INSTITUTE FOR BEHAVIORAL HEALTHCARE IMPROVEMENT

# Improving Emergency Department Flow for People with Behavioral Health Problems
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# Introductions

- We have half an hour for introductions
- In that time we would like everyone to introduce themselves
- Tell us:
  - Your name
  - The organization where you work and your role
  - Whether you are in an Emergency department which does or does not have a dedicated unit for behavioral health crises
  - What you would like to get out of today
- If you do not work in an ED then where you do work

# Plan for Today

- The current ED environment, Key issues,
- Behavioral Health Patient Experience and Perception
- Examples of System Changes and Boarding Reductions
- Essential features of improvement, staff culture and training
- Engaging the Community: Addressing the “boarding” problem. How other jurisdictions have developed methods to avoid having people stay long periods
- Important topics in ED management: managing suicidality, agitation, decisions about medication, especially opioids, meeting Joint Commission requirements
- New developments in ED operations including  Use of Telemedicine, crisis centers, non-ED centers
- Building your improvement effort

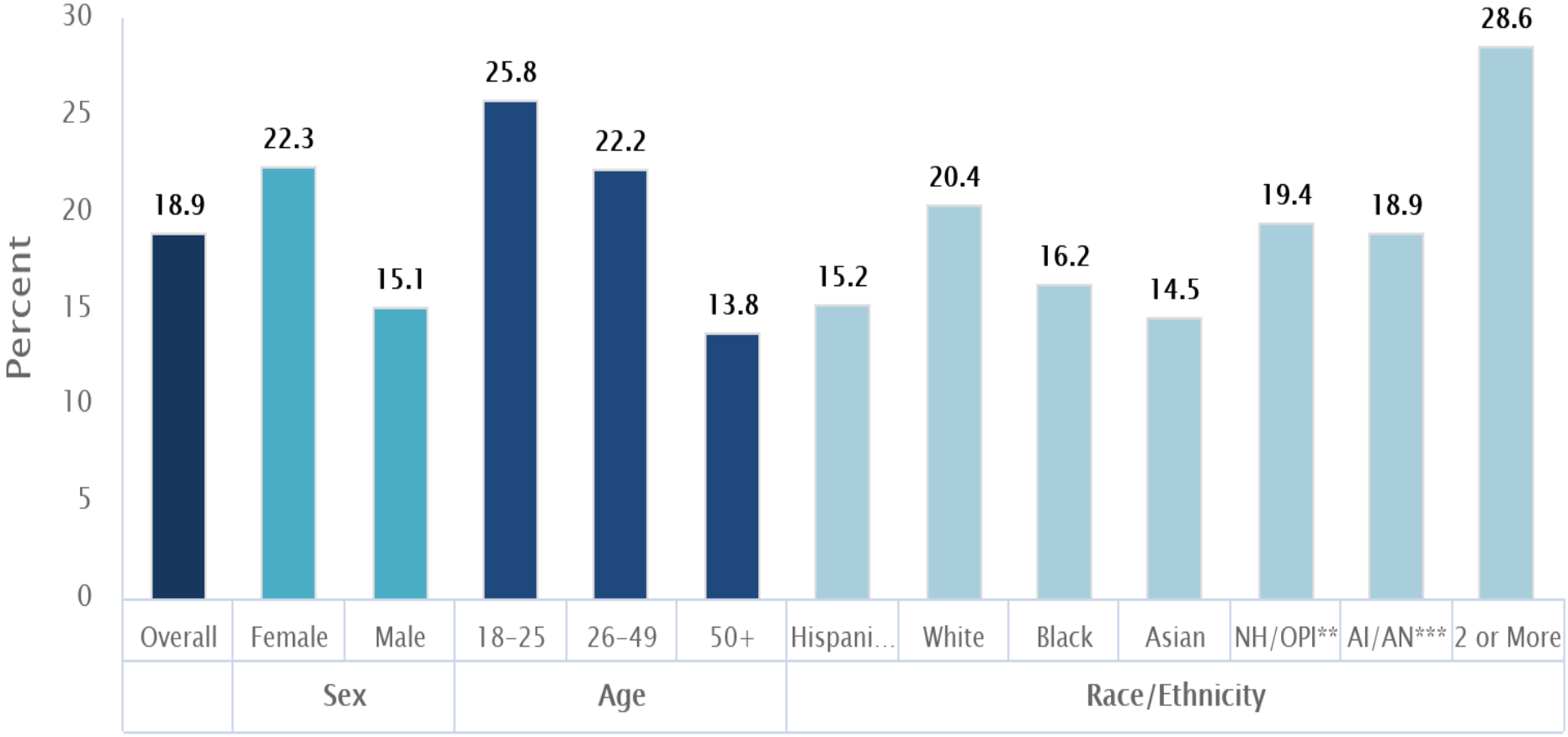
# Current Situation: Access to Care

- In 2017 18.9% of all adults in U.S., 46.6 million, had a mental illness.
- Among the adults with Any Mental Illness, 19.8 million (42.6%) received mental health services in the past year.
- More than three quarters of counties in the US have a serious shortage of mental health professionals.
- Suicidal ideation and intentional self-inflicted injury as a reason for Emergency Dept visit Increased between 2006 and 2014 414.6% from 43,800 to 225,600
- The cost of care continues to rise at an alarming rate, with *needs* a key contributor
- BH providers have high rates of burnout, and feel unprepared to address these issues

# Serious Mental Illness

- NSDUH found 9.8M adults, or 22.6% of adults with any mental illness, were seriously mentally ill – one causing substantial functional impairment. Highest prevalence is among uninsured, and those below 100% of the federal poverty level
- Roughly 1 in 2 adults experience a MH illness in their lifetime
- Depression is the leading cause of disability worldwide
- Over 70,000 deaths by drug overdose every year
- Every 12 minutes someone dies from an opioid overdose
- 1 in 8 adults meet the criteria for alcohol use disorder
- Adults with serious mental illness have shorter life expectancies, 25 years less than those without such an illness, and a much higher risk of chronic medical conditions.
- Nationally 57% of adults with a disorder receive no tx and 64% of youths receive no tx.

# Past Year Prevalence of Any Mental Illness Among U.S. Adults (2017)



# A National Public Health Problem

- The number of behavioral health patients treated in EDs has been steadily rising
- The rate of mental health/substance abuse-related ED visits increased 44.1 percent from 2006 to 2014, with suicidal ideation growing the most (414.6 percent increase in number of visits)
  NIMH 1 September 2017 Trends in Emergency Department Visits, 2006–2014Brian J. Moore, Ph.D
- Overall, the number of ED visits in the United States increased 14.8 percent from 2006 to 2014.
- Among mental health/substance abuse-related ED visits, alcohol-related disorders were the most frequent diagnoses in 2014 (1.5 million visits).

# Substance Dependence or Abuse

- Alcohol dependence or abuse is the most commonly reported substance use disorder with 21.5M people or 8.1% having at least one SUD within the year.
- 80% of substance users reported alcohol, 33% illicit drug use, 20% reported marijuana, 12% reported pain reliever use disorder
- Alcohol dependence or abuse prevalence is highest among the 18-25 year olds.

# Mental Health Professional Shortage

- According to 2018 estimate, 115 million Americans live in designated mental health professional shortage areas where population to provider ratio is at least 30,000 to 1.
- There is an uneven geographic distribution of MH providers who are concentrated in urban areas. Unmet need is highest in the South and lowest in the Northeast.
- Racial/ethnic composition in beh. health professions does not match demographic composition of those seeking services. For ex.: White professionals constitute 84% of the psychologist workforce.
- Improved mental health coverage following MH Parity and Addiction Equity Act and ACA increased demand
- Increasing prevalence of mental health conditions among young adults
- Opioid epidemic increased demand
- The return of war veterans with behavioral needs increased demand
- A shift from incarceration to treatment-oriented behavioral health care in the criminal justice system increased demand

# Psychiatrist Shortage

- More than 50% of psychiatrists are expected to retire by 2025 and more than half of US counties have zero practicing psychiatrists. While increases in residency numbers are encouraging, a few thousand total residents each year are not adequate to fill the gap, given the growing demand and the numbers of psychiatrists moving into retirement.
- There is inadequate residency funding. Slots have increased from 1,117 in 2012 to 1,740 in 2019, but the rate of increase is still inadequate to meet the growing demand for services and replace the aging workforce.

# High attrition, low wages, and lack of prof. development opportunities also cause shortages

- High burnout and turnover rates are attributed to chronic underfunding of the behavioral health safety net, historically low wages, and high case loads. For example, 85% of federally designated mental health professional shortage areas are in rural locations, and may experience additional difficulty in recruiting qualified providers without the support of incentives like loan repayment.
- Low wages and benefits from low reimbursement rates for behavioral health services in Medicaid and Medicare, and lack of reimbursement for critical services like care coordination make providing care financially untenable. Low reimbursement rates also make it difficult to recruit qualified staff to meet the needs of the community.
- Limited opportunity for career advancement and inadequate training or support to grow into leadership roles reduces retention .
- “Associative stigma” and discrimination from working with individuals with mental health or substance use disorders, especially for addiction professionals and peer providers who use their lived experiences and skills from formal training to deliver services.

# Other Issues Affecting Staffing

- Insufficient campus investment, combined with significant state budget cuts in higher education, have resulted in increased reliance on student tuition and fees, which in turn increases student indebtedness.
- Levels of debt vary by profession, but educational costs may deter students from choosing behavior health as a field or specialty across the board if they have concerns about their level of future compensation relative to the indebtedness they will incur.

# Challenges to ED Care Coordination

- A cycle of fear among providers, patients, and families contributes to poor quality of care.
- Lack of standardization and implementation of effective care processes within the ED.
- ED teams lack the right personnel with the right processes and skills to provide effective care.
- Families are excluded in the current system of care in EDs.
- Care settings do not coordinate or communicate across a community.

SOURCE: Tackling The Mental Health Crisis In Emergency Departments: Look Upstream For Solutions, Mara Laderman, Amrita Dasgupta, Robin Henderson, Arpan Waghray, January 26, 2018, Doi:10.1377/hblog20180123.22248

# Other Issues

- Shortage of psychiatric beds around the country combined with lack of access to community outpatient resources impacts Eds.
- Experiencing increase in numbers of boarded patients.
- Recent ACEP poll of more than 1,700 ER physicians reported seeing patients at least once a shift who required hospitalization for psychiatric treatment. 21 percent, said patients were waiting two to five days in the ER for inpatient beds. “Absolute number of psychiatric visits increased by 55 percent, far outpacing the growth of non-psychiatric visits."

# What Typically Happens in the ED

- Very common for EDs to have no mental health services on site or available to respond, other than staff working on finding an inpatient psychiatric bed
- Much variation in ED expertise and training in MH/SU problems, leading to inadequate care and negative patient experience
- Staff often feel burdened by behavioral health patient
- ACEP survey found 62% indicated no psych services while patients are in the ED. And 59 % had no substance abuse or dual diagnosis patient services available. 23% no community psych services
- Over admission to inpatient: In 2016, according to US AHRQ, it was 2.5 times the rate for other conditions.
- Discharge Problems: Often leaving without referral due to lack of knowledge of community resources, and limited relationships with behavioral health programs

# Staff Impacts

- Overcrowded ED facilities and those with mental health “boarders” are correlated directly with walkouts, increased medical errors, increased injuries, and increased negligence claims
- 85% of EDs surveyed said wait times for all patients in the ED would improve if there were better psych services available
- ED crowding cited as a potential cause of compromised patient care.
- 2012 US survey of 3,500 ED clinicians in 65 sites found
  - 3461 physical attacks over 5 yr period, guns
  - Prevalence of agitation up to 1.7M ED visits
  - Guns/knives brought into the ED daily

# What Drives Patient Satisfaction with Emergency Services?

Findings from the Literature

# Background

**Why should we focus on the care experience in the emergency department?**

- **High patient satisfaction with the ED experience is associated with:**
  - **Increased compliance with treatment**
  - **Increased ED physician and staff satisfaction**
  - **Connection to reimbursement**
- **Higher levels of patient satisfaction with the ED may be related to decreased liability**

References: Taylor, 2006; Aragon, 2003; Trout, 2000; Sun, 2000; Bursch, 1993



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# Literature Review —Drivers of Satisfaction

**Comprehensive study done by Boudreaux and O'Hea in 2004, replicated by Press Ganey and Gallup. In-depth review found top predictors of satisfaction were:**

- **MD / Nurse / Staff interaction with patients, including providing information to patients *(in 10 of 13 multivariate studies)***
  - ***Listened, Cared, Courteous, Concerns Taken Seriously.***
  - ***Explanation about delays, ED processes and clear discharge instructions***
- **Perceived technical skills of providers *(in 2 of 13 studies)***
- **Perceived wait for care *(in 1 of 13 studies)***
  - ***To Provider,***
  - ***Total Wait in ED***



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# Most Helpful Aspects of Treatment

- Patient responses about the most helpful aspects of treatment were similar across **all** surveys and focus groups:

  **The most important aspect of a patient's experience is not the quality of medical care, but how they are treated by staff.**

# What was the Least Helpful Aspect of Your Treatment?

Chief complaints:

- Force
- Lack of Information
- Hostile or mocking attitudes
- Not receiving requested medical care
- Violations of confidentiality
- ED staff doesn’t understand mental illness

# Most Helpful Aspects of Treatment

**The most important aspect of a patient's experience is not the quality of medical care but how they are treated by staff.**

# COMPETENT CARING

NAMI VIDEO: When Mental Illness becomes a Traumatic Even

http://www.nami.org/

# Key Issues

- What care are you providing while boarding the patient if admitting to psychiatric hospitals or hospital alternative programs ?
- What connections do you have to community services?
- Reducing Boarding reduces cost and potential for harm

# Developing Community Response

- Community response broadens opportunities
- Requires connection with other organizations
- Builds new types of care
- Highly successful when partnered with law enforcement
- Multiple examples of cross agency partnering
- Establish quick non-judicial care
- Partnerships generate community wide pressure for funding
- Dare to see what might be.

# Examples of Changing CarE For Better Results

- IBHI Collaborative
- Kaiser in Northern California
- Riverside Hospital Columbus Ohio
- St Anthony’s Oklahoma City
- Harborview Seattle WA

# IBHI Learning Collaborative Process

- Formed an “Expert Panel” met six months prior to the start
- 7 hospitals from various regions in the country: NY, Virginia, Louisiana, Colorado, Washington, Oklahoma and Minnesota
- Met for 11 months, three face to face: in Chicago, New Orleans, and San Antonio
- First three months were every other week phone calls, then monthly calls

# Formation of the Learning Initiative

- Obtain clear support from Sr. Leadership
- Organize key operational leaders in BH and the ED to develop the change process
- Agree to share data on results

# Initial Key Observations From Hospitals:

- Need for community outreach and collaboration
- Better access to Beh. Hlth. specialists (adult, adolescent, CD)
- Need standardization of lab tests and tox screens
- Medication protocols and algorithms-Need for more understanding on medication sedation
- Need transportation improvements in moving and receiving BH patients
- Need Police and security integration and education
- Need more emphasis on suicide assessment & measurement
- Need to address patient rights concerns (disrobing)
- Need to lower agitation levels and use of restraints
- Need to evaluate the physical environment in the ED
- Need to customize existing patient satisfaction tools to specify BH patients
- Need to developing behavioral crisis or swat teams to deal with behavioral emergencies

# Typical Issues Complicating Change

- Staffing very limited, not keeping up with demand
- No effective, or rigid, hierarchy of management
- Lack of staff concern for behavioral health issues
- ED physical space constricted and in demand
- No capacity for flexible space utilization
- Waiting area disconnected from treatment area
- Staff not trained to see/treat BH symptoms
- Hospital protocols not related to needs
- Fear of adverse outcomes drives unnecessary psych admissions
- Staff hardened to the ED environment
- Security staff not part of the team
- Staff fear of welcoming environment as encouraging undesired behavior such as overuse

# Community Interventions

- Meeting with community physicians, community mental health programs, community agencies, and outpatient programs.
- Community developed crisis stabilization beds following monthly ED meetings with the County
- Created single point of entry for community beds
- County funded a Gero-Community Diversion Program
- System-wide treatment conferences for high use consumers
- Developed community wide resource information
- Developed substance abuse diversion program that included court process

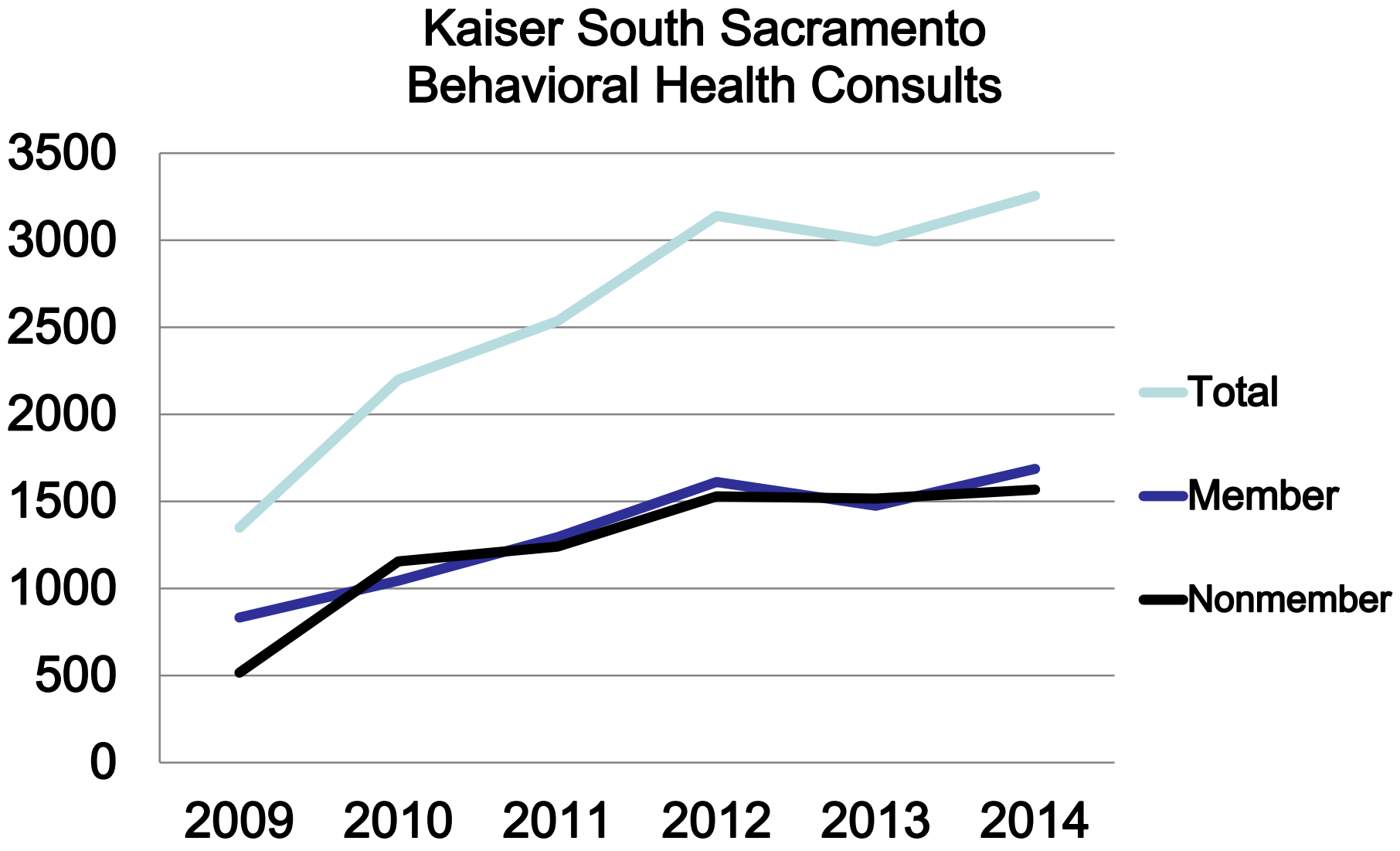
# Results

- Decrease in overall time in the ER over 2 hours on avg
- Decreased LWOBS
- Increased use of psychotropic meds
- Decreased time to BH assessment
- No significant change in restraint number but decrease in average length of time in restraint – under an hour
- Decreased readmissions to the ED (1 day, wk, 30 day)
- Data hard to come by for patient "satisfaction" Needed to go back to Press Ganey and others for BH information. Developed own short survey

# Kaiser Northern California ED **Context**

- Journey of one ED b/c of a crisis throughout the county
- Co Mental Health Center closed crisis unit and 50% of other beds
- Direct cost shifting to the ED's, becoming psychiatric triage center for CMH population
- KP's Busiest ED
- Serves mixed payer/socioeconomic population (40% uninsured/Medi-Cal)
- Level 2 Trauma Center
- Saw 103,000 Patients – number of behavioral health consultations went from 1300 to 3500 with non-members greater number than members

# Increased Demand



# Essential Features

- One size does not fit all : consider volume of behavioral health patients in the ED
- Begin treatment as soon as possible
- Periodic re-assessment; particularly for boarded patients
- ED MD's understand and deliver first line treatment with protocols
- Psych team available when issues beyond first line capabilities, with a psychiatrist easily accessible
- Effectively connecting to outpatient treatment and the rest of the behavioral health continuum

# Measures of Success

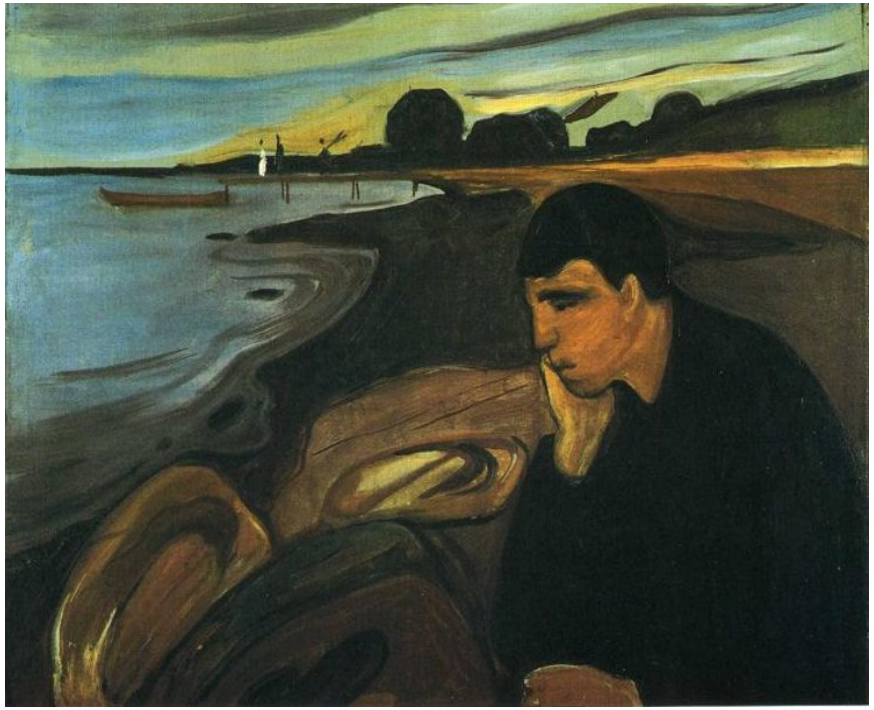
- ED throughput – length of stay in the ED
- Lower numbers of short inpatient psych admissions
- Increased discharges home (diversion rate)
- Patient satisfaction
- Follow-up to outpatient services
- Reduced readmissions to the ED and to inpatient psych

# New Paradigm

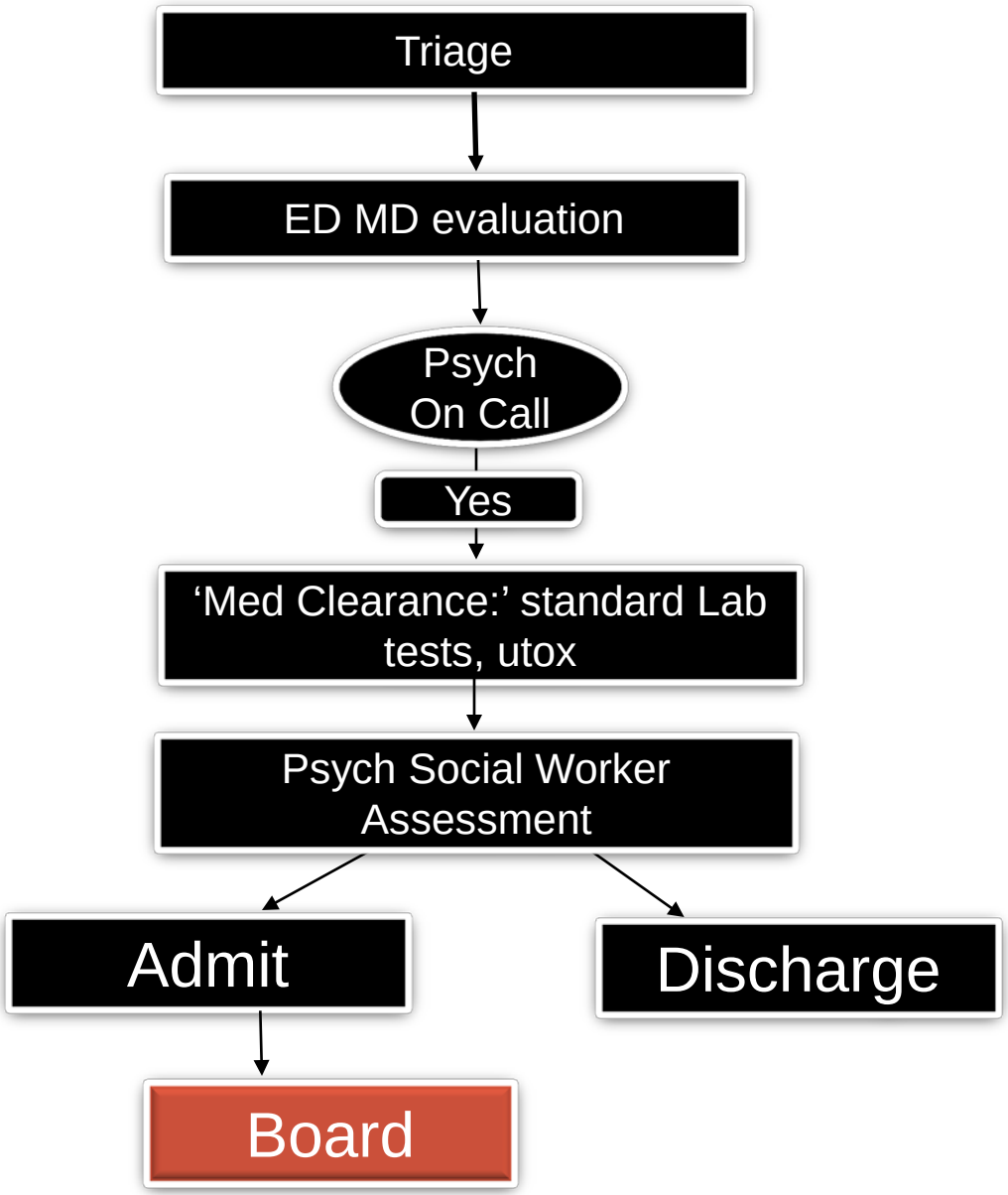
- Everyone trained in assault prevention (CIT)
- Active treatment in the ED
- Reassessment
- Medications
- Avoid unnecessary testing
- Beh Hlth Interventions -

Dedicated Team

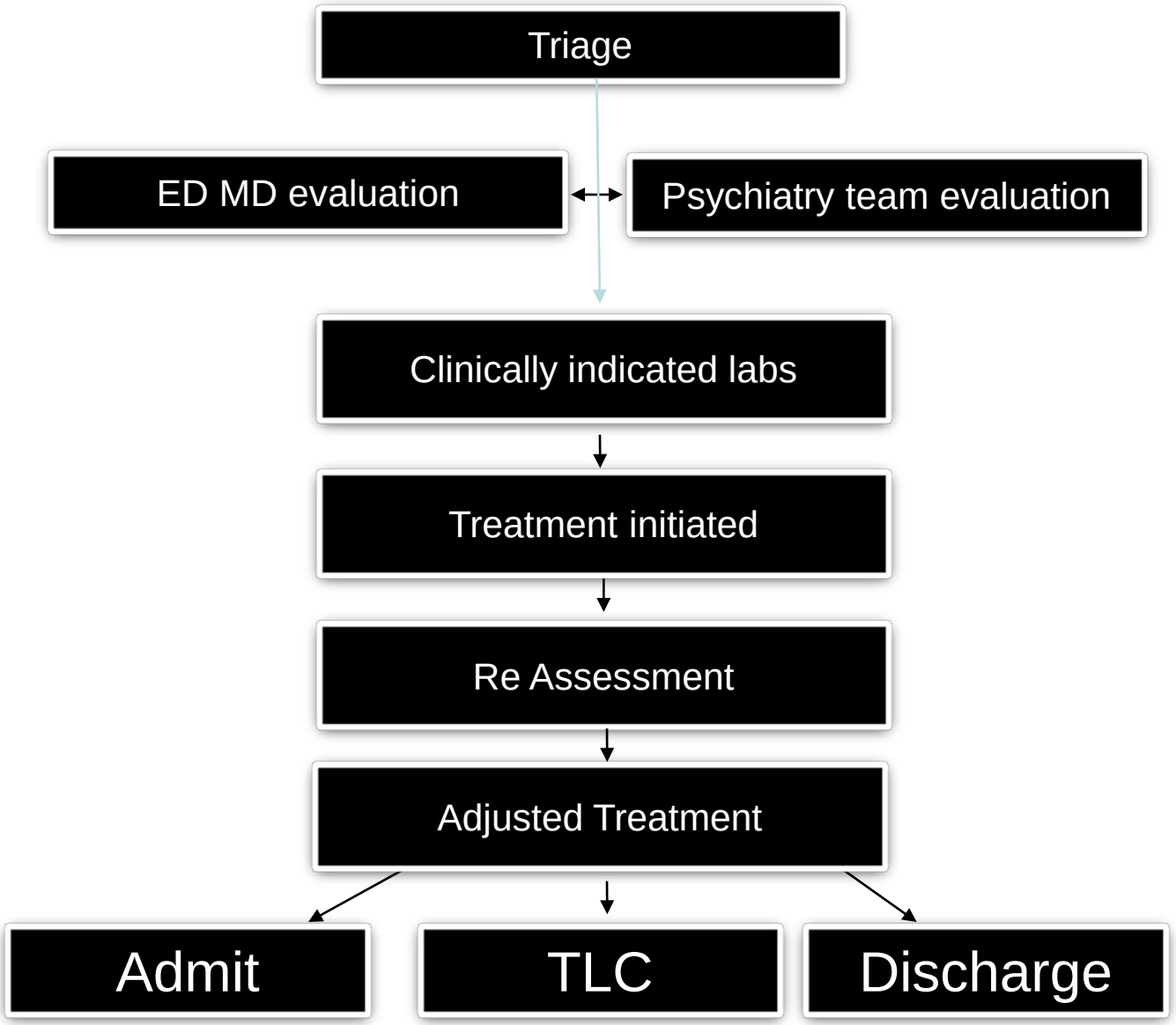
- Collateral
- Discharge *safely* when possible



# Old model


Triage
ED MD evaluation
Psych
On Call
Yes
‘Med Clearance:’ standard Lab tests, utox
Psych Social Worker Assessment
Admit
Discharge
Board

# Ideal model


Triage
ED MD evaluation
Psychiatry team evaluation
Clinically indicated labs
Treatment initiated
Re Assessment
Adjusted Treatment
Admit
TLC
Discharge

# SMART Medical Clearance Form

**S**uspect New Onset Psychiatric Complaint?.....if "**NO**" continue ☐

**M**edical Conditions that Require Screening?.....if "**NO**" continue ☐

- ☐ Diabetes (FSBS > 250)
- ☐ Possibility of pregnancy
- ☐ Other complaints that require screening

**A**bnormal:..... if "**NO**" continue ☐

- ☐ **Vital Signs?**
  - ☐ Temp: > 38.0°C (100.4°F)
  - ☐ HR: < 50 or > 110
  - ☐ BP: BP < 100 systolic or > 180/110 mm Hg (≥ 2 consecutive readings)
  - ☐ RR: < 8 or > 22
  - ☐ $O_2$ Sat: < 95%
- ☐ **Level of Consciousness?**
  - ☐ Cannot answer name, month/year and location
  - ☐ If inebriated HII score ≥ 4 (see next page)
- ☐ **Physical Exam (unclothed)?**

**R**isky Presentation?..... if "**NO**" continue ☐

- ☐ Age < 12 or > 55
- ☐ Possibility of ingestion
- ☐ Eating disorders
- ☐ Significant traumatic injury, prolonged struggle or "found down"

**T**herapeutic Levels Needed?..... if "**NO**" continue ☐

- ☐ Dilantin
- ☐ Lithium
- ☐ Digoxin
- ☐ Coumadin

- **If ALL SMART categories CAN be answered with "NO" then the patient is considered medically cleared and no additional testing is indicated.**
- **If ANY SMART category CANNOT be answered with "NO" then appropriate testing and/or documentation of rationale for medical clearance must be reflected in the patient's chart.**

**Completed by:** _____ _____**, MD/DO** **Date:** _____

Signature Print

# TLC: *Transitional Lounge for Care*

- Observation and treatment area in the ED
- Used for behavioral health needs that can be assessed and treated for potential discharge within 24 hours of acceptance or for boarded patients
- Structured milieu
  - Medication management
  - Psycho-educational & coping skills groups
  - Supportive therapy
  - Substance use counseling

# TLC Exclusion Criteria

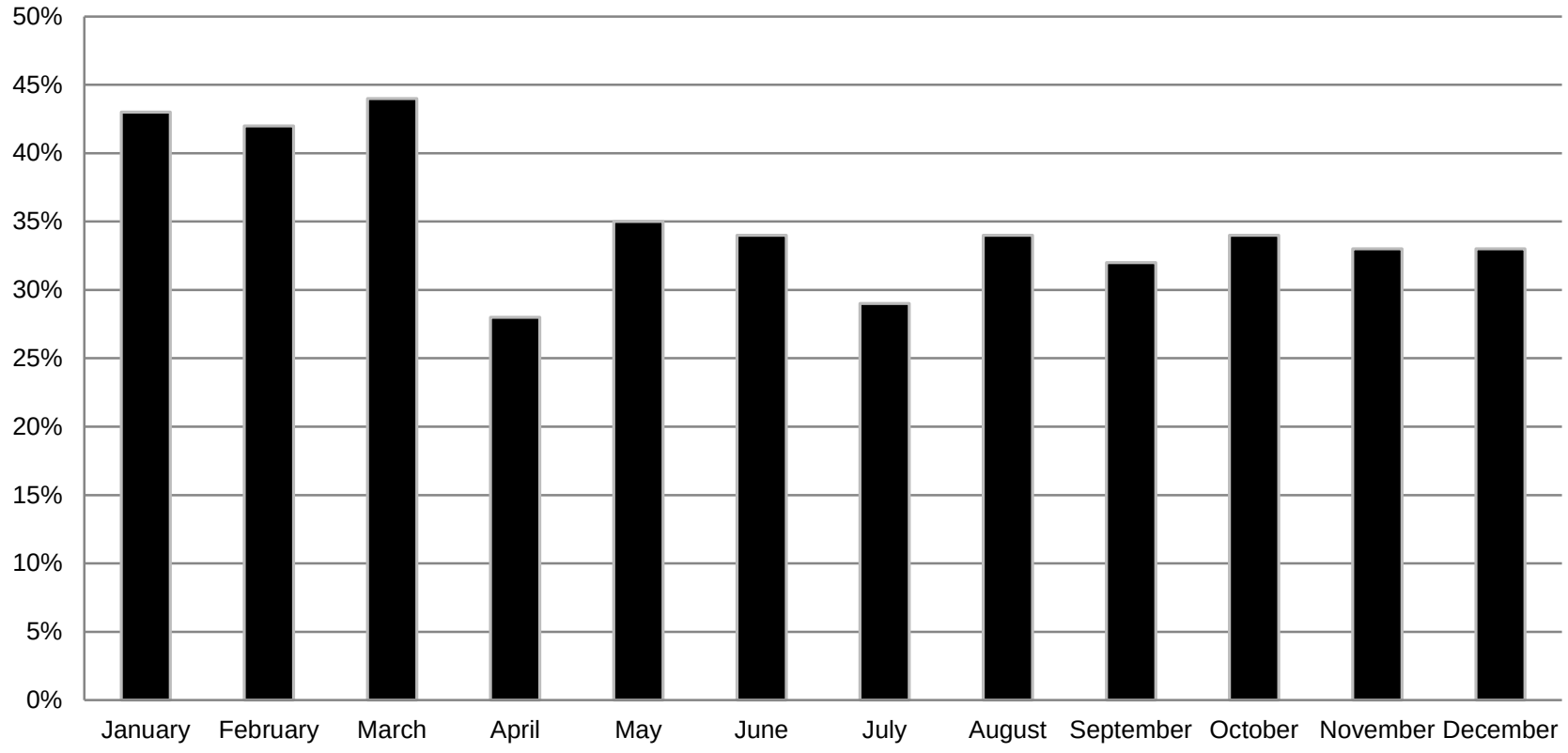
- Acute agitation within six hours
- Acute substance intoxication
- Potential increased length of stay (secondary gain)
- Acute psychosis
- Sexually inappropriate behaviors
- Minors

# Benefits of the TLC

- Decreased admission rates
- Decrease inpatient admission times if admission ultimately required
- Improved quality of care
- Increased space in ED for medically ill patients

# Results:
# Initial 10% drop in admission percentage

## Admission Percentage
## 32% average since ED BH Start



# Discharge Destinations

- Inpatient
- Crisis Stabilization Units
- Crisis Residential and Residential facilities
- KPPACC
- IOP
- Intensive Case Management
- Intensive Community Treatment

# Changing the ED Culture