THIS MONTH WE SPOKE WITH AAEM MEMBER and Social EM pioneer, Dr. Darin Neven. Dr. Neven introduced impactful programs beginning in his home hospital, then expanded to state and regional initiatives. He also founded and serves as CEO of the medical professional services company Consistent Care.

Many emergency physicians struggle to address seemingly intractable challenges like homelessness and substance use disorder. They feel burned out, disempowered and disincentivized from helping. Others see opportunity to make change and put the strengths of our specialty — empathy, creativity, adaptability, and systems expertise — to work for patients most in need. In this feature, we will spotlight AAEM members changing the game for patients and physicians by addressing social emergency medicine issues head on.

SOCIAL EM SPOTLIGHT: DR. DARIN NEVEN

Putting Emergency Medicine Ingenuity to Work in Service of Marginalized Patients

Sara Urquhart, BSN MEd and Megan Healy, MD FAAEM

Tell us about your practice.

I'm in an independent democratic practice at a 600-bed hospital that has 90,000 visits per year in Spokane, WA, which is in Eastern Washington near Idaho.

How did you first become interested in social EM?

I moved to Spokane in 2005 and there were a lot of social needs in a downtown area with a lot of homelessness and drug use. I felt like we weren't helping some patients and I had to do something about it if I were to continue working there. The one patient that got me started had 80 visits in a year related to alcohol use. There *were* resources to help him outside the ER, and if I went through his hundreds of records, I could figure out his story.

What was your first social EM endeavor?

At the time, all hospitals in Spokane used the same EMR. We created a module in the shared EMR so that every doctor could see a summary of the patient's story and recommendations for their care. Together with software developers, we created an ED care guideline summary. A multidisciplinary committee developed the plans with social work, pharmacy, and nursing input. We included the patient's case manager and contact information. The plan allowed the doctor to build upon what had been done before.

> The biggest challenge is patient buy-in and funding—you have to get health programs to realize they need to invest in their "costliest" patients.

How did you generate these reports and get buy-in from your team?

We generated these reports on patients with frequent visits and we had a dedicated case manager funded quarter-time. She wrote the guidelines, presented at an interdisciplinary meeting, and reached out to the patient to help with medical and mental health treatment. ER doctors love already-synthesized information, so if there is a concise summary from a reliable source, they use it.

What other social EM programs have you initiated?

Many of the programs involve intensive case management in partnership with nurses. I believe that nurses are uniquely qualified to do medical social work because they can help the patient navigate the system. We developed a readmission avoidance program with an assessment and checklist where we see discharged patients within a day of being discharged and then follow them for a month.

We also developed the Bridges program for patients that are homeless and have debilitating conditions. Our intensive nurse case management team can take them all the way through rehab, substance use disorder treatment, and outpatient mental health. We then have employment and housing navigators that help find housing and jobs. The biggest challenge is patient buy-in and funding—you have to get health programs to realize they need to invest in their "costliest" patients.

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What would you say are aspects of a successful social EM endeavor?

I like to look for the triple wins—something that is not only good for the patients, but that is also good for the community and health plans. If the health plan sees savings and you're helping the patient and community, it's a triple win. Having connections in the community is vital. The ER can often be isolated, which makes social EM impossible.

How do you go about approaching your hospital administration or the health plans to get something going?

If you have a few cases, you can go to your hospital or health plan and show it can be done. In medicine there is a lot of inertia not to change, but if you can show that you've already successfully done it and you can pencil out the savings, you can get a pilot. Say "we just want to do one patient a month or 10 patients a year." Let the program speak for itself and show the staff that you're finally doing something about a problem. You have to be unafraid to cold call and use connections. Pick up the phone or email the medical director—outline the problem and your solution.

Why should AAEM members in particular be interested in social EM topics?

There is an economic case to be made for social emergency medicine. We are spending a lot to incarcerate, hospitalize, and put patients in homeless shelters and multiple rounds of treatment. That spending is hard to measure, but if you have a program that can show those savings, it's an entrepreneurial opportunity. I have also not seen CMGs come up with these programs. While social EM endeavors benefit both the hospital and community, the fact that it's independent groups coming up with these shows the value they have to their community.

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What is your response to physicians who say "this isn't my job?"

It will make your life easier. Once, in the history of emergency medicine, trauma was seen as a drudgery. It was hard to get various specialists to rally around a complex patient with severe trauma. Now we have developed trauma teams, trauma surgeons, trauma ICUs. In EM, if it's something you hate, it's probably because you don't have the resources to deal with it. I've found it's very rewarding to learn ways to help vulnerable people because then it's another tool you have and you don't feel you're letting people down. If you feel you can't address problems like SUD and homelessness in the ER, you're going to feel inadequate. But if you learn these ways, it is very rewarding. I love going into a room and seeing a patient with a horrible addiction and knowing exactly what I'm talking about with regards to addiction treatment, housing, and being able to do a really good referral. That is one of the most rewarding parts of my job.

Do you know an AAEM member who should be featured for their social emergency medicine or population health expertise? Send ideas to: info@aaem.org. ●

References

1. Murphy SM, Howell D, McPherson S, Grohs R, Roll J, Neven D. A Randomized Controlled Trial of a Citywide Emergency Department Care-Coordination Program to Reduce Prescription Opioid-Related Visits: An Economic Evaluation. *J Emerg Med.* 2017 Aug;53(2):186-194.
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3. Murphy SM, Neven D. Cost-effective: emergency department care coordination with a regional hospital information system. *J Emerg Med.* 2014 Aug;47(2):223-31.