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, its impact on behavioral health consumers and what the recently added standards for Joint Commission accreditation mean for hospitals behavioral health and emergency care.
- Streamlining ED Operations: What is a system, why should we care and how do we change a system. The Model for Improvement. Finding the problems. Measuring results
- Creating Community Connections: Addressing the “boarding” problem How other jurisdictions have developed methods to avoid having people stay
- Creating your own plan
- Important topics in ED management: managing agitation, decisions about medication, staff culture and training
- Legal issues in EDs related to behavioral health patients and ways to address them
- New developments in ED operations including Use of Telemedicine, crisis centers, non-ED centers

Current Situation: Access to Care

- 1 in 4 individuals will struggle with mental health and substance abuse disorder annually
- 25% of all disability world wide are due to MH/SA disorders.
- National Comorbidity Survey showed that access to behavioral health or substance abuse disorders is limited. Only 36% of people with these conditions receive clinical care.
- Many studies show substantial increase in costs and reduced life expectancies with comorbid mental health and physical health conditions and positive results from collaborative care models
- More than three quarters of counties in the US have a serious shortage of mental health professionals.

Community Resources & Impact

- Cuts in the Safety Net throughout the country: State mental health programs were cut by more than 20% since 2010 with cuts affecting low income patients the most. State Gov't spending comprises only about half as much as it did in 1986. (HR 2646)
- The proportion of all health care spending devoted to MH and SA is 28% smaller today then in 1986.
- US Suicide rate has grown since 2006. CDC reports 13 per 100,000 in 2014, the highest since 1986. It is important to recognize the effects of social determinants and disparities on those with serious mental illness – health, housing, socio-economic status

Community Resources & Impact Cont.

- There is a shortage of psychiatric beds around the country including California. Despite our comprehensive system of care and comparatively low rates of readmissions and lengths of stay this impacts KP.
- This shortage of psychiatric beds combined with lack of access to community outpatient resources impacts EDs which are experiencing increased numbers of behavioral patients who come to the ED, and increasing numbers of boarded patients.
- A recent ACEP poll of more than 1,700 ER physicians reported seeing patients at least once a shift who required hospitalization for psychiatric treatment. One-quarter, 21 percent, said they had patients waiting two to five days in the ER for inpatient beds, "The absolute number of psychiatric visits increased by 55 percent, far outpacing the growth of non-psychiatric visits"

Vanishing EDs:
Number of EDs has declined by 18% in last 15 years

- Study Conducted at UCSF found about one-third of the U.S Emergency Departments have closed between 1989 and 2009. The ED closures predominately affected safety-net hospitals that see a large proportion of low-income patients.
- "While some people think ER crowding is a demand issue—there's too many people going, there's people with inappropriate reasons going---it is also related to the availability of how many ERs are out there"…"many of these patients are quite ill and have waited a long time, they now need to be hospitalized…they stay in the ER waiting for a bed".

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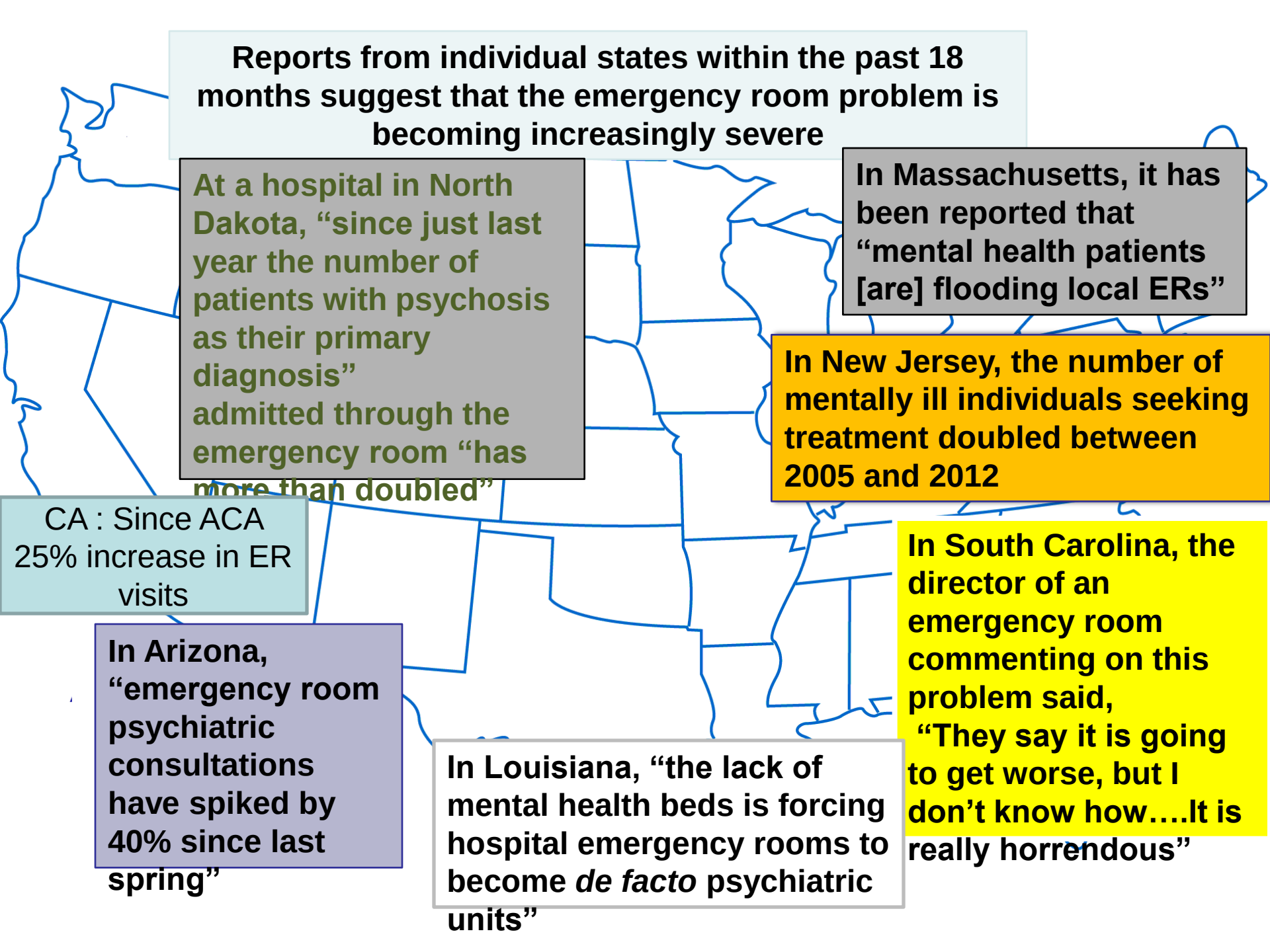
A National Public Health Problem

- The number of behavioral health patients treated in EDs has been steadily rising
- In 2000 5.4% of adult ED visits were MH related, in 2007 it had increased to 12.5%. Mental Health Dx now account for anywhere from 10-20 percent of patients in the ED
- Yet 2014 NSDUH survey found of the pop 18.1% with MH and 8.1% with SUD in the past yr. = Largely unchanged.


Reports from individual states within the past 18 months suggest that the emergency room problem is becoming increasingly severe
At a hospital in North Dakota, "since just last year the number of patients with psychosis as their primary diagnosis" admitted through the emergency room "has more than doubled"
In Massachusetts, it has been reported that "mental health patients [are] flooding local ERs"
In New Jersey, the number of mentally ill individuals seeking treatment doubled between 2005 and 2012
CA : Since ACA 25% increase in ER visits
In Arizona, "emergency room psychiatric consultations have spiked by 40% since last spring"
In Louisiana, "the lack of mental health beds is forcing hospital emergency rooms to become *de facto* psychiatric units"
In South Carolina, the director of an emergency room commenting on this problem said, "They say it is going to get worse, but I don't know how….It is really horrendous"

Emergency room visits up for drug-related suicide attempts

By Jonathan Shorman, USA TODAY

Updated 06/17/2011 12:54 AM

Emergency room visits by men ages 21 to 34 involving drug-related suicide attempts increased 55% from 2005 to 2009, according to a report out today by the Substance Abuse and Mental Health Services Administration.

Use of prescription drugs in particular increased significantly, it says. Attempts involving anti-depressants increased 155% and those with anti-anxiety and insomnia medication rose 93%.

"I think a lot of these people don't see these drugs as dangerous because it's a nice, clean little pill," says Peter Delany, director of the Center for Behavioral Health Statistics and Quality at SAMHSA.

Doctors should ask patients about their mental health as well as their physical health before prescribing drugs, Delany says. "You've got to monitor everybody you have on a medication."

The use of narcotic pain relievers such as hydrocodone and oxycodone in suicide attempts rose 73%, the study says. Prescription drugs accounted for more than 90% of the suicide attempts.

Delany says take-back programs that allow people to get rid of old meds can prevent misuse.

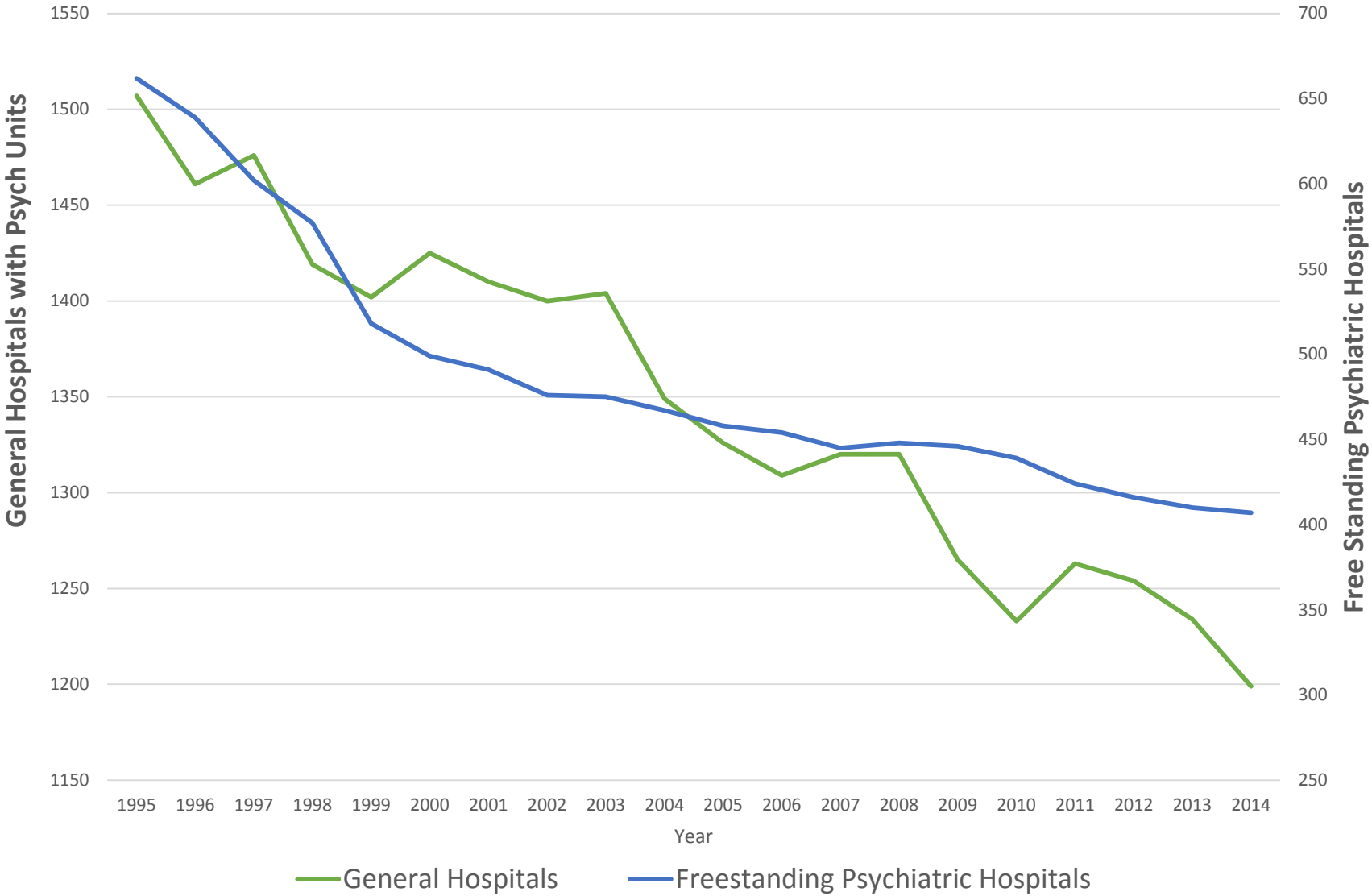
Despite the increase in drug-related suicide attempts, the report may contain one upside.

"It's good to hear that men are coming to the ER," says Paula Clayton, medical director of the American Foundation for Suicide Prevention. Often men don't seek help after an overdose or suicide attempt, she says.

Impact on the ED

- Survey of ED physicians found psych pts are boarded more than twice as long as medical patients. ED staff spend twice as much time locating inpatient psych beds
- Longer stays: ACEP ED Behavioral Health Study/Survey found **79** percent psychiatric patients are boarded in their ED
- 2012 Harvard Study: Psych patients spend avg. of 11.5 hrs per visit in the ED. Those waiting for inpatient beds avg 15 hrs.

Psychiatric Inpatient Care Units and Freestanding Psychiatric Hospitals, 1995-2014



SOURCE: Health Forum, AHA Annual Survey of Hospitals, 1995-2014.

- Hospitals with a psychiatric unit are registered community hospitals that reported having a hospital-based inpatient psychiatric care unit for that year.

- Freestanding psychiatric hospitals also include children's psychiatric hospitals and alcoholism/chemical dependency hospitals.

Impact on the ED

- In 2012 survey 90% of ED Directors reported boarding psych patients every week with more than 55% with daily boarding. In New Hampshire, 62% waited more than 24 hrs for involuntary admissions
- 6-10% are in the ED more than 24 hrs
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What Typically Happens in the ED

- Under treatment or no treatment, because of lack of expertise
- 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/training in MH/CD problems, leads 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 in the ED, 59 % no substance abuse or dual diagnosis services available,23% no community psych services
- Over admission to inpatient: For 2010 AHRQ reported 2.5 times the rate for other conditions.
- Discharge Problems : Often leaving without referral due lack of knowledge of community resources and 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.
- 2008 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

Care Experience

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**
- **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

One of the most comprehensive studies was done by Boudreaux and O'Hea in 2004 and replicated by Press Ganey and Gallup . Their 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***
  - ***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.

BH Patients Experience in the ED

- "Why do I have to treat this person with a self inflicted wound, instead of someone with a serious problem"
- "What do I do with them once I find they have a problem? They can't live here."
- "Here he comes again."
- "I waited hours to be seen…they saw other people while I waited…no one cared."
- "They don't even ask why I cut myself they just sent me to the hospital…I didn't need to be in the hospital I needed someone to talk to"
- "Even though I was hallucinating I could hear them talking about me as a crazy psych patient"
- "Every time mom and dad get mad at me they drop me off in the ED."

Disturbing reports regarding ignoring or misdiagnosing medical complaints

“I had pain in my abdomen. Once the ED doctor found out I had been in a facility for an eating disorder, she blamed the pain on eating food. The next day I found out I had a cyst in my ovary. They didn’t believe it was real pain. The doctor didn’t listen about my pain…”

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/

ED plays an important role in Suicide Prevention:

- US Suicide rate has grown since 2006. CDC reports 13 per 100,000 in 2014, the highest since 1986.
- 1 in 10 suicides by people seen in ED within 2 months or less of dying. Many were never assessed for suicide risk (Nat'l Suicide Prevention Lifeline)
- Dallas' Parkland Memorial Hospital implemented universal screening in the ED and Hospital 150,000 patients and found 1.8% of patient at high suicide risk and 4.5% at moderate risk.

  (Jacobson S, Sept. Dallas Morning News, Sept 2015)
- 10% of all ED patients have suicidal thoughts (US prevention task force, 2015)

TJC – Sentinel Alert

- Recognizes increasing rate of suicide
- Prev. suicide attempts or self-inflicted injury: the risk of suicide is 100% greater than general suicide rates for the next year.
- Discharge from inpt. Psych: within the first yr after and particularly the firs t weeks and months of discharge
- 1,089 suicides occurring between 2010-2014 at 24 hr care or within 72 hrs of discharge including an ED many without a risk assessment.

Revised Joint Commission Patient Flow Requirements

Standards revised to enhance patient safety in ED & hospital-wide by addressing:

- use of data and metrics to better manage patient flow as a hospital-wide concern;
- safe provision of care for patients should boarding occur; and
- mitigating risks experienced by patients with psychiatric emergencies who are boarded in the emergency department.

Community Connection

Effective January 1, 2014

LD.03.04.11 EP9: When the hospital determines it has a population at risk for boarding due to behavioral health emergencies, hospital leaders communicate with behavioral health care providers and /or authorities serving the community to foster coordination of care for this population.

Joint Commission Surveyor Considerations

- Patient flow a hospital-wide concern
- Boarding a symptom of flow problem
- ED a symptom but not always source
- Focus on quality & safety (not elimination of overcrowding or boarding), especially for behavioral patients in ED
- Dynamics beyond individual accredited hospital (local, regional, national)

Key Concepts for Improving Connection in the ED

- Security and Nursing Observation tool
  - Training
  - Protocols
- Improving the Physical Setting
- Clinical Interventions
  - Active non-judgmental listening, acceptance of pt's feelings, eliciting patients thoughts about suicidality, ideas about what would lessen his or her suicidality.
  - Move patient to a quiet area, reduce stimulation, remove objects that can be used as weapons, verbal de-escalation, medication, restraints DO NOT WAIT TO BEGIN TREATMENT
  - Use of medication in treatment of agitation
  - Restraints as last resort

Issues Facing Hospitals

- Overall cost of care
- Increased Medicaid and other coverage
- Value based purchasing, ACOs, need to accept risk, need behavioral health
- BH not ready to take risk, risk has to be identified for plans, et al.
- Demand for hospitals to become part of network
- No integration of care, so up the learning curve
- No cost based reporting = no basis for care
- Most efficient care will be contractors' objective

Additional Impinging Issues

- Health plans behind in thinking out implications. Starting to move out of exchanges and into Medicaid.
- DSRIP: California, Texas, Massachusetts, Kansas, New Jersey, New Mexico and New York, others on the way (Alabama, New Hampshire and Illinois) = major emphasis on BH
- Parity
- Workforce isn’t prepared

Effects on Emergency Departments

- Future success of plans, ACOs depends on continued connection.
- Multiple care managers = Who ya gonna call?
- DSRIP requires attention to behavioral health
- Quicker is not necessarily better. Connection, placement and long term reduction in cost is objective
- Health plans, ACOs can be your friend

Implied Improvements

- Plans and ACOs should help you with transitions
- Identifying coverage can speed placement
- Emergency care becomes part of a continuum
- More pressure to discharge with problems unless the plan sees better long term outcomes
- Medication is not a long term answer

Discharge Planning

- What care are you providing while boarding the patient if admitting to psychiatric hospitals or hospital alternative programs: ?
- Crisis Stabilization Programs
- Crisis Residential Programs
- Case Management
- Outpatient Resources: Develop and document a crisis plan
- Use of Peers
- Follow-up is essential in preventing suicide. Develop network of community and professional resources: National Suicide Prevention Lifeline – 3-5 follow-up phone calls

Reducing Boarding

- Reducing Boarding reduces cost and potential for harm
- Payers want this change and can help
- Out of ED is cheaper, but not if it causes frequent readmits
- Use these points in making the case for better systems of care
- Be prepared for new pressures and use them to build a new system of care
- Both the patient and the hospital benefit