Best Practices for Evaluation and Treatment of Crisis Patients – the Missing Links

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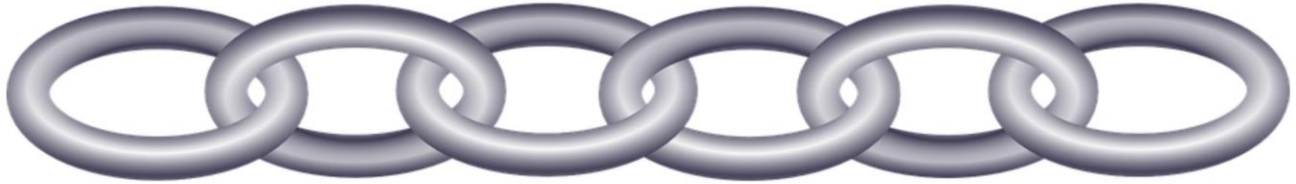


Throughout California since Lanterman-Petris-Short began, five decades ago to today

- Patients in crisis told to “call 911 or go to the nearest emergency room (aka Emergency Department, ED)
- 911 calls often result in a 5150 hold, with patients brought to nearby hospital ED for medical evaluation
- Assumption that most 5150 patients will be sent to a psychiatric inpatient bed for 72 hours or more after the ED

Focus for the past decade has been on community-based crisis solutions, with a goal of reducing the numbers of patients going to hospital EDs

- But the number of behavioral health patients coming to hospital emergency departments has only INCREASED during the past 10 years

- Behavioral emergencies are now 1 in every 7 patients in hospital ERs nationwide! CA ED stays often *average* over 30 hours.

- **HOSPITALS NO LONGER LOOKING TO EXCLUDE, NOW REALIZE "THESE ARE OUR PATIENTS TOO" AND ARE WILLING TO ENGAGE WITH QUALITY, TIMELY CARE**

Many wonderful community crisis programs have been created with the hopes of reducing ED use for psychiatric patients – but here's why these often don't solve everything, and many emergency psychiatry patients still come to the ED:

1) **These programs tend to be set up for mild-to-moderate severity patients**
2) **They have exclusion algorithms for the more acute patients, which resort to 'send to the ED' or 'call 911"**

Common Exclusion Criteria for Community Crisis Centers

- ✓ **Patients who are currently agitated/aggressive or history of violence**
- ✓ **Patients with profound symptoms of psychosis/disorganization**
- ✓ **Patients with severe suicidal ideation or a serious suicide attempt**
- ✓ **Patients with active substance/alcohol intoxication or withdrawal**
- ✓ **Patients on involuntary status or with active criminal charges**
- ✓ **Patients pronounced comorbid medical issues**
- ✓ **Patients with vital signs abnormalities**
- ✓ **Patients with serious developmental disabilities/neurologic issues**
- ✓ **Patients who have utilized the crisis program too frequently/recidivists**
- ✓ **Patients who refuse indicated medications**

Since many psych patients are still going to be coming to most EDs, *we should begin care there* rather than only board to wait for inpatient. Most psychiatric emergencies can stabilize and be discharged in less than a day if treatment is started promptly, just as in all other medical emergencies.

Boarding

- Definition: Patients in hospital medical EDs on 5150s who are medically stable and just waiting for a psychiatric evaluation or disposition.
- Often these patients are kept with a sitter, or in “holding rooms” or hallways on a gurney – often with no concurrent active treatment
- ED environment itself can often make crisis patient symptoms worse

ERs always accept ALL with no discrimination!

- Emergency Departments have long been at the forefront for equity impacting racial, ethnic, LGBTQ and other populations, catering to everyone in need immediately
- Federal law* states legally ERs cannot turn anyone away, must evaluate all people who request help, for presence of emergency medical conditions, and then attempt to stabilize, without consideration of ability to pay
- Federal law* defines psychiatric emergencies as medical emergencies
- Suggesting behavioral emergency patients “don’t belong” in ERs and should be only seen in community is stigmatizing, discriminatory, “wrong door”

*Emergency Medical Treatment and Active Labor Act (EMTALA)

Boarding Solutions Suggested

- Most suggestions – even ideas that include community-based drop-in care and mobile crisis units – still follow concept that virtually all ***emergency*** psychiatric patients need hospitalization as the only possible disposition
- Results in far too many patients being unnecessarily hospitalized at a very restrictive and expensive level of care
- Roughly equivalent to hospitalizing every patient in an ED with Chest Pain (typically only 10%-20% of such patients get hospitalized)

Wrong Solutions: Treating at the Destination instead of the Source!

- All these solutions call for more availability for hospitalizations, nothing innovative at the actual ED level; **efforts to stabilize a crisis should not only be focused in the community and then have efforts end at the ED front door**

- Change in approach needed – beginning with recognition that **the great majority of psychiatric emergencies can be stabilized in less than 24 hours, in less time than they would be boarding in an ED waiting for an inpatient psychiatric hospital bed to open**

- *To* reduce boarding in the ED, shouldn't the approach be at the ED level of care? Understanding that **there are different levels of acuity for conditions, and we wouldn't insist plane crash victims be treated at the corner urgent care –** there also should be a psych care continuum with **hospitals, EDs and community together as complementary**

Mental health professional stationed in ED, or ED access to Telepsychiatry

- Great improvement over mere boarding, but typically is used only to determine ‘yes or no’ on need for inpatient admission, no treatment is commenced, and patient remains in same suboptimal ED environment until disposition
- So how to improve on this?

The "Six Goals for Emergency Psychiatric Care"[1]

1. Exclude medical etiologies and ensure medical stability
2. Rapidly stabilize the acute crisis
3. Avoid coercion
4. Treat in the least restrictive setting
5. Form a therapeutic alliance
6. Formulate an appropriate disposition and aftercare plan

1. Zeller, *Primary Psychiatry*, 2010

EmPATH

Emergency **P**sychiatric **A**ssessment **T**reatment **H**ealing

Research shows that **75% or more** of severe psychiatric emergencies can be **stabilized within 24 hours**

What makes the EmPATH Approach Different?

- Designated destination for all medically-cleared patients in crisis prior to determination of disposition or IP admission; not viewed as an alternative destination but *THE* destination
- Designed and staffed to treat all emergency psychiatric patients – philosophy of “no exclusion”
- Immediate patient evaluation and treatment by a psychiatrist, constant observation and re-evaluation
- Provides a calming, healing, comfortable setting completely distinct from the Medical ED
- Wellness and Recovery-oriented approach

Physical Space Design

Calming, healing environment that prioritizes safety and freedom

Large, open ‘milieu’ space
where patients can be together in the same room – high ceilings and ambient light, soothing decor

Designed to facilitate
socialization, discussion, interaction and therapy

Per chair model
outfitted with fold-flat recliners

Space recommendation
80 sq. ft. total per patient, which includes 40 sq. ft. patient area around each recliner

Open nursing station w/instant access to staff
No ‘bulletproof glass fishbowl’ separate from the patients

Voluntary Calming Rooms
Avoids locked seclusion rooms or restraints

A Calming, Comfortable Environment

Diverse Professionals Staffing the Unit

EmPATH is an academic term, not copyrighted or licensed, and each unit differs

Multidisciplinary Team Approach

- Psychiatrists/Psychiatric Providers
- RNs
- Social Workers
- Psychiatric Assistants
- LVNs/ LPTs
- Peer Support Specialists

Patient Benefits

Trauma-informed Unit, a home-like care setting different from a chaotic ED; relaxation, movement, recreation encouraged

Multi-disciplinary Treatment Team involved from arrival to disposition

Rapid Evaluation by Psychiatrists, ensuring care integration with comprehensive care plan development

Calming Environment that best meets patients' needs, can serve themselves snacks, beverages, linens

Constant Observation & Re-evaluation leads to much higher diversion from hospitalization

Restraint Elimination Typically far less than 1%

Academic Emergency Medicine
A GLOBAL JOURNAL OF EMERGENCY CARE

Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) Unit Decreases Hospital Admission

Published: 17 August 2021

- **Reduced ED boarding from an average of 16.2 hours to just 4.9 hours (70% reduction!)**
- **Reduced inpatient psychiatric admissions by 53%!** ***(from 57% of patients to just 27% of patients)***
- **Improved the outpatient follow-up of patients from 39.4% to 63.2% (60% improvement!)**
- **Reduced 30-day psych patient return to ED (recidivism) by 25%**

M Health Fairview's new EmPATH approach to mental health crises shows 58% reduction in hospital admissions to just 17% of all patients

KSTP.COM EYEWITNESS NEWS

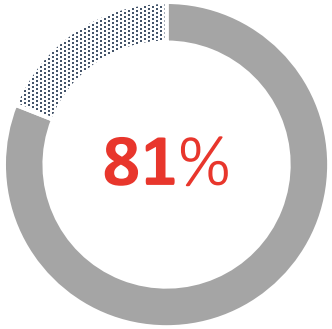
Providence Little Company of Mary EmPATH, Los Angeles

12-Chair EmPATH Unit (opened November 2017)

Solution

- ✓ Board-certified onsite psychiatrists and telepsychiatrists
- ✓ Nursing leadership
- ✓ Psychiatric nursing education
- ✓ Collaboration to enhance patient experience & operational efficiency

Results



Patients Discharged
To home or community programs

16 hours

Average LOS

>3,500

Annual Visits

0.2% Restraints
0.1% Patient injury

Safety

Dignity Mercy San Juan EmPATH, Carmichael, CA

Collaboration between Hospital and **Sacramento County** - Opened September 2019

Celebrating the Early Wins

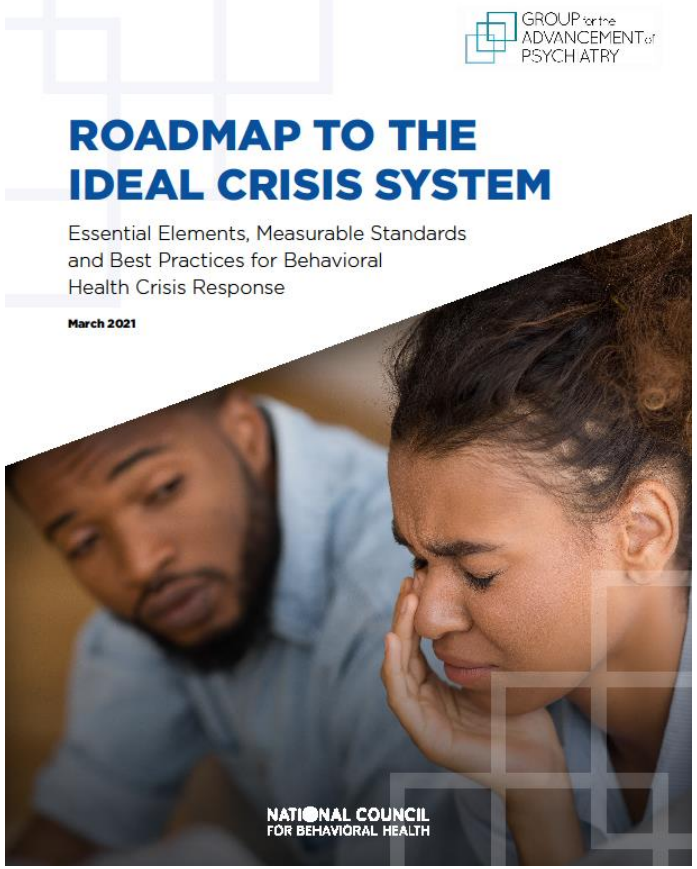
- ✓ Baseline boarding time for psych patients in the ED FY ‘19 was 32.9 hours – in the first month this fell to 19 hours, by December the average was 7.6 hours (**77% reduction**)
- ✓ Since opening, restraints have only been used **one time** (January 2020)

FY 2021 Impact (July – Oct)

- ✓ Avg ED Length Of Stay before transfer = 6.3 hours (median = 4.3 hours)
- ✓ From Medical Clearance in the ED to CSU Acceptance = 1 hour
- ✓ 80% of patients discharged home
- ✓ Patient Satisfaction = 85%
- ✓ Average telepsychiatry response time after-hours = 35 mins
- ✓ ED Recidivism = declined 30%

EmPATH Units complement community crisis programs, for the highest-acuity patients

- *National Council for Mental Wellness*, ***"Roadmap to the Ideal Crisis System"***: specifically cites EmPATH units in their recommendations, saying that there "should be at least one in every mental health system"



Financial Benefits of EmPATH units for County Mental Health Medi-Cal reimbursement

- On average, **EmPATH units stabilize 75% of the 5150 patients they see** – in a typical ER, 100% of these patients by definition would be sent to inpatient hospital beds. Therefore, EmPATH units avoid an expensive inpatient hospitalization in three out of every four patients!
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- Typical inpatient stay cost to county Medi-Cal: $12,000
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- Typical EmPATH unit county Medi-Cal reimbursement: $2,000
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- Thus: for every four patients at $2,000 = $8,000, EmPATH units save county mental health the cost of three inpatient stays at $12,000 = $36,000.
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- **So for every $8,000 a County Mental Health Medi-Cal pays for EmPATH care, they avoid $36,000 in inpatient payments – documentable savings!**


Thank
You