New England Regional Healthcare Risk Management Conference

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Reinventing the ED for America's Mental Health Crisis

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Presenter

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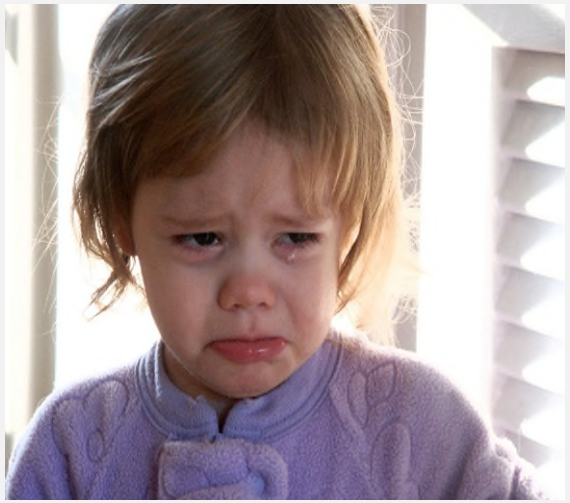
Please refer to the Presenters' Bios available on the table and online for more information

If You Only Remember One Thing…..

The disparity in the care of mental health and substance use patients in the ED

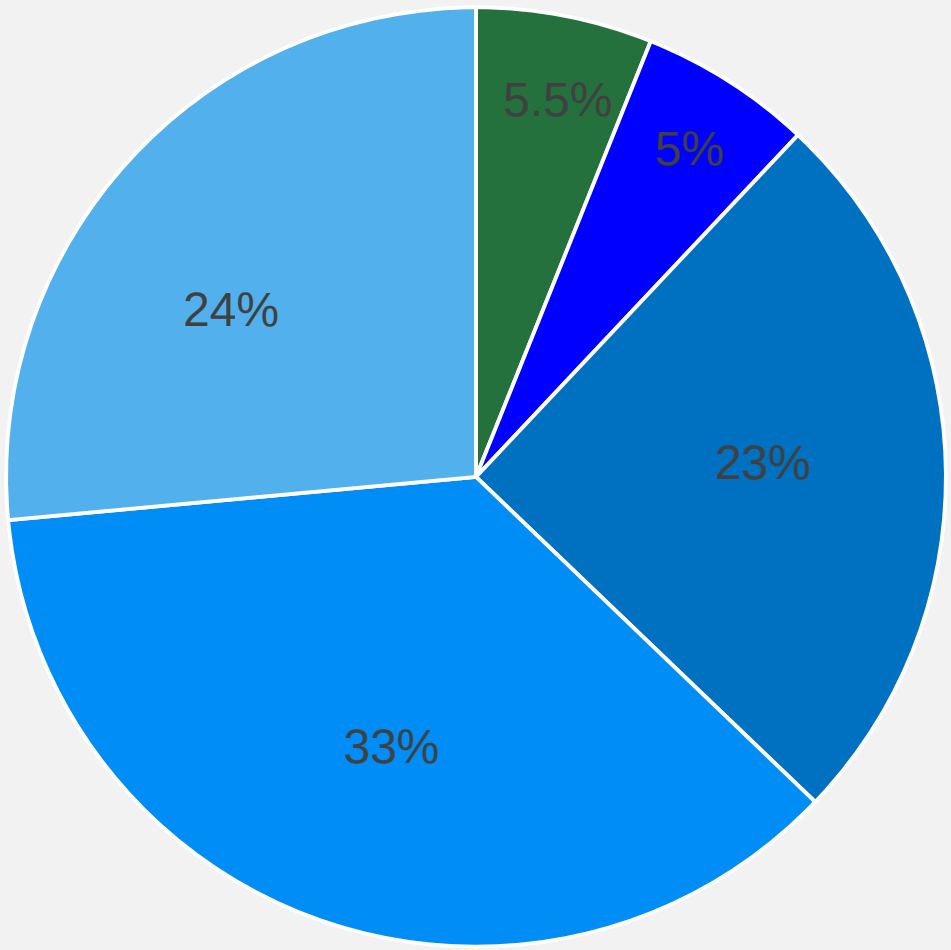
is unsafe, inhumane, & unacceptable



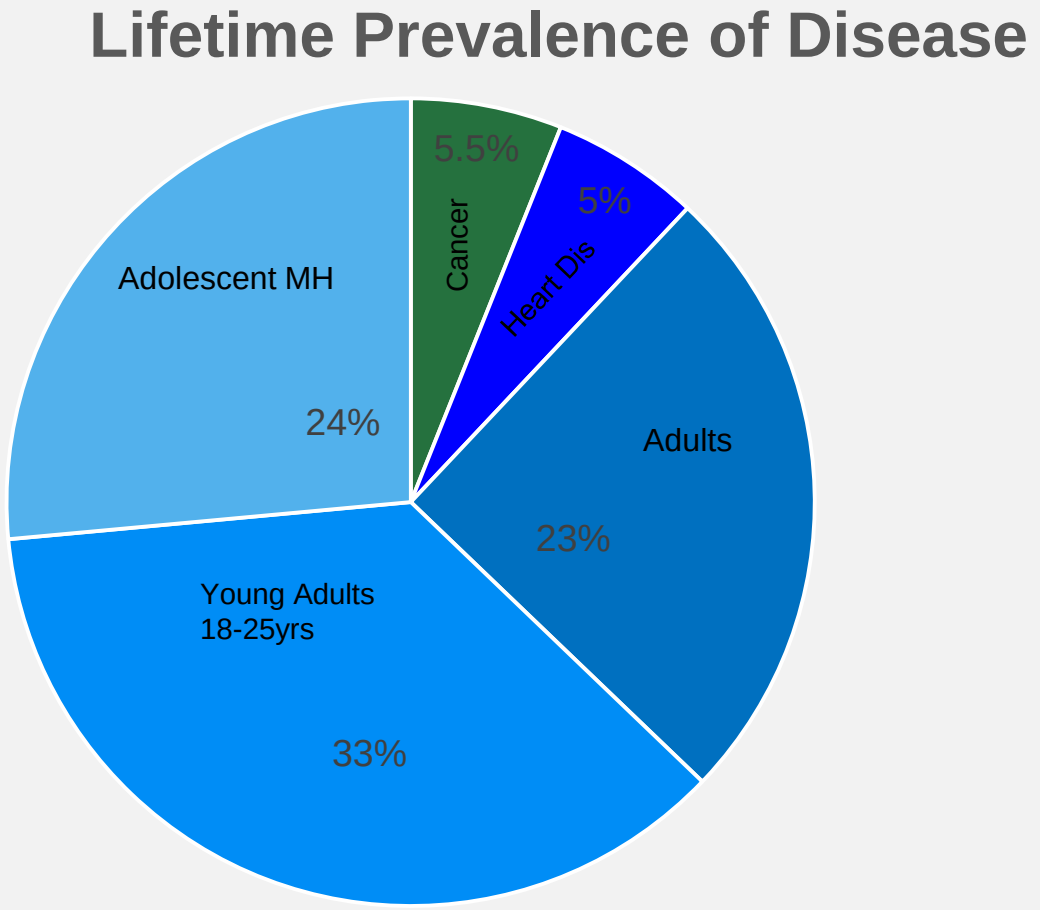
Objectives

- Discuss the current state of mental health ED presentations and the impact on the organization.
- Identify the reasons and the urgency to begin to reshape the care provided in ED's for mental health and substance use patients.
- Describe at least two strategies that can create efficient and safe care for mental health patients.

Lifetime Prevalence of Disease



Heart Disease and Cancer are Small Potatoes



What *Exactly* is a MH Crisis/Emergency?

- Any situation in which a person's behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community

- Person is overwhelmed, uses ineffective use of coping mechanisms leaving them disorganized and with intolerable thoughts and life processes

- Suicidal, violent, extreme panic, hallucinations/paranoia, dangerously intoxicated, or overwhelmed with life situations/symptoms of illness or injury so that they cannot function

These sound like emergencies

MH/SUD Patients in the ED: Current State

- Literature reports that MH/SUD presentation is 3% to 13%
- Rate of SUD adults increased from 74.4 per 10,000 (2018-2019) to 103.8 (2020-2021) per 10,000
- Stays are three times longer than non-MH/SUD patient blocking at least two medical patients from more timely care.
- 55% and 84% will be discharged without ever seeing a MH professional

ED-BH Presentation is Higher Than We Know

Indiana University Study – Nov 2022

- 794 participants presenting to ED with a medical condition
- Completed a computer adaptive test to screen for 5 conditions: Depression, anxiety, PTSD, suicidality, substance use disorder
  - * 45% - Patients in ED for physical injuries have a MH or SU disorder
  - * 24% - Moderate to severe risk for suicidality
  - * 8.3% - for depression
  - * 16.5% for anxiety
  - * 12.3% for PTSD
  - * 20.4% for substance use disorders
- 2+ ED visits in previous year had 62% increased odds of being intermediate-high suicide risk compared to those with no prior visits
- Persons in the intermediate-high suicide risk group had 63% greater odds of another emergency department visit within 30 days

The ED Dilemma

- Historically well manage emergent medical conditions
- Ill-suited for MH/SUD
- Lack of staff training/education
- Lack of adequate/safe design
- Limited or lack of resources for MH/SUD clinical care/treatment
- Lack of available inpatient settings for transfer
- Limited or no community resources for aftercare referral
- Delayed follow up appointments

FACT: MH/SUD presentations will continue to rise well into the future

ED Healthcare Workers Beliefs

- They don't belong here
- We don't have time to deal with them
- We are overtaxed enough with hundreds of patient presentations
- I don't like working with these patients
- They are not dying/emergent
- I didn't sign up for this
- They just want 3 hots and a cot
- I'm scare of them and don't know how to manage them
- The ED is not designed to handle these patients
- Someone else should take care of them

IT'S NOT WHAT WE DO!

MH/SUD Patients Beliefs

- Coercive and Restrictive Practices ("terrifying, dehumanizing, isolating")
- Judgmental and inappropriate comments
- Staff are impatient/Lack of care and emotional support
- Lack of communication of information and involvement in decision making
- Inadequate space and lack of privacy making them feel vulnerable
- Overstimulating environment, unwelcoming
- Needs not met: cultural, food, drink, bathroom
- Discriminatory treatment
- Like a prison ("I didn't do anything illegal")
- Discharge information/pamphlets walking out the door not useful

Care in Many ED's

- Clothing and belongings removed
- Placed in empty room with nothing to do (or hall bed)
- Frightening/agitating environment
- Monitored by police/security/person staring at them
- Long wait to be seen/assessed
- No room to move about/confined
- Over stimulated by the noises/sounds/hectic activity
- Little if any attention/intervention/support
- Staff with little time or competency
- Ignored, afraid, stigmatized
- May be restrained for severe agitation/aggression
- Long waits for transfer or discharge
- Wasted time when therapeutic healing can occur

ED Visit Effect on MH/ SUD Patients

- Poor outcomes – re-presentations to ED
- Negative Emotional Impact – shame and guilt
- Re-traumatization
- Heightened symptoms
- Fear of future help seeking
- Harm or Death after discharge

Boarding

- MH/SU patients are boarded for hours or days
- One survey revealed that “11% of all ED patients were boarded but 21.5% of all psychiatric ED patients were boarded” ACEP Jul 22, 2019
- MH patients remain in ED 3.2 times longer compared to medical patients
- ED Providers report more medical boarders than MH boarders when there is a separate MH ED area/setting

Why is Boarding Such an Issue?

- Delays in treatment
- Increased risk of patients leaving without being seen (LWBS)
- Increased ED and inpatient length of stay (LOS)
- Reduced patient satisfaction
- Increased staff stress
- Violence toward ED personnel
- If not housed in the ED: 2.2 medical patients could be treated
- A 1-hour reduction in overall ED boarding time could result in $9,693 to $13,298 of additional daily hospital revenue by capturing LWBS patients and diverted ambulances
- Others have found that completely eliminating patient boarding, patient elopements, and ambulance diversions could result in $3.9 million in annual revenue or cost savings

IT'S UGLY

Let's Change the Status Quo

Beginning with

THE ENVIRONMENT OF CARE

Scott Zeller, MD

- In 2012, Scott Zeller, head of psychiatric emergency services at the Alameda Health System, in Oakland, California
- Zeller thought ED's were missing a more fundamental point.

"Why is mental illness the only emergency where the treatment plan is, Let's find them a bed somewhere?"

"If someone comes in with an asthma attack, we don't say, 'We've got a gurney here in the back for you. We're going to try to find you an asthma hospital in a day or two, so sit tight."

- For psychiatric patients, this transitional time was therapeutic dead space—a missed opportunity.

COULD IT BE TRANSFORMED INTO A PERIOD OF HEALING?

EmPATH: Emergency Psychiatry Assessment, Treatment, and Healing

- Concept originally the “Alameda Model”
- Emergency Crisis Stabilization
- *Separate area that treats MH/SU patients in a safe, therapeutic setting*
- Up to a 1-2 day stay with active treatment (can be less)
- Effectiveness: data demonstrates that up to 80% of patients can achieve stability within 24 hours
- Data claim: Seventy-five percent of patients treated in an EmPATH unit stabilize and return home within 24 hours without admission or boarding
- Some ED’s have established Psychiatric Emergency Services (PES)
- Often, current PES does not provide the level of quality or empathetic care

EmPath Model for the ED

EmPATH Space Design

- Separate secure space that is calm and communal (natural lighting or windows)
- Open Nurses Station
- An open communal care setting (recliners)
- Sensory rooms – music, rocking chairs, bean bag chairs
- Snacks, beverages, Possibly exercise equipment (bike)
- Shower
- Distractions: books, magazines, TV, games freely available, art items
- Staff with psychiatric care competencies
- Single-patient observation/quiet rooms
- Rooms for intake, consultation, and counseling

EmPATH Staff

- Psychiatrist or Advance Practice Clinician
- Psychiatric Nurses
- Mental Health Technicians
- Psychiatric Social Workers
- Recovery Peer Support
- Security: ONLY if clinical interventions have failed and support is needed

Care Model

- Non-aggressive MH and SUD patients are treated
- Quick/supportive assistance through the open design
- Staff are integrated into the milieu – not walled off
- Provider evaluation soon after admission
- Supportive therapy/counseling begins
- Peer Recovery Specialist interaction
- Medication management/adjustment

Benefits

- Therapeutic setting to support compassionate care
- Human interaction, which is incredible important during crisis
- Trained, skilled, empathetic staff
- Comprehensive evaluation/medication management
- Initiation of therapy
- Avoids inpatient hospitalization/transfers
- Safety/well being of staff and patients
- Increase patient satisfaction
- Reduced restraint/seclusion
- Reduce hospitalizations
- Substantial improvement in outcomes

Financial Impact

- Annually, estimated three-quarters of a million emergency-department visits for mental-health crises
- Average monetary cost to board ED-BH patient estimated at $2,264
- Cost related to less efficiency/morale of staff
- Can break even or organization may have to tolerate the losses in exchange for:
  * Clinically humane, empathetic care
  * Reduced workplace violence events
  * Improved throughput
  * Elevated staff satisfaction and morale
  * Reduced need for psychiatric beds – averted admission, averted ED diversion, etc.
  * Decreased readmissions to ED
  * Elimination of transfer to medical unit due to long lengths of stay
- Some EmPATH's rely on grants from local/state governments

BUT Why the ED?

- The ED IS the place for crises/emergencies
- Community care settings that exist cannot manage all the presentations
- Lack of care crisis care settings – often limited to lower acuity patients

NO SAFELY DESIGNED
THERAPEUTIC SPACE RIGHT NOW?

LEADER SUPPORT NOT THERE YET?

NEVER PLAN ON DEVELOPING AN EmPATH?

Start Here….

- Establish a safe area or pod to treat multiple MH/SU patients as a “pod”
- Utilize Mental Health Technicians (routine care and monitoring)
- At least one psychiatric RN on each shift
- Psychiatric Nurse Practitioner at least 16 hours per day (Tele-sych?)
- Social Worker to provide for supportive crisis counseling and discharge planning
- Recovery Peer Support personnel

Provide at Least Minimal Competency

The quality of the helping relationship with positive interactions IS protective against the negative experiences of care

- Establishment of the therapeutic relationship with the patient
- Communication and active listening
- Principles of psychiatric care management
- Proactive and crisis use of medications
- Withdrawal syndromes
- Restraint/seclusion-federal guidelines and documentation
- Non-violent crisis intervention – to include *non-escalation*
- Assessment practices (suicidality, aggression, withdrawal status, etc.)
- Documentation of behaviors, interventions, and patient response

ED Patients With Substance Use Disorders

- Unique position to start treatment for alcohol & opioid use patients
- Screening tools for alcohol and opioid use
- Brief interventions (5 minutes): Proven to be effective in reducing alcohol consumption/harmful events post discharge
- Evidence based withdrawal protocols
- Protocol for medication assisted treatment
- Patient/Provider Agreements for inpatient admission

Policies/Procedures/Protocols

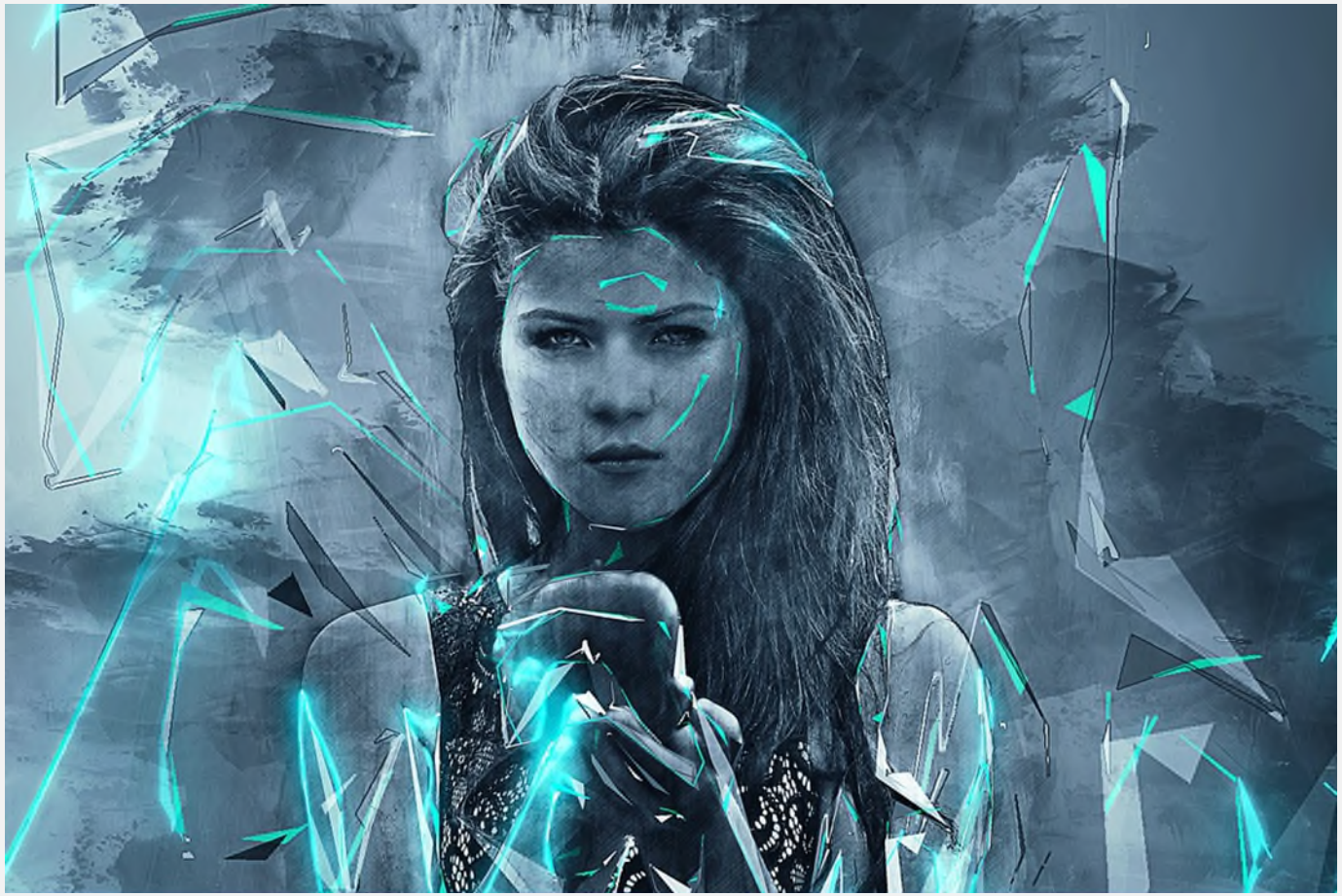
- Frequent reassessment of patients (every hour) by an RN
- Initiate rapid treatment of agitation with the goal to calm, not sedate
- Regular use of appropriate medications to reduce anxiety, agitation (PRN?)
- Revise policy on Suicidal Patient Care
  * Allow for telemonitoring of high-risk patients (multiple)
  * Outline various levels of observation based on risk assessment

Minimize/Shift Fiscal Resources

- Decrease the use of 1:1 – monitor multiple patients, routinely assess for decreased levels of risk
- Instead of ED nurses/techs, use psychiatrically competent staff
- Instead of Security managing patients, use a "Safety Specialist"
- Use of Tele-psych

Risk Management Considerations

- Workplace violence
- Restraint/Seclusion
- Human Resource Risk
- Complaints/Grievances
- Regulatory Risks – OSHA, Dept. of Heath, CMS, TJC
- Legal risk related patient harm or violations in care



Conclusion

- The situation is dire
- ED's will never <u>not</u> have to manage MH/SUD emergencies until societal priorities/laws/reimbursement change well into the future
- MH/SUD patients are our Mothers, Fathers, Sisters, Brothers, Children, Friends, etc.

Remember One Thing:

The disparity in the care of mental health and substance use patients in the ED is

Unsafe

Inhumane

Unacceptable.

LET'S FIX IT.

Suggested Tools

SBIRT -Screening, Brief Intervention and Referral for Treatment (SBIRT) Https://health.maryland.gov/pophealth/Documents/Local%20Health%20Department%20Billing%20Manual/PDF%20Manual/Section%20IV/SBIRT%20Toolkit.pdf (Massachusetts)

Design of BH Crisis Unit: https://fgiguidelines.org/resource/design-of-behavioral-health-crisis-units/

AUDIT-C - Alcohol Use Disorders Identification Test

DAST-10 - Drug Abuse Screen Test

Resources

- https://fgiguidelines.org/wp-content/uploads/2022/06/FGI-Design-of-BHCUs_2022-06.pdf
- TJC Quick Safety 19 - ED boarding of psychiatric patients, www.thejointcommission.org
- National Institute on Drug Abuse (Tools) https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools
- Exploring the therapeutic relationship in nursing theory and practice, Mental Health Practice 24(8), July 2021, https://www.researchgate.net/publication/353494451_Exploring_the_therapeutic_relationship_in_nursing_theory_and_practice
- Sine, David, Hunt, James. White paper: Design Guide for the Built Environment, January 2022, https://www.bhfcllc.com/design-guide

THE END

THANK YOU

Questions/Comments?

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Questions/Discussion