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INSIDE

Address Social Determinants of Health with Multidisciplinary Team, Community Partnerships

Every day, frontline clinicians see patients presenting with medical problems exacerbated by unstable housing, lack of healthy food, substance use issues, or lack of money. Further, many such patients return repeatedly to the ED because these underlying social concerns continue to deleteriously affect their health.

This is a frustrating cycle for emergency providers who often lack the time and resources to delve into a patient's complex needs. In fact, it is not uncommon for clinicians to suffer from moral distress over their inability to act on underlying social conditions that keep driving patients back to the ED.

What is the solution? A multidisciplinary group at Zuckerberg San Francisco General Hospital (SFGH) has created an ED Social Medicine (EDSM) team to deliver better outcomes for patients who present to the ED and to lift some burden off the shoulders of providers.

In operation since 2017, investigators are finding the EDSM team approach is delivering dividends on multiple fronts. They also believe they have created a roadmap to follow for other facilities struggling with similar concerns.

Assess Needs

The creation of the EDSM team grew out of a push to address challenges related to patient flow across the organization, explains **Hemal Kanzaria**, MD, EDSM team co-developer and medical director of the department of care coordination at SFGH.

"We were actually encouraged by our executive team to think about and study how often patients are hospitalized for primarily complex social needs, and then to understand and develop some solutions around that [patient population]," he recalls.

Initial funding for this effort came from the San Francisco Health Plan, the main Medicaid managed care payor in the region. Developers studied how they could create better care capable of addressing medical and social needs. Concurrently, they wanted to provide an alternative to hospitalization for patients who present with lower medical

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acuity but higher social complexity. "You want to preserve those really precious hospital beds for patients who [require the kind of medical interventions] that can only be provided in the hospital," Kanzaria says.

As a safety net hospital, SFGH sees many patients with medical and nonmedical needs, yet ED providers had been focused primarily on immediate medical concerns. However, Kanzaria says medical and nonmedical needs often are inextricably linked. "Those underlying social, environmental, and economic needs are really foundational to a person's health. If my job is to improve [a patient's] health overall, I need to be skilled at meeting both their medical and social needs," he says. "This program allows us to get closer to ... the foundational needs of those patients who are presenting here."

There were times when Kanzaria believed he should admit a patient and hope that sometime during the stay a solution would emerge to address the lack of housing, food insecurity, or financial distress. Alternatively, clinicians would just discharge the patient to an unsupported environment.

The EDSM team is designed to offer emergency providers a third alternative: Do right by the patient — and with tools at their disposal to achieve that goal.

Jenna Bilinski, RN, MBA, director of health operations, social medicine, and the Kaizen promotion office at SFGH, says the EDSM team is fortunate to work in an organization that is mission-driven and supports doing what is right for patients. "When you work in a safety net organization and your point of entry for folks is the ED, then you should be putting the services they need the most at the point of entry," she says. "That is really what our focus has been ... and it has turned out to be beneficial for both the organization and for the people we are serving."

Emphasize Collaboration

The EDSM has grown to include a patient navigator, multiple physicians, a pharmacist, social workers, care coordination nurses, and transitional care staff. The team also has nurtured multiple links with community resources such as substance use treatment providers, housing assistance groups, behavioral health providers, and organizations that can assist people dealing with food insecurity or domestic violence.

Jack Chase, MD, FAAFP, FHIM, co-developer of the EDSM team, recalls the recent case of a woman in her 70s who struggled to walk, lived with chronic hearing loss, and had fallen in her home where she lives alone. "She called 911 and was brought to the ED for evaluation and had a laceration on her forehead," says Chase, associate professor of family community medicine at the University of California, San Francisco. "The ED team that received her overnight [told] the day team that they felt very concerned about the patient's safety."

Chase, who was the consulting physician on the EDSM team that morning, learned about the case as he and other team members were rounding with the day shift clinicians in the ED. The attending physician was worried about the prospect of sending the patient home.

"[The attending] was seeing this person in front of her who she felt was very unsupported in the community, high risk, had just fallen, and had a significant head injury

that required stitches," Chase recalls. "How were we going to make sure that it was safe for her to go home?"

After reviewing the case with the attending physician, Chase and other EDSM members visited the patient to hear her concerns and what she wanted from the ED encounter. "The patient was very clear. She was desperate to go home. She really did not want to be hospitalized and she did not want to go into long-term care. She was actually very satisfied with her home environment," Chase explains.

However, considering the patient's wishes did not alleviate the attending's concerns, there was a conversation among the attending, the patient's primary care provider (PCP), and the EDSM team. "We understood a little bit more about her longstanding values and healthcare-related needs," Chase observes. "She didn't have a hearing aid, and she had no help at home. We facilitated a referral for a home health team to go and visit her. We actually purchased — with dedicated funding — a hearing aid for the patient so she could ... better communicate with the PCP and her new home nurse."

In addition, the EDSM team ensured the patient received food delivery, and coordinated with the PCP to follow up after discharge. All these steps reassured the attending the patient would receive appropriate care. "It's a nice example of coordination of care throughout the system involving multiple disciplines," Chase shares. "We were meeting different kinds of needs, and [our efforts] also aligned with what the patient's values were."

Nurture Relationships

Besides regular rounding, there are multiple other ways the team can be brought into a case. For instance, an emergency provider can call the patient care coordinator or the consulting physician who is on service with the EDSM team that day. Nurse managers in the ED also will email the EDSM team about a patient.

"Increasingly, over the course of our team's existence, as word has gotten out about our team, people actually reach out to us about clients who are not even in the ED at the current time," Kanzaria observes. "We get referrals from protective service social workers who are caring for clients they are worried about. In a previous iteration, they would have just brought the patient to the ED and said they were concerned about the patient's safety, [indicating he or she] just needs to be hospitalized."

Now, there often is some prework whereby the social workers contact the EDSM team. They work together while the patient is in the community to either beef up services there or try some other alternatives before the patient comes to the ED.

Such steps are the result of increasingly robust relationships the EDSM team has formed with community organizations. "Adult protective services has started reaching out to us about clients who they are worried about," Chase reports. "We have had some really moving examples of people who were being abused or physically threatened in their home environment."

In such cases, the EDSM team often will partner with a community-based social services organization to create a plan that provides for needed services and a safe environment. "We know that we always have a backup safety net in that the patient can always be transported to the ED at any point, and we will help to facilitate their care within the building if need be," Chase says.

However, in many instances, such collaborative planning can put these individuals in a safe environment and ensure their medical needs are met without an ED trip.

Prioritize Mental Health

Patients who present to the ED with significant social needs often live with behavioral health issues,

EXECUTIVE SUMMARY

Clinicians at Zuckerberg San Francisco General Hospital (SFGH) created an ED Social Medicine (EDSM) team to tackle social issues that often sabotage positive health outcomes and prompt repeat ED visits. First deployed in 2017, the EDSM team has expanded to include a multidisciplinary group consisting of clinicians, social workers, mental healthcare providers, patient navigators, a pharmacist, and transitional care personnel.

- The EDSM team addressed food insecurity, homelessness, substance use, domestic violence, and other complex issues.
- The team provides an alternative to hospitalization for patients who present with low medical acuity but high social complexity.
- In terms of volume, EDSM members work with three or four patients each day.
- This group has served more than 4,500 patients and averted 600 to 700 admissions or readmissions. Members also helped more than 200 patients obtain stable housing.

too. Kanzaria notes most patients the EDSM team works with present with some combination of substance use disorder, mental illness, homelessness, and low-level medical acuity.

While addressing such needs in an expeditious manner can be difficult, SFGH offers a psychiatric emergency service that operates next to the medical ED 24/7. "We work closely with [the staff there], and we collaborate on a number of patients because people will present to both places," Kanzaria explains.

For example, there was a young woman with a history of severe trauma involving both physical and sexual abuse. She suffered from symptoms of PTSD, experienced instances of panic and severe agitation, and also was battling a comorbid substance use disorder. "All of those symptoms and behaviors had resulted in her being denied service at various community-based settings," Chase explains. "This rendered her with basically not a lot of options. She would just end up coming to the ED or psychological emergency services over and over again in really severe crisis."

The EDSM team decided to convene a meeting with representatives from various community organizations, the inpatient psychiatry consult team, psychiatric emergency physicians, and representatives from some residential treatment centers. Meeting participants agreed the next time the patient presented to the ED, clinicians would try to provide her with medications to reduce her psychosis while also presenting options for further treatment.

They understood the patient might be so ill she would have to be involuntarily observed for psychiatric treatment for a period until she was stabilized enough to voluntarily engage in treatment. Ultimately, the plan proved successful.

"The next time this patient showed up, she was hospitalized and provided with acute mental health treatment for crisis. She started on medication, and she started on groups," Chase notes. "There were some ups and downs ... and there were some episodes of agitation that she had, but they were manageable."

At the end of acute treatment, the patient transitioned to a treatment program where she stabilized. "Our role there was to try to bring people together, and to lower the barriers to doing the right thing for the patient," Chase adds.

Test Ideas, Interventions

On a typical day, the EDSM team will work with three or four patients who present to the ED. While the number of patients who could benefit from engaging with the EDSM team far exceeds the group's current capacity, data show the multidisciplinary approach to addressing patient needs is making a difference.

"We have served well over 4,500 patients, and we have multiple different initiatives," Kanzaria explains.

For instance, one initiative that provides medications free to patients who cannot access them has helped more than 2,000 people. Another initiative has helped more than 230 vulnerable clients obtain stable housing. "We have helped to avert 600 to 700 admissions or readmissions ... mostly by offering support and providing a safe alternative to hospital care," Kanzaria adds.

Further, in a study Chase, Kanzaria, and Bilinski published about the EDSM team, they reported 60-day ED use following an EDSM consultation decreased by 5.8% from October 2017 to March 2020.[1]

While the EDSM team continues to expand, Kanzaria's advice to leaders thinking about following a similar path is to understand the local landscape.

"Look at what your patient and community needs are, and use data to make transparent what these needs are — whether [they include] financial insecurity, food insecurity, access to affordable housing, or healthy food," he offers.

Then, it is a matter of devising potential solutions to apply to the identified needs, and testing to see if they are effective. When successful, use the results to obtain support. "We were able to garner interest from our hospital leadership and our city leadership to expand on our initial ideas. We have been fortunate to have some success," Kanzaria explains.

With any investment of resources, there will be concerns. At SFGH, ED leaders wanted to know how EDSM team consultations would affect operational metrics such as length of stay.

"We were able to understand those concerns, and then overcome them with data," Kanzaria says. "We were also able to engage with [the hospital's] executive team and align what we were trying to do with what their needs were."

Enhance Understanding

Kanzaria urges clinicians to advance their understanding of the underlying social, environmental, and economic factors that drive health.

"If you are taking care of a patient with an infection, cancer, or congestive heart failure who also is experiencing homelessness, unless you are someone who recognizes

the impact of homelessness on that person's health, there is a missed opportunity to advocate and to help your patient to improve their health," he observes.

Even in hospitals without the kind of resources available to SFGH, an emergency clinician might partner with a social worker or pharmacist to address an identified social need in a patient or the community. The idea is to make the effort multidisciplinary.

"You also want to look beyond your hospital. You can't do this in a silo," Kanzaria says. "Healthcare systems have to partner with ... community organizations and community members outside of the medical care system to advance the community's health." ■

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Start Small, Employ Relevant Personnel to Manage Complex Social Problems

How does one design a model to manage social determinants of health that will be effective? It is all about problem-solving.

"Our hospital uses Lean. We follow plan-do-study-act [PDSA]," explains **Jenna Bilinski**, RN, MBA, director of health operations, social medicine, and the Kaizen promotion office at Zuckerberg San Francisco General Hospital (SFGH).

However, Bilinski notes every hospital relies on a problem-solving method for performance improvement. "The approach of using small tests of change and understanding what the problems really are before addressing some sort of solution can be replicated at any organization and in any department," Bilinski says.

The key is putting the right people on the intervention. For example, when Bilinski and two other clinicians at SFGH created the ED Social Medicine (EDSM) concept, they started with a vision, but recognized they were not the best people to devise every intervention involved with this work.

"If there is an intervention related to pharmacy, our pharmacist comes up with that intervention," Bilinski explains.

Likewise, social workers develop solutions relevant to their arena. "Allowing the folks who do the work to be part of that problem-solving process is really beneficial for the whole team."

To achieve success, start small. "It is a basic tenet of the PDSA problem-solving concept," Bilinski says.

This was a tenet Bilinski and colleagues followed rigorously when developing interventions for the EDSM team.

"We would start with one shift of workers trying [an intervention] with the patients, or we would try it with one chief complaint and not every patient who walked through the door," she says. "This allowed us to learn from what we were testing, and then to scale up as we were adjusting and improving our intervention along the way." ■

Multilayered Approach to 911 Calls Targets Social Needs, Cuts ED Visits

Many EDs fill up with patients without serious medical concerns, but social or mental health problems clinicians may not be well-equipped to address. Putting social workers and other resources on scene to address these needs can expedite an appropriate response.

Another potential solution is to meet these patients where they are, eliminating the need for an ED visit altogether. In Denver, instead of sending an ambulance or law enforcement, some 911 callers in nonviolent circumstances will receive a visit from a mental health clinician and an EMT, a duo referred to as Support Team Assisted Response (STAR).

The idea for the STAR team grew out of a co-responder program in which a mental health clinician is paired with a police officer. Denver officials have been using this approach since 2016. Thanks to a partnership between the Mental Health Center of Denver and the Denver Police Department, STAR has grown to 32 responders.

When officials in Denver heard about CAHOOTS (Crisis Assistance Helping Out On The Streets), a program in Eugene, OR, that pairs

an EMT with a mental health worker to respond to some calls, they saw an opportunity to add another layer to STAR. *(See more about CAHOOTS at: https://bit.ly/31zMB7W.)*

"Running these calls with the Denver police [co-responder program] over the past several years, we really noticed that people call 911 for a variety of different reasons, some of which require a law enforcement officer, and some that don't," says **Carleigh Sailon**, LCSW, LAC, the program manager of criminal justice services at the Mental Health Center of Denver. "We really saw adding the STAR program as an additional response option ... that could be a force multiplier for the police and also [a way to] reroute calls that have historically gone to the police to a more appropriate team that can assist when the calls are more public health and resource in nature."

Guide Dispatchers

CAHOOTS administrators assisted Denver officials in developing a decision tree to guide 911 dispatchers as to what type of response should be deployed.

"They have been running [this type of response] in Eugene for 30 years," Sailon observes.

The dispatcher asks callers different questions. Based on their answers, either the police, a co-responder team, or the STAR team will be deployed. For instance, Sailon, who serves on the STAR team, has responded to several mental health crisis calls.

"We can connect people with long-term services or reconnect them to their existing treatment team if they have one," she says. "The clinicians in the van have a long history of working in the community on mental health, and can leverage the contacts they have made over their careers to connect people to the services they need mental health-wise in a kind of low-barrier, efficient way."

There have been some STAR calls that resulted in a mental health hold. This can be based on the symptoms an individual is exhibiting and whether the person is suicidal or greatly disabled because of mental illness.

"Since we are licensed, we can initiate those [mental health holds] without calling the police," Sailon explains. "If there is any sort of weapon or any sort of risk element present, [the dispatcher] would send a co-responder team. The police officer can work on team safety, while the clinician addresses the mental health crisis."

Other STAR calls may involve transporting people to shelters or connecting them with treatment. Also, while the STAR team does not respond to any acute medical crises (e.g., an overdose), they occasionally encounter people with substance use problems.

"We partner pretty closely with our local syringe exchange, The Harm Reduction Action Center. We carry safe injection supplies on the van and portable syringe disposal so that we can give those out, and people can participate in syringe exchange," Sailon notes. "We can also connect people to substance use resources, if they are looking for that."

Build on Relationships

The EMTs on the STAR team can assess and triage any low-level medical needs.

"We have redirected people either back to their primary care provider or an urgent care center when the ED isn't necessary," Sailon says. "We also get requested by ambulances quite a bit."

Sometimes, an ambulance crew arrives, only to recognize there is no need for emergency medical care. "They will call STAR over so that we can route those [individuals] over to a more appropriate level of care," Sailon shares. "We will take people to the ED if that is the level of care they need. We are really looking at connecting them to what is going to help them in the long run vs. just sort of funneling everything to the ED."

A single STAR team approach has been running on a pilot basis since June 2020, Monday through Friday, 10 a.m. to 6 p.m. As of mid-March 2021, the STAR team had responded to 1,100 calls, and there was no need to ask for police backup in any of those cases. "There is definitely a need for more vans and more staff. We are hoping to get those rolled out this summer," Sailon reports.

Those interested in pursuing a similar approach will find it easier if they already have a similar foundation on which to build. "We already had experience working with the 911 system, and we already had a strong working partnership with the police," Sailon says. "About 30% of the time on our calls, it is actually an officer who shows up [on the scene] first, and then requests a STAR team to take over the call. [He or she] recognizes that it is not a law enforcement issue and is more appropriate for STAR."

That collaborative history has driven the success of STAR. "We weren't starting from square one in terms of building those relationships. I do think having a multilayered response system is important, not just having one option for people but having multiple options based on [whether] there is a risk situation, or if it is more of a resource call." ■

Developers Unveil Universal Screening Tool for Suicide Risk

The rate of suicide among U.S. adolescents has been rising. Experts note that the suicide rate among adolescents has grown by 62% over the past two decades, making it the second-leading cause of death among teenagers in the United States.[1] In 2019, 1,580 youngsters between the ages of 12 and 17 died by suicide, according to the CDC.[2]

Sadly, many teens at risk remain unidentified, explains **Cheryl King**, PhD, a professor of psychiatry at the University of Michigan.

"So many teens who die by suicide [about half] have never received any mental health services," she says. "The risk has really gone unrecognized."[1]

Experts believe there is a need for an efficient and accurate method for providing universal screening for suicide risk to every teen who presents for care to an ED for any reason, a group that includes almost 20% of all adolescents in the United States.[1]

"Then, it would be possible to screen a broader swath of the community," King says.

King and colleagues have been working to perfect the Computerized Adaptive Screen for Suicidal Youth (CASSY), a tool that can reliably identify which patients are at risk and perform this task through a brief and efficient approach that does not disrupt care in the ED.

Push for Accuracy

To develop the algorithms in the tool, King and colleagues studied a cohort of more than 2,000 adolescents age 12 to 17 years who presented to one of the 13 geographically diverse EDs that are part of the Pediatric Emergency Care Applied Research Network (PECARN). Patients completed questionnaires regarding suicidal ideation, past suicide attempts, depression, self-harm, substance use, and other factors associated with suicide risk.

Participants and their parents received follow-up calls at three months following the screening to determine whether there had been a suicide attempt during that period. Researchers constructed CASSY using these data.

The authors validated the tool with a second cohort of 2,754 teenagers. There, CASSY predicted a suicide attempt with 88% accuracy within three months. A total of 165 adolescents in the group attempted suicide during this period.[3]

While many traditional screening instruments work, King and colleagues are striving to improve accuracy with an adaptive instrument that is more personalized.

"After the first few questions, the next question that a teen is presented with depends on how [he or she] responded previously," King says. "We have learned that there are different profiles of risk. There is no one risk factor that is necessary or sufficient to suggest someone is going to make a suicide attempt."

To the contrary, King notes teenagers who are suicidal are heterogeneous in terms of risk factors. "We may have a teen with bipolar disorder who is emotionally up and down with strong emotions, and may even be abusing substances, who is at risk for suicide. But we may have another teen who is severely depressed, withdrawn, and is not bothering anyone," King explains. "That teen is also at risk for suicide. By having these algorithms [for] different people with different questions, we can probably get a more accurate prediction of risk."

Assessing suicide risk in adolescents can be tricky because the way teens think and what they fear can vary day to day.

"There is no time in the human lifespan where there is such a high range of suicidal thoughts and suicide attempts as during the teen years," King says. "We have more deaths by suicide among adults, but we have more reported suicidal thoughts and suicide attempts among teens, which makes prediction of a suicide attempt really tough."

Further, when teens do attempt suicide, it is difficult to know if they intended to die by suicide.

"Sometimes, we meet them in the ED when they first come in and they say they did have intent," King says. "Then, they get hospitalized, and you talk with them the next morning, and they say they were never trying to kill themselves; they had some other motive."

Consider Resources

However, accurately assessing risk is important because parents do not want to hear their adolescent is at risk when he or she really is not. Such a message can be highly disruptive to a family. Further, a false-positive assessment can lead to using mental health resources that often are in short supply in busy EDs.

"In general medicine EDs ... if 35% of all teens screen positive [for suicide risk] on a tool, they simply don't have the resources to do full mental health evaluations on that many teens every day," King notes.

In addition to seeing either a "positive" or "negative" indicator of risk from the screen, CASSY also delivers information indicating what level of risk a patient has displayed. "You can get a level ranging from negligible to severe," King says.

Further, the system includes different risk thresholds.

"What I understand health systems like is that depending on their resources, they can choose their threshold," King adds.

For example, if there is plenty of space, mental health resources, and personnel, leaders can set a high threshold, capturing almost all the youth at risk. But they will see more false-positives, for which they are ethically obligated to follow up.

"However, a health system could set a different threshold, knowing that it won't identify all the youth at risk, but it will do better than it is doing now," King says. "The health system won't get such a high proportion of false-positives, and [the caseload] might be more manageable."

There is no point in screening for suicide risk if there is no mechanism in place to act on the result. Consequently, investigators have turned their attention to developing triage recommendations for patients who screen positive based on four risk levels: negligible, low-moderate, moderate-high, and severe.

"It is really clear that for the high level of risk, we are going

EXECUTIVE SUMMARY

Suicide remains the second-leading cause of death among adolescents, but many at risk remain unidentified. One solution is universal screening in the ED, a place nearly 20% of all U.S. adolescents visit annually. Investigators developed the Computerized Adaptive Screen for Suicidal Youth (CASSY) tool, which enables teens to undergo the screening on a tablet computer, with results immediately available.

- To boost accuracy, CASSY is adaptive, gradually personalizing the questions asked based on previous responses.
- While not all patients are asked the same number of questions in CASSY, the average number is 11, making the process brief and efficient for the emergency setting.
- In a validation study, investigators found CASSY predicts an attempted suicide within three months of screening with 88% accuracy.
- There are two other instruments: the Ask Suicide-Screening Questions (ASQ) and the Columbia-Suicide Severity Rating Scale (C-SSRS). If a patient screens positive on ASQ, then he or she takes C-SSRS.
- When conducting a suicide screen on an adolescent, ask questions in private, away from parents or friends who may influence answers.

to recommend that there is a full mental health evaluation and steps taken to ensure safety that day," King says. "Systems may have some choice points for the low-moderate and moderate-high [risk levels]."

CASSY is geared toward patients age 12 to 17 years, and questions are designed to be answered on a tablet computer. The results are available to the provider immediately, and can be reviewed through an application programming interface or linked to an electronic medical record, if desired. Results pop up in real time.

Also, while the number of questions in CASSY can vary given its adaptive nature, the average number of questions is 11, making the screen easy to complete while patients wait for a provider.

Screen Privately

Some pediatric EDs already maintain universal suicide screening protocols, using tools typically administered in person.

For instance, every patient who presents to the ED at Cohen Children's Medical Center (CCMC) of Northwell Health in New York will be screened at some point during the encounter, explains **Vera Feuer**, MD, director of pediatric emergency psychiatry.

"We use a screening tool called the ASQ [Ask Suicide-Screening Questions]," she says.[4] "If kids screen positive [on the ASQ], then they are further assessed with the Columbia-Suicide Severity Rating Scale.[5] If their concerns are severe or acute, then they are seen by our psychiatry team that is in the ED."

The ASQ is a secondary screening tool. Feuer says one ASQ item regards suicidal ideation.

"There are kids who have had these thoughts in the past, but they no longer have them, so they are not necessarily acutely at risk. However, they still come up as positive," she says.

How a screening tool is administered can make a big difference in how youngsters respond.

"The recommendation is to always do [the questioning] in private, even among children as young as 10," Feuer says. "Do not have the parent there when you are asking these questions because we know from adolescents that this really influences the way that they answer."

In some cases, emergency staff may not be trained properly to conduct the assessments, but this is an issue that should be relatively easy to address.

Also, these computer-based questionnaires, such as CASSY, offer another way to ensure questions on suicide risk screens are answered privately.

With its busy, fast-paced environment, the ED is not an ideal setting for patients with mental health concerns. Some administrators have found a way around this environmental concern.

Feuer notes CCMC has established an ambulatory crisis center one floor above the ED.

"We try to assess kids there as much as possible. We have worked with our community, pediatricians, and schools in the area to be aware that there is another option, and that people don't have to present to the ED to see a child psychiatrist," she explains. "People can come to this ambulatory center and be assessed there in a very different kind of environment."

Most kids with mental health concerns do not require the "super-restricted environment" of the ED in terms of safety.

"They are cooperative, they are talking to us, and they are not out of control or unsafe. They really can be assessed elsewhere," Feuer says.

However, in cases where patients present to the ambulatory center, but it is determined they do require the ED- or hospital-level care, they are easily redirected since the ED is in the same building.

"The set-up has been extremely successful in our health system. I have worked with other organizations to establish similar structures," Feuer says.

Many EDs do not have the space or resources to create a separate center for behavioral health. In these departments, there may be a room or two, or a less-chaotic corner that can be dedicated to patients who present with behavioral health needs.

"Ideally, you have dedicated space, and you have dedicated, trained staff who know how to engage patients and know how to verbally de-escalate or coach kids on how to utilize coping skills in real time," Feuer says. "This is something we try to do. That seems to really help in terms of [preventing] things like the need to medicate kids or the need to use restraints."

Small changes or interventions can improve the ED experience for families with behavioral health needs. Feuer notes providing educational materials to guide parents can be beneficial. Such a step is not costly or staff-intensive.

"We try to do the same thing for the kids so that every visit has some sort of a therapeutic component," Feuer says. "We now have these little cards with motivational messages and a hotline number, just small things to provide support and help [parents] cope."

The idea is to guard against such a negative experience that patients or families are turned off from ever again seeking help.

"We don't want that," Feuer says. "We want them to have a different feeling when they walk away. My experience is that even small things can make a big difference in how the patient experiences the ED visit." ■

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Huddles Vital to Effectively Conveying Important Safety, Risk Information

Frontline providers fully understand the importance of safety and risk information. However, considering the ease with which managers and colleagues can communicate such information, some of the most important messages can be lost or overlooked in the barrage of emails, texts, pages, alarms, and other alerts clinicians receive every day.

Information overload is of concern, according to **Ashley K. Barrett**, PhD, an assistant professor of communication studies at Baylor University. Barrett and colleagues studied how healthcare workers experience the problem.[1]

"Communication overload occurs when people encounter high levels of fatigue and stress due to their experiences with information exchange and the expectations placed upon them for information exchange," Barrett explains. "New technologies and mobile devices now allow people to be accessible

and available for incoming/outgoing messaging anytime and anywhere."

Further, all these new channels are forcing workers to multitask more than ever.

"They must ... satisfy demands for verbal and nonverbal messaging and in-person and electronic messaging," Barrett says. "Imagine a nurse who is expected to simultaneously work on the floor, providing and receiving messages with co-workers and patients, but is also expected to keep up with his or her emails concerning daily safety updates or risks."

Barrett and colleagues interviewed 40 workers at two hospitals in the same Midwest network. They found frontline workers often express a different view than managers regarding how they prefer to send or receive safety and risk information. However, workers may not speak up about these preferences unless managers ask.

"Workers are heavily influenced by the thoughts, perceptions, and communications of other co-workers. This is a common finding in my research relating to healthcare organizations and how communication technologies are implemented and used in organizations," Barrett says. "Managers should try to keep their thumb on the pulse of frontline workers' perceptions regarding issues with safety and risk messages, and how [these] messages can most effectively be communicated."

Leaders like to convey safety and risk messages via email because this is an easy way to reach the target audience. These messages can be saved for future reference. Email may seem obsolete to frontline workers, and these messages can be lengthy, tending to overload readers.

"Managers should understand the difference between convenience and effectiveness when it comes to safety and risk messaging. Email should only be one tool in their safety and messaging toolkit, a toolkit that should be very diverse [and] sophisticated," Barrett emphasizes. "In many cases, the key to effective messaging is message redundancy through multiple [communication channels] — although not complete repetition, as this can turn employees away and even result in more communication overload."

MANAGERS SHOULD BE INTENTIONAL ABOUT THE PURPOSE OF HUDDLES, THE INFORMATION CONVEYED, AND HUDDLE LEADER ASSIGNMENTS.

Nurses give high marks to using huddles for conveying safety and risk information. "Huddles seem to be the key to effective risk and safety messaging. They are short in duration, often no longer than a few minutes, have a clear agenda, and yet offer opportunities for asking questions and interaction," Barrett reports. Huddles also are generally timely, happening once a day or several times a day.

"They are face-to-face, so they really capture workers' attention and can cut through the communication noise on the healthcare floor," Barrett says.

Huddles demand workers pause and listen to messages. When paired with a whiteboard, these sessions can add visual cues to audible messaging, making it more likely staff retain the information.

Nonetheless, Barrett says there are some drawbacks to huddles. Generally, these are the result of mismanagement or leaders not taking full advantage of communications platforms.

"Leaders should be intentional about the purpose and organization of huddles, the information that is to be included, and huddle leader assignments," Barrett says.

Additionally, leaders should insist huddles be interactive, and they should employ various types of huddles in different levels of the organizational hierarchy. ■

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CME/CE QUESTIONS

1. **The creation of the ED social medicine team at Zuckerberg San Francisco General Hospital initially grew out of a push to address challenges related to:**

   a. patient flow across the organization.
   b. patient boarding.
   c. rising volumes.
   d. psychiatric patients.

2. **One key to achieving success in an approach to addressing complex social issues in the ED is to:**

   a. bring in consultants.
   b. work in concert with other hospitals.
   c. crack down on frequent ED users.
   d. start small.

3. **The Support Team Assisted Response (STAR) program in Denver is an additional 911 option that reroutes calls that usually went to police to a more appropriate team that can assist when the calls are of a:**

   a. psychiatric nature.
   b. medical nature.
   c. public health and resource nature.
   d. domestic nature.

4. **By what percentage has the suicide rate among adolescents increased over the past two decades?**

   a. 77%
   b. 80%
   c. 50%
   d. 62%

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.