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SEPTEMBER 2018

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Offering Patients Hospital Care at Home

Model could deliver equal or superior outcomes at significantly lower costs, but reimbursement is a critical barrier

With hospitals and EDs overwhelmed with patients in many communities, there is growing interest in a concept that provides hospital-level care in the home for certain patients. Such candidates present to the ED and meet criteria for hospitalization with general medicine issues such as exacerbations of chronic conditions or infections.

Through this home care approach, advocates note that patients can avoid healthcare-associated infections and other adverse consequences that have been associated with inpatient care. Meanwhile, facilities can preserve hospital beds and other resources for patients who require intensive care or other services that must be delivered in the hospital. Further, when carried out on a large enough scale, advocates note that such an approach should be able to relieve ED boarding or crowding related to a lack of inpatient beds.

While the hospital-at-home concept comes with numerous challenges, particularly regarding reimbursement, several health systems are demonstrating

that the approach can save significant dollars without jeopardizing care quality or safety. Studies show that along with equal or superior outcomes to similar hospitalized patients, such a model can deliver improved patient satisfaction. Now, some health systems with years of experience working with the concept are crafting new ways to leverage the approach.

Foster Collaboration

Emergency clinicians are an integral part of the home hospital program at Brigham and Women's Hospital in Boston, according to **David Levine**, MD, MA, an internist and clinical investigator who is leading the program. "This requires very close collaboration with emergency providers because they are the admitting team," he says.

Given that all appropriate patients are identified for the program in the ED, emergency staff played a significant role in development, particularly enrollment process designs, Levine



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ED Management.
ISSN 1044-9167, is published 12 times annually by Relias LLC
111 Corning Road, Suite 250
Cary, NC 27518-9238

Periodicals Postage Paid at Cary, NC, and additional mailing offices.

POSTMASTER: Send all address changes to
ED Management, Relias LLC
111 Corning Road, Suite 250
Cary, NC 27518-9238

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Online only: 1 year (Single user) with free AMA PRA Category 1 Credits™: \$469
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This activity is intended for emergency physicians, ED nurses, and other clinicians. It is in effect for 36 months from the date of the publication.

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observes. "We made sure we would be incredibly fast in approaching patients so that we wouldn't slow down [the ED] workflow and end up creating bottlenecks," he says. "We also then involved key ED stakeholders in the entire process so that there would be a feeling of collaboration the entire time."

The program, in effect for about two years, generally targets patients who otherwise would be hospitalized on a general medicine ward. "These are patients who require acute care, but they are not going to crash," Levine notes. "They are not going to need intensive care and end up in the ICU."

For instance, patients with pneumonia, heart failure, or complications related to chronic conditions such as diabetes or COPD might be good candidates for the home hospital program. "It's really the bread and butter of internal medicine," Levine adds.

Identify Potential Candidates

Emergency providers triage and examine all patients as usual, Levine observes. First, a resident or physician assistant sees the patient. Then, an attending physician visits the patient. However, the case-finding process begins as soon as patients present to the ED. Nonclinical staff members who have been trained by the home hospital team rely on inclusion and exclusion criteria to identify which patients might be appropriate for the program.

Further, eligible patients must live within a specific geographic area surrounding Brigham and Women's main campus or Brigham and Women's Faulkner Hospital, a community facility in Boston that

also is participating in the home care program, Levine says. Also, while there are no age requirements, the median age of patients in the program is around 82 years, Levine says.

"We are trying to take care of acutely hospitalized Americans," Levine says. "We have built a lot of important processes around older adults ... [however], we have 20-year-olds in our program sometimes."

With the list of potential candidates for the program, a member of the home hospital team will consult with ED team members to hear their opinions on which patients would be a good fit for the program.

"Sometimes, [the emergency clinicians] will call us [with a potential candidate for the program] because we have signs everywhere, including the conditions we treat," Levine notes. "However, we will often come to them, and our team will facilitate a conversation."

Following this discussion, both the ED team and the home hospital team will approach patients who both teams have mutually agreed are good candidates for the program. Team members will describe the program to patients and offer the home care option as an alternative to inpatient hospitalization. The option appeals to some patients more than others, some of whom may be hesitant or concerned about receiving acute care at home.

"It is an interesting struggle sometimes to get patients to enroll in the program," Levine acknowledges. "It really runs the gamut from patients who are cheering with joy after they learn of this opportunity to [patients from whom] we get very much the opposite response, who feel they never could go back home [in their condition]."

Patients who select the home hospital approach are returned to their residences via professional transport in a manner that is tailored to their needs, Levine explains. “Often, a team member will ride with [patients] or meet them at their home,” he says. “The core of the team is a nurse and a physician who will see the patient. Then, we can ratchet up or down the needs of the team based on what the patient needs.”

For instance, the team can bring in a social worker, physical therapist, occupational therapist, home health aide, or other assistance, as needed, during the acute episode, Levine notes. Everyone who goes home is monitored continuously through technology.

“We monitor heart rate, respiratory rate, and telemetry on patients,” Levine says. “We have a set of machine algorithms that are monitoring the data, and when there is a problem in the data, it alarms ... whoever is on call in the home hospital team.”

Further, the home hospital team can visit with patients via video. Patients are always free to communicate with providers via phone and text messaging. “We provide a tablet to patients and a platform for them to communicate with us while they are at home,” Levine adds.

While the program generally serves only about four patients receiving acute care in the home at one time, results from the approach thus far show promise, Levine reports.

“In general, we have shown large reductions in the direct cost of care compared to a control group of patients who stayed in the hospital,” he explains. “We have shown no appreciable differences in the quality of care or the safety of care between patients who go home in our program

EXECUTIVE SUMMARY

There is growing interest in an approach that delivers hospital-level care to appropriate patients in their homes. Generally, such programs identify potential candidates for the approach upon their presentation to the ED. Then, depending on the program, emergency physicians and/or hospitalists determine whether patients should be offered the option of receiving care for their acute condition at home. Investigators have found the approach can deliver equal or superior outcomes to similar hospitalized patients at considerably lower cost, although reimbursement remains a major obstacle.

- The home hospital program at Brigham and Women’s Hospital in Boston generally targets patients who otherwise would be hospitalized on a general medicine ward but will not require ICU care.
- Emergency physicians are involved intimately in the home hospital program, serving as part of the admitting team.
- In the hospital-at-home program at Mount Sinai Health System in New York City, administrative assistants monitor patients electronically as soon as they present to the ED to identify potential candidates who meet clinical, geographic, and payer criteria.
- Generally, physicians or nurse practitioners visit hospital-at-home patients daily. If such patients require IV medication administration, a nurse might visit up to three times daily.
- Experts note that not all hospitals are good candidates for a hospital-at-home approach. Many variables, including overcrowding, geography, and patient population sizes and types, factor into the decision.

versus those who stay in the hospital. We have shown improvements in the patient experience [in the home hospital program].”

Levine adds that in one recent study, investigators found that patients in the home hospital program logged fewer readmissions at 30 days than similar patients who were cared for in the hospital.¹ However, it is still unclear how public and private payers will handle home hospital approaches, as the concept doesn’t fit neatly into traditional payment models. Currently, care provided through Brigham and Women’s home hospital program is funded mostly through grants and support from the Partners HealthCare Center for Population Health, which is a group affiliated with Brigham Health. Some insurance

reimbursement is available for physician house calls. Nonetheless, buoyed by performance outcomes, Levine notes that the program is in expansion mode. “We are adding lots of new diagnoses and some new technological capabilities,” he says. “We are also working to increase the geography in which we operate.”

While the home hospital program remains a research enterprise, it has evolved into a service line, Levine observes. “A lot of people think of research and operations as two completely separate entities. I would argue that is a very old-fashioned view,” he offers. “I try to position our home hospital work in between both research and operations ... it is definitely both.”

The Mount Sinai Health System in New York City started its own

hospital-at-home program in 2014. Since then, the program's shape and focus have evolved significantly. For instance, the program initially was limited to patients with six conditions clinical leaders determined could be managed safely in the home: community-acquired pneumonia, cellulitis, congestive heart failure, high and low blood sugars for diabetes, deep vein thrombosis, and COPD. However, those parameters have widened in recent years.

"We have definitely increased the number of medical diagnoses that we look for in our EDs," notes **Linda DeCherrie**, MD, clinical director of Mount Sinai's hospital-at-home program and a professor of geriatrics and palliative medicine. "Retrospectively, we have coded in over 59 different DRGs [diagnostic-related groups]. We really look at every patient who comes through our ED at this point in time who meets our insurance and geography criteria to see why they are being admitted, and [whether] it is something we could take care of in the home."

For example, if someone requires care in the ICU or cardiac monitoring, that patient is ruled out from the hospital-at-home approach immediately, DeCherrie notes. "But if they are going to go to a general medicine floor, we are really looking at their case to see if it is something we could offer to them."

Another change from the early days: Patients referred to observation used to be prime candidates for hospital at home. "Observation is still a source, but I would say we try to go more upstream now and focus much more on our EDs," DeCherrie notes. "We used to wait to even review charts until after the ED physician had determined the patients required admission. We still absolutely need to make

sure the patient meets criteria to be admitted. Now, we follow patients [electronically] from the moment they arrive in the ED."

Administrative assistants monitor the ED board continuously to see which patients meet insurance and geography criteria. "Then, from that point, every potentially eligible patient is followed electronically by a clinical person," DeCherrie says. "One of our nurses, nurse practitioners, or physicians will follow them in the ED if there are reasons they seem appropriate for the program or definitely not appropriate."

Prioritize Awareness

Program developers have found that if one waits until after an emergency physician tells a patient he or she needs to be admitted, it is much harder for patients to conceptualize the idea of receiving care at home, DeCherrie explains. Patients already may have told family that they are going to be admitted, and made arrangements for pets or other issues, she says.

Instead, what works better for the program is if the hospital-at-home concept is introduced to patients well before the emergency physician has made a decision on disposition. Typically, program staff will tell appropriate patients that if the emergency physician determines they require admission, they likely will meet the criteria for hospital at home. "Then, patients are generally more interested in doing the program," DeCherrie says.

DeCherrie adds that as soon as program administrators think a patient is appropriate for receiving acute care in the home, a hospital-at-home physician will visit the

ED and talk with the emergency physician. "The emergency physicians are not the ones clinically deciding if someone might be appropriate, but they all have to know about the program," she says. "We are also making sure that primary care providers [PCPs] in our community know about us. People who are connected to PCPs are going to call [patients] from the ED to tell them they are being admitted [to hospital at home] and ask what they think about it."

However, training every single emergency physician who works at Mount Sinai's main campus hospital about the nuances of determining which patients are appropriate for hospital at home is practically impossible, DeCherrie notes. "We have a large group of faculty and a large group of residents," she says. "Plus, we have residents from multiple other services like medicine and psychiatry, and all sorts of services who all rotate through the ED."

At some smaller hospitals participating in the program, emergency physicians may play a role in identifying patients who are appropriate for the program. DeCherrie explains that because these providers are part of a much smaller faculty, training them about eligibility criteria and the other intricacies of the program is easier.

Note Benefits, Outcomes

Patients who are enrolled in hospital at home generally receive daily visits by a physician or nurse practitioner. If a patient needs IV medication management, a nurse might visit up to three times daily. "We do some visits via video in the home; that is a newer approach for

us," DeCherrie reports. "We may do the middle-of-the-hospital-course visit as a televisit. A nurse will set it up in the home so the physician can [interact via] video with the patient."

At the program's busiest point, when it could receive Medicare fee-for-service patients as part of a Center for Medicare & Medicaid Innovation grant, the hospital-at-home program was admitting 10 to 12 patients every week. There could be as many as 30 patients involved in the program at one time. However, that grant ended in August 2017. Now, the program works with just three payers: Healthfirst, EmblemHealth and Oxford-UnitedHealthcare.

The incentive for insurance participation? It could be that the approach has demonstrated consistently that it can deliver cost savings in the 19-38% range compared to similar patients who have been hospitalized. Further, one recent, three-year study of the hospital-at-home model combined with a 30-day transitional care program demonstrated additional benefits. Those benefits included shorter lengths of stay, lower rates of hospital admissions, fewer follow-up ED visits, fewer transfers to skilled nursing facilities, and higher patient satisfaction scores.²

Monitor CMS Changes

Despite positive outcomes from the approach, numerous challenges to the hospital-at-home program remain. Certainly, coming up with a more consistent method of reimbursement is a big issue, although there has been some progress. DeCherrie notes that CMS has approved a proposal for a new payment model in which the government would provide 95% of the DRG to cover a 30-day episode

of care, and shared savings based on quality metrics compared to similar hospitalized patients.

"It was approved for everyone in the country, not just for Mount Sinai," DeCherrie explains. "It was a pretty major thing."

However, with multiple leadership changes at the Department of Health and Human Services, implementation of the new payment approach has yet to occur, DeCherrie notes. "It was approved last September, and that is where it stands. No information has come to us since then," she laments. "We think it will be at least another year, if not longer."

In the meantime, for the insurers that have offered reimbursement for hospital-at-home programs, it has not been easy, DeCherrie notes. "[Insurers] have to fit a program that is providing inpatient care into outpatient rules and regulations," she says. "They have to process [reimbursements] through an ambulatory, outpatient methodology, which requires insurance companies to make ... infrastructure changes in order to process this."

Consider Variables

Hospitals need to consider patient volume when thinking about starting their own hospital-at-home programs. Administrators have to justify the cost of employing a robust team providing 24-hour care in the home to acutely ill patients.

"Probably somewhere between 200 and 300 patients need to come through every year [to justify] appropriate minimal staffing," DeCherrie says.

To meet this requirement, Mount Sinai has expanded the reach of the hospital-at-home service line to maintain adequate staffing.

For example, the program offers observation care in the home for patients who are only with the program for 24 hours. Also, Mount Sinai provides palliative care at home for patients who otherwise would be hospitalized in the facility's palliative care unit. In certain cases, Mount Sinai might even provide at-home services for patients who fear hospitals, even if clinicians believe those patients need to be in a medical facility.

"Also a very large, successful part of our program is something called subacute rehabilitation at home," DeCherrie says. "People don't want to go to a nursing home for three weeks [following an inpatient hospitalization]. We can provide six days a week of physical therapy, occupational therapy, nursing services, and oversight from a physician ... in their home."

It is a much higher level of service than a visiting nurse would be able to provide, DeCherrie observes.

"We have diversified our services as one way that we are able to have more robust staffing for our program."

Another barrier to consider with a hospital-at-home approach: the logistics of delivering the right supplies and equipment into the home at all hours. "Sometimes, I feel like we run a mini-Amazon here," DeCherrie quips.

Reducing ED crowding was a key goal of Mount Sinai's hospital-at-home approach. The idea might appeal to other large, academic medical centers that deal with volume-related congestion. However, the approach probably would not be a good fit for hospitals that rely heavily on inpatient admissions for revenue, DeCherrie says. She does note that if medical facilities use value-based contracts, then a hospital-

at-home approach might be worth considering. "One of the first things [interested hospitals] should do is talk to people who are already doing this, and get some help from the outset," Levine recommends. "Someone who has been doing this can help you figure it out." ■

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Which Chest Pain Patients Require Further Testing, Intervention, or Discharge?

Emergency physicians seek new processes to prevent adverse outcomes in this population

Patients who present with chest pain or other symptoms suggestive of acute coronary syndrome (ACS) are a concern, but emergency physicians struggle to determine which of these patients are at risk for an adverse outcome. Studies have shown that most will not suffer a

heart attack or die in the near term, but how might clinicians identify the small number of patients for whom interventions (or at least further testing) would be beneficial? Adam Sharp, MD, MS, a research scientist and emergency medicine physician at the Southern California Permanente

Medical Group in Pasadena, CA, explains that the quest for a new approach for this patient group has been a high priority for him for several years.

"[Chest pain] is a very common complaint. Emergency physicians see hundreds of thousands of these patients over the course of their careers, and there is a lot of variability," he says. "I think [it is an area] that has a lot of opportunity for improvement from a patient care perspective, from a quality perspective, and from an efficiency/affordability perspective."

Sharp is sharing how he implemented a solution to the problem he thinks would help other emergency providers. At the core of his approach is a standardized method for risk-stratifying patients that Sharp has found is both effective and manageable in the emergency setting. There are several decision-support tools that have been designed to help physicians risk-stratify patients with low-risk chest pain. Sharp's own initiative began with an internal review of all these tools to determine effectiveness and suitability for Kaiser EDs. Investigators found that while there

EXECUTIVE SUMMARY

Hospitals in Kaiser Permanente's Southern California region have implemented a new approach to help identify which patients who present with chest pain require further testing or intervention and which can be discharged safely. The core of this approach is use of the HEART score, a tool developed in the Netherlands to help physicians risk-stratify such patients quickly. Full implementation of Kaiser's approach followed an investigation of how it performed at 14 participating sites.

- Between May and December 2016, investigators found that the HEART score performed well as a risk-stratification tool. Out of 12,128 patients evaluated using the HEART algorithm, the tool missed just 22 patients at 30 days post-ED visit. Investigators noted this is well below published national miss rates, which are in the 2% range.
- Investigators also monitored compliance with the recommended use of the HEART algorithm. They discovered 12% of patients identified as low risk by the HEART score received noninvasive testing, were observed, or were admitted to the hospital.
- While there have been no formal flow analyses, investigators noted that the new approach has affected efficiency positively, as more patients are discharged rather than remain in the hospital for further testing or procedures.

was no clear winner among the tools in terms of effectiveness, the HEART score, a tool developed in the Netherlands, offered some advantages. "It was created from an ED perspective with information that every patient should have," Sharp says. "That made it easier to actually put into place, and it was as good as any of the other options from our perspective."

The next step involved integrating the HEART score algorithm into the electronic medical record (EMR) systems at 14 participating EDs so that the tool could be used to inform clinical decision-making for patients, Sharp explains. (*Editor's Note: See box at top right for more information.*)

Some information, such as lab results, would populate the HEART algorithm automatically in the EMR, while clinicians could easily enter other data points, Sharp notes.

Further, while clinicians maintained autonomy in their medical decision-making, the guidance from Kaiser was that patients with a score of 0-3 would be considered low risk and safe for discharge with follow-up by their primary care physician. Patients with scores of 4-6 would be deemed moderate risk and could be admitted to observation or to outpatient stress testing if troponin tests at zero and three hours were negative. Patients with scores in the 7-10 range would be considered high risk and should be admitted for inpatient evaluation and consultation by a cardiologist.¹

The logistics of integrating the HEART score into the systems and flow of participating EDs were not difficult. The bigger challenge was convincing clinicians to use the new tool and to rely on the results in their clinical decision-making, Sharp observes. "Nobody wants to miss anything — in this case, a potential heart attack — if we could have

THE HEART ALGORITHM

Sharp and colleagues integrated the HEART score algorithm into the electronic medical record systems at 14 participating EDs so that the tool could be used to inform clinical decision-making. Represented by the acronym HEART, clinicians were prompted to note a patient's:

- **History** — low, moderate, or high risk (0-2 points);
- **ECG** — whether the results show a new ischemic change, a nonspecific change, or normal readings (2, 1, or 0 points);
- **Age** — older than 65 years, 45-64 years, or younger than 45 years of age (2, 1, or 0 points);
- **Risk factors** — known coronary artery disease, a prior stroke, or peripheral artery disease (2 points) or other risk factors, including smoking, diabetes, or high blood pressure. Three or more risk factors = 2 points, one to two risk factors = 1 point, and no risk = 0 points;
- **Troponin** — greater than 0.12 ng/mL (2 points), 0.041 ng/mL-0.12 ng/mL (1 point), and 0-0.40 ng/mL (0 points).

identified it and done something to change it," he says.

To address such concerns, Sharp and colleagues reviewed what the evidence base shows. Sharp indicated that there is no evidence that hospitalizing a patient with low-risk chest pain or sending such a patient for a stress test will somehow avoid the risk of a heart attack or even death for up to a one-year window following the ED visit.

"There is a lot of evidence to suggest that medical management of [low-risk chest pain] patients — just doing a good job of trying to mitigate the risks with blood pressure management, aspirin for those who need it, or whatever medical management may be ... is at least as good as the other interventions and tests that we have historically used to try and help people," Sharp says. "[Furthermore], we know that based on science, if you take a low-risk population and do any diagnostic test on that group, there is more likely to be a false-positive than a true-positive. That leads you down a path where [patients] may get invasive procedures like coronary catheterization, which can cause all

sorts of potential side effects. No one wants to go through a procedure like that if there is not a reason it is going to benefit them."

Consequently, a big part of Sharp's initiative involved engaging in discussions with clinicians about evidence and patient-centered care. "That is the part that really takes a lot of effort and culture change," he says. "If you look at the ED, there is always a risk that when somebody goes home, something bad could happen. The more important question is: Have you identified the group that you might be able to help? That is what this assists with."

Additionally, initiative leaders held a summit with both emergency and hospitalist physicians to present the evidence as well as their expectations that the clinicians would integrate the HEART algorithm into their decision-making for patients with potential ACS. The information presented at the summit was compiled into an online continuing medical education module that the physicians could access. Investigators noted that a small financial incentive was available to emergency physicians

who participated in the quality improvement effort. Between May and December 2016, investigators found that the HEART score performed well as a risk-stratification tool. Out of 12,128 patients evaluated using the HEART algorithm, the tool missed just 22 patients at 30 days post-ED visit. Investigators noted this is well below published national miss rates, which are in the 2% range.

Investigators also monitored compliance with the recommended use of the HEART algorithm across the 14 participating sites. They found that 12% of patients identified as low risk by the HEART score received noninvasive testing, were observed, or were admitted to the hospital. This suggests there is room for improvement in persuading more physicians to use and rely on the HEART score in their decision-making. Sharp notes that decisions about care involve both the physician and the patient.

"Institutionally, because this has been a priority and incentivized in

some ways to get physicians to use [the HEART score], they all use it. That doesn't necessarily mean that they all follow the recommendations we have made for low, moderate, and high risk," Sharp observes. "That goes back to the autonomy of physicians and the shared decision-making that goes on between the doctors and the patients they are treating. There always should be some variability there. The overwhelming majority of physicians are now using HEART scores for patients they are seeing."

Efficiency has improved, too, although investigators did not perform any formal flow analyses, Sharp reports.

"We certainly see that more patients — predominantly, those in the lower-risk categories — are able to go home and not stay in the hospital and be observed [or admitted]. Fewer patients are being referred to noninvasive stress-testing centers," he says. "These are clearly efficiency markers." Such gains not only affect efficiency,

but also patient care, Sharp suggests. "We know in the ED there are always patients that we can spend more time on. This helps to reassure both patients and physicians that there is a large, low-risk group that really doesn't warrant the extra observation and testing," he says. "Physicians can then spend that time on patients who would otherwise be waiting for the limited resources that we have."

For chest pain patients in particular, the HEART score provides a way to talk with patients about the risks and benefits associated with different care options.

"This creates a standard, evidence-based way to have those discussions," Sharp says. "No one tells the physicians that they have to do anything in particular. They maintain their autonomy, as they should, to make what they consider to be the best clinician decisions for the patient, but here is some pretty strong evidence to discuss with patients and to use in decision-making."

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Are patients receptive to the information? Sharp says his group has not studied that aspect. However, in his own experience as a practicing emergency physician, Sharp has found most patients to be appreciative.

"There is no one right decision that is a cookie-cutter answer for everyone. I would say anecdotal experience has been overwhelmingly positive," he says. "In fact, patients seem far less worried about this minuscule risk than the physicians."

Sharp acknowledges that there are some patients who want to undergo available medical interventions — even when their risks are low. He notes that this is a valid opinion worth further discussion; however, patients should know about possible complications related to those interventions. "Some patients are still willing to take those chances, and that is part of the clinical decision-making process," Sharp adds.

While more data from the initiative are forthcoming, using the HEART score is a standard practice now in Kaiser's Southern California

region. Kaiser EDs in other regions are beginning to adopt similar strategies, either with the HEART algorithm or similar tools as part of a standardized approach, Sharp reports. However, such strategies don't imply that patients found to be at low risk for ACS simply should be discharged. "I think it is important to emphasize to these patients that they need to manage their chronic diseases," he stresses. This may involve treatment for diabetes, high blood pressure, weight management, dyslipidemia, or other conditions, Sharp says. While emergency physicians do not typically provide ongoing treatment for chronic problems, they can refer patients to a primary care physician for such follow-up.

"I personally do have these discussions with patients," Sharp says. "When I say there is no evidence that bringing the patient into the hospital or doing a stress test is going to reduce his risk of having a heart attack or potentially dying, I note that what we do know is that managing his diabetes well or managing his blood pressure,

weight, and exercise ... are things we know will decrease the patient's risks." These are factors that patients and physicians can work together to control, and there is no need for additional cardiac testing to do that, Sharp advises.

"It helps to identify things patients do have control over and can do to mitigate the risks of down-the-road problems," he says. "Those are discussions that can happen between physicians and patients regardless of the system you are in." ■

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Burnout Linked to Medical Errors, Malpractice, and Suicide

Research suggests more than half of physicians report signs of burnout, caused in part by increasing administrative burdens

While provider burnout has long been a concern throughout the medical profession, the issue is gaining greater visibility.

Increasing evidence shows that in addition to threatening provider well-being, burnout is a significant source of medical errors. In a survey of more 6,600 physicians in active practice, researchers from Stanford University found that physicians with signs of burnout are more than twice as likely

to make medical errors. Physicians with signs of fatigue are 38% more likely to make errors.¹ Researchers also found that 55% of surveyed physicians reported symptoms of burnout, 33% reported high levels of fatigue, and more than 6% had considered killing themselves in the past year.

Previous research has shown that among various specialties, emergency providers are particularly vulnerable

to burnout, given the stress and time pressures they deal with daily. **Laura McPeake, MD, FACEP**, director of wellness for the department of emergency medicine in the Lifespan Health System in Providence, RI, notes the issue is multifactorial. "I think the ED is kind of the canary in the coal mine for a lot of changes that are happening in medicine in general, with the EMRs [electronic medical records] and a lot more administrative

requirements,” she says. “We are seeing a lot of fallout from the opiate epidemic. A lot of that falls on the ED in terms of blame, but I don’t think we are actually responsible for a lot of it. I don’t think we have control over a lot of it.”

McPeake adds that the ED is the main door to the hospital, offering the biggest snapshot of what goes on in the hospital regarding boarding and crowding from the patient’s point of view. “Yet, we have very little control over the availability of inpatient beds, staffing models, and things like that,” she says. “A lot of responsibility falls on us without a lot of the power to [make changes]. We know that is a big driver of burnout. The lack of ability to control and manipulate your environment leads to burnout.”

What are the indications that burnout is an issue? A big warning

sign is when clinicians become emotionally exhausted, McPeake advises.

“They may depersonalize and see patients as things rather than people,” she says. “When they are just clicking boxes and trying to get through the day, and when they are more engaged with their computers than with interpersonal interactions, those are all signs that things are off balance.” When that happens, it is important to start engaging in conversations with people, McPeake explains. “That has two benefits. It has the personal benefit of venting and getting out what is on your plate, and also [the benefit of] reaching out to others and realizing there is a community connection,” she says. “By communicating with colleagues on a personal level and finding a way to voice [your concerns] and empower yourself, you can give more voice to [the issue] at

the administrative and leadership levels.”

McPeake adds that leadership teams can’t address issues if they don’t know about them. “There is a tendency among physicians in general and emergency physicians in particular ... to just keep their heads down ... and go on to the next thing,” she says. “We are good at advocating for others ... but we are not used to advocating for ourselves. We just have to remember that we are advocating for patients. The only way we can really take care of patients is if we are really taking better care of ourselves.”

While individual-level action is needed to address burnout, systems-level changes deliver much more impact. There is evidence that some healthcare organizations are taking the issue seriously. For instance, **Jonathan Ripp, MD, MPH**, was recently named chief wellness officer in the Mount Sinai Health System in New York City. He also serves as the senior associate dean for well-being and resilience at Mount Sinai Hospital.

“The literature has become much more in-depth and robust in demonstrating some of the problems nationwide across specialties,” says Ripp, in advocating for more attention to the issue of provider well-being. “There are pretty high numbers of burnout [cases] and very serious concerns and consequences associated with burnout like medical errors, quality of care, malpractice, and also, on an individual level, depression and even suicide.”

Ripp offers three key reasons why it is in a hospital’s interest to confront burnout. First, if someone is suffering, it is the right thing to do, he says. “If you have a medical problem that is affecting 50% of the population, you would have a sense of urgency to address it. That is what

EXECUTIVE SUMMARY

While no specialty is spared, emergency physicians are particularly vulnerable to burnout, a problem that produces several negative consequences. Experts note the problem must be addressed at both the individual and system levels, but stress that effective interventions likely will deliver a return on investment.

- In a survey of more 6,600 physicians in active practice, researchers from Stanford University found that physicians with signs of burnout are more than twice as likely to make medical errors. Physicians with signs of fatigue are 38% more likely to make errors.
- A big warning sign for burnout is emotional exhaustion. As a result, providers may begin to depersonalize, seeing patients more as things than people. Providers may find themselves more engaged with their computers than with human interactions.
- Experts note the causes of burnout include increasing administrative burdens and other responsibilities placed on frontline providers. They also report that emergency providers in particular tend to shoulder a lot of blame for problems over which they have little control.
- At the systems level, effective interventions may include the use of scribes or technologies that reduce the administrative burdens on physicians while also improving efficiency.

we are dealing with here,” he explains. “Some would argue over whether burnout is a medical condition or not, but it doesn’t matter. We see there is this condition that is affecting most physicians. That is a problem.”

Second, Ripp notes that some regulatory bodies are beginning to mandate organizations address well-being in training programs. Third, there is a strong business case for taking action in this area. “Burnout is associated with decreased productivity as well as turnover where people are simply leaving their jobs,” Ripp stresses. “There is less meaning derived from work because of all the administrative and clerical tasks that are being placed on physicians. In many ways, this is a systems issue.”

Certainly, individual responsibility is important, but the onus is on the system to create a workplace where clinicians are enabled to perform their jobs, Ripp offers. “If you remove some of the clerical work so that it no longer falls on the physician, and you can improve team-based care ... practices can run much more efficiently,” he explains, noting this development could help physicians derive more meaning from their work. “It is about trying to identify ... systems-level changes that both improve efficiency of practice and the well-being of physicians.”

Hiring scribes is one way that some health systems are removing some of the documentation burdens from physicians, Ripp notes. If one scribe helps one clinician, Ripp estimates that clinician can visit two additional patients per day, thereby offsetting the cost of hiring the scribe.

Another potential solution involves fully leveraging speech-to-text software, which has advanced considerably in recent years, or other technologies that may be able to reduce the clerical burdens

on physicians, Ripp offers. Even maximizing the current functionality of existing EMRs may offer some relief.

“That is an area we are working on. We are essentially giving additional training on how to use what currently exists, but to use it more efficiently,” Ripp observes. “Sometimes, people learn how to use the EMR when they first start using it, and then they are still using it the same way five years later. There have been improvements, so you can give them just a little additional training, and suddenly you’ve shaved off minutes out of their day.”

For clinical and administrative leaders, a first step toward addressing burnout is simply to keep an open mind about just how significant a problem the issue is and what the real consequences are, Ripp explains. “Also, be a willing partner in assessing locally the well-being of the population for whom you are responsible,” he says. “There are a lot of really well-validated instruments that can be used to measure well-being ... you can’t fix a problem until you have first diagnosed it. Diagnose it by measuring it.”

Ripp cautions that there may be some resistance to exploring interventions that are costly. However, he notes there is likely to be a return on investment (ROI) when it comes to investing in physician well-being.

Ripp advises administrators consult the American Medical Association’s “Steps Forward” website, which is part of the organization’s effort to promote provider well-being (<https://bit.ly/1MSg91r>).

“[The website] includes a business-case calculator where you can plug in the amount of burnout at your institution, the number of physicians, and the turnover rate. It spits out the amount of money lost per year to physician burnout,” Ripp says. “There is a real potential ROI, but it does require a leap of faith.” ■

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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.

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CME/CE QUESTIONS

1. The home-hospital program at Brigham and Women's Hospital in Boston generally targets patients who otherwise would:

- a. be transferred to a skilled nursing facility.
- b. experience a lengthy stay in the ED.
- c. require a short stay in the ICU.
- d. be hospitalized on a general medicine ward but not require intensive care.

at the Southern California Permanente Medical Group in Pasadena, CA. The bigger challenge was:

- a. convincing clinicians to use the new tool and to rely on the results.
- b. documenting results from the approach.
- c. convincing patients to go along with the results and recommendations.
- d. persuading leaders to sign off on the risk-stratification tool.

2. The case-finding process for potential candidates for Brigham and Women's home-hospital program begins:

- a. once an emergency physician examines the patient.
- b. as soon as the patient presents to the ED.
- c. when an emergency physician determines the patient meets inpatient criteria.
- d. as soon as all labs and other testing are complete.

4. According to Laura McPeake, MD, FACEP, the director of wellness for the department of emergency medicine in the Lifespan Health System in Providence, RI, a big warning sign for burnout is when physicians become:

- a. angry and short-tempered.
- b. prone to missing work.
- c. emotionally exhausted.
- d. difficult to work with.

3. The logistics of integrating the HEART score into the systems and flow of participating EDs were not that difficult, according to Adam Sharp, MD, a research scientist and emergency medicine physician

ED ACCREDITATION UPDATE

COVERING COMPLIANCE WITH JOINT COMMISSION STANDARDS

Better Management of Patients With Psychiatric Needs

With limited care options, patients with psychiatric emergencies often present to the nearest ED where they may wait for hours, if not days, for some sort of disposition. The ED may get backed up as beds become scarce, wait times will increase, and all involved will be left frustrated and resigned that this scenario will repeat.

It's happening in every region of the country. The call for solutions couldn't be more deafening as frontline providers struggle to manage a patient population that many providers misunderstand and some even fear.

That's why Boston-based Institute for Healthcare Improvement (IHI) has teamed up with Well Being Trust, a national organization focused on advancing mental, social, and spiritual health, to identify better approaches to the care of patients with behavioral health concerns in the emergency setting. IHI leaders established ED & UP, a learning community in which nine hospitals are working with expert faculty to test new ideas. Their goal is to better equip EDs and their community partners to meet the needs of patients with mental health concerns while also improving outcomes for patients and families.

In an online presentation, IHI leaders recently discussed what they have learned thus far from the project. Leaders included steps that administrators can take now to improve the way their facilities manage patients who present with psychological problems.

Consider Costs, Impact

Scott Zeller, MD, the vice president of acute psychiatry at Vituity, is one of the faculty members working with ED & UP to formulate and test improvements. He noted that the dearth of mental health

resources is contributing to the problem. "Even if [patients with psychiatric needs] are fortunate enough to have a psychiatrist or a clinician that they work with, they might call them up when they are having a difficult time and hear a voicemail that says 'If you are having a psychiatric emergency, please hang up and dial 911 or go to your nearest ED,'" he explained.

However, Zeller noted that the nearest ED often is ill-equipped to work with such patients. These patients wait three times longer to be seen than patients with traditional medical concerns. "The staff in the ED spends tons of time trying to help these folks out, and get them the kind of treatment and dispositions they need. This interferes with their ability to care for other ED patients," he said.

It is also important to consider financial implications. Psychiatric patients in the ED can cost hospitals more than \$100 per hour in lost billing. The overall costs to the hospital are even greater, Zeller noted. "Each time a hospital boards a patient ... if you put everything together, [it costs] about \$2,300," he explained.

While the expense is high, the effect on a psychiatric patient who is boarded is far from optimal. Typically, such patients are just waiting for either a psychiatric evaluation or a psychiatric disposition, Zeller said. "Sometimes, these folks are [stationed] with a sitter in very close confines. Sometimes, they are strapped to a gurney in a hallway. Sometimes, they are in restraints. Many times, this is all going on without any kind of intervention or treatment," he observed. "It can be very disruptive and very unpleasant for people having a psychiatric crisis. Sometimes, as a result, their symptoms get worse."

Unfortunately, more of these types of patients are coming to the ED. Zeller noted that there has been a 55% increase in psychiatric patients visiting EDs in the past decade. In the same period, there has been a 414%

increase in patients arriving for suicidal ideation.

"Boarding in and of itself can last a long, long time. It usually averages between eight and 34 hours for someone who is boarding in a regular ED. Sometimes, it can last for days and even weeks," Zeller said.

Employ Training, Innovations

What is the solution to such bottlenecks? There have been numerous calls in recent years for more inpatient psychiatric beds. However, Zeller argued that would be an unusual approach, as it would not be the default option for any other medical condition.

"If you come in with chest pain, high blood pressure, or an asthma attack, we are going to address that in the ED. We are going to find out what is going on, start treatment, and hopefully stabilize you in the ED, and get you back home," he said. "But for some reason, in far too many EDs, the default treatment

— if a person is having psychiatric symptoms — is to find him [or her] a psychiatric bed."

Hospitalization for every patient with psychiatric symptoms is not a workable or affordable option, Zeller lamented.

"Even if we had tons of psychiatric hospital beds, we would use them all up if we were doing that," he explained. "If you are at a place where the default treatment is hospitalization ... I can guarantee you that those psychiatric hospitals are having a lot of unreimbursed one- to two-day admissions where the insurers are coming back from Medicare and Medicaid saying that these persons didn't really need to be hospitalized."

Further, Zeller added that such a policy is disruptive for the patient and bad for the ED.

"It is just not a good situation for anybody," he said.

Rather than looking for places to send all patients who present with psychiatric concerns, a better approach is to address the issues in the ED just like emergency personnel

address most other medical problems, Zeller argued.

"What we found in our research is that the great majority of psychiatric emergencies can be stabilized in less than 24 hours in an emergency level of care," he explained.

In fact, Zeller noted there are simple steps that EDs can take almost immediately to improve management of these patients. For instance, he recommended better training for emergency staff in behavioral health best practices so that personnel understand that psychiatric emergencies are, in fact, medical emergencies.

"These are people who are experiencing painful conditions that need our assistance," he said. "If we can intervene appropriately, we are going to have phenomenal improvement and great outcomes."

Zeller added that one focus of this training should be on eliminating the idea that people with psychiatric emergencies need to be treated in a coercive way, either with restraints or forced medication.

"Those things really draw out and create a lot of the boarding," he said. "Once you put someone in restraints, or you have involuntarily medicated them, it is a lot more unlikely that your exit resources — psychiatric facilities — are going to be interested in taking them."

Another innovation that can help EDs accelerate appropriate treatment to patients with psychiatric concerns is on-demand telepsychiatry, which has been initiated in many areas, Zeller noted.

"There is nowhere near enough psychiatrists to drive over to your site. We may be able to have psychiatrists come and see your patient almost immediately over high-definition video conferencing," he said, noting there have been some

EXECUTIVE SUMMARY

Recognizing an urgent need to improve the way patients with psychiatric needs are managed in the ED, the Institute for Healthcare Improvement has teamed up with Well Being Trust and nine participating hospitals to test and implement new approaches.

- There has been a 55% increase in psychiatric patients arriving at EDs in the past decade. During the same period, there has been a 414% increase in patients coming for suicidal ideation.
- Most psychiatric emergencies can be stabilized in less than 24 hours in an emergency level of care. However, experts note that in far too many EDs, the default treatment is to find an inpatient psychiatric bed.
- A trauma-informed approach to managing these patients may require EDs to review their practices and for clinicians to reevaluate their own perspectives.
- Innovations such as telepsychiatry, emPATH units, and streamlined access to child psychiatric expertise offer potential solutions for improved care and ED operations.

good outcomes reported from such interventions.

Busier EDs that see four or more psychiatric patients a day might want to consider creating an emergency psychiatric assessment, treatment, and healing unit (also known as an emPATH unit), Zeller suggested.

"It is basically a separate section of the ED, or an adjacent section ... that is just for emergency psychiatric patients who otherwise might have been boarding in the ED," Zeller explained. "It is a much more home-like, supportive setting with experienced psychiatric personnel to work with these folks for up to 24 hours."

Instead of gurneys, patients sit in recliners. Patients can move about in an emPATH unit freely, Zeller explained.

"We are seeing amazing results with these units, not the least of which is that physical restraints and involuntary meds occur in less than 1% of patients," he added.

Address Upstream Levers

Initiative leaders understand that improvements in the care of patients with mental health concerns require work in the ED, explained **Mara Laderman**, MSPH, a director at IHI and the content lead for the organization's work in behavioral health. But, she added, leaders also know that improvements are needed in some of the levers upstream that are driving patients to the ED.

"We have developed a change package that is focused on the theory that we will have greater impact by intervening at multiple points ... than we can in working on isolated parts of the system," she shared. (*Editor's Note: Learn more about the change*

KEY DRIVERS OF CHANGE

The creators of the ED & UP program are testing ideas for change around these five primary drivers:

- Build and leverage partnerships with community-based services;
- Coordinate and communicate between EDs and community-based services;
- Standardize processes from ED intake to discharge for a range of mental health and substance use issues;
- Engage and empower patients and family members to support self-management following ED discharge;
- Create a trauma-informed culture among ED staff.

package in the sidebar at the top of this page.)

Robin Henderson, PsyD, the clinical liaison to Well Being Trust and the chief executive of behavioral health for Providence Medical Group in Portland, OR, noted that emergency personnel typically respond quite differently to psychiatric trauma than physical trauma.

"Normally, when we are looking at someone coming in to the ED with a minor trauma like a broken arm or a broken finger, we will take them back and let them stay in their own clothes. We may let them have a family member with them. They keep things like their cellphone and their wedding ring," she explained. "But when we have someone coming in, and they are hearing voices, or they may be actively psychotic, we will take those things that are a comfort to them ... we don't understand the unintended consequences of our best intentions."

Sometimes, such practices stem from an unfortunate event in the past that resulted in serious consequences, Henderson explained. For example, she recalled working in one ED that was the site of a suicide four years earlier. "They created an entire series of activities for every psychiatric patient who presented based on that

one aberrant event," she said. "It changed their entire culture."

Henderson explained this kind of thinking and practice stem from a hospital culture where everybody is always looking to fix defects. For example, instead of acknowledging that a practice is working well 97% of the time, hospital staff will focus on the tiny percentage of times things did not go well, she observed.

"When we apply that same thinking to a trauma-informed culture, what we create are environments that are very based on fear, the false evidence that appears to be real as opposed to basic facts," Henderson offered. "And 97% of the time, when a psychiatric patient presents to an ED, there won't be violence, there won't be harm to staff, and there won't be a self-harm incident. Yet, we have created cultures, processes, and policies around the 3% of the time that [something bad will happen]."

To address this disconnect, Henderson advised ED leaders to review their policies to see what can be done to ensure that they are based on what actually happens in the ED with psychiatric patients as opposed to what might happen. She also suggested clinicians reevaluate their own perspectives. For example, instead of wondering what is wrong

with a patient, think in terms of what happened to the patient or what matters to the patient, she said. These changes regarding thoughts, questions, and attitudes are the building blocks of a trauma-informed culture within an ED, Henderson added.

Facilitate Access to Expertise

Vera Feuer, MD, the director of pediatric emergency psychiatry and behavioral health urgent care at Cohen Children's Medical Center in New Hyde Park, NY, one of the participating hospitals in the ED & UP program, noted that, on average, U.S. children are hospitalized more frequently for psychiatric issues than for medical problems.

"In most of the country, kids get seen either by adult emergency medicine providers or psychiatrists. Only a few places have pediatric psychiatric expertise present," she explained.

This frequently results in adult-level concerns about safety, which leads to overuse of inpatient resources. Another problem, according to Feuer, is that kids are sent to EDs often purely because there is no outpatient alternative

available. "Let's say a child draws a picture of a person hanging from a tree [at school], and nobody is sure what that means. The child might end up in the ED for a suicide assessment. [He or she] might be right next to a child who is there for a very different and much more serious reason," Feuer explained. "In pediatrics, in many ways, the solution ... is providing access to expertise quickly in an ambulatory setting for those kids who don't necessarily need the ED, but require an assessment."

To address this problem, Cohen Children's Medical Center is developing an urgent care program that is staffed by a child psychiatrist.

"It allows immediate access to expertise that is often needed when schools or therapists have concerns about kids, and [those kids] need to see a physician," Feuer said. "It helps to avoid revisits to the ED. If there are issues that come up for the kids that we see in the ED, we have them come to urgent care for follow-up. If they are not in care and need the transitional space, it can also help avoid an inpatient stay or serve as an alternative."

As part of the ED & UP collaborative, Feuer explained that the hospital is working to better educate patients, families, and hospital staff on how to manage

things like agitation and other psychiatric issues while minimizing the use of coercion and medication. Also, Cohen Children's Medical Center is collaborating with primary care physicians, schools, and community partners to establish streamlined referrals and provide more overall wraparound care for families. ■

SOURCES

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