Mental Health Crisis Case Management in a Rural Emergency Department

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Providence Seaside Hospital
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What if?

If Physical Health Problems Were Treated Like Mental Health Problems

What if video
Objectives

• Acknowledge challenges of mental health crises management in rural Oregon.

• Review one model of case management by Social Work in the ED and its impact on care versus boarding.

• Identify next steps for Oregon in individual Emergency Departments and state wide advocacy.
Things I want the ER staff to know as a person with mental illness

Things I Want the ER Staff to Know as a Person With a Mental Illness
If at first you
Don't succeed
try Two More Times
So that your
Failure
is
Statistically Significant

Twisteddoodles.com
The United States

- From their historic peak in 1955, the number of state hospital beds in the United States had plummeted almost 97% by 2016.

- Even when private hospitals are included, the number of psychiatric beds per 100,000 people in the United States ranks the nation 29th among the 34 countries in the Organization for Economic Cooperation and Development.

- 10 times more people with serious mental illness are in prisons and jails than in state mental hospitals.

- The Treatment Advocacy Center (TAC) recommends 40 to 60 psychiatric beds for every 100,000 people. The national average is 11.7, and the group estimates that the country needs an additional 123,300 state psychiatric beds, though it is urging the federal government to do its own assessment. [Aug 2016]

Source: www.treatmentadvocacycenter.org
Oregon

103,573 – the number of people with serious mental illness
3.0 to 1 – the odds of a seriously mentally ill person being incarcerated compared to a hospital
Yet the state only has 32.4% of the beds necessary to meet the needs of its population with serious mental illness
Mental Health America recently ranked Oregon the worst in the country for mental illness rates and little access to help for it.

Source: www.mentalhealthamerica.net
- In 2005, Oregon had 19.2 beds/100,000 population, placing the state in the TAC category of currently having a “severe bed shortage.”

-- Aug 2016:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>700</td>
<td>653</td>
<td>16.2</td>
</tr>
</tbody>
</table>

Source: www.treatmentadvocacycenter.org
Suicide in Oregon

• In 2015, 762 Oregon residents died by suicide.

• Suicide is the second leading cause of death among Oregonians aged 15 to 34 years of age, and the 8th leading cause of death among all ages in Oregon.

• In addition, more than 2,000 hospitalizations are due to self-harm or suicide attempts in Oregon each year.

Source: http://geo.maps.arcgis.com/apps/MapSeries/index.html?appid=9c59be59ef7142dfad40d95e3b36f588
Clatsop County

How Clatsop, Columbia, and Tillamook counties compare to Oregon overall
(adults ages 18+)

- All 3 counties have fewer primary care physicians and mental health providers per person than Oregon overall
- All 3 counties have higher older adult suicide rates than Oregon overall

Source: Oregon Health Authority & Portland State University Institute on Aging
ASTORIA, Ore. (AP) — The family of a woman who jumped off the Astoria Bridge in northwestern Oregon seeks nearly $1 million in a lawsuit filed against a county mental health contractor.

The lawsuit filed alleges the county mental health agency was negligent in not providing an adequate treatment and recovery plan for her.

The suit also named the County, An Astoria hospital and emergency room doctor who treated her before her April 2015 suicide.
Where Patients Get Behavioral Health Care in Clatsop County

Half (50.0%) of respondents reported that their usual source of behavioral health care was a primary care clinic. 14.0% received behavioral health care at a county clinic, and 4.1% used a hospital emergency room. While we observe different trends in usual source of care by subpopulation, these differences were not statistically significant.

<table>
<thead>
<tr>
<th>Q11: Usual source of behavioral health care for adults</th>
<th>TOTAL</th>
<th>RACE/ETHNICITY</th>
<th>INCOME</th>
<th>INSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Non-Hispanic White</td>
<td>200% FPL or lower</td>
<td>201% FPL or higher</td>
</tr>
<tr>
<td>Primary care clinic</td>
<td>50.0%</td>
<td>49.3% *</td>
<td>63.6%</td>
<td>45.5%</td>
</tr>
<tr>
<td>County clinic</td>
<td>14.0%</td>
<td>15.0% *</td>
<td>33.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Hospital emergency room</td>
<td>4.1%</td>
<td>4.4% *</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>32.0%</td>
<td>31.3% *</td>
<td>2.9%</td>
<td>54.5%</td>
</tr>
</tbody>
</table>

* We did not report results when five or fewer respondents from a subgroup answered the question.

**DISPARITY FLAG:** An orange box indicates a statistically significant disparity in results by subgroup. (two-tailed chi-square test, p<0.10) Differences among subgroups should not be considered statistically significant unless indicated by an orange box. The significance test is not valid for variables where expected cell sizes are small; in these cases the table cells have been shaded blue-gray.
Providence Seaside Hospital

Services include the entire North Coast with 25 beds in the critical access hospital, rural health clinic with 4 medical home teams, and the only home health agency for Clatsop County
Seven beds in the ED
Challenges in a Small ED in a Critical Access Hospital

- Limited beds/space
- No “Safe room” – we make rooms “safer”
- Challenges in maintaining confidentiality in small spaces /impact on patient experience for others
- No psychiatrist on sight, daily tele-psych (Mon-Fri)
- Minimal distractions or therapeutic interventions available
- Staff safety concerns
- Staffing challenges when 1 to 1 constant observation or security is needed
- Felt like we were ‘boarding’ patients
When in Doubt, Refer to the Mental Health Hotline

Hello and Welcome to the Mental Help Hotline

Mental Health Hotline Video
https://www.youtube.com/watch?v=sqyiYd4iCYY
We Asked The Team

- How can we decrease LOS for behavioral health patients? Lots of ideas
- Are we doing all we can? no
- How do we break down the barriers we have to providing the best care? Need to be bold and innovative
- Can we do better? YES!
The Planning: We can do better (Phase I)

Social Work to provide “case management” for all Behavioral Health patients
  – SW becomes point person with CMHP & coordinates internal care
  – Ensure necessary documentation is in EMR

Barriers:
  – SW Staffing (buy in needed from departments/budgets across the continuum)
  – SW Training needs (OHA, Providence Oregon region)
  – CMHP challenges

Caregiver support:
  – Removed many of the tasks and exposure to challenges for ED team
  – SW provided more insight into the patient’s “story”
First Set of Results From Phase I: How Can We Reduce LOS?

- CMHP assess immediately
- Assign case manager at PSH to manage communication with CMHP
- Ask RN to review checklist each shift
- Daily tele-psych consult

Graph showing percentage changes from pre to post.
ED feedback on Phase I

• Both pre and post surveys strongly indicated that assigning a case manager in the Emergency Dept could help decrease LOS (90% & 94%)

• The areas of most improvement: *feeling informed, feeling we are helping and feeling supported by Providence in caring for behavioral health patients.*

• Increasing availability for telepsych consults and starting to administer medications quickly were both positively endorsed.

• The scarcity of inpatient psych beds was acknowledged and there is some hope that the new crisis respite center could be a valuable resource. There was a feeling that there could be better consistency among assessments and care planning by various CMHP workers, and feeling more outpatient support from CMHP is needed to perhaps prevent ED visits.
We Can Do Even Better (Phase II)

- Social Work will “assess, treat and case manage” & the hospital will “own” the patient/process
- Memorandum of Understanding (MOU) finalized with CMHP
- Transport Custody Certification obtained from the state of Oregon
- Increased caregivers on team (7 days per week, 10 hour shifts + on call)
- Training on the law (Oregon Health Authority)
- Workflows & checklists
- DO something everyday (not “boarding”)
Management of patients in mental health crisis

1. Patient arrives

2. Patient is medically cleared. 12 Hour Transport custody initiated as needed

3. MSW available?
   - Yes
     - MSW assess and contact outside people and agencies
     - Patient is voluntary
   - No
     - Patient is involuntary
     - Contact CBH

4. CBH places Director’s Hold and NMI (5 judicial days timeline starts)

5. MSW takes lead looking for placement (CBH helps as needed)

6. MSW assess daily and communicate with CBH (when pt is on Hold), daily note in Epic with assessment and list of hospitals contacted with outcome

7. Placement found, patient voluntary
   - MSW leads arranging transport

8. Placement found, patient involuntary
   - Patient discharged, CBH takes to court for commitment hearing

9. No placement after 5 judicial days
   - Judge commits, CBH arranges transport to ED with psychiatric unit

10. Judge dismisses, CBH offers outpatient follow up
Management of patients in mental health crisis

Patient arrives

If police transported to ED, priority fax peace officer custody into chart

Patient is medically cleared. 12 Hour Transport custody initiated as needed

MSW available?

Yes

MSW assess and contact outside people and agencies prn

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Last updated: 12/19/2017
<table>
<thead>
<tr>
<th>TASK</th>
<th>DATE/INFO</th>
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<tbody>
<tr>
<td>If patient arrived by police, priority fax peace officer custody</td>
<td></td>
</tr>
<tr>
<td>MSW assigned (in Epic) and assesses patient (SW order in Epic)</td>
<td></td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td></td>
</tr>
<tr>
<td>Call patient contacts and other agencies involved (CBH or county of residence, NWSDS, etc)</td>
<td></td>
</tr>
<tr>
<td>Request CBH assess as needed (patient involuntary or respite candidate)</td>
<td></td>
</tr>
<tr>
<td>Director’s Hold documentation and CBH records priority faxed, ROI</td>
<td></td>
</tr>
<tr>
<td>Notify patient of rights (or confirm done), priority fax into Epic</td>
<td></td>
</tr>
<tr>
<td>Director’s Hold expires:</td>
<td></td>
</tr>
<tr>
<td>Activity suggestions/other individualized care plan (access to personal belongings, visitors, phone use, etc)</td>
<td></td>
</tr>
<tr>
<td>Labs/medical records shared with CBH when pursuing an inpatient or residential bed</td>
<td></td>
</tr>
<tr>
<td>Attend Telepsychiatry consult (Mon-Fri 1pm)</td>
<td></td>
</tr>
<tr>
<td>Hospitals contacted/outcome</td>
<td></td>
</tr>
<tr>
<td>Current plan of care</td>
<td></td>
</tr>
<tr>
<td>Data recorded on tracking sheet</td>
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Phase I

• Social Work managed communication

• Fax and call immediately (bed availability changes quickly)

• Mental health professionals speaking the same language

• Improvement in daily management

Phase II

• Social Work leads assessment and planning

• Owning and prioritizing dispo planning to minimize delays

• Clinical experience & close SW team communication (more consistency)

• And more…
**Additional benefits**

- Improved patient care & experience for mental health patient and other ED patients
- Improved caregiver experience for ED team
- Social Work performing at top of clinical license
- Improved collaboration with CMHP; other staff shielded from process challenges
- Calling CMHP to ED less = more time for CMHP to be in community to prevent crisis/ED
- Significant decrease in patients on “involuntary” status (civil rights)
- Improved mental health clinician documentation (per hospitals receiving referrals)
- Decreased length of stay (documentation available sooner, SW prioritizes crisis work)
- Increase in cost saving/less $ loss assumed
- ED diversion with mental health evaluation process used in clinic
Compared with prior practice, having Social Workers case manage patients in mental health crisis in the ED...

- Allows me to focus on medical patients
- Decreases amount of patients placed on holds
- Helps patients get to the right level of care
- Helps me feel more supported
- Keeps us better informed of the plan of care
- Decreases LOS
- Improves care we provide

Key:
- Always true
- Somewhat true
- No opinion
- True at times
- Not at all true
I believe we are doing all we can to reduce LOS

Pre

Post

0% 10% 20% 30% 40%

TRUE
ED Feedback On Phase II

“Our Social Worker team has done much to raise the level of quality behavioral crisis management for our community and works closely with our community providers when necessary to ensure our patients get the appropriate follow up care or hospitalization needed.”
Suggestions

• Administer medications as soon as possible and daily; include plan for emergent meds if patient escalates

• Routine meal time delivery to help with orientation

• Diversion activities (tv, books, games)

• More involvement from tele psychiatry

• The team would like 24 hour Social Work
Average LOS for patients in PSH ED over 12 hours

- Q1 2016
- Q1 2017
- Q2 2016
- Q2 2017
- July/Aug 2016
- July/Aug 2017

LOS hours
2017 Transferred Average LOS (BH) hours

- Dec
- Nov
- Oct
- Sept
- Aug
- July
- June
- May
- Apr
- Mar
- Feb

Average LOS (BH) hours:
- Dec: 34 hours
- Nov: 110 hours
- Oct: 20 hours
- Sept: 50 hours
- Aug: 60 hours
- July: 100 hours
- June: 200 hours
- May: 320 hours
- Apr: 220 hours
- Mar: 300 hours
- Feb: 160 hours
LOS > 72 hr

• 2016: 13 total patients

• Jan-Jun 2017: 4 patients

• July – Dec 2017: ZERO patients
But What About…

…voluntary adults?
…under 18? (minor in Jan 2018 approx 99 hrs, stabilized)
How long might they be in our ED?

Ongoing process improvement:
- Refine medication reconciliation process
- Further refine documentation for all team members
- Continue to explore other interventions so patients are not “boarded” but are receiving treatment/help toward stabilization
- Continue to partner with CMHP when appropriate
- Social Work regional documentation changes coming
What Can You Do?

• What resources/processes can you implement (or develop)?
  – Who are your partners (internal and external)?
  – Who can consult as needed?
  – How can you support staff with individual cases (phone a Social Work friend)?

• Advocacy - Be a voice for your community…we need you!
  [Link: http://www.cqrcengage.com/treatmentadvocacycenter/?0]
Remember The Struggle For The Patient

My childhood was spent in and out of hospitals, feeling alone, but taken care of. My early adult life was a much harsher reality. The system treated me like a wild animal, and I was thrown into jail or boarding facilities with little actual care. I was behind bars, I was shackled – I would have taken padded walls and straitjackets over that any day. I was constantly waiting for a bed or seeking help in the ER, only to be sent back out to the streets...

...While I still struggle, I know I'm successfully managing my mental illness because of the support I received and because I was able to access an inpatient bed. Because of this, I'm a vocal advocate for legislation that increases others' chances of getting a bed. –Joy Torres

Anderson Cooper Video
https://www.youtube.com/watch?v=yL9UJVtgPZY
“It Takes A Village”

Contact

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