Mental Health Crisis Case Management in a Rural Emergency Department

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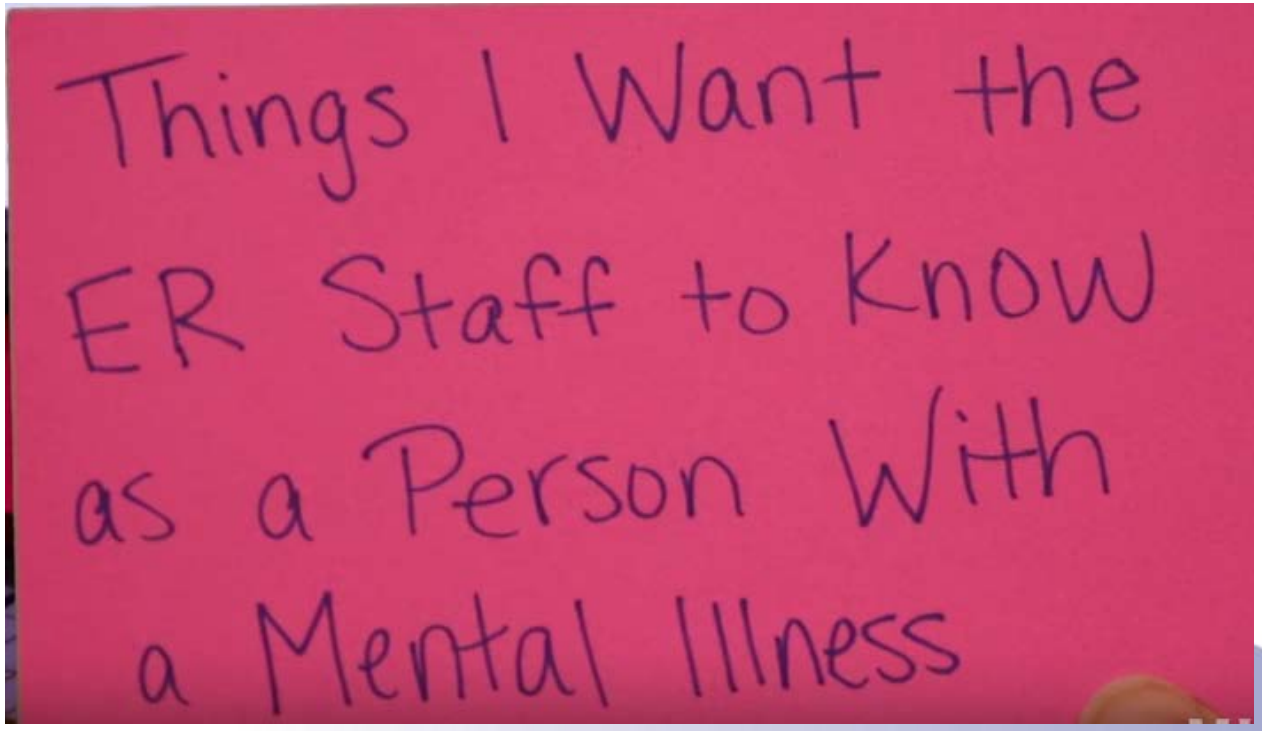
What if?

What if video

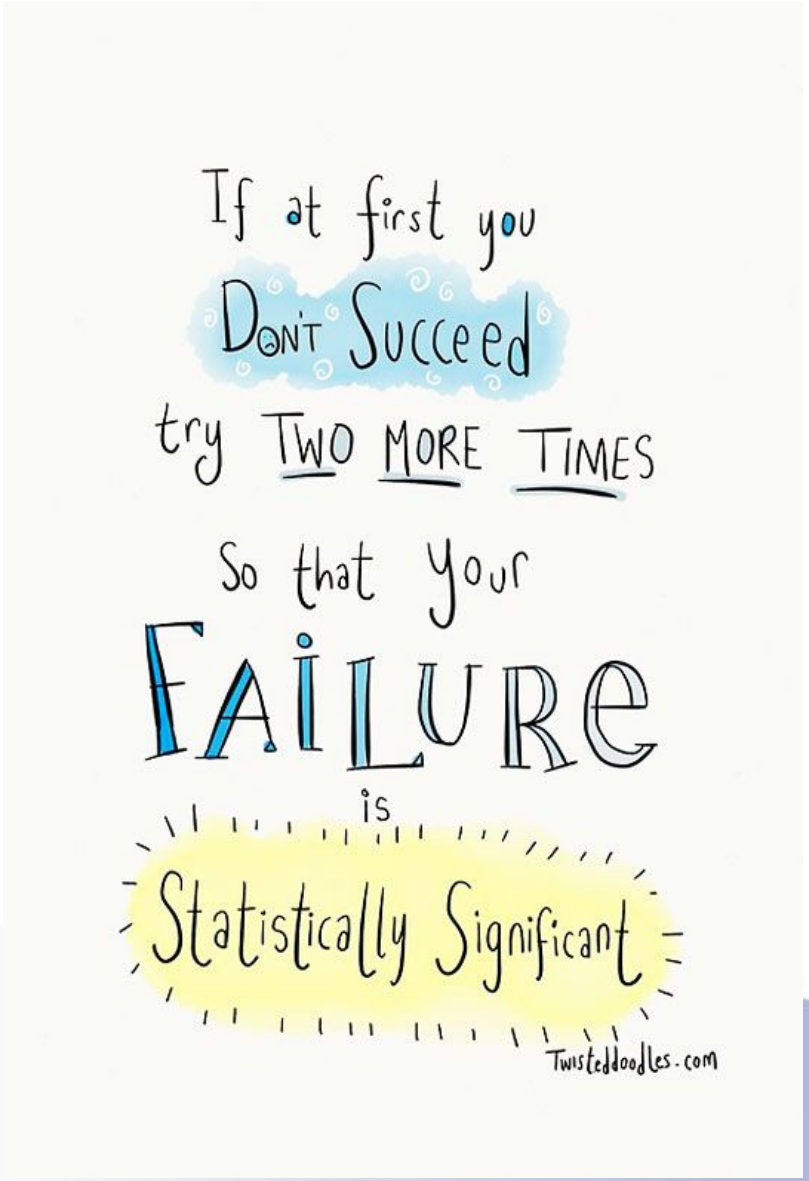
Objectives

- 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



Video Link


If at first you
Don't Succeed
try TWO MORE TIMES
So that your
FAILURE
is
Statistically Significant
Twistedoodles.com

Once upon a time…

…there was a country called America…

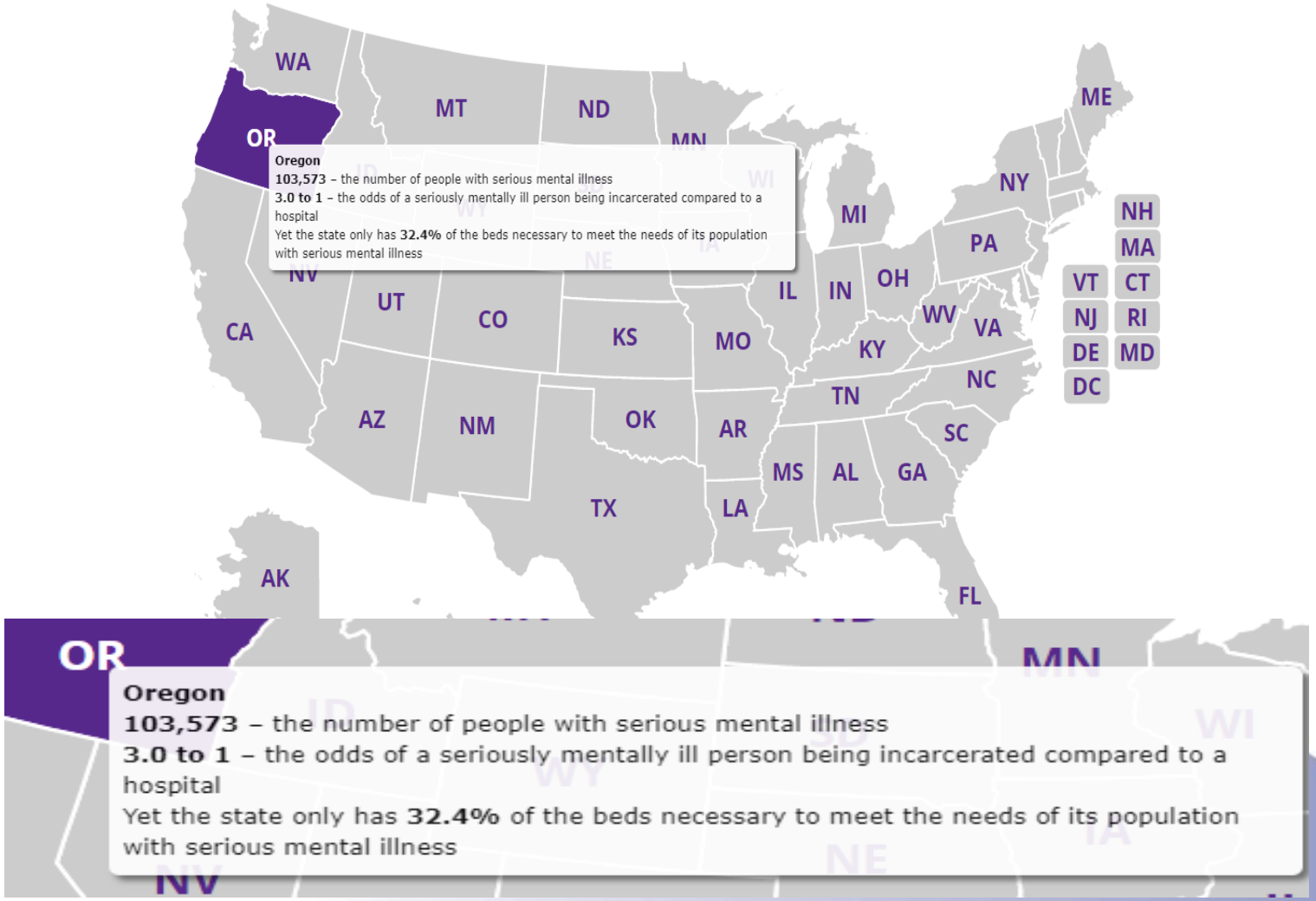
…and in this country…

- 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

…and in America there was…

…a state named Oregon…



Rank	State
1	Minnesota
2	Massachusetts
3	Connecticut
4	Vermont
5	South Dakota
6	New Jersey
7	North Dakota
8	Iowa
9	Alaska
10	New York
11	New Hampshire
12	Illinois
13	Maryland
14	Pennsylvania
15	Kansas
16	Delaware
17	Maine

Rank	State
18	Georgia
19	Colorado
20	Nebraska
21	Kentucky
22	Hawaii
23	California
24	Ohio
25	Florida
26	Oklahoma
27	North Carolina
28	DC
29	Wyoming
30	Missouri
31	Alabama
32	Michigan
33	Texas
34	Montana

Rank	State
35	Mississippi
36	New Mexico
37	Wisconsin
38	South Carolina
39	West Virginia
40	Tennessee
41	Arkansas
42	Virginia
43	Louisiana
44	Indiana
45	Idaho
46	Utah
47	Washington
48	Rhode Island
49	Nevada
50	Arizona
51	Oregon

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:

Psychiatric Beds in Short Supply

Around the country, state psychiatric hospital beds are in short supply and their numbers are declining. Advocates suggest at least 40 beds for every 100,000 people.

State	Psychiatric hospital beds (2010)	Psychiatric hospital beds (2016)	Beds per 100,000 people (2016)
Oregon	700	653	16.2

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

…and in the State of Oregon… Was a place called 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

Local Headline: Family Sues Over Oregon Bridge Suicide

- 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.

Q11: Usual source of behavioral health care for adults	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=25	Hispanic/ Latino/ Other n=1	200% FPL or lower n=11	201% FPL or higher n=10	Medicaid/ Other/ Uninsured n=9	Medicare n=11	Private n=6
Primary care clinic	50.0%	49.3%	*	63.6%	45.5%	76.4%	54.7%	33.3%
County clinic	14.0%	15.0%	*	33.4%	0.0%	13.7%	40.3%	0.0%
Hospital emergency room	4.1%	4.4%	*	0.0%	0.0%	0.0%	0.0%	0.0%
Other	32.0%	31.3%	*	2.9%	54.5%	9.8%	5.0%	66.7%

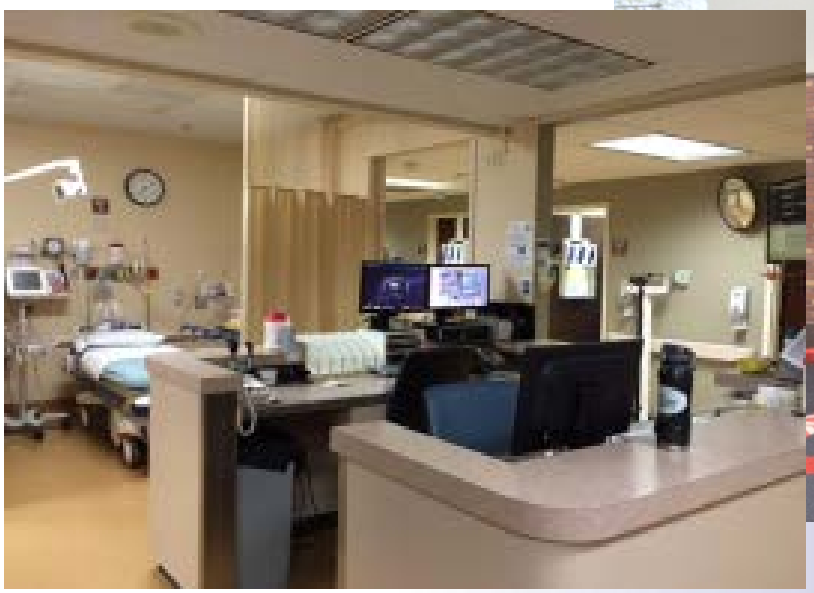
** We did not report results when five or fewer respondents from a subgroup answered the question.*

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.*

…and Serving the County was… a Critical Access Hospital Called Providence Seaside

Services include the entire North Coast with 25 hospital beds and rural health clinic

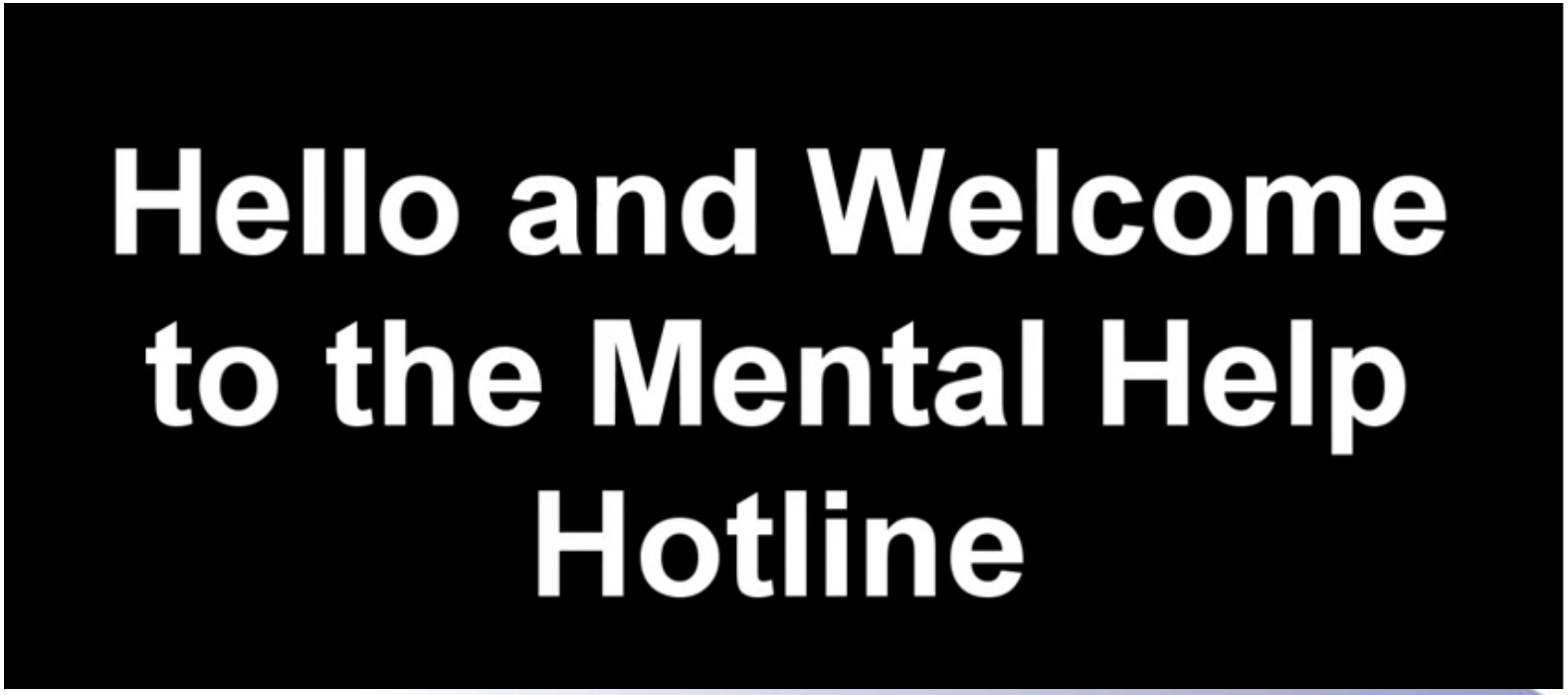
…and in Providence Seaside Hospital… was a Small Emergency Department With Seven Beds



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



Mental Health Hotline Video

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

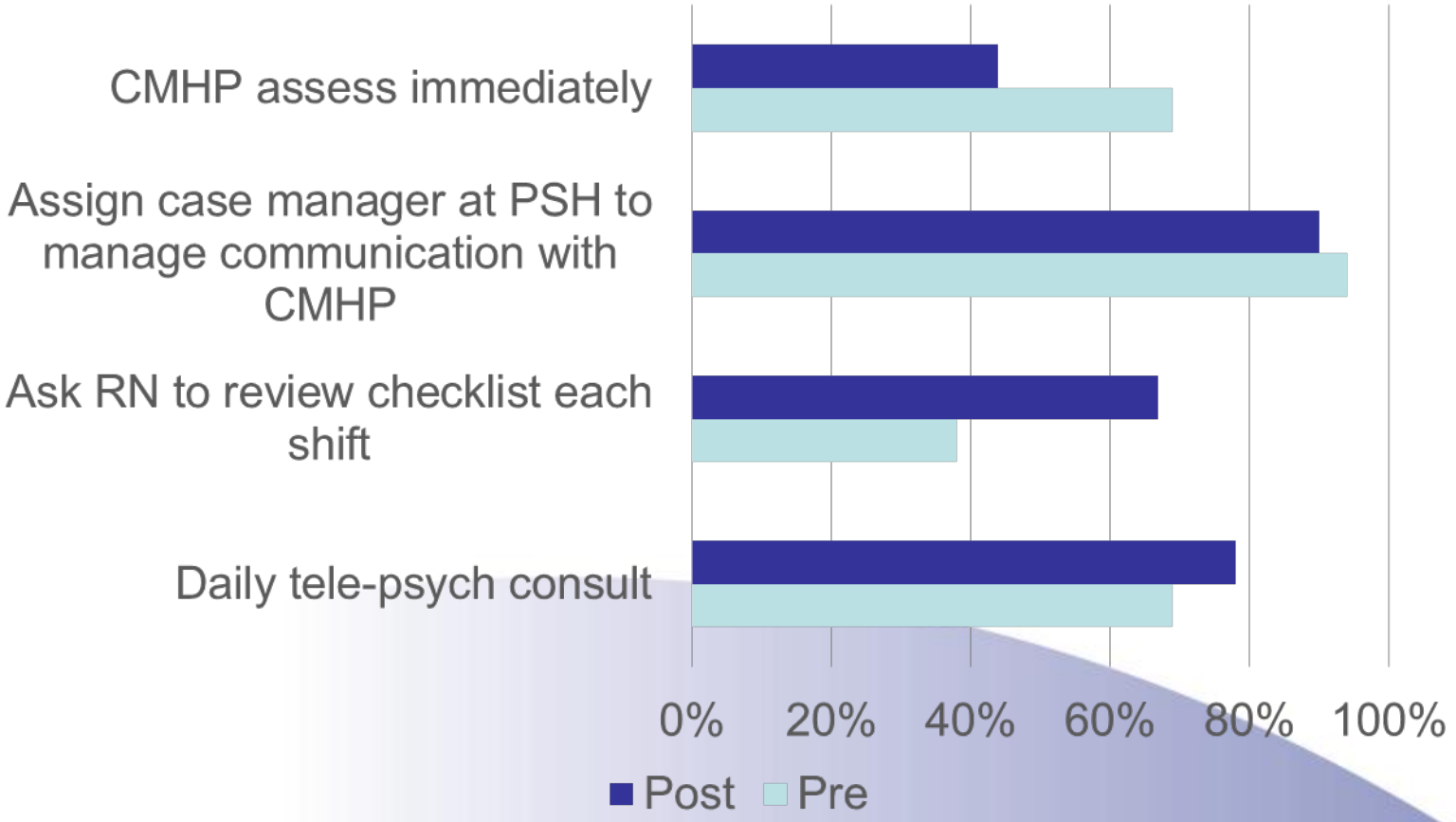
Barriers:

- SW Staffing
- SW Training needs

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?



ED feedback on Phase I

- Both 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 telepych consults and starting to administer medications quickly were both positively endorsed,

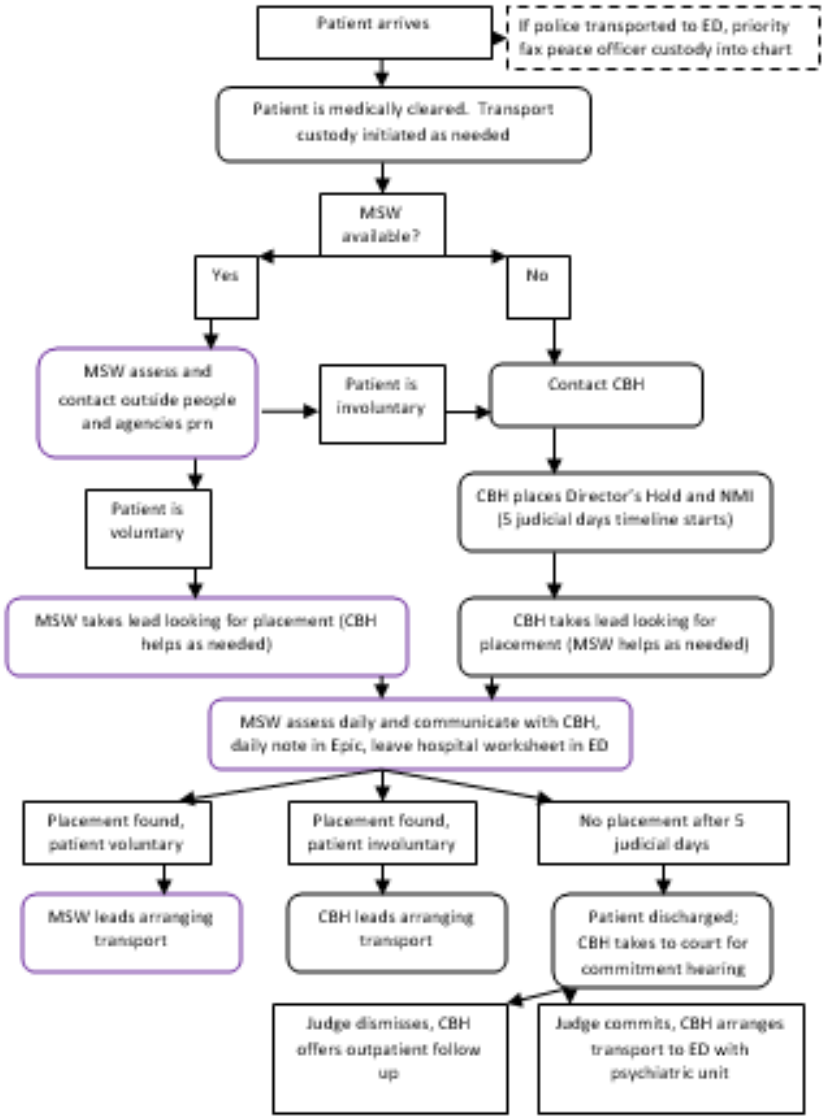
- The scarcity of inpatient psych beds was acknowledged and there is some hope that the respite center will be a valuable resource. There was a feeling that there could be better consistency among assessments and care planning by various CMHP workers, and feeling more outpatient support from CMHP is 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 + on call)
- Training on the law (Oregon Health Authority)
- Workflows & checklists
- DO something everyday (not “boarding”)

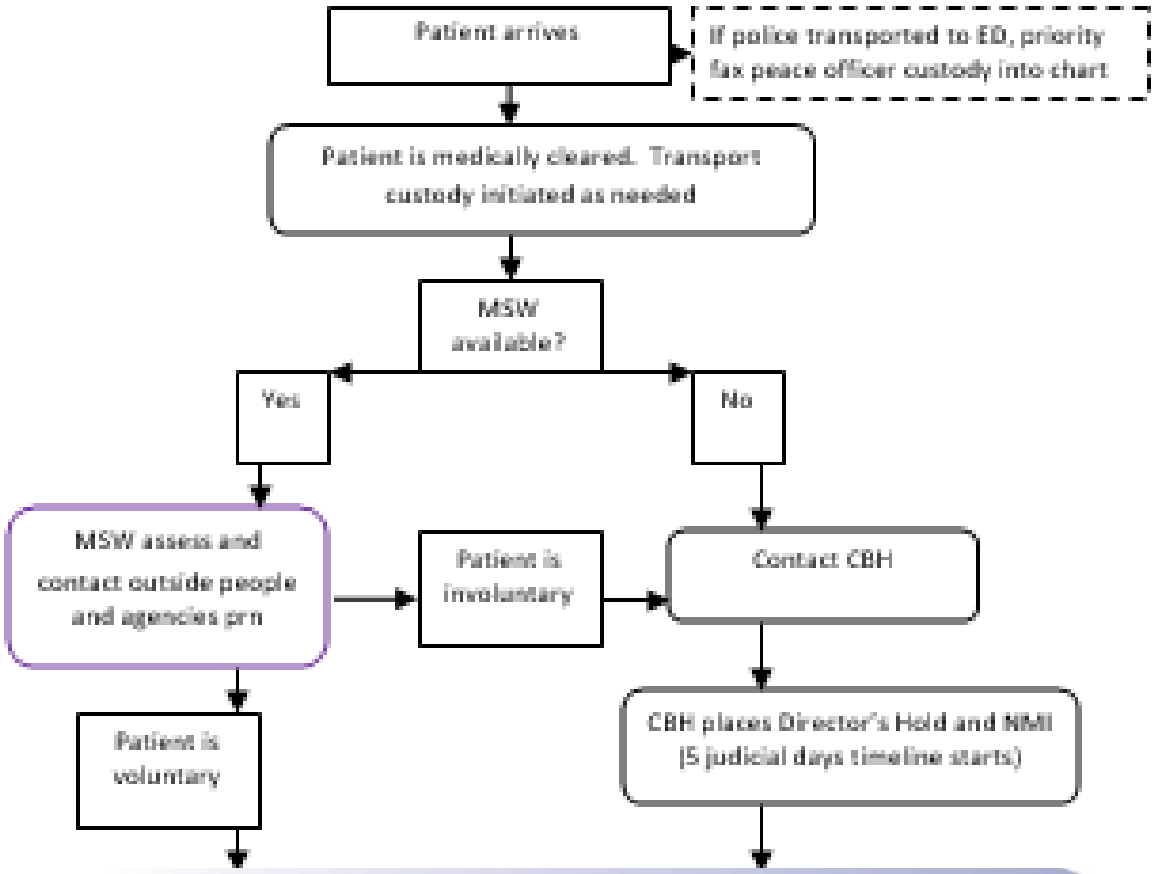
PROVIDENCE Health & Services

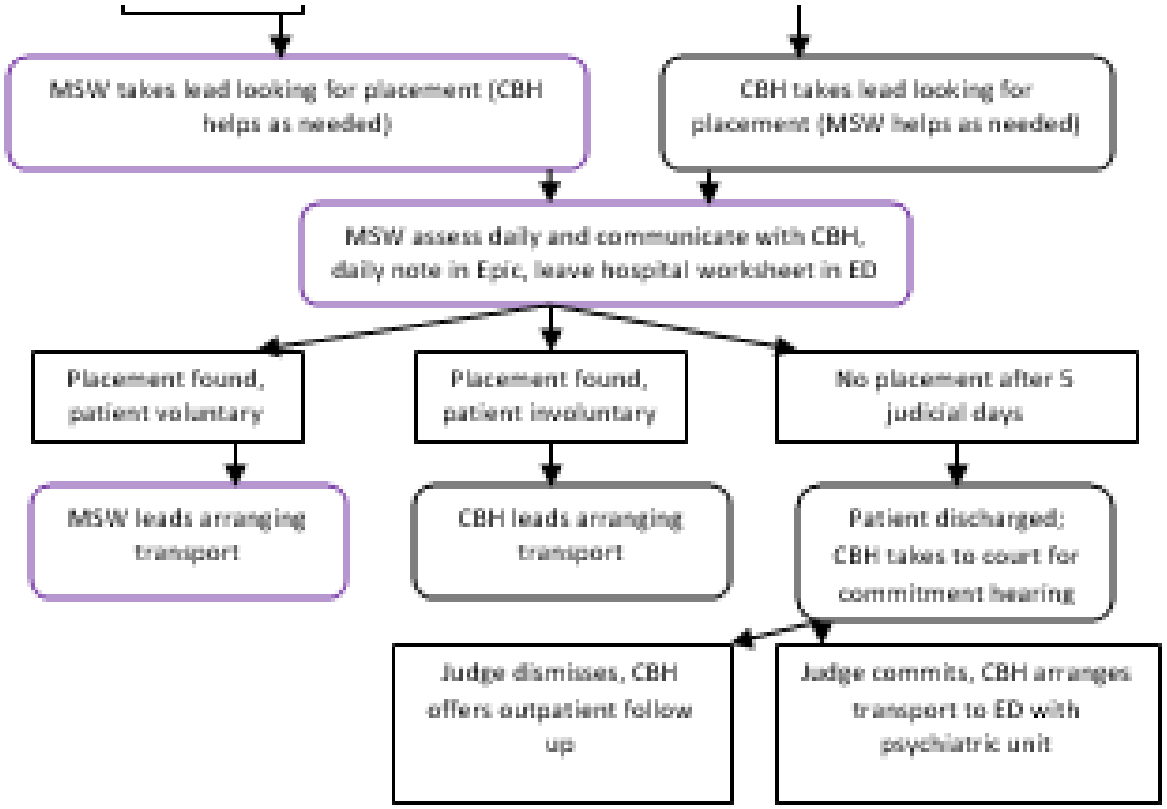
Management of patients in mental health crisis



Last updated: 6/15/2017

Management of patients in mental health crisis





Last updated: 6/15/2017

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

PROVIDENCE Health & Services

Phase I vs Phase II: What was different this time?

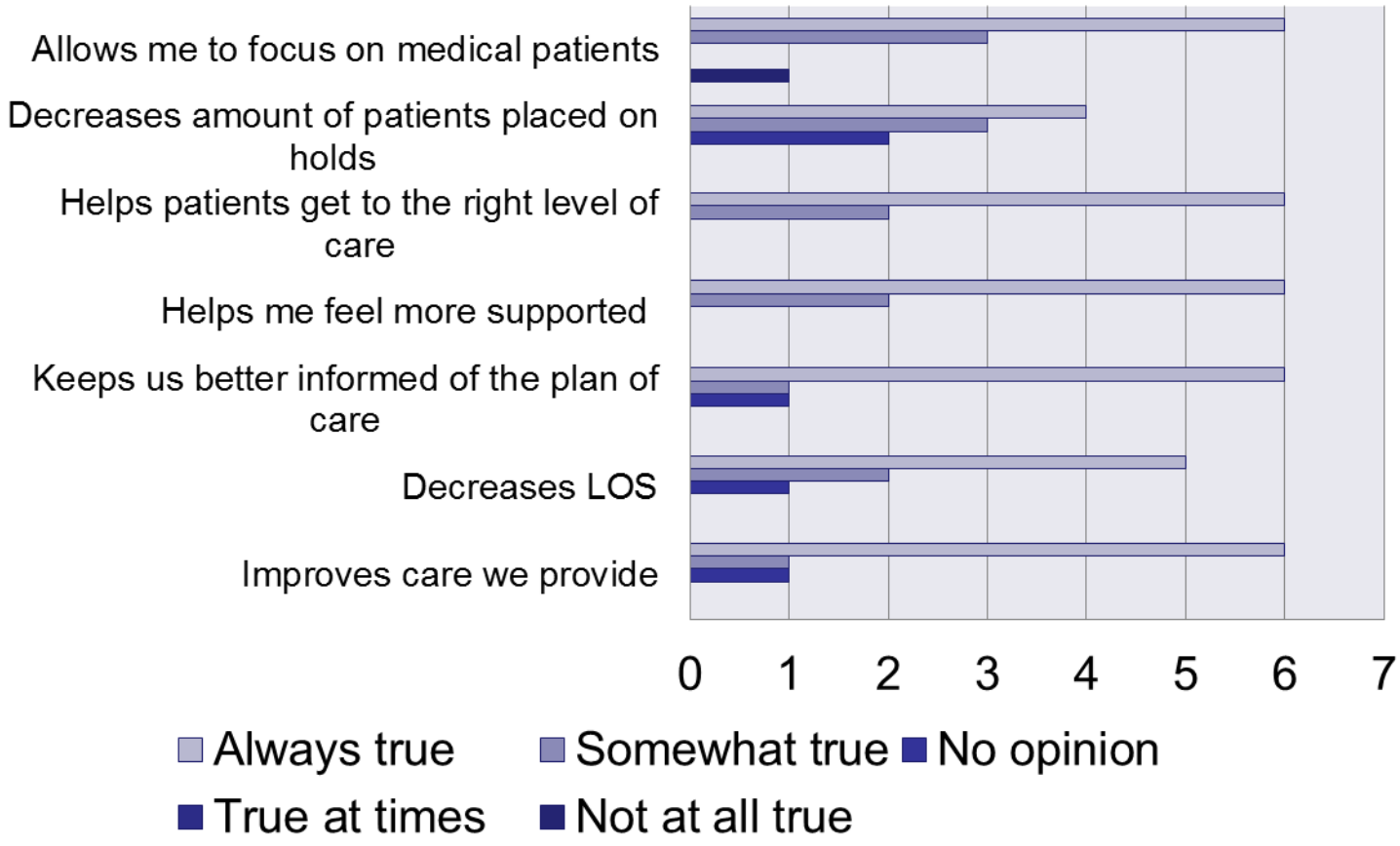
- Social Work managed communication
- Fax and call immediately (bed availability change quickly)
- Mental health professionals speaking the same language
- Improvement in daily management
- Social Work leads assessment and planning
- Owning and prioritizing dispo planning to minimize delays
- Clinical experience & close SW team communication (more consistency)
- And more…

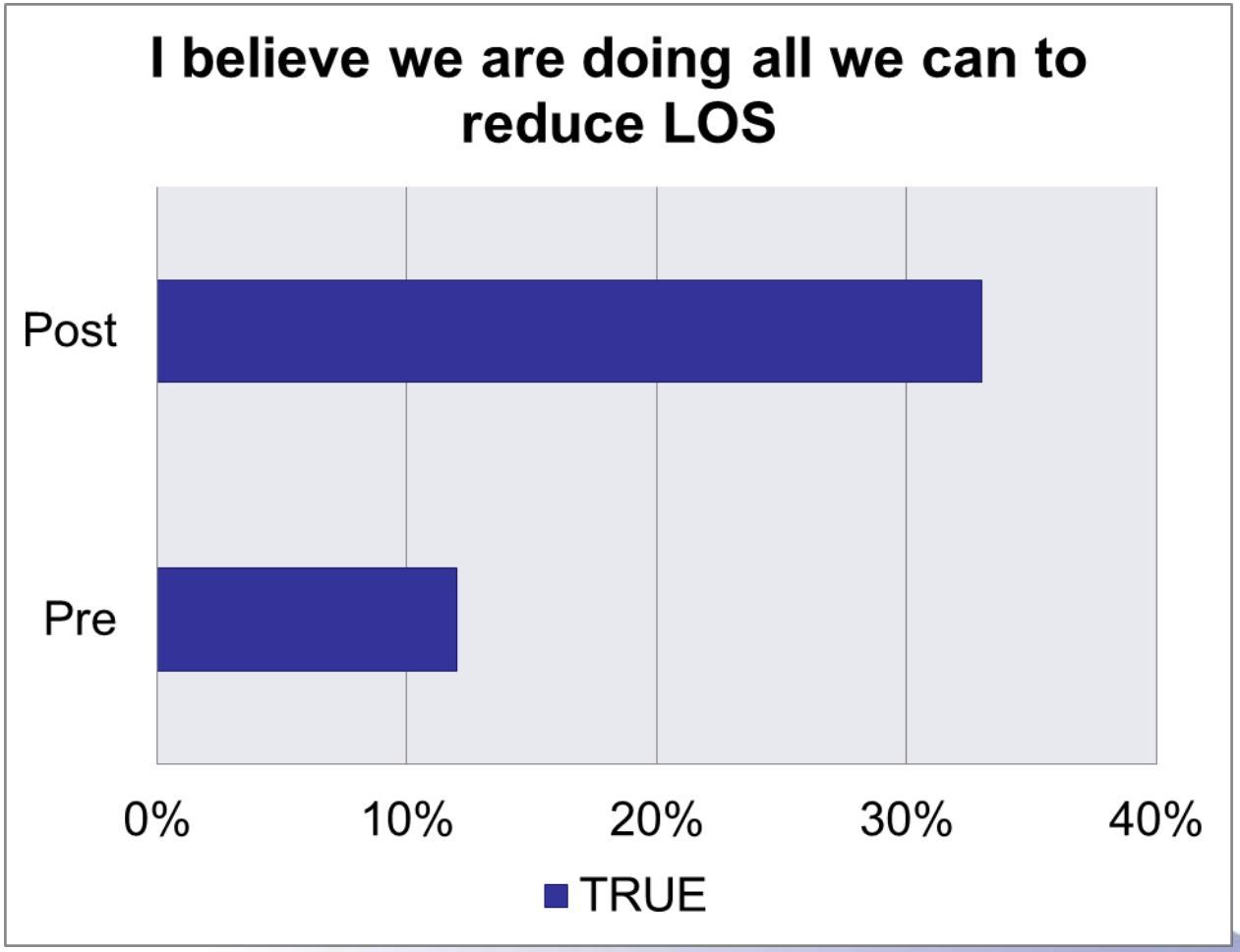
Additional benefits

- Better patient care and improved patient experience for mental health patient and other ED patients
- Improved caregiver experience, including increased job satisfaction for Social Workers – performing at top of clinical license
- Improved collaboration with CMHP; other staff shielded from process challenges
- Significant decrease in patients on “involuntary” status (civil rights)
- Decreased length of stay
- Increase in cost saving/less $ loss assumed

PROVIDENCE Health & Services

Compared with prior practice, having Social Workers case manage patients in mental health crisis in the ED...




I believe we are doing all we can to reduce LOS
Post
Pre
0%
10%
20%
30%
40%
TRUE

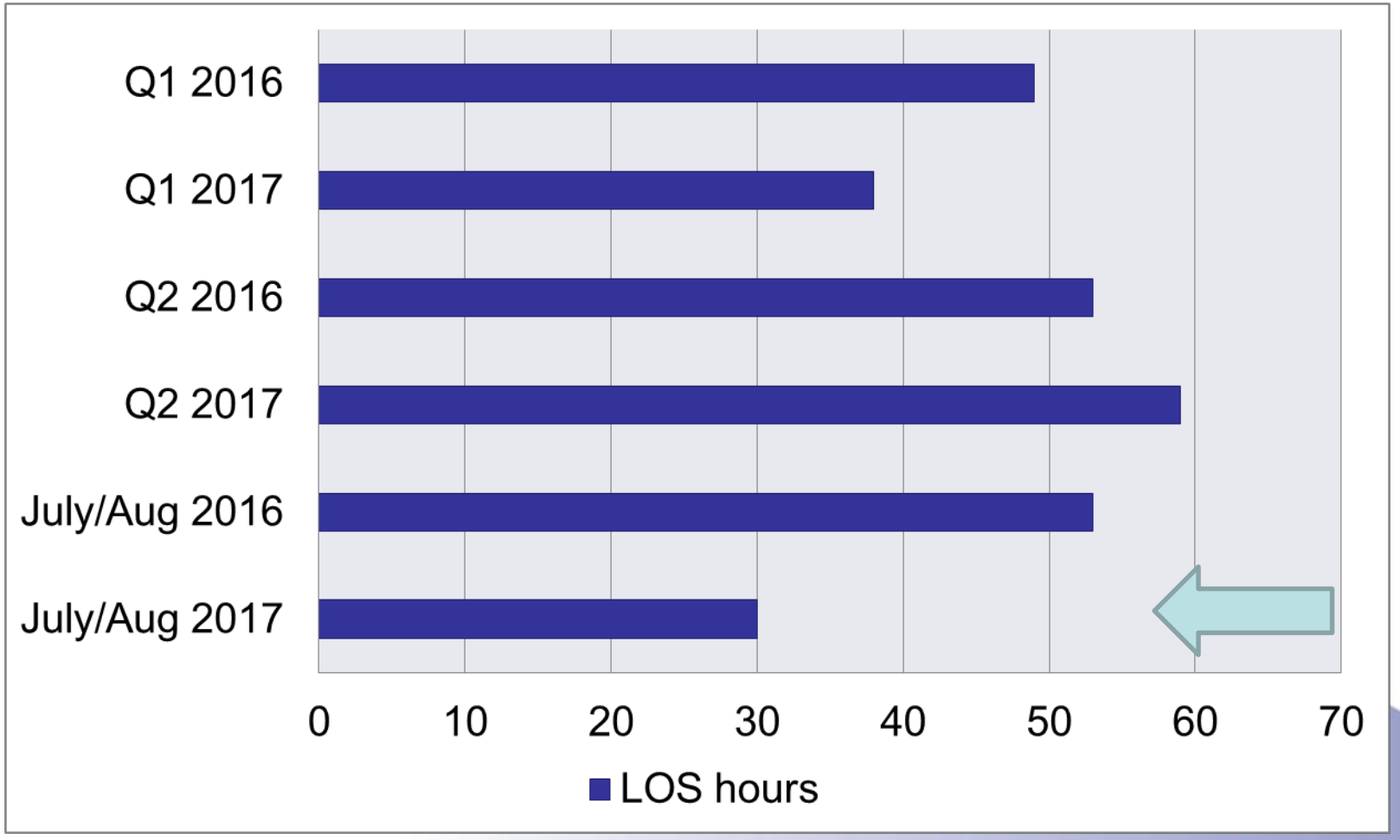
ED Feedback On Phase II

"Our Social Worker team has done much a 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



But What About…

…voluntary adults?

…under 18?

How long might they be in our ED?

Ongoing process improvement:

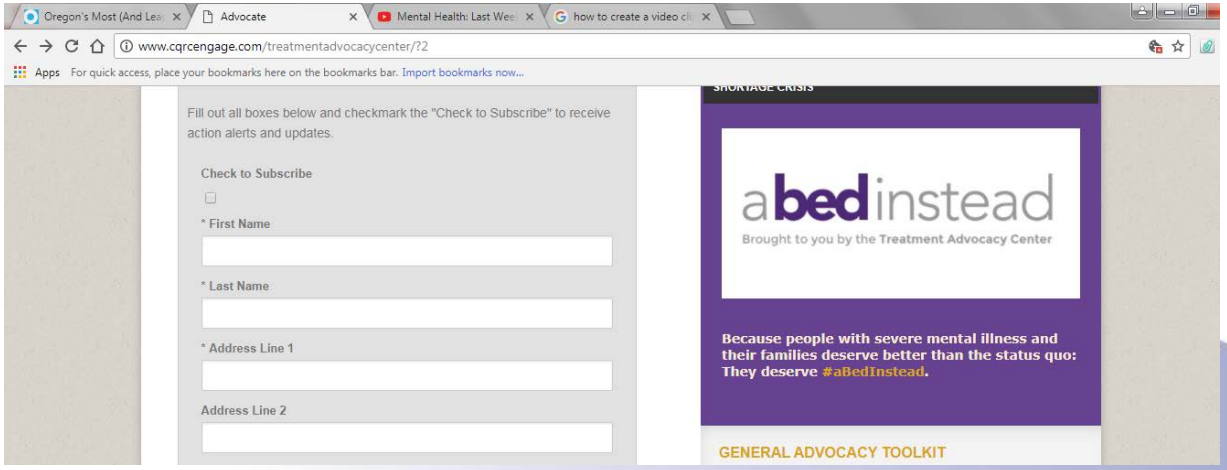
- Refine medication reconciliation process
- Clarify/solidify telepsychiatry consult process
- Further develop relationships with hospitals with psychiatric units
- Further refine documentation for all team members
- Continue to explore other interventions so patients are not “boarded” but are receiving treatment/help toward stabilization

What Can You Do?

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

- Advocacy - Be a voice for your community…we need you!

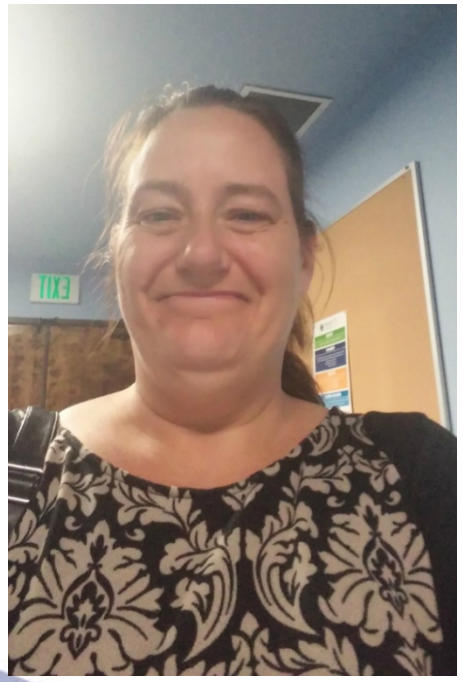
http://www.cqrcengage.com/treatmentadvocacycenter/?0



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



Video

“It Takes A Village”

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