SOCIAL EM

Fall 2021 ACEP Section Newsletter

Save the Date

The Social EM Section Meeting at ACEP Scientific Assembly 2021 will be held Wednesday, Oct 27th from 9:00 – 10:30 am

Council Awards

Nominations for SEM awards are due by Sep 28th!

Council Resolutions

You can provide asynchronous testimony on ACEP resolutions using this link here. Deadline: October 14th at 12pm CST

ACEP Candidates

Get to know the ACEP candidates at ACEP SA! On 10/23: President-Elect Candidate Forum 2-2:30pm EST, Board and Council Officer candidates: 2:45-4:30pm. Candidate Reception: 6:15-7:15pm.

New Textbook

Social Emergency Medicine: Principles and Practice, edited by some of our very own section members, is now available for download and purchase. Check it out here: https://link.springer.com/book/10.1007/978-3-030-65672-0

Letter from the Chair: Dennis Hsieh, MD, JD

Hello! Looking forward to seeing everyone in Boston in a few weeks after working and talking with everyone remotely over the past year and a half. We are excited to get everyone together to discuss some of the challenges that have been highlighted by the COVID-19 pandemic, especially around disparities in vaccination rates and access to safe housing while continuing our shared work in advancing social emergency medicine to improve the health of our patients and our communities. This year, the Social EM section submitted a number of council resolutions including:

2021 Council Resolution 42: Administration of COVID-19 Vaccines in the Emergency Department

2021 Council Resolution 44: Caring for Transgender and Gender Diverse Patients in the Emergency Department

2021 Council Resolution 54: Understanding the Effects of Law Enforcement Presence in the Emergency Department

2021 Council Resolution 57: Social Determinants of Health Screening in the Emergency Department

2021 Council Resolution 59: Use of Medical Interpreters in the Emergency Department

If you wish to offer testimony in support of these resolutions or can help with co-sponsorship of resolutions, please let us know as soon as possible. You can email nikkole.Turgeon@med.uvm.edu.

In addition to these resolutions, our committee co-chairs are very excited and have been working on a number of efforts that they are looking forward to sharing with the Section during out get together at the annual meeting. We see this meeting as especially important

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Section Leadership

Chair: Dennis Hsieh, MD, JD

Chair-Elect: Quincy Moore, MD

Secretary/Treasurer: Betty Chang, MD, FACEP

Newsletter: Vidya Eswaran, MD

EMRA Representative: Alexis Kimmel, MD

Alternative Councilor: Breena Taira, MD

Alternative Councilor: Laura Janneck, MD, MPH, FACEP

Alternative Councilor: Katherine Dowdell, MD

Board Liaison: Arvind Venkat, MD, FACEP

Staff Liaison: Loren Rives, MNA

Immediate Past Chair: Harrison Alter, MD, FACEP

Find Us Online

https://www.acep.org/how-we-serve/sections/social-emergency-medicine/

https://engaged.acep.org/home

https://www.socialempact.com/announce-podcast

and as a time to renew our focus on these pressing issues. The team is hoping that at the meeting everyone will come together to add to the projects that are underway and incorporate new ideas - so please come join us in Boston on October 27, 2021 at 9 AM EST. We will be there in person but will also have a remove video/call in option.

Finally, a special shout out to Drs. Alter, Dalawari, Doran, and Raven et al. for their recent publication of Social Emergency Medicine: Principles and Practice. Congratulations on all your hard work!

- Dennis Hsieh, MD, JD

Letter from the Board Liaison: Arvind Venkat, MD, FACEP

It is a distinct privilege to serve as the ACEP Board Liaison to the Social Emergency Medicine Section. As we all have experienced, your vision "to incorporate social context into the structure and practice of emergency care" is extraordinarily important to successfully address the multiple social inequities highlighted and exacerbated by the COVID-19 pandemic. If it was not as widely apparent before, it is certainly clear now that to ensure all of our patients not only receive quality emergency care, but actually improve their health and well-being, understanding and addressing the social circumstances of their lives is critical. As your Board liaison, I view my role as assisting Section leaders and members in bringing their expertise and passion to the wider ACEP audience and, more importantly, for the benefit of our patients and the public as a whole.

From working with the Section over the past year, I also believe that as we confront multiple challenges as emergency physicians, including workforce, staffing shortages, economic pressures, and expectations of addressing a multitude of social ills, there is a golden opportunity to leverage your skill set as a model that all emergency physicians should incorporate in their practice. On a very pragmatic level, there is a great deal of attention being paid to social determinants of health. With our health care safety net role as emergency physicians, learning how all of us can assess and effectively intervene in this area to the benefit of our patients will not only help them, but also highlight and enhance the critical role that emergency physicians play in our healthcare system. On a more fundamental level, giving emergency physicians the skills to improve the social context of our patients can address some of the significant burnout issues facing our profession where it can commonly feel we are simply 're-arranging deck chairs on the Titanic' rather than making a difference over the long-term.

So where do we go from here, when social emergency medicine has truly met the moment? I believe that the Section should consider how it can disseminate its expertise to all emergency physicians as well as medical students and emergency medicine residents and fellows in training. I also believe that it is vital that members of the Section engage with ACEP leaders at the national and Chapter levels to ensure that we as an organization advocate for policies that take into account the social context of our patients. We no longer can simply focus on the acute episode of care when all stakeholders expect, whether it be for public health, economic, or clinical reasons, us to show our value as emergency physicians. Finally, members of the Social Emergency Medicine section, in my opinion, should continue to highlight publicly where there are opportunities for ACEP to best advance emergency care in a comprehensive way for all patients. When I was a resident, I never felt that I could affect a patient's outcome beyond the medical care I provided. Now, and in no small part due to your leadership and vision, it is clear that the medical care I and other emergency physicians provide are simply the tip of the iceberg of what is needed. That is a message and a vision that all emergency physicians and ACEP should stand behind, and I hope I can be a partner with and supporter of the Social Emergency Medicine Section to make that a reality. - Arvind Venkat, MD, FACEP

Meet the Workgroup Leaders

Advocacy and Community Engagement Workgroup- Nikkole Turgeon and Laura Janneck

I am the Chair of the Advocacy and Community Engagement work group within the SEM section. I am also a fourth-year medical student at the University of Vermont applying into EM this cycle. My role as the chair of the working group is to help organize our group around current events and topics within social EM. Most recently, we have worked diligently to submit 5 unique resolutions and co-sponsored 2 which align with the values of the Social EM section.

Our working group has primarily been working on creating the resolutions up to this point. This was the largest number of resolutions submitted by the section. We have been garnering support for co-sponsorship from other sections and now we are seeking individuals who would be interested in providing testimony for additional support during the ACEP council.

I believe that EM has a unique position to be at the forefront of addressing many of the inequities that our patients face, often which confound their course in the emergency department. My hope for this group is that we are able to get the resolutions passed so that there is universal recognition and support for these issues and this will help up in cultivating equitable environments for our patients. In the next few months, I am planning for us to do more with the community engagement aspect of our working group. We welcome anyone interested in this group to join! - Nikkole Turgeon

I'm currently one of the Alternate Councilors, meaning that I help represent the Social EM section at ACEP Council. This is a gathering that takes place before the Scientific Assembly every year with representatives from each chapter (states, Puerto Rico, DC, and government services), each section (including the Social EM section), and affiliate organizations (AACEM, CORD, EMRA, and SAEM). The Council elects members of the Board of Directors, ACEP Presidents, and Council speakers, and votes on resolutions. The resolutions can be submitted by any member of ACEP and are instrumental in guiding the Board of Directors on what ACEP should prioritize as an organization, whether and how ACEP should respond to current issues and challenges, and any issues that the membership deems important.

As the Social EM section, our Advocacy and Community Engagement workgroup has written six resolutions this year: Social Determinants of Health, Interpreter Use in the ED, COVID-19 Vaccine Distribution in the ED, Naloxone Distribution in the ED, Law Enforcement Presence in the ED, Transgender Care in the ED (click on the links to review and provide asynchronous testimony).

We are working on getting other sections of ACEP to offer their support, and will be ready to advocate for them at the Council meeting in October.

- Laura Janneck, MD, MPH, FACEP

Meet the Workgroup Leaders

Diversity, Equity, and Inclusion Workgroup - Molly Curtiss & Dennis Hsieh

Molly Curtiss is serving as the junior co-chair of the Diversity, Equity, and Inclusion Workgroup this year. Molly is a fourth-year medical student from Ohio University Heritage College of Osteopathic Medicine. Dennis Hsieh, MD is serving as the senior co-chair of the Diversity and Inclusion Workgroup this year. Dennis is also the current chair of the Social EM section.

This year, our main goal is to create a DEI curriculum resource that is available for use by individual EM physicians and residency programs across the country. We believe that that all emergency physicians should have access to resources to learn how to practice equitable medicine, and how to care for diverse patient populations. Many larger institutions and residency programs have created a DEI curriculum for use at their own institutions. However, other smaller hospitals and community programs with less resources do not have this crucial educational content available for their residents and faculty. Creating a centralized DEI curriculum resource would help educate physicians across the country on the importance of DEI in the emergency room.

Our vision for this project is to create a collaborative DEI curriculum using content from physicians and institutions across the country. The curriculum will be available in FOAMed form. We are looking for physicians or institutions who may have DEI related content available and may be willing to share their work. Content can be in the form of recorded video lectures, PowerPoint or pdf format, articles, blog posts, etc. All content will be credited to the original author. If you or someone you know are interested in collaborating on this project, please reach out to Molly Curtiss at ml679117@ohio.edu. - Molly Curtiss, OMS IV

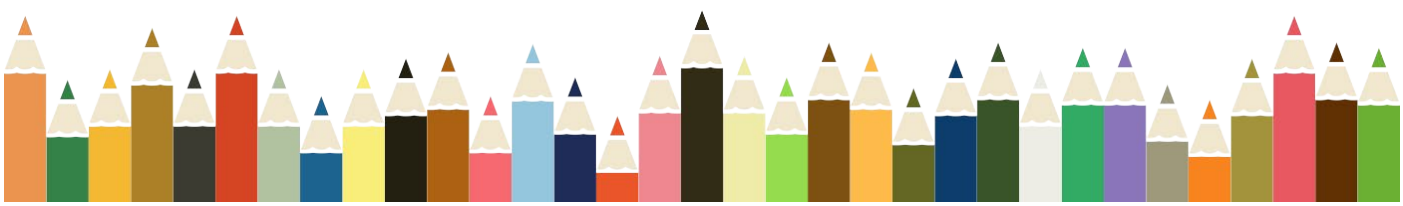
Meet the Workgroup Leaders

Education Workgroup - John Lewis

My name is John Lewis. I am an Assistant Professor of Emergency Medicine at Emory University in Atlanta, GA. I currently serve as the co-chair of the education workgroup for the SEM section of ACEP. I have taken a unique path to my current position in that I practiced community emergency medicine for thirteen years before returning to academia. I returned fueled by a passion for bridging the gap between medical education and the places it is most commonly practiced, the community. I am excited about the great good that this workgroup can bring forth for such a time as this.

I would like to charge our group to take up the mantle of layperson's health literacy as it applies to social determinants of health. I believe the public health and social upheaval of the last year and a half make this an imperative. The ultimate goal would be to create pragmatic educational modules and partnerships between stakeholders, patients, and providers to reduce health disparity. As our first campaign, I would like us to explore addressing the issue of medical mistrust in the emergency department as a form public health for one simple reason- "Two cannot walk together unless they agree." In other words, trust is an essential first step in the journey towards health. Let's go!

- John E. Lewis, Jr, MD, MS, FACEP



Meet the Workgroup Leaders

Program Implementation and Evaluation Workgroup - Cole Ettingoff and Tehreem Rehman

The Program Implementation and Evaluation Workgroup is co-chaired by Cole Ettingoff, a medical student at Tel Aviv University and Tehreem Rehman, an Administration, Operations, and Quality Fellow at the University of Colorado School of Medicine.

We have three major projects in the works. First, we are in the process of building a survey to conduct a census of sorts of social EM programs nationally. We are thankful to Alex Rucker from Children's National for leading the charge on this project and the ACEP Med Directors Section for their help in distributing that survey. While the survey will be very limited in its scope, it will give one of the first big picture assessments of social EM and help us identify programs which are providing robust services.

Secondly, in partnership with the website Social EMpact, we are planning to produce a series of profile pieces discussing specific social EM programs and spotlighting their efforts. We welcome any member who would be interested in writing such a profile piece to contact Cole Ettingoff (cole.ett@gmail.com) or Tehreem Rehman (tehreemrehman@gmail.com) to join the conversation.

Ultimately, our goal is to use data and information from the two projects above to produce best practices documents for several SDoH domains: 1) access to care, 2) discrimination/group disparities, 3) exposure to violence/crime, 4) food insecurity, 5) housing issues/homelessness, 6) language/literacy/health literacy, and 7) socioeconomic disparities/poverty. We are beginning with best practices guides on food insecurity and health literacy being led by Nick Yeisley from the University of Missouri-Kansas City and Dominique Gelman from the University of Maryland respectively. These best practices are a significant undertaking but we believe they have the potential to make a significant contribution to the field and ultimately to improve the quality of service provided nationally. Anyone interested in helping with these best practices is encouraged to contact us.

- Cole Ettingoff, MPH and Tehreem Rehman, MD, MPH

Meet the Workgroup Leaders

Awards Committee - Dominique Gelmann

The ACEP Social EM Section (SEMS) is seeking nominations for a potential award in one of 3 categories, that if chosen would be presented at the ACEP21 Scientific Assembly in Boston. The purpose of these awards is to recognize and honor individuals or institutions who have made distinguished contributions to the field of Social EM. Awards will be given in recognition of truly exceptional contributions, without an expectation that any or all of them will be given each and every year. **Nominations for this year are due by Wednesday, September 29, 2021. Fill out this** google form **to nominate yourself or someone else for these awards!**

2021 Potential Awards:

- Thea James Lifetime Achievement Award: presented to a SEMS member who has demonstrated a sustained commitment to advancing Social EM, in a way that has resulted in tangible progress, within their community, the country at large, or the world of EM.
- Exemplary Achievement Award: awarded to an individual who has made a significant recent and/or ongoing contribution to the field of Social EM.
- Distinguished Program Award: awarded to a department/program that has demonstrated an outstanding commitment to advancing Social EM, resulting in tangible benefit to the institution and or community.

Nominees will be evaluated holistically, including in but not limited to the areas of research, service, education, and clinical practice. Awardees will be honored and presented with a plaque at the Annual Assembly in Boston.

- Dominque Gelmann, M.D. Candidate, University of Maryland School of Medicine

Mentorship matters!

Go to https://mentor.acep.org and learn more about the ACEP mentoring initiative

Social EM Highlight

In each newsletter, we will highlight a Social EM pioneering program which aims to meet health-related social needs.

The Zuckerberg San Francisco General Hospital ED Social Medicine Team

The ZSFGH ED Social Medicine (EDSM) Team is an interdisciplinary team which focuses on addressing patients' self-identified needs — frequently housing, food and social services. Meeting psychosocial needs facilitates partnership with patients on their medical care. **The team supports patients' ability for self-care through connection to community-based health and social services**, including emergency housing, ambulatory medical care clinics, substance use disorder and mental health treatment, supplementary nutrition services, social welfare organizations including Adult Protective Services, and street-based medical care teams.

The EDSM proactively supports ED clinicians and patients by facilitating a better alternative to discharging the patient to self-care or hospitalization for non-acute needs. The team employs quality improvement, emphasizing standard practices, data analysis, and leadership by frontline staff of patient care initiatives.

Individual patient outcomes have been transformative, helping many patients surmount homelessness and connect with services in the community. Individual patients have shown 50 to 100-fold reductions in ED utilization following successful transition from living on the street to long-term residential care. Equally important, such transitions have allowed the city's most vulnerable residents to live with dignity.

The EDSM leadership team includes Co-Directors Jenna Bilinski, RN, MBA, Jack Chase, MD, FAAFP, FHM, Sandra Hall, LCSW, and Hemal Kanzaria, MD, MSc and Program Manager Kenneth Hill AAS, BS.

I interviewed the team to learn more about the program!

Can you paint a picture of the context in which the Social Medicine team was created? What were the driving forces and from where did the idea for this team originate?

Emergency Department (ED) patients discharged with unaddressed psychosocial needs, including homelessness, mental illness and substance use, display negative outcomes and preventable re-visits. Simultaneously, ED clinicians must prioritize the acutely ill. In the care of low acuity, psychosocially complex patients, **ED clinicians face a difficult challenge: attempt to adequately treat complex needs while balancing more acute patients, or social admission. We present a preferable alternative: team-based multidisciplinary care for ED patients with complex psychosocial needs.**

In 2017, 1/3 of ZSFG inpatients stayed less than 2 days. Physician and nurse leaders used A3 Lean thinking to explore the reasons why, finding that ED patients with low medical acuity and high social complexity were often admitted primarily for social reasons. In August 2017, they partnered with the performance improvement office and ED clinical teams to develop Social Medicine: an interdisciplinary, team-based holistic care model comprised of ten frontline-owned improvement initiatives that address ED patients' self-identified social needs using lean methodology.

Historically, the two goals of the Social Medicine program were to:

a) reduce psychosocial-needs-related short-stay hospitalizations by 50% by December 2018, and

b) increase multidisciplinary teamwork in the care of ED patients with complex needs. The approach of the team was to understand and meet patients self-identified needs, and to provide the patient and ED team a safe alternative to hospitalization. Key social needs include homelessness, substance use, mental illness, violence, food insecurity and poverty.

Our mission: To provide equitable and exceptional care for people with complex bio-psychosocial needs through multidisciplinary teamwork, systems-integration, and data driven improvement.

Our vision: To improve healthcare delivery, rebuild trust in the medical system, and inspire staff and the public by modeling person-first, wholistic care, with a commitment to equity, diversity, and community partnership.

Let's talk numbers: how many patients does the EDSM team work with?

The Social Medicine team performs 80-150 consults per month, with mean ~120/month, 4/day.
Since the outset of the program in 2017, the EDSM team has served over 6,000 patients:

- Thousands linked to emergency housing, mental health care & treatment for substance use
- ~1,500 provided critical medications in hand at no cost

- Prevention of 800+ avoidable hospital admissions and readmissions by meeting patients' medical and health-related social needs in the Emergency Department

Can you describe a typical patient with whom the Social Medicine team interacts?

In short, our team focuses on improving and integrating the care of people living with complex social and behavioral health needs, such as homelessness, substance use disorders, serious mental illness, poverty and social isolation, and complex medical illness, such as heart failure, end stage liver disease, end stage renal disease, and cancer. We seek to help patients to access care in the lowest barrier fashion and according to their values and preferences. As a specific example, here is a passage from a blog post we wrote for ALIEM: https://www.aliem.com/social-medicine-emergency-department/.(Please note that minor details of this patient's information were modified to protect confidentiality.)

> "On the day we met Jane, a woman in her 70's with diabetes and mobility impairment, she was visiting an Emergency Department (ED) for the 50th time in the past year. Jane was experiencing homelessness and spent much of her day riding public transportation in her wheelchair. Bystanders, often concerned for her health after noticing she had an episode of incontinence, would call 911 after which Jane would be brought to the nearest ED.
>
> On the day Jane came to our ED, our multidisciplinary ED-based Social Medicine team was asked to help in her care. She was very thin, her clothes were wet from rain, and her belongings were falling from the plastic bags draped on the back of her wheelchair. Our team sat with Jane to understand what type of help that she wanted — she was hungry, she hadn't had stable access to food for months, and her bottom was painful as she had developed wounds from spending hours sitting in soiled clothes. That day, our team provided her with a sandwich and hot coffee, brought her a set of

clean, dry clothes, and built enough rapport with her to interest her in moving indoors to a nearby respite center. Over the ensuing months, Jane gained back her strength, she established care with a primary care physician and improved her diabetes control, her wounds healed, and she built a relationship with a case manager who helped her to move into long-term housing. And, as a secondary outcome, her use of acute care services dropped substantially – she had less than 5 ED visits and no hospitalizations in the following year. Caring for Jane and watching what happened next was a lesson for all of us about the impact of addressing medical and social needs together."

What barriers did you face when creating the team? How about facilitators?

Among many challenges :

- Creating trust in a new type of consultative service and proving that consultation and intervention would not increase ED Length of Stay
- Changing the culture in the ED to incorporate a third disposition option for patients (apart from admit for social needs or discharge with medical intervention alone): discharge after intervention care integration for medical/social/behavioral health needs
- Refocusing on listening to the patients' self-defined goals
- Growing pains within the team related to new types of teamwork in a setting that is historically understaffed, overburdened, and siloed.

Among many facilitators:

- Strong support from executive and ED leadership
- Financial support from a number of sources including strong philanthropic support
- Mission driven team members who believe in health equity and service to marginalized people
- Clinical expertise across a wide range of medical, behavioral health and social illnesses
- Open communication, generosity and trust within program leadership team.

Table. EDSM Team Personnel and Roles

Roles	FTE %	Source of FTE	Primary focus on care team
Patient care coordinator	100	Grant specific to EDSM	Receive consultation requests, organize team members, facilitate community-based care, track program data
Social worker[a]	10	Existing hospital FTE	Assess patient and refer to community social services
Care coordination nurse[a]	10	Existing hospital FTE	Coordinate with hospital eligibility, clinicians, and community care agencies
Pharmacist[a]	10	Existing hospital FTE	Perform medication assessment, provide prescription with bedside medication teaching
Physician consultant	30	Existing physician FTE and grant specific to EDSM	Assess patient and document treatment plan with medical and social interventions; communicate with hospital and ambulatory care clinicians
Addiction treatment linkage coordinator[a]	NA	Supported by hospital addiction medicine program	Assess patient and refer to community-based substance use treatment programs
Housing linkage coordinator[a]	10	Existing health system FTE	Assess patient and coordinate placement into emergency housing and short-term residential case management
Administration and performance improvement	10	Existing hospital FTE	Develop and deploy strategic vision for program, oversee and manage grants and funding, coach and teach performance improvement and team development

Abbreviations: EDSM, emergency department social medicine; FTE, full-time equivalent; NA, not applicable.

[a] Roles that predate the EDSM team formation but were not previously integrated as a coordinated team.

JAMA 2020 Dec 22;324(24):2550-2551. doi: 10.1001/jama.2020.17017)

What is the cost of the SM team and where does your money come from?

We are grant-funded through community philanthropic funding, funding from partner health systems and hospital foundation funds directed toward quality improvement. Our yearly budget now is approximately $750,000. You can learn more about the financial aspect of the team in their recent JAMA article.

Have there been any struggles in bringing together such an interdisciplinary team?

We have grown from 3 to over 40 associated team members and partners over the past 4 years. We have hired multiple members, provided training and professional development support to team members across multiple professional disciplines, and created increasing structure with regular coaching and mentoring. We often talk about forming, storming, norming and performing stages of team development. We meet weekly to review data together and to discuss our current interventions and consider adjustments. During these meetings, we make an intentional effort to incorporate team building and wellness activities. We use the 5 Dysfunctions of a Team framework (absence of trust, fear of conflict, lack of commitment, avoidance of accountability, and inattention to results) and assess for improvements in team morale and areas for improvement every 6 months.

Tell me about how the Social Medicine team has evolved over time and what your goals are for the future.

We started as a trio (JB, HK and JC), looking at data on behalf of the hospital administration about alternatives to social admissions for patients with complex social and behavioral health needs. Our first grant came from SFHP (managed MediCal) with the goal of decreasing social admissions by 7.5 per month. We started with two interventions – a consult service and medications in hand. There were two clinicians who split 5 day/week coverage for the first 2.5 years, partnering with a patient care coordinator.

Fast forward to the present, we have grown to a group of over 40 affiliated multidisciplinary providers including care coordinators/navigators, pharmacists, social workers, nurses, nurse practitioner, quality improvement specialists and physicians. Our leadership team grew with an additional Co-Director (SH) who is a Social Work Supervisor in the hospital's Department of Care Coordination and a Program Manager (KH) with deep experience in health equity, workforce development and community partnerships.

Our initial two interventions have grown to ten plus interventions led by team members in areas such as housing referrals, distribution of self-care supplies to patients, partnership with substance use treatment programs, and more. We have spread from the ED to inpatient, behavioral health and ambulatory settings. We are fortunate to participate in multiple large-scale policy and funding initiatives in the SF Department of Public Health related to care for populations experiencing health inequities and complex social determinants of health. We are very grateful for the opportunity to continue and expand partnerships with new clinical teams and partners across the health system, SF City and County and community organizations to achieve our vision.

How has COVID impacted the team?

COVID has presented significant challenges in a number of ways, notably decreases in available emergency housing options and narrowing of existing community-based social support services and supplies. In response to emergency housing shortfalls, the Social Medicine Patient Care Coordinator has responded by facilitating community housing referral assessments in the ED and across campus. Her work has contributed to an increase in number of patients experiencing homelessness who were prioritized for community housing. Social Medicine leadership continued to advocate to the SF Department of Public Health regarding the need for more universal access to emergency housing for patients who are unhoused.

Related to the decrease in the availability of community-based social services, such as limited access to food programs, clothing access, financial support, and public transportation shutdowns, the Social Medicine team began to provide such items to patients during their care encounter across the SFGH campus. Items such as hygiene kits, food vouchers, pharmacy cards, phones and clothing were purchased through an emergency grant from the City and County of SF and distributed to patients at inpatient and ambulatory care encounters across the hospital campus.

In addition, members of our leadership have provided consulting opinions to the SF Health Officer regarding the intersection of ethics, social determinants of health and the balance between individual liberties and public health in COVID-19.

What are you most proud of with respect to what the Social Medicine team has achieved?

Demonstrating proof of concept that we can humanize and improve the accessibility of care for people experiencing homelessness, substance use disorders, serious mental illness and advanced medical illnesses.

What advice would you give to someone looking to start a Social Medicine team at their own institution?

The team referred me again to their ALiEM Blog Post from earlier this year.

1. **Partner up:** We encourage you to understand the underlying social needs of your patients and work with partners, such as your ED social workers and community social services, to help meet those needs. The ED visit can be an opportunity to go beyond **healthcare**, and help our patients realize optimal **health**.

2. **Ask the patient:** At the frontline, we recommend asking your patients about their primary concerns and social needs, and doing what you can to help.

3. **Form a team:** If you want to go a step further, form a team and develop partnerships with staff in your ED (e.g., social workers) and outside your health setting (e.g., community-based organizations) to understand a system problem (e.g., access to medications, food or emergency housing) more

deeply. Talk to your patients to get their input and recommendations. Then, use quality improvement techniques to improve the care of that problem in service to your patients.

4. **Look upstream:** If you want to work upstream of direct care, join or form a group to understand a problem at the community level and advocate for increased social services available to your organization and community

"With intentional effort, it is possible to help meet patients' social and behavioral health needs in the context of a medical encounter. For us, this effort has been transformative in our careers thus far. It makes all the difference in making the care more meaningful to patients' health and the work experience more joyful and fulfilling for providers."

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Trauma Center

A Social EM Approach to Chronic Opioid Use

4/21/23

Qi Charles Zhang, MD, MPH

Midwestern University Emergency Medicine Residency

The emergency department and healthcare as a whole has had a complex relationship with opioids, both as a medication and toward those who use it chronically. This relationship has been further complicated by the rising deaths due to opioid overdose and the ensuing response on all levels of society and government. COVID19 isolation has only made things worse resulting in unprecedented numbers of deaths due to overdose in the US. Our patients are being caught in the middle, and proper care of these patients requires an understanding of the history and disease as well as an approach that is patient centered and tailored toward supporting their goals and health.

The healthcare treatment of those who use opioids chronically or recreationally is significantly biased and has a historical basis.

- Opioids have existed in various forms for millenia, but our current relationship with opioids as illicit substances of abuse stem from policy initiatives targeted toward black Americans and underserved communities.

"You want to know what this was really all about. The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I'm saying. We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did." John Ehrlichman, aide to Richard Nixon

- There are known disparities in how pain is treated when it comes to men versus women and when it comes to white patients versus people of color.
- When it comes to chronic pain, black patients are less likely to be referred to pain management and face more referrals for substance treatment or drug urine tests. At the same time, ED patients

who have chronic pain report frustration in communicating with providers and helplessness in addressing their symptoms.

- Patients meanwhile who use opioids recreationally and/or have opioid use disorder (OUD) continue to face stigma often resulting in increased morbidity and mortality. Chronic pain and opioid use disorder are hard to address well in the ED, and many times we are unsuccessful whether by undertreatment or bias and stigma.

Changing our treatment of chronic pain and chronic opioid use begins by affirming our understanding of it as a chronic disease, not as a choice or moral failing.

- It is well understood that opioid use disorder is a chronic illness. As such, the treatment shouldn't be to just "stop" but to address it as a chronic disease with medications andsupportive strategies known to improve outcomes, such as methadone and buprenorphine.
- Forcing patients with opioid use disorder into abstinence or abstinence-based treatment can have devastating consequences as patients have high risk of relapse and overdose.
- Patients with chronic pain on opioids experience pain that is more than just physical pain but compounded by social and emotional factors, possible dependence, and other conditions such as opioid-induced hyperalgesia.
- Previous perceptions of these patients as "drug seeking" must be avoided, as studies have shown that these behaviors are often due to inadequate pain management ("pseudoaddiction") and only further stigmatize the patient.
- Much like the social justice movements of the last few years, we must recognize that words have power and words matter. Avoid words that stigmatize patients including substance abuse, drug abuser, or addict. This applies when speaking to patients, speaking to each other, and in your charting. Instead use medical terms that describe the use pattern - chronic opioid use, opioid dependence, opioid use disorder.

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When treating our patients in the ED, use a patient-centered approach with principles of harm reduction.

- ACEP has published guidelines on treating pain, treating acute on chronic pain, prescribing opioids, and naloxone at discharge for those at high risk of overdose. As patients commonly present to the ED for acute on chronic pain, treat the acute pain as you would with the understanding that if given opioid medications these patients will often require higher doses.

- Much as you would any other patient, listen, acknowledge their disease or pain, educate them on heir health condition, and guide them toward a path forward once they leave your ED.
- Refer to pain management and community resources if available, and respect pain contracts as the patient may lose their pain management prescriber if violated.
- Use PDMP wisely to understand the daily opioid use and morphine milligram equivalents (MME) to gauge risk of overdose, but be aware that PDMPs also introduce bias toward patients with under-treated pain.
- For patients who use street drugs and/or opioids recreationally, apply the principles of harm reduction that promote empowerment of the patient and safer use to minimize harm. Interventions we can use in the ED include starting methadone while in the ED and recommending its continuation if admitted, teaching the patient safe injection and wound care, directing to community resources for new syringes and supplies, and giving or prescribing naloxone at discharge.

Naloxone saves lives - prescribe or dispense take home naloxone for patients presenting with overdose or at high risk for overdose. Advocate for your institution to implement take home naloxone as there remain numerous barriers toward filling naloxone prescriptions.

The relationship between healthcare providers and opioid medications is complex, and we must constantly remind ourselves of the biases embedded into healthcare systems and society that worsen care and outcomes for our patients. We can improve our care by ensuring that it is patient-centered and socially minded, and every step forward that we take will be a positive one toward a future both for better pain treatment and decreasing deaths for those we serve.