#NAMICon16

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

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NAMI National Convention

Denver. July 6-9, 2016

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?

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Substance Abuse and Mental Health Services Administration Center for Mental Health Services: PRACTICE GUIDELINES: CORE ELEMENTS FOR RESPONDING TO MENTAL HEALTH CRISES. www.samhsa.gov. Accessed April 24, 2016.

- 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?

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Substance Abuse and Mental Health Services Administration Center for Mental Health Services: PRACTICE GUIDELINES: CORE ELEMENTS FOR RESPONDING TO MENTAL HEALTH CRISES. www.samhsa.gov. Accessed April 24, 2016.

- 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 — ER
  - Suicidal
  - Homicidal
  - Unable to care for self
  - Acute medical problem
- Medication related — ER
- Patient in crisis — Crisis Care
- Inter-personnel issue — 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?

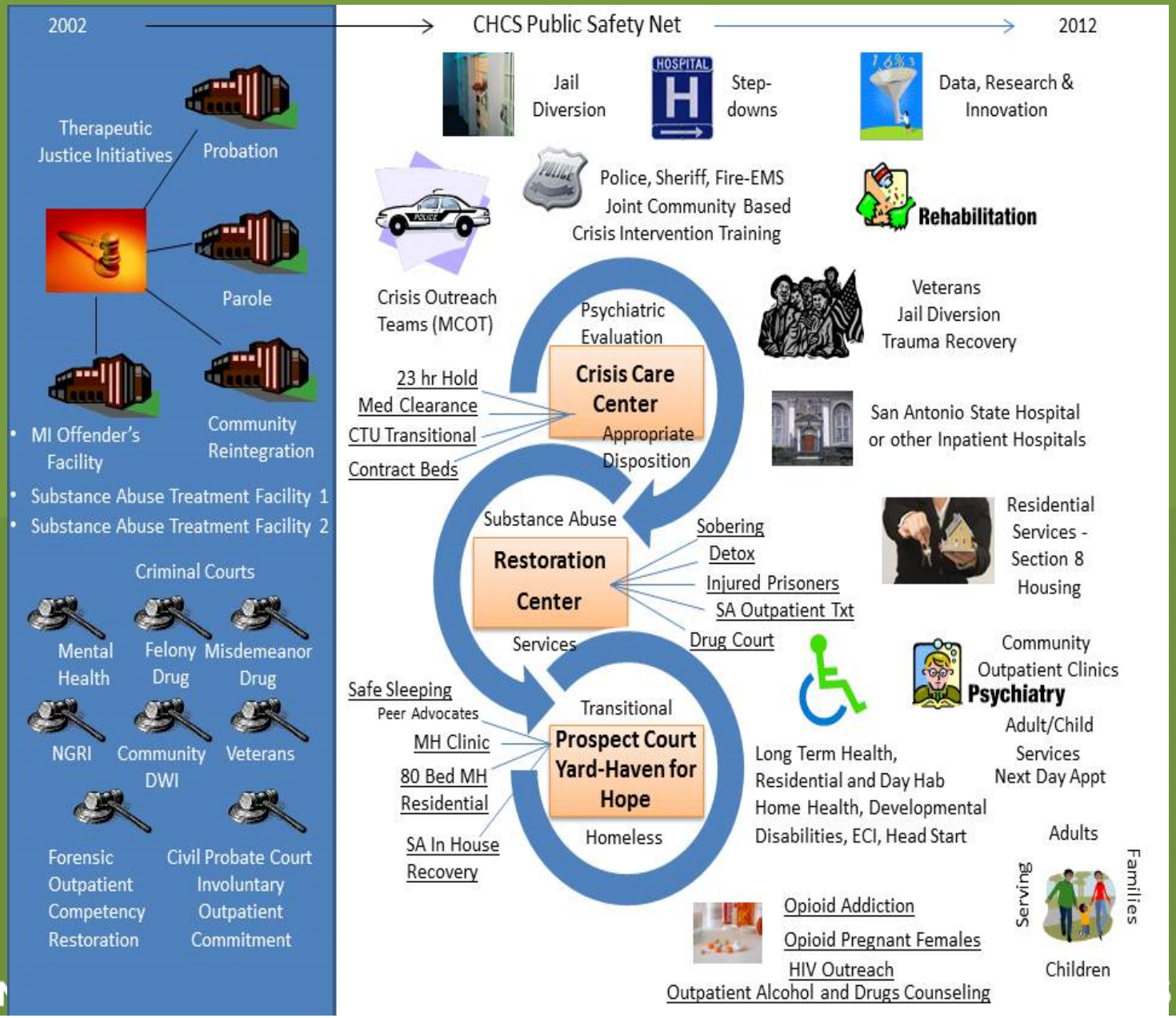
Mobile Crisis Units

- Mobile Crisis Units

Jugo, M, Smout, M, Bannister, J: A comparison in hospitalization rates between a community based mobile emergency service and a hospital-based emergency service. Aust N Z Psychiatry 2001;36:504-508.

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

Alternative to the ER



Crisis Oriented Residential Treatment

Weisman, GK: Crisis-oriented residential treatment as an alternative to hospitalization. Hosp Commun Psych 1985;36:1302-1305.

- 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

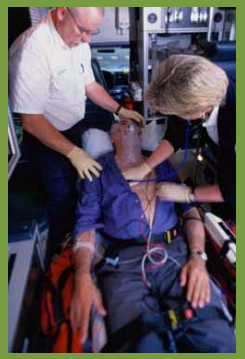
- 3,964 Emergency Departments
  - 42,000 ED MDs/27,990 EM Board certified
- 140+? Psychiatric ERs or PESs
  - Staffed by psychiatrists with psych training
  - No sub-specialty in emergency psychiatry

	PES or Psych EDs	Regular or Medical EDs
Patients	Psych only	All comers
Physicians	Psychiatrists	Emergency Physicians
Length of Stay	1-3 days	Hours
Psych Treatment	Therapeutic	Non-therapeutic
Treatment Modalities	Limited	All except psych tx

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
- Insensitive
- Bad attitudes

Psychiatric Boarders Adult Demographics



Larkin, GL, et al, Psych Services 2005; 56:671-677.

- 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

- ED Administrators Schumaker Group: 2010 Survey Hospital Emergency Department Administrators. http://schumachergroup.com/_uploads/news/pdfs/ED%20Challenges%20and%20Trends%2012.14.10.pdf.
  - 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

- Mental Health Patients Boarding in the ED Baraff LJ, Janowicz N, Asarnow JR. Survey of California emergency departments about practices for management of suicidal patients and resources available for their care. Ann Emerg Med. 2006 Oct;48(4):452-8, 458.e1-2. Epub 2006 Aug 21.
  - 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

Patient's ER Experience
NAMI Video

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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?

SINAI
Sinai Health System

Does Psychic Pain Manifest as Agitation in the Emergency Setting: Results of the Pilot

L S Zun[1], L Downey[2]

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2. 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 psyche pain when they present to an emergency Department and whether there was a relationship between this psyche 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 psych pain, it could explain many patients presentations. Addressing a patient's level of agitation could be used to reduce their agitation and thereby, reduce their psychic pain.

This study was part of a larger study of psychic

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

Tool 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, 63% 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

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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

AHRQ: Navigating the Health Care System. http://archive.ahrq.gov./news/navigatting-the-health-care-system/090109.htm. Accessed April 11, 2016.

- 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

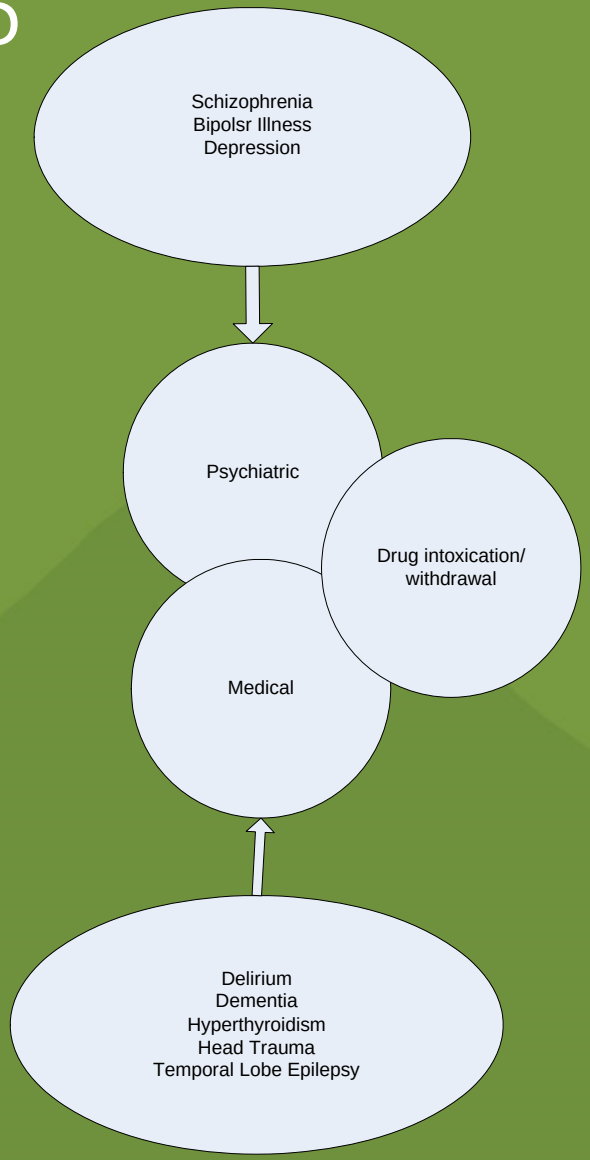
Migdole, S, Et al: Exploring new frontiers: Recovery oriented peer support programming in a psychiatric ED. Am J Psych Rehab.

2011:14: 1-12 .

- 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



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

AAEP: Use and Avoidance of Seclusion and Restraint: Consensus Statement of the American Association for Emergency Psychiatry BETA De-escalation Work Group, West J Emerg Med 2012:13:35-40.

- Avoid restraint and seclusion
- Not treatment modality but treatment failure
- Reduction of use of seclusion and restraints

Treatment Recommendations

AAEP: The Psychopharmacology of Agitation: Consensus Statement of the American Association for Emergency Psychiatry BETA De-escalation Work Group, West J Emerg Med 2012:13:35-40.

- 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

Balaban, R, et al:A randomized controlled trial of a patient navigator intervention in reduce hospital readmissions in a safety new healthcare system. CMAR 2013:3:157-158.

- 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

Severity	Description	Suicidal	Disposition	Need for Admission
Stable	Functional, works	None	Outpatient	No
Low level	Had medical or psych stressor	Mild	Outpatient	No OBS or CSU
Moderate	Decompensated, agitated	Moderate	Psych consultation	Yes
Severe	Severe decompensation	High	Inpatient care	Yes

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

Breslow, RE, Klinger, BI, Erickson, BJ: Crisis hospitalization on a psychiatric emergency service. Gen Hosp Psych 1983:15:307-315.

- 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

Neal, MT: Partial hospitalization. Nur Clin NA 1986:21:461-471.

- 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

Sledge, WH, et al: Day Hospital/Crisis care versus inpatient care, Part II: Service utilization and costs. Am J Psych 1996:153:1074-1083.

- 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

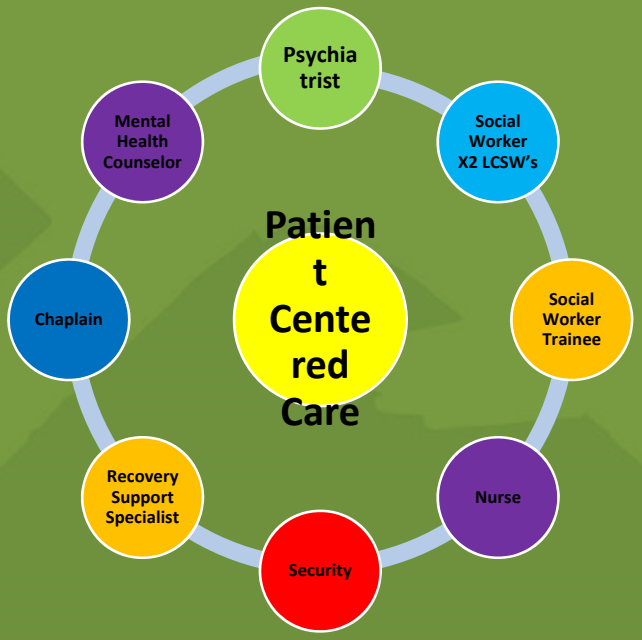
Psychiatric Home Health

Biala KY: Psychiatric home health: the newest kid on the block. Home Care Provid. 1996 Jul-Aug;1(4):202-4..

- 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

SINAI

Sinai Health System

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NAMI National Convention

SINAI
Sinai Health System

December 7-9
Las Vegas

Treasure Island

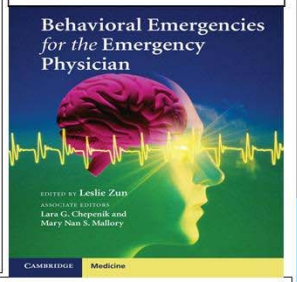
7th Annual National Update on Behavioral Emergencies

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



Selected Topics (Tentative)
Day 1

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

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 disruptive patient and visitor program

CME Approval pending
CEUs available for RNs and SWs

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

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

Course Director
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For Further Details

www.behavioralemergencies.com