Strategies to Integrate Care of the Chronically Mentally Ill in Crisis

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Learning Objectives

• To review the problems with limited resources for psychiatric patients
• To define crisis and emergency conditions of mental health patients
• To understand the needs of the psychiatric patient
• To consider care options for these patients
• To review means to integrate their care
Boarding

• Definition: Patients in hospital medical Emergency Departments 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 – some languishing for hours in physical restraints, often with no concurrent active treatment

• Some psychiatric boarders even kept in the very expensive option of the Intensive Care Unit because of need for close supervision
Boarding Across the USA

• Studies showing average psychiatric patient in medical emergency departments boards for an average of between 8 and 34 (!) hours

• 2012 Harvard study: Psych patients spend an average of 11.5 hours per visit in ED; those waiting for inpatient beds average 15-hour stay

• 2012 CHA Study: After decision made for psychiatric admission, average adult waits over ten hours in California EDs until transferred
Impact of Boarding

• Boarding is a costly practice, both financially and medically

• Average cost to an ED to board a psychiatric patient estimated at $2,264

• Psychiatric symptoms of these patients often escalate during boarding in the ED

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Psychiatric Patients Adding to ED Overcrowding

• Patients waiting for a psychiatric bed wait three times longer than patients waiting for a medical bed in hospital EDs.

• ED staff spend twice as long locating inpatient beds for psychiatric patients than other patients

• Psych patients boarding in an ED can cost that hospital more than $100 per hour in lost income alone\(^1\)

1. Treatment Advocacy Center, 2012
What is a Mental Health Crisis?

- Status post suicide attempt or violent behavior
- Extreme emotional disturbance or behavioral disturbance
- Considering harm to self or others
- Florid Psychosis or Active Manipulation
- Disoriented
- Compromised ability to function
- Otherwise agitated and unable to calm
What is an Emergency Psychiatric Condition?


- Imminently threatening harm to self or others
- Severely disoriented
- Severe inability to function
- Otherwise distraught and out of control
What is the Right Setting?

• Mental Health or Psychiatric Office
  • Walk in?
  • Primary Care
  • Psychiatry

• Alternatives
  • Community Mental health
  • Living room
  • Hospital at home
  • Home health

Hospital - Outpatient
  • Emergency Department
  • Psychiatric Urgent Care
  • Crisis stabilization Units

Hospital-Inpatient
Where Patients Go Depends on the Problem?

- Life or limb threat  
  - Suicidal  
  - Homicidal  
  - Unable to care for self  
  - Acute medical problem  

- Medication related  
  - ER  

- Patient in crisis  
  - Crisis Care  
  - Office/Drop in  

- Inter-personnel issue  
  - Crisis Care
Crisis Care Options

Mobile Crisis Units

- Refer to psychiatrist, counselor or family physician
- Safety plan
- Contact call services – National Suicide Prevention Network, NAMI, Crisis call centers
- Support systems
- Peer mentor
What do the Psychiatric Patients Want?

Allen 2013.

- Verbal interventions
- Collaborative approach to care
- Use of oral medications
- Input form patient regarding medication experiences and preferences
- Increased training of ED staff
- Peer support services
- Improved discharge planning
- Concerns about triage process
- Long waits for treatment
- Lack of privacy
Alternatives to Going to the ER

- Case management
- Psychiatric urgent care
- Mobile crisis care
- Combined services
- Sobering centers
- Crisis residential
Interviews were conducted with 2578 homeless and marginally housed persons

40.4% of respondents had 1 or more emergency department encounters in the previous year;

7.9% exhibited high rates of use (more than 3 visits)

Factors associated with high use rates
  - Less stable housing
  - Victimization & arrests
  - Physical and mental illness
  - Substance abuse.

Targeted underlying risk factors among those exhibiting high rates of use.
Homeless


- Case management of chronically homeless, alcoholic persons
- Compared intervention to controls
- Reduced ED visits by 12.1 ED visits for 6 months
- Reduced 8.5 inpatient days
- 18 participants intervention group accepted shelter
- None in control group accepted housing
Psych Urgent Care Services

• Psychiatric evaluation, counseling and medication, referral to long-term treatment,
• Does not take incoherent, extremely aggressive or need emergency medical attention
• Group therapy
Mobile Crisis Units

  - Comparison of mobile unit to ED admission rate
  - ED admitted 3x more than mobile units
Divert Prior to the ED

2002
- Therapeutic Justice Initiatives
- Probation
- Parole
- Community Reintegration
- MI Offender’s Facility
- Substance Abuse Treatment Facility 1
- Substance Abuse Treatment Facility 2

2012
- CHCS Public Safety Net
- Jail Diversion
- Step-downs
- Police, Sheriff, Fire-EMS Joint Community Based Crisis Intervention Training
- Data, Research & Innovation
- Rehabilitation
- Veterans Jail Diversion Trauma Recovery
- San Antonio State Hospital or other Inpatient Hospitals
- Residential Services - Section 8 Housing
- Community Outpatient Clinics
- Adult/Child Services Next Day Apt
- Opioid Addiction
- Opioid Pregnant Females
- HIV Outreach
- Outpatient Alcohol and Drug Counseling
- Respite Services

Restoration Center
- Crisis Outreach Teams (MCOT)
- 23 hr Hold Med Clearence
- CTU Transitional Contract Beds
- Psychiatric Evaluation
- Substance Abuse
- Forensic
- Outpatient
- Competency
- Restoration
- Civil Probate Court
- Involuntary
- Outpatient
- Commitment

Prospect Court Yard-Haven for Hope
- Homeless
- Safe Sleeping
- Peer Advocates
- MH Clinic
- 80 Bed MH Residential
- SA In House Recovery
- Sobering
- Detox
- Injured Prisoners
- SA Outpatient Tx
- Drug Court

Crisis Care Center
- Appropriate Disposition
- Long Term Health, Residential and Day Hab
- Home Health, Developmental Disabilities, ECI, Head Start
- Opioid Addiction
- Opioid Pregnant Females
- HIV Outreach
- Outpatient Alcohol and Drug Counseling
- Serving
- Adults
- Families
- Children
Patient Types-Alcoholic
Sobering Center-Definition

- Facilities that provide a safe, supportive environment for mostly uninsured, homeless publically intoxicated persons to become sober
- Alternative holding facility for patient who are intoxicated
- Alternative to jail holding cell or ED
- May go directly to sobering center by police, ambulance or center sponsored transport
- May go to an ED first
- May receive counseling and referrals
Crisis Oriented Residential Treatment


- For acutely distributed chronic patients
- For acutely decompensated patients that might need acute hospitalization
- Highly structured
- Group and individual therapy
- Therapeutic activities
- Expectations of appropriate behavior
- Cost effective
- Reduction of hospital admissions
Psych EDs and PESs

- 3,964 Emergency Departments
  - 42,000 ED MDs/27,990 EM Board certified
- 140+? Psychiatric ERs or PESs
  - Staffed by psychiatrists with psych training
  - No sub-specialty in emergency psychiatry

<table>
<thead>
<tr>
<th></th>
<th>PES or Psych EDs</th>
<th>Regular or Medical EDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>Psych only</td>
<td>All comers</td>
</tr>
<tr>
<td>Physicians</td>
<td>Psychiatrists</td>
<td>Emergency Physicians</td>
</tr>
<tr>
<td>Length of Stay</td>
<td>1-3 days</td>
<td>Hours</td>
</tr>
<tr>
<td>Psych Treatment</td>
<td>Therapeutic</td>
<td>Non-therapeutic</td>
</tr>
<tr>
<td>Treatment Modalities</td>
<td>Limited</td>
<td>All except psych tx</td>
</tr>
</tbody>
</table>
What is the Role of the ER?

Medical Clearance Process

• Drug and alcohol intoxication or withdrawal
• Medical
  • Hypoglycemia
  • Hyperthyroidism
  • Delirium
  • Head Trauma
  • Temporal Lobe Epilepsy
• Psychiatric
Evaluation Concerns
Who Does the Psychiatric Evaluation

• ED MD
• In-house psychiatry
• ED mental health worker
• Telepsychiatry
• Community mental health
• Outside contracted mental health worker
ED Treatment
Interventions

• **Brief intervention**  Fleishmann: Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries Bull WHO 2008;86:703-709.
  • International study of 8 EDS
  • Brief intervention and enhanced follow up
  • Reduced number of deaths

  • 18 month study of female Hispanic patients
  • Soap opera video, family therapy, and staff training
  • Reduced suicide re-attempts and ideation
ED Treatment
Medication

• Re-start prior meds
• Start new medications
  • Psychiatry via telepsychiatry
  • Assistance from C and L service
• Medications to start in ED
  • Antipsychotics
  • Mood stabilizers
  • Benzodiazepines
ED Discharge

• Set up follow up appointments
  • 62,746 COPD patients, 66.9% had PCP follow up
  • Patients who follow up visit reduced the risk of an ED visit and readmission

• Begin case management
  • Involve social work and pharmacy
  • Set up home health services
  • Med reconciliation and F/U phone calls

• Communicate with PCP
  • Hand off to primary care
Admission Criteria
Does the Patient Need to Be Admitted?

• Not always an easy decision
• Use of admission criteria or guidelines for many conditions
  • Risk to self
  • Risk to others
  • Unable to care for self
• Alternatives to inpatient stay

• Crisis Triage Rating Scale

• Scores three categories 1-5
  – A. Dangerousness
  – B. Support system
  – C. Ability to cooperative
• Scoring
  – 9 or more – outpatient/crisis intervention
  – 8 or less - admit
For Discharged Patients from ER

• Clear, detailed discharge plans tailored to patient, family, clinicians, case managers and payers
  • Teach self-care
  • Improved instructions and instruction process
  • Patient read back
  • Encourage self-management

• Safety plan

• Physician/nurse/social worker phone calls

• Assign a patient navigator
Psychiatric Patient Admission Criteria
Does the Patient Need to Be Admitted?

• Not always an easy decision
• Use of admission criteria or guidelines for many conditions
  • Risk to self, Risk to others, Unable to care for self
• Improved assessment for admission
  • Telepsychiatry
  • Diversion programs
  • Suicide risk assessment
• Alternatives to inpatient stay
Inappropriate Psychiatric Admissions

- Legal and liability of sending psychiatric patients home
- Secondary utilizes such as police, group homes, nursing homes and families
  - Send to ED to resolve conflict
- Lack of appropriate assessment
  - Difficulty in obtaining collateral information
  - Problem with obtaining old medical “psychiatric” records
- Iatrogenic escalation of the patient while in the ED
## Appropriate for Psych OBS

### Severity of Illness

<table>
<thead>
<tr>
<th>Severity</th>
<th>Description</th>
<th>Suicidal</th>
<th>Disposition</th>
<th>Need for Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable</td>
<td>Functional, works</td>
<td>None</td>
<td>Outpatient</td>
<td>No</td>
</tr>
<tr>
<td>Low level</td>
<td>Had medical or psych stressor</td>
<td>Mild</td>
<td>Outpatient</td>
<td>OBS</td>
</tr>
<tr>
<td>Moderate</td>
<td>Decompensated, agitated</td>
<td>Moderate</td>
<td>Psych consultation</td>
<td>Yes</td>
</tr>
<tr>
<td>Severe</td>
<td>Severe decompensation</td>
<td>High</td>
<td>Inpatient care</td>
<td>Yes</td>
</tr>
</tbody>
</table>
No Beds for Inpatient Care

• What options available besides admission?
• What other institutions can I go to?
• Is insurance coverage the issue?
Alternatives

• Admit to inpatient unit
  • 34% Peds patients admitted to inpatient beds
    • Sharfstein, 2000
  • 33% adult patients admitted to medical floor
    • Mansbach, 2003
Alternatives to Inpatient Admission

• Brief admission
• Day hospital
• Crisis respite
• Psychiatric home health
• Case management
• Comprehensive psychiatric emergency program
• Overnight observation
• Acute stabilization units
Brief Admission Programs


• Functions
  • Acute treatment
  • Brief intensive therapy
  • Long term supportive re-socialization or rehabilitation

• Day hospital
  • Usually 5 days a week for 2-3 months
  • Mon-Friday

• Patient types
  • Not suicidal, homicidal or assaultive
  • ? Psychotic patient & substance use disorders
Day Hospital vs. Crisis Respite Care


• Voluntary patients in need of acute psychiatric care
• Compared day hospital/crisis respite program to inpatient stay
• Programs were equally effective
• Average cost savings of $7,100 per patient
Psychiatric Home Health


• Psychiatric nurses, social workers, home health aides, and occupational therapists visit the patient with a primary psychiatric diagnosis in the patient's own home.

• CMS broadened the service capacity by allowing all physicians, not just psychiatrists, to sign a Medicare psychiatric plan of care.

• Resulted in significant reduction in both hospital admission and recidivism rates.
Case Management in the ED
Advocate Illinois Masonic

• The Medically Integrated Crisis Community Support (MICCS) Team, was created in the Spring of 2014. It combines the typical range of interventions to stabilize a crisis with new interventions and methods. It mirrors the intensity of ED care, but seeks to move that level of care into community settings and transition brief, high-cost interventions into longer, engagement-oriented support episodes.
Comprehensive Psychiatric Emergency Program


• By law emergency psych eval, tx and dis, extended OBS to 72 hours
• 20% brought by police, self/family 63%
• Dx
  • Schizophrenia 27%
  • Drug and alcohol 14%
  • Bipolar 13%
  • Depression 11%
• Inpatient 43%
Observational Care

Appropriate use of OBS units for psychiatric patients

- Psychosis
- Suicidal
- Depressed
- Anxiety
- Alcohol and drug intoxication/withdrawal
- Social situation

Requirements

- Provides adequate stability and containment
- Availability of consultation liaison service
Overnight Observation in VA Medical Center


• Designed to avoid unnecessary admissions
• 92 pts in 1996, came through ED

• Characteristics
  • 80% unemployed, 41% homeless
  • 55% suicidal or homicidal ideation
  • 49% intoxication, 77% substance use
  • 88% referred to outpatient

• 9.8 inpatient days before and 2.7 days after
• No variables to determine inpatient care
Acute Stabilization Units


• Functions
  • Allows time for diagnostic clarity
  • Develop alternatives to admission
  • Respite function
  • Denies dependency needs

• Patient types
  • Schizophrenia
  • Personality disorder
  • Sucidality
  • Substance use disorders

• 41% of total patients seen
Sinai CSU

• Establish pilot to determine the best practice
• Treatment safe/low stimulation milieu to rapidly assess, stabilize and discharge patient
• Population adults 18-64 self-preservation & ADLs
• Capable of decrease pt boarding time in ED
• Increase utilization of ED resources/beds
• Increase pt access to psych services/tx
• Earlier psych consult & meds
• Increase pt connection with outpatient services
• Initiate psych assessment earlier in process
Sinai CSU

• Size
  • 1800 sq. feet
  • 12 beds/treatment spaces

• Staffing
  • RN 2 per shift
  • Techs 3 per shift
  • Security 1 per shift

• Type of patients
  • Suicidal
  • Depression
  • Psychotic
  • Substance use disorder co-occurring)
Sinai CSU

• Psych assessments
  • ED
  • Q 4 hours

• Current Volume
  • 5-7 pts per day
  • Percent admitted – 47% target 25%

• Current Throughput time
  • ED 7 hours
  • CSU 15.2 hrs.
Challenges

• Timeliness of evaluations
• Treatment protocols
• Collaborate with county sheriff, Chicago police
• Increase volume
• Peer program
• Psychiatrists used to different model of care
• Patient satisfaction assessment
• What department is it under
Psychiatric Regionalization Models

• Psychiatric Emergency Care
• Sobriety Centers
• Substance use disorders
• Homeless
• Psychiatric and medical care
• Pediatric Psych
• Geriatric Psych
Benefits to Regionalization

• Benefits
  • Reduce Costs
  • Experience
  • Enhanced services
  • Better care
  • Examples – stroke, trauma, chest pain, peds

• Concerns
  • Time delay
  • Transportation risk
  • Clinical deterioration
  • Inter-transfer resources
  • Handoff communications
  • Neglected patient preferences
The Key Is Collaboration
Psychiatric Regionalization

• Arizona-Pima County
  • Walk in psychiatric services
  • Substance abuse/detox center
  • Psych ED
  • 24 hr. Obs
  • Inpatient beds
  • Hub for 24 hr. crisis hotline
  • Mobile response deployment

• Minnesota
  • Crisis system and licensing

• Colorado
  • Crisis Care
  • Substance Use treatment
  • Jail based
  • Family oriented
  • Integration with medical home
  • Juvenile and adolescent care
Alameda Model

• Serves as a Regional Dedicated Psychiatric Emergency Service (PES) for all of Alameda County, large county with population > 1.5 Million (Oakland, Berkeley, Fremont etc.)

• Accepts patients from all eleven (11) adult medical Emergency Departments in the region as soon as medically stable, regardless of insurance coverage
Alameda Model – John George PES

- John George Psychiatric Hospital is a stand-alone psychiatric-only campus, part of eight-campus medical center
- Main affiliated medical ED is 12 miles away
- John George campus has 69 inpatient psychiatric beds and EMTALA-compliant PES
- PES has attending-level psychiatrists on duty 24/7/365
2014 Alameda Model PES Study

• Compared medical ED psychiatric patient boarding times and hospitalization rates in a system with a Dedicated Regional Psychiatric Emergency Service to statewide averages in California

• Published in Western Journal of Emergency Medicine
  http://escholarship.org/uc/item/01s9h6wp
Regional Dedicated Emergency Psychiatric Facilities

- Can accept self-presentations and ambulance/police directly, only medically-unstable psychiatric patients go to general EDs

- Accepts medically-stable transfers from area medical EDs that do not have psychiatric care onsite

- “Higher Level of Care” outpatient service so no need to wait for “a bed” to transfer from general ED – comparable to transferring patient to a trauma service from general ED
Regional Dedicated Emergency Psychiatric Facilities

- Will treat onsite up to 24 hours (or longer in some areas), avoiding many inpatient stays

- Discharge rates within first 23 hours of 70% or higher very common, meaning less that 30% admitted to inpatient beds – better for patients and preserves inpatient bed availability

- Of great interest to insurance companies, which are often willing to pay more than daily hospital rate for single day of crisis stabilization to avoid multiple-day inpatient stay
Alameda Model

• Almost no police transport of patients for psychiatric evaluations, which can “criminalize a psychiatric crisis”

• Instead, peace officers placing a 5150 hold summon an ambulance, then paramedics do a field screening with criteria approved by PES and EMS

• Transport decision based on medical stability
  • Medically stable go directly to PES (2/3 of all patients)
  • Medically unstable go to nearest of 11 area Emergency Departments for medical clearance (1/3 of all patients)
Improving Transitions

- How to accomplish a good transition
- Hand offs
- Follow up appointment
- Patient navigator
- Peer mentors
- Care managers
Improving the Hand Off Process

• Formal standardized process
  • Reduces variation
  • Clarifies one-to-one or in a group
  • Stipulates process

• Technique
  • Clear language
  • Use effective communication techniques
  • Standardized the process
  • Add predictability
  • Use technology

• Types of handoffs
  • Physicians
  • Nurses
  • Allied health providers
  • Students, residents, others

• Outside resources
• Family/relatives
Peer Mentor Program


• Peer based patient support program for the hospital ED

• Goals
  • Understanding policies and procedures
  • Treated with dignity and respect
  • Act as liaison
  • Meaningful work for consumers
  • Challenge stigma about consumers role in recovery

• Accessed patient satisfaction
  • With peers 38%
  • Without peers 34%
Psychiatric Handoffs

- Inpatient to outpatient
- ED to outpatient
- ED to inpatient
- Inpatient to community mental health
- Others
  - Pharmacy
  - Social work
Value of Patient Navigator


• Role of patient navigator
  • Support and guidance throughout healthcare continuum
    • Coordinates appointments
    • Maintains communications
    • Arranges interpreter services
    • Arranges patient transportation
    • Facilitates linkages to follow up

• Study of patient navigators
  • 423 patient navigator and 513 in control
  • 12.1% were readmitted in patient navigator group and 13.6% in control group.
How to put it all together

• Who are the stakeholders?
  • Law enforcement
  • Corrections
  • Substance abuse
  • Hospitals
  • Community mental health
  • ACOs
  • Patients

• Who has the resources?

• What services are needed?
  • Homeless
  • Mental health
  • Substance use disorders

• What is the projected costs?
  • Physical plan
  • Personnel
  • Equipment

• What are the projected savings?
  • Hospitalizations
  • Incarcerations
Take Home Point

• Look for ED deflection programs such as mobile crisis teams and law enforcement for those that do not need an ED
• Some patients can go home after ED evaluation with or without telepsychiatry
• Consider admission options such as observation, short stay or crisis respite
• Work on regionalization of care
• Improve the transition process
Chronically Mentally Ill in Crisis

Other Options
- Psychiatric Home Care
- Living Room
- Crisis Phone Service
- Crisis Mobile Units
- Integrated Services
- Crisis Stabilization Unit
- Observational Care
- Psychiatric Urgent Care

Emergency Department

Mental Health or Community Mental Health
- Psychiatrist
- Mental Health Worker
- Community Service

Inpatient Care

Day hospital

Crisis Stabilization Unit

Psychiatric Home Care

Psychiatric Urgent Care
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