VPQHC
Vermont Program for Quality in Health Care, Inc.

Vermont Association of Hospitals and Health Systems

Strategies for Improving the Quality of Mental Health Care in Vermont Emergency Departments

June 18, 2021

About VPQHC

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Agenda

- 12:00 pm -12:05 pm: Welcome & Housekeeping
- 12:05 pm -12:10 pm: Introduction
  - Emma Harrigan, Director of Policy Analysis and Development, VAHHS
- 12:10 pm -1:10 pm: Dr. Scott Zeller Presentation
- 1:10 pm – 1:30 pm: Q&A

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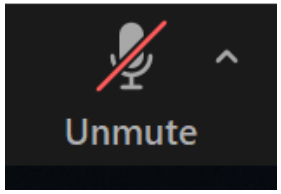
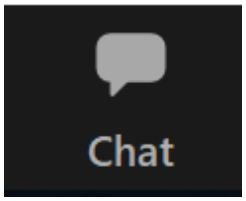
Housekeeping



- Remain on mute when you're not speaking.
- Put questions into the chat box at any time - we will be sure to address everything during the Q&A



- If you would like to ask a question during the Q&A, please let us know in the chat box or raise your hand – I will call on people

- Be sure to introduce yourself – name, position title, where you work
- Recording & slides will be available on the VPQHC website after the event

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Introduction

Emma Harrigan, Director of Policy Analysis & Development, VAHHS

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SCOTT ZELLER, MD

Scott Zeller, MD is Vice President for Acute Psychiatry at Vituity, a professor at two medical schools, and Past-President of both the American Association for Emergency Psychiatry and the National Coalition on Psychiatric Emergencies. He was formerly Chief of Psychiatric Emergency Services for Oakland, CA, where he developed the “Alameda Model”. He has authored multiple textbooks, book chapters and peer-reviewed articles, lectures internationally as a keynote speaker, and is known as the co-inventor of On-Demand Emergency Telepsychiatry. He led Project BETA (Best Practices in the Evaluation and Treatment of Agitation), which has revolutionized the care approach to agitation around the world. He was named the 2015 USA Doctor of the Year by the National Council for Behavioral Health, and was recently named one of the "ten most influential people in healthcare design" by Healthcare Design Magazine.

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Strategies for Improving the Quality of Mental Health Care in Vermont Emergency Departments

Scott Zeller, M.D.

Vice-President, Acute Psychiatry, Vituity

Assistant Clinical Professor, University of California, Riverside

Past President, American Association for Emergency Psychiatry

Past Chair, National Coalition on Psychiatric Emergencies

Prevalence

12-15%

- Between 12% - 15% of all emergency department visits nationwide are mental-health related
- At least 7 to 8 million emergency psychiatric assessments are made each year in the USA
- Only expected to grow after Covid

Overcrowding

- Overcrowded ED facilities and those with “boarders” correlated directly with increased walkouts, increased medical errors, and increased negligence claims.
- ED patient crowding cited as a potential cause of compromised patient care.
- Situation only expected to worsen with the “next wave” of covid-

  – **a mental health crisis**

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

Consumers Wants and Needs During a Psychiatric Emergency[1]

Surveyed Patients <u>Strongly Disagreed</u> that:

Staff treated them with respect:	***63%***
Seen in a timely manner:	***65%***
Listened to their story/version of events:	***68%***
Spent enough time with them:	***77%***
Adequately addressed their problems:	***80%***
Understood ethnic, cultural, racial or religious backgrounds	***53%***

(1. Allen, et al. Journal of Psychiatric Practice 2003)

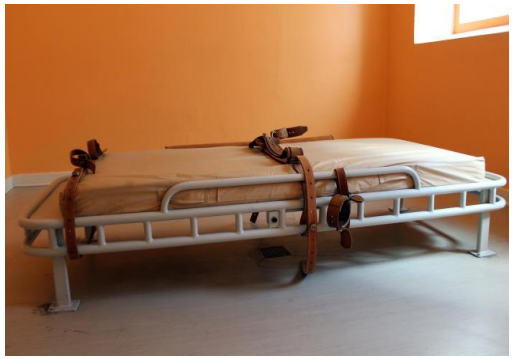
Consumers Wants and Needs During a Psychiatric Emergency[1]

- ***Themes regarding staff interactions:***
  - ***Importance of being treated as a human being; allowed to retain one's dignity***
  - ***Importance of staff <u>listening to what the person has to say</u>, respecting wishes as much as possible, answering questions and informing about what is happening***
  - ***Importance of being asked what you need or want***
  - ***Importance of being soothed and helped to calm down and not be afraid***
  - ***Importance of staff having a positive outlook and conveying that things can get better***

1. Allen, et al. Journal of Psychiatric Practice 2003

Consumers Wants and Needs During a Psychiatric Emergency[1]

Regarding Patient Experiences with the use of Physical Restraints:



- No other intervention attempted: 67%
- **Terrified witnessing others in restraints: 93%**
- Unwilling to seek outpatient care: 54%
- Kept in restraints too long: 68%
- Requests generally ignored: 77%

- *Made easier*: Someone there to explain why in restraints and offer alternatives
- *Made harder*: darkness, lack of stimulation, unsympathetic staff, muscle cramps, cold, worrying about vomiting, choking, not being allowed to urinate

1. Allen, et al. Journal of Psychiatric Practice 2003

The traditional approaches may actually cause more harm than good

- it is recommended that use of mechanical/physical restraint should be reduced to significantly decrease the complications and prevent the patient isolation, which can predispose future violent actions[1]

- Better results can be achieved by thinking of Agitation and Aggression as symptoms of acute illness, rather than criminal acts, and treating humanely, just as one would with a cardiac arrest

1. Knox & Holloman West J Emerg Med. 2012

'Zeller's Six Goals' of Emergency Psychiatric Care

- Exclude medical etiologies of symptoms and ensure medical stability
- Rapidly stabilize the acute crisis
- Avoid coercion
- Treat in the least restrictive setting
- Form a therapeutic alliance
- Formulate an appropriate disposition and aftercare plan

- from Zeller, Primary Psychiatry, 2010

Simple Changes all EDs can make

- **Adopt a Trauma-Informed Approach**
- **Consider psychiatric emergencies the same as other medical emergencies in terms of obligations**
- **Start Mental Health Assessment and Medical Assessment simultaneously**

Verbal De-escalation and Calming Techniques

- The goal is to help the patient regain control so that he or she can participate in the evaluation and treatment.
- While engaging the patient in verbal de-escalation, the clinician's observations and medical judgment must drive decisions regarding management of the patient.
- Successful de-escalation of the patient is the key to avoiding seclusion and restraint.

Benefits of Mastering Skills

- Verbal de-escalation usually takes less time than the process of restraint and involuntary medication.
- Avoiding “containment” procedures will result in fewer injuries to both staff members and patients.
- Patients are more trustful when not restrained or forcibly medicated.
- Receiving facilities may be more willing to accept a patient who has not been restrained, improving throughput.

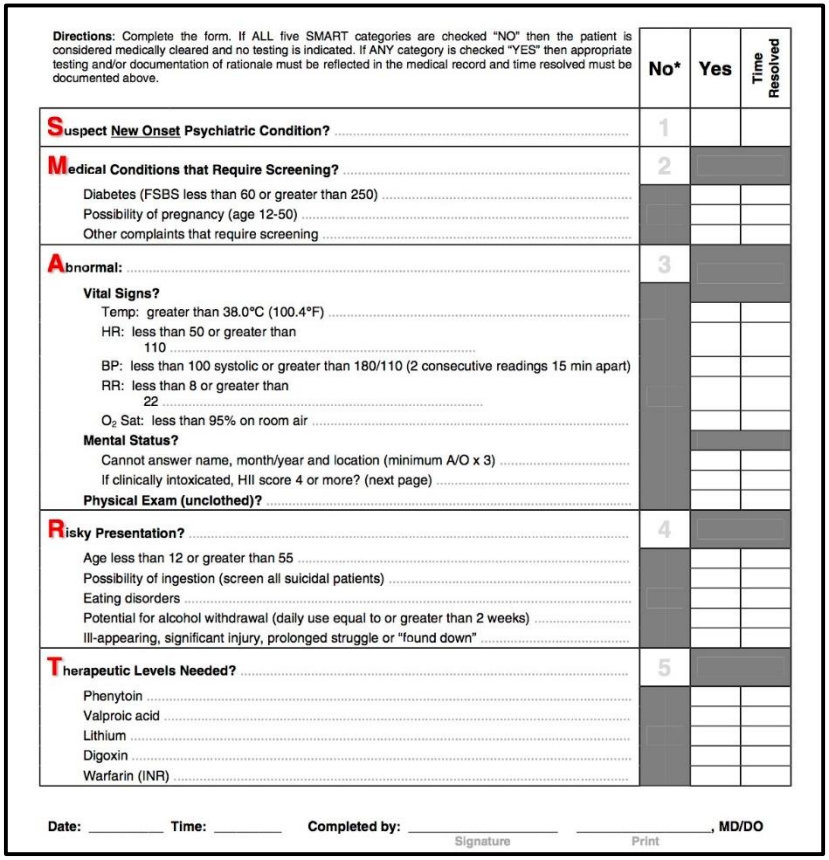
Improving Throughput

Restraint use leads to a length of stay of psychiatric patients in Emergency Departments averaging

<u>4.2 hours longer</u> than that of patients not requiring restraints[1]

1. Weiss AP et al, Annals of Emergency Medicine 2012

Standardizing Assessment – The SMART tool



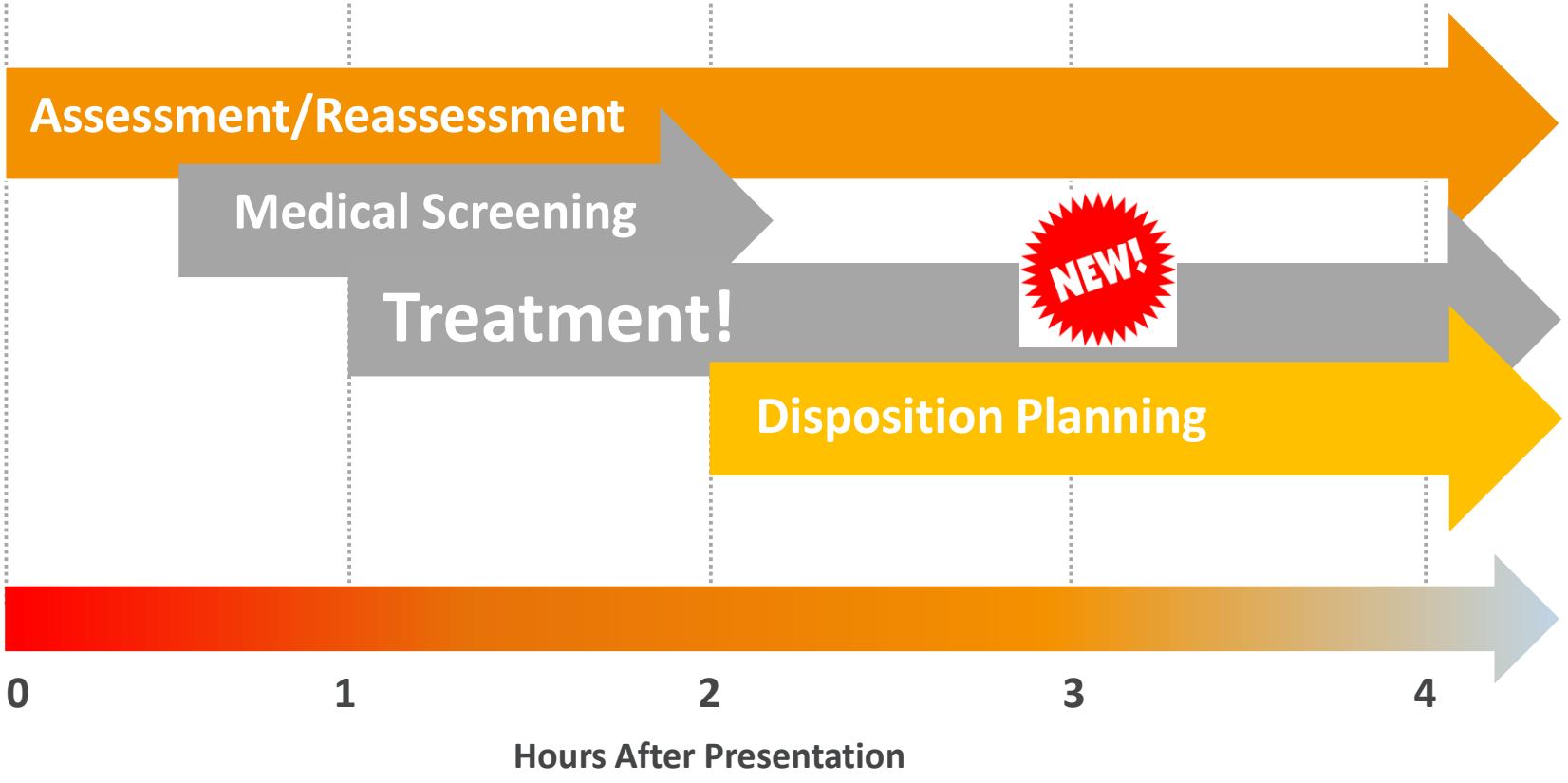
Directions: Complete the form. If ALL five SMART categories are checked "NO" then the patient is considered medically cleared and no testing is indicated. If ANY category is checked "YES" then appropriate testing and/or documentation of rationale must be reflected in the medical record and time resolved must be documented above.

		No*	Yes	Time Resolved
Suspect New Onset Psychiatric Condition?	1			
Medical Conditions that Require Screening?	2			
Diabetes (FSBS less than 60 or greater than 250)				
Possibility of pregnancy (age 12-50)				
Other complaints that require screening				
Abnormal:	3			
Vital Signs?				
Temp: greater than 38.0°C (100.4°F)				
HR: less than 50 or greater than 110				
BP: less than 100 systolic or greater than 180/110 (2 consecutive readings 15 min apart)				
RR: less than 8 or greater than 22				
O_2 Sat: less than 95% on room air				
Mental Status?				
Cannot answer name, month/year and location (minimum A/O x 3)				
If clinically intoxicated, HII score 4 or more? (next page)				
Physical Exam (unclothed)?				
Risky Presentation?	4			
Age less than 12 or greater than 55				
Possibility of ingestion (screen all suicidal patients)				
Eating disorders				
Potential for alcohol withdrawal (daily use equal to or greater than 2 weeks)				
Ill-appearing, significant injury, prolonged struggle or "found down"				
Therapeutic Levels Needed?	5			
Phenytoin				
Valproic acid				
Lithium				
Digoxin				
Warfarin (INR)				

Date: _____ **Time:** _____ **Completed by:** _____ _____, MD/DO

Signature Print

Goal-directed Interventions



Starting psychiatric meds in the ED – most useful for acute psychosis, agitation, anxiety

- **Oral meds preferred**
  - Less coercive, therapeutic alliance, reduced risk from needle use, easy to administer
- **Second Generation Antipsychotics preferred for both PO and IM when antipsychotics indicated**
  - Calming is initial goal rather than heavy sedation
- **Traditional haloperidol/lorazepam cocktail can lead to oversedation and serious side effects**, which can also seriously delay throughput, cause significant patient distress

Special Considerations for Kids and Adolescents

- Environmental options
- Entertainment and Distractions
- Avoiding Co-mingling
- “Kid Kit”

Environmental Impact:

Making Positive Change

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**

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 Solution: Treating at the Destination instead of the Source!

- All these solutions call for more availability for hospitalizations, nothing innovative at the actual ED level
- Change in approach needed – beginning with recognition that **the great majority of psychiatric emergencies can be stabilized in less than 24 hours**
- ***To reduce boarding in the ED, shouldn't the approach be at the ED level of care?***

Longer-Range Possibilities for Positive Change

- Recognition that the ED is usually not the best environment for psychiatric emergencies

- Creating patient care spaces where causes of Agitation and Aggression such as frustration, paranoia, anger, resentment are less likely to occur results in far less assaults and need for coercive interventions

EmPATH units

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

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%

Hospital Benefits

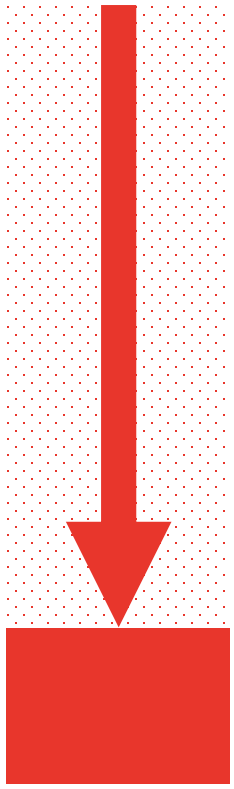
EMTALA-Compliant
for both voluntary and involuntary mental health crises

ED Capacity Creation
Alleviate volume pressure in the ED and reduce psychiatric holds and boarding

Reimbursement Options
Among CMS and private payers

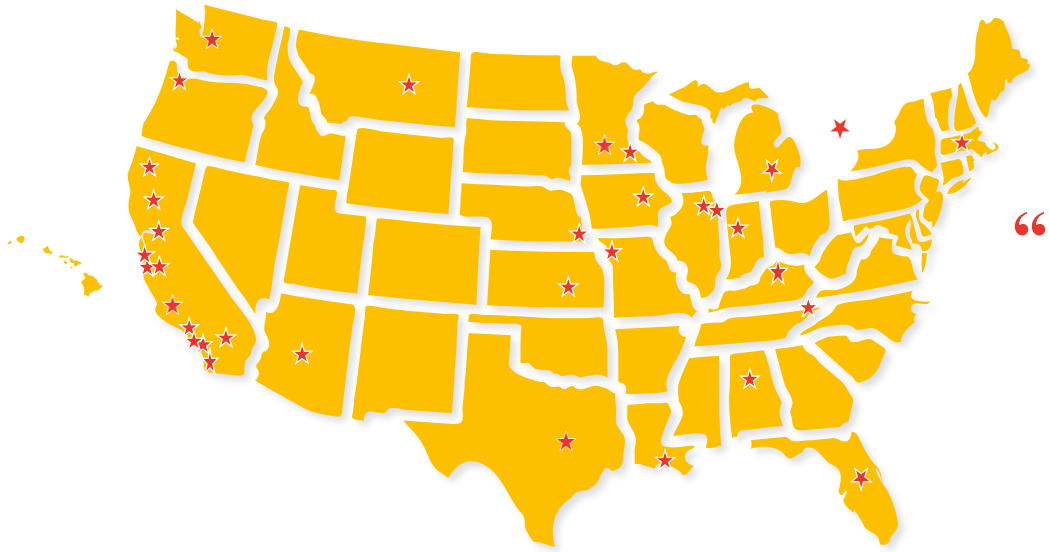
Eliminate Unnecessary Admissions
While reducing payer denials for inpatient psychiatric units

Cost-Effective Implementation
by remodeling available, unused hospital spaces



Up to
80%
Reduction in Admission Rates

The Model is Expanding Across North America



"EmPATH units should be considered a National Best Practice, and we will take the EmPATH unit knowledge back as a *best practice to Joint Commission Central*…"

- Joint Commission Surveyor


APPROX 4,310 SF UNDER CONSTRUCTION
18' - 0"
38' - 5"
9' - 1"
23' - 0"
8' - 2"
SHELL
305 SF
TOIL/
SHWR
65 SF
7' - 0"
TYP
ADULT PATIENT
1237 SF
ADOL
PATIENT
464 SF
CALM 1
138 SF
DBL
DR?
STAFF OFC
243 SF
TOIL/
SHWR
67 SF
SHELL
1947 SF
N.I.C
EXISTING TO REMAIN
(SHOWN HATCHED)
INT
149 SF
CALM 2
133 SF
CALM
84 SF
INTAKE
135 SF
LKRS
COR
269 SF
COR
202 SF
COR
183 SF
SOIL
90 SF
W/D
CLN
205 SF
CTR
INT
65 SF
FAMILY
106 SF
STOR
67 SF
1
SP.1
SCALE: 1/16" = 1'-0"
SPACE PLAN - OPTION E W/ CONSULTANT INPUT
UPDATED 07/07/2020
PLAN NORTH

Success Stories Across Geographies and Hospital Sizes

Providence Little Company of Mary,

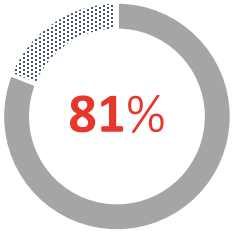
Los Angeles

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

>4,000

Annual Visits

0.2% Restraints
0.1% Patient injury

Safety

Calendar year 2018 results

The University of Iowa Hospitals & Clinics

Challenge: Rising number of patients experiencing psychiatric emergency. Decreasing number of psychiatric beds in Iowa. ED a stopgap for patients in crisis.

Solution: 24-hour Crisis Stabilization Unit, where each patient receives a thorough psychiatric evaluation and prompt treatment from specially trained professionals. **Opened September 2018.**

Results

Patients Discharged
or transferred from CSU in less than 24 hours

Patients Admitted
who visit ED
decreased from 50% to 25%

Decrease in LWBS
(left without being seen) rate for all patients in the ED

Additional ED Generated Revenue

Academic Emergency Medicine Journal Study Conclusion: "The EmPATH unit had a positive financial impact on ED revenue and decreased boarding time and length of stay for psychiatric patients."

Testimonials

> I've been in psychiatry for more than 20 years and this is probably one of the most rewarding things I've done. **We're able to get interdisciplinary care to people in crisis right away, in a patient-centered, team-based, non-coercive approach. I love it, the patients love it, and the staff love it.**"
>
> – Jodi Tate, MD
> Vice Chair for Clinical Services, University of Iowa Hospitals and Clinics

> It looks like **a very patient-centered facility**. They are really paying attention to those folks and not hiving them off into different places."
>
> – Dave Loebsack
> U.S. Representative (D-Iowa)

Billings Clinic, MT – Psychiatric Stabilization Unit

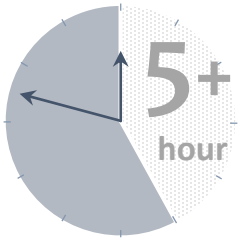
12-chair adult EmPATH unit and 5-chair youth EmPATH unit, opened Spring 2018

$784K funding support from Helmsley Charitable Trust

Readmissions Reductions

37%
decrease in psych 30-day readmission
from 19% to 12%

51%
decrease in overall readmission
from 57% to 28%



Reduction in ED ALOS
for psychiatric patients

0.2%
seclusion or restraint
(4100+ patients seen to date)

50%

Reduced recidivism
rates for ED psychiatric patients by nearly 50%

$1.7M
Annual Cost Savings
for public and private insurers

Ontario Shores Centre for Mental Health Sciences

Ontario Shores are leaders in the recovery model of care and are best positioned to develop the first EmPATH Unit in Canada and to help advance this model across Ontario. Our mental health emergency room will be there for people in Durham and across Ontario.

Questions