the original study.

Even so, these visits increase overall health care expenditures because emergency room care costs far more to deliver than treatment in an office or clinic setting. Moreover, when one out of nine visits is avoidable, there is a perceptible impact on ER capacity; it can make the difference between an overcrowded emergency room or simply a busy one. More difficult to quantify is the potential for improving outcomes and long-term patient health with appropriate care that goes beyond treating the symptoms presented in the ER.⁴



While not included in the potentially avoidable visits, the report also looked at ER visits for dental and mental health care. Dental care accounted for 2.0 percent of all ER visits and 0.3 percent of all ER charges (\$36.3 million). Mental health services were the primary diagnoses in 4.5 percent of ER cases and represented 3.9 percent of all ER charges (\$532.2 million) in the study population.

While potentially avoidable use of hospital ERs is a contributing factor to the increasing cost of health care, its overall cost impact is relatively minor when compared to other medical cost drivers. The costs of programs to reduce this inappropriate use need to be examined carefully to ensure their cost effectiveness.

⁴ These numbers do not include visits for mental and dental conditions, which are discussed separately.

Characteristics of potentially avoidable visits

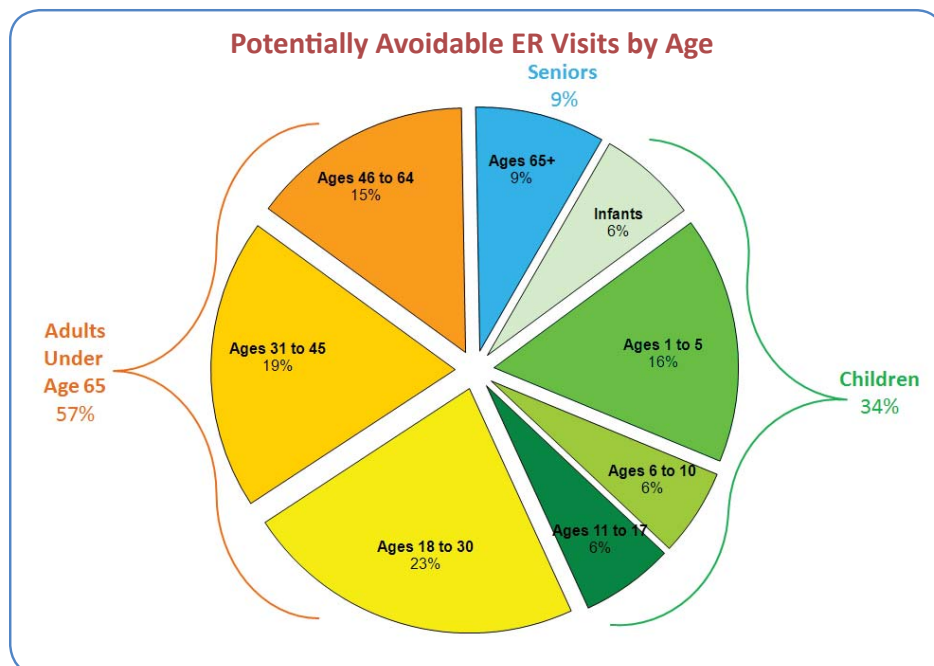
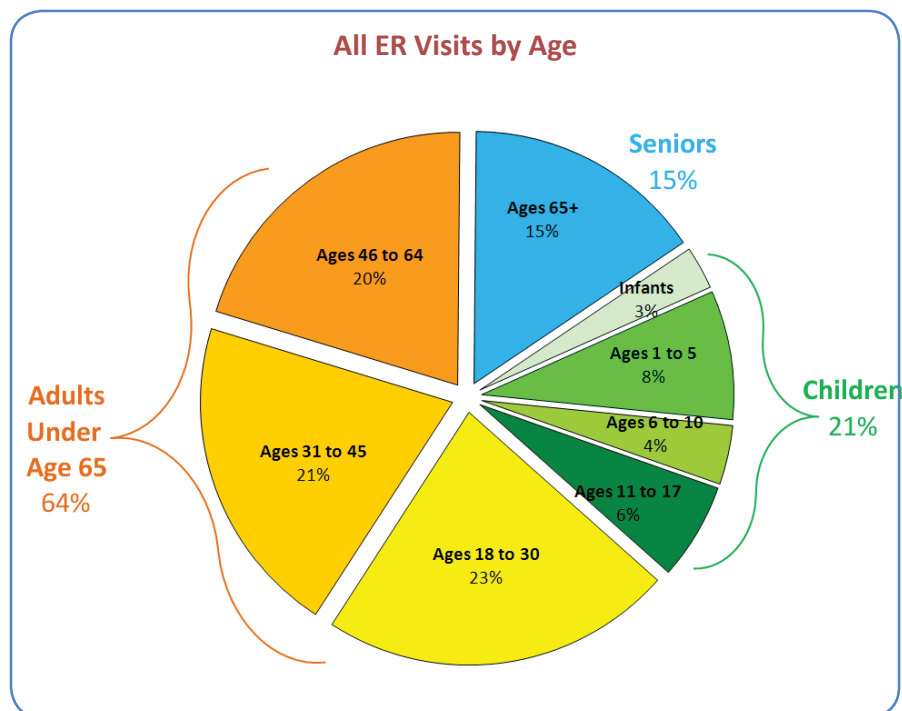
Age:

Visits by children under age 18 account for more than one-third of avoidable visits, 34 percent, a much larger presence than their 21 percent share of all ER visits. Pediatric ear and acute upper respiratory infections are potentially avoidable and account for 10 percent and 12 percent, respectively, of all ER visits by children.

Gender:

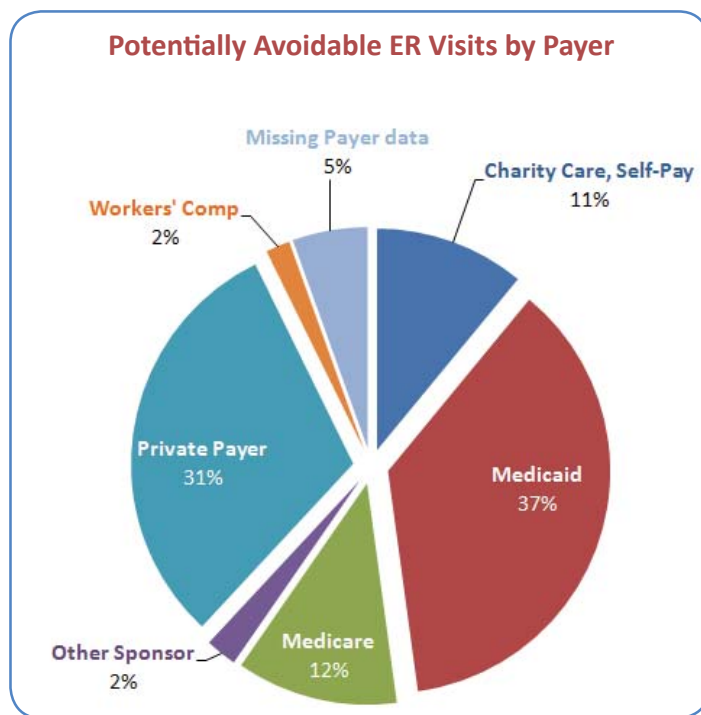
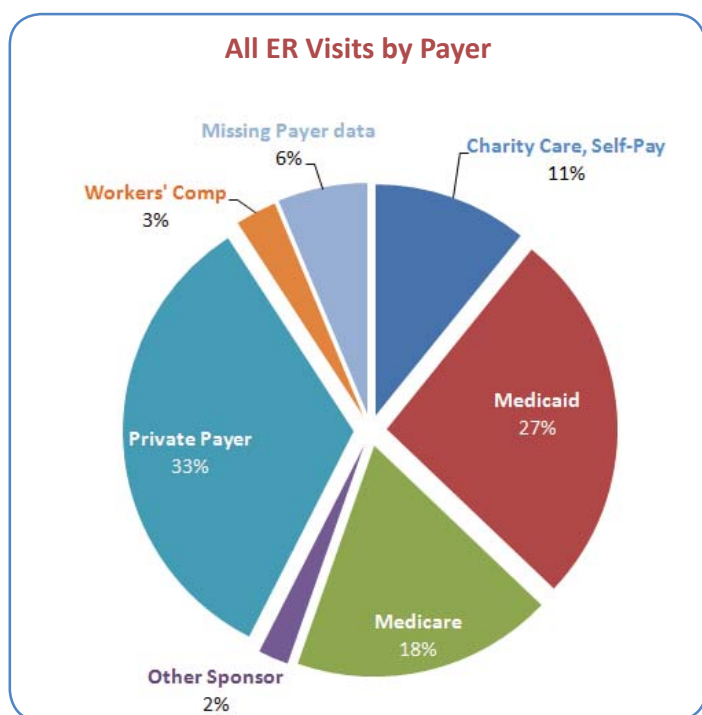
Patients with avoidable visits are much more likely to be female – 60 percent of these visits are made by female patients, 40 percent by male. This gender gap is larger than that found in all ER visits, where 54 percent are made by women and 46 percent by men. This is due to the much higher proportion of urinary tract infection (UTI) visits by women, 83 percent, compared to men, 17 percent, and a two to one ratio of women to men in headache diagnosis visits. UTI visits and headache visits for women are each 10 percent of total avoidable visits.

In summary, the ER patient population with avoidable diagnoses is younger and has a higher percentage of visits made by females than the total ER population.



Insurance Coverage:

A surprising finding is that the uninsured (charity care, self-pay) have the same proportion of avoidable visits as of total ER visits, 11 percent. Those with private insurance are only slightly less likely to have an avoidable diagnosis at their ER visit than people with other insurance. Medicaid patients, with 37 percent of avoidable visits, account for the largest share by visits. Interestingly, visits by those with private insurance, and presumably better access to care, accounted for 31 percent of visits.



Geographic and Urban/Rural Variation

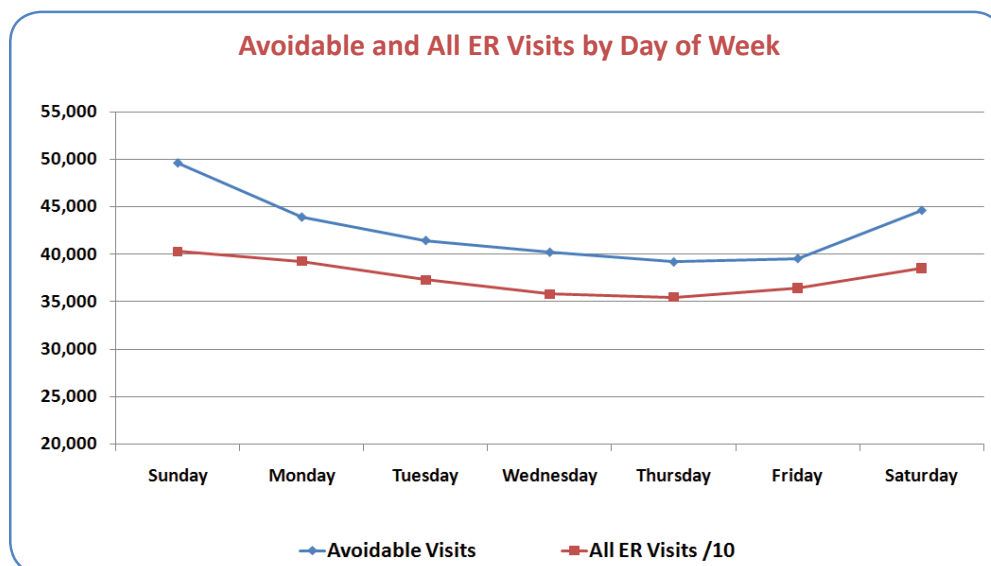
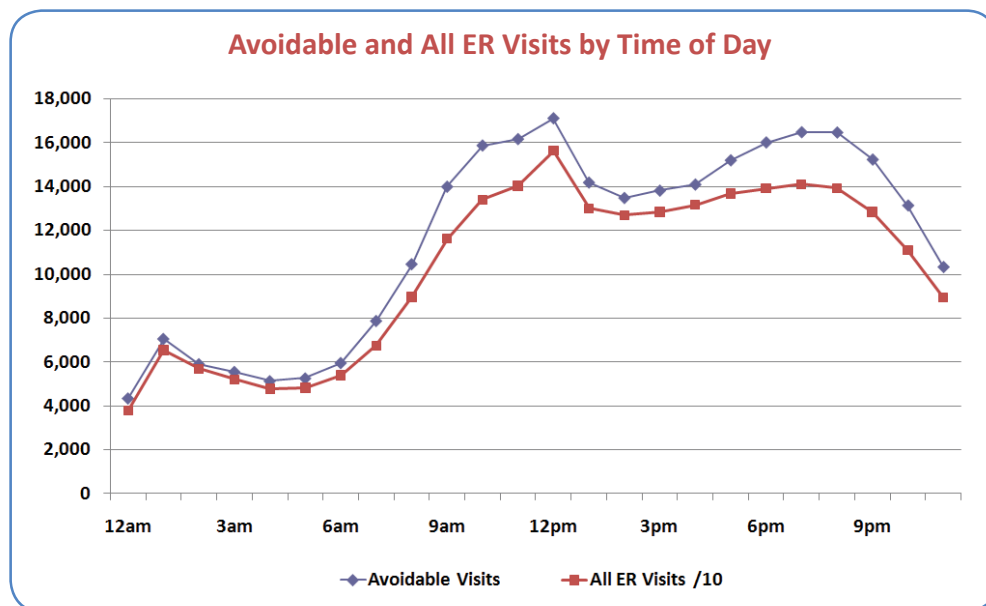
The east/west and urban/rural ratios are very similar for avoidable incidence and for overall ER use. However, the small differences that do exist support an argument that avoidable ER visits may be the result of limited access to regular care.

Rural ER facilities account for 10.5 percent of all visits in the study, but have 12.5 percent of all avoidables. For the east/west dichotomy, there is a similar pattern: facilities in eastern Washington have one-quarter of the total ER visits, but a somewhat higher proportion of avoidable visits, 29 percent. It is interesting that there are geographic areas, most notably south-central and south-east Washington which seem to have higher rates of avoidable ER use.

Time of Day and Day of Week:

- Time of day and day of week patterns for avoidable visits and all ER visits are very similar, virtually identical for time of day. Visits are most likely to occur between noon and 8:00 p.m. and least likely overnight.
- Avoidable visits are more likely to occur on the weekend, when most primary care providers are not available.

In the following graphs, “All ER Visits” are displayed as 1/10 of their actual counts to allow for comparison of visit patterns with avoidables.



Most common reasons for a potentially avoidable ER visit

Eighty-seven percent of all potentially avoidable visits in the study were accounted for by 10 primary diagnosis codes. These same 10 also appear among the top 50 most frequent primary diagnoses in WSHA's emergency room study (not including dental or mental health services). The potentially avoidable diagnoses are:

- Acute upper respiratory infection
- Headache
- Urinary tract infection
- Otitis media (ear infection) (two separate diagnosis codes)
- Back pain (two separate diagnosis codes)
- Acute throat inflammation
- Acute bronchitis
- Issuance of a repeat prescription

These eight conditions comprise nearly 10 percent of all ER visits in the study, but only 3.2 percent of ER charges. Some key findings about these visits are:

By Payer Segment:

- For Medicaid patients, acute upper respiratory infection (57 percent) closely followed by ear infection (55 percent for both Otitis media diagnoses) were the highest incidence diagnoses. This is likely due to the younger average age of this population.
- For Medicare patients, acute urinary tract infection was the most prevalent diagnosis, at 33 percent.
- For private insurance patients, headaches represented 40 percent of avoidable visits.

By Gender:

- The same gender gap is seen in the avoidable diagnosis subset as the complete set of all ER visits (60 percent female versus 40 percent male) than in total ER visits (54 percent female versus 46 percent male).
- Males outnumber females for only three avoidable diagnoses: issuance of repeat prescription (58 percent), and the two ear infection diagnoses (51 percent each).

By Diagnosis of Headache, UTI, and Earache

Within a specific primary diagnosis, that data shows that there can be a wide range of cases that vary by diagnostic methods, severity of illness, and treatment – and also by hospital charges. Three diagnoses are explored in this section: headache, urinary tract infection, and earache.⁵

While headache is a potentially avoidable diagnosis, all headaches may not be the same. Data from Washington hospitals included visits with bills ranging from a few hundred dollars to tens of thousands of dollars. Further analysis of the secondary diagnoses, however, revealed little difference among the diagnoses between the lowest charge group and the higher charge group. It could be that the higher cost headache cases were due to “sicker” patients with more complicated conditions, but it is difficult to know from the limited administrative data available.

⁵ The diagnosis codes used in this section are: headache (594.0), urinary tract infection (599.0), and earache (both otitis media, 382.9, and acute suppurative otitis media, 382.0).

By Diagnosis (continued)

Some of the variation in charges is due to differences in services provided. Far less than one percent of the headache visits with charges under \$1,000 included any diagnostic radiological services. Sixty percent of the patients with charges of more than \$1,000, however, had some type of radiology service (CT scan, MRI, X-ray). This suggests that at least half of these cases presented with a headache could have been a symptom of a



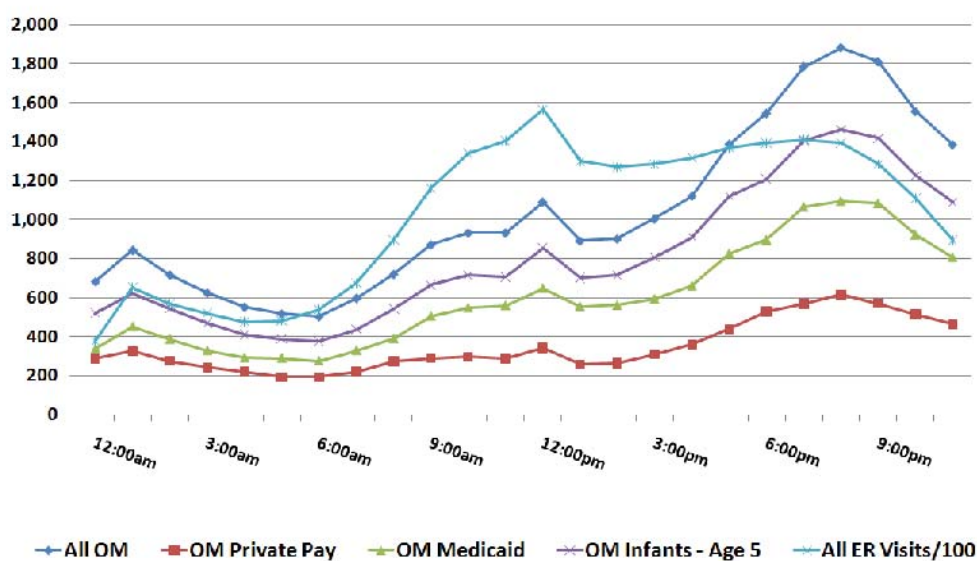
more serious diagnosis, triggering more extensive testing. Ruling out serious causes of headache is an important medical practice. In the end, more serious diagnoses were not supported. It is important to remember, however, in many cases there is likely no way of knowing this is the case when these patients walk into the ER.

Similar variation in services was also observed in patients with UTI. More radiology services and higher charges were incurred for adults 18 to 64 than for children, and the highest average charges and most radiology tend to be for those 65 and older.

Patient visits for earache are often used as an example of avoidable emergency room use (although they account for just 1.4 percent of all ER visits and only 0.2 percent of all ER charges). As expected, 65 percent of otitis media cases are children under the age of six, and another 12.5 percent are between the ages of six through ten. Because otitis media is often considered a clear-cut primary care condition that should not show up in the ER, it is useful to compare *when* these cases are brought to the ER.

Regardless of insurance coverage, earache visits occur at the same times, and this pattern is somewhat different from the overall ER time pattern: relatively fewer earache cases during the day time, and significantly more in the evening, starting from 6 p.m. until midnight, and continuing through the night. Because earaches are usually accompanied by fevers and uncontrolled crying, parents are often advised to seek care when they occur at night – and the ER is their only resource. The charges for these visits are relatively low, at just over \$500.

ER Visits for Otitis Media (OM) Primary Diagnosis by Time of Day



“All ER Visits” are displayed as 1/10 of their actual counts to allow for comparison of visit patterns with avoidables

Dental care in the ER

This section provides a deeper exploration of dental health care delivered in emergency rooms across Washington State. As explained in the introduction, diagnoses in this category are not considered potentially avoidable. They are, however, topics of great interest when discussing ER utilization. This section is by no means an exhaustive exploration of dental care, but rather presents a few interesting findings.

	Dental Dx as Percent of ER visits
Western WA	2.12
Eastern WA	1.90
Urban	2.09
Rural	1.86

WSHA identified 74 diagnoses (see Appendix for a complete list) that appear to be related to lack of access to dental care. Patients come to the ER for pain relief from cavities, broken teeth, and abscessed roots. Usually the only treatment that can be provided is a painkiller and a referral to a community dental clinic. Consequently, the average charge for a dental ER visit is \$669, far less than the

\$1,601 average charge for avoidable diagnoses. While individual dental ER visits stand out as examples of inappropriate use, as a category they account for only two percent of all ER visits, and for significantly less than 1 percent (0.3) percent of all ER charges. The rate of incidence shows little difference by geography (east/west), or by community size (urban/ rural).

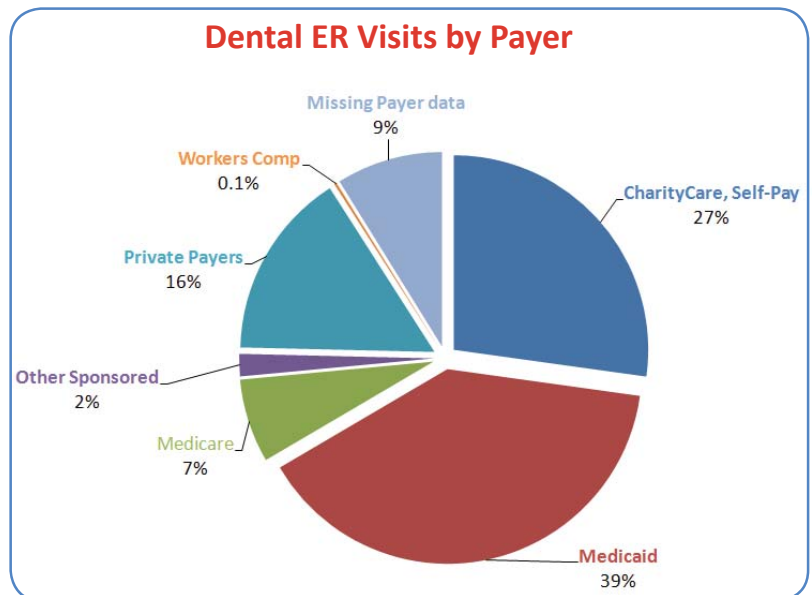
The three most frequent dental primary diagnoses account for 80 percent of all dental visits, and 75 percent of all dental charges:

- Dental disorder (not otherwise specified), 43 percent of visits
- Periapical (root) abscess, 24 percent
- Dental caries (cavity), not otherwise specified, 13 percent

ER visits for dental care are typically made by adults, with 93 percent of visits made by someone who is at least 18 years old. Dental visits make up 4 percent of ER visits by young adults 18 to 30.

Medicaid recipients and the uninsured account for two-thirds of all ER dental visits. While the number of cases is relatively small, this finding suggests an access problem for these populations. The shortage of dentists who will take Medicaid patients, due to low reimbursement, is widely noted.

For the uninsured who come to the ER, affordable dental care is probably not an option. Five percent of all ER visits made by the uninsured are for dental diagnoses. “Dental disorder otherwise unspecified” is the most frequent primary diagnosis of all the uninsured ER visits, comprising two percent of their visits.



The proportion of ER dental patients who have private health coverage is surprisingly high at 16 percent. One out of six ER dental patients with some financial stability, evidenced by employment and health insurance, apparently do not access routine dental care. Having health insurance does not necessarily mean a person has dental coverage or a dental provider.

Mental health in the ER

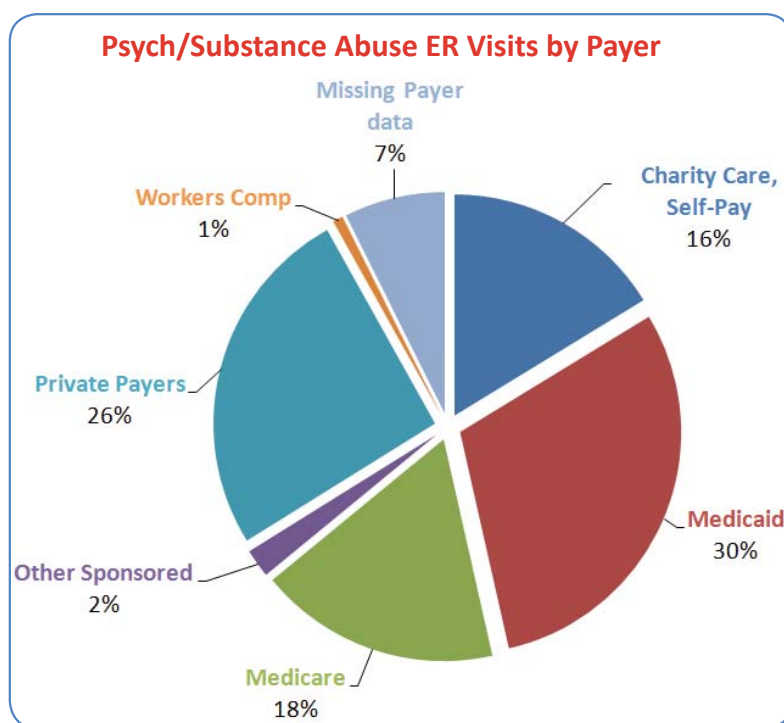
This section provides a deeper exploration of mental health care delivered in ERs across Washington State. As explained in the introduction, diagnoses in this category are not considered potentially avoidable. They are, however, topics of great interest when discussing ER utilization. This section is by no means an exhaustive exploration of mental care, but rather presents a few interesting findings.

Psychiatric and substance abuse cases brought to the emergency room are a particular focus of concern for health care organizations. They are usually life-threatening and require immediate care. They provide dramatic and frustrating evidence of the seriously broken mental health system. The incidence of such cases varies from hospital to hospital, but overall, they comprise 4.5 percent of all ER visits, much less than the list of other avoidable visits at 11.4 percent. However, because the average charge for each mental health visit is so much higher (\$4,487, compared to \$1,601), the financial impact is larger – 3.9 percent of all ER charges, compared to the 3.5 percent of all avoidables share. (See Appendix 2 for a complete list of mental health and substance abuse diagnoses used in this analysis.)

The ER mental health patient population has a mix of insurance coverage similar to that found in the avoidable or dental visit data. Medicaid is the largest segment in frequency (30 percent), followed by private pay (26 percent). Medicare is in third place with an 18 percent share, closely followed by the uninsured at 16 percent.

Mental health visits differ from the avoidables group in age and gender. More than 90 percent of mental health ER visits are made by adults age 18 and older, in contrast with the larger avoidables population in which just under 65 percent of visits are by adults.

In contrast to the potentially avoidable visits, which are 60 percent female, the mental health visits are evenly divided between male and female patients. The gender split shifts when the psychiatric disorder visits are separated from substance abuse ones. The psychiatric subset is the larger of the two components explored in this section, with 62 percent. A slight majority of these visits, 53.5 percent, are made by females. This gender gap is reversed in the substance abuse subset where male patients make 57 percent of the visits.



Why are people seeking potentially avoidable care in the ER?

One national study of emergency room use found long wait times for physician offices increased ER visits while greater community health capacity led to a reduction in ER visits for poor and low-income people.⁶ The same study found that more care management resulted in lower ER utilization. As will be discussed in the next section of this paper, some Washington health care organizations have successfully used this approach with patients who have a higher frequency of ER visits.

Another national report⁷ noted among the reasons people use the ER were:

- People truly think that they have an emergency
- An individual may not have access to primary care or cannot get in to the office in a timely manner
- Primary care was not open when they needed it or they could not access it
- Some individuals do not realize that they have options outside the ER.

Several studies have noted the impact on avoidable ER use from high utilizers or “frequent fliers.” These are people who repeatedly seek care in the ER for a variety of reasons from chronic conditions to mental illness or drug seeking behavior. Since the data set contained no information to identify individual patients, this issue could not be addressed using this data set. In one study 40 percent of responding hospitals cited this population as linked to avoidable ER use.⁸ The study also noted that, for the 40 percent, the most common conditions were: chemical dependency (20 percent), mental health (10 percent), pain management (20 percent) and medication non-adherence (20 percent).



In 2007, a report⁹ from a Washington State task force study on strategies to reduce unnecessary emergency room use outlined a list of complex issues driving use patterns. Reasons noted in the report include:

- Lack of primary care providers, or access to these providers
- Decisions by the patient to seek more immediate care rather than wait to visit their physician
- Patients with mental illness and patients with substance abuse issues use the ER as their medical home
- Lack of incentives for primary care health delivery
- Lack of disincentives to use ER services for non-emergent conditions

6 Cunningham, Peter J. What Accounts for Differences in The Use of Hospital Emergency Departments Across U.S. Communities? *Health Affairs*. Web Exclusive. July 2006.

7 27 Interventions to Reduce Avoidable ER Use. Tactics to Manage Non-Urgent Cases, High Utilizers, and Special Populations. The Health Care Intelligence Network. November 2010.

8 2010 Performance Benchmarks in Reducing Avoidable ER Visits. The Health Care Intelligence Network. 2010.

9 ESSB 5930 Report: Reducing Unnecessary Emergency Room Use. Presentation to the Washington State House Health Care & n Wellness Committee,

The solutions

Many hospitals across Washington State are working on solutions to address avoidable ER visits. WSHA is working with payers to incentivize collaborations within the health care community to reduce unnecessary ER use. This section provides a few examples of the work hospitals are already undertaking.

Preventing Drug Seeking Behavior

According to the Centers for Disease Control and Prevention, the number of ER visits involving patients who were seeking a prescription for a narcotic for a non-medical reason more than doubled in the United States between 2004 and 2008. Hospitals across Washington State are working to prevent drug seeking patients from feeding their habits in emergency rooms.

One effective strategy is to limit the prescription pain medications, especially opioids, prescribed through the emergency rooms.

One effective strategy is to limit the prescription pain medications, especially opioids, prescribed through the emergency rooms. Several hospitals across Washington State are working to ensure individuals with drug addiction know the emergency room is not a source for narcotics. A number have become “Oxy-free.” Physicians working in these ERs will not give out prescriptions for Schedule II drugs, a group including OxyContin and Percocet.¹⁰



Other hospitals are tracking patients who frequently visit emergency rooms for drugs. Hospitals in Skagit County are taking a coordinated approach to treating individuals feeding a drug addiction who do not need medical care. When a patient makes a repeat visit to any hospital in the area seeking pain medications, the patient is counseled on more appropriate options for care and informed that the emergency room will not be providing prescriptions. The patient is then asked to sign a form acknowledging receipt of the information.

“They hear the same thing from all the hospitals in the area and get the message,” said Donna McCabe, RN, Director of Emergency Services at Skagit Valley Hospital.

Another example is in Spokane, where hospitals are using a computer database created and hosted by the Washington State Department of Health called the Emergency Department Information Exchange. Through the database, hospitals flag patients who frequently visit the ER and include information about the patient’s primary care provider and care plan. The information is then available to any other hospital using the system. Hospitals report that these strategies have significantly reduced visits by patients seeking opioid prescriptions. Nearly 20 additional hospitals from across the state are currently in the process of joining the information exchange network.

¹⁰ Seattle Times “New state pain-medication law has doctors and patients nervous”. http://o.seattletimes.nwsources.com/html/localnews/2012873602_drugs12m.html Accessed January 18, 2011.

Better Coordinated Care

Many visits to the emergency room could be avoided by providing care in a more appropriate setting. In some cases the ailment is non-emergent; in others the visit could have been avoided if a condition had been addressed by a primary care provider before it became emergent. In some cases patients end up in the emergency room because they have not been able to get primary care. Several communities are addressing this issue by coordinating care among physicians, hospital emergency rooms, and community clinics to targeted patient populations with chronic access issues. The communities are tackling the issue of inappropriate care through care coordination, patient education, and the use of technology. Here are a few examples:

In 2003, Providence St. Peter Hospital in Olympia partnered with CHOICE regional health network to connect frequent ER visitors with appropriate primary care services. Since its inception, four additional hospitals have joined the Emergency Department Consistent Care Program: Capital Medical Center, Grays Harbor Community Hospital, Mark Reed Health Care District, and Providence Centralia Hospital.

Those who voluntarily joined the program reduced their visits to the ER by 58 percent.

After two visits in a month or four visits in six months, the charts for these patients are flagged. This triggers a RN care coordinator evaluation of their case for chronic health problems, mental illness, and/or drug addiction. The patient is then invited to participate in a program to provide more coordinated care. Once the patient is accepted for intervention, a multi-disciplinary team reviews the case and an individual care plan is developed.

About 11 percent of the patients identified elect to accept the help. The program, however, tracks visits of all flagged patients. Contacting these patients and flagging their records has been effective in reducing visits by patients only seeking medications. Those who voluntarily joined the program reduced their visits to the ER by 58 percent, while patients who were referred and did not accept had a 43 percent reduction in visits.¹¹

Four years ago, Spokane hospitals also began working to coordinate care for frequent emergency room visitors. The model they adopted is very similar to that developed at Providence St. Peter's. Using the statewide Emergency Department Information Exchange, hospitals record care plans for patients and these plans are accessible to any other ER connected to the system. Each hospital uses an RN care coordinator to manage the program. Across the entire Spokane area, ER visits for enrolled patients are down 56 percent.

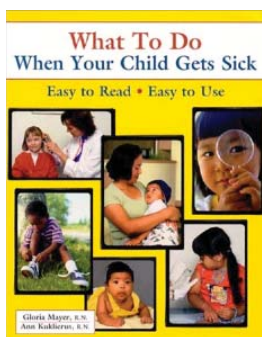
"Ninety to 95 percent of the patients referred to the program respond well," said emergency physician Dr. Darin Neven. "A lot of these patients are dealing with concurrent health issues. This program connects them to tools to take care of themselves so they don't end up in the ER."

In the past year, Providence Regional Medical Center Everett also adopted the same model to reduce avoidable ER visits. Emergency room leaders point out an additional benefit to the program: increased staff satisfaction.

"ER staff love it because they know these patients and they know that the ER is not the appropriate place for them to receive care," said Julie Zarn, RN, Director of Emergency/Trauma in Everett. "They love that a system is finally in place to get these patients the care they need."

11 Emergency Department Consistent Care Program at Providence St. Peter Hospital: An Evaluative Report. Published April 21, 2010.

Similar work is being done in collaboration with community clinics at four pilot sites in Washington – Auburn, Bellingham, Spokane, and Pasco. The Washington State Department of Social and Health Services is conducting this pilot study to determine the effectiveness of programs in reducing potentially avoidable ER visits using care coordination through community and migrant health centers. All of the sites implemented a 24-hour nurse hot line where patients can call to determine the best place to go for care. They are also using patient navigators to assist patients with getting health care that is appropriate for their needs. The community and migrant health centers in the pilot communities have extended their operating hours to make getting primary care more convenient.



The pilot is also testing the use of public education to change behavior, including distributing a book called “What to Do When Your Child is Sick.” The book targets parents because families with young children are often the highest utilizers of ER services that could be delivered at a clinic.

The project based at Lourdes Medical Center in Pasco has taken public education one step further with public service announcements on local radio stations and educational videos played at food banks and other outlets where people get social services. Results from this community clinic and hospital pilot project should be published later this year.

Partnerships for Dental Care

Providence Centralia Hospital is tackling potentially avoidable use of the ER on several fronts. A year ago, space on the campus was donated for a community urgent care clinic, run by a local non-profit. The clinic gives patients an appropriate alternative to the ER in a convenient location.

The organization has also developed an effective system for dealing with patients who come to the ER with a dental complaint. The hospital partnered with a local federally-qualified community health center that provides dental services. Patients who come to the ER with a dental complaint are triaged and then scheduled for an appointment within 24 hours at the dental clinic. If the patient does not show up for his or her scheduled appointment, the dental clinic notifies the ER and a note is placed in the patient’s record. If the patient returns, ER staff are able to talk with them about their missed appointment and explain that the ER is not an appropriate setting for dental treatment.

One outstanding result is the instances of patients seeking pain medication for dental cases in the Providence Centralia ER has decreased by 50 percent within the last year. Staff believe the system is connecting patients with appropriate care and eliminating visits where tooth pain is used as a path to prescription pain medication.



Multiple Strategies Lead to Lower Rates

The UW Medicine Health System has one of the lowest rates of potentially avoidable emergency room visits in the state at its Harborview Medical Center, UW Medicine/Northwest Hospital & Medical Center, and University of Washington Medical Center ERs.

For several years, the system has focused on ensuring that patients have access to the appropriate level of care. UW Neighborhood Clinics offer same day appointments and clinics are open from 8 a.m. to 8 p.m. on weekdays and also have weekend hours.

“We have found that convenient same day clinic access reduces lower intensity emergency department visits,” said Johnese Spisso, Chief Health System Officer, UW Medicine and Vice President for Medical Affairs, University of Washington.

Another strategy the UW system employs is a 24/7 community care nurse advice line. The number is given to all patients upon discharge from an acute care hospital. The nurse line also answers after-hours calls to clinics.

To help patients with drug abuse issues, the UW system implements and follows very specific care plans and offers access to programs that address addiction. The approach has greatly reduced the number of patients requesting narcotics through the ER.

Public Education

A recent study states “more and more patients regard the emergency department as an acceptable or even the proper place to go when they get sick and the reality is that the ER is frequently the only option.” There are many cases where going to the ER is a matter of convenience.

For this population, there is an opportunity to provide education about why the emergency room is not the best choice for care. Some communities across the country have implemented education programs. For example, North Carolina has implemented a medical home and ER communication initiative to provide families with education about the importance of contacting their primary care physician first before going to the emergency room. In Louisville, the EMS system refers ambulance calls for earaches, stomachaches, or other minor issues to a nurse call line, which helps the patient find the most appropriate facility for care.

The Washington State Hospital Association is developing a brochure to educate patients about when to use the ER and how to access more appropriate care if they do not have a medical emergency. The brochure explains what conditions might be better cared for in a primary care or urgent care clinic.

Doctor's Office,
Urgent Care Clinic,
or the Emergency Room?

A guide to
help you choose
the best place
to go for
health care.

Conclusion

The findings in this report show that while avoidable ER visits are occurring in hospitals across Washington State, they account for only a small percentage of the cost of care provided in the ER. The report also shows that, regardless of their insurance status, people go to the ER with ailments that could be treated elsewhere. In addition to better access to regular sources of care, education may be needed to change behavior.

The findings from this analysis suggest that many potentially avoidable visits may be eliminated if adequate access is given to other venues for care. Key points to remember in considering this issue are:

- **Many potentially avoidable ER visits are related to failures of the payment and delivery systems.** With adequate primary care, dental and mental health services widely available and paid for, the use of ERs would be reduced and services could be better provided as a part of coordinated patient care in better, less costly settings.
- **Directing patients to other alternatives requires patient education and interventions.** This can only be accomplished by all parts of the health care system working on this issue. The acuity of some of these “avoidable” visits appears to indicate that an individual is potentially much sicker than would be assumed based on the primary diagnosis. Some of this may reflect coding issues, and some may be related to the impact of “defensive medicine.”
- **Not everyone agrees that these diagnoses are always avoidable.** One national report on urinary tract infection patients in the ER, Kaiser Permanente found, “subsets of these patients need to present because there is a possibility of a kidney stone. In general, the guideline states that those members over 65 or who have recurrent UTIs really need to be seen, so we’re treating them.”
- **Hospitals in Washington State are implementing effective programs to reduce potentially avoidable ER visits and directing patients to appropriate care.** These successful programs should be replicated in other hospitals.



Impact of State Budget Cuts

The Governor and state legislators are contemplating eliminating or significantly cutting back three state health insurance programs — Basic Health, Disability Lifeline, and Apple Health. Making these cuts could mean as many as 100,000 newly uninsured in Washington State, virtually overnight.

These cuts would put significant and immediate pressure on hospital ERs. Many people covered by these programs have significant health problems and need ongoing care. The ER will be their only source of care. Hospitals can only address the issues of potentially avoidable ER visits if there are community alternatives where patients will be seen and treated.



Improving Quality. Increasing Access. Serving Members. Since 1933.

Special thanks to data analysts Suzie Burton and Thom Rees for their work with the data set. For more detailed information on any of these topics, please contact the Health Information Program through Jim Cannon at jimc@wsha.org or (206) 216-2551 or Jane Feldman at janef@wsha.org or (206) 216-2505 .

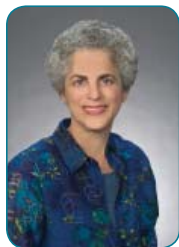
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Appendix 1

Medi-Cal Avoidable ICD 9 Diagnosis Codes used in ER study

ICD-9 Code	Description
1105	Dermatophytosis of body
1120	Candidiasis of mouth
112	Candidiasis of mouth
1121	Candidal vulvovaginitis
1122	Candidias urogenital NEC
1123	Cutaneous candidiasis
1128	Candidiasis-other specified sites
11282	Candidal otitis external
11284	Candidal esophagitis
11285	Candidal enteritis
11289	Candidiasis site NEC
1129	Candidiasis site NOS
133	Acariasis
1330	Scabies
1338	Acariasis NEC
1339	Acariasis NOS
372	Disorders of conjunctiva
3720	Acute conjunctivitis
37200	Acute conjunctivitis unspecified
37201	Serous conjunctivitis
37202	Ac follic conjunctivitis
37204	Pseudomemb conjunctivitis
37205	Ac atopic conjunctivitis
37210	Chronic conjunctivitis, unspecified
3721	Chronic conjunctivitis
37211	Simpl chr conjunctivitis
37212	Chr follic conjunctivitis
37213	Vernal conjunctivitis
37214	Chr allrg conjunctivitis NEC
37215	Parasitic conjunctivitis
3722	Belpharoconjunctivitis
37220	Belpharoconjunctivitis, unspecified
37221	Angular blepharoconjunct
37222	Contact blepharoconjunct
3723	Other and unspecified conjunctivitis
37230	Conjunctivitis, unspecified
37231	Rosacea conjunctivitis

ICD-9 Code	Description
37239	Conjunctivitis NEC
37203	Other mucopurulent conjunctivitis
37333	Xeroderma of eyelid
382	Suppurative and unspecified otitis media
38200	Acute suppurative otitis media without spontaneous rupture of ear drum
3820	Acute suppurative otitis media
38201	Acc supp om w drum rupt
3821	Chr tubotympan suppur om
3822	Chr atticofuruncul sup om
3823	Chr sup otitis media NOS
3824	Suppur otitis media NOS
3829	Otitis media NOS
38302	Ac mastoiditis-comp NEC
460	Acute nasopharyngitis
462	Acute pharyngitis
4650	Acute laryngopharyngitis
465	Acute upper respiratory infections of multiple of unspecified sites
4658	Acute uri mult sites NEC
46659	Acute uri NOS
4660	Acute bronchitis
466	Acute bronchitis and bronchiolitis
4720	Chronic rhinitis
472	Chronic pharyngitis and nasopharyngitis
4721	Chronic pharyngitis
4722	Chronic nasopharyngitis
4730	Chronic maxillary sinusitis
473	Chronic sinusitis
4731	Chr frontal sinusitis
4732	Chr ethmoidal sinusitis
4733	Chr sphenoidal sinusitis
4738	Chronic sinusitis NEC
4739	Chronic sinusitis NOS

ICD-9 Code	Description
4740	Chronic tonsillitis and adenoiditis
47400	Chronic tonsillitis
474	Chronic disease of tonsils and adenoids
47401	Chronic adenoiditis
47402	Chronic tonsils and adenoids
4741	Hypertrophy of tonsils and adenoids
47410	Tonsils with adenoids
47411	Hypertrophy tonsils
47412	Hypertrophy adenoids
4742	Adenoid vegetations
4748	Chr T & A Dis NEC
4749	Chr T & A Dis NOS
595	Cystitis
5950	Acute cystitis
5951	Chr interstit cystitis
5952	Chronic cystitis NEC
5953	Trigonitis
5954	Cystitis in oth dis
5958	Other specified types of cystitis
59581	Cystitis cystica
59582	Irradiation cystitis
59589	Cystitis NEC
5959	Cystitis NOS
5990	Urinary tract infection, site not specified
616	Inflammatory disease of the cervix, vagina, vulva
6160	Cervicitis and endocervicitis
6161	Vaginitis and vulvovaginitis
6288	Female infertility NEC
6988	Pruritic conditions NEC
6989	Pruritic disorder NOS
7051	Prickly heat
7242	Lumbago
7245	Backache NOS
7247	Disorders of coccyx

ICD-9 Code	Description
7248	Other back symptoms
7840	Headache
V67	Follow up examination
V670	Surgery follow up
V6700	Following surgery, unspecified
V6701	Follow up vaginal pap smear
V6709	Following other surgery
V671	Radiotherapy follow up
V672	Chemotherapy follow up
V673	Psychiatric follow up
V674	Fu exam treatd healed fx
V675	Following other treatment
V6751	High risk Rx NEC exam
V6759	Follow up exam NEC
V676	Comb treatment follow
V679	Follow up exam NOS
V68	Encounters for administrative purposes
V680	Issue medical certificat
V6801	Disability examination
V6809	Other issue of medical certificates
V681	Issue repeat prescript
V682	Request expert evidence
V688	Other specified administrative purposes
V6881	Referral-no exam/treat
V6889	Other specified administrative purposes
V689	Administrtrve encount NOS
V70	General medical examination
V700	Routine medical exam at health facility
V701	Psych exam-authority req
V702	Gen psychiatric exam NEC
V703	Med exam NEC-admin purpose
V704	Exam-medicolegal reasons
V705	Health exam-group survey
V706	Health exam-pop survey (population)

ICD-9 Code	Description
V707	Exam-clinical research
V708	General medical exam NEC
V709	General medical exam NOS
V72	Special investigations and examinations
V720	Eye and vision examination
V721	Ear and hearing examination
V7211	Encounter for hearing examination following failed hearing screening
V7212	Encounter for hearing conservation and treatment
V7219	Other examinations of ears and hearing
V722	Dental examination
V723	Gynecologic examination
V7231	Routin gynecological examination
V7232	Encounter for papanicolaou cervical smear to confirm findings of recent normal pap smear following initial abnormal pap smear
V724	Preg exam-preg unconfirm
V7240	Pregnancy examination or test, pregnancy unconfirmed
V7241	Pregnancy examination or test, negative result
V7242	Pregnancy examination or test, positive result
V725	Radiological exam NEC
V726	Laboratory examination
V727	Skin/sensitization tests
V728	Examination NEC
V7281	Preop cardiovsclr exam
V7282	Preop respiratory exam
V7283	Oth spcf preop exma
V7284	Preop exam unspcf
V7285	Oth specified exma
V7286	Encounter blood typing
V729	Examination NOS

Appendix 2

Dental Diagnosis Codes used in ER study

ICD-9 Code	Description
5206	Tooth eruption disturb
5207	Teething syndrome
5208	Tooth devel/erup dis NEC
5210	Dental caries NOS
52100	Dental caries NOS
52101	Dental caries - enamel
52102	Dental caries - dentine
52103	Dental caries - pulp
52108	Dental caries-root surf
52109	Dental caries NEC
52120	Abrasion NOS
52130	Erosion NOS
52131	Erosion-enamel
52134	Erosion-localized
52181	Cracked tooth
5220	Pulpitis
5221	Necrosis of tooth pulp
5224	Ac apical periodontitis
5225	Periapical abscess
5226	Chr apical periodontitis
5227	Periapical absc w sinus
5228	Radicular cyst
5229	Pulp/periapical dis NEC
5230	Acute gingitis, plaque

ICD-9 Code	Description
52300	Acute gingitis, plaque
52301	Ac gingivitis,nonplaque
52310	Chronic gingitis,plaque
52311	Chr gingivitis-nonplaque
52320	Gingival recession NOS
52330	Aggres periodontitis NOS
52331	Aggres periodontitis,loc
52333	Acute periodontitis
52340	Chronic periodontitis NOS
5235	Periodontosis
5238	Periodontal disease NEC
5239	Gingiv/periodont dis NOS
52409	Oth specf anmly jaw size
52410	Unspecf anm jaw cranl bse
52430	Tooth position anom NOS
52433	Horizontl displace-teeth
52434	Vertical displace-teeth
52460	TMJ disorders NOS
52462	Arthralgia TMJ
52469	Other specf TMJ disorders
52510	Acq absence of teeth NOS
52511	Loss of teeth d/t trauma
52512	Loss teeth d/t peri dis
52519	Loss of teeth NEC

ICD-9 Code	Description
52520	Atrophy alvlar ridge NOS
52540	Complete edentulism NOS
52550	Partial edentulism NOS
52560	Unsat restore tooth NOS
52563	Fx dental mat w/o loss
52564	Fx dentl material w loss
52571	Osseo fail dental implnt
52573	Post-osse mech fail impl
52579	Endos dentl imp fail NEC
5258	Dental disorder NEC
5259	Dental disorder NOS
5260	Devel odontogenic cysts
5262	Cysts of jaws NEC
5264	Inflammation of jaw
5265	Alveolitis of jaw
52689	Jaw disease NEC
5269	Jaw disease NOS
52800	Stomatitis/mucositis NOS
52801	Mucositis d/t antineo rx
52809	Stomatitis & mucositis NEC
52879	Dist oral epithelium NEC

Mental Health/Substance Abuse Diagnosis Codes used in ER study

ICD-9 Code	Description
29042	Vasc dementia w delusion
29043	Vasc dementia w depressn
2910	Delirium tremens
29100	Delirium tremens
29110	Alcohol amnestic disordr
29120	Alcohol persist dementia
29130	Alcoh psy dis w hallucin
29140	Pathologic alcohol intox
29181	Alcohol withdrawal
29189	Alcohol mental disor NEC
29190	Alcohol mental disor NOS
2920	Drug withdrawal
29200	Drug withdrawal
29211	Drug psych disor w delus
29212	Drug psy dis w hallucin
29220	Pathologic drug intox
29281	Drug-induced delirium
29282	Drug persisting dementia
29284	Drug-induced mood disord
29285	Drug induced sleep disor
29289	Drug mental disorder NEC
29290	Drug mental disorder NOS
2930	Delirium d/t other cond
29381	Psy dis w delus oth dis
29382	Psy dis w halluc oth dis
29389	Transient mental dis NEC
2939	Transient mental dis NOS
29411	Dementia w behavior dist
2948	Mental disor NEC oth dis
2949	Mental disor NOS oth dis
2950	Simpl schizophren-unspec
29500	Simpl schizophren-unspec
29510	Hebephrenia-unspec
29513	Hebephren-subchr/exacerb
29514	Hebephrenia-chr/exacerb
29520	Catatonia-unspec
29524	Catatonia-chr/exacerb
29530	Paranoid schizo-unspec
29532	Paranoid schizo-chronic
29533	Paran schizo-subchr/exac
29534	Paran schizo-chr/exacerb
29540	Schizophreniform dis NOS
29542	Schizophren dis-chronic
29543	Schizo dis-subchr/exacer
29544	Schizophr dis-chr/exacer
29550	Latent schizophren-unsp

ICD-9 Code	Description
29560	Schizophr dis resid NOS
29562	Schizophr dis resid-chr
29563	Schizo resid subchr/exac
29564	Schizophr resid-chro/exac
29570	Schizoaffective dis NOS
29572	Schizoaffective dis-chr
29573	Schizoaff dis-subchr/exac
29574	Schizoafftv dis-chr/exac
29580	Schizophrenia NEC-unspec
29582	Schizophrenia NEC-chr
29583	Schizo NEC-subchr/exacer
29584	Schizo NEC-chr/exacerb
29590	Schizophrenia NOS-unspec
29592	Schizophrenia NOS-chr
29593	Schizo NOS-subchr/exacer
29594	Schizo NOS-chr/exacerb
29595	Schizophrenia NOS-remiss
2960	Bipol I single manic NOS
29600	Bipol I single manic NOS
29604	Bipo I sin man-sev w psy
29610	Recur manic dis-unspec
29620	Depress psychosis-unspec
29621	Depress psychosis-mild
29622	Depressive psychosis-mod
29623	Depress psychosis-severe
29624	Depr psychos-sev w psych
29626	Depr psychos-full remiss
29630	Recurr depr psychos-unsp
29631	Recurr depr psychos-mild
29632	Recurr depr psychos-mod
29633	Recur depr psych-severe
29634	Rec depr psych-psychotic
29635	Recur depr psyc-part rem
29636	Recur depr psyc-full rem
29640	Bipol I currnt manic NOS
29642	Bipol I currnt manic-mod
29643	Bipol I manc-sev w/o psy
29644	Bipol I manic-sev w psy
29645	Bipol I cur man part rem
29650	Bipol I cur depress NOS
29651	Bipol I cur depress-mild
29652	Bipol I cur depress-mod
29653	Bipol I curr dep w/o psy
29654	Bipol I currnt dep w psy
29655	Bipol I cur dep rem NOS
29660	Bipol I currnt mixed NOS

ICD-9 Code	Description
29661	Bipol I currnt mix-mild
29662	Bipol I currnt mixed-mod
29663	Bipol I cur mix w/o psy
29664	Bipol I cur mixed w psy
2967	Bipolar I current NOS
29680	Bipolar disorder NOS
29681	Atypical manic disorder
29682	Atypical depressive dis
29689	Bipolar disorder NEC
29690	Episodic mood disord NOS
29699	Episodic mood disord NEC
2970	Paranoid state, simple
2971	Delusional disorder
2978	Paranoid states NEC
2979	Paranoid state NOS
2980	React depress psychosis
2981	Excitativ type psychosis
2982	Reactive confusion
2983	Acute paranoid reaction
2988	React psychosis NEC/NOS
2989	Psychosis NOS
2990	Autistic disord-current
29900	Autistic disord-current
29980	Pervasv dev dis-cur NEC
29990	Pervasv dev dis-cur NOS
3000	Anxiety state NOS
30000	Anxiety state NOS
30001	Panic dis w/o agorophobia
30002	Generalized anxiety dis
30009	Anxiety state NEC
30010	Hysteria NOS
30011	Conversion disorder
30012	Dissociative amnesia
30013	Dissociative fugue
30015	Dissociative react NOS
30019	Factitious ill NEC/NOS
30020	Phobia NOS
30021	Agoraphobia w panic dis
30022	Agoraphobia w/o panic
30029	Isolated/spec phobia NEC
3003	Obsessive-compulsive dis
3004	Dysthymic disorder
3005	Neurasthenia
30081	Somatization disorder
30089	Somatoform disorders NEC
3009	Nonpsychotic disord NOS

Mental Health/Substance Abuse Diagnosis Codes (continued)

ICD-9 Code	Description
30113	Cyclothymic disorder
3013	Explosive personality
30151	Chr factitious illness
3016	Dependent personality
3017	Antisocial personality
30181	Narcissistic personality
30183	Borderline personality
30189	Personality disorder NEC
3019	Personality disorder NOS
30250	Trans-sexualism NOS
30270	Psychosexual dysfunc NOS
30272	Inhibited sex excitement
30289	Psychosexual dis NEC
3029	Psychosexual dis NOS
3030	Ac alcohol intox-unspec
30300	Ac alcohol intox-unspec
30301	Ac alcohol intox-contin
30302	Ac alcohol intox-episod
30390	Alcoh dep NEC/NOS-unspec
30391	Alcoh dep NEC/NOS-contin
30392	Alcoh dep NEC/NOS-episod
30393	Alcoh dep NEC/NOS-remiss
3040	Opioid dependence-unspec
30400	Opioid dependence-unspec
30401	Opioid dependence-contin
30403	Opioid dependence-remiss
30410	Sed,hyp,anxiolyt dep-NOS
30411	Sed,hyp,anxiolyt dep-con
30420	Cocaine depend-unspec
30421	Cocaine depend-contin
30422	Cocaine depend-episodic
30423	Cocaine depend-remiss
30430	Cannabis depend-unspec
30431	Cannabis depend-contin
30433	Cannabis depend-remiss
30440	Amphetamin depend-unspec
30441	Amphetamin depend-contin
30460	Drug depend NEC-unspec
30461	Drug depend NEC-contin
30470	Opioid/other dep-unspec
30471	Opioid/other dep-contin
30480	Comb drug dep NEC-unspec
30481	Comb drug dep NEC-contin
30490	Drug depend NOS-unspec
30491	Drug depend NOS-contin
3050	Alcohol abuse-unspec

ICD-9 Code	Description
30500	Alcohol abuse-unspec
30501	Alcohol abuse-continuous
30502	Alcohol abuse-episodic
3051	Tobacco use disorder
30520	Cannabis abuse-unspec
30521	Cannabis abuse-contin
30530	Hallucinog abuse-unspec
30531	Hallucinog abuse-contin
30540	Sed,hyp,anxiolytc ab-NOS
30542	Sed,hyp,anxiolytc ab-epi
30550	Opioid abuse-unspec
30551	Opioid abuse-continuous
30552	Opioid abuse-episodic
30553	Opioid abuse-in remiss
30560	Cocaine abuse-unspec
30561	Cocaine abuse-continuous
30562	Cocaine abuse-episodic
30570	Amphetamine abuse-unspec
30571	Amphetamine abuse-contin
30572	Amphetamine abuse-episod
30590	Drug abuse NEC-unspec
30591	Drug abuse NEC-contin
30592	Drug abuse NEC-episodic
30593	Drug abuse NEC-in remiss
3060	Psychogen muscelskel dis
3061	Psychogenic respir dis
3063	Psychogenic skin disease
3064	Psychogenic GI disease
3068	Psychogenic disorder NEC
3069	Psychogenic disorder NOS
3070	Stuttering
3071	Anorexia nervosa
30720	Tic disorder NOS
30723	Tourette's disorder
30742	Persistent insomnia
30743	Transient hypersomnia
30745	Nonorganic circadian rhy
30746	Sleep arousal disorder
30747	Sleep stage dysfunc NEC
30750	Eating disorder NOS
30751	Bulimia nervosa
30754	Psychogenic vomiting
30759	Eating disorder NEC
3076	Enuresis
3077	Encopresis
30781	Tension headache
30789	Psychogenic pain NEC

ICD-9 Code	Description
3079	Special symptom NEC/NOS
3080	Stress react, emotional
3082	Stress react, psychomot
3083	Acute stress react NEC
3089	Acute stress react NOS
3090	Adjustmnt dis w depressn
3091	Prolong depressive react
30924	Adjustment dis w anxiety
30928	Adjust dis w anxiety/dep
30929	Adj react-emotion NEC
3093	Adjust disor/dis conduct
3094	Adj dis-emotion/conduct
30981	Posttraumatic stress dis
30989	Adjustment reaction NEC
3099	Adjustment reaction NOS
3100	Frontal lobe syndrome
3101	Personality chg oth dis
3102	Postconcussion syndrome
3108	Nonpsychot brain syn NEC
3109	Nonpsychot brain syn NOS
311	Depressive disorder NEC
3120	Unsocial aggress-unspec
31200	Unsocial aggress-unspec
31201	Unsocial aggression-mild
31202	Unsocial aggression-mod
31203	Unsocial aggress-severe
31210	Unsocial unaggress-unsp
31220	Social conduct dis-unsp
31223	Social conduct dis-sev
31230	Impulse control dis NOS
31233	Pyromania
31234	Intermitt explosive dis
31235	Isolated explosive dis
31239	Impulse control dis NEC
3124	Mix dis conduct/emotion
31281	Cndct dsrdr chldhd onst
31282	Cndct dsrdr adlsent onst
31289	Other conduct disorder
3129	Conduct disturbance NOS
3133	Relationship problems
31381	Opposition defiant disor
31389	Emotional dis child NEC
3139	Emotional dis child NOS
3140	Attn defic nonhyperact
31400	Attn defic nonhyperact
31401	Attn deficit w hyperact
3158	Development delays NEC

Mental Health/Substance Abuse Diagnosis Codes (continued)

ICD-9 Code	Description
3159	Development delay NOS
316	Psychic factor w oth dis
3181	Severe mental retardat
319	Mental retardation NOS
64833	Drug dependence-antepart
64843	Mental disorder-antepart
9650	Poisoning-opium NOS
96500	Poisoning-opium NOS
96501	Poisoning-heroin
96502	Poisoning-methadone
96509	Poisoning-opiates NEC
9651	Poisoning-salicylates
9654	Pois-arom analgesics NEC
9655	Poisoning-pyrazole deriv
96561	Pois-propionic acid derv
9657	Pois-no-narc analges NEC
9658	Pois-analges/antipyr NEC
9659	Pois-analges/antipyr NOS
9670	Poisoning-barbiturates
9671	Poisoning-chloral hydrat
9678	Pois-sedative/hypnot NEC
9679	Pois-sedative/hypnot NOS
9680	Pois-cns muscle depress
9682	Poison-gas anesthet NEC
9683	Poison-intraven anesthet
9684	Pois-gen anesth NEC/NOS
9685	Pois-topic/infilt anesth
9690	Poisoning-antidepressant
9691	Pois-phenothiazine tranq
9692	Pois-butyrophenone tranq
96930	Poison-antipsychotic NEC
96940	Pois-benzodiazepine tran
9695	Poison-tranquilizer NEC
9696	Poisoning-hallucinogens
96970	Poison-psychostimulants
9698	Poison-psychotropic NEC
9699	Poison-psychotropic NOS
9701	Poison-opiate antagonist
9708	Pois-cns stimulants NEC
9709	Pois-cns stimulant NOS
9710	Pois-parasympathomimetic
9711	Pois-parasympatholytics
9712	Poison-sympathomimetics
9713	Poisoning-sympatholytics
9719	Pois-autonomic agent NOS
9751	Pois-smooth muscle relax
9752	Pois-skelet muscle relax

ICD-9 Code	Description
9753	Poison-muscle agent NEC
9754	Poisoning-antitussives
9755	Poisoning-expectorants
9757	Poisoning-antiasthmatics
9761	Poisoning-antipruritics
9763	Pois-emol/demul/protect
9770	Poisoning-dietetics
9773	Poison-alcohol deterrent
9779	Poison-medicinal agt NOS
9800	Toxic eff ethyl alcohol
9801	Toxic eff methyl alcohol
9802	Toxic eff isopropyl alc
9803	Toxic effect fusel oil
9808	Toxic effect alcohol NEC
9809	Toxic effect alcohol NOS
9820	Toxic effect benzene
9828	Toxic eff nonpetrol solv
9870	Toxic eff liq petrol gas
9871	Tox ef hydrocarb gas NEC
9872	Toxic eff nitrogen oxide
9875	Tox eff lacrimogenic gas
9876	Toxic eff chlorine gas
9878	Toxic eff gas/vapor NEC
9879	Toxic eff gas/vapor NOS
V6284	Suicidal ideation
V702	Gen psychiatric exam NEC
V7020	Gen psychiatric exam NEC
V7101	Obsv-adult antisoc behav
V7102	Obsv-adolesc antisoc beh
V7109	Observ-mental cond NEC
V799	Screen-mental dis NOS