The Role of the Emergency Department in Patients in Crisis

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Disclosure

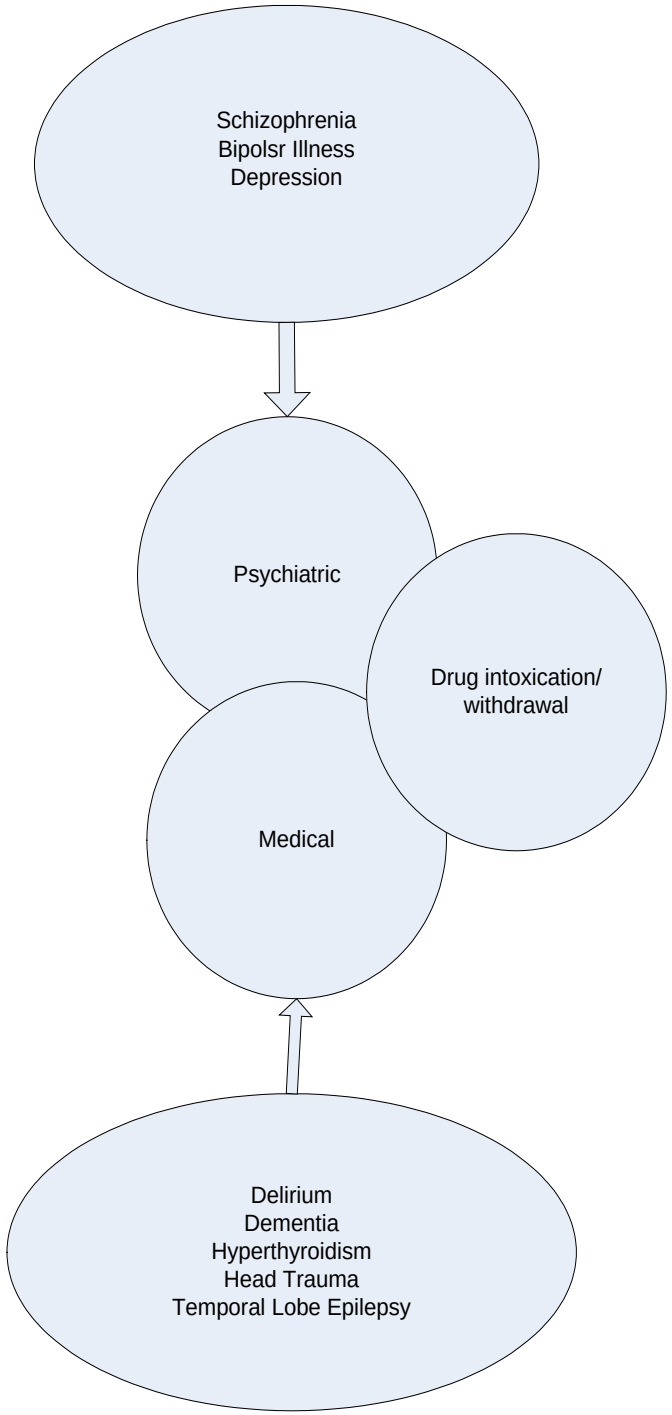
- Dr. Zun is the principal investigator for two research grants from Teva Pharmaceuticals given to Mount Sinai Hospital.

Learning Objectives

- To understand the medical clearance process
- To learn who needs testing
- To use protocols in the evaluation of the psychiatric patients

Primary Purpose Etiology

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



Mortality Rate of Delirium

Barron, EA and Holmes, J: Delirium within the emergency care setting, occurrence and detection: a systematic review. Emerg Med J 2013;30:263-268.

- ED incidence 7-20%
- Frequently missed
  - 24% maximum detection rate
  - Due to lack of screening
- High rate of mortality
  - 36% undetected vs. 10% detected
- High rate of morbidity

Medical Clearance
Purpose

- **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.**

Secondary Purpose - Incidental Medical Problems

- What is the patient's concommitant problems?
  - Retrospective review of 300 patients
  - 178 had medical problems and 122 did not
  - Most common hypertension, asthma and diabetes
- What are the capabilities of the receiving facility?
  - Assessments
    - Monitor vital signs & glucose
    - Routine neurological monitoring
    - Laboratories and radiographics
  - Treatment
    - Intramuscular and subcutaneous injections
    - Insertion and maintenance of urinary catheters
    - Oxygen administration

What part of the evaluation is useful?

Olshaker, JS, Browne, B, Jerrard, DA, Prendergast, H, Stair, TO: Medical clearance and screening of psychiatric patients in the emergency department. Acad Emerg Med 1997;4:124-128.

- Retrospective, observation study of psychiatric patients over 2 month period
- 352 patients with 19% having medical problems
- Sensitivity
  - History 94%
  - Physical exam 51%
  - Vital signs 17%
  - Laboratory testing 20%

History
Is the patient reliable?

Olshaker, JS, Browne, B, Jerrard, DA, Prendergast, H, Stair, TO: Medical clearance and screening of psychiatric patients in the emergency department. Acad Emerg Med 1997;4:124-128.

- Patients asked about drug and alcohol use
- Patients had alcohol and toxicological screening
- Reliability of patients self-reported history

	Sensitivity	Specificity
• Drugs	92%	91%
• ETOH	96%	87%

Physical Exam Performed and Documented by Canadian EPs

Szakowicz, J Emerg Med 2007

	Documented in
• Complete vitals	52%
• Pulse ox	28%
• Glucose	5%
• Neurologic system	36%
• Respiratory system	54%
• Cardiovascular system	52%
• Behavior exam	76%

Formal Mental Status Examination

- Elements routinely assessed while interviewing pt
  - Appearance, behavior and attitude
  - Mood and affect
- Not routinely assessed while interviewing pt
  - Disorders of thought – Suicidal & homicidal ideation
  - Insight and judgment – Knowledge about illness
  - Disorder of perception - Hallucinations & delusions
  - Sensorium and intelligence - Cognitive impairment

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
- The bottom line is ED physician's or psychiatrist's responsibility to ensure correct disposition

Evaluation of Intoxication?

- What does a level of .08 in a comatose teenager mean?
- What does a level of .325 in normal acting adult mean?
- Clinical Assessment of intoxication
  - Level of consciousness
  - Cognitive function
  - Neurologic function
    - Coordination
    - Gait
    - Nystagmus
- ACEP guidelines “The patient’s cognitive abilities, rather than a specific blood alcohol level, should be the basis on which the clinicians begin the psychiatric assessment.”

Which patients?
Psych history vs. new onset

Hennenman, PL, Mendoza, R, Lewis, RJ: Prospective evaluation of emergency department medical clearance. Ann Emerg Med 1994;24:672-677.

- 100 consecutive patients aged 16-65 with new psychiatric symptoms.
- Patients with fever received CT and LP
- 63 of 100 had organic etiology for their symptoms
  - History in 27
  - PE in 6
  - CBC in 5
  - SMA-7 in 10
  - CPK in 6
  - ETOH and drug screen in 28
  - CT scan in 8
  - LP in 3.
- Patients need extensive laboratory and radiographic evaluations including CT and LP.

What do the experts say?

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 urine toxicologic screens for drugs in alert, awake, cooperative patients do not affect ED management and need not be performed as part of the ED assessment” (ACEP Guideline)
- 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.
- How do we get these diverging opinions resolved?

How to reconcile testing?

- When is testing not indicated?
  - Chronic mental illness with the same presentation
  - Normal vital signs without any clinical concerns
- When is testing indicated?
  - Red flags of medical etiology
  - New onset of psychiatric symptoms
  - Altered mental status without etiology
  - Accommodating psychiatric facility
    - Communication between EDs and receiving psychiatric facilities

Red Flags of Medical Etiology

Age >45 years old
Exposure to toxins or drugs
Substance intoxication or withdrawal
Abnormal vital signs
Physical examination findings
Cognitive deficits
Focal neurologic findings

Use of a Protocol for Medical Clearance

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.

Advanced Testing: EEG, CT and MRI

Lippmann, SL: Emergency brain imaging :CT or MRI? Current Psychiatry 2013;12:55.

- EEG
  - Enrolled pts with AMS including agitation, disinhibition, psychosis
  - In 8 pts with psych presentation, all had new onset of symptoms
  - 2 had NCS, 3 had slowing and 3 were nl
- CT scan
  - Acute hemorrhage, calcifications and bones
  - Poor for white matter and posterior fossa
- MRI
  - Demyelination and metastasis
  - Problems close quarters, metal, gadolinium
- Indications for advanced testing
  - New onset psychiatric illness
  - Recent or advanced cognitive dysfunction
  - AMS, neurologic or focal findings
  - Candidates for ECT

The Term “Medically Clear”

Tintinalli, JE, Peacodk, 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**”

Take Home Point

- The role of the ED to ensure a medical etiology has been considered
- Testing
  - Test indicated for patients with new onset of psychiatric illness
  - Testing rarely indicated for patients with known psychiatric illness
- The use of a protocol is useful for the medical clearance process

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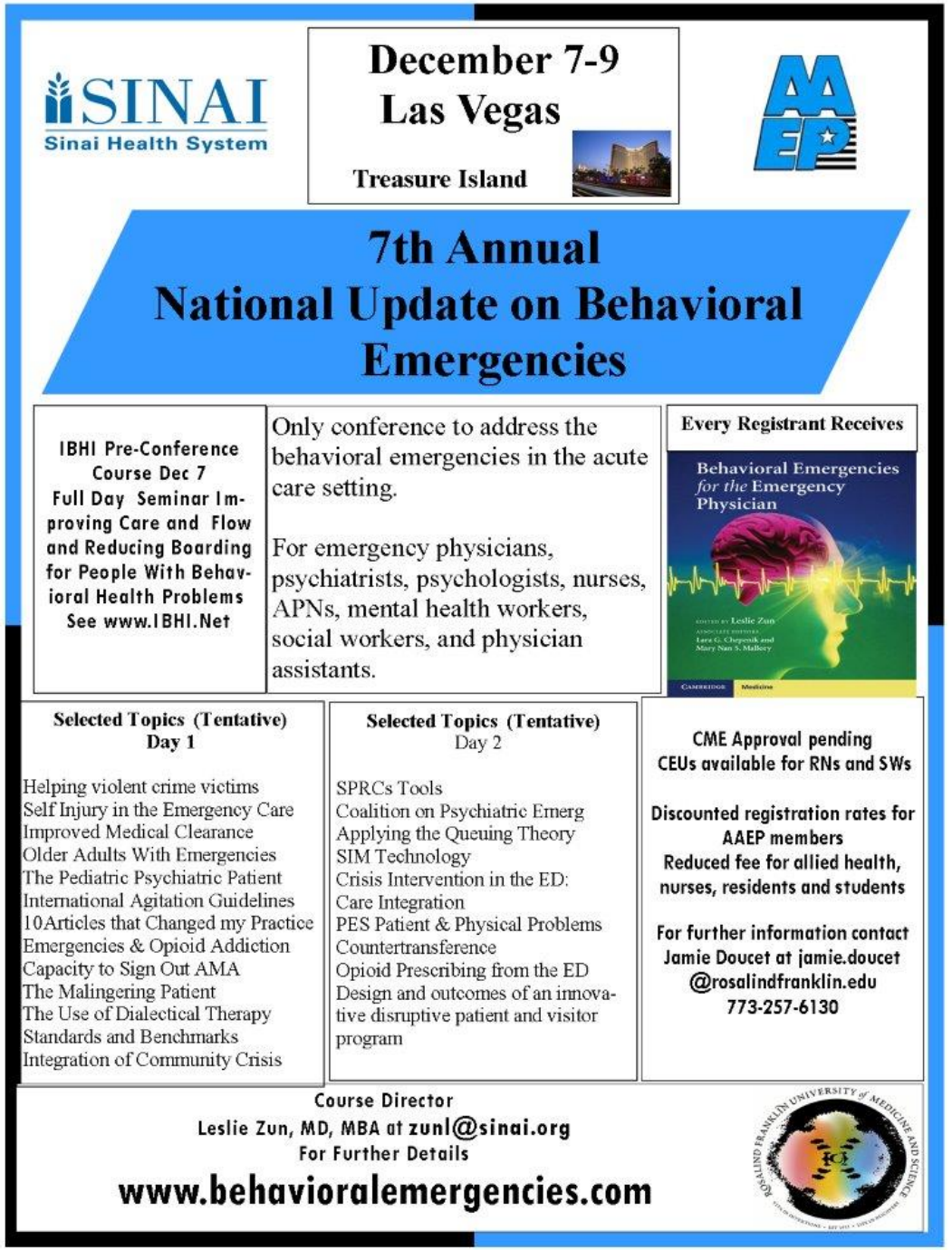
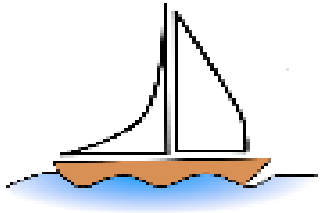


Implementing
Psychiatric ERs and Crisis Stabilization Units


***IMPROVING** TIMELINESS, ACCESS, AND QUALITY * * **LOWERING** COSTS AND RE-HOSPITALIZATIONS*

Scott Zeller, MD

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CEP America, Emeryville, CA

Assistant Clinical Professor of Psychiatry, University of California-Riverside

Past President, American Association for Emergency Psychiatry

Psychiatric Patients Adding to ED Overcrowding

- Patients waiting for a psychiatric bed wait three times longer than patients waiting for a medical bed in hospital EDs.

- ED staff spend twice as long locating inpatient beds for psychiatric patients than other patients

- Psych patients boarding in an ED can cost that hospital more than $100 per hour in **lost income alone**[1]

1. Treatment Advocacy Center, 2012

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
- Some psychiatric boarders even kept in the very expensive option of the Intensive Care Unit because of need for close supervision

ACEP Study Results 2008

- More than 90 percent indicated that they board psychiatric patients every week with more than 55 percent daily or multiple times per week.

- 62 percent indicated there are no psychiatric services involved with patient care while patients are being boarded in the emergency department prior to admission or transfer.

Psychiatric Patients Boarding in Medical Emergency Departments is a National Problem Getting National Attention


Redskins comeback falls short as Eagles win, 24-46. Sports

The Washington Post

Pulling the plug on a model Kabul clinic

Capital gains

Internet gambling battle heats up

The Seattle Times

StarTribune

Los Angeles Times

Bloomberg

Boarding Across the USA

- Studies showing average psychiatric patient in medical emergency departments boards for an average of between 8 and 34 (!) hours
  - 2012 Harvard study: Psych patients spend an average of 11.5 hours per visit in ED; those waiting for inpatient beds average 15-hour stay
  - 2012 CHA Study: After decision made for psychiatric admission, average adult waits over ten hours in California EDs until transferred

Impact of Boarding

- Boarding is a costly practice, both financially and medically
- Average cost to an ED to board a psychiatric patient estimated at **$2,264**
- Psychiatric symptoms of these patients often escalate during boarding in the ED

Nicks B, Manthey D. *Emerg Med Int*. 2012.

Boarding Solutions Suggested

- CMS “Emergency Psychiatry Demonstration Project” – not about Emergency Psychiatry, but about opening selected private psychiatric hospital beds to Medicaid

- Collaboratives to Identify Open Psychiatric Beds in a Region

- **More beds, someone? Anyone? Bueller?** But not a likely option – building de novo psych beds a very expensive and long-term project that counters current political and philosophical treatment approaches

Boarding Solutions Suggested

- Most suggestions still follow concept that virtually all emergency psychiatric patients need hospitalization as the only 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% 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?***

Psychiatric Emergencies *are Medical Emergencies*

- Federal EMTALA Laws already designate psychiatric emergencies as equivalent to heart attacks and car accidents – time to start intervening with the same urgency and importance as medical emergencies

- Psychiatric Emergencies are not going to “go away” – better to start preparing for these, and designing emergency programs with the recognition that abilities to treat crises are as necessary to ERs as EKG machines, oxygen and IV equipment

- Creating strategies for appropriate level of psychiatric emergency care will actually cost less and save money over the status quo!

"Zeller's Six Goals of Emergency Psychiatric Care"[1]

- **Exclude medical etiologies 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**

1. Zeller, *Primary Psychiatry*, 2010

ACEP Study Results 2008

- 81% of surveyed emergency medicine leaders agreed that regional dedicated emergency psychiatric facilities nationwide would be **better** than the current system

Regional Dedicated Emergency Psychiatric Facilities

A 2003 survey of psychiatric consumers reported that a majority had **unpleasant experiences** in medical emergency facilities and would prefer treatment in a specialized

Psychiatric Emergency Service location.

Allen MH et al. Journal of Psychiatric Practice, 2003

Regional Dedicated Emergency Psychiatric Facilities

- EMTALA-compliant “dedicated emergency departments” for mental health crises, both voluntary and involuntary

- Can serve to screen/evaluate and treat all acute psychiatric patients for a region, eliminating need for urgent psychiatric consults in a general ED

Regional Dedicated Emergency Psychiatric Facilities

- Can accept self-presentations and ambulance/police directly, only medically-unstable psychiatric patients go to general EDs
- Accepts medically-stable transfers from area medical EDs that do not have psychiatric care onsite
- “Higher Level of Care” outpatient service so no need to wait for “a bed” to transfer from general ED – comparable to transferring patient to a trauma service from general ED

Regional Dedicated Emergency Psychiatric Facilities

- Are considered an outpatient service, avoid many of the regulatory demands of inpatient psychiatric care
- Thus no need for actual “number of beds” which would limit capacity – many programs use recliner chairs or other furniture that flattens out for rest/sleep
- Focus is on relieving the acute crisis, not comprehensive psychiatric evaluation – much like medical emergency departments, *treat the presenting problem*

Regional Dedicated Emergency Psychiatric Facilities

- Will treat onsite up to 24 hours (or longer in some areas), avoiding many inpatient stays
- Discharge rates within first 23 hours of 70% or higher very common, meaning less that 30% admitted to inpatient beds – better for patients and preserves inpatient bed availability
- Of great interest to insurance companies, which are often willing to pay more than daily hospital rate for single day of crisis stabilization to avoid multiple-day inpatient stay

Alameda Model

- Serves as a Regional Dedicated Psychiatric Emergency Service (PES) for all of Alameda County, large county with population > 1.5 Million (Oakland, Berkeley, Fremont etc.)

- Accepts patients from all eleven (11) adult medical Emergency Departments in the region as soon as medically stable, regardless of insurance coverage

Alameda Model

- Almost no police transport of patients for psychiatric evaluations, which can “criminalize a psychiatric crisis”
- Instead, peace officers placing a 5150 hold summon an ambulance, then paramedics do a field screening with criteria approved by PES and EMS
- Transport decision based on medical stability
  - Medically stable go directly to PES (2/3 of all patients)
  - Medically unstable go to nearest of 11 area Emergency Departments for medical clearance (1/3 of all patients)

Alameda Model – John George PES

- John George Psychiatric Hospital is a stand-alone psychiatric-only campus, part of eight-campus medical center
- Main affiliated medical ED is 12 miles away
- John George campus has 69 inpatient psychiatric beds and EMTALA-compliant PES
- PES has attending-level psychiatrists on duty 24/7/365

Alameda Model – John George PES

- Currently averaging 1500-1800 very high acuity emergency psychiatric patients/month, approximately 85% on a 5150 involuntary detention
- Focus is on collaborative, non-coercive care involving a therapeutic alliance when possible, with voluntary treatment in the least-restrictive setting as the goal
- Presently averaging **only 0.1% of patients placed in seclusion/restraint** – comparable USA PES programs average 8%-24% of patients in seclusion/restraint
- John George Psychiatric Hospital in Top 10% of patient satisfaction scores in USA though competing with voluntary, luxury facilities

2014 Alameda Model PES Study

- Compared medical ED psychiatric patient boarding times and hospitalization rates in a system with a Dedicated Regional Psychiatric Emergency Service to statewide averages in California

- Published in

Western Journal of Emergency Medicine
http://escholarship.org/uc/item/01s9h6wp

Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments

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Introduction: Mental health patients boarding for long hours, even days, in United States emergency departments (EDs) awaiting transfer for psychiatric services has become a considerable and widespread problem. Past studies have shown average boarding times ranging from 6.8 hours to 34 hours. Most proposed solutions to this issue have focused solely on increasing available inpatient psychiatric hospital beds, rather than considering alternative emergency care designs that could provide prompt access to treatment and might reduce the need for many hospitalizations. One suggested option has been the "regional dedicated emergency psychiatric facility," which serves to evaluate and treat all mental health patients for a given area, and can accept direct transfers from other EDs. This study sought to assess the effects of a regional dedicated emergency psychiatric facility design known at the "Alameda Model" on boarding times and hospitalization rates for psychiatric patients in area EDs.

Alameda Model Study:
Benefits of PES to a Medical System

- Psych patient boarding times in area EDs were only One Hour, 48 minutes – compared to California average of Ten Hours, 03 minutes:

  an **improvement of over 80%**

- Approximately **76% of these patients were able to be discharged** from the PES, avoiding unnecessary hospitalization and sparing inpatient beds for those with no alternative

Study: Benefits of PES to System

- 2/3 of patients deemed medically stable in field, brought directly to PES, avoiding area medical EDs altogether
- PES programs **can reduce overall costs by average of thousands of dollars per patient**, while leading to improved quality and access to care, and decreased hospital admissions
- Adding a PES in appropriate systems perfectly aligns with these goals of healthcare reform

Regional Dedicated Emergency Psychiatric Facilities

- Can be expensive to staff and maintain 24/7
- But California Medicaid (Medi-Cal) pays hourly bundled “Crisis Stabilization” rate (also available in several other states), as do many private insurers via contract, but difficult to get adequate Medicare reimbursement
- Crisis Stabilization pays hourly in California for up to 20 hours maximum, enough to make programs self-sufficient
- Yet total cost for top Crisis Stabilization reimbursement is still LESS than typical cost just to board a psychiatric patient in a medical Emergency Department

Crisis Stabilization Units (CSU)

- Similar to outpatient-level program of Psychiatric Emergency Facilities, but do not directly accept ambulances
- Typically affiliated with medical ED, which will receive patients, do physician evaluation, transfer medically appropriate patients to CSU
- Can fill same role as a “PES” in systems with lower census numbers, for less staffing and less costs
- Many variations on PES/CSU model, with many names – but all with idea that patients can improve in < 24 hours, and patients do better in appropriate setting/treatment

Increasing Emergency Psychiatry Programs Nationally

- All Medicare, Medicaid, Private Insurers should have available Crisis Stabilization hourly rate
- This will make programs self-sufficient or even profitable, which will lead more provider organizations to consider implementing without need for public funds!
- Creative staffing mixes including use of “peer” counselors can provide high quality while being cost-effective

Applicability

- “**But can this work in our system?”**
- A model of Crisis Stabilization can be developed for just about any size hospital or community mental health program
- **Burke Center, Texas**
  - Remote PES served by telepsychiatry 50 miles from nearest delivery point for FedEx
  - Winner of American Psychiatric Association

    “**Gold Award** for Innovation”

Increasing Emergency Psychiatry/ Crisis Stabilization Programs Nationally

Perfectly aligned with health care reform: improves access to care, quality of care, and timeliness of care, while being **patient-centric**, avoids unnecessary inpatient hospitalizations and rehospitalizations, and dramatically lowers overall costs.

Questions

THE DISCONTINUUM:

Or How I Learned to Stop Worrying and Love Boarding & Multiple ED Visits

Jon S Berlin MD

APA IPS 2016

DISCLOSURES

No ties to industry

Currently working in sub-acute and ambulatory care settings.

MAIN POINTS

- To succeed, deinstitutionalization requires easy movement between community and hospital settings.

- Even with this, some patients fail.

- Boarding cases and frequent visitors are loaded with information for improving the system.

The ER, 50 Years On. Kellermann AL, Martinez R. NEJM 364;24. June 16, 2011

DATA

- Approx. 5% of persons with severe mental illness have needs that cannot be met by existing alternative community placements coupled with crisis hospitalization.

Beyond Deinstitutionalization: A New Class of Facilities for the Mentally Ill. Gudeman JE, Shore MF. *NEJM* 311;13. Sept 27, 1984.

FIVE MOST DIFFICULT TYPES

1. Elderly with dementia & psychosis

2. D/D with severe behavior problems

3. Impulse control D/O with head trauma or neurodegenerative disorders

4. Severe mental illness with persistent high risk of harm to self, others, sexual offending. Some schizophrenia, some borderline PD too severe for DBT

FIVE MOST DIFFICULT cont'd

5. Disruptive, regressed, vulnerable schizophrenia. "exhibit behaviors that make them vulnerable to exploitation and are unacceptable even in enlightened communities.

Eg, random yelling on the street, walking into strangers' homes, disrobing, open masturbation, fire setting, refusing to treat bed bugs, refusing medical care, etc.

BOARDING

Multiple causes of boarding

All reversible with adequate knowledge, a cooperative community effort, and political will.

Practical Solutions to Boarding of Psychiatric Patients in the Emergency Department – Does Your Emergency Department Have a Psychiatric Boarding Problem? By Workgroup 3 of the Committee on Psychiatric Emergencies and the American College of Emergency Physicians. 2016.

https://www.acep.org/physician-resources/policies/policy-statements/practical-solutions-to-boarding-of-psychiatric-patients-in-the-emergency-department

CASE EXAMPLES

- High risk poor responders
- Boarding

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Integration of Care for the Patient in Crisis:

Community Engagement,
Re-Engagement &
Effective Outpatient Treatment

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The Problem

- SMI patient have HIGH rates of Tx Discontinuation
  - 30-45% don’t attend initial appointments
  - < 50% receive continuous care for 12 months

Result?

- Symptom relapse, inpatient readmission, homelessness, substance use, incarceration

TE Smith, et al: Determining engagement in services for high-need individuals with serious mental illness. *Psychiatric Services*, 2014 November 1; 65(11): 1378-80.

Origins

- Community Mental Health Centers Act (1963)
  - CMHC in every community
  - Decrease in Inpatient beds across U.S.
    - 400,000 in 1970 → now less than 50,000!

- Managed Behavioral Health Care (1980s, 90s)
  - Budget cuts/Low reimbursement for MH services
  - Limited medication coverage

Result?

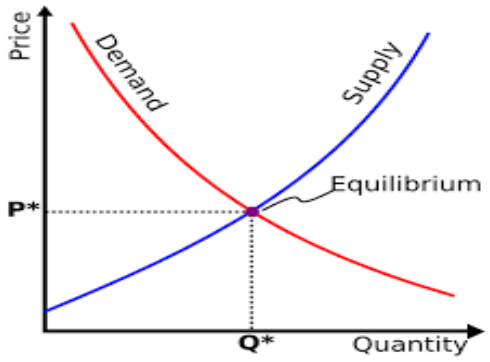
Reliance on ER "Safety Net"

Alakeson V, Pande N, and Ludwig M: A plan to reduce emergency room 'boarding' of psychiatric patients. *Health Affairs* 29, no. 9 (2010): 1637-42


IT'S GOOD TO SEE THE SAFETY NET STILL FUNCTIONING.
STAHLER

Economics 101

- (Mental) Healthcare DELIVERY Issue
  - Supply Chain issue
    - Starting in ER: long wait for an inpatient bed
  - Complex System
    - Variability in state, hospital, and insurance regulations
    - ER vs CMHCs: different Funding, Governance, Licensing
- SUPPLY & DEMAND
  - Shrinking psychiatric resources
  - Expanding patient population



American College of Emergency Physicians: Care of the Psychiatric Patient in the Emergency Department, A review of the literature. October 2014

Policy Overview

- Mental Health Parity and Addiction Equity Act (1996, 2008)
  - Equal financial requirements & treatment coverage for MH and Medical/Surgical benefits
  - “Carve out” MH benefits

- Affordable Care Act (ACA, 2010)
  - Expanded mental health and substance use disorder benefits & federal parity protections to approximately 62 million Americans

Policy Overview

- ACA, Section 2703
  - Medicaid Health Home State Plan Option
    - www.Medicaid.gov:

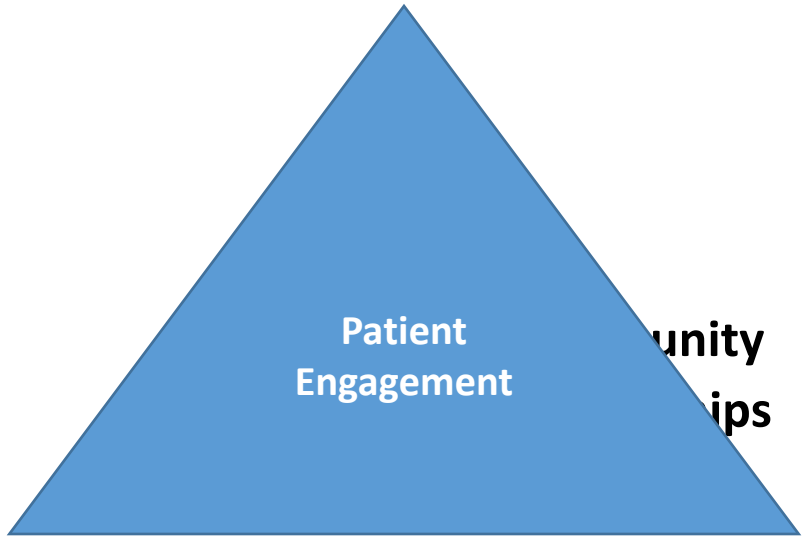
    "Health Homes providers will **integrate and coordinate** all primary, acute, behavioral health, and long-term services and supports to treat the **whole person**."

    - Chronic conditions (including MH and Substance Abuse)
    - State-designed, Federally funded

Alakeson V, Pande N, and Ludwig M: A plan to reduce emergency room 'boarding' of psychiatric patients. *Health Affairs* 29, no. 9 (2010): 1637-42

Community Engagement

Shared Responsibility of SMI Patients



Team-based Treatment

unity

ips

Shared Responsibility

- Collaboration between ERs and CMHCs
  - **Joint ownership of SMI patient needs**
    - CMH Liaison to ER
    - CMH staff on-call or in ER for treatment/disposition needs
    - ER communication with CMH (linked EHR?)
    - Timely follow up after discharge from ER/Inpatient unit
- Barriers
  - Separate funding/licensing/governance
  - No precedent

Alakeson V, Pande N, and Ludwig M: A plan to reduce emergency room 'boarding' of psychiatric patients. *Health Affairs* 29, no. 9 (2010): 1637-42

Team-Based Treatment

- Psychiatry
- Social Work
- Nursing
- Case Manager
- Peer Support
- Patient advocates (family, community, NAMI)
- Primary Care

CMH ⟷ Emergency Room

Community Partnerships

- Law Enforcement
  - Crisis Intervention Team (CIT)
  - Co-responder model
- Mental Health Advocacy Groups
- Companies
- Local/State government
- Academic medical centers
- Pharmaceutical companies

Alakeson V, Pande N, and Ludwig M: A plan to reduce emergency room 'boarding' of psychiatric patients. *Health Affairs* 29, no. 9 (2010): 1637-42

Comprehensive Community Crisis Services

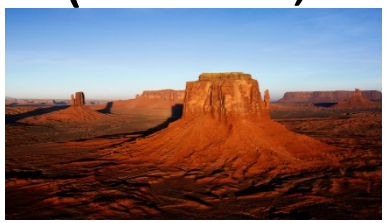
Crisis Care Center (San Antonio, TX)

THE CENTER
FOR HEALTH CARE SERVICES
Mental Health & Substance Abuse Solutions

Re: solve Crisis Network (Pittsburg, PA)

re:solve
CRISIS NETWORK
1.888.7.YOU CAN
(1.888.796.8226)

Community Partners, Inc. (Tuscon, AZ)



One size does NOT fit all

- Nearly 50% of patients with SMI did **not** receive MH treatment in prior year
- How to engage? Or re-engage?
  - RECOVERY (SAMHSA definition):

"a process of change through which individuals
  - improve their health and wellness,
  - live self-directed lives, and
  - strive to reach their full potential."

Dixon L, et al: Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry.* February 2016, 15: 13-20.


Hope
Person-Driven
Many Pathways
Holistic
Peer Support
Relational
Culture
Addresses Trauma
Strengths / Responsibility
Respect
SAMHSA's
WORKING DEFINITION OF
RECOVERY

Recovery-Oriented Care

- Strong therapeutic alliance
- Person-centered treatment
  - Housing, Finances, Employment
- Shared decision making
- Patient empowerment & Autonomy

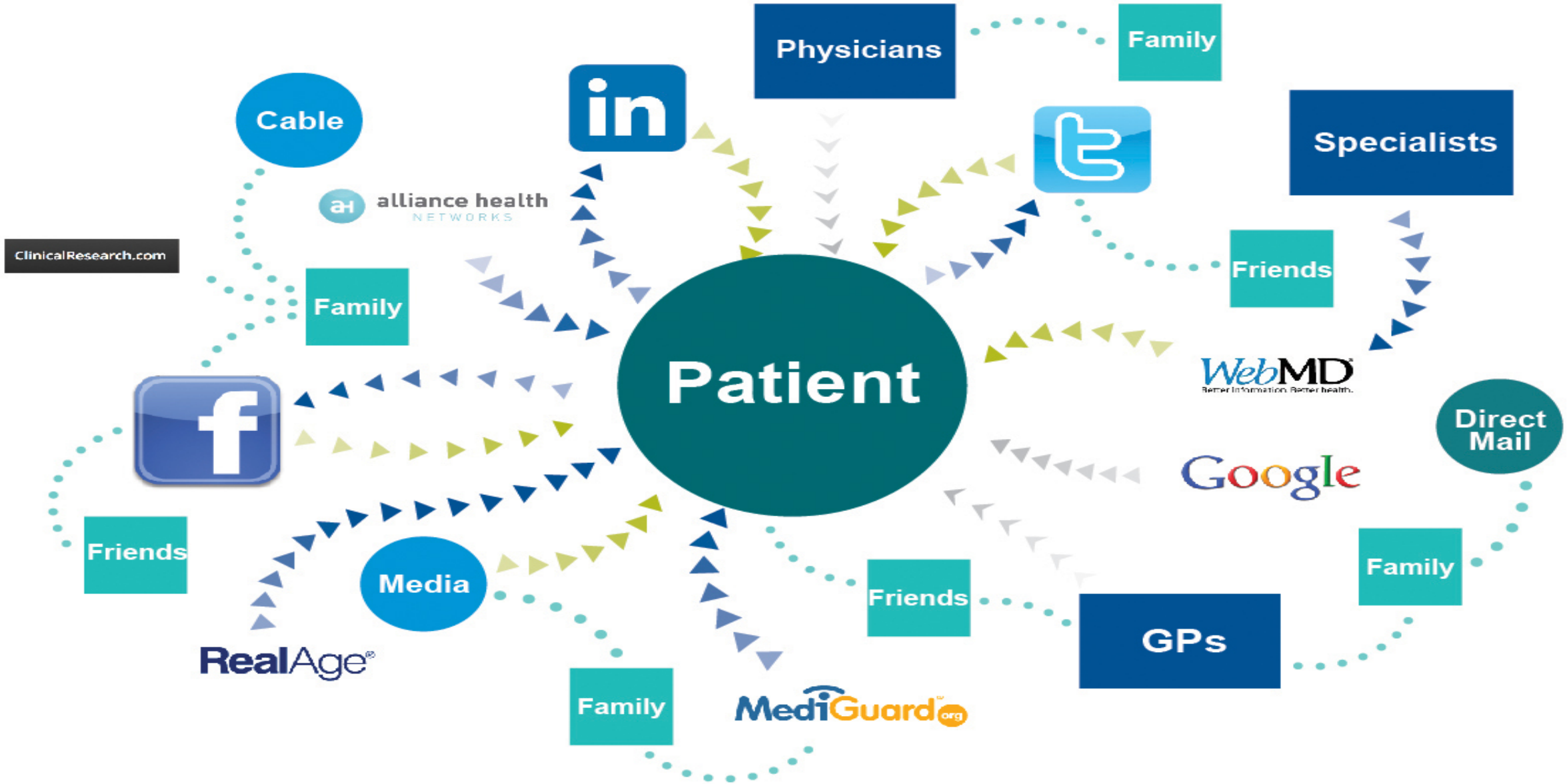
Engagement Now

- Assertive Community Treatment (ACT)
  - Homeless SMI population
  - Multidisciplinary team
  - Reduces ER use and hospitalization…but is it too passive?

- Integrated Care
  - Evidence-based best practice
  - MH services embedded in Primary Care
  - Now the reverse: Medical care embedded in CMHCs

- Telepsychiatry
  - Improved access
  - Low cost
  - Concerns: Privacy, Patient safety, reimbursement?

Unutzer J et al: The Collaborative Care Model: an approach for integrating physical and mental health care in Medicaid health homes. *Health Home Information Resource Center,* Center for Health Care Strategies, Inc. May 2013


Physicians
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Specialists
alliance health
NETWORKS
ClinicalResearch.com
Friends
Family
Patient
WebMD
Better Information. Better Health.
Direct Mail
Google
Friends
Media
Family
Friends
GPs
RealAge
Family
MediGuard.org

Disruptive MH Innovations

- Technology
  - Mobile phone check-ins
  - Online outreach (the new ACT?)
  - Consolidating EHRs
- Peer-based services
  - Medicaid reimburses
  - WRAP (Wellness Action Recovery Plan)
- Culturally competent Care

Dixon L, et al: Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry.* February 2016, 15: 13-20.

In Conclusion

- Triple Aim
  - Integration of care
  - Improved quality of care
  - Lower costs