Improving Care in Crisis: Should I (or my Patient) Go to the ER?

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Objectives

• When do I (or my patient) need to go to an ER?
• What are the problems with going to an ER?
• What is a better way to care for mental health patients in the ER?
• What other options do I (or my patient) have besides the ER?
• What do we need to make it better?
What is a Mental Health Crisis?

- Non-life threatening situation
- Extreme emotional disturbance or behavioral disturbance
- Considering harm to self or others
- 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
Where Patients Go Depends on the Problem?

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

- Medication related

- Patient in crisis

- Inter-personnel issue

ER

Crisis Care
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
Is There a Better Option Than Going to an ER for a Crisis?

• Refer to psychiatrist, counselor or family physician
• Safety plan
• Contact call services – National Suicide Prevention Network, NAMI, Crisis call centers
• Support systems
• Peer mentor
Psychiatrist or Mental Health Offices

- Is the office open?
- Do they have walk in hours?
- Do they know me?
- Is there a call in number?
Mobile Crisis Units

- Mobile Crisis Units


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

- MI Offender’s Facility
- Substance Abuse Treatment Facility 1
- Substance Abuse Treatment Facility 2
- Criminal Courts
- Mental Health
- Felony Drug
- Misdemeanor Drug
- NGRI
- Community DWI
- Forensic Outpatient
- Competency Restoration
- Civil Probate Court
- Involuntary
- Outpatient Commitment
- Therapeutic Justice Initiatives
- Probation
- Parole
- Community Reintegration

2002

CHCS Public Safety Net

2012

- Jail Diversion
- Step-downs
- Data, Research & Innovation
- Police, Sheriff, Fire-EMS
- Joint Community Based Crisis Intervention Training
- Veterans Jail Diversion Trauma Recovery
- San Antonio State Hospital or other Inpatient Hospitals
- Residential Services - Section 8 Housing
- Community Outpatient Clinics
- Psychiatry
- Adult/Child Services Next Day Appt
- Outpatient Addiction
- Opioid Pregnant Females
- HIV Outreach
- Outpatient Alcohol and Drugs Counseling
- Long Term Health, Residential and Day Hab
- Home Health, Developmental Disabilities, ECI, Head Start
- Adults
- Seniors
- Children

Crisis Care Center
- Appropriate Disposition
- Psychiatric Evaluation
- 23 hr Hold
- Med Clearance
- CTU Transitional Contract Beds

Restoration Center
- Substance Abuse Services
- Drug Court
- Injured Prisoners
- SA Outpatient Tx
- MH Clinic
- 80 Bed MH Residential
- SA In House Recovery

Prospect Court Yard - Haven for Hope
- Homeless
- Safe Sleeping
- Peer Advocates
- Long Term Health, Residential and Day Hab
- Home Health, Developmental Disabilities, ECI, Head Start

NAMI...
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
The Living Room Model
Michelle Heyland, MSN, APN, PMHNP-BC; Courtney Emery, MA, LCPC; Mona Shattell, PhD, RN

• Community crisis respite center that offers individuals in crisis an alternative to ED.

• Patients deflected from EDs - 213 of 228 visits or a 93% deflection rate.

• Deflections represent a savings of approximately $550,000

• In 84% (n=192) left The Living Room and returned to the community
Sobering Center

- 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
- Safe place to “sleep it off”
- Alternative to jail holding cell or ER
- May go directly to sobering center by police, ambulance or center sponsored transport
- May go to an ER first
- May receive counseling and referrals
Psychiatric 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
Psych ERs 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>
Problems with ERs

- Overcrowded
- Chaotic, loud, bright
- Not patient centered
- All patients with psychiatric complaints are treated the same
- Lack of expertise in mental health
- Overuse of restraints, seclusion and medications
- Competing patient priorities
- Long waits
- Inensitive
- Bad attitudes
Psychiatric Boarders
Adult Demographics

- 53 million mental health related visits
- Increase from 4.9%-6.3% of all ED visits from 1992-2001
- 17.1 to 23.6% visits per thousand over 10 years
  - Increase in non-Hispanic whites, elderly and those with insurance
- Diagnoses
  - Substance-use disorders 22%
  - Mood disorders 17%
  - Anxiety related 16%
- Treatment 61% in ED
Psychiatric Boarders
Burden of Care

  - 86% ED administrators indicated they are often unable to transfer pts
  - >70% of ED administrators report boarding > 24 hrs; 10% report > 1 wk
  - > 90 percent of survey respondents say this boarding reduces the availability of ED beds

  - 67 % of the emergency physicians reported a decrease in the number of psychiatric beds
  - 23% send ED patients home without seeing a mental health professional due to a lack of resources
  - 76% reported a lack of resources
    - Psychiatrist availability – 31% community, 3% rural and 81% teaching

NAMI National Convention
Denver. July 6-9, 2016
Patient’s ER Experience
NAMI Video
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
- Shorter waits for treatment
- More privacy
What About Psychic Pain?

• Introspective experience of negative emotions
  • Anger, despair, fear, grief, shame, guilt, hopelessness, loneliness and loss
• Do the mental health patients in the ED suffer psychic pain?
• Should it be evaluated and treated like somatic pain?
• Does psychic pain manifest as agitation?
Does Psychic Pain Manifest as Agitation in the Emergency Setting: Results of the Pilot

Leslie Zun, MD, Professor and Chairman, Department of Emergency Medicine, Chicago Medical School, Mount Sinai Hospital, Chicago, IL
Lavonne Downey, PhD, Assistant Professor Public Administration, School of Policy Studies, Roosevelt University, Chicago, IL

Objectives
The objective was to determine a patient’s level of psychic pain when they present to an emergency Department and whether there was a relationship between this psychic pain and the patient’s level of agitation.

Introduction
Some in the field of emergency psychiatry believe that patients who are agitated are exhibiting psychic pain. The argument is that somatic pain is no different than psychic pain. If the level of agitation can be used as a surrogate marker of psychic pain, it could explain many patients presentations.

Methods
A convenience sample of 100 patients presenting to the ED that fit criteria when a trained research fellow is present have been enrolled.

Urban, inner-city trauma level 1 hospital with 60,000 ED visits a year. After obtaining consent, the fellow administered 4 validated tools for assessing agitation and a psychological pain assessment at admission.

Tools for assessing agitation
Brief Agitation Marker (BAM) Positive and Negative Syndrome Scale-Excited Component (PNSS) Agitation Calmness Evaluation Scale (ACES) and Self-Reported Level of Agitation

Tools for psychic pain
Mee-Bunney Psychological Pain Assessment.

The data was analyzed with SPSS, Version 22.

Results
A total of 74 patients were enrolled at this time. The most ED diagnosis was depression, schizophrenia or bipolar disorder.

The self-reported tool demonstrated 20% none, 16% mild 21% moderate and 42% marked level of agitation.

ACES rating 55% as none/calm, 25% as mild, 14% moderate, and 5% as marked. BAM on the had 10% none, 16% mild, 31% moderate, 42% marked.

PANSS had 23% none, 31% mild, 8% moderate, and 5% marked.

MBPPAS has 4% none, 9% mild, 67% moderate, 19% marked significant with self report F= 5.5, p=.02

Discussion
Psychiatric patient frequently present to the emergency department with a high level of psychic pain and high level of self-reported agitation. This correlation may signal the need to address a patient’s level of agitation early in the evaluation process.

Limitations
Small sample size but enrollment is ongoing. All patients were enrolled from one inner city ED site.

Conclusion
Psychiatric patient frequently present to the emergency department with a high level of psychic pain and high level of self-reported agitation. This correlation may signal the need to address a patient’s level of agitation early in the evaluation process.

This study was underwritten, in part, by research grant from Teva Pharma.
Physician Frustration

Bystrek 2010.

• Little training in behavioral emergencies in emergency medicine residencies or psychiatric residencies
• Gap in detecting patients with substance use disorder
• Lack of education in care of psych patients
• More familiar with alcohol effects than drugs
• Substance abuse patients managed inadequately
• Shortage of services to treat these patients
Nursing Frustration

- Nurses perceive lack of knowledge, skills and expertise
- Triage risk assessment
- Frustration with frequent psychiatric patient visits
- Insufficient resources
- Ongoing patient and staff safety
- Feeling of helplessness at received broken mental health system
If I have to go to an ER, which One?

- Research ERs in your community before you need one
  Psych ER or Medical ER
- Call ahead
- Have your doctor or therapist the ER prior to arrival
- Prepare for an ER visit
Navigating the Healthcare System


- Have information available when going to the ED
- Medical conditions and illnesses
- Medicines you take
- Allergies and other known reactions
- Names and contact information
- Other helpful info like personal identification, insurance card, advance directive.
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%
What Happens in the ER?

• Medical Evaluation
  • Primary Purpose - To determine whether a medical illness is causing or exacerbating the psychiatric condition.
  • Secondary Purpose - To identify medical or surgical conditions incidental to the psychiatric problem that may need treatment.

• Testing
• Psychiatric Evaluation
• ?? Treatment

Schizophrenia
Bipolar Illness
Depression

Psychiatric

Drug intoxication/ withdrawal

Medical

Delirium
Dementia
Hyperthyroidism
Head Trauma
Temporal Lobe Epilepsy

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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
When is Treatment Indicated?

• Agitation
• Psychic pain
• Treat underlying psychiatric condition
• Treat medical conditions
Psychological Distress from Restraint and Seclusion


• Avoid restraint and seclusion
• Not treatment modality but treatment failure
• Reduction of use of seclusion and restraints
Treatment Recommendations


• General
  • Use non-pharmacologic approaches first
  • Use medication tailored to diagnosis
  • Adjust medication to level of agitation
  • Calm the patient do not “snow” the patient

• Medications
  • First generation antipsychotics- Haloperidol and Droperidol
  • Second Generation Antipsychotics
  • Oral vs. IM
Going Home
What Should I Expect?

• Hand off to a provider
• Referral to primary care provider, psychiatrist and/or mental health services
• Information about community resources
• Medications if appropriate
• Care plan
• Safety plan if suicidal
Going Home
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.
Admission Decision

- Obvious
  - Suicidal
  - Homicidal
  - Unable to care for self
- Not so obvious
  - Worsening condition
  - Low risk suicidal
  - Social situation
- Medical problem
# Admission Decisions

<table>
<thead>
<tr>
<th>Severity</th>
<th>Description</th>
<th>Suicidal</th>
<th>Disposition</th>
<th>Need for Admission</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>No OBS or CSU</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>
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
No Beds for Inpatient Care

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

• Observation
• Crisis Stabilization Unit
• Living room
• Day hospital
• Psychiatric home health
• Respite care
• Crisis drop in
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
Acute Stabilization Units


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

• Patient types
  • Schizophrenics
  • Personality disorder
  • Suicidality
  • Substance use disorders

• 41% of total patients seen
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 hospitalization 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.
Are There Any Solutions?

- Education and experience
- Need for standards
- Better triage process
- Improved evaluation
- Better treatment
- Reduce long waits and boarding
American Association for Emergency Psychiatry

• Multidisciplinary organization that serves as the voice of emergency mental health.

• The membership includes directors of psychiatric emergency services and emergency departments, psychiatrists, emergency physicians, nurses, social workers, psychologists, physician assistants, educators and other professionals involved in emergency psychiatry.

• AAEP promotes timely, compassionate, and effective mental health services, regardless of ability to pay, in all crisis and emergency care settings.

• AAEP sponsors educational programs
Improving Care for the Psychiatric Patient Coalition for Psychiatric Emergencies

• Group of more than 30 national leaders in emergency medicine, psychiatry and patient advocacy
• The Collaboration hopes to improve patient care:
  • Developing a continuum of care
  • Ensuring education and training for ED staff
  • Improving the treatment experience for patients and staff
  • Driving improved quality and safety of diagnosis
  • Decreasing boarding of psychiatric patients
Take Home Points

• Determine whether you need to go to an emergency room
• Consider other options for care
• Speak up for what you want
• Work with your local community to improve care
Contact Information

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December 7-9
Las Vegas
Treasure Island

7th Annual
National Update on Behavioral Emergencies

IBHI Pre-Conference Course Dec 7
Full Day Seminar Improving Care and Flow and Reducing Boarding for People With Behavioral Health Problems
See www.IBHI.Net

Only conference to address the behavioral emergencies in the acute care setting.

For emergency physicians, psychiatrists, psychologists, nurses, APNs, mental health workers, social workers, and physician assistants.

Every Registrant Receives
Behavioral Emergencies for the Emergency Physician

Selected Topics (Tentative)
Day 1
- Helping violent crime victims
- Self-Injury in the Emergency Care Environment
- Improved Medical Clearance
- Older Adults With Emergencies
- The Pediatric Psychiatric Patient
- International Agitation Guidelines
- 10 Articles that Changed my Practice
- Emergencies & Opioid Addiction
- Capacity to Sign Out AMA
- The Malingerer Patient
- The Use of Dialectical Therapy Standards and Benchmarks
- Integration of Community Crisis Care

Selected Topics (Tentative)
Day 2
- SPRCs Tools
- Coalition on Psychiatric Emerg
- Applying the Queuing Theory
- SIM Technology
- Crisis Intervention in the ED
- Care Integration
- PES Patient & Physical Problems
- Countertransference
- Opioid Prescribing from the ED
- Design and outcomes of an innovative disrupter patient and visitor program

Course Director
Leslie Zun, MD, MBA at zunl@sinai.org
For Further Details
www.behavioralemergencies.com

CME Approval pending
CEUs available for RNs and SWs

Discounted registration rates for AEP members
Reduced fee for allied health, nurses, residents and students

For further information contact Jamie Doucet at jamie.doucet
@rosalindfranklin.edu
773-257-6130

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