Objectives

- Describe the real challenges of serving behavioral health patients and discuss countermeasures
- Identify the opportunities to improve the flow of and service to behavioral health patients

The presenters have nothing to disclose
• Yes, the situation is difficult...
• Things are likely to get worse...
• No, it isn't fair...
• We do have options...
Rules for Caregiver Survival
Adapted from "The Fifteen Minute Hour"

Rule 1: Do Not Take Responsibility for Things You Cannot Control

Rule 2: Take Care of Yourself or You Can’t Take Care of Anyone Else

Rule 3: Trouble Is Easier to Prevent Than to Fix

Rule 4: When You Get Upset, Tune into What Is Going on with You and Go Through the Three-Step Process
   1. What am I feeling?
   2. What do I want?
   3. What can I do about it?

Rule 5: If the answer to Step 3, Rule 4 is “Nothing,” Apply Rule 1

Rule 6: Ask for Support When You Need It-Give People Permission to Feel What They Feel

Rule 7: In a Bad Situation You Have Four Options
   1. Leave it.
   2. Change it.
   3. Accept it.
   4. Reframe it.

Rule 8: If You Never Make Mistakes, You’re Not Learning Anything

Rule 9: When a Situation Turns Out Badly, Look at Where the Choice Points Were, Then Decide What You Would Do Differently Next Time

Rule 10: At Any Given Time You can Only Make Decisions Based on the Information You Have

Rule 11: Life Is Not Fair—or a Contest

Rule 12: You Have to Start Where the Patient Is At

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An Introduction to Our Challenge:

- 2 million people seek treatment for Behavioral Health Care problems each year in hospital emergency departments at a cost of about $4 billion
- ED staff often feel burdened by behavioral health patients
- There is much variation in ED expertise and training in mental health problems, which can lead to inadequate care and negative patient and staff experiences

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*The Fifteen Minute Hour: Therapeutic Talk in Primary Care*
• More than 62 million Americans (22.2%) have some form of mental disorder.
• Of this group, 8.7% have what is categorized as severe mental illness.
• Ninety percent of Americans with severe mental illness are unemployed and 50% do not receive psychiatric treatment.
• 6 to 12% of all US ED visits are related to psychiatric complaints
• The average ED length of stay for psych patients is double that of non-psych patients (median 5.5 hours) exacerbating ED overcrowding.

Strategies for Expediting Psych Admits by J.D. McCourt, MD, Emergency Physicians Monthly February 14, 2011

One out of every five U.S. hospitalizations involves a mental health condition, either as a primary or secondary diagnosis, according to an Agency for Healthcare Research and Quality (www.ahrq.gov) analysis published in late 2008

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A 2008 survey of 328 emergency room (ER) medical directors done by the American College of Emergency Physicians found that 79% of the survey respondents said psychiatric patients were boarded in their EDs, with a third of the patients boarded for 6 hours or more; 62% said these patients received no psychiatric services while they were being boarded.

American College of Emergency Physicians. ACEP psychiatric and substance abuse survey 2009 [Internet]. Irving (TX): ACEP; 2008
The behavioral health field has the same basic objectives and stages of care as all the rest of medicine. The first requirement is to establish hope – the therapeutic relationship. Next is treatment for recovery, then maintaining wellness.

Behavioral Health in Emergency Care, Peter C. Brown, MA David Hnatow, Damon Kuehl, MD, FACEP
Chapter 47, Emergency Department Management, December 2013
TREATMENT GOALS OF EMERGENCY PSYCHIATRY

- Exclude medical etiologies for symptoms
- Rapid stabilization of acute crisis
- Avoid coercion
- Treat in the least restrictive setting
- Form a therapeutic alliance
- Appropriate disposition and aftercare plan

Basic service operation principles can and do apply to behavioral health patients:

- Define the incoming behavioral health patient streams
- Measure patient demand by shift or by day of the week and design a system to handle it
- Process flow chart the current service process(es)
- Define resource needs and resource availability
- Whiteboard the “ideal state” for the level and quality of service desired
- Match your service delivery options to your patient streams
  - Remove all work that does not add value
- Commit to the right staff, space, supplies and services

The Value of a Defined Process

Diagram:
- Start
- Alarm Rings
  - Ready to Get Up? (YES)
    - Climb Out of Bed
    - End
  - NO
    - Delay
      - Hit Snooze Button
        - Set for 5 Min.
        - Average 3 Times
You need and want a defined, refined and reliable approach to the individual psychiatric patient

Psychiatric and medical patients use the same space and staff

TRIAGE

Physician Evaluation

Psychiatric Condition

Psych Social Worker or Under Arrangement

Admit to Hospital* or Transfer to Hospital

Medical Condition

*Admit up to three days.

The Psychiatric Medical Screening Exam (PMSE)

Although it can be agreed by both specialties that psychiatric illness can coexist with medical illness, can exacerbate medical illness, can be a presenting symptom of a medical illness, and can coexist with substance abuse emergencies, no consensus has been reached regarding a standardized clinical pathway outlining the scope and extent of the PMSE.

Strategies for Expediting Psych Admits by J.D. McCourt, MD, Emergency Physicians Monthly February 14, 2011

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"Mandatory laboratory testing for emergency department psychiatric medical screening exam: Useful or useless?"

We presented a study at the Society of Academic Emergency Medicine annual meeting titled "Mandatory laboratory testing for emergency department psychiatric medical screening exam: Useful or useless?"

- This was a retrospective chart review of 1095 consecutive psychiatric patients presenting to the ED for medical clearance.
- Mandatory laboratory testing included CBC, Chemistry 7, alcohol and toxicological serum testing totaling 8872 laboratory tests.
- Records were analyzed to determine if the results of mandatory laboratory testing had any effect on patient management or disposition.
- Fifty-four (4.9% [54/1095]) patients were considered to have moderate to severe abnormalities, a complete database was obtained for 29 (54% [29/54]) of these patients.
- Mandatory lab testing identified 12 (41% [12/29]) patients in which history and physical exam would not have predicted these results and of these patients 6 had no management changes and 6 had minor management changes.

From this study, it may be concluded that mandatory laboratory testing in the psychiatric medical screening exam of psychiatric patients presenting to the ED rarely yields abnormalities that would not have been predicted based on the history and physical exam alone or resulted in a significant management change.

- This practice is also extremely expensive, subjects the health care workers to unnecessary exposure risks and is time consuming for the staff and patients.
A Seven Point Action Plan

1. Quantify and Monitor the Problem
2. Improve ER Care of Psychiatric Patients
3. Make More Efficient Use of Existing Capacity
4. Implement Low-Cost Collaboration
5. Work With Law Enforcement
6. Invest In Comprehensive Community Crisis Services
7. Invest in Continuity of Care

Alakeson, V., Pande, N., and Ludwig, M. “A plan to reduce emergency room ‘boarding’ of psychiatric patients.” Health Affairs. 29(9):1637-42, Sept. 2010

1. Quantify and Monitor the Problem

- Quantifying the extent of psychiatric boarding is the first step toward tackling the problem.

- It is difficult to make the case for any substantial investment in solutions without this information. Addressing this information gap is crucial.
2. Improve the ER Care of Psychiatric Patients

- Define what your psychiatric patients need

- High-quality care in a time of crisis can reduce the need for inpatient admission

- Patients who get better care are more likely to go home than to stay in emergency rooms as boarders.
Poor care is the result of several factors.

- Emergency rooms are generally loud, hectic environments that are poorly suited to deescalating a mental health crisis.
- ER psychiatric assessments are often inadequate, and when treatment is provided, it is generally no more than medication.
  - This is because psychiatrists are not available in all emergency rooms, and ER staff members are often not trained in psychiatry.

Case Study: Carilion Clinic

Improving the Front End

- All mental health patients = Level 1 triage
- Standardized patient intake
- Creation of dedicated ED Mental Health Unit
- Triage process changes and direct to ED Mental Health Unit
- Care plans for unique patients
Case Study: Carilion Clinic

Throughput
- Standard order sets and ED zone placement
- Dedicated ED Psych Nursing Staff
  - Additional 1 FTE RN, 1 FTE med tech for ED psych unit
- Psych RN coordinators (Connect Team)
- Parallel evaluations (med clearance and Connect team)
- ED Physician rounder on boarders (2hrs/day)
- Chronic disease management
- ECO and placement concurrently
- Transportation protocols (EMS and Law Enforcement)
Making More Efficient Use of Existing Capacity on the Emergency Department Side

Separate Emergency Department Based Areas or Units for Psychiatric Patients

- A separately staffed 6 – 10 bed holding unit staffed with a nurse and technician, with an emergency physician overseeing the care of the patient.
- The major benefit is that psychiatric patients are removed from the distractions of the main ED.
- Factors such as ambulance traffic, continuous overhead paging, and constant communication over the police radios tend to escalate the patient’s behavior.
- The Emergency Physician provides ongoing care for the patients until a bed in an inpatient facility is available.
- A partial solution with the same goals is to set up a “psychiatric area” or two or three rooms in a designated portion of the ED which are specifically intended for psychiatric emergencies.
- In one approach, a “pod” was developed around four rooms supplied with cameras to assist in patient monitoring.

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Development of Formal Mental Health Care Teams:
A Mental Health Team is responsible for the care of the patient from initial evaluation to discharge, freeing the ED staff to care for other patients.

Increase the Availability of Psychiatric Consultation
The Clinical Advisory Board

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KPMAS Medical Centers: 484,000 Members

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21. Falls Church
22. Fredericksburg
23. Fauquier
24. Reston
25. Springfield
26. Tysons Corner
27. Woodbridge

Washington DC

28. Capitol Hill
29. Northwest

Director of IT, a Psychiatrist began performing telemedicine with some of his clinic patients

Integrated this platform with similar work through the Call Center and Emergency Medicine
Director of IT, a Psychiatrist began performing telemedicine with some of his clinic patients

Integrated this platform with similar work through the Call Center and Emergency Medicine

Plan is to screen depressed patients for preventative intervention in those that are high risk

Will expand the program to Panic Disorder

Patient Health Questionnaire (PHQ-9)

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Over the last 2 weeks, how often have you been bothered by any of the following problems?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Little interest or pleasure in doing things</td>
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<tr>
<td>b. Feeling down, depressed, or hopeless</td>
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<tr>
<td>c. Trouble falling/staying asleep, sleeping too much</td>
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<td>d. Feeling tired or having little energy</td>
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<tr>
<td>e. Poor appetite or overeating</td>
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<tr>
<td>f. Feeling bad about yourself or that you are a failure or have let yourself or your family down</td>
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<td></td>
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<tr>
<td>g. Trouble concentrating on things, such as reading the newspaper or watching television</td>
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<tr>
<td>h. Moving or speaking so slowly that other people could have noticed or the opposite, being so fidgety or restless that you have been moving around a lot more than usual</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>i. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td></td>
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</tbody>
</table>

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>
Patient with PHQ-9 Score over 20 will receive frequent check-ins to assess their mental health.

They will also receive a special code that allows them to check in directly with the HouseCalls physician whenever they feel they need help.

HouseCalls physician can either address the issue or connect them with the on call Psychiatrist for immediate or next day intervention.
Managing Boarded Patients

After formal psychiatric evaluation, patients may be held for days. Mechanisms to improve care for these patients include:

- During high volume periods, nurses may be recruited from an inpatient psychiatric unit to add staff to the ED. While they cannot take over care of other ED patients, they can relieve ED nurses by taking over care of the psychiatric patients.
- Holding orders may help maintain consistent care for the boarding patient. It also helps develop the idea that the boarded patient is now essentially an “inpatient” and requires regular evaluation and medication. This becomes most important when there are concurrent chronic medical concerns.
- Encourage the initiation of psychiatric medications. This may mean re-starting the patient’s usual psychiatric medication regimen. At least one site has developed a protocol to validate medications with family or others.
- Subtle designation of the patient as a boarding psychiatric patient may help staff keep the patient’s special needs in mind. Techniques include separately colored charts or armbands.
- Frequent attending physician re-evaluation. Some sites require formal re-evaluation with documentation every shift.
- Psychiatrist or psychiatric social worker re-evaluation every 24 hours.
Make More Efficient Use of Existing Capacity on the In-Patient Side

On the inpatient side, **use-review teams** improve inpatient capacity planning and implement more-timely discharges of patients.

In New York, for example, legislation was adopted encouraging and funding the following programs. Legislation calls for:

- **Hospital-based crisis intervention services** in the emergency room, including triage, referral, and psychiatric and medical evaluations and assessments;
- **Extended observation beds** in the hospital to provide for extended evaluation, assessment, or stabilization of acute psychiatric symptoms for up to 72 hours;
- **Crisis outreach services** in the community, including clinical assessment and crisis intervention treatment; and
- **Crisis residence services** in the community for temporary residential and other necessary support services for up to five consecutive days.
Make More Efficient Use of Existing Capacity at the Community Level

Improved customer service and better management for no-shows and cancellations of appointments creates more timely access to mental health services for patients who do keep their appointments.

4. Implement Low-Cost Collaboration

- Use community mental health clinicians to train ER staff in the management and care of patients with serious mental illnesses.
- Have a social worker in the emergency room who can connect individuals with community service when they are discharged, improving continuity of care.
Obstacles:

- The lack of shared responsibility and accountability between the community mental health systems and the hospital emergency room.
  - This is exacerbated by the fact that the two systems do not share funding, governance, or licensing.
- State mental health agencies have little or no formal relationship with emergency departments.
- The first step in establishing collaboration is often to bring the relevant stakeholders together to develop joint ownership of the problem of boarding, and to get everyone’s commitment to remedying the problem.

5. Work With Law Enforcement
6. Invest in Comprehensive Community Crisis Services

- Harris County, Texas, has developed the Comprehensive Emergency Psychiatric Program,
  - The American Psychiatric Association has recognized this as a model for comprehensive emergency services in an urban setting.
- The program has six core features: a round-the-clock public health line; round-the-clock psychiatric emergency services; a mobile crisis outreach team; a crisis stabilization unit with beds for sixteen adult psychiatric patients; a voluntary emergency residential unit with beds for eighteen adult psychiatric patients; and a crisis counseling unit.
- The most important of these six features for reducing emergency room boarding are the twenty-four-hour community-based psychiatric emergency services and the mobile crisis outreach team.
7. Invest in Continuity of Care

Case Study: Carilion Clinic

Back Door
- “One Call” for all Mental Health Patients
- Expanded weekend bed capacity
- 1 to 1 communication with ED physician and Psychiatric team
- County/City Mental Health Coordination with Connect Team
- Automatic Psychiatry Consult for ED >24 hrs
- Direct Facility Protocol Placement for Unique Patients
- Law Enforcement/Magistrate - Drug Intervention Programs
Improvement...

Mental Health Patients Days/Month
Average ED Stay >800 minutes

Carilion Clinic (Roanoke, VA) Case Study compliments of Damon Kuehl MD, FACEP

Mental Health Patients ED LOS in Minutes

Carilion Clinic (Roanoke, VA) Case Study compliments of Damon Kuehl MD, FACEP
Mental Health High Utilizers
LOS in the ED

Other Success Stories
Univ. of Pittsburgh Medical Center (UPMC) Mercy

- Partnerships:
  - With the largest behavioral health facility in Allegheny County (Western Psychiatric Institute and Clinic) to facilitate transfers, secure urgent outpatient post-ED follow up visits
  - With an outpatient crisis center (ReResolve) with community-based crisis clinicians from this center staffing the UPMC Mercy ED 16 hours a day to facilitate care out of the hospital when appropriate.
- A team of nursing staff trained to work full time in providing detoxification assessments 16 hours a day in the ED
- Post discharge planning begins on day 1 for admitted patients
- Access to outpatient programs enhanced with appointments obtained within 7 days post discharge from the hospital or ED
- Training of detoxification assessment and treatment on inpatient medical floors to decrease patient deterioration and ICU utilization

**UPMC Mercy Results**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mean ED length of stay for patients admitted to addiction medicine service</td>
<td>20 hours in June 2012 to less than 6 hours in June 2013</td>
</tr>
<tr>
<td>2. Mean ED length of stay for patients discharged after detoxification evaluation</td>
<td>10 hours in June 2012 to less than 5 hours in June 2013</td>
</tr>
<tr>
<td>3. Mean wait time to evaluation for patients presenting for detoxification</td>
<td>63 minutes June 2012 to 14 minutes June 2013</td>
</tr>
<tr>
<td>4. Detoxification recidivism within 30 days</td>
<td>17% to 10%</td>
</tr>
<tr>
<td>5. Mean ED length of stay for patients admitted for behavioral health services</td>
<td>38 hours June 2012 to 11 hours June 2013</td>
</tr>
<tr>
<td>6. Mean ED length of stay for patients presenting for behavioral health services</td>
<td>20.25 hours June 2012 to 10.25 hours June 2013</td>
</tr>
<tr>
<td>7. Mean wait time to evaluation for patients presenting for behavioral health</td>
<td>68 minutes September 2012 to 15 minutes by June 2013</td>
</tr>
</tbody>
</table>
Community Wide Jail Diversion
The Problem

- Criminalization of Mentally Ill
- Inappropriate Cost to Society
  - 20% in jail
  - Increase use of emergency rooms
  - Homelessness
- Public Safety Net
  - Consumers at risk
  - Law Enforcement at risk
  - Public at risk

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Crisis Care Center

- Crisis Line
- Crisis Assessment
- Mobile Crisis Outreach Team
- Crisis Transitional Unit
- Receives consumers from law enforcement 24/7
- Minor medical clearance
- Call ahead preferred
- Can not take violent or medically compromised individuals

Crisis Intervention Team (CIT)

Mental Health Detail

- Mental health professional partners with a CIT Officer together to respond on calls dealing with a psychiatric crisis.
- Team responds to high utilizer calls for the City providing follow up services to reduce the call volume.
- **Goal is to put officers back into service for patrol as soon as possible.**
  - Reduce inappropriate incarcerations and costly emergency room visits.
  - Offer quality training to law enforcement.
- Co-locate officer with the City unit and Sheriff Mental Health Unit for better collaboration and expedited call response

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Dispatcher Training for 911 Call Takers and Dispatchers

- In 2007 - decided that dispatchers would also benefit from CIT Instruction and met with SAPD leadership to establish training.
- Provided an abbreviated 12 hour CIT course for call takers and dispatchers in collaboration with CHCS.
- The goal of this training is to increase safety by educating call takers on essential intelligence gathering and dispatching a CIT Trained officer to the scene.

Partnered with Fire and EMS

- As of 2007 SAFD has attended every community training
- Have become co-trainers with joint PD and Sheriff’s Officers
- Have added a CIT component to their EMS In-service training.
- Partnering for Integrated training with Fire/EMS has extended numerous opportunities for growth:
  - Officer and Fire/EMS better communication
  - Safety
  - Better utilization of resources
The Restoration Center opened April 15, 2008

- Public Safety-Sobering Unit
- Detoxification Facility
- Community Court
- Outpatient Substance Abuse Services

Emergency Room utilization has dropped 40% since the inception of the Crisis Care Center.

40% of (7619 total seen at CCC) 3048 Persons diverted from the ER (in first year) X $1545

Cost Savings relative to ER Utilization $4,709,160

Source: University Health System
Conclusion

- The evaluation and care of Behavioral Health Patients in the ED and the boarding of psychiatric patients is so much more than a purely behavioral health problem.
  
  It is a health care systems delivery problem...

- It is crucial to develop connections between community-based outpatient services, community-based crisis services, inpatient services, and emergency room services.

- A systematic operations management approach is helpful, if not mandatory

- There is a portfolio of options that may be available to you

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We Remain Optimistic...

“You can always count on Americans to do the right thing - after they’ve tried everything else.”

~Winston Churchill

The number one reason to commit to this is...

"It’s good for the patient…and it’s good for the people who take care of those patients…"

~ Thom Mayer, M.D.

Case Studies Courtesy Of:

- David A Hnatow, MD, FACEP, Greater San Antonio Emergency Physicians, Medical Director, Public Safety Unit, Center for Healthcare Services, San Antonio, Texas

- Damon Kuehl, MD, Assistant professor, Department of Emergency Medicine, Virginia Tech Carilion School of Medicine Residency program, Director, Carillion Clinic, Virginia Tech Carilion Emergency Department Residency Program, Vice Cahir, Emergency Medicine, Virginia Tech Carilion School of Medicine, Roanoke, Virginia

- Michael A Turturro, MD, FACEP, University of Pittsburgh Medical Center Mercy Hospital Campus, Location: Pittsburgh, PA

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References

- Alakeson, V., Pande, N., and Ludwig, M. “A plan to reduce emergency room ‘boarding’ of psychiatric patients.” Health Affairs. 29(9):1637-42, Sept. 2010


