COLLABORATING WITH EMERGENCY DEPARTMENTS

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OBJECTIVES/CONCERNS

- The need for Crisis Residential Programs from an ER perspective
- Where do crisis residential programs fit in the system of care?
- What can be expected from the emergency department?
- What can be expected from the crisis residential programs?
- How to connect and communicate with the emergency department?

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
  - Crisis Residential Programs

Hospital - Outpatient
- Emergency Department
- Psychiatric Urgent Care
- Crisis stabilization Units

Hospital-Inpatient

PSYCH EDS 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

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

INCIDENCE OF PSYCHIATRIC ILLNESS PRESENTING TO EDS

STATISTICAL BRIEF #92:MENTAL HEALTH AND SUBSTANCE ABUSE-RELATED EMERGENCY DEPARTMENT VISITS AMONG ADULTS, 2007 PAMELA L. OWENS, PH.D., RYAN MUTTER, PH.D., AND CAROL STOCKS, R.N., M.H.S.A.

- In 2017, 15% of all ED visits related to mental health and/or substance use disorder
- 41% resulted in hospital admission
- Admission rate that is over two and a half times that for ED visits related to other conditions

PSYCHIATRIC BOARDERS

- ED Administrators Schumaker Group: 2010 Survey Hospital Emergency Department Administrators
  - 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 Survey of California emergency departments about practices for management of suicidal patients and resources available for their
  - 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

WHAT IS THE ROLE OF THE EMERGENCY ROOM?

- Medical evaluation
- Psychiatric stabilization
- Treatment
- Disposition decision

MEDICAL CLEARANCE PURPOSE

- **Primary Purpose**

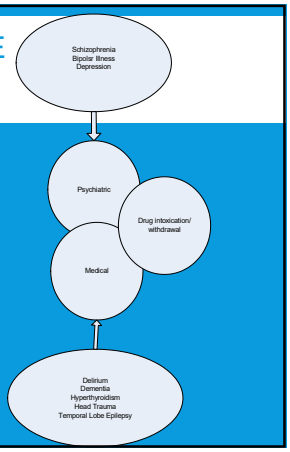
  Determine whether a medical illness is causing or exacerbating the psychiatric condition.

- **Secondary Purpose**

  Identify medical or surgical conditions incidental to the psychiatric problem that may need treatment.

PRIMARY PURPOSE ETIOLOGY

- Drug and alcohol intoxication or withdrawal
- Medical
  - Hypoglycemia
  - Hyperthyroidism
  - Delirium
  - Head Trauma
  - Temporal Lobe Epilepsy
- Psychiatric



CONCURRENT MEDICAL PROBLEMS

- Retrospective review of 300 patients
- 178 had medical problems and 122 did not
- Most common hypertension, asthma and diabetes

SUBSTANCE USE BY CHRONIC MENTALLY ILL

SAFER, D. SUBSTANCES ABUSE BY YOUNG ADULT CHRONIC PATIENTS HOSP COMMUN PSYCH 1987;38:511-514.

- 44% current substance users
- 29% history of substance use
- 27% had little or no substance use history

PRIMARY PURPOSE - DIFFERENTIATE MEDICAL FROM PSYCHIATRIC ETIOLOGY

- History
- Physical exam
- Mental status examination
- Cognitive assessment
- Laboratory testing?

WHO NEEDS TESTING AND WHAT TESTS?

- What labs are done?
  - CBC, lytes, UDS, ETOH, UCG
  - Evidence that routine labs rarely change clinical management
  - Drug screen, alcohol level
    - One indication - Altered mental status without etiology
- When is more advanced testing indicated?
  - EEG, EKG, CT Scan Head, Chest radiograph
- Which patients?
  - All comers
  - Chronically mental illness with same presentation
  - New onset

ARE ROUTINE LABS INDICATED?

LUKENS, TW ET AL: CLINICAL POLICY: CRITICAL ISSUES IN THE DIAGNOSIS AND MANAGEMENT OF ADULT PSYCHIATRIC PATIENT IN THE EMERGENCY DEPARTMENT. ANN EMERG MED 2006;46:79-99. APA PRACTICE GUIDELINES ON PSYCHIATRIC EVALUATION OF ADULTS

- ACEP Guidelines
  - Routine laboratory testing of all patients is of very low yield and need not be performed.
  - In adult ED patients with primary psychiatric complaints, diagnostic evaluation should be clinically directed by the history and physical examination.
- APA Guidelines
  - Psychiatrist may need to request or initiate further general medical evaluation to address diagnostic concerns that emerge from the psychiatric evaluation.
  - "Psychiatrists and emergency physicians sometimes have different viewpoints on the utility of laboratory screening."

ARE DRUG AND ALCOHOL TESTING INDICATED?

- "Routine urine toxicologic screens for drugs in alert, awake, cooperative patients do not affect ED management and need not be performed…" (ACEP Guideline)
- "The patient's cognitive abilities, rather than a specific blood alcohol level, should be the basis on when the clinicians begin the psychiatric assessment." (ACEP Guideline)
- Intoxication is a clinical diagnosis; not a lab diagnosis
  - Level of consciousness
  - Cognitive function
  - Neurologic function
    - Coordination
    - Gait
    - Nystagmus

WHEN IS TESTING INDICATED?

- Red flags of medical etiology
  - Age >45 years old
  - Exposure to toxins or drugs
  - Substance intoxication or withdrawal
  - No prior psychiatric/medical history
  - Abnormal vital signs
  - Cognitive deficits
  - Focal neurologic findings
  - Slurred speech
  - Seizures
- New onset of psychiatric symptoms
- Accommodating psychiatric facility

PROTOCOL FOR THE EMERGENCY MEDICINE EVALUATION OF PSYCHIATRIC PATIENTS: ZUN, LS, LEIKEN, JB, SCOTLAND, NL ET. AL.: A TOOL FOR THE EMERGENCY MEDICINE EVALUATION OF PSYCHIATRIC PATIENTS (LETTER), AM J EMERG MED, 14:329-333, 1996.

Medical Clearance Checklist

	Yes	No
1. Does the patient have new psychiatric condition?		
2. Any history of active medical illness needing evaluation?		
3. Any abnormal vital signs prior to transfer?		
4. Any abnormal physical exam (unclothed)?		
5. Any abnormal mental status indicating medical illness?		

If no to all of the above questions, no further evaluation is necessary.

If yes to any of the above questions, tests may be indicated.

THE TERM "MEDICALLY CLEAR"

TINTINALLI, JE, PEACOCK, FW, WRIGHT, MA: EMERGENCY MEDICAL EVALUATION OF PSYCHIATRIC PATIENTS. ANN EMERG MED 1994; 23:859-862.

- Poor documentation of medical examination of psychiatric patients
  - 298 charts reviewed in 1991 at one hospital
  - Physician deficiencies was mental status in 20%
  - Term "medically clear" documented in 80%
- Tintinalli states the term "Medically Clear" should be replaced by a discharge note
  - History and physical examination
  - Mental status and neurologic exam
  - Laboratory results
  - Discharge instructions
  - Follow up plans
- Other use the term "medically stable"

EVALUATION CONCERNS WHO DOES THE PSYCHIATRIC EVALUATION AND DISPOSITION DECISIONS

- ED MD
- In-house psychiatry
- ED mental health worker
- Telepsychiatry
- Community mental health
- Outside contracted mental health worker

PSYCHIATRIC PATIENT ADMISSION CRITERIA DOES THE PATIENT NEED TO BE ADMITTED?

- Not always an easy decision
- Use of admission criteria or guidelines for many conditions
  - Risk to self, Risk to others, Unable to care for self
- Improved assessment for admission
  - Telepsychiatry
  - Better means to determine who needs to be admitted
- Alternatives to inpatient stay

ADMISSION DECISION

- Suicidal
- Homicidal
- Unable to care for self
- 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	Yes
Moderate	Decompensated, agitated	Moderate	Psych consultation	Yes
Severe	Severe decompensation	High	Inpatient care	No

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?

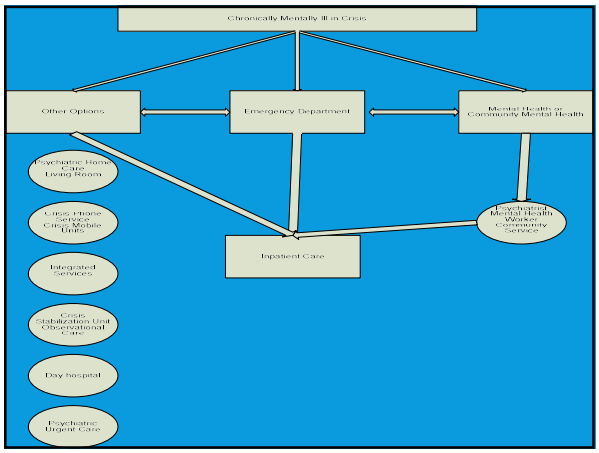
OVERALL RISK FACTORS FOR PSYCHIATRIC READMISSION

MACHADO,V, ET AL: PSYCHIATRIC READMISSION: AN INTEGRATIVE REVIEW OF THE LITERATURE. INT NURSING REV 2012;447-457.

- Low level of schooling
- Younger age
- Schizophrenia
- Personality Disorders
- Psychoactive substances
- Males
- Time for complete recovery
- # of prior hospitalizations
- Condition of living
- Admitted prior year
- Receiving disability
- No discharge plan for PCP

INPATIENT ISSUES THAT REDUCE READMISSIONS

- Weekly readmission rounds
- Readmission focus in discharge rounds
- Teach back method
- Outpatient follow up in 3 days
- Family engagement focus
- Post discharge phone calls
- Improving community linkages



MOBILE CRISIS UNITS AND TELEPSYCHIATRY

- Mobile Crisis Units

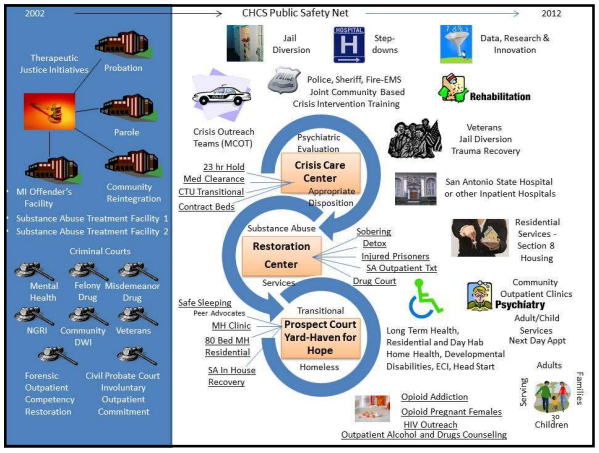
Jugo, M, Smout, M, Bannister, J: A comparison in hospitalization rates between a community based mobile emergency service and a hospital-based emergency service. Aust N Z Psychiatry 2001;36:504-508.

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

- Telepsychiatry

Shre, JH, Hilty, DM, Yellowlees, P: Emergency management guidelines for telepsychiatry. Gen Hosp Psych 2007:29:199-206.

- High provider and patient satisfaction
- Wide variety of diagnosis, age and complaints
- Consultations, diagnostic assessment, medication management, family and patient psychotherapy



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

ROLE OF COMMUNITY MENTAL HEALTH CENTER

- Specialized clinics for specific disorders
- Early intervention and teams
- Assertive community treatment teams
  - Multidisciplinary approach to intensive services in the community (home or work)
  - Psych, nursing, social work, substance abuse tx, employment
- Alternative forms of occupational and vocational rehabilitation

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 to work at pt's home
- CMS allows all physicians to sign a Medicare psychiatric plan of care.
- Results in significant reduction in both hospitalization admission and recidivism rates.

INVOLUNTARY OUTPATIENT COMMITMENT

SWARTZ, MS, ET AL: CAN INVOLUNTARY OUTPATIENT COMMITMENT REDUCE HOSPITAL RECIDIVISM? AM J PSYCH 1999;156:1968-1975

- Compared hospital release to hospital discharge to outpatient commitment
- 57% fewer hospitalizations
- 20% fewer hospital days
- Non-affective psychotic disorders had highest rate 72% reduction

CRISIS 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
  - Sucidality
  - Substance use disorders
- 41% of total patients seen

INDIVIDUALS APPROPRIATE FOR CRP (CRITERIA VARIES)

- Patients must be ≥18 years old on date of admission.
- Manage their own Activities of Daily Living (ADL's)
- Meet the criteria for at least one DSM V diagnosis
- Patient's judgment and impulse control must be appropriate
- Patient is cooperative with staff direction and treatment modalities
- Medically stable *

INDIVIDUALS NOT APPROPRIATE FOR CRP (CRITERIA VARIES)

- Need for ongoing medical treatment which surpasses program capabilities
- Infectious diseases such as active, uncontained MRSA, active pulmonary TB
- Untreated/active scabies, lice, or bedbugs
- Need for specialized medical equipment beyond what can be maintained in a community-based environment
- Indwelling Tubing: (includes Foley, feeding tubes, colostomy)
- Drug or alcohol withdrawal requiring medical intervention/detox
- Unmanageable behavioral issues

MEDICAL STABILITY/CLEARANCE

- Understanding medical limitations at the crisis residential
- Stability/clearance defined by the crisis residential vs. the ER
- Finding common language
- Outreach and education between both settings and staff

COORDINATION OF CARE BETWEEN ER AND CRP

- Points of contact
  - Referral to crisis residential
  - During admission to crisis residential
  - During crisis residential treatment
- Nurse to Nurse (or) Doctor to Doctor consults
- Managing PHI
- Risk assessment
- Creation of "Medical Guidelines" by crisis residential provider addressing common issues *

COMMON MEDICAL CONCERNS

- Hypertension
- Diabetes
- Seizures Disorders
- Active Detox
- Incontinence
- Non-ambulatory/mobility compromised

MEDICAL GUIDELINES EXAMPLE (FROM START MODEL)

- Diabetes: CRP can accommodate referrals who have both Type I and Type II diabetes, including those who are insulin dependent.
  - Clients must be self-sufficient in the management of their diabetes and should arrive for admission with their own supplies (glucometer, test strips, lancets, and insulin).
  - Blood glucose levels should be approximately within 65-250 for 24 hours prior to CRP admission
  - Sliding scale medication orders for blood glucose levels up to 350 are required for insulin dependent individuals
  - California State Licensing requires clients with diabetes have a PCP in the community, managing their diabetic care, prior to admission

COMMON MEDICATION CONCERNS

- Opiates
- Benzodiazepines
- Coumadin
- Stimulants
- Sleep aids
- Suboxone/Methadone

MEDICATION GUIDELINES EXAMPLES (FROM START MODEL)

- Suboxone/Methadone
  - Individuals prescribed these medications may be admitted when they are prescribed and followed by a community provider and arrangements can be made to obtain medications while in crisis residential treatment.
- Coumadin
  - Prior to admitting a client taking Coumadin, the client is required to have an outpatient medical provider who will be responsible for blood laboratory draws for International Normalized Ratio (INR) tests and medication services.

OTHER IDEAS…

- Use of community clinics, when available, and medical concern is not urgent
- Sharing referral form (if applicable) to prep referring ER staff
- Creation of a "client fact sheet" to help hospital staff discuss the crisis residential option with patients
- Speak with clients being referred
- Specialized "admission coordinator" role to reduce number of crisis residential staff taking referrals
- Survey hospitals periodically so crisis residential managers can monitor referral process/referral experience

OTHER LIMITATIONS OF CRISIS RESIDENTIAL PROGRAMS

- Prior authorization
- Time to take and clear a referral
- Competing priorities
- Scheduling assessments/new intakes
- Bed capacity
- Level of care and setting considerations

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