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INSIDE

RELIAS MEDIA

Is It Time for EDs to Play a Central Role in Opioid Use Disorder Treatment?

While COVID-19 rages across much of the country, capturing the full attention of clinicians and policymakers, there is growing evidence that America's other epidemic, opioid use disorder (OUD), is getting worse.

Data show that after briefly decreasing in 2018, drug overdose (OD) deaths surged to nearly 72,000 in 2019, up almost 5% from the year before, and experts note OD deaths are continuing their upward climb this year.[1]

Gail D'Onofrio, MD, professor and chair of the department of emergency medicine at the Yale School of Medicine, notes there are "two epidemics colliding, making everything worse in many ways."

She points to data from the Overdose Detection Mapping Application Program, a federally funded effort that collects OD data with the aim of improving both law enforcement and treatment approaches to the U.S. drug use problem. "It has actually generated more alerts from January to April [this year] than ever before, an increase of almost 200% compared to last year at that time," D'Onofrio says.

Furthermore, in a recently published commentary, D'Onofrio and colleagues made a forceful case that the adverse effect of COVID-19 on people with OUD underscores the need and presents the opportunity for EDs to assume a central role in initiating these patients on treatment.[2]

Tackle the Barriers

There are multiple ways the COVID-19 pandemic is contributing to worsening conditions related to treatment for OUD and OD deaths, D'Onofrio argues. For example, with many clinics and doctor offices closed to normal business, it is harder for patients to access medications or harm-reduction tactics. Further, fear of COVID-19 is making bystanders less likely to use naloxone if they witness someone in trouble.

D'Onofrio also fears that without access to needle exchange programs, clinicians could see more cases of

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AUTHOR: Dorothy Brooks
EDITOR: Jonathan Springston
EDITOR: Jill Drachenberg
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS DIRECTOR: Amy M. Johnson, MSN, RN, CPN

hepatitis C and HIV. "All of these things are horrific consequences of COVID-19 in this population," she says, noting that a significant number of patients with OUD come from highly vulnerable groups.

Plenty are homeless and lack access to the internet, cutting them off from even telehealth services.

"Many also tend to smoke or vape, and that is a risk factor for worsening COVID-19. For all of these reasons, we are very worried," D'Onofrio says. "We have all seen overdoses more lately than we have in the past, and we are concerned there are more deaths that we have not seen."

However, considering EDs are accessible 24/7, D'Onofrio stresses they are well-positioned to address many of these barriers through a screening, brief intervention, and referral to treatment (SBIRT) approach like the one she pioneered at Yale-New Haven Hospital several years ago.

Using SBIRT, patients with OUD who were initiated on buprenorphine in the ED and then referred to a treatment provider for ongoing care were much more likely to be engaged in treatment for their addiction after one month than patients who only received a treatment provider referral.[3]

With data proving the efficacy of the approach, other EDs have implemented similar techniques. Still, considering the scope of the problem, not nearly enough EDs are engaging, according to D'Onofrio.

"[Emergency medicine clinicians] do so many time-sensitive interventions for people who have other things wrong with them," she states.

For example, D'Onofrio notes EDs devote significant resources to ST-elevation myocardial infarction (STEMI), including. "We are huge here [in New Haven, CT]. We have three sites, and we probably see 20 [STEMI cases] per month. Most EDs will probably see 10 [STEMIs] in a month," she explains. "We probably see that many patients [with a nonfatal OD] in half a day."

D'Onofrio points to a study out of Massachusetts showing the one-year mortality rate for patients presenting to the ED with a nonfatal OD was 5.5%.[4] Nevertheless, EDs across the country routinely discharge such patients without initiating treatment. She argues a STEMI patient never would be discharged without aggressive treatment.

"It just doesn't jibe," she says. "We are ignoring all of these deaths, and I don't understand it."

Require Waivers

D'Onofrio acknowledges regulatory barriers are hindering progress in this area. For instance, the requirement that providers obtain a Drug Addiction Treatment Act (DATA) 2000 waiver to prescribe buprenorphine is onerous and should be discarded, she says.

Nevertheless, she urges ED leaders to require providers to obtain the waiver. It is a step she has taken in her own ED at Yale-New Haven Hospital, where she serves as physician-in-chief of emergency services.

"It is not a discussion. [Emergency physicians] have to take the class, and they have to get their waiver," D'Onofrio says.

If there is a silver lining from the COVID-19 pandemic, it is that some regulatory obstacles standing in the way of providing treatment for OUD have been eased, making

it easier for clinicians to obtain the waiver. "We have been able to train people for these DATA 2000 waivers over Zoom, which we were never allowed to do before," she explains. "Everyone had to show up, and it was difficult to get everybody in the same room. But now ... I have run three classes on Zoom, and we have trained hundreds of emergency practitioners."

Regulations also have been loosened to enable patients to connect with addiction treatment providers via telemedicine. This was a needed move since many treatment clinics have closed. Also, telemedicine removes transportation barriers. "When we refer patients, they can [connect to treatment] by phone or by telemedicine ... and that has never happened before," D'Onofrio shares.

Further, patients are receiving take-home doses of methadone, a drug that must be taken every day. Requiring patients to visit clinics daily to receive this medication can be difficult.

"If you have a job or lack transportation, that can be a problem. But right now, [treatment providers] are supplying larger amounts of [methadone] to take home ... and the vast majority of these cases have gone well," D'Onofrio reports.

Indeed, some are calling for at least some loosened regulatory changes to be made permanent.[5]

Contact Local Clinics

Another barrier to OUD treatment: a lack of community-based resources for ongoing care. In D'Onofrio's experience, treatment resources *are* available, it is just a matter of connecting with these resources and establishing a working relationship. "That might take a little bit of work in some places, but it is doable," she says.

For three years, the 24-bed ED at Marshall Medical Center in Placerville, CA, has been initiating patients on OUD treatment and then referring them to ongoing care at community clinics.

"The reason we were an early adopter was because I looked at the evidence, and I streamlined it into what I do with every other medical problem," explains **Arianna Sampson**, PA-C, a physician assistant in the ED. "I saw there is a better medication for a medical problem that I treat all the time, it is more efficient ... and there is decreased mortality with it."

Sampson had to ensure there was a clinic in the community that would accept her patients for follow-up. She connected with a clinic and "cut a deal" to ensure they would see patients the day after ED-initiated buprenorphine. The arrangement was appealing for both sides.

"For outpatient clinics, sometimes they have to book longer appointments for people when they are starting them on medication, whereas this is just easy for us to do the ED," Sampson shares. "We are happy to start patients [on treatment] 24/7 as long as [the outpatient clinic] sees them the next business day ... it has been consistently successful. We have just been an open door."

In addition to serving as a clinician in the ED at Marshall Medical Center, Sampson is a regional director for the California Bridge Project, a program that has helped dozens of EDs across the state implement medication-assisted treatment (MAT) programs. She notes a key step in this process is normalizing the treatment of OUD in the emergency setting.

"The reason I didn't do this for a long time is we were told this is a specialty thing ... you send [patients] to another place where they get help," Sampson observes. "That is something that has made clinicians feel like this is more complex than it is ... like it is a bit scary."

It also adds to the stigma that patients with OUD feel, Sampson

EXECUTIVE SUMMARY

While frontline providers have their hands full with COVID-19, overdose deaths (OD) are surging across the country, in part, because of pandemic-related barriers. Some experts argue now is the perfect time to implement needed reforms in care for patients with opioid use disorder (OUD). In particular, they say it is time to fully leverage emergency departments (ED) in the quest to initiate these patients on treatment and connect them with ongoing care.

- With many treatment clinics and doctor offices closed, it is harder for patients with OUD to access treatment or harm-reduction techniques.
- Without access to needle exchange programs, clinicians fear there will be a rise in cases of hepatitis C and HIV.
- Considering EDs are accessible 24/7, they are well-positioned to address many pandemic-related barriers, including initiating medication-assisted treatment and making referrals to ongoing care.

notes. She stresses it is possible to eliminate that stigma just by normalizing treatment, and then observing its efficacy. "I see people who I may have started on [buprenorphine] two or three years ago, and I can see how well they are doing. It is incredibly meaningful in terms of our staff, our clinicians, and decreased burnout," she says. "For me, it has been very transformative for my career."

Use Telemedicine

The COVID-19 pandemic has affected case numbers at Marshall Medical Center, Sampson acknowledges. "Our volume of people seeking treatment [for OUD] went down 50%," she says, referring to the early days of the pandemic when shelter-in-place orders were in effect. "That was very striking."

While much of the usual patient volume has returned, it is unclear how the pandemic has affected OD deaths. Sampson fears those numbers could be higher.

"I made a connection with our county coroner to see if we saw an increase in OD deaths, and it wasn't really clear yet because we had double the [usual] number of suicides ... it takes a couple of months for toxicology results," she says.

Early in the pandemic, Sampson contacted her referral sites to make sure they were continuing to accept patients and had developed telemedicine capabilities to facilitate access.

"We were able to make that happen overnight with the two places we now refer to," she says.

Also, since most clinicians who work in the Marshall ED have obtained DATA 2000 waivers, they have provided patients with longer prescriptions for buprenorphine when access to next-day follow-up care is a problem.

Considering the enhanced focus on COVID-19 and the burdens placed on frontline caregivers, is now really the time to push for reform in the way EDs manage patients with OUD? Sampson agrees with D'Onofrio: The answer is absolutely yes.

"This is the perfect time to make sure we are advocating for marginalized populations and people who otherwise don't have access to care," Sampson says. "This is an incredible time to address this because it is the call of medicine. I see it as advocating for people who ... have historically been treated poorly, and not with the same kind of treatment that we provide to people with other medical conditions." ■

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For OUD Treatment, Leverage Existing Resources, Keep Referral Process Simple

When it comes to developing an emergency department (ED)-based treatment and referral program for patients who present with opioid use disorders (OUD), there is no need to scrounge for tools, processes, or information. Multiple pioneers in this area are freely sharing how their own programs work and what instruments they use. For instance, many assessments and algorithms used in the ED at Yale-New Haven Hospital are available to any facility that wants to start. *(Learn more online at: https://bit.ly/2OMuxBc.)* In the same vein, the California Bridge Project, which is rapidly helping EDs throughout the state implement programs, offers tools, education, and other resources for download through its website. *(Learn more at: https://bit.ly/2ORRaEg.)*

Arianna Sampson, PA-C, a regional director for the California Bridge Project, advises emergency medicine colleagues interested in developing programs to ensure their

pharmacist maintains buprenorphine in the formulary so ED providers can access and administer the drug easily.

When working with community-based treatment providers, keep the referral process simple, Sampson advises. "We literally have an appointment time set every single day at 9 a.m. We tell the patient to show up at the clinic the next day at that time," she says. "We didn't want to have someone have to call around ... so we just made it no nonsense."

Sampson credits the established, premade appointment time for the high follow-up rate for patients initiated on buprenorphine in the ED. "We have excellent partners," she says. "We just start people on the right medication, and they take over."

Some clinicians struggle to engage with patients about OUD. Even Sampson acknowledges such conversations used to feel awkward. However, creating a good treatment option has made such encounters much easier.

Also helpful: Signage in the ED indicating addiction treatment is available. Sampson wears a button on her coat that reads "treatment starts here." Thus, it is not uncommon for patients to bring up the subject. "The important thing is for patients to feel like they can self-disclose," Sampson says. "I had someone who came in following a car accident. He was there for a totally different reason, and he asked for help. I asked him what made him feel like he could talk to me about this. He said he saw the button on my jacket."

When Sampson wants to raise the subject of drugs or alcohol, she starts by asking the patient for permission. "It's just showing that respect," she observes. "I haven't had anyone say no." ■

COVERED Project Seeks to Protect ED Personnel from COVID-19

Few questions are of greater concern to emergency health personnel these days than how they can protect themselves from COVID-19.

It is an issue loaded with nuance. Much depends on such factors as how someone works in the emergency department (ED), what procedures they perform, what specific practices they use when performing those procedures, and how often they are exposed.

Nonetheless, a multidimensional study that seeks to capture all these complexities is well underway, with the goal of delivering solid answers to nurses, physicians, and even many nonclinical personnel who staff EDs across the United States.

In the COVID-19 Evaluation of Risk in Emergency Departments (COVERED) project, investigators from UCLA and the University of Iowa are aiming to identify which practices and which pieces of personal protective equipment (PPE) make the most difference in preventing personnel from acquiring COVID-19.

The Centers for Disease Control and Prevention (CDC) is funding the project with a $3.7 million grant, enabling researchers to enroll and follow participants at 20 academic medical centers.

The project is a collaboration between EMERGEncy ID NET, a CDC-supported network of 12 EDs studying emerging infectious diseases, and the National Emergency Airway Registry (NEAR), a multicenter group studying the intubation of patients in the ED.

"The question of how we protect healthcare workers is something that we have been interested in throughout the COVID-19 pandemic," explains **Nicholas Mohr**, MD, MS, clinical professor of emergency medicine, anesthesia - critical care, and epidemiology at the University of Iowa and co-principal investigator of the COVERED study. "Through the two national networks, we pulled together this collaborative with the goal of really having a national platform to be able to understand what the risk is of COVID-19 transmission to healthcare workers across sites around the country."

To understand the granularity of this investigation, Mohr says 1,600 participants have been divided into four groups:

- emergency physicians who perform endotracheal intubation in patients with confirmed COVID-19 infections;
- emergency physicians who do not perform endotracheal intubations;
- emergency nurses;
- nonclinical ED staff.

Specifically, Mohr notes there are about 800 physicians, 400 nurses, and 400 nonclinical staff participating in the study.

"They tell us information every week about their use of PPE and how many patients they are taking care of in certain risk groups. They're also telling us what their practices are around certain procedures," he shares. "For instance, one of the procedures we are very interested in is endotracheal intubation, which involves putting people on ventilators. We know that is a high-risk practice. We also know that it is a life-saving procedure."

Mohr states that from prior work involving severe acute respiratory syndrome and Middle East respiratory syndrome, researchers know those who performed endotracheal intubations were at significantly higher risk of contracting these coronavirus infections.

Consequently, when participants in the COVERED study perform endotracheal intubations, they are asked to provide information such as what type of equipment they used, how they used the equipment, how long they were in the room, what types of countermeasures they were using, what types of PPE they were wearing, and other patient-specific details.

Collect Samples

Similarly, regarding CPR, Mohr notes participants are reporting how it is performed, whether people are performing CPR in special rooms in their ED, whether specific filters are used to protect clinicians, or whether special masks are used. "All of that information is helping us to understand what the risk is throughout the study period," he says.

Furthermore, in addition to inputting data, participants are providing blood samples and nasal specimens regularly. This will enable investigators to determine which participants have been exposed to COVID-19 and which participants have developed the disease over the course of the study.

Specifically, participants submit blood and nasal samples at the start of the study, at week two, and then at week four. After that, participants submit samples for testing every four weeks for a 20-week period. However, Mohr stresses participants are reporting on what their exposures are every week. "They log in to the system [we have created], and tell us how many patients they have seen and what kind of procedures they have done," he says. "Then, with certain procedures, even every day they are telling us about those procedures and about the equipment they used."

By collecting information at the time of possible exposure, investigators believe the data quality is much better than what has been collected during previous studies. The authors of that work asked participants to recall well after the fact what they were doing and how they were practicing at the time when they might have been infected.

The nonclinical participants in the study include reception staff, clerks who page, financial services people, and some social workers, depending on their specific job.

"We [are following] a cohort of people who work in the area of the ED, but who don't go into patient rooms or provide clinical care and aren't within six feet of patients routinely," Mohr says. "We have tried to take into consideration how different staff function within each institution, but we really wanted people who are within an ED but don't have patient-facing care responsibilities."

Under such criteria, environmental services staff are not part of this study because this is a group that faces different types of risk than nonclinical staff investigators are following. "The [environmental services sector] is clearly a higher-risk group," Mohr notes.

In addition to specific data points about individuals, COVERED investigators also are collecting information from participating facilities about whether they are experiencing shortages of PPE, and whether they are sanitizing PPE that was originally intended for single use. "We are

certainly capturing a window of time where physicians and nurses are taking care of patients with COVID-19, and we are tracking ... how health systems have responded to those challenges dynamically," Mohr says. "That is something we can include in our analysis as we try to understand what the risk factors are."

Analyze Data

With so much information to distill, interpreting the results will involve a fair amount of complexity.

"We are collecting more than a thousand data points from each of our 1,600 participants. In the course of the project, we are collecting blood and nasal specimens seven times from all of these participants, which [amounts to] almost 12,000 COVID-19 tests," Mohr says. "As the study goes on, we have people enrolled in the cohort who continue to be diagnosed with COVID-19. That is the type of information we will be using to really try to nail down what the quantifiable risk is, and how we can reduce that risk to certain healthcare providers in the future."

Despite the complexity involved, investigators anticipate they will be able to share their results this fall. For ED personnel eager to learn how they can most effectively protect themselves, that may seem too late. Mohr argues that from a biomedical research standpoint, the COVERED study has unfolded lightning-quick.

"The way this project has rolled out has just been unprecedented. From the time we first had the idea and started talking with the CDC to the time we had a funded project was just three weeks," Mohr reports. "Even from the time that our study had been funded until the time we launched and enrolled participants was just another four weeks."

While it may feel like the study is plodding along, it is moving much faster than any other large public health surveillance project, at least in terms of trying to understand a pandemic while it is happening, according to Mohr. "The opportunity to be able to test healthcare workers prospectively during the course of the pandemic while we collect this really detailed data is a once-in-a-generation opportunity for us to learn how to take care of patients better in the future," he says. "But it is something that really requires a little bit of time to pass so that we can understand what those exposures are and how those translate into risks." ■

ED-Based Response Center Helps with Children's Mental Health Needs

Managing more patients with mental health concerns is an ongoing struggle for many emergency departments (EDs) in the United States. Pediatric EDs are no exception.

Many families have no idea where to turn for help with their child's mental health issue. Thus, they present to an ED, even in cases where the child is not experiencing a psychiatric emergency. This can lead to ED congestion and long waits for care, both for mental health patients and those with common emergency care needs.

Looking for a new solution to this problem, leaders at Children's of Alabama in Birmingham developed the Psychiatric Intake Response Center (PIRC) in 2018, a new organization embedded within the hospital's ED.

PIRC staff members divide their time between assessing patients with mental health concerns who present to the ED and providing guidance to families who call the PIRC for help in finding the right mental healthcare for their children.

Cynthia Jones, MA, LPC-S, NCC, CRC, director of the PIRC, says the purpose of the center is to give people the ability to navigate the healthcare system.

"There are a lot of parents and caregivers in the community who simply don't know where to go or who it is they need to see on behalf of their children with mental health issues. They call us, and we help them navigate and find an appropriate provider for them in the community," she explains. "We joke that we are the Match.com of mental health. We find out what it is that the child needs, and match [him or her] with the appropriate provider."

PIRC staff constantly updates a database of community-based mental health providers and resources.

"This database has grown significantly to the point where we now have 1,400 providers that we have been able to identify," Jones reports. "These are psychiatrists, psychologists, counselors, social workers, marriage and family therapists, and other resources like support groups, long-term

residential facilities, and substance use facilities."

The database enables PIRC staff to quickly respond to the needs of families who call the PIRC with specific mental healthcare needs. By connecting these families with an appropriate mental health provider in the community, some ED visits likely are avoided.

Serve a Dual Purpose

Nonetheless, the ED seemed like the best fit for such a service. The PIRC is staffed with an array of licensed mental health professionals who can help provide assessments for patients who present to the ED with mental health concerns, explains **Jesse "Tobias" Martinez, Jr.**, MD, a psychiatrist and medical director of the PIRC.

"When [PIRC staff members] are not assessing patients and families over the phone, they are able to see the patients in the ED," he says. "Though we are not advertised as a crisis hotline, we, of course, do get calls from families that are in crisis when they have a child who may be at risk of harming themselves or others. We direct them to the ED. The same PIRC therapist [who spoke with family] is able to make that connection with the child in the ED to provide that continuity of care and handoff."

PIRC therapists wear two hats. "They are answering the telephone for those families that are calling in looking for mental health resources, and they are also seeing patients," Jones observes. "They have blocked time set aside for them to be on the phone and blocked time for when they are seeing patients in the ED."

Mental health professionals who staff the PIRC are part of a larger psychiatric consult team operating in the ED.

"We have psychiatric nurse practitioners with us in the ED. We also have child adolescent psychiatric fellows who are doing their fellowship training, and then myself as the attending working with the team here evaluating patients," Martinez notes. While the ED is open 24/7, the PIRC operates from 8 a.m. until 11 p.m. seven days a week. These are the hours when patients tend to check in for mental health complaints.

"We know that the majority of patients will come in during the later afternoon, after school ... so we always make sure we have appropriate staffing," Martinez explains.

"Any patient who checks in to the ED with a psychiatric complaint in the middle of the night will be seen by the emergency medical team," Martinez continues. "[The medical team] will staff the case with our child psychiatry fellow over the phone. Then, [the patient] will be seen the next morning by our PIRC team."

Accelerate Care

As is the case with most EDs, patients who present with mental health concerns are seen by medical providers first. These providers will perform a brief medical exam to determine whether there are any medical concerns that require treatment.

In many EDs, there is no psychiatrist on site. Patients might be handed off to a therapist or a social worker, or they might be discharged with a list of mental health resources. However, in the ED at Children's of Alabama, there are psychiatry team members ready to assess and evaluate patients.

"Once patients have been cleared by the medical team, psychiatry is involved to provide our consultation. Then, we will help with disposition options," Martinez notes. "These could be discharge with outpatient resources, discharge to our crisis bridge clinic, or inpatient psychiatric admission." The PIRC accelerates

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Responding to an identified need in the community, Children's of Alabama in Birmingham created a Psychiatric Intake Response Center (PIRC) in 2018 to prioritize mental health care for youth. Mental healthcare professionals divide their time between assessing patients who present to the emergency department (ED) with mental health concerns and providing guidance to families who call the PIRC for help.

- PIRC staff constantly update a database of mental health providers and resources in the community so they can quickly connect families with the appropriate resources.
- Administrators credit PIRC staff with shortening the time behavioral health patients spend in the ED. Despite an increase in the volume of psychiatric patients this past year, lengths of stay were two hours shorter.
- Calls to the PIRC have increased, too, from 1,500 in 2018, to 2,200 calls in 2019. Further, the PIRC consulted on more than 3,600 ED patients last year.

care to patients even in cases where patients are waiting in the ED for an open inpatient psychiatric bed.

"We have a behavioral health pod ... which consists of four rooms," Martinez says. "We have the clinical services needed to provide clinical care for these patients."

The hospital includes an inpatient psychiatric unit for patients requiring admission. When the unit is full, medical therapists from the PIRC will work to find a bed in another hospital for inpatient psychiatric care.

Martinez says there is an electronic bed board ED staff control, which enables PIRC workers to see where inpatient beds are available in the behavioral health units of public hospitals. In addition, PIRC staff maintain good communication with other hospitals in the community with inpatient beds. "We get phone calls on a daily basis to the point where the other hospitals are calling us and letting us know they have beds available if we have children who need inpatient psychiatric admissions," Martinez says. "We have learned which hospitals and which doctors would prefer which types of patients. That is how we are able to keep our constant flow."

There are risks associated with extended boarding periods, Martinez observes. For example, behavioral health patients can become more agitated, the likelihood of self-harm tends to increase, and the use of restraints increases as well. The extent to which PIRC staff can help limit long ED stays is positive.

Already, there is evidence the PIRC is making a difference. Jones reports that over the past year, PIRC staff have shortened the amount of time behavioral health patients spend in the ED by working more efficiently across patient care teams.

"Despite an increase in the volume of [psychiatric] patients this past year, there was a decrease in length of stay by 2.1 hours. That was from 7.4 hours in 2018 to 5.3 hours in 2019," Jones explains.

Furthermore, it is clear that calls into the PIRC from the community are on the rise. In 2018, the new center received 1,500 calls. In 2019, the PIRC fielded 2,200 calls, which led to consultations on more than 3,600 ED patients.

Provide Assessments

A typical case might involve a young patient who has been referred to the ED for a psychiatric evaluation. An employee from the child's school may have observed evidence of suicidal ideation or a behavioral disturbance. In other cases, there might be signs a child is thinking of self-harm because of bullying.

A medical provider starts by examining the child, looking for any signs of lesions, cuts, or any other wound. From there, the child is handed off to a PIRC therapist for a more in-depth assessment.

"The therapist will do risk stratification and safety planning for the family member who accompanies the patient to the ED. Then, the therapist will hand the patient off to me," Martinez notes. "As the psychiatrist, I will review everything with the mental health therapist. Then, I will go into the room and summarize our plan, our treatment options, and what we are going to do."

In most cases, such patients can be discharged if PIRC staff can ensure it is safe, there is appropriate follow-up, and therapy resources have been identified.

"Our surrounding schools are already aware they are going to receive discharge information from the ED saying that the child has been seen and is psychiatrically cleared to go back to school with follow-up instructions," Martinez says.

Occasionally, the ED will see young patients who are acting out,

are aggressive, or are even violent. Again, the medical team will look for any medical or organic reason for the behavior.

"For example, if it is a child with autism who is acting out, the medical team will make sure that the child is not acting out or becoming agitated because of any possible infection, constipation, or an issue like that," Martinez explains. "Once the child is medically cleared, the parents are then told they will be speaking with a PIRC therapist who will do an assessment, make sure we have a safety plan, or an appropriate disposition plan. That could either be an inpatient admission or an outpatient plan."

Community Outreach

Martinez acknowledges mental health centers like the PIRC may be difficult for many hospitals to support because such services do not generate much revenue. However, he stresses Children's of Alabama administrators recognized psychiatric patients tend to use many resources, especially when they are boarding in the ED.

Hospital leaders were convinced a center like the PIRC was a good idea when a community needs assessment revealed mental health should be prioritized for pediatric patients.

Fortunately, considerable funding for the PIRC has been provided through private entities. "There is an ongoing effort to let people know what we are doing and to seek out more opportunities for funding," Jones shares.

"We have a PIRC advisory board with several members from the community. We meet quarterly to discuss the role of the PIRC, its mission, and other ways that we can improve," Martinez says. "We also go out to community events and to the schools. That has really helped us develop relationships with the school system in our surrounding areas and with other mental health agencies."

Martinez adds that he, Jones, and some PIRC therapists have attended community events to talk about mental health, provide education, and advocate for the PIRC. In addition, there are printed materials in the ED that describe what constitutes a psychiatric emergency.

The idea is to encourage families with pediatric mental health needs to call the PIRC for guidance. If families do not require emergency care, they can be connected to the appropriate care setting and not contribute to congestion in the ED. Martinez suggests there is evidence their outreach and education efforts are working.

"Even though across the nation the number of psychiatric patients coming to the ED is increasing ... we are still able to maintain good numbers with regard to shorter patient boarding times and appropriate dispositions," he says. "We are seeing that patients who come to the ED are truly in a psychiatric emergency and may need to be admitted vs. [patients] who are discharged. The community is utilizing our PIRC line more frequently ... and getting connected with mental health resources in the community."

Track Key Metrics

For those interested in developing a PIRC-like solution, make sure there is broad support for such an initiative within an institution, particularly the ED. "The ED is a big advocate for our services here," Martinez says.

Further, be prepared to identify and track key metrics associated with any such initiative because stakeholders will want to know what the new center or service is accomplishing. For instance, Martinez notes the PIRC is keeping close tabs on declining boarding times and the move away from restraints and seclusion.

Follow-up data also may be critical to the long-term sustainability.

"When we provide mental health resources to callers and to those in the ED, we want to be able to call them back and ask whether they were able to be connected," Jones says. "It is closing the loop and making sure they got from point A to point B. If they have not, then we are following up to make sure they get to that next level. Many times, there are barriers that we don't even know about."

Jones acknowledges there is no reimbursement for such follow-up calls, but they are crucial to staying connected with the community and, potentially, to securing ongoing financial support. ■

Pandemic-Driven Mental Health Problems Emerge in Children Presenting to ED

When the COVID-19 pandemic began to sweep across the United States, volume in the emergency department (ED) at Children's of Alabama in Birmingham began to plunge.

Jesse "Tobias" Martinez, Jr., MD, a psychiatrist and medical director of the Psychiatric Intake Response Center (PIRC), a unit that operates within the Children's of Alabama ED, fielded calls from families in need of mental health resources. Concurrently, he helped assess patients who presented with mental health concerns. A few weeks into the pandemic, a different picture began to emerge.

"As schools were closing and children were at home, some of the first cases that we had coming in were children suffering with autism, developmental delays, and intellectual disabilities," Martinez explains. "In talking with the families, it was because [these children] lost that structured environment. They lost the opportunity to go to a school or a program for a certain amount of the day ... it has been very difficult for those patients and their families."

ED providers, as well as mental health therapists in the PIRC, witnessed a lot of caregiver burnout, Martinez observes. "Children with autism can sometimes be difficult for families to work with [outside] that structured environment that their school or a program provides," he says. "Some of the families were lost in how to appropriately mange or work with their child at home. The Zoom or video education that schools were trying to provide did not really work for a lot of these patients."

As a result, the Children's of Alabama ED began to see more patients presenting with an acute psychiatric crisis. Now, several months into the pandemic, the ED is seeing more patients who feel socially isolated and upset.

"There is a high level of anxiety happening to the patients as well as the families," observes **Cynthia Jones**, MA, LPC-S, NCC, CRC, director of the PIRC. "We are seeing that more than normal."

To protect patients and staff, the hospital has instituted a policy requiring all patients and caregivers to wear a mask, except for children younger than age 2 years, Martinez reports.

"We have several main entrances where people in the community — and even all of our clinicians and staff — come into the hospital. They are all screened daily [at these locations] with COVID screening questions and a temperature check. Then, they are provided with an ID sticker saying they have been screened for that day," he explains. "Another thing we have done in the ED is we have limited the number of visitors to only one caregiver with the patient." ■

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;
3. Implement managerial procedures suggested by your peers in the publication.

COMING IN FUTURE MONTHS

- Anticipating another flu season in the age of COVID-19
- How EDs in rural areas are managing the pandemic
- A new ED accreditation program for pain and addiction care
- The latest developments regarding acute flaccid myelitis

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CME/CE QUESTIONS

1. **A key step in the process of implementing an ED-based treatment and referral approach for patients who present with opioid use disorder (OUD) is:**

   a. normalizing the treatment of OUD in the emergency setting.
   b. developing a detailed process for making referrals.
   c. creating a committee to oversee the program.
   d. hiring experienced treatment providers.

2. **When bringing up the subject of drugs or alcohol with a patient for the first time:**

   a. make sure security is nearby.
   b. conduct a thorough review of the patient's medical history.
   c. ask the patient for permission.
   d. check with a treatment provider in the community.

3. **COVERED project investigators believe the data quality is better than what has been collected elsewhere because these authors are gathering information when people:**

   a. first experience symptoms.
   b. are experiencing exposures.
   c. present to the emergency department.
   d. are first diagnosed.

4. **While resources like the Psychiatric Intake Response Center may not generate much revenue, hospital administrators recognize psychiatric patients:**

   a. tend to use a lot of resources.
   b. often require transfer to another facility.
   c. require specialized care.
   d. can be treated effectively with medications.

ED ACCREDITATION UPDATE
COVERING COMPLIANCE WITH JOINT COMMISSION STANDARDS

Workforce Well-Being Takes on Added Significance as COVID-19 Battle Continues

Experts urge healthcare leaders to respond to basic needs, facilitate connections for clinicians who require treatment, psychological support

Clinicians have long understood they should put their patients first. However, in recent years, as there has been more focus on clinician burnout and fatigue, the importance of clinician wellness has come into sharper focus.

Today, with the country depending on the healthcare workforce like never before, it is vital for leaders to consider the burdens placed on frontline clinicians. They must be prepared to respond to employees' physical and mental health needs.

"I think we have learned more and more that if we don't attend to the emotional and psychological needs of the caregiver, the clinician, then patients don't get a fair shake," noted **Donald Berwick**, MD, MPP, FRCP, the president emeritus and a senior fellow at the Institute for Healthcare Improvement (IHI). Berwick recently spoke as part of an expert panel discussion on precisely what it means to "care for the caregiver" during times of crisis.

Berwick shared there has been some evolution in how this concept has been interpreted over the years. With patient volumes surging in many regions of the country, he observed healthcare leaders have witnessed how this stress affects the workforce.

In one tragic example, Berwick referred to the suicide of Lorna Breen, MD, who was emergency department director (ED) at NewYork-Presbyterian Allen Hospital in Manhattan. In addition to contracting and then recovering from COVID-19, Breen, 49, saw dozens of patients with the virus pass through her ED, including many who died from the ailment.

"We are even more in touch than we have been before of the behavioral burdens, the mental health issues that arise when dealing with a health crisis like this," Berwick said. "We have definitely broadened our view of what the workforce is and realize the stressors are just as great, and even greater in some ways, for people who don't have an MD or a degree as an RN."

View Stress as a Toxin

What can research tell us about how this pandemic is affecting the psychological health of clinicians and other healthcare workers? During the IHI panel discussion, **Joshua Morganstein**, MD, shared that much of what we know on the subject comes from the study of disasters.

"It is important to remember that for the vast majority of people, including those who experience difficulties during the pandemic, they will ultimately do well," explained Morganstein, assistant director of the Center for the Study of Traumatic Stress in the Uniformed Services University of the Health Sciences in Bethesda, MD. "Many people will even experience an increased perception of their ability to manage future stressors." Morganstein noted that while communities typically go through well-established phases following disasters, pandemics like COVID-19 disrupt these phases.

For example, he noted there is a honeymoon phase during which there is a natural coming together of people following a disaster. But Morganstein said some

have turned physical distancing requirements into a fear of others. He also noted communities are affected at different times to varying degrees.

Such factors complicate response efforts. "Public health emergencies open the fault lines in our society. They lay bare divisions across race, religions, and socioeconomic status," he said. "Leaders and other institutional elements within our organizations really play an important role in shaping community response and behaviors."

The effects of the pandemic on healthcare workers is complicated. Morganstein thinks of stress as like a toxin, similar to lead or radon.

"To understand risk and intervene effectively, we have to understand aspects of exposure," he noted. "Caregivers who are involved in prolonged patient care, those exposed to extremes of suffering as well as human remains and mass death, may certainly be at increased risk."

Further, Morganstein observed healthcare workers not involved in direct patient care can experience other types of stresses such as heavier work demands, less recognition of their work in the community, a devalued sense of meaning from their work, and even feelings of guilt for not serving on the front lines.

Prioritize Communication

Morganstein observed one way leaders can reduce stress and improve functioning following exposure to trauma is by employing psychological first aid, an evidence-based framework for supporting resilience. He noted the elements that form this framework include:

- enhancing a sense of safety;
- calming;
- self and community advocacy;
- social connectedness;
- hope and optimism.

"The scope of this event really requires a whole-of-healthcare approach to caregiver sustainment," Morganstein added.

Considering the range of needs, organizations must tailor their interventions, according to Morganstein. For instance, he noted practical supports are needed most often early on.

"Emotional support is helpful as well, but the reality is that it is often difficult to talk about feeling sad when your stomach is growling and you don't know if you can pay the rent," he said.

Consequently, interventions that provide access to food, transportation, and childcare can be particularly helpful at this stage.

Also helpful is a system that facilitates peer support. Morganstein noted so-called "buddy systems" can be used to promote safety, efficacy, and social support — all protective elements.

"The 'battle buddy' system, which was popularized by the U.S. Army, has actually been adopted in some healthcare settings to support the safety and well-being of caregivers," Morganstein explained. "Whether you call it a battle buddy or something else that works better for your organization, having someone with whom caregivers commit to maintaining a regular, ongoing connection for mutual encouragement can be an invaluable source of support during a crisis."

Morganstein added that during the pandemic, leaders need to prioritize keeping workers informed, checking in with them frequently. "Communication is not only a means by which we deliver interventions, but it is in and of itself a behavioral health intervention," he said. "Messaging during a crisis has a profound impact on community well-being. It influences people's perceptions of risk and, ultimately,

EXECUTIVE SUMMARY

With frontline healthcare workers across the country facing unprecedented burdens, there is ample evidence of stress, anxiety, and other behavioral health concerns. Experts note it is critical for leaders to prioritize workforce well-being, and to facilitate connections to treatment and other forms of support, as needed.

- The COVID-19 pandemic's effects on workers is complicated, but experts note one way to think of this stress is like exposure to a toxin like lead or radon.
- One way leaders can reduce stress and improve functioning following trauma is by using psychological first aid, an evidence-based framework for supporting resilience.
- Considering the range of needs, organizations must tailor their interventions. For example, practical supports such as food, transportation, and childcare assistance may be most helpful early on.
- Regular communication is a pivotal tool for addressing uncertainty and anxiety in the workforce.

the willingness of society to engage in recommended health behaviors."

Address Basic Needs

When the COVID-19 pandemic began, there already was an office of well-being and a chief wellness officer at The Mount Sinai Health System in New York City. These resources enabled the organization to respond quickly to caregiver needs in many of the ways Morganstein described.

"We could bring to bear resources ... that we already had in place because of the recognition [here] of the importance of the well-being of clinicians," explained **Jonathan Ripp**, MD, MPH, senior associate dean for well-being and resilience and the chief wellness officer at the Icahn School of Medicine at Mount Sinai.

While cases of COVID-19 in New York City have declined markedly, the city was, for a time, the epicenter of the pandemic, placing unprecedented demands on the healthcare workforce.

"Just as there is a pandemic curve, there are phases of stress response and stressors that become priorities in the midst of the pandemic that we observed firsthand," noted Ripp, alluding to Morganstein's observations about how different interventions are required depending on the crisis phase. In the early days of the pandemic, Ripp noted there were huge disruptions in society that took place even before hospitals began to see a surge in patients. Thus, things that were taken for granted, such as arriving to work safely or owning enough personal protective equipment (PPE), emerged as core concerns in the workforce.

> STEADY COMMUNICATION PROVED TO BE AN INVALUABLE TOOL FOR ADDRESSING UNCERTAINTY AND ANXIETY.

"We tried to match in real time a response to each stressor as it was unfolding. In the beginning, it was all about creating resources to meet basic daily needs," Ripp observed. "We brought food, we secured PPE, we created childcare resources, and we addressed transportation."

Echoing Morganstein's comments about the pivotal role of communication, Ripp said he was struck by "how incredibly important" it was for leadership to provide "honest, authentic, and regular" communications to healthcare personnel. Steady communication proved to be an invaluable tool for addressing uncertainty and anxiety in the workforce. As the health system faces a significant uptake in requests for leave, Ripp said communication remains just as vital.

The health system also moved early to ensure a broad array of support and treatment resources were readily accessible to staff. "Some things that were already in existence we made more accessible, and other things we ramped up in real time," Ripp said.

One example of this was the deployment of proactive mental health liaisons from the system's department of psychiatry who spent time contacting clinical units to check in on staff. The health system also maintained phone lines workers could call for support on a 24/7 basis.

As all these resources were leveraged, the system's digital health team quickly created a new website to make it easy for personnel to find out what well-being resources were available.

"We organized [the resources] by basic needs, mental health, psychosocial support, and on-the-ground resources," Ripp said.

The site was designed to make it easy for someone to find the type of support they were looking

for, whether that was one-on-one counseling, group-based discussions, or spiritual care.

One of the most well-received interventions that Mount Sinai deployed was the creation of recharge rooms. The idea behind these rooms came to fruition under the direction of a team in the Department of Rehabilitation and Human Performance. In rapid fashion, they created a series of spaces where in the course of busy shifts clinicians could spend time away from their intense work environment, Ripp explained.

"They provide immersive — sights, sounds, smell, taste — experiences where in a matter of 10 minutes you are completely removed from the clinical setting, and you have recharged," Ripp shared.

Room designers incorporated music, scents, lighting, meditative visual elements, rest areas, and nourishing food to give clinicians an opportunity to destress for a few minutes before returning to work. There even was a facility dog who would come by to visit staff spending time in the recharge rooms, Ripp shared.

"The extent to which this [concept] resonated with our workforce was truly astonishing," he observed. "This just highlighted how in times of crisis, it is basic needs [that need to be prioritized]. You just need that break."

The recharge rooms have proven so popular that the biggest problem has been making sure people maintain appropriate distance from each other when they visit the rooms to destress.

"We have had to have people in there continually ... managing flows," Ripp said. "There has just been a steady flow [of staff], and that continues. We now have [the recharge rooms] in six of our eight hospitals. Pretty soon, we will have them at [all our] hospitals."

Now that COVID-19 has partially retreated from New York City, Ripp said Mount Sinai is in the process of pivoting back to normal operations — but not entirely, because there are some lingering effects.

"We sent surveys measuring symptoms of PTSD [post-traumatic stress disorder], depression, and anxiety, and found significant burden, as anticipated, within our workforce," he explained. "Some will need treatment. We are continuing many of our initiatives into this next phase with lots of resources and ongoing efforts to make sure that communication is central."

THE CHALLENGE FOR LEADERS NOW IS TO MAKE THE CASE THAT MANY OF THE INTERVENTIONS USED TO SUPPORT WORKERS DURING THE PANDEMIC NEED TO CONTINUE BEYOND THIS CRISIS.

One focus of this next phase is a mental health destigmatization campaign. "We are encouraging our leaders to speak openly, honestly, and authentically about the impact this [crisis] is having on them," Ripp said. "We are fortunate that some philanthropic dollars have now been dedicated to a new center for stress resilience and personal growth, another effort that is underway that will really focus on the mental health needs of our workforce as a result of COVID-19."

Sustain Wellness Interventions

The challenge for leaders now is to make the case that many of the interventions used to support workers during the pandemic need to continue beyond this crisis.

"There are so many variables that influence the ability to put things in place in the first place, and then to keep them," Ripp said.

He added that as chief wellness officer, a big part of his job is demonstrating where there are priorities and how they overlap in the institution.

"The top leaders of institutions have multiple priorities, so we need to be able to speak that language," he said. "I think now more than ever the well-being of the workforce is recognized. [It is important] to make that case."

Ripp explained there were plenty of reasons to focus resources on workforce well-being before the pandemic. These include the moral imperative, the regulatory environment, and the business case.

"But now, more than ever, it is concern about the mental health consequences to our workforce working through a pandemic. Collect data to show that ... and get up there as if you are in a courtroom and argue for what you need," Ripp suggested.

For more information on supporting personnel during the pandemic, see The Joint Commission's guidance: "Promoting the psychosocial well-being of health care staff curing a crisis" online at: https://bit.ly/3hnyHM6. ■