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INSIDE

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Care coordination with CMs results in 33% decrease in ED visits

Program also decreases inpatient stays

Embedded care managers in primary care offices, telephonic care managers, and a population health approach have helped a major health system in its transition from a fee-for-service model to a value-based care model.

Nine years after deciding to embrace a total health model that uses a holistic approach to caring for patients, the Greenville Health System (GHS) in South Carolina has stacked up success stories, says **Jennifer Z. Snow**, MBA, director of accountable communities at GHS.

"In 2007, GHS committed to becoming a total health organization where we care for the whole patient, taking a holistic approach," Snow explains. "In 2009, we started our first attempt at managing a patient population, with a grant funded by The Duke Endowment, in our internal medicine clinic."

The program began with an initial focus on identifying high-risk patients

EXECUTIVE SUMMARY

Care coordination program addresses wide range of issues that result in repeated emergency department and hospital visits, including issues related to social determinants of care.

- Program results in 25% decrease of inpatient utilization and 33% decrease in emergency department use.
- It uses a robust algorithm to identify patients' risk status.
- Care managers, embedded in primary care offices, provide follow-up phone calls to patients, giving needed information and making certain they have follow-up appointments scheduled.

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by disease states. "Within that first year of the grant, we decided we needed to adjust our approach and changed the model," Snow says. "We started looking at emergency room utilization and hospital admissions."

The grant-funded pilot program had a care management team that included a nurse care manager, a social worker, and added primary care access with a nurse practitioner. The team worked with patients at the internal medicine clinic, she says.

What GHS and care managers discovered is that patients' health conditions only accounted for about 20% of healthcare costs, Snow says.

"It is well known in the industry that 80% are more reliant on social determinants of care, rather than health conditions," she says. "We took that model and nurse care manager approach to include a focus on social determinants to our ER department and were also successful managing care in our internal medicine clinic."

The program added care managers to the employee health plan, Snow says.

"They looked at the at-risk patients within the physician practices and targeted care interventions based on the patient's condition and risk level," Snow adds.

"We have seen reductions in emergency department utilization, in inpatient admissions and readmissions, and we've also seen clinical outcome improvements in terms of lowering cholesterol levels and hemoglobin A1C," says **Nancy Markle**, RN, vice president of care transformation, Care Coordination Institute at GHS. The care management program focuses on care coordination across the continuum of care, and the team includes registered nurses, social workers, health coaches, and community health workers.

Outcomes from care coordination among the health system's Medicaid population include the following:

- 25% decrease of inpatient utilization,
- 33% decrease in emergency department use,
- 300% increase in wellness and prevention visits, and
- 20% decrease in 30-day, all-cause readmissions.

After the health system expanded the care management program to its 15,000-employee population — which largely is self-insured by the health system — similarly positive results ensued, including a reduction in hemoglobin A1c from 9.02 to 8.56 within one year for patients with diabetes.

The care management program continued to grow. It expanded to more populations, including an accountable care organization (ACO), which has a contract with the Centers for Medicare & Medicaid Services (CMS) for approximately 56,000 Medicare Shared Savings Program beneficiaries. It's also expanded to a population of uninsured, high-risk patients, and it has been offered as a service to more than 100 employers for their high-risk employees. Now there are more than 40 employees in the health system's ambulatory care management program, Snow says.

The following is how the program works:

- **A robust algorithm identifies patients' risk status.** Care management is a costly resource, so it's used with patients at the greatest risk of having poor medical management, high costs, and overutilization of hospital resources. The Care Coordination Institute also looks at data from ICD-10/CPT 4 codes to identify those who would

most benefit from care management, Markle says.

"We looked at triggers to identify patients for care management," she says. "We break these up between inpatient and outpatient and chronic diseases with the potential of down-the-road complications, including diabetes, asthma, hypertension, heart disease, depression, and other indications that indicate poor self-management."

These additional triggers include frequent emergency department visits, frequent hospital admissions and readmissions, psychosocial barriers to care, and lack of caregiver support, Markle says.

"That's a broad overview, and the risk stratification analytics and algorithm take a much deeper dive into the data," Markle says.

• **A transitional care component targets those at high risk.** Patients with acute care admissions and a high risk for readmission, poor outcomes, and increased utilization receive a 30- to 90-day intensive course of care management.

"In addition to our ambulatory care management approach, we have established our patient-centered medical neighborhoods model," Snow says. "We have identified at-risk neighborhoods and deployed the resources in the communities where our patients need them the most."

Some high-risk patients need home visits, which is a program GHS provides to the most vulnerable neighborhoods in its county.

"We have a community paramedic and social worker who go to people's homes and help them set up pill reminders, arrange transportation, talk to the patient's family about caregiver support, and do anything else they can to address the social determinants of health," Snow says.

• **Care management includes a focus on social-behavioral obstacles.** For example, one person targeted with case management services had visited the emergency department nearly 150 times, including almost 40 in one year, Snow says.

Once the patient's case was closely assessed, the care team discovered that the visits were unnecessary, almost always the result of the patient needing non-emergency medical care but not having transportation to get to a doctor, she explains.

"All this patient needed was a primary care provider and access to a gastrointestinal doctor," Snow says. "We arranged for transportation and got the patient into a primary care home, and now the patient sees that provider and doesn't come to the ER."

Another patient they assisted had a change in blood pressure medications that the patient was not taking correctly, Snow recalls.

"It was making the patient sick, so we sent someone out to the home to explain the change in medication and how to set up pill reminders," she says.

Other examples include a asthma patient who lives with a smoker. "So we went into the patient's home and asked the roommate to smoke outside, and help change air filters," Snow says.

"It can be any of these social determinants of health," she says. "We look at the patient as a whole."

The healthcare delivery system is difficult to navigate for everyone, but especially daunting for people who lack access and resources, which is why care management can make a big difference in outcomes.

"We're bridging that gap in the communities where patients who need it the most live," Snow says. "We need to be innovative with our care management design."

• **Care managers provide support to physicians and office staff.** "Our philosophy is that we position the care managers as a support to the physicians and their office staff," Markle says. "We take on a lot of the interventions between office visits so physicians can focus on the care at the point of service."

Care managers provide follow-up phone calls to patients, making certain they have follow-up appointments scheduled. They provide patient education and coordinate with clinical pharmacists for medication reconciliation, she says.

"Our care managers do a lot of coordination and support physician care," Markle says. "The staffing model consists of both embedded care managers in practices with large volumes of high-risk patients, as well as telephonic care managers that can cover several practices with lower volumes."

The embedded case managers log into computer systems that are linked with physician offices' electronic medical records so doctors can access any care plans case managers created with patients, she notes.

Care managers who manage via phone provide the following care management services:

• They call and/or visit patients to assess risk status.

• They call patients who have been discharged from the hospital within 24 hours of discharge and schedule a follow-up appointment within 48-72 hours after discharge.

• They provide telephone interventions tailored to patients' risk levels, including calling the highest-risk patients more frequently and focusing more on health and wellness with the lower-risk patients, Markle says. ■

CDC's new opioid guidelines are welcome change from case management perspective

Opioid prescriptions quadrupled in past 17 years

Case managers, like other healthcare professionals, have seen firsthand the damage caused by prescription opioid abuse. The new opioid prescription guidelines from the Centers for Disease Control and Prevention (CDC) are a welcome change, some case managers say.

"This is the first time the federal government is stepping up with a stronger message and actually saying what states and physicians need to be doing to stop this [opioid] runaway train," says **Kathleen Fraser**, RN-BC, MSN, MHA, CCM, CRRN, national president of the Case Management Society of America (CMSA).

"I think everybody has acknowledged that there is a problem, and we need more stringent guidelines," says **Cheri Bankston**, RN, MSN, director of clinical advisory services at Curaspan Health Group in Newton, MA.

The CDC's new recommendations push for more cautious opioid prescribing and more consistent and informed monitoring of patients using the drugs. Released in March 2016, the CDC's guidelines are in response to what the federal agency calls an epidemic of prescription opioid overdoses. One out of five patients who have non-cancer pain symptoms is prescribed opioids. This is one of the reasons why opioid prescriptions and sales have quadrupled since 1999.[1]

Now there are more than 14,000 Americans dying — about 40 per day — from overdoses of the prescription drug, says CDC Director **Tom Frieden**, MD, MPH. *(See the CDC's recommendations, page 53.)*

Chiefly, the guidelines are for primary care physicians who prescribe opioids for chronic pain that is not related to active cancer treatment, palliative care, or end-of-life care. This same population often has chronic conditions that result in their receiving case management services.

"One of the problems we've seen — and the CDC brought out a lot of this with the release of the guidelines — is the sheer volume of people who are using or dependent on prescription opioids: Nearly 2 million Americans either were dependent or abused opioids in 2014," Bankston says.

In 2012, more than half a million emergency department visits were due to people misusing or abusing prescription pain killers, and these visits were by people who used emergency rooms in hopes of getting more pain medication, Fraser notes.

"From a case management perspective, we deal with the downstream effect of opioid abuse," Bankston says. "I think these guidelines will help support what we've been doing all along, including directing patients to the best therapy and avoiding any side effects or long-term negative impact of therapy that leads to an abuse or addictive situation."

Physicians can use the guidelines to inform their opioid prescribing policies, but the CDC's paper also provides an additional tool for case managers when they wish to educate patients about opioid use risks.

"Case managers can educate patients about the statistics and death rates from accidental overdoses of these prescription medications and the dangers of being on them daily for a very long period of time," Fraser says.

In workers' compensation cases, case managers should consider statistics showing that injured employees who start taking short-term prescription opioids have three times the claim costs — from

EXECUTIVE SUMMARY

The Centers for Disease Control and Prevention (CDC) issued new guidelines for prescribing and managing prescription opioids in hopes of curtailing some of the nation's more than 14,000 opioid overdose deaths each year.

- CDC recommends more cautious opioid prescribing and more consistent and informed monitoring of patients who are using these drugs.
- Case managers can educate patients about the risks of prescription opioids and give them information about alternative pain management solutions.
- Case managers also can identify community resources for patients who have been using prescription opioids and either have an addiction issue or need to find alternatives to opioids.

$13,000 to $39,000 — as workers who are prescribed over-the-counter pain medications, Fraser says.

"Yet when that same employee is prescribed a long-acting opioid, the claim costs explode to $117,000," Fraser adds.

Case managers also should consider quality-of-life issues faced by patients who use opioids for chronic pain, Fraser says.

"We are patient advocates, and you are not a patient advocate if you don't address this issue," Fraser says.

For example, case managers can educate patients about pain therapies that do not involve opioids.

"We can be experts and resources for our patients about other pain therapies that might be appropriate or prescribed when the physician is moving away from opioids," Bankston says. "We need to be aware of pain therapy, physical therapy, counseling, and other medication therapies other than opioids."

The CDC's guidelines highlight the importance of medication reconciliation. "Medication reconciliation is something we do every time we encounter a patient, whether in the home, community, or acute care setting at the hospital," Bankston says. "We want to make sure we have a clear picture of what kind of medication the patient has, which prescribers are involved, and reconciling these before we transition the patient to another setting."

One way providers can make certain patients are not abusing opioids through using different prescribers and pharmacies is to access state prescription drug monitoring program (PDMP) data, Bankston says.

A PDMP is a statewide electronic database that can be used to identify and prevent drug abuse and diversion.

"A lot of times, what we run into is there are multiple prescribers," Bankston explains. "A patient might use multiple pharmacies, and this could lead to a lot of problems with miscommunication and overprescribing."

Using the PDMP is a way providers and institutions can gain a clearer picture of what's going on with a patient's opioid use, she adds.

Case managers also can assist with monitoring patients who are prescribed opioids to make sure they are benefiting from the drug, including having improved pain and function, Bankston says.

"At the same time, case managers need to be prepared and make sure they understand the guidelines, recognize problems, and focus on medication reconciliation," Bankston says.

As physicians begin to change opioid prescribing habits in response to the CDC guidelines and media attention on the issue of prescription opioid abuse and overdoses, case managers have another helpful role to play: "We understand the community resources available to the patient," Bankston says.

"So we need to make sure when we're looking at those resources that we're considering those that might be able to meet the needs of the patient, whether that's a substance abuse program or a mental health provider or a pain management clinic," she explains. "We need to have easy availability and connectivity to those providers so we can give patients choices and so that we know in advance which providers can meet those patients' needs."

REFERENCE

1. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain – United States, 2016. *MMWR*. 2016;65(1):1-49. ■

Summary of the CDC's 12 recommendations

They're divided into three categories

The CDC issued 12 recommendations related to opioid prescription use.[1] The following is a summary of those recommendations:

Determining when to initiate or continue opioids for chronic pain:

1. Non-drug therapy and non-opioid drug therapy are preferred for chronic pain. Clinicians should consider opioid therapy only when expected benefits are expected to outweigh risks to the patient. When opioids are prescribed, they should be combined with non-drug therapy and non-opioid drug treatments.

2. Clinicians should establish treatment goals with all patients before starting opioid therapy for chronic pain. Goals should be realistic and consider how therapy will be discontinued if benefits do not outweigh risks to patient safety. Opioid therapy should be continued only when there is meaningful improvement in pain and function and these outweigh risks.

3. Clinicians should discuss

known risks and realistic benefits of opioid therapy with patients before starting and periodically during opioid therapy.

Opioid selection, dosage, duration, follow-up, and discontinuation:

4. Prescribe immediate-release opioids instead of extended-release/long-acting opioids when starting opioid therapy for chronic pain.

5. Prescribe the lowest effective dose when starting opioid therapy.

6. Prescribe the lowest effective dose of immediate release opioids and prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less often is sufficient; more than seven days is rarely necessary.

7. Evaluate benefits and harms to patients within one to four weeks of starting opioid therapy for chronic pain or dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every three months or more frequently. If harms outweigh benefits, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing risk and addressing harms of opioid use:

8. Continually evaluate risk factors for opioid-related harms. Incorporate strategies to mitigate risk into the management plans, including offering naloxone when there are factors that increase risk for opioid overdose.

9. Review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is using opioids in dangerous doses and combinations that place the person at risk for overdose.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually.

11. Avoid prescribing opioid pain medication and benzodiazepines concurrently.

12. Offer patients with opioid use disorder evidence-based treatment, which usually is medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies. ■

Bridge model blends social work with case management

Goal is better transitional support

A care transitions program that relies on social work principles has resulted in a huge drop in 30-day readmissions: from more than 100 among a high-utilizer cohort to a handful. It also significantly reduced the number of Medicare high-utilizers at an academic medical center.

Building on a strong community mission, Rush University Medical Center in Chicago created Bridge, a model that brings social work core competencies to the transitional care environment. The program, started a decade ago, targets at-risk Medicare beneficiaries, including the high-utilizer population that accounts for nearly half of hospital readmissions, says **Walter Rosenberg**, LCSW, manager of transitional care, health, and aging at Rush University Medical Center.

"We have 1,000 Medicare discharges every month," he says. "We wanted to support patients who came home from the community."

A recent six-month analysis looked at 456 high utilizers at Rush and found that pre-Bridge, the 30-day readmissions were 29.1%, while the 30-day readmissions after Bridge was implemented were 11.3%. Emergency department visits and post-discharge no-shows also declined, Rosenberg says.

A separate analysis of Medicare patients in a two-year demonstration project found the following, according to Rosenberg:

• The Bridge program's results from 2012 to 2014 showed 31% fewer 30-day readmissions.

• Results also showed a 60-day readmission rate that was 9.4% fewer than the weighted hospital average, and a 90-day readmission rate that was 13.9% fewer.

• The number of Medicare high utilizers at Rush declined from a peak of 282 in September 2014, to 249 in February 2015, a nearly 12% decrease.

In 2006, the health and aging department began to pilot making telephone calls to recently discharged patients, contacting over 2,500 over the next two years.

"People were confused, anxious, depressed, you name it, and we were a department of social workers. So we asked, 'How do we support these

patients better?'" Rosenberg says.

Rush researchers completed a randomized, controlled trial about the program at the same time the Affordable Care Act (ACA) became a reality, a stroke of good luck in timing, he notes.

"We were able to call ourselves 'evidence-based,' and the next thing we know, we had a lot of people reaching out to us, asking for training," Rosenberg says. "Now we have 55-66 sites across the country, implementing the model."

The Bridge model consists of the following three basic parts:

• **Pre-discharge phase:** Social workers conduct a medical review at each referral. An electronic database generates a daily list of patients who could benefit from Bridge based on their risk factors, Rosenberg says.

"Then we connect with the interdisciplinary team and collaborate with discharge planners and conduct a care continuity call," he explains. "The purpose is to connect a clinician from the inpatient side — either a hospitalist or resident — with an outpatient provider like a primary care provider or specialist."

A case manager makes the care continuity call with Bridge care coordinators, leading the informal, 10-minute call with the goal of identifying all of the patient's needs.

Then, social workers visit the patient at bedside, spending as much as 30 to 40 minutes. Their goal is to connect with each patient and strip away barriers to the patient's health self-management, Rosenberg says.

"The big picture is we want to connect with the patient on a human level, so we have a conversation about the patient's goals, ambitions, interests, hobbies, and family situation," he explains. "We want to know what the nonmedical picture is of this person and who the person is in terms of motivation and the kinds of things they look forward to."

The nonmedical information is used after discharge as a way to put the patient's medical problems into a social context. This type of information can be crucial to helping to change a person's behavior and activities to enhance health, he says.

"There's this notion that if we write prescriptions and tell patients what to do with them, they'll do it because it's important to them," Rosenberg says. "But they go home and real life takes over, and the next thing you know, they're not taking medications."

There are more compelling motivators than improving one's health, he notes.

"We find out that people can be motivated by TV shows, board games, grandkids, and gardening," he explains. "So we will say, 'Mrs. Johnson, you should take your medication so you can get back to gardening.'"

• **Post-discharge phase:** A first visit post-discharge could be via phone or in person. While in-person visits are more costly, they're also likely to result in richer data, Rosenberg says.

Organizations that replicate Bridge might choose phone visits because they are easier to implement, and they can obtain additional data from other providers, such as home health and community-based care providers, who visit patients' homes, he says.

"In 50% of cases, we work primarily with caregivers and have another set of eyes and ears on the ground," Rosenberg says.

At first post-discharge contact with patients, the intent is to conduct a comprehensive, bio-psychosocial assessment. "We want to find out what needs to be stabilized immediately on the medical side," Rosenberg says.

Goals include care coordination, case management, and patient engagement, including answering the following questions:

- Does the patient have his/her appointment scheduled?
- Does he/she have a way to get to the appointment?
- What is the patient's understanding of the appointment?
- Has the patient been connected to resources?
- Did the patient show up for the medical appointment?
- Did the scheduled home visit occur?

When working with patients, social workers use psychotherapeutic techniques and motivational interviewing, Rosenberg says. "We

EXECUTIVE SUMMARY

A care transitions model that bridges the gap for patients with social-environmental barriers to better health management has expanded to more than 50 sites across the country.

• The Bridge model's success includes dramatic decreases in 30-day readmissions among Medicare beneficiaries.

• The Bridge model also reduced 60-day and 90-day readmission rates and resulted in a decline in the number of high utilizers at Rush University Medical Center in Chicago.

• The program has social workers conduct a comprehensive, bio-psychosocial assessment, and goals include care coordination, case management, and patient engagement.

use cognitive behavioral therapy and techniques from those approaches to try to impact patient engagement."

It's not enough to schedule appointments for patients or to hand them brochures with medical information. There has to be follow-through, Rosenberg says.

So for the first 30 days post-discharge, the care team learns more about patients, has conversations about what motivates them, and checks in with them at least weekly, he adds.

• **Termination phase:** "This is ongoing, and it starts at the beginning," Rosenberg says. "It's very difficult to terminate these cases because patients really like the support: Here's someone listening and helping, and it's very hard to say 'goodbye.'"

However, a transitional care program is for 30 days, he adds.

"We want to make sure there's a connection to long-term services and support, so by the time of the last phone call, there have been several critical phone calls leading up to that one," Rosenberg says.

The next to last calls involve making sure patients understand everything they need to do to stay healthy and how they can obtain community resources: "We want to hammer home the importance of primary care," he says.

"We essentially want to make sure patients understand all the components before we let them go and disengage ourselves from them," Rosenberg says. ■

Sounding the alarm about suicide risk

Given that EDs are among the most likely places for patients at risk for suicide to present, experts say training staff to recognize and manage such patients is critical.

In its latest *Sentinel Event Alert*, The Joint Commission (TJC) spotlights the inescapable fact that in too many instances, healthcare providers are not recognizing signs of suicide risk in patients who present for care. It is a critical lapse, as most people who go on to commit suicide have interacted with the healthcare system in the year before their deaths, according to TJC.

The agency notes that between 2010 and 2014, its Sentinel Event Database received 1,089 reports of suicides. The most common root cause cited in these cases was inadequate assessment. According to TJC, in 2014 more than 21% of accredited behavioral health organizations and 5% of accredited hospitals were noncompliant with conducting a risk assessment to identify patient characteristics or environmental factors related to suicide risk.

As a result of these findings, TJC is calling on healthcare providers to review every patient's personal and family history for suicide risk factors, and to screen all patients using an evidence-based tool that includes questioning about suicidal thoughts. Further, TJC notes professionals should review these screens before discharge. Patients who screen positive for potential suicide risk should be subjected to more in-depth evaluations.

Know when to probe further

In issuing this alert, TJC encourages all healthcare organizations to develop "clinical environmental readiness" by developing and integrating the kind of behavioral, primary, and community care resources that ensure patients who are at risk for suicide continue to receive appropriate care when they transition back to the community or to the next healthcare setting.

While TJC's *Sentinel Event Alert* targets providers in all healthcare settings, expertise in both identifying the risk of suicide and managing this risk effectively is particularly important in the emergency environment.

"If there is a crisis involving someone who is suicidal, the most common advice is to call 911 or bring someone to the ED. Every year, hundreds of thousands of people who have made suicide attempts [and] many others who are thinking about suicide arrive at EDs," explains **Richard McKeon**, PhD, MPH, chief of the suicide prevention branch in the division of prevention, traumatic stress, and special programs in the Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services. "The ED is one of the most likely places for people at high risk for suicide to be encountered."

Further, while TJC highlights shortcomings in assessment as one of the most common root causes for suicide in patients who have recently visited a healthcare setting, McKeon observes that the problem of identifying risk is not even an issue in many patients who present to the ED.

"While screening is a good thing that can identify additional people, when someone is brought to the ED because of a suicide attempt or because the person has been talking about suicide and has been brought in by a family member, for example, then the issue of how to identify them is not present," he says. "You already know the person is at risk. Then the issue is assessing their risk and determining

what needs to happen next."

Beyond the obvious instances of risk, there are strong tipoffs that should prompt providers to probe further.

"The strongest predictor of future behavior is past behavior, so the absolute strongest indicator of a future suicide attempt or death by suicide is a past suicide attempt," explains **Cheryl McCullumsmith**, MD, PhD, an associate professor in the Department of Psychiatry and Behavioral Neuroscience at the University of Cincinnati. "Certainly, if you have in the record that someone has had a past suicide attempt or a family history of death by suicide, those are very specific things that people should be taking quite seriously."

Other indications that a person may be at risk for suicide can be picked up by questioning, but too often providers don't take this extra step, McCullumsmith notes. For instance, simply asking a patient whether he or she has had thoughts of self-harm or whether he or she feels that life is not worth living often yields critical information regarding risk.

"There are other things that we consider strong warning signs. Hopelessness has been very much associated with suicide attempts and death by suicide, so someone who just has no sense of the future or has no future plans" should alert the provider of potential risk, she says. McCullumsmith also notes that impulsivity and substance use are significantly underplayed as warning signs for suicide risk, but she acknowledges these issues are more difficult to address.

Whether patients will actually disclose they are thinking about suicide is a tougher question, but McCullumsmith suggests there is evidence that many people at risk for suicide do reach out for help, and that more active probing could make a difference.

"We do know that many people who have died by suicide have sought care from a primary care provider or someone else in the month or two before their death," she says. "It is unclear whether these people told their providers [about their plans], but a lot of people do seek help."

McCullumsmith is collaborating with colleagues at Cincinnati Children's Hospital to identify linguistic and auditory patterns associated with suicide risk, but this work is in early stages of development.

Develop approach for follow-up

McKeon estimates that about half of patients seen in EDs for a suicide attempt are not admitted but rather discharged, setting off a time period of critical importance.

"Typically, when someone walks out of an ED, the ED's responsibility ends. Someone may be referred to an outpatient department or a community mental health center, but the community mental health center's responsibility typically doesn't begin until the person walks through their door. There is a lethal gap between the ED and the outpatient department unless there is a system in place to pay attention to that," McKeon explains. "The rates of follow-up care can be poor, so it is vitally important that EDs are linked to community systems that can do a better job of improving these kinds of care transitions."

McCullumsmith agrees, noting she worked with colleagues at the University of Cincinnati and previously at the University of Alabama at Birmingham to set up programs to follow people within 1 or 2 days of discharge from an ED to make sure they are stable, and that they are able to connect with appropriate care. She stresses that this follow-up can involve phone calls or in-person visits, and physicians don't have to be the ones conducting these follow-ups.

"It can be done by a trained social worker, a psychologist, or a therapist," she says.

However, there is no question that putting such systems in place can be challenging, given the demands that are placed on busy EDs every day.

"Emergency medicine is under siege in this country. You go to any urban ED and people are stacked to the rooftops. There are stretchers in the hallway," says **Glenn Currier**, MD, MPH, chair and professor in the College of Medicine Psychiatry and Behavioral Neurosciences at the University of South Florida. "There is this notion that ED boarding of psych patients is one of the problems. Even if you find people who are at some elevated risk for suicide, the question is, what do you do with them? Then it often involves an involuntary commitment to a hospital. Make sure that you know what you're treating before you detain people and strip them of their civil rights in what, in many communities, is a very long wait for a psych bed."

Currier points out that the Washington State Supreme Court ruled last year that the boarding of psych patients violates peoples' inherent constitutional rights, but the court offered no suggestions on how to address the problem.

"Psych beds in this country are about one-tenth of what they used to be, so it is a complex problem," he says, noting that solutions must address how to safely and effectively manage patients who are found to be at some elevated risk of suicide in the ED. "It is not just a cost question. It is a rights question for the patient."

Currier observes that he has spent most of his life working in large EDs where demand for psychiatric services was so high that the health

systems incorporated freestanding psychiatric components to meet the needs of mental health patients in the emergency setting. With this setup, Currier found traditional emergency providers are willing to take on mental health issues once they learn how to provide evidence-based care.

"However, it is really incumbent on mental health to come up with protocols, algorithms, and treatments that work," he notes.

"Regionalization of this, similar to what we have done with trauma care, makes a whole lot of sense," Currier adds, noting that what he is referring to is a centralized receiving facility that makes optimal use of community assets to care for patients with mental health issues. Such programs often employ mobile crisis teams, shelter beds, and an array of resources that can help them maintain patients in the community. But such models often suffer over the long term.

"As long as [these programs] are attached to a hospital system, they work great. However, once you carve them off and put them in the community ... the support behind them tends to dwindle. Regionalization is a great idea; it just has to be done well."

Directing a psychiatric emergency service for many years gave McKeon empathy for emergency providers, many of whom are already overwhelmed with responsibilities.

"I know what a busy medical emergency room is like, and there is no question that it is important to figure out how to best integrate suicide prevention activities into the ongoing workflow of an ED," he says.

Screening for suicide risk is one of the issues, but McKeon suggests this may not be as big a barrier as some people think.

"People spend a lot of time waiting in EDs, so patients may well have time for screening," he says. "What is needed is the kind of systems that are able to communicate that [screening] information to emergency physicians and nursing staff quickly so that they can consider it in their dispositions."

McKeon acknowledges that connecting patients with appropriate mental healthcare is typically an easier task for EDs that are affiliated with major teaching hospitals.

"Then you may have the availability of psychiatric residents to come down to the ED, but the average ED doesn't have that. Particularly in rural or remote areas, there may not be the availability of any kind of mental health resources to the ED," he says.

> "PSYCH BEDS IN THIS COUNTRY ARE ABOUT ONE-TENTH OF WHAT THEY USED TO BE, SO IT IS A COMPLEX PROBLEM."

In these cases, EDs must partner with community mental health resources, McKeon notes. For instance, he explains that there are currently 165 crisis centers that are participating with the National Suicide Prevention Lifeline, many of which are funded through SAMHSA. Another option is to link with a telepsychiatry provider so that an informed suicide risk assessment or psychiatric assessment can be provided while patients are still in the ED.

"Trying to establish these relationships is key," McKeon says. "There isn't a substitute for it unless an ED is part of a hospital that is fortunate enough to have its own comprehensive system where an ED is able to refer to its own [psychiatric] service within the hospital or health system. If you don't have that, then there is a need for partnering."

Provide staff training

Access to referral sources for mental healthcare is critical, but traditional providers also need training on how to effectively identify and manage patients who are at risk.

"The issue of suicide makes many people — both traditional providers and mental health providers — anxious," McKeon says. "If you haven't been trained about what to do, then your anxiety is even higher ... people need to know what steps that they can take."

Also, knowing that there is someone who can follow up quickly if a patient is discharged is a key piece because otherwise you can get into a vicious cycle, McKeon adds.

"If the answer is always needing a hospital bed, and there are no hospital beds available, and the patient is just going to wait and wait for a bed to come available, then that ends up being a disincentive [to the provider] for looking too closely," he says. "The fundamental issue is one of anxiety, which is why it is important for people to be trained in risk assessment, trained in treatment options that are available, trained in how to collaboratively work with a patient toward keeping themselves safe, and [training] in how to work with families."

McKeon acknowledges emergency providers have a limited amount of time with patients.

"We are certainly conscious of the fact that if you urge people in EDs to

do things, you have to be [aware of] what the work flow actually is and what can realistically be done," he says.

Consequently, SAMHSA works with emergency providers and emergency psychiatrists to develop consensus steps for how to manage patients at risk of suicide in the ED. This work happened through the Suicide Prevention Resource Center (SPRC), and is available through the SPRC's website at: http://bit.ly/1MZPgYE.

Also available to frontline providers is what is called the Safe-T Card, a tool that actually walks providers through the fundamental steps of a suicide risk assessment, at: http://1.usa.gov/1UxwyPU.

Much of the same basic information from the Safe-T Card is also available in electronic form as the Suicide Safe App. ■

Look for weak links to prevent drug diversion

Consider drug audits by pharmacy staff

Kimberly New, RN, JD, founder of Diversion Specialists in Knoxville, TN, who frequently consults with healthcare facilities on drug diversion, cites the following common areas of weakness in diversion prevention programs:

- Lack of internal controls over controlled substances stored in emergency kits for trauma or urgent needs.
- Pain response documentation not regularly reviewed for patterns.
- Inadequate segregation of duties.
- End user passwords not changed per hospital policy.
- End users not terminated from system after job changes/responsibilities, termination.
- Discharged patient list remaining available for hours after discharge.
- Drug testing not done at pre-employment screening; drug testing not performed randomly for staff with drug access.
- Staff with little or no training/competency on system (poor practices).
- Built-in system controls "turned off"— too cumbersome.[1]

Signs of HCW diversion/impairment:

- Tardiness, unscheduled absences and an excessive number of sick days used.
- Frequent disappearances from the work site and taking frequent or long trips to the bathroom or to the stockroom where drugs are kept.
- Volunteers for overtime and is at work when not scheduled to be there.
- Arrives at work early and stays late.
- Pattern of removal of controlled substances near or at end of shift.
- Work performance alternates between periods of high and low productivity, may suffer from mistakes, poor judgment, and bad decisions.
- Interpersonal relations with colleagues, staff, and patients suffer. Rarely admits errors or accepts blame for errors or oversights (denial).
- Insistence on personal administration of injected narcotics to patients.
- Heavy or no "wastage" of drugs.
- Pattern of holding waste until oncoming shift.

CDC prevention tips:[2]

- Prepare medications as close as possible to the time of administration.
- Properly label pre-drawn syringes to include patient name.
- Consider use of tamper-resistant and tamper-evident syringes and automated dispensing cabinets with security and tracking features.
- Conduct audits by pharmacy staff, with testing to verify the identity or concentration of unused drugs that are returned to the pharmacy or discarded by healthcare workers.

REFERENCES

1. New KS, Loya KC. Health Facility Drug Diversion: Essential Compliance & Auditing Measures. Slide presentation, 2013.
2. Schaefer, M.K., Perz, J.F. Outbreaks of infections associated with drug diversion by US health care personnel. *Mayo Clin Proc* 2014;89:878–887. ■

COMING IN FUTURE MONTHS

- Population health model with ambulatory care management demonstrates success
- Targeting at-risk patients with psychiatric disabilities
- Leadership is crucial to developing high-performing care coordination teams
- How can case managers help identify victims of human trafficking?

CASE MANAGEMENT ADVISOR™

CE INSTRUCTIONS

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CE QUESTIONS

1. A care coordination program that has embedded case managers in physician offices can provide which of the following care management services?

A. Care managers can call and/or visit patients to assess risk status.
B. Care managers can contact patients who have been discharged from the hospital within 24 hours of discharge and schedule a follow-up appointment within 48-72 hours after discharge.
C. Care managers can provide telephone interventions tailored to patients' risk levels, including calling the highest risk patients more frequently and focusing more on health and wellness with the lower risk patients.
D. All of the above.

2. The CDC says that what proportion of Americans with non-cancer pain symptoms is prescribed opioids?

A. One out of two patients.
B. One out of six patients.
C. One out of five patients.
D. One out of three patients.

3. Which of the following is not one of the CDC's recommendations for opioid prescribing and management?

A. Prescribe the lowest effective dose when starting opioid therapy.
B. Evaluate benefits and harms to patients within one to four weeks of starting opioid therapy for chronic pain or dose escalation.
C. Prescribe extra-strength Tylenol for most of patients' complaints of chronic pain.
D. Continually evaluate risk factors for opioid-related harms.

4. A care transition program based on the Bridge model provides which type of comprehensive assessment at the first post-discharge contact with patients?

A. A bio-psychosocial assessment.
B. An activities of daily living inventory.
C. A checklist of health and safety in community environment.
D. None of the above.

Case Management Advisor

2016 Reader Survey

In an effort to learn more about the professionals who read *CMA*, we are conducting this reader survey. The results will be used to enhance the content and format of *CMA*.

Instructions: Fill in the appropriate answers. Please write in answers to the open-ended questions in the space provided. You may fax the completed questionnaire to (678) 974-5419, return it in the enclosed postage-paid envelope, or complete online at: https://www.surveymonkey.com/r/CMA_2016_survey. The deadline is **July 1, 2016.**

In future issues of *CMA*, would you like to see more or less coverage of the following topics?

A. more coverage B. less coverage C. about the same amount

1. disease management	O A	O B	O C
2. legal and ethical issues	O A	O B	O C
3. professional development	O A	O B	O C
4. staffing and caseloads	O A	O B	O C
5. quality improvement	O A	O B	O C
6. case management technology	O A	O B	O C
7. continuum-of-care issues	O A	O B	O C
8. elder care and end-of-life issues	O A	O B	O C
9. workers' compensation	O A	O B	O C
10. occupational health	O A	O B	O C

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15. overall value	O A	O B	O C	O D
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O D. 10-15
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O C. vice president/president
O D. owner
O E. other_____

22. What is the highest degree that you hold?

O A. ADN (2-year)
O B. diploma (3-year)
O C. bachelor's degree
O D. master's degree
O E. other_____

23. To what other publications or information sources about case management do you subscribe?

24. Including *CMA*, which publication or information source do you find most useful, and why?

25. Which web site related to your position do you use most often?

26. Please list the top three challenges you face in your job today.

27. What do you like most about *CMA*?

28. What do you like least about *CMA*?

29. What are the top three things you would add to *CMA* to make it more valuable for your money?

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