Behavioral Health in
The Emergency Department
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A little background...
Overview:
Hospital ED Throughput

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MACHE
Maryland’s Performance on CMS ED Throughput Measures

State Policy to Incentivize Performance Improvement

• Background:
  ▪ Concern over relatively poor performance on national ED throughput metrics, particularly in context of Maryland’s demonstration
    – Sensitivity to the appearance of access issues
  ▪ Concern expressed by some Maryland ED physicians
  ▪ MIEMSS supports policy incentives to lessen diversions
  ▪ Pressure from legislators in Annapolis in the form of a required report that identified solutions

• Result:
  ▪ ED-1b and ED-2b added to state’s Quality Based Reimbursement Program starting 2018
Primary Causes of ED Diversion and Long Wait Times

- Medicaid Expansion
- Behavioral Health
- ED Diversion and Wait Times
- Non-Emergent Cases
- Nursing Shortage
- Care Redesign
Behavioral Health—Mental Health & Substance Use—ED Visits on the Rise

Composition of Behavioral Health ED Visits

1Source: HSCRC, Maryland All-Payer Model Monitoring Report 2016, June 2016
2Source: MHA analysis of HSCRC 2016 outpatient claims data. Primary diagnoses used in conjunction with the Agency for Healthcare Research and Quality’s Clinical Classifications Software categories to stratify behavioral health visits
Time Spent in ED is Also Increasing

Visit Count of Patients with Psychiatric Behavior Complaint with ED Length of Stay Greater Than 24 hours

Source: MHA adapted from hospital-specific dashboard
Complexity of Behavioral Health Patient is on the Rise

Visit Count of Patients who Arrive by Police

Source: MHA adapted from hospital-specific dashboard
Medicaid ED visits increased 9 percent, while non-Medicaid decreased by 7 percent

Medicaid admissions increased 8 percent, while non-Medicaid decreased by 11 percent

Source: HSCRC inpatient and outpatient claims data, CY 2013 – CY 2016
Medicaid Behavioral Health ED Visits & Admissions Are Skyrocketing

Medicaid behavioral health visits increased 39 percent, while non-Medicaid increased 9 percent

Medicaid behavioral health admissions increased 28 percent, while non-Medicaid decreased 5 percent

Change in Behavioral Health ED Visits for Patients with Medicaid Relative to Non-Medicaid

Change in Behavioral Health Admissions for Patients with Medicaid Relative to Non-Medicaid

Source: HSCRC inpatient and outpatient claims data, CY 2013 – CY 2016. Primary and secondary diagnoses used in conjunction with the Agency for Healthcare Research and Quality’s Clinical Classifications Software categories to distinguish behavioral health admissions and visits from other diagnoses.
Nationally, 37 percent of all ED visits are non-emergent.

Nationally, more than 48 percent of hospitals reported a nurse vacancy rate of 7.5 percent or more\(^1\)

In Maryland, high nurse retirement and turnover rates results in increased reliance on temporary staffing agencies

\(^1\)Source: Nursing Solutions, Inc. 2016 National Healthcare Retention & RN Staffing Report

\(^2\)Source: The Chesapeake Registry Program
Care Transformation and Redesign Contribute to Longer ED Time

- Hospitals are increasingly adopting lifesaving practices intended to meet goals of the demonstration—lower admissions and potentially avoidable utilization.
- The result—some patients are in ED longer.
- Examples of lifesaving practices that have been implemented including:
  - Screening, brief interventions, and referrals to treatment—or SBIRT
  - Cardiac screening and treatment protocols
  - Asthma protocols intended to treat acute episodes and prevent future hospital use.
Hospitals are Implementing New Approaches to Address Hospital ED Overcrowding

- Creative staffing approaches
- Innovative screening practices
- Improvements with patient flow
- Discharge lounges to relieve inpatient beds
- And more…
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Changing the World of Health Care

Focus Remains On:
1. Quality of Care
2. Patient Satisfaction
3. Reduced Total Cost of Care
4. Efficient and Effective Patient Through Put
5. Provider and Organizational Satisfaction

Emergency Rooms are the front door of our organizations and a place that we can have a significant impact on cost of care, connection to care and patient education → Changing Behavior
What is the Problem?

• Increased demand for Psychiatric Evaluations
• Competing priorities between the medically and psychiatric Crisis
• Often EDs do not have the expertise or appropriate space to manage this population
• Behavioral issues are disruptive to the general ED operations
• Backlog of patient boarders- costly ($100/hr~ $2,000/pt)
• Increased Substance Use Disordered Individuals seen
Why Are We Seeing This Problem?

1. Severe reduction of psychiatric beds
   ⇒ 1955 - 558,922 beds in U.S.
   ⇒ 2010 - 43,318 Psychiatric beds
   ⇒ 2012 - 38,847 and falling

2. Shorten Lengths of Stays on Inpatient units

3. Reduction in Community Programs – businesses closing

4. Public or no Health Insurance

5. Decreased access to care - long waits

6. Increase in Substance Use Disorders (SUD) in our Society

** 1 in 8 ED patients have a Mental Health or SUD Problem. **
Changes to Consider

Changes need to be considered on multiple levels:

1. Provider/Staff Level Changes
2. Organizational Level Changes
3. System Wide Changes
Current thinking: We need a change!

- Patients who come to the ED must be admitted for safety reasons.
- ED physicians see this as a high risk area and admit automatically to mitigate risk to themselves and the hospital.
- Crisis interventions need to occur, treatment started and appropriate disposition needs to be planned.

Reality Check:

- Majority of Psychiatric Emergencies can be stabilized in < 24 hrs.
- 70% of Psychiatric ED patients can be discharged safely.
Provider & Staff Approach to Care Changes

1. Skilled Mental Health Staff-Crisis Evaluators
2. Knowledge of Brief Interventions to alleviate crisis
3. Establishment of Treatment Protocols for the ED Physicians when a Psychiatrist is not available- (Access to Psychiatric Consultation via live or Tele-mental health)
4. ED Care Managers/Social Workers to assist with aftercare planning, who have full knowledge and working relationship with community programs

**Individual Treatment Planning** with access to:

- Crisis beds
- Outreach Programs
- Next Day Partial Programs
- Out Patient Appointments
- Individual Safety Plans
Implement SBIRT in Your ED

**Screening, Brief Intervention and Referral to Treatment**

Using Peer Recovery Coaches who have experience with addictions themselves and are trained in Patient Engagement, Crisis Assessment, Motivational Interviewing and Referral to Addiction Treatment

Has made a *significant* impact on High utilizers and getting individuals with addiction where they need to be— in Treatment and out of the ED!
Program/Organizational Considerations

A. Designing a separate, designated space for Behavioral Health Patients in the ED-Behavioral Unit
   - Part of & adjacent to the General Adult ED
   - Patients are cleared medically and moved to EDBU
   - Area is secured for EP patients and those certified
   - Remain ED patients- can be moved back if medically necessary at any point

   **WHY?** Psychiatric patients stabilize faster and have better resolution of crisis in a quiet, sensitive environment where they can be managed by MH staff.

B. Walk-in Urgent Care- medication refills
System Level Considerations

Advocacy for:

1. Statewide Dashboards- know bed availability

2. Use of Centralized Data Base- CRISP
   a. Ability to identify high utilizers of ED services
   b. Plans of Care can be developed and shared

   “Mr. Jones, you were just seen, the plan that was developed was…… did you follow through?... Do you have your medication? Did you keep your appointment?”
In Conclusion...

This is a *National* Problem that will take:

- Creative Thinking
- Improved Education to Providers
- Increased Resources
- County and State Wide Advocacy
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Behavioral Health Diversion through Care Coordination

Maryland Association of Healthcare Executives
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Medical Director Mental Health Services
Discussion questions
Question:

ED Environment

What are we doing well and what could we do better?

Examples of the “ideal psychiatric ED”
Question:

ED Population

What is unique about the patients seeking treatment in the ED setting?

Are there socioeconomic and diagnostic characteristics that set this population apart?
Almost all of psychiatric intervention in the ED is handled by case workers (non-physicians). Is this reasonable?

Do you think we could alleviate some of the problems if we had psychiatrists in the ED?

If you had a magic wand, how would ED intervention change?
**ED Resources**

What are the options for these patients (inpatient, IOP, close follow up, none of the above)?

What programs are working? Which are not?
Question:

Prevention

What programs are you seeing to divert care away from the ED?

What works & what does not work?
Q&A