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Sounding the alarm about suicide risk

The Joint Commission urges universal screening and increased efforts to link at-risk patients to appropriate care

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 non-compliant with conducting a risk assessment to identify patient characteristics or environmental factors related to suicide risk.

> BETWEEN 2010 AND 2014, THE SENTINEL EVENT DATABASE RECEIVED 1,089 REPORTED SUICIDES, WITH INADEQUATE ASSESSMENT LISTED AS THE MOST COMMON ROOT CAUSE.

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.

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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.

Know when to probe further

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." (*Also see: "Three questions to recognize suicide risk," p. 52.*)

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.

EXECUTIVE SUMMARY

The Joint Commission (TJC) issued a *Sentinel Event Alert*, noting that in too many instances healthcare providers are not recognizing signs of suicide risk in patients who present for care. While the agency calls on all frontline providers to screen for suicide risk, experts note the issue is of particular importance to EDs because this is one of the most likely places for patients at high risk for suicide to present. Beyond identifying risk, experts note emergency providers and staff must receive training to effectively manage patients at risk for suicide. Further, TJC calls for the development of appropriate referral sources and mechanisms for follow-up contact.

- TJC reports that between 2010 and 2014, its Sentinel Event Database received 1,089 reports of suicides. The most common root cause was inadequate assessment. According to TJC, in 2014 more than 21% of accredited behavioral health organizations and 5% of accredited hospitals were non-compliant with conducting a risk assessment to identify patient characteristics or environmental factors related to suicide risk.
- Beyond instances of obvious risk, strong tipoffs that suicide is a concern include signs of hopelessness or evidence that the patient has no sense of the future. Further, experts note the strongest indicator of a future suicide attempt is a past attempt, so evidence in the record of a past suicide attempt, or a family history of suicide, should be taken very seriously.
- Researchers found that a three-item instrument, dubbed the Patient Safety Screener-3, can double the number of patients identified as at risk for suicide over usual care in a busy emergency setting. Experts recommend asking screening questions during the primary nursing assessment for most patients, and at triage for patients who present with a primary psychiatric complaint.
- Some experts suggest regionalizing mental health care, much like the country does with trauma care. However, communities must ensure they maintain adequate funding for such endeavors.

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

Three questions to recognize suicide risk

Edwin Boudreaux, PhD, uses a three-item suicide risk screen, dubbed the Patient Safety Screener-3, to effectively identify suicide risk, doubling the number of patients identified as at risk over usual care when applied universally in a busy ED setting.[1,2] The first question asks patients if they have felt down, depressed, or hopeless in the previous 2 weeks. The second question asks if patients have had suicidal thoughts in that same period. The third question asks if patients have ever attempted suicide. Answering "yes" to two questions suggests a patient is at risk. If the screen is to be applied universally to all patients, at what point in the workflow is the best time to ask patients the three questions? While Boudreaux hasn't studied that issue specifically, he believes for most EDs the best time to review these questions with patients who present with a non-psychiatric problem is during primary nursing assessment. "Many facilities want triage to be as fast as possible, and to be very focused on the problem that the patient is presenting with," he explains. "Any other kind of screening — public health, behavioral health, or anything related to metrics that are reported — really have a better utility once the patient is back [in a treatment room] and a more comprehensive assessment is performed."

For patients presenting with a psychiatric problem or emergency, Boudreaux advises screening at triage. "You've got two [screening] tiers that work," Boudreaux notes, indicating that the same screen is effective at both stages of the workflow. "My site has made the decision to implement the screen at triage rather than during the primary nursing assessment because it fits in with the workflow of the ED acceptably."

While there are no data on this point, Boudreaux suggests patients may not be as comfortable discussing or disclosing thoughts of suicide during triage as they are in a more private location. "You may get more false negatives if you do it that way," he says. The most private method may be through self-reporting via an electronic device. "When you administer a computerized self-assessment, you get as good or better results than when [the screen is administered] by an interviewer," Boudreaux offers. "The more sensitive the information, the more likely you are to get better information from the computer because you don't have … social issues influencing responsiveness." Additionally, computers ask questions exactly the same way every time, eliminating variability. Busy nurses often blend screening questions together, making the instrument less effective at determining risk. "You don't want a patient who screens positive for suicide risk leaving the waiting room before being seen," Boudreaux notes. "If you are going to screen for suicide in the waiting room, you specifically have to make sure there are procedures and protocols in place for reviewing those results quickly, identifying patients, bringing them in quickly to prevent elopement." ■

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urban ED and people are stacked to the rooftops. There are stretchers in the hallway," offers **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.

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.

"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.

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 tele-psychiatry 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: 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. (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. ■

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New opioid prescribing guidelines favor non-opioid alternatives

Citing a quadrupling of opioid prescriptions in recent years, the guidelines nudge providers to do more to combat the epidemic of overdose deaths

Noting that emergency providers often see firsthand the consequences of opioid abuse, the American College of Emergency Physicians (ACEP) voiced strong support for new guidelines on the prescribing of opioid medications for chronic pain. Issued in mid-March by the CDC, the recommendations are designed to combat the growing epidemic of overdose deaths related to opioids.

In a tele-briefing about the guidelines, the CDC noted that painkiller prescriptions have quadrupled since 1999, fueling both the use and misuse of opioids. In response, the recommendations aim to increase the use of non-opioid medications and/or physical therapy for the treatment of chronic pain, and they direct providers to work with patients in assessing both the benefits and risks associated with opioid medications. The guidelines also offer direction with regard to drug selection as well as the appropriate dosages and duration of treatment, and offer guidance on how to reassess treatment progress and discontinue medication.

During the tele-briefing, **Sylvia Burwell**, secretary of the U.S. Department of Health and Human Services, said her agency is committed to equipping health professionals with tools to fight this epidemic.

EXECUTIVE SUMMARY

Determined to make a dent in the growing problem of opioid addiction, the CDC has unveiled new guidelines for opioid prescribing for chronic pain. The recommendations urge providers to be more judicious in their prescribing, opting for opioids only after carefully weighing substantial risks and benefits.

- Public health authorities note the rampant use and misuse of opioids have "blurred the lines" between prescription opioids and illicit opioids.
- The new guidelines are designed to help frontline providers balance the need to manage their patients' chronic pain with the duty to curb dangerous prescribing practices.
- The recommendations are built around three principles: favor non-opioid alternatives for most cases of chronic pain, use the lowest effective dose when prescribing opioids, and exercise caution/monitor patients who are treated with opioids.

"We need to help primary care providers make the most informed prescribing decision, balancing the need to manage their patient's chronic pain with the duty to curb dangerous prescribing practices," she said. "We believe these guidelines will help healthcare professionals provide safer and more effective care for patients dealing with chronic pain, and we also believe they will help these providers draw down the rates of opioid use disorder, overdose, and sadly, ultimately death."

Noting that more than 40 Americans die from a prescription opioid overdose every day, **Tom Frieden**, MD, MPH, director of the CDC, said it has become increasingly clear opioids carry substantial risks, but only uncertain benefits.

"Beginning treatment with an opioid is a momentous decision, and it should only be done with full understanding by both the clinician and the patient of the substantial risks and uncertain benefits involved," he said. "We know of no other medication that's routinely used for a nonfatal condition that kills patients so frequently."

While noting that the rampant use and misuse of opioids have "blurred the lines" between prescription and illicit opioids, Frieden acknowledged prescription opioids play an important role in pain management when potential benefits outweigh potential risks. For example, he noted opioids are appropriately used in end-of-life care, palliative care, and following treatment for cancer, but said there is no evidence opioids control chronic pain effectively long term.

"[However], we do have evidence that other treatments such as exercise therapy, nonsteroidal inflammatory drugs, and a variety of other treatments and modalities can be effective for chronic pain with far lower risks," Frieden said.

The new guidelines reflect this evidence, pointing providers in a direction that will improve safety and prevent opioid overdoses, he added.

Favor safer alternatives

The recommendations address chronic rather than acute pain, but when compiling the advice, Frieden said public health authorities received ample feedback from physicians and others that long-term opioid use often begins with treatment of an acute episode. In recognition of this point, the guidelines recommend physicians take care to prescribe the lowest effective dose of immediate-release opioids when treating a patient with an acute pain issue, and to refrain from prescribing more than is needed.

> THE GUIDELINES RECOMMEND PHYSICIANS TAKE CARE TO PRESCRIBE THE LOWEST EFFECTIVE DOSE OF IMMEDIATE-RELEASE OPIOIDS WHEN TREATING A PATIENT WITH AN ACUTE PAIN ISSUE, AND TO REFRAIN FROM PRESCRIBING MORE THAN IS NEEDED.

"Three days or less will often be sufficient," Frieden said. "More than seven days will rarely be needed for most acute pain syndromes."

Frieden observed that each of the recommendations contained within the new guidelines is based on three key principles:

- **Favor non-opioid therapy for treatment of chronic pain except in cases involving active cancer, palliative care, or end-of-life care.**
- **When prescribing opioids, do so at the lowest possible effective dosages to minimize risks.**
- **Always exercise caution when prescribing opioids, and monitor patients closely.**

The guidelines were designed to be a flexible tool that will both support clinical decision-making and encourage communication between clinicians and patients, Frieden explained.

"Clinicians and patients need to carefully weigh the decision on whether to start opioids, and proceed only when there is a full understanding of the risks, and the benefits are likely to outweigh the risks," he explained.

Frieden acknowledged chronic pain is a very challenging condition to treat.

"For many years the status of medical practice in the United States was such that pain was not adequately addressed, and there are still patients whose pain is not adequately addressed," he said. "The challenge is when we generalize that situation to chronic pain in which opioids are of unproven benefit, we can get into really big problems because

these medicines are so addictive and lethal."

Consider unintended consequences

Following the release of the guidelines, **Jay Kaplan**, MD, FACEP, president of ACEP, released a statement, agreeing with Frieden and the American Medical Association that sound scientific evidence must guide any public health policy.

"This is especially true in the complicated area of pain, for which no objective test exists," he said. "Every day in our nation's EDs we treat patients suffering acute pain and must balance their immediate needs against the long-term risk of becoming opiate-dependent."

Kaplan added that it is critical emergency providers educate patients about what they should expect from pain treatment in the ED. As part of this process, he noted EDs should be allowed to post signs informing patients about their opioid prescription policies.

"It is also important that health insurance companies reimburse alternative approaches to pain treatment so that opioid prescriptions are not the only way to provide affordable pain relief to patients," he added.

The practice of emergency providers is already in line with some of the key recommendations noted in the guidelines, according to Kaplan. For instance, he noted emergency providers typically provide only short-term prescriptions for opioids, and they only choose this option after exhausting other options for pain relief.

"The recommendation that emergency physicians restrict prescriptions to no more than seven

The 12 CDC opioid guidelines

1. Nonpharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.
4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
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 to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. ■

days' worth of opioid medication aligns well with our practices," he observed. "We support prescription drug monitoring programs as recommended by the CDC, though remain mindful of their potential for unintended consequences, such as denying legitimate pain patients the pain relief they need."

To read the guidelines in their entirety, along with the CDC's process for creating their recommendations please visit: http://1.usa.gov/1LqoPQR. ■

Massachusetts hospitals try to stem overdose deaths

Hospitals in Massachusetts have implemented a plan that instructs emergency providers to develop an approach to screen for substance abuse, provide brief intervention, and arrange appropriate referrals for patients who have an active substance use disorder or are at risk for developing such a problem. The nine-point plan, which is outlined on the website of the Massachusetts Hospital Association (MHA, www.mhalink.org), also calls on physicians to consult the state's prescription monitoring program before prescribing an opioid, and to use health information exchange systems to share ED visit histories with other emergency providers. Other points in the plan call on EDs to:

- coordinate care processes for patients who frequent the ED with substance use issues;
- notify a patient's primary care provider or primary opioid prescriber following an ED visit for acute exacerbations of chronic pain;
- refrain from replacing prescriptions for controlled substances that patients report have been lost, stolen, or destroyed;
- refrain from prescribing long-acting or controlled-release opioids;
- mandate patient counseling on the proper usage, storage, and disposal of opioids when prescribed by an emergency provider;
- limit prescriptions of opioid analgesics to no more than a 5-day supply to patients who present with acute pain.

The plan, which was developed by a substance abuse disorder and treatment task force of the MHA, is intended to standardize opioid prescribing by emergency providers across the state, although developers stipulate that the recommendations should not interfere with a treating physician's judgement in deciding what course of treatment is best for an individual patient. All 51 MHA-member hospitals in the state have pledged to put the recommendations into practice in their EDs, and future plans call for extending the plan to hospital outpatient settings and eventually to private medical practices in the state as well. ■

Fresh policies and procedures, transparency fuel ED turnaround

Team building and educational outreach efforts help win staff over to push for improvement at an Arizona hospital

When Phoenix-based Banner Health purchased Payson (AZ) Regional Medical Center in the summer of 2015, there were clear signs things needed to change. One of the biggest sore spots at the 44-bed hospital was the ED, where long waits and low patient satisfaction were tempting patients to seek other care alternatives.

However, just a few months later, average wait times have been cut in half, patient satisfaction has turned in a positive direction, and volumes are up. Hospital administrators don't point to any particular change that led to the turnaround. Rather, they credit a flurry of improvements ranging from ED staffing changes, a push for transparency, and fresh policies and procedures that are motivating personnel to collectively push for a higher level of care and service.

Match staffing to volume patterns

With his background as an emergency nurse, **Mike Herring**, MSN-L, MBA, RN, CENP, the new chief nursing officer at Banner Payson Regional Medical Center, focused much of his early attention on bringing the ED patient flow process into alignment with the other 28 hospi-

tals in the Banner Health system.

"The model we brought here is bedside triage. Bring patients back immediately and try to decrease that time from when they walk in the door to when they see a physician," he explains. "Focus on the three time periods that you can control: door to doctor time, doctor to disposition time, and disposition to actually being discharged or admitted time."

Adjust schedules

To expedite patient flow, administrators adjusted provider schedules so that they better reflected patient volume patterns at the facility.

"They had a physician on duty 24/7, and they had a physician assistant (PA) ... who would usually come in at about 2 p.m.," Herring notes. "Historically, EDs pick up at around 11 a.m. or 12 p.m. ... but in this community the ED actually picks up at around 9 a.m. or 10 a.m. just because we are a little short on primary care physicians [in this region]."

Consequently, the schedule for the PA was adjusted to begin at 9 a.m. or 10 a.m., depending on the day of the week.

"Now, there's two providers on board before the rush hits, which allows patients to be seen more [expeditiously]," Herring says. "Of course, this decreases length of stay and allows you to stay ahead of the curve."

Hospital management also took steps to beef up staffing in the ED to a level that is more in line with what Herring refers to as a safer staffing model. In particular, the hospital added ED techs during peak hours.

"This really empowers nurses to feel that they can manage and provide that safe care, which is what every nurse wants," he says. "They were an extremely engaged group, and they still are."

Part of this empowerment stems from the implementation of a series of standing orders that enable nurses to proceed with standard steps such as starting an IV or collecting a urine specimen when patients present with certain specific complaints.

"Applying those standing orders helps decrease that length of stay, which creates more real estate in the ED," Herring observes. "It starts the ball rolling."

End-of-shift huddles

One new strategy that has been a big winner with nursing staff is end-of-shift huddles.

"Usually, the physician will pull the team together and they will review what went well and where the challenges were. It is kind of a constant performance improvement/self-evaluation [exercise]," Herring explains. "Also, the physician will take the opportunity to discuss an interesting case, just to [develop] the nursing staff from an educational standpoint."

One of the primary dividends from these huddles is improved physician/nurse communication, Herring observes.

"That is imperative, and it is huge for patient care," he stresses.

Bring scribes on board

Implementing so many changes can prove daunting to existing staff. However, the fact that the hospital brought in a new emergency provider group from TeamHealth, a physician staffing organization that was already familiar with the Banner model, certainly kept the transition manageable.

One technique TeamHealth brought to bear on the ED turnaround is the use of scribes, explains **Joel Betz**, MD, the new medical director of the ED.

"The reason we use them is to get the doctor out of the computer as much as possible and back to the patient," he explains. "Scribes help us with documentation. Instead of having your face in a computer typ-

EXECUTIVE SUMMARY

The ED at Banner Payson Medical Center in Payson, AZ, has charted dramatic improvements on key metrics through a range of staff and policy changes. In just a few months, the ED has halved wait times, patient satisfaction has improved, and daily volume is up. Administrators say the secret to the success of the effort is a move to be transparent by posting key metrics regarding patient flow, a tactic that has helped the team pull together and feel a sense of accomplishment when performance goals are achieved.

- Administrators adjusted staff schedules to better match patient volume patterns in the ED, and they added staff to help nurses during peak hours.
- A new provider group enlisted the assistance of scribes during peak hours to manage the documentation workload while also enabling physicians to focus more patient interaction.
- Physicians hold end-of-shift huddles to review successes and challenges, and to improve physician/nurse communication. The tactic also helps develop the staff from an educational standpoint.

ing when patients are talking to you, you can look at them and see them as patients, providing a little bit better connection on a human level."

A scribe is typically on staff in the ED from 9 a.m. to 9 p.m., and he or she primarily works with the physician. It isn't complete coverage, but it makes a difference in expediting patient flow, Betz says.

"As we are doing one thing, the scribe can do another, such as getting discharge paperwork done," he explains. "There has been some research that we have done showing there is a benefit in turnaround time, productivity, and that kind of thing."

Most scribes are nursing or medical school students, so they are usually well-versed in the most recent medical terms and standard practices, Betz explains.

"We have used them at some other facilities that are a little bit bigger. You've got to judge how busy the facility is and whether it is worth having them or not, but here it does seem to be a significant benefit," he observes. "I know it helps with provider satisfaction because none of us went to medical school to be computer guys. We went to medical school to be involved with people. It makes us more interactive with the patient, and it does seem to help with patient satisfaction."

Post key metrics

While all these tactics have helped, Betz notes one of the most powerful change agents has been the practice of posting key time metrics regarding patient flow so that staff can see how the department is doing collectively, and how their own performances are contributing.

"That is important because you have to have buy-in from the nurses and everyone working together to get those times down," he says. "If you feel like you are part of a team and there is something you can measure, that really seems to make a difference."

ONE OF THE MOST POWERFUL CHANGE AGENTS HAS BEEN THE PRACTICE OF POSTING KEY TIME METRICS REGARDING PATIENT FLOW SO THAT STAFF CAN SEE HOW THE DEPARTMENT IS DOING COLLECTIVELY.

Herring concurs with these sentiments, noting that there is evidence that patients who may have previously turned to other alternatives for care are now returning to the Banner Payson ED. While average daily volume to the 10-bed ED has traditionally stood at about 44, the ED often treats 50 patients in a day, he says.

"The reputation has improved. People know they can be seen in a timely fashion, and we have staff who feel they can make a difference," Herring says. "That is where you want to be." ■

SOURCES

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CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Apply new information about various approaches to ED management;
2. Discuss how developments in the regulatory arena apply to the ED setting; and
3. Implement managerial procedures suggested by your peers in the publication.

COMING IN FUTURE MONTHS

- A trauma-like resuscitation unit for critical care patients
- Better recognition of ischemic stroke in the ED
- The role of providers in addressing community violence
- A new front in the battle against antibiotic-resistant HAIs

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CME/CE QUESTIONS

1. **One of the most common root causes for suicide in people who have been seen recently in a healthcare setting is:**

   A. poor staff training.
   B. inadequate resources.
   C. time constraints.
   D. shortcomings in assessment.

2. **For most EDs, the best time to review suicide risk screening questions with patients who have presented with a non-psychiatric primary complaint is:**

   A. while the patient is in the waiting room.
   B. during the physician's evaluation.
   C. during the primary nursing assessment.
   D. during triage.

3. **How many Americans die every day from a prescription opioid overdose?**

   A. 20
   B. 30
   C. 40
   D. 50

4. **End-of-shift huddles lead to:**

   A. improved physician/nurse communication.
   B. faster discharges.
   C. improved patient satisfaction.
   D. a reduced need for documentation.

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