How Can Emergency Departments Improve Care for Patients with Mental Health Issues?

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9:30 – 10:45 AM
11:15 AM – 12:30 PM

#IHIFORUM
Session Objectives

- Understand the critical need for health systems to better meet patients' mental health & substance misuse needs in the emergency department, including the imperative to engage with community partners.
- Describe best practices and a conceptual framework to integrate care for mental health & substance misuse conditions into the emergency department.
- Identify next steps for their organization.
Today’s Agenda

- Why is this work so critical?
- Review themes, gaps, and theory of change
- Discuss specific strategies and case examples
  - Importance of upstream factors
  - Trauma-informed care and impact on patients and staff
  - Improving processes in the ED
  - What does a good disposition look like? How do we meld the medical and behavioral health approaches?
- Q&A
“The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated.”

- Plato
Why is this work so critical?
Voice of the Patient

https://drive.google.com/open?id=131GlrljSqi-Qc5jMG6lZdH6ce_Q2xxS
Scope of the Problem

- One in five visits (20%) to the ED is related to a mental health or substance abuse issue.
- Psychiatric boarding in the ED can be days long.
- 37% of patients discharged for mental health or substance abuse concern are readmitted or visit the ED again within 12 months.
- Connection to follow up care is often lacking and poorly coordinated.
- Estimated cost to health care providers of $2,264 for patients with MH needs boarded in ED.
Seeking Treatment in an Emergency Department During a Psychiatric Emergency

Experiences of Individuals Living with a Mental Health Condition, and Their Families’

How various factors correlate to a patient’s overall experience in an emergency department (ED) during a mental health crisis*

A look at the patients who agreed with each of the following factors and their corresponding overall experience in the ED.

<table>
<thead>
<tr>
<th>Good ED Experience</th>
<th>FACTORS</th>
<th>Bad ED Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>2%</td>
<td>The staff didn’t treat me with respect</td>
<td>78%</td>
</tr>
<tr>
<td>3%</td>
<td>The staff didn’t communicate effectively and listen to my concerns</td>
<td>72%</td>
</tr>
<tr>
<td>4%</td>
<td>The staff made me feel ashamed as a result of my mental illness</td>
<td>71%</td>
</tr>
<tr>
<td>7%</td>
<td>When agitated, I was injected or restrained without consent</td>
<td>68%</td>
</tr>
<tr>
<td>10%</td>
<td>I waited over 10 hours to be seen by a mental health professional</td>
<td>60%</td>
</tr>
</tbody>
</table>

* With no single factors isolated, 20% of patients had a good experience and 44% of individuals had a bad experience in the emergency department.

How patients were treated by the staff

<table>
<thead>
<tr>
<th>While in the ED, the staff:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated me with respect</td>
</tr>
<tr>
<td>Communicated effectively and listened to my concerns</td>
</tr>
<tr>
<td>Encouraged me to sign a privacy release so that my family could be kept informed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>9*</td>
</tr>
</tbody>
</table>

* Roughly 20% patients reported that they didn’t remember or feel IC was not applicable.

Each figure represents 100 people

Information provided to patients and families

<table>
<thead>
<tr>
<th>The ED staff provided me with information about:</th>
</tr>
</thead>
<tbody>
<tr>
<td>My or my loved one’s mental health condition and/or mental health conditions in general</td>
</tr>
<tr>
<td>Medications given in the ED and their side effects</td>
</tr>
<tr>
<td>Where to get mental health services (community and outpatient)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>21%</td>
<td>60%</td>
</tr>
<tr>
<td>15%</td>
<td>54%</td>
</tr>
<tr>
<td>18%</td>
<td>65%</td>
</tr>
</tbody>
</table>

*There was no explanation of the meds they first gave me when admitted. I asked what it was and they just said take it.*
—Patient

*I was not given any information about what I should do if I continue to feel suicidal, which I certainly did.*
—Patient

*Active push NAMI information, especially the NAMI Family-to-Family class. This saved my family and gave us the correct information in order to provide our son with better care.*
—Family member

Survey results based on over 3,000 responses: 1,113 individuals living with a mental health condition, 1,207 family members, caregivers, friends and significant others of an individual living with a mental health condition.
# A Sampling of Barriers

<table>
<thead>
<tr>
<th>Structural</th>
<th>Non-Structural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment systems</td>
<td>EDs are set up to deal with medical acuity, not MH crises</td>
</tr>
<tr>
<td>Shortage of inpatient psych beds – mismatch of supply &amp; demand</td>
<td>Staff attitudes towards individual with mental illness and substance use disorders (stigma, “not my job”)</td>
</tr>
<tr>
<td>Lack of shared accountability b/w community mental health and ED</td>
<td>Lack of staff training and education on how to address patients with behavioral health concerns</td>
</tr>
<tr>
<td>Inadequate upstream prevention or diversion from ED</td>
<td>Lack of access to behavioral health expertise within the ED</td>
</tr>
<tr>
<td>Lack of dedicated beds for psych patients in ED</td>
<td>Few available treatment options in ED</td>
</tr>
<tr>
<td>Decrease in outpatient options</td>
<td>Lack of clinical and practice standards and guidelines for many common issues</td>
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</tbody>
</table>
Themes, Gaps, & Theory of Change
What we’re up to

Integrating Behavioral Health in the Emergency Department and Upstream: A Learning Community
Phase 1: Content Development & Health System Recruitment
Activity: Rapid cycle research process; outreach to health systems
Output: Change package for ED, 8-10 health systems recruited

Phase 2: Prototype Learning Community
• Activity: Prototype testing with 8-10 health systems
  • Output: Tested set of changes & 8-10 health systems with evidence of improved outcomes in pilot EDs.

Phase 3: Harvesting, Evaluation, & Planning for Scale
• Activity: Harvest learning; develop scale-up plans for health systems
  • Output: Plan to scale work within health systems and spread to additional health systems

Real-Time Dissemination & Awareness-Building
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Real-Time Dissemination & Awareness-Building
Components of an IHI 90-Day Learning Cycle

1. **Question**
   - Pose & refine question to be answered

2. **Scan**
   - Review literature, conduct interviews, identify exemplars

3. **Theory Building**
   - Identify core underlying principles & theories

4. **Focus & Design**
   - Develop a new concept design for testing

5. **Test**
   - Work with one or more settings to test new concept
Methods

- Literature scanning on existing approaches in emergency departments and in communities

- 20 key informant interviews with a range of stakeholders in various settings:
  - ED team members
  - Health care leaders
  - Mental health providers
  - Researchers
  - Policymakers
  - Advocates
  - Family members of individuals with mental health needs
Results from Scan and Interviews

- There are several models with positive results, but uptake and spread has been limited.

- Many models focus on modifying the standard, reactive consult model and rely on adding psychiatric resources, which are often in short supply.

- Others focus on one part of a complex system, e.g. screening. This is important, but insufficient to see meaningful changes.

- Few approaches take a system view that includes health care + community-based services.
Themes & Gaps

- A cycle of fear among providers, patients, and families contributes to a negative culture and poor quality and experience of care.
- Lack of standardization and implementation of effective care processes.
- ED teams lack the right people with the right processes and skills.
- Families are excluded in the current system.
- Care settings do not coordinate or communicate.
- Programs to divert patients from ED can work, but maintain separate systems.
In 18 months, participating teams will improve patient outcomes* and experience of care while decreasing ED re-visits for individuals with mental health and substance abuse issues who present to the emergency department.

*Draft outcome measures:
- Suicide attempt and completion rate post-ED discharge
- Fatal overdoses post-discharge

Our High Level Aim

**Primary Drivers**
- Build and leverage partnerships with community-based services
- Coordinate and communicate between ED and other health care & community-based services
- Standardize processes from ED intake to discharge for a range of MH/SA issues
- Engage and capacitate patients and family members to support self-management
- Create trauma-informed culture among ED staff

**Secondary Drivers**
- Understand landscape of players in community e.g. pops served, incentives, payment
- Identify where people are coming to ED from in community (top referents)
- Identify root causes of ED utilization
- Ask comm.-based agencies how they’d like to engage with health systems to prevent ED utilization
- Build relationships with law enforcement, EMS, mobile crisis teams
- Enhanced care management: Coordinate appointments within ED; active follow up post-discharge
- Develop shared language b/w partners
- Develop standardized, evidence-based approach to triage and temporary symptom management
- Simplify and disseminate existing clinical guidelines; create when needed
- Identify needed roles & how to build MH capacity on multidisciplinary team
- Standardize & utilize strengths-based approach to understand & incorporate patient history, context into care plan
- Deploy specific strategies to reduce fear
- Shift from medical to “whole person”
- Identify types of biases, e.g. MH, “drug-seeking” behavior, racial biases
- Education & training for ED teams about MH & SA issues, care for pop.
- Model behaviors that can drive culture change
Strategies & Case Examples
Adam’s Story
People start to heal the moment they feel heard.

- Cheryl Richardson

"Trying to implement trauma-specific clinical practices without first implementing trauma-informed organizational culture change is like throwing seeds on dry land."

- Sandra Bloom, MD, creator of the Sanctuary Model
Trauma informed Care

- Aims to avoid re-victimisation
- Appreciates many problem behaviours began as understandable attempts to cope
- Strives to maximise choices for the survivor and control over the healing process
- Seeks to be culturally competent
- Understands each survivor in the context of life experiences and cultural background

Alvarez & Sloan, 2010
Going upstream: Homelessness

“Priority-wise, housing is absolutely the top. Especially for high utilizers, they have medical needs for a safe, dry, regimented environment. I am absolutely confident that every community worker that currently or has worked in this position would agree.”

Ron Abrams
Challenges

- Environment in the ED
- Lack of guidelines/training/education
- Limited family engagement
- Poor aftercare plans
Building blocks of our theory of change

- Build and leverage partnerships with community based services
- Coordinate and communicate with other health care and community based services (EDIE, Care Everywhere)
- Standardize process from ED intake to discharge
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- Create a trauma informed culture
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Driver Diagram

Our High Level Aim

Ease Access

Reduce Suffering and Decrease Addiction

Build Resilience

Create Hope and Eliminate Stigma

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Questions?