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Paramedics Empowered to Administer Addiction Treatment to Patients in the Field

While many EDs are struggling with the idea of enabling emergency providers to administer buprenorphine to patients who present with symptoms of opioid withdrawal, Cooper University Health Care in Camden, NJ, is out front on this issue. Not only have all emergency physicians (EPs) in the health system been trained and X-waivered to prescribe buprenorphine to appropriate patients, EPs, addiction medicine specialists, and Camden EMS are developing a protocol that allows paramedics to administer buprenorphine in the field.

Many patients who overdose (OD) refuse transport to the ED after they have received OD-reversal drugs, which often plunge these patients into immediate, severe withdrawal. As a result, OD patients miss out on effective linkages to treatment, choosing instead to find a new source of opioids to ease their symptoms. The protocol in development is designed to end this cycle, thereby capturing more patients into treatment.

The ED will play a big role in the approach. Paramedics will be able to

administer buprenorphine under the supervision of an EP. Many patients who receive buprenorphine in the field will be transported to the ED, where they will be linked into effective treatment. The idea relies on treatment resources and approaches that already are well-developed in this community. The proposal has captured the interest of other communities and healthcare providers, too.

Listen to EMS

Gerard Carroll, MD, FAAEM, a paramedic, EP, and medical director for EMS at Cooper University Health Care, notes that the idea for this new approach stems directly from concerns expressed by EMS personnel.

“The highest call type in Camden is ‘unconscious and OD,’ whereas in the past it had been chest pain or respiratory distress,” he explains.

Frustrated with the status quo, EMS providers approached leadership, complaining that the way they were responding to calls was a Band-Aid,

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Carroll relates. “[They said] we are waking people up with Narcan [naloxone] until the next OD until finally they are dead. How do we combat this?”

The plea prompted a discussion among leaders from EMS, emergency medicine, and addiction medicine specialists about what more could be done to address the opioid OD problem. At this point, there already were Suboxone (buprenorphine and naloxone) and methadone treatment programs in place, and a bridge clinic had been established through the ED.

“The idea behind the bridge clinic was that we could begin patients on medication-assisted therapy in the ED and then bridge them into the clinic so we would hit that opportunity,” Carroll notes.

However, it was clear that the healthcare system was missing a chunk of the population that was in need of treatment.

“EMS was interacting with these people on the frontlines. Many of them were not ever coming to the hospital. Even if they were, they often couldn't get through the volume of the ED [before leaving]. We thought how could we interact with them there [in the field],” Carroll says.

To approach these patients in a different way, paramedics first began to share information and research about opioid use when they interacted with patients with opioid use disorders in the field. “We see a lot of these patients recurrently,” Carroll shares.

Further, with the knowledge that buprenorphine was provided to these same types of patients in the ED *and* in the addiction clinic, EMS leaders then considered whether they also could use the drug in the field. Considering this is something that

has not been done before, it would require state-level regulatory approval to clear the way. But that was not the only roadblock. Not all paramedics were on board with the idea.

Begin With Education

When EMS staff were first approached about the concept six months ago, feelings were mixed, observes **Rick Rohrbach**, BSN, RN, CFRN, CCRN-K, MICP, EMS director for air and ground services at Cooper University Health Care.

“We had some folks that have been out there a long time. They had dealt with this for years, and they were a bit resistant,” he explains.

To overcome this resistance, the first step toward implementation of the new plan involved educating EMS staff.

“They spent time in our addiction clinic and they spent time with our physicians. We really made them see what this disease [of addiction] is really all about,” Rohrbach says. “Just like with diabetics and just like with cardiac patients, we do have a role in treatment and prevention that is more than just a 911 call.”

Gradually, more EMS personnel have become supporters (if not fans) of the new approach.

“That education and the feeling that they are actually part of something that is new to EMS ... have energized a lot of them,” Rohrbach reports. “They are very much engaged now. We are still getting requests from frontline staff members who want to spend time in the [addiction] clinic. They want to see how that works, and how we communicate [with patients].”

Participating staff's active engagement is critical; yet, others interested in this approach should

understand that it can be a heavy lift. For instance, even Carroll acknowledges that he was initially resistant to empowering paramedics to administer buprenorphine in the field.

“What got through to me, and what is getting through to the majority of my colleagues, is that the mortality of this disease is so much higher than so many of the things that we think are our bread and butter,” he says. “When you explain that to our paramedics, when they see the graphs, and when they realize that having a heart attack is almost less dangerous than this, that is when we really get that buy-in from them.”

Put Pieces in Place

Another game changer is the fact that effective treatment for opioid addiction is available, explains **Rachel Haroz**, MD, an EP and an assistant professor of emergency medicine and medical toxicology at Cooper Medical School of Rowan University. Haroz also helps run the health system’s addiction clinic.

“I did residency and fellowship training almost 20 years ago. Back then, buprenorphine hadn’t even been approved yet,” she says. “With the exception of methadone, which everyone was probably unjustly very leery of [back then], we had nothing that we could do for [patients with opioid withdrawal] in the ED. Other than sending them to rehab and detox, which we now know is not good evidence-based treatment for these patients, there was nothing we could do.”

However, with the approval of buprenorphine, there is a treatment that works, and it is not ethical to withhold this treatment, Haroz stresses. “We know it works, and

we know it decreases mortality by two-thirds, which in the world of medicine is huge,” she says.

Nonetheless, reaching the point where it makes sense to put buprenorphine in the hands of paramedics to administer in the field has taken some time. For instance, Haroz notes there first needed to be an addiction clinic or “landing pad” where these patients could receive longer-term treatment. Also, many more physicians in Camden needed to undergo the X waiver training required by the Drug Enforcement Administration (DEA) to prescribe Suboxone. (*Learn more about waiver training at: <http://bit.ly/2MsbHPU>.)*

“In 2015, we had a waitlist of 600 patients [to receive Suboxone], and that was simply not feasible. We had to open our own landing pad; hence, we launched our outreach clinic, which now functions five days a week, and we have five physicians staffing that,” Haroz explains. Also, beginning in fall 2016, the health

system started providing resident EPs with the training required to prescribe Suboxone. The next spring, attending EPs received this training.

“We actually used the X waiver course as a way to change hearts and minds,” Haroz notes. “What is great about emergency physicians is that they do like evidence-based medicine and data, and the treatment for [opioid addiction] is evidence-based. There are even ED-specific data that we were able to show them.”

Another critical key to the success of the approach was that the healthcare system’s administrative and clinical leadership strongly supported the effort. “Our own department chair simply mandated that all of the emergency medicine physicians become X-waivered,” Haroz notes. “Once emergency physicians started to use buprenorphine, they realized it is a fantastic tool in their toolbox, and that they could actually help their patients,” Haroz says. “The more they did it, the more they wanted to do

EXECUTIVE SUMMARY

Cooper University Health Care in Camden, NJ, is rolling out a new approach that will enable paramedics to administer buprenorphine to overdose (OD) patients in the field. The paramedics will be operating under the guidance of emergency physicians who have been X-waivered to prescribe the drug. The idea is to reduce the barriers that prevent many patients from entering into treatment for their substance use disorders.

- The program was developed in response to EMS providers contending they are providing nothing more than a Band-Aid when they administer naloxone to OD patients on the scene, thereby saving the patients’ lives (but often plunging those patients into severe withdrawal).
- Patients often refuse transport to the ED, instead opting to quickly find another source of opioids to relieve their withdrawal symptoms.
- Considering buprenorphine can relieve withdrawal symptoms, developers hope that more OD patients will be receptive to entering into long-term treatment for their addictions.
- To move forward with the approach, New Jersey’s health commissioner issued an executive order giving paramedics the ability to administer buprenorphine under the supervision of an X-waivered physician.

it.” The strong integration between ED and EMS providers has been instrumental in the push to further expand the use of buprenorphine to paramedics in the field, Carroll notes.

“Day in and day out, our paramedics use our ED for their patients and for medical command,” he says. “For every ALS [advanced life support] call, they talk to one of our emergency medicine physicians to go over the case and the treatment options. They are already very used to working in tandem in that very classic model with the paramedic [operating as] a physician extender.”

Paramedics always want to bring OD patients to the ED. However, even in cases in which patients refuse transfer to the ED, a decision on whether to administer buprenorphine will be made in concert with an X-waivered physician in the ED, Carroll explains.

“We are very sure that this medication is safe and we know it reduces mortality. How well it can work in this venue is a part of this program that we are going to find out,” he says. “We are going to train the paramedics, and they will have the full support of a board-certified emergency physician ... every step of the way. We are going to bring that expertise out of the hospital to the patients where they need it and when they are in the most trouble.”

Carroll makes the case that administering buprenorphine in the field will enhance the opportunity to engage patients in treatment.

“When someone is given [naloxone] and resuscitated, it precipitates varying degrees of withdrawal, some of which can be very severe,” he says.

Generally, the more severe the symptoms of withdrawal are, the less willing patients are to engage with providers, Carroll notes. “By the time

they get to the hospital, some of these patients are so fed up and dope sick that they just walk out because they would rather just go find some more [opioids] because they are miserable,” he says.

“We just saved their life, but this is a side effect of the [naloxone]. Our hope is that by getting them right away with this treatment [the buprenorphine], we can alleviate those symptoms, and we can lower that barrier to entering care.”

The patient interaction with EMS will not necessarily be a one-time event under the new program, according to the protocol that is in development.

“Once patients [agree to] enter into treatment, our mobile integrated health program through our EMS service is willing to go out daily to bring the patients [buprenorphine] while we bridge them to the clinic so they can get into long-term therapy,” Carroll explains. “We will be bringing this treatment to the patients to give them that time to re-enter their lives and to function [without] relapsing.”

Consequently, patients will not just receive a dose of buprenorphine with the hope that they will make it to the addiction clinic in a week.

“We are going to engage with them daily in some form as best we can to make sure we support them through this highest-risk period before they get to the clinic,” Carroll says. “We are going to do everything we can to keep patients from just going back to their addiction cycle in that really critical period of three to six days before they get [into longer-term care].”

Precisely how patient interactions will proceed following an initial paramedic encounter likely will vary under the new program, Haroz shares. “In a city like Camden, an unusually large number of patients

don’t want to go to the ED at all after they have received [naloxone]. Many of them refuse transfer,” she says.

“Part of our mission is to engage that population that won’t even come to the ED, whatever we can do to keep them safe and try to engage them in treatment.”

The paramedic-focused effort is rolling out in stages. To this point, the education piece has been the primary focus.

“I think it is important that we have laid the foundation for this over the past six months through education and talking to our folks about how to engage these patients because that is half the battle,” Rohrbach shares.

In June 2019, New Jersey Health Commissioner Shereef Elnahal, MD, issued an executive order enabling paramedics in the state to administer buprenorphine under the supervision of an X-waivered physician, although only the state’s 21 mobile ICUs are authorized to carry the drug. Nonetheless, the move has given program developers in Camden the green light to move forward with protocol development. (*Editor’s Note: Elnahal left his post as state health commissioner in July 2019 to become president and CEO of University Hospital in Newark, NJ.*)

“We have already been using our X-waivered EMS physicians to respond to calls to start this program in the field in a limited way,” Carroll observes. “Our plan is that we will actually have a physician on scene for a lot of these calls initially. This will provide apprenticeship training [to the paramedics] above and beyond just reading a book or taking a test. That is our safety valve to make sure this is rolled out correctly.”

Such an approach will allow for any tweaking of the protocol that may need to take place as developers

observe what happens when paramedics respond to calls involving patients who have overdosed.

“We are trying to figure out the best way to treat these patients and save their lives,” Carroll says.

Haroz stresses that none of this would be possible without close collaboration among emergency medicine, addiction medicine, EMS, and community partners. “We are hoping to be able to bridge these patients not just to [our own addiction clinic], but also to some

of our community partners,” she says. “Some of these patients are going to be homeless and have other needs. Some will be best serviced by our local FQHC [Federally Qualified Health Center], which does a phenomenal job treating these patients with Suboxone as well.”

With all these pre-existing partnerships, Camden, NJ, is perhaps uniquely prepared to roll out this approach, but other communities are taking an interest in the model, too. “I have had four or five EMS

directors from around the country contact me and ask for our protocol,” Carroll shares.

There may be other communities in New Jersey that eventually adopt the model, too, although Carroll is unsure at this point which communities have developed the appropriate partnerships and put the infrastructure in place to go down this road.

“I am hoping that we have a model that [others] can learn from and adapt to their needs,” he says. ■

Clinicians Need the Right Tools to Care for Older Patients With Cognitive Deficits

As the U.S. population ages, hospital providers are confronting the complicated challenge of meeting the needs of more patients with dementia, delirium, and other cognitive deficits.

To get ahead of this demographic trend, some health systems have developed initiatives aimed at equipping their workforce with the knowledge and tools to recognize and manage this population better while also offering a more compassionate and welcoming face to patients and families.

Meanwhile, the American College of Emergency Physicians (ACEP), the Institute for Healthcare Improvement, and other professional organizations are taking steps to identify best practices and improve the care that is provided to older patients. While most of these initiatives maintain a strong focus on boosting clinical results, the creators of some programs also have made a strong business case for their efforts.

As of 2018, there are an estimated 170,000 people 65 years of age and older in North Carolina living with

Alzheimer’s dementia. That number is expected to grow to 210,000 by 2025.¹ Hospitals in the state are well aware of this reality. Dementia poses significant challenges to clinicians as they strive to provide appropriate care to patients who often struggle to communicate their needs and may be fearful of the care providers

who are trying to help. Considering such encounters can be difficult for even the most experienced clinicians, UNC Health Care in Chapel Hill, NC, has launched a large-scale effort aimed at providing the thousands of employees who work in four of the health system’s hospitals with training so they can assess, treat, and

EXECUTIVE SUMMARY

Hospitals and other healthcare organizations are putting a new focus on best practices for delivering optimal care to older adults. This includes the deployment of training and evidence-based tools so that clinicians and other hospital employees are well prepared to optimally recognize and interact with patients with cognitive deficits related to dementia or delirium.

- UNC Health Care in Chapel Hill, NC, is rolling out a dementia-friendly initiative aimed at providing hospital employees with the skills to confidently and compassionately care for dementia patients in a cost-effective manner while also positively affecting hospital use.
- The American College of Emergency Physicians is one year into its Geriatric Emergency Department Accreditation program, which offers three levels of accreditation to EDs that demonstrate they have adopted best practices.
- Hartford Hospital’s institution-wide Actions for Delirium Assessment, Prevention, and Treatment program has demonstrated that it can improve outcomes related to delirium while also reducing resource use associated with the condition.

communicate better with patients who have dementia.

Dubbed the dementia-friendly hospital initiative, the goal is not only to provide hospital employees with the skills to confidently and compassionately care for dementia patients in a cost-effective manner, but also to affect hospital use. Developers believe that by reaching patients with dementia in the hospital setting, they could shorten the average length of stay (LOS) and curb 30-day readmissions. Data show that patients with dementia stay in the hospital longer, comprise more 30-day readmissions, experience worse outcomes, and die at a faster rate than the general population.

Funded by a grant from The Duke Endowment, the initiative is in pilot testing at UNC Hospitals Hillsborough Campus where every employee who may come in contact with a patient who has dementia is receiving the new training. However, staff members in the ED at Hillsborough may have a head start in the process. The ED there recently became the first in the state to receive Geriatric Emergency Department Accreditation (GEDA), a program sponsored by ACEP.

Kevin Biese, MD, MAT, FACEP, co-director of the Geriatric Emergency Medicine Service at the UNC School of Medicine, is on the board of advisors for the dementia-friendly initiative and also chairs ACEP's accreditation effort. He sees both initiatives driving toward the same goal of improving care for older adults.

"We have to make sure that all of these initiatives talk to each other and offer a cohesive range of options for healthcare systems," he says. "They are getting at many of the same issues, but from different angles. We want healthcare system leaders to

have a simple, comprehensive way of creating strategies that are better for taking care of older adults."

Use Cognitive Screening

As the dementia-friendly hospital initiative rolls out, Biese envisions more use of cognitive screening, a practice he has found to be particularly valuable in the ED.

"It is important to understand the capacity of your patients for giving you an accurate history," he says. "So much of what we are worried about depends on the history of what is bothering the patient ... but if he or she doesn't have good short-term memory, then the patient is not a reliable historian." Consequently, Biese adds that it is important to conduct cognitive screening to ensure the clinician's evaluation is appropriate to why the patient is there.

A second reason to conduct cognitive screening is because it addresses the inescapable fact that the U.S. population is aging.

"More of our patients are older and demented. The sooner we can recognize that and provide them with appropriate interventions, the better," Biese shares.

Further, some of the simple, fast screeners that are available for cognitive screening can identify opportunities to intervene even if the issues identified are not what brought a patient to the ED.

"We should take advantage of the opportunity that a patient presents by coming to the ED, to plug him or her back in with their primary care provider or other community resources so that this opportunity is not missed," Biese advises. He adds that one instrument with which he is familiar, the Mini-Cog, can be

administered quickly.² "If we can identify and intervene with patients who have dementia sooner than they might otherwise be identified, that is a good thing."

Make it Interdisciplinary

One feature that is common to both the GEDA program and UNC's dementia-friendly initiative is the focus on interdisciplinary training, Biese explains.

"For example, with GEDA you must have a nursing champion as well as a physician champion. Both the physician and nurse have to receive additional education in geriatric syndromes and conditions," he says. "Then, we also incorporate [this education] into pharmacy, case management, social work, occupational therapy, and physical therapy ... it is absolutely an interdisciplinary effort. The same practice is being utilized in the dementia-friendly initiative."

For frail patients or any patient with cognitive impairment, the entire team has to approach the situation therapeutically. For instance, a clinician may walk into a room calmly, putting a patient with dementia at ease. Suddenly, a tech arrives and turns on bright lights, which could agitate or frighten the patient.

"All of us have to work together to accomplish [a positive result for the patient], and that is true of both initiatives," Biese notes.

The GEDA program, based on Geriatric Emergency Department Guidelines developed on an interdisciplinary basis in 2013, outlines 27 best practices that EDs can adopt to better meet the needs of their older patients. As more best practices are adopted, EDs can

achieve a higher level of accreditation. Level 3 is the lowest level; level 1 is for EDs that have adopted at least 20 best practices.³

“We accredited our first EDs in May of 2018 ... there are now 55 accredited EDs, and there are more than 200 EDs that have started the process of accreditation in one way or another,” Biese observes.

The dementia-friendly initiative will cover some of the same ground, although on a hospitalwide basis. Further, program developers note that the program is moving beyond a provider-centric focus by involving both clinical and non-clinical staff in the effort to connect with dementia patients more effectively and in a way that makes them feel safe and well cared for.

Once training has been completed on the Hillsborough Campus, program administrators plan to expand the program to North Carolina Memorial Hospital in Chapel Hill, Pardee UNC Health Care in Hendersonville, and Wayne UNC Health Care in Goldsboro.

Embed the Program

Hartford (CT) Hospital also is focused on improving the care it provides to the growing population of older patients. In particular, since 2012, clinicians have been engaged in a hospitalwide program to prevent and address delirium, a sudden change in mental status that is common in older adults during an illness or injury. The program is a geriatric consult service referred to as ADAPT (Actions for Delirium Assessment, Prevention, and Treatment). The program has been in place for seven years, and in that time administrative leaders have documented significant gains from

the effort, both in terms of patient outcomes and reduced resource use.

“[Delirium] is associated with increased mortality, morbidity, falls, persistent and future cognitive impairment, and post-traumatic stress disorder, all harms that can occur to the patient,” explained **Christine Waszynski**, DNP, APRN, GNP-BC, the coordinator of ADAPT, who outlined the program on June 13 during a presentation entitled “Assessing the value of age-friendly health care,” sponsored by the Institute for Health Care Improvement.

“[Delirium] is also associated with less-than-optimal system-related outcomes such as prolonged length of hospitalization, discharge to a higher level of care, readmission, and increased cost.”

Waszynski noted that experts believe delirium is as much as 30% to 40% preventable, and that the condition can be caused by the action or inaction of the healthcare team.

“The condition is often under-recognized and poorly managed, which then leads to delayed diagnosis and [delayed] implementation of treatment and management,” she said. “Therefore, early recognition and implementation of best-practice interventions can improve outcomes.”

Consequently, the first step of the ADAPT program focused on implementation of a hospitalwide screening program for delirium that could identify all instances of the condition at an early stage. To do this, the hospital used a screening tool called the confusion assessment method (CAM) and a companion tool called the CAM ICU.⁴

“Since 2012, we have had nurses performing these delirium screens on every patient in our hospital every eight hours. This has required many different approaches to educate the

nursing staff initially as well as on an ongoing basis,” Waszynski noted.

To make this possible, program administrators embedded the structure of the program into the hospital’s systems, **Robert Dicks**, MD, FACEP, a geriatric internist and the director of geriatric programs at Hartford Hospital, explained during the same June 13 session.

“We were able to integrate the CAM into our electronic health record [EHR]. With strong nursing engagement, we made the CAM a required field,” he noted. “That allowed us to get nearly 100% compliance for screening. Because of EHR integration and the reporting of results, we have been able to pull the CAM [findings] into a real-time registry.”

From the registry, program administrators can monitor both the compliance with screening and protocols as well as outcomes, according to Dicks.

“We have been able to capture our own outcomes rather than deal with reference outcomes,” Dicks said. “Over time, we have been able to track the incidence [of delirium], LOS, disposition and readmission, and the response to protocol enhancements over time.”

Employ Data-Driven Approach

Once program administrators showed delirium’s effect on patient outcomes in the hospital, they developed a delirium care pathway that includes interprofessional approaches to care and advice to clinicians, other professionals, volunteers, patients, and families, Waszynski said.

“It spells out the best practices for prevention, screening, treatment,

and management, with a big focus on patient safety, patient comfort, and preserving patient function.”

The protocol is updated as new data come to light, Waszynski observed. “From this [pathway], order sets and structured notes have been created to produce a tangible method of standardizing care for patients at risk for delirium and for those who are experiencing delirium at our hospital,” she said.

Further, by collaborating with finance to acquire actual cost data to go along with clinical data captured through the program, administrators have demonstrated the value that the

ADAPT approach has delivered, both in terms of outcomes and costs, Dicks shared.

“In our most recent analysis, we experienced a 40% decrease in delirium-attributable days over the last six years ... with an estimated cost savings of \$6.5 million annually,” he said. “We are now engaged with finance and research to do a more structured, deeper dive [into the data] to look at matched outcomes.” ■

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Initiative Identifies Four-Component Framework for Age-Friendly Care

Recognizing that the current U.S. health system is not well prepared to care for the rapidly aging population, the Institute for Healthcare Improvement (IHI) and the John A. Hartford Foundation are partnering with the American Hospital Association and the Catholic Health Association of the United States on the Age-Friendly Health Systems initiative. **Tam Duong**, MSPH, a senior project manager and research associate at the IHI, outlined what the initiative entails during an IHI-sponsored presentation called “Assessing the value of age-friendly health care” on June 13.

“We know that in the current system, older adults experience harm and may not receive care that is consistent with what matters to them,” Duong noted. “[However], the good news is we know there are evidence-based models for effective geriatric care. At IHI, we saw this as an opportunity to increase the reliability of these models to achieve

better outcomes for older adults.” Initiative developers hope to build a movement to ensure that all the care provided to older adults is age-friendly. “That means that the care is evidence-based, causes no harm, and sticks with what matters to the older adults and their families,” Duong noted. “The first goal that we set is that by the end of 2020, 1,000 hospitals and 1,000 primary care practices will be age-friendly.”

To get there, the initiative is focusing on what program developers refer to as the 4Ms framework, a series of interrelated priorities:

- **What matters** refers to the need to align care with what older adults desire in terms of health outcome goals and preferences across all settings of care. Duong noted that this first “M” is viewed as the foundation of age-friendly care;

- **Medication** refers to using age-friendly medicines that do not produce results that do not produce results that are contrary to the wishes

of older patients or that negatively affect their mobility or mental status. It also means understanding and reducing medications that pose higher risks for older patients;

- **Mentation** refers to the prevention, treatment, and management of dementia, depression, and delirium;

- **Mobility** pertains to the need to ensure that older adults can move safely, maintain function, and carry out tasks that are important to them.

Implementation of the framework has been assessed in five health systems across the country. “These systems have tested the four Ms and gave us detailed insight on how to make them work,” Duong explained, noting that all of this guidance is available to health systems online (<http://bit.ly/2K7Rz2A>). “Also on our website, we have outlined how [an organization] can become recognized as an age-friendly health system.”

Further, although there is a strong moral case for engaging in this work,

Duong noted that the initiative recognizes hospitals operate in a business environment. Consequently, a financial case must be made to further the initiative's age-friendly care goals, she said.

To that end, the initiative worked with Victor Tabbush, PhD,

an adjunct professor emeritus at the UCLA Anderson School of Management, to build a business case for the 4Ms framework, along with two return on investment calculators that healthcare systems can use to assess the returns from their own age-friendly care efforts. One calculator is

designed for inpatient activities, while the other is focused on measuring results on the outpatient side.

Both calculators, along with other tools and information about making the business case for age-friendly care improvements, are available online at: <http://bit.ly/2Y8URMX>. ■

Authorities Call on Providers to Report Suspected Cases of Acute Flaccid Myelitis Promptly

In the wake of the third nationwide outbreak of acute flaccid myelitis (AFM) since 2014, the CDC is calling on frontline providers to act quickly to report suspected cases and to collect specimens. In a media briefing on the subject on July 9, **Anne Schuchat**, MD, the CDC's principal deputy director, noted that a heightened awareness of AFM symptoms and immediate reporting to the health department is needed for investigators to make headway against the illness.

"When specimens are collected as soon as possible after symptom onset, we have a better chance of understanding the causes of AFM and these recurrent outbreaks and for developing a diagnostic test," Schuchat noted. "Rapid reporting also helps us to identify and respond to outbreaks early and to alert clinicians and the public."

The frightening illness causes limb weakness, mostly in children, and can be devastating to patients and their families, Schuchat said.

"We have seen a seasonal pattern to this illness. Most patients develop AFM between August and October," she stated. "Most [of the identified patients] had a mild respiratory illness or fever less than a week before they developed arm or leg weakness. These are important pieces of evidence

that point to viruses, including enteroviruses in particular, playing a role in AFM."

The CDC began tracking AFM after the outbreak of the illness that occurred in 2014. Since then, the agency has been working with local and state public health departments to investigate the illness by reviewing each case and testing every specimen received. Further, the agency is collaborating with universities and the National Institutes of Health to conduct research on AFM.

"Our sustained work will help lead to more answers about this serious illness, such as why some children develop AFM and why these outbreaks are occurring," she said. "The CDC's AFM task force of national experts is also playing a critical role in the AFM investigation by evaluating the current understanding of the causes of AFM and strengthening the knowledge base about the best ways to support patients through treatment and rehabilitation."

Eliminate Delays

Tom Clark, MD, MPH, deputy director of the CDC's Division of Viral Diseases, is leading the agency's investigation into AFM. "The CDC confirmed that 233 patients in 41

states had AFM. This was the third and largest outbreak since we started our surveillance of AFM in 2014," he said of the 2018 AFM outbreak during the July 9 media briefing. "Similar to the outbreaks in 2014 and 2016, most AFM cases were in young children; the average age was 5 years."

Clark noted that children identified with AFM in 2018 were severely affected by the disease, with 98% hospitalized, 60% admitted to the ICU, and 27% requiring machines to help them breathe.

While all stool samples tested were negative for the poliovirus, roughly half of the stool and respiratory samples tested were positive for an enterovirus or rhinovirus, including EVA-71 and EVD-68.

"The spinal fluid [from these patients] tested positive in two cases. One had evidence of EVA-71 and one had evidence of EVD-68," Clark explained.

Since 2014, Clark noted the spinal fluid from patients has been tested in most AFM cases, but investigators have identified a pathogen in only a few cases. However, when a pathogen is found in the spinal fluid, that is good evidence that it was the cause of the patient's illness, he said. Data from 2018 indicate that patients identified

with AFM that year received prompt medical care.

“On average, patients were hospitalized within one day after they started experiencing limb weakness, and an MRI was performed within two days,” Clark shared.

However, he observed that specimen collection from these patients for virus testing occurred within two to seven days, on average, and suspected cases were not reported to the CDC until 18 to 36 days after the onset of limb weakness.

“This delay hampers our ability to understand the causes of AFM,” Clark advised. “The CDC urges healthcare providers to recognize AFM symptoms, collect specimens early, and immediately report all suspected cases to their health department.”

Boost Awareness

As of June 24, 11 cases of AFM have been reported this year to the CDC from eight different states. While an uptick in cases typically occurs from August through October, the illness can occur year-round. Schuchat noted that the every-other-year pattern of the outbreaks of AFM observed since 2014 is intriguing, but she cautioned clinicians against assuming that this will be a long-term pattern. “We want clinicians and parents to be ready for a possible

significant outbreak this year,” she said. “We really need to be ready to rapidly detect, report, and investigate each case this year and to be ready for a possibly bad year.”

Nonetheless, the biannual pattern of the outbreaks of AFM is pointing investigators toward viruses as a likely cause of the illness.

“We really do suspect viruses play a role, and enterovirus is among the leading suspects,” Clark observed. “These are really ubiquitous infections common in childhood. As you age, you’ve had many of them, so it may be that adults are less susceptible ... but we have a lot to learn through the research we’ve proposed in understanding what triggers AFM in some children.” Roughly 93% to 95% of AFM cases occur in children, but a handful occur in adults, Clark added.

While the CDC has published some interim considerations for clinicians on how to manage cases of AFM, there is not enough evidence to support any specific treatments (<http://bit.ly/2YlkENh>). Investigators are collaborating with the National Institutes of Health on a prospective study to better understand the treatments used and what steps might improve outcomes, Clark observed.

“We really do think that early and aggressive physical therapy and rehabilitation holds good promise to help kids strengthen the function that they have after AFM and regain

as much strength and function as possible,” he shared.

Unfortunately, the experiences published from some of the cases that have occurred since 2014 indicate that 70% to 80% or more of the patients have experienced ongoing limb weakness, lasting several months after the onset of AFM, reported Clark, although he acknowledged there are some gaps in the investigators’ understanding in this area.

“We’re going back to all of the cases that occurred in 2018 to assess muscle function, strength, and ability to perform activities of daily living up to six and 12 months after the illness onset,” he said. “We will learn a lot more about the persistence of limb weakness after AFM.”

Investigators also will be conducting structured interviews with patients and families to try to identify any potential risk factors for the illness, although most patients diagnosed with AFM thus far have been healthy children with no unusual patterns or exposures that have come to light.

Although diagnosing AFM is a challenge, CDC investigators are working with clinicians on the frontlines, such as those in EDs or in urgent care centers, to make sure they are aware of AFM and that they move to quickly report any suspected cases. ■

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Room for Improvement Regarding Antibiotic Prescriptions for Patients With Pneumonia

The results of a new study suggest that antibiotics are prescribed too liberally to adult patients with pneumonia as they leave the hospital. The findings come from an analysis, led by researchers from the University of Michigan, that points to an area that may be ripe for improvement.

The analysis involved a review of the medical records of close to 6,500 pneumonia patients who were treated at 43 Michigan hospitals and phone conversations between researchers and 60% of the study participants within one month of their discharge.¹ Based on the analysis, investigators concluded that two-thirds of patients who present to the hospital with pneumonia receive more antibiotics than they likely need.

The researchers noted that the problem does not generally involve the care patients receive in the hospital, but rather the prescriptions for antibiotics they receive upon discharge. Specifically, researchers found that 93% of the overly long antibiotic prescriptions they identified in their analysis were provided as patients were released from the hospital.

Investigators noted that antibiotic stewardship involves both choosing the right drug and the right duration. Their analysis suggests that providers should focus more attention on stewardship at the point of discharge. They also suggested that guidelines in this area should be clearer on how to calculate the right duration based on a patient's condition.

In a press statement, the lead author of the study, **Valerie Vaughn**, MD, MSc, an assistant professor of internal medicine at the University of Michigan, indicated that national guidelines on the treatment of

pneumonia are currently not very precise.² Further, she noted that determining how long a patient should receive antibiotics typically depends on their diagnosis and how long it takes the patient to stabilize after treatment commences. In general, she noted that patients without risk factors require five days of treatment, while patients with risk factors or pneumonia caused by especially resistant bacteria require seven days of antibiotics.

In the study, patients identified with prescriptions that were overly long received two extra days of medication. Each extra day put the patients at risk for added side effects without any improvement in care. Indeed, these patients were 5% more likely to report an adverse effect, such as diarrhea, gastrointestinal distress, or a yeast infection.

Hospital performance regarding antibiotic prescriptions for this patient group varied. At some hospitals, roughly 50% of patients received prescription durations that were too long, while at other hospitals nearly all adult patients with pneumonia received longer prescriptions. Further, investigators

reported that close to one-third of all prescriptions they reviewed were for fluoroquinolones, a class of strong antibiotics that pose added risks to the patient.

Researchers are working with the participating hospitals to investigate the issue further and chart a path toward improvement in this area. "We have a perfect opportunity to really improve antibiotic use for many patients," Vaughn said. "If we can improve just one moment in time, that prescription patients get as they leave the hospital, we can eliminate nearly all unnecessarily prolonged treatment." ■

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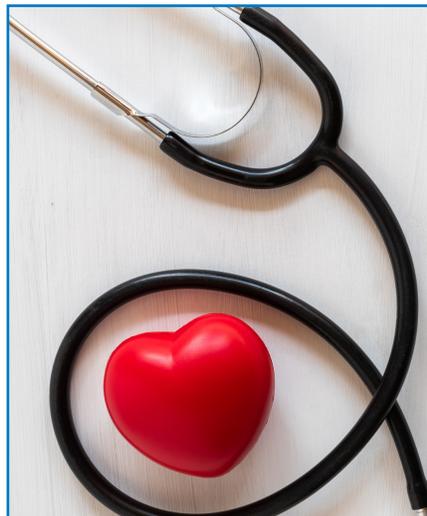
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CME/CE QUESTIONS

1. The Age-Friendly Health Systems initiative features a 4Ms framework. Which "M" is viewed as the foundation of age-friendly care?
 - a. Mortality
 - b. What matters
 - c. Mentation
 - d. Medical necessity
2. According to the CDC, what symptom did most patients identified with acute flaccid myelitis experience less than a week before they developed arm or leg weakness?
 - a. Mild seizure
 - b. Respiratory illness or fever
 - c. Gastrointestinal distress
 - d. Extreme fatigue
3. Using buprenorphine can reduce mortality in patients addicted to opioids by as much as:
 - a. one-quarter.
 - b. one-third.
 - c. one-half.
 - d. two-thirds.
4. As the dementia-friendly hospital initiative rolls out in the UNC Health Care System, leaders envision the increased use of:
 - a. restraints.
 - b. social workers.
 - c. cognitive screening.
 - d. antidepressant medications.



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The Joint Commission Calls on Hospitals to Confront Employee Drug Diversion

Considering their access, healthcare workers may be tempted to steal powerful painkillers and even sell or abuse them

Noting that roughly 10% of all healthcare workers abuse drugs, The Joint Commission (TJC) has issued an advisory, urging systems to develop a comprehensive approach to help detect and prevent the diversion of controlled substances.¹

The issue is of particular concern in light of the opioid epidemic. TJC notes that the powerful drug fentanyl is the most commonly diverted drug and the leading culprit behind opioid overdose deaths. Further, experts suggest that only a small number of hospital employees who are diverting fentanyl or other illicit drugs are identified, adding more urgency.

Diversion is not just a safety issue for hospital employees. The methods used to acquire opioids subversively can come at the expense of patients, depriving them of needed pain relief or, in some cases, leading to hepatitis C or other bloodstream infections.

Although diversion is a difficult problem to address, there are some best practices health systems can implement not only to close the gaps that allow diversion to occur, but also help guide employees with substance use problems into treatment programs that will give them the opportunity to achieve wellness and return to their clinical careers.

“What hospitals in particular offer is access,” observes **Elaine Cox**, MD, FAAP, the chief medical officer at

Riley Hospital for Children at IU Health and a professor of clinical pediatrics at Indiana University School of Medicine. “While there have been a lot of safety measures put into place, there are still opportunities for access.”

For instance, although investigators can monitor the use and amount of addictive medications

that clinicians remove from medication-dispensing machines while caring for patients, it can take time to pick up on individuals who may be engaged in diversion, Cox observes. Typically, a clinician must enter his or her own identifying information and information about the patient requiring medication to open the drawer on a medication-dispensing machine.

“That unlocks the drawer, and then [the clinician] can take the dose. In many cases, the patient doesn’t require the whole vial,” she says.

In such instances, the clinician would record the waste; however, the wasted medication often is not measured, leaving a loophole for

potential diversion, Cox explains.

“We have to look for patterns of lots of removals of those sorts of [addictive] medications in higher-than-the-average [doses] and large amounts of waste,” she says. “The medication-dispensing machines can run those reports of usage. Then, you have to go back through and ask whether [the patterns] make sense for each patient.”

EXPERTS SUGGEST THAT ONLY A SMALL NUMBER OF HOSPITAL EMPLOYEES WHO ARE DIVERTING FENTANYL OR OTHER ILLICIT DRUGS ARE IDENTIFIED, ADDING MORE URGENCY.

There are other access points for drugs that have to be managed, too. Sometimes, there is a little bit of unused medication left in an IV bag that must be disposed. There also are the “sharps” boxes hospitals use to dispose of used syringes, some of which contain unused portions of opioids or other addictive medications. Administrators have to think about how such waste will be monitored and removed in a way that prevents potential diversion.

“Our [sharps] boxes are locked to the wall and they require a key to get into them,” Cox says. “You empty them when they get to a certain line, which is about two-thirds of the way up into the box so that not even a small hand can reach into the slot and get [to the disposed needles]. Now, [hospital employees] don’t even empty these boxes. They go to a central place where the process is managed and watched.”

Another diversion-preventing technique is installing a special sink where unused medication can be discarded. “We don’t want people disposing of drugs down the drain or in the toilet because you don’t want them to get into the water supply,” Cox says. “You put the unused medication into one of these sinks ... and there is a chemical or charcoal-like substance in the sink that deactivates the drugs so that you don’t then have active drugs anywhere in your labs.”

While such approaches are not entirely foolproof, they are considerably more effective than the way medications were handled long before the opioid crisis swept the nation. “In operating rooms or EDs, people would just get a box of drugs for their cases during that day,” Cox recalls. “Then, at the end of the day, they would turn their boxes back in, which wouldn’t [reveal] what

happened with those medications over the course of the day.”

Generally, EDs and operating rooms are two of the highest-risk areas for diversion. “The rapidity with which patients turn over in those areas makes the patterns very hard to detect,” Cox says. “We can still see the [medication usage] patterns over time, but they are harder to see than on a med-surg floor because we don’t use as much medication up there, and the patients are there longer.”

From a physician’s standpoint, the literature has identified anesthesia as the practice most at risk for diversion, Cox notes. “Nursing across the board is high risk as well just because nurses have high access [to medications],” she says. “What we have found is that most diversion has been for personal use. While there are certainly lots of articles that talk about diversion for the purposes of distribution, in my experience, I haven’t seen that as much as when diversion is done for personal use or for close family members.”

EXECUTIVE SUMMARY

Considering healthcare workers’ broad access to addictive drugs, along with the rampant opioid epidemic that is sweeping the nation, The Joint Commission (TJC) is urging hospitals to develop a comprehensive approach to the prevention and detection of drug diversion. Experts note that the problem can be addressed in multiple ways, including direct prevention techniques and broader initiatives that focus on awareness of employee behaviors and workplace wellness. Professional organizations also are urging healthcare systems to move to alternative-to-discipline (ATD) approaches for employees identified with substance use problems.

- TJC notes that the powerful drug fentanyl is the most commonly diverted drug and the leading culprit behind drug overdose deaths.
- Some methods used by healthcare employees to divert drugs can put patients at risk by depriving them of needed medicines and by exposing them to bloodstream infections (in some cases).
- Experts urge hospital administrators to monitor drug usage closely and to look for patterns that may be indicative of drug diversion.
- The Emergency Nurses Association and the International Nurses Society on Addictions issued a position statement in favor of an ATD approach that includes specialized treatment and a pathway for a return to practice for nurses and nursing students identified with substance use disorders.

Take a Broad View

In addition to the more direct methods for preventing diversion, hospitals also should consider what Cox refers to as adjuvant tactics. For example, consider the overall use and abuse of certain addictive medications and why healthcare professionals in certain specialties are turning to addiction. “I think you link this directly to people’s wellness and the environment in which they work,” Cox offers. “[Think about] how we can support people in different ways so that they do not turn to addiction.”

Further, when healthcare workers become addicted, it is important for health systems to support them in

the same way they would support individuals with other health conditions so employees do not turn to diversion. “It used to be if you were a physician and you had any kind of addiction problem ... your career was over,” Cox shares. “This, as opposed to recognizing that addiction is a health condition, and that perhaps the intense work environment and responsibility contribute to the problem.”

It is not an easy area for hospitals to navigate, Cox acknowledges. “Society is just beginning to understand this [issue]. Many hospital systems, including my own, have recently redesigned their policies on employees who are addicted, including physicians,” she says.

How can hospitals most effectively identify employees with this problem, and then support them through treatment and monitoring after they return to work so they do not relapse?

“We use our state medical society now to help us. State nursing societies all have programs for this as well,” Cox says. “I think a lot of entities are moving toward that sort of management.”

Rethink Policies

In May 2017, the Emergency Nurses Association and the

International Nurses Society on Addictions (IntNSA) issued a position statement in favor of an alternative-to-discipline (ATD) approach that includes specialized treatment and a pathway for a return to practice.²

Since its release, several other professional organizations have endorsed the position paper, including the American Nurses Association, the American Association of Nurse Anesthetists,

“PERHAPS THE INTENSE WORK ENVIRONMENT AND RESPONSIBILITY CONTRIBUTE TO THE PROBLEM.”

and the Association of periOperative Registered Nurses. Also, the paper has been distributed broadly to state boards of nursing, explains **Stephen Strobbe**, PhD, RN, PMHCNS-BC, CARN-AP, FIAAN, FAAN, a statement co-author, a clinical professor at the University of Michigan School of Nursing, and past president of IntNSA.

“The prevalence of substance use among nurses and other health professionals is generally comparable

to that of the general population, but healthcare professionals have a higher probability of misusing opioids with serious consequences,” Strobbe says. “The ways the issue has been addressed ... have not only perpetuated but exacerbated the problem.”

Strobbe notes that from a disciplinary standpoint, a substance use problem has either been ignored or treated harshly and punitively. “People may have been fired, but without treatment and recovery,” he says. “As a result, many have simply started working at another facility, still placing patients and themselves at risk.”

Why should hospitals consider a nonpunitive approach even in cases in which health professionals have engaged in diversion? Because it is more likely to promote transparency, consistency, and fairness, with far more positive outcomes, according to Strobbe.

“There is a preponderance of evidence to demonstrate that not only is ATD a more humane approach, but it is also the approach that is more likely to lead to increased patient safety,” he shares.

Start the Process

The University of Michigan Health System was jolted into action on diversion when two separate

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incidents occurred on the same day in December 2013. A nurse and a physician were both found in hospital bathrooms after they overdosed on stolen injected drugs. The nurse died, while the physician, an anesthesiology resident, was revived. A Drug Enforcement Administration investigation followed, and the health system faced stiff penalties related to diversion.³ The health system has revamped its policies completely, making the prevention of drug diversion a top priority.

“We have a director of diversion prevention ... who works closely with pharmacy, leadership, security, and managers to consistently address problems,” Strobbe notes. “We have also developed a highly sophisticated software program that helps to identify outliers in terms of documentation in the dispensing of opioids. That has resulted in the successful identification and movement into treatment [of employees with substance use problems], utilizing an ATD approach.”

Putting such a system in place has been a process with many layers.

“We had some tragic events that involved staff members here, and that shocked people into an awareness of the need to do things differently,” Strobbe explains. “By this time, any institution that is willing to take a clear-eyed view of

this probably has similar stories or good reasons to show that things need to be done differently.”

Shift the Culture

An effective ATD program must be structured around compassion, consistency, and accountability, Strobbe notes.

“There needs to be a structure in place that treats substance use problems as medical disorders. Historically, that has not been the case,” he says. “That has contributed to stigma and discrimination.”

Strobbe acknowledges that many organizations will require education at all levels to make the cultural shift necessary to implement a successful ATD program.

“The perspective that a healthcare facility, department, or leadership team takes in even viewing the problem will contribute to the way in which it is identified and addressed,” he says.

Often, healthcare professionals with substance use problems will need a period away from the jobs to undergo treatment and recovery. “This may include residential treatment or intensive outpatient treatment. During this time, the individual is generally removed from the clinical setting to attend to the disorder the same way a person might take medical leave for

other illnesses or diseases, and then return,” Strobbe shares. Another important component of an ATD approach includes the involvement of a professional monitoring program, followed by a return to the practice setting. This can take place in several different ways, Strobbe observes. Individuals may return to a job in which they have no access to narcotics for a period.

“When they have successfully completed at least certain portions of their treatment program, some individuals may return to their previous roles, although during an interim period, no access to narcotics is more often the rule,” Strobbe adds. ■

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