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JULY 2016

Vol. 28, No. 7; p. 73-84

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Take a Multidisciplinary, Team-based Approach on Elder Abuse

The ED presents a good opportunity to identify and intervene with victims of elder abuse, but such cases often go unrecognized and unreported

Experts say elder abuse is not only common, it is also linked with adverse outcomes among victims, costing the country billions of dollars every year. Despite the scope of the problem, signs of elder abuse often go unreported and unrecognized. That's understandable, given that it can be difficult to discern between abuse and various disease processes that occur in older adults.

Nonetheless, new research suggests there is ample room for improvement in the way elder abuse is identified and managed, and as with so many other issues, the emergency setting offers perhaps the best opportunity to identify elder abuse and begin to remedy a situation in which an elder person is unsafe at home.

Seek Out Privacy

Why do staff often miss signs of elder abuse in the emergency setting? There are multiple contributing factors, according to **Anthony Rosen**, MD, MPH, an emergency physician at New York Presbyterian Weill Cornell Medical Center.

"There are disincentives to evaluate this. [Emergency providers] are busy, and we realize that if we do identify this, then suddenly we've got a whole set of things that we have to deal with," he explains. "In addition, physicians [often] aren't educated on this, aren't comfortable assessing for it, or aren't comfortable with what they would do if they found something to be positive."

Rosen, who specializes in geriatric emergency medicine, adds that while physicians may feel ethically and morally obligated to report signs of potential elder abuse, they are much less confident in assessing for this issue.

"If you are assessing a patient in a hallway, assessing a patient very briefly, or assessing a patient with the perpetrator standing right next to the patient, you are not likely to find it," he says.

Further complicating the assessment

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ED MANAGEMENT®

ED Management®,
ISSN 1044-9167, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
ED Management®
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421
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Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST

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SUBSCRIPTION PRICES:
Print: U.S.A., 1 year with free *AMA PRA Category 1 Credits™*: $519. Add $19.99 for shipping & handling.
Online only: 1 year (Single user) with free *AMA PRA Category 1 Credits™*: $469
Outside U.S., add $30 per year, total prepaid in U.S. funds

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This activity is intended for emergency physicians, ED nurses, and other clinicians. It is in effect for 24 months from the date of the publication.

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process is the fact that it is often difficult for the at-risk patient to be interviewed alone without the presence of a caregiver, and it can be inconvenient to conduct an exam without a caregiver present, Rosen observes.

"In addition, patients themselves may have significant incentives not to tell us the truth," he says. "Particularly for older patients, the caregiver is providing them care; even if [he or she] is also abusing them or neglecting them, this person is also providing them care, and there is a significant concern among many patients ... that this caregiver will abandon them and they might go to a nursing home or there will be another very concerning outcome for them."

Address the Need for Privacy

Add to these challenges the reality that some of these older patients have dementing illnesses that may make it difficult for them to report neglectful or abusive behavior.

"Even if they do report it, the provider may not be sure that the report is accurate because of the dementing illness, and so the provider will doubt the story," Rosen notes. "The fact the caregiver is more easily able to offer information may incline the physician to trust the perpetrator."

In other instances, the older adult may not suffer from cognitive impairment, but he or she may speak a different language, complicating the reporting process.

"The translator may be the caregiver at the bedside who may also be the perpetrator, and so we may not take the time to use a translator to speak to the patient alone," Rosen explains.

Providing great care to a victim of elder abuse requires time and setting up a circumstance whereby one can actually communicate with the patient reliably and alone, Rosen stresses.

"In addition, it takes time to then do follow-up, whether that means connecting with a social worker, connecting with adult protective services [APS], or connecting with the police," he explains. "If you find something, you are likely to have created additional work for yourself."

Push Pendulum Toward More Detection

While most states require providers to report suspected cases of elder abuse to APS, there is little evidence that this requirement has incentivized more reports in the same way a similar requirement has prompted providers to report cases of suspected child abuse.

Rosen acknowledges providers may well be concerned about negative consequences if a suspected case turns out not to be elder abuse at all. But he also observes that providers apparently feel very differently about child abuse.

"With suspected child abuse, providers would much rather identify a case and have someone else tell them later that it was not child abuse than let a questionable case go home," Rosen notes. "We have decided as a society that we would rather be sensitive than specific with child abuse."

However, providers have not made the same calculation with respect to elder abuse, Rosen argues.

"Because we are only finding one in every 24 cases, the pendulum needs to swing more toward overde-

tection," he says. "Right now, we are dramatically underdetecting."

Establish a Team Approach

Rosen acknowledges that it is often much more difficult to detect signs of elder abuse than child abuse, for which there is a large base of literature documenting that certain injury patterns are almost unequivocal red flags. He notes older adults are more likely to bruise because of blood thinning medications, and they are more likely to present with fractures due to diseases such as osteoporosis or medications that can cause bone thinning.

To get around some of these issues, Rosen and colleagues are working to identify injury patterns that are consistent with elder abuse so that providers have more tools to work with in identifying a problem that can be very difficult to confirm.

Rosen also advocates for a multidisciplinary, team-based approach to identify elder abuse in the ED, and he is working with colleagues to establish such a team in his own setting.[1]

"Every person can have a role, and every set of eyes is worth training to have focused on this issue because [elder abuse] is worth finding, and it is really hard to find," he explains. "Training every member of the team and empowering every member of the team is important."

For example, Rosen notes that in many EDs the radiology suite is the only area in which a patient is free to discuss sensitive issues without input or influence from others. Consequently, an observant radiology tech could prompt a discussion with the patient about the source of an injury or the patient's safety at home.

EXECUTIVE SUMMARY

While EDs are well positioned to identify incidents of elder abuse, providers often miss the opportunity. Experts say providers find only one in every 24 cases, and that the pendulum must swing toward over-detection. Investigators acknowledge elder abuse is difficult to confirm, given that disease processes can explain some of the signs. Further, older adults are often reluctant to report abuse because they fear they will be removed from their homes or separated from their caregivers. Given the complexity involved with addressing the issue, investigators recommend EDs establish a multidisciplinary approach to the problem.

- Providing great care to a victim of elder abuse requires time and setting up a circumstance whereby one can actually communicate with the patient reliably and alone.
- While most states require providers to report suspected cases of elder abuse to Adult Protective Services, there is little evidence this requirement has incentivized more reports in the same way a similar requirement has prompted providers to report cases of suspected child abuse.
- Investigators advise ED leaders to train and empower every member of their team to identify potential signs of elder abuse.

"People don't go into the radiology suite with their spouse or their daughter or their mother, so the radiology suite is truly a zone of privacy," Rosen says. "In an emergency practice, it is the only place where you are guaranteed to have the patient alone."

Further, Rosen suggests that EMS providers offer a key perspective, given they have actually seen the patient in his or her home setting, but the other members of the team have to be open to receiving and acting on the information.

"In my own clinical experience, one of the real challenges is making sure that the information that EMS learns — a lot of which is gold, some of which relates to elder abuse, and some of which relates to all kinds of different things that are important to knowing how to care for the patient — does not get lost in the EMS/ED interface," he explains. "That is a ripe area for improvement."

In fact, Rosen notes that he and colleagues working on this issue find EMS workers are often frustrated that their reports about situations in a patient's home are ignored or discounted, he explains. For instance, when EMS providers bring to the ED an elderly patient who has suffered a fracture from a fall, they may inform a social worker and the emergency medical team that there is a fall risk in the home.

"A week later they are called back to the same place for the same patient for the same problem," Rosen explains. "They get a lot of feedback that their information is not getting passed on."

To encourage such reporting, emergency providers need to recognize the critical information that EMS provides, Rosen stresses.

"Make sure to seek it and act on it," he says. "EMS has a critical role here. They can open up the refrigerator, look at the pill bottles ... and notice an unusual interaction in the home."

Marguerite DeLiema, PhD, a postdoctoral researcher at the Stanford University Center on Longevity, agrees that prehospital providers can play a critical role in giving emergency providers a clearer picture of what is actually happening with an older patient. She has reported on how physical signs or symptoms can easily be misinterpreted.[2]

"The real story is in the home and in the interactions between the caregiver and the patient," she explains. "That will give you so much more information on whether a patient is a victim of criminal negligence or whether [the caregivers] are just struggling and can't meet the needs of an older person even though they are doing the best they can."

Paramedics are in a prime position to know where the older person is living in comparison to other family members and whether the environment is clean and safe. Unlike with social workers' planned visits, for example, there is little chance for the environment to be staged by a caregiver or perpetrator of elder abuse, Rosen notes.

Learn from Colleagues

Another benefit of the multidisciplinary team approach is that it provides opportunities for clinicians to expand on their command of the issue.

"Physicians can learn a lot by working with a geriatrician who identifies the signs [of elder abuse] or working with a social worker who understands more of the nuanced social side of caregiving and why some people might show up in the ED looking the way they do," DeLiema observes. "It brings the issue [of elder abuse] more on their radar screen ... and informs the physician's decision about what is a safe place for the patient moving on."

DeLiema would like to find a way for emergency providers to interact more with APS, but she observes that resources are strained.

"Funding [to APS] has not kept pace with the growth of the older adult population, and there is a lot of turnover in those agencies and a lack of follow-up," she explains.

WHILE IT'S CLEAR THAT ELDER ABUSE IS SIGNIFICANTLY UNDERREPORTED, ROSEN BELIEVES THIS IS AN AREA THAT EMERGENCY PROVIDERS CAN IMPROVE.

Another concern is that in cases of suspected elder abuse or neglect in which older adults have maintained their cognitive capacity, they have the right to refuse APS services.

"A lot of times we see these older adults being brought in by a caregiver, and the older adults will defend their caregiver no matter what," DeLiema says. "They would rather live in an acknowledged abusive situation than face the risk of maybe being moved into a nursing home or assisted living facility, or having anything bad like an arrest happen to their caregiver ... so APS has its hands tied in a lot of situations, and providers know that."

Even in cases in which an older adult refuses services, however, it is important for emergency providers to note their concerns.

"Keep really accurate documentation so that if law enforcement or APS needs these records they can subpoena them ... if the case goes to court," DeLiema explains. "It really is the emergency providers who might be the first providers that these patients see. They are on the front lines."

Make the Case for Action

While it's clear that elder abuse is significantly underreported, Rosen believes this is an area that emergency providers can improve. In fact, he likens the state of affairs on this issue to the way things used to be with respect to intimate partner violence (IPV).

"One of my mentors told me that 20 or 30 years ago emergency providers didn't even ask about intimate partner violence or spousal abuse. They had nothing to offer the victims, so it [apparently] wasn't even worth knowing about," he explains.

While emergency providers generally don't feel this way about IPV anymore, Rosen suspects providers now may be reluctant to identify elder abuse, feeling they don't have the resources, time, or expertise to address it.

Rosen has received feedback on his elder abuse research from emergency providers, telling him that without money or resources, emergency providers should not be expected to address yet another social problem.

"That is a reasonable perspective," Rosen offers. However, he and his research colleagues offer a different perspective. "We make the argument that [elder abuse] is medical, and that the ED is the ideal place to

evaluate for it."

There is no question that large, academic medical centers such as New York Presbyterian Weill Cornell Medical Center often are better equipped to take on the issue than small community hospitals.

"We have a social worker available 24/7 in our ED, but many of my colleagues and former residents don't have that luxury, and it changes the dynamics of what you are able to do," Rosen explains.

Create Incentives

To get around such barriers, Rosen and colleagues are making a business case for developing incentives that would encourage providers to take on elder abuse.

"You could certainly imagine settings in which payers would be interested in reducing all the associated medical costs, which are thought to be in the billions of dollars," Rosen suggests. "This is worth finding."

DeLiema agrees, but observes there is too little evidence that medical providers are stepping up to the plate.

"This is a big concern, but only lip service is being paid to detecting elder abuse, and not just in the ED, but for many different providers," she says.

What can providers do to improve their recognition and management of elder abuse? Rosen notes that resources are available nationally and locally. In particular, he suggests emergency providers reach out to the National Center on Elder Abuse (http://www.ncea.aoa.gov/). Further, he encourages EDs to find and connect with groups targeting this issue in their local communities.

"Most of these local task forces or teams are desperate for physician input and physician communication," he says. Another source is Geri-EM, a website (http://geri-em.com/) that offers training and a range of information on caring for the older adult.

Additionally, Rosen and colleagues are preparing some training resources on elder abuse designed specifically for emergency providers. Rosen notes that providers should feel free to reach out to him if they are interested in obtaining these materials or if they have any questions about how to move forward on this issue in their own settings. ■

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Fresh Approach for Critically Ill Patients with Time-sensitive Needs

Developers at the University of Maryland Medical Center say their approach could work well at other large medical centers that serve many critically ill patients.

A well-developed system is in place for patients who suffer traumatic injuries. In each community, paramedics and emergency medical technicians (EMTs) know where to take patients who need specialized trauma care. However, what about critically ill patients who need rapid evaluation and treatment? Such patients may have to sit in an ED until space is available in an appropriate ICU, and for patients with time-sensitive critical care needs, this lack of speedy access to specialized care can lead to negative outcomes. For some EDs, this state of affairs also can put a squeeze on space, staffing, and other resources that are in constant demand.

Recognizing this gap, the University of Maryland Medical Center (UMMC) in Baltimore developed a six-bed unit designed to accelerate care to these specific patients. Dubbed the critical care resuscitation unit (CCRU), the new space is modeled after UMMC's trauma resuscitation unit, but with resources and staff geared toward non-trauma, critically ill patients, many of whom require life-saving care. It's a model that developers believe could deliver benefits at many other large medical centers that serve a high number of critically ill patients.

Focus on Critical Care Needs

The CCRU serves a function that most ICUs or EDs do not serve, explains **Thomas Scalea**, MD, FACS, director of the program in trauma at the University of Maryland School of Medicine (UMSOM) and the physician-in-chief of the shock trauma center at UMMC.

"EDs see a large volume of patients and their job is to sort through and get people where they belong: home, the operating room, or wherever. They are not designated to provide intensive care to a small number of people," he observes. "ICUs are intended to provide longitudinal care to people who are very sick. They are not designed to do rapid evaluation. The CCRU does both. It does rapid evaluation, stabilization, and provides critical care."

While not all medical centers require such a specialized unit, it can fulfill a vital function for large tertiary or quaternary care centers, many of which receive hundreds of transfer patients from smaller facilities every year, Scalea notes.

"If you have [these critically ill patients] land in the ED, you have half their needs covered, but not all of them," he says. "If you have them land in the ICU, you have to make a bed, which is also true for EDs, which are very crowded places these days.This is designed specifically to serve those purposes."

In place at UMMC since July 2013, developers say the CCRU has been highly successful at its mission of accelerating care to critically ill patients while also enabling UMMC to care for more patients. For example, in its first year of operation, critically ill transfer patients to UMMC increased by 64.5% over the previous year, and these patients were processed at a much faster clip. The average transfer time was 129 minutes as compared to 234 minutes before the creation of the CCRU. In addition, for patients requiring surgery, the median time to arrival dropped dramatically (from 223 to 118 minutes) as did the time to the operating room (3,424 to 1,113 minutes). Investigators add that average length of stay fell from 17 days to 13 days, and they observed a trend toward lower mortality as well.[1]

In the past, transfers often were delayed because there was no space available in an appropriate ICU, Scalea observes. However, now the CCRU is available 24/7 to commence care of these patients right away, speeding access to diagnostics, specialty care, and even surgery when required. Staff then move patients to an appropriate setting for ongoing care.

"If you are a large tertiary care center, like we are, or a quaternary care center, you need to be able to do this because a lot of patients are transferred in. Where do you have them land?" Scalea asks.

Work Across Specialties

Patients admitted to the CCRU present with a wide range of complex critical care needs that require immediate attention, observes **Lewis Rubinson**, MD, PhD, an associate professor of medicine at UMSOM and director of the CCRU. These include patients with large ruptured blood vessels, aortic dissections, stroke patients who require neuro

EXECUTIVE SUMMARY

To meet the needs of critically ill patients with time-sensitive needs, the University of Maryland Medical Center (UMMC) created the Critical Care Resuscitation Unit (CCRU), a six-bed, short-stay ICU designed to accelerate care to resource-heavy patients who require immediate evaluation and treatment. The CCRU is modeled after UMMC's trauma resuscitation unit, but with resources and staff geared toward non-trauma, critically ill patients, many of whom require life-saving care. The unit is largely staffed by emergency providers who have undergone additional training in critical care.

- In place at UMMC since July 2013, the CCRU has enabled UMMC to accommodate many more incoming critically ill patients than it has in the past. In its first year of operation, critically ill transfer patients increased more than 64%. Investigators also observed reduced hospital length of stay for these patients, and they noted trends toward lower mortality.
- Before the creation of the CCRU, developers say that care of critically ill patients often was delayed because there was no space available in an appropriate ICU.
- Patients admitted to the CCRU present with a wide range of complex critical care needs that require immediate attention, such as ruptured blood vessels, aortic dissections, strokes requiring neuro interventional radiologic procedures, and aneurysmal bleeds.
- Developers have streamlined the transfer process so that appropriate care can commence even before patients arrive in the CCRU.

interventional radiologic procedures, patients with aneurysmal bleeds in their heads, and patients who require surgery but the surgeon at their hospital is not comfortable managing them, he explains.

"Yes, these patients [might otherwise] remain in the ED, but the bigger issue is that the ED has nowhere to send them for their care and they are likely to have a bad outcome," Rubinson says. "Different hospitals have different capabilities, and when a patient exceeds their capabilities there is no formal system of how these people get to somewhere else unless it is within their own hospital network system, and even then it can be hit or miss."

For example, a referral center within a hospital system may say it can accept a patient, and that administrators will call when they have an open ICU bed, but the delays involved come at a cost.

"Some ED physician is in a world of hurt because he has a patient who needs something he can't provide, and he is just witness to watching the patient get suboptimal care," Rubinson observes.

When deliberating how to address these gaps at UMMC, administrators noted that adding more ICU capacity would make a difference, but even adding two more beds to each of its seven specialized ICUs wouldn't solve the problem if there was a surge in strokes that exceeded the capacity of the neuro ICU, Rubinson says.

"Our idea was don't build additional capacity in every single unit because we can't economically maintain that, and we can't be sure [appropriate ICU space] will always be available," he explains. "Instead, the thinking was [creating] one place that can work across specialties that is able to accept people at a moment's notice without a worry for a definitive ICU bed afterwards."

Streamline Transfer Process

Recognizing that the transfer process is a key component, UMMC has taken steps to streamline the approach.

CRUCIAL TO THE SUCCESS OF THE TRANSFER PROCESS IS EMPLOYING AN ATTENDING PROVIDER ON STAFF 24/7 WHO IS FULLY KNOWLEDGEABLE ABOUT THE CAPABILITIES OF HELICOPTER AND AMBULANCE CRITICAL CARE TRANSPORT TEAMS.

"We didn't need to build a transfer center. We already had that. We just didn't have systematic and organizational control of how those referrals happen, and that is really what we took over," Rubinson explains.

There is now a systematic approach for determining which patients go to which units and when, and there is also specialized support for incoming patients.

"We do medical direction for our transport teams," Rubinson notes. "We have 24/7 attending staff in house that have direct phone access so that when an outside ED is calling for consultation, they are calling both our subspecialists and our intensivist."

The referring ED will receive immediate guidance on management of the patient even before the patient boards a helicopter or ambulance to be transferred.

"We are working with them on information so that when the patient gets here we can hit the ground running," Rubinson observes. "If we know what drips they are on, we can already have those drips ready to go here. If we know they are coming for an ECMO [extracorporeal membrane oxygenation] evaluation, the ECMO circuit is already here ready to go rather than being caught on our heels."

Crucial to the success of the transfer process is employing an attending provider on staff 24/7 who is fully knowledgeable about the capabilities of helicopter and ambulance critical care transport teams, Rubinson explains.

"We make [the transfer process] easier for referring facilities," he says. "We have essentially made it a much smarter system."

In fact, the CCRU process borrows heavily from the way trauma patients have been dealt with at UMMC for five decades.

"We [treat] 8,000 patients a year in trauma, and many of our patients come from other hospitals where they will get stabilized at that first hospital, and then when it is noted that they exceed the capabilities of that hospital, they will be brought here," Rubinson explains. "We just modeled that same system for non-trauma [patients] because no one was

formally doing that for non-trauma patients."

Prioritize Admissions

To hear a description of the CCRU, it almost seems like an ED that operates at a higher level of complexity, but at the same time offers ICU-level care. Rubinson calls it an ICU with an ED attitude.

"We do all the things that an ICU does, which is very unlike what an ED does, but we have very much an ED attitude in that we need to be ready for the next patient, and we need to be moving [patients] out so that we can still be taking care of the community," he explains. "We also have a huge interface with EMS."

Rubinson adds that the workflow in a typical ICU is quite different than what you will find in a resuscitation unit.

"If you are rounding on 14 patients and it is 9 a.m., and you get two requests for transfer from an outside hospital, you still have your work rounds to do. [In a typical ICU], the patients will come, but the entire unit is not geared around making sure the patients get there and that they can be pounced upon immediately," he explains. "For us, we really turn that around to where our rounds never get in the way of admissions, so admissions are always our priority."

To accommodate the need for urgency, the CCRU has its own blood refrigerator and a mechanism for cutting through bureaucratic snags such as patients who are not registered correctly.

"When that happens, there is normally a delay in being able to write orders, but when a patient is dying you don't want there to be any delay in being able to organize medicines or blood products," Rubinson says. "We have a way that we already figured out from our trauma side of how to be able to manage that patient — even if [he or she is] improperly registered.

Rubinson adds that if every unit had to operate at such a high level, to the point where every charge nurse and every clerk was up to speed on the workarounds and the complexity involved, it would be an impossible task.

TO ACCOMMODATE THE NEED FOR URGENCY, THE CCRU HAS ITS OWN BLOOD REFRIGERATOR AND A MECHANISM FOR CUTTING THROUGH BUREAUCRATIC SNAGS SUCH AS PATIENTS WHO ARE NOT REGISTERED CORRECTLY.

"However, because we concentrate it all in a small unit, we are really organized around [the mission]," he says.

The downside of a short-stay ICU unit like the CCRU is that it necessitates an additional handoff when the patient is transferred out of the unit to another ICU.

"We really need to make sure the handoffs go well because it is one additional unit that the patient is going to be in," Rubinson notes. "Over our three years here, we have focused tremendously on standardized communication and multiple redundant levels of communication to make sure things are not lost in the handoffs."

Target Resource-heavy Patients

In keeping with the importance of providing quick and efficient care, many of the providers staffing the CCRU are emergency physicians with added training in critical care.

"Since we happen to have the biggest training program for emergency physicians in critical care, we hired many of our own graduates," Scalea explains.

Further, with the rapidly increasing number of transfer patients coming through the CCRU, expansion of the unit is in the planning stages.

"Hospital real estate is pretty cherished ... we are often right at capacity already, and we believe we could grow this if we had more beds," Scalea says.

With greater capacity, the unit will alleviate crowding in UMMC's own ED, but the mission will remain focused on those resource-heavy patients rather than just ICU patients, Rubinson suggests.

"If [our ED] has someone who really requires an enormous amount of resources ... such as a patient with profound ventilator needs, major vasopressor titration needs, or someone who is bleeding out ... then we will bring the patient up," he explains.

The unit can even accelerate care to a patient with an urgent need for renal replacement therapy because it can handle dialysis and ultrafiltration

right in the unit, Rubinson adds.

"The UMMC moves 11,000 patients from outside hospitals into our hospital, and that is a third of our admissions, so we are really the safety net for life-threatening care throughout the state," Rubinson explains. "We need to be able to receive those patients and to immediately intervene." ■

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ED-based Counseling Sessions Reduce Risky Opioid Use Among Certain Patients

Investigators say focusing on harm reduction rather than ending use of all opiate medications represents a major shift in thinking, making participants more receptive to the intervention

Could a brief, ED-based counseling intervention curtail risky opioid use among patients who have a history of using the powerful painkillers for non-medical reasons? Investigators at the University of Michigan School of Medicine believe this may well be the case following a randomized clinical trial that tested the approach with 204 emergency patients who reported opioid misuse within the previous three months.

Half these patients were randomized to receive usual care as well as printed educational materials detailing how to prevent or respond to overdoses and listing local resources for treatment and suicide prevention. The other half received the printed educational materials as well as a 30-minute counseling session with a trained therapist who used motivational interviewing techniques to strengthen their desire to move away from risky opioid use behaviors. (*See also: "Opioid-related Hospitalizations, Infections Up," page 82*)

Investigators followed up with all patients after six months, finding that those in the group that received the counseling intervention experienced a 40.5% reduction in behaviors that heighten the risk of an overdose on average, and they had a 50% average reduction in non-medical use of opioids. Patients who received printed materials but no counseling session experienced a 14.7% reduction in risky behaviors on average, and a 39.5% reduction in the non-medical use of opioids.[1]

Focus on Harm Reduction

Amy Bohnert, PhD, a co-author of the research and an assistant pro-

EXECUTIVE SUMMARY

Investigators at the University of Michigan have shown promising results from an ED-based intervention designed to curb risky opioid use among patients who have reported opioid misuse within the previous three months. The intervention includes a 30-minute counseling session with a therapist who utilizes motivational interviewing techniques to strengthen their desire to move away from opioid use behaviors.

- The randomized clinical trial included 204 emergency patients, divided between patients receiving printed educational materials and patients receiving printed materials as well as counseling sessions.
- Researchers followed up with all patients after six months, finding that those who received the counseling intervention demonstrated a substantially higher reduction in behaviors that heighten the risk of an overdose than patients who received only printed materials.
- Investigators are working now to adapt the counseling intervention so that it can be delivered by more cost-efficient means, such as via interactive voice response messages or computer.

fessor of psychiatry at the University of Michigan School of Medicine, explains that the researchers didn't have to start from scratch when designing the intervention to reduce risky opioid behaviors.

"Our group had experience doing motivational interviewing interventions specifically for ED patients dealing with alcohol use and other drug use issues," she explains.

Developers used the framework from these earlier interventions, which involves building a rapport with patients and getting to know their values, and repurposed it for the new intervention, with a few changes.

"A major shift in our thinking was that rather than focusing just on level of use, we had to spend some time thinking about this from a harm-reduction standpoint or reducing risky use, but not emphasizing so much on whether the use [of opioids] should continue at all," she says. "We felt like that was really helpful in the participants being receptive to the intervention."

Bohnert adds that the intervention fit in well with the full range of patients who present to the ED.

"The way we screened, we got people with injection heroin problems, and then on the other end of the spectrum we got people whose primary problem was chronic pain that was difficult to treat," she says. "One of the neat things about this intervention, and one of the things I was excited about in designing it, is that it is not specific to one target population. "It has the potential to give therapists the tools to learn one intervention that could be helpful to a lot of different types of patients."

Investigators note that motivational interviewing has been used effectively to help people reduce their use of alcohol and drugs as well as lose weight, but this is the first time the technique has been put to the test in a randomized clinical trial to see if it can reduce the risk of overdose.

The 30 minutes required to conduct the counseling sessions might be an issue for some EDs, Bohnert acknowledges. But she notes it did not present obstacles at the study site.

"It is not unusual for patients who are there for non-life-threatening problems to be [in the ED] for a couple of hours, so having a dedicated therapist who can work around the other needs of the treatment team was able to work pretty well," she explains. "There were very few cases where we weren't able to complete the whole session during the ED visit and had to finish it later."

Bohnert says the counseling sessions would clearly not work as well if the burden of delivering them was on physicians.

"That wouldn't work with the flow [of patients], but with the therapists, whose purpose is to deal with these more case management situations, it was feasible," she explains.

However, investigators are working now on adaptations to the intervention to make it more feasible and cost efficient so that it could be applied in almost any emergency

Opioid-related Hospitalizations, Infections Up

The opioid crisis sweeping the country is putting considerable pressure on healthcare utilization and costs, according to new research from Beth Israel Deaconess Medical Center and the VA Boston Healthcare System. Analyzing discharge data from a nationally representative sample of inpatient hospitalizations, investigators found that while the number of hospitalizations overall remained consistent between 2002 and 2012, hospitalizations related to opioid use or dependence increased by 72% to 520,275 during this period. Within this group, hospitalizations related specifically to a serious infection increased by 91% to 6,535.[1]

With regard to costs, total inpatient charges related to opioid abuse or dependence quadrupled during the decade to $15 billion in 2012. From this sum, researchers noted that $700 million went toward hospitalizations related to opioid-associated infections. The total average cost of an opioid-related hospitalization was more than $28,000 in 2012; however, the average cost for hospitalizations that involved opioid-related infections topped $107,000.

Investigators said the burden of these costs was particularly costly for Medicaid, which was the most common payer for opioid-related hospitalizations. Just 20% of the discharges related to opioid use or dependence and 14% of discharges associated with an opioid-related infection were covered by private payers.

To ease such burdens, researchers recommended a commitment to curbing access to opioids as well as a stronger focus on early treatment and preventive strategies. ■

REFERENCE

1. Ronan M, Herzig S. Hospitalizations related to opioid abuse/dependence and associated serious infections increased sharply, 2002-12. *Health Aff* 2016;35:832-837.

setting. For example, Bohnert notes that investigators have developed other drug and alcohol-related, brief motivational interventions that have been fully computerized.

"That is one option that would obviously have pretty broad potential for implementation in the ED," she says.

The computerized option is under consideration, but the most immediate next step involves devising the intervention so that it can be delivered by interactive voice response (IVR) calls after patients leave the ED.

"There will be an artificial intelligence component that is going to optimize the frequency of contact," Bohnert notes. "The real advantage of this approach — of identifying people while they are in the ED, and then delivering the intervention afterward — is that we can adapt the intervention to how much opiate medication the patients received as part of that ED visit."

One option that will be available with the IVR approach is connecting patients with a live therapist if their perceived risk merits this level of interaction.

"It will be interesting to see how often that connection is really necessary," Bohnert observes. "That will be a neat thing we will be able to learn because we are using artificial intelligence."

One challenge for any intervention that targets patients at risk for opiate misuse is getting patients to disclose that they have actually used opiate medications for non-medical reasons. In the trial, more than 2,700 emergency patients between the ages of 18 and 60 were screened, and only those patients who disclosed that they engaged in opiate use for non-medical reasons were asked to fill out a questionnaire and agreed to participate in the study. Investigators say two-thirds of study participants had received a prescription for opiate medication within the past six months.

"In the case of this study, we have the benefit of the fact that we are collecting this data for research, and people are more willing to disclose in that situation," Bohnert says. "We use the Current Opiate Misuse Measure (http://bit.ly/1VsExO4) to screen for opiate use, which has been specifically designed to not be as reactive to some of those issues of stigma with substance use, and better at picking up what might be called medical misuse or use that is beyond the prescribed level and possibly risky."

Such validated instruments help clinicians identify appropriate patients for intervention, but Bohnert acknowledges the issue is an implementation challenge. Nevertheless, investigators are buoyed by the early results they have received thus far and are anxious to build on what they have learned.

"We really need the long-term health outcomes of the intervention, so we will continue to study this," Bohnert notes.

Researchers will make their handbook and a therapist's guide available on the University of Michigan Injury Center website: http://bit.ly/1zSvHOY. ■

REFERENCE

1. Bohnert A, Bonar E, Cunningham R, et al. A pilot randomized clinical trial of an intervention to reduce overdose risk behaviors among emergency department patients at risk for prescription opioid overdose. *Drug Alcohol Depend* 2016;163:40-47.

SOURCE

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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

- Managing emergency patients with limited English proficiency
- The role of "the warm handoff" in addressing the opioid crisis
- The growing role of ED-based violence interruption programs
- Meeting the needs of transgendered patients in the ED

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CME/CE QUESTIONS

1. **How many cases of elder abuse do providers identify?**

   a. one in every 10
   b. one in every 15
   c. one in every 24
   d. one in every 50

2. **Providers may be reluctant to identify elder abuse because:**

   a. they don't have the resources to address it.
   b. they don't have the time.
   c. they lack expertise in elder abuse.
   d. All of the above

3. **Before the creation of the Critical Care Resuscitation Unit (CCRU) at the University of Maryland Medical Center (UMMC), the transfer of critically ill patients was often delayed because:**

   a. there was no space available in an appropriate ICU.
   b. the ED was overcrowded at UMMC.
   c. of staffing challenges.
   d. of poor communication with EMS.

4. **The downside of having a short-stay ICU unit like the CCRU at UMMC is that it necessitates:**

   a. a change in culture.
   b. the hiring of additional emergency staff.
   c. longer work hours for providers.
   d. an additional handoff when the patient is transferred out of the unit.