ABC’s of PES

Greg Miller, MD MBA
CMO Unity Center for Behavioral Health
Content Outline

Overview of Unity Services

Emergency Psychiatry: Historical Perspective

Emergency Psychiatry: Current Service Delivery models

The Case for PES in Portland

Questions for Future Planning

Overview of Services in PES

Psychiatry Training in PES

What is our data telling us?

What are the next steps for the PES?
Unity Center for Behavioral Health

- **Unity Inpatient Services:** Opened January 31, 2017
  - 22 Inpatient Child and Adolescent Unit (ages 9-18)
    - Formerly 16 bed unit at Randall Children’s Hospital
  - 80 Adult Inpatient Beds
    - Four adult inpatient units
    - Soon to add an additional 5 inpatient beds
    - Formerly 90 beds operated between OHSU; Adventist Medical Center; Legacy Good Samaritan; Legacy Emanuel

- **Psychiatric Emergency Services (PES):** Opened February 2, 2017
  - Major innovation in mental health service delivery in Portland
  - 3-4 years of collaboration, planning and fund raising

- **Model of Care:**
  - Trauma Informed
  - Pathways to Recovery
MENTAL HEALTH SYSTEM
USA

"THERE'S REALLY ONLY ONE QUESTION—DO YOU HAVE MONEY?"
Emergency Psychiatry: Historical Perspective

- Community Mental Health Act: 1963
  - Funded development of CMHC’s
  - Converted to block grants to states during Regan
  - Less than ½ of planned centers built
  - Required that all funded centers provide for treatment of mental health emergencies

- Deinstitutionalization

- Emergence of SMI/ Homeless crisis in urban centers

- 1988: Requirement for emergency psychiatry training in psychiatry residency

unity center for behavioral health
<table>
<thead>
<tr>
<th>Psychiatric Emergency Services: PES</th>
<th>Comprehensive Psychiatric Emergency Programs (CPEP)</th>
<th>Non-hospital based Crisis Intervention/ Emergency Services</th>
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</thead>
<tbody>
<tr>
<td>• Initially segregated areas of care in Medical ED’s</td>
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<td>• Development of payment systems</td>
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<tr>
<td>• Unity PES: Licensed component of Emanuel ED</td>
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<tr>
<td>• Psychiatric Emergency Room</td>
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<tr>
<td>• Extended Observation Beds</td>
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<td>• Mobile Crisis Teams</td>
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<tr>
<td>• Crisis Residence</td>
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<tr>
<td>• Wide variety of models based on core desired outcomes</td>
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<tr>
<td>• Payer operated OR county OR local not-for profit</td>
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<tr>
<td>• Attached to services OR Integrated within CMHC’s</td>
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<tr>
<td>• Inpatient Diversion Services</td>
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<tr>
<td>• ED consultation often delivered by Crisis Teams</td>
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<tr>
<td>• Mobile Crisis Services</td>
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The Case for PES In Portland

Emergence and Increase of Mental Health Boarding in Medical ED’s
- Often full evaluation did not occur in ED leading to increased admissions
- ED Divert time and delivery of necessary medical care impaired
- High cost impact
- Increased restraint rate

Closure of POSH

Strange bedfellows! (Collaboration of Partners)

Fund Raising Success (Portland is generous)
### Questions for the Future

<table>
<thead>
<tr>
<th>Are Emergency Psychiatric Services a permanent part of ideal community psychiatry services?</th>
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<td>• Centralized vs localized</td>
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<td>• Hospital based vs detached?</td>
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<tr>
<td>• Community services driven vs acute care driven</td>
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<th>Elaboration of the Psychiatry Practice model</th>
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<tr>
<td>• Differences in practice are significant, but poorly studied</td>
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<td>• Problem focused vs comprehensive</td>
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<td>• Triage based (demand dependent) vs definitive services</td>
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<tr>
<td>• Practice Guidelines</td>
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<tr>
<td>• Training</td>
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<td>• Research</td>
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</table>
123’s of PES

Anne Gross, MD
PES Medical Director
Consultation-Liaison Psychiatry Fellowship Director
Associate Professor, Department of Psychiatry, OHSU
What Clinical Services Are Offered In The PES?

- Multidisciplinary assessment and treatment plan involving BHAs/BHT, nursing, CIS and providers
- Symptom stabilization for up to 24 hours
- Care coordination
- Peer support
- Co-located partners
- Legacy Internal Medicine consultation if needed
What Educational Opportunities Are Offered In The PES?

- PGY2 6 week psychiatry rotation
- MS III exposure while on inpatient rotation
- Medical student elective
- PMHNP students
What Innovation Has Occurred In The PES?

- Trauma informed approach to emergency psychiatry
- Multidisciplinary emphasis
- Physical environment
- Integrated peer support
- Triage acuity scale developed by Andrea Hughes DNP, PMHNP-BC
How Many Patients Are Being Seen In The PES?

Visits

Avg Daily

[Graph showing visits and average daily visits from February to December with an upward trend]
Where Are The Patients Coming From?

Non-Transfer 82%
Medical ED 16%
Hospital medical unit 2%
Medical Inclusion and Exclusion Criteria

Medical Inclusion
- Voluntary patient or patient on police or mental health director hold.
- Primary 911 call or police request.
- Age between 18-70.
- Mental Health complaint (depression, psychosis, suicide or homicidal ideation), substance abuse or behavioral disorder with no acute medical or traumatic condition requiring treatment.
- Alert and oriented to person, place, and time.
- No evidence of trauma other than minor abrasions.
- Able to perform activities of daily living (ambulate, bathe, toileting, eat and drink).
- If CBG is obtained, between 60 and 300 mg/dl.

Vital Signs
- HR 60-130.
- O2sat > 90%.
- Systolic BP 90-200 mm Hg.
- Diastolic BP < 110 mm Hg.
- Temperature between 96.0 and 100.4 F (38C) if taken.
Medical Inclusion and Exclusion Criteria

Medical Exclusion

- Possible drug overdose or acute intoxication impairing ability to ambulate or perform activities of daily living.
- Acute medical or traumatic condition including altered level of consciousness, chest or abdominal pain, significant bleeding, respiratory distress, or acute illness or injury.
- Patients with abnormal vital signs or physical findings.
- Patients who require chemical restraint (olanzapine ODT IS NOT an exclusion).
- Signs/ symptoms of acute drug/alcohol withdrawal (tachycardia, hypertension, tremor, visual hallucinations).
- Central or peripheral IV lines.
What Is The Payer Mix of Patients Presenting To The PES?

- MGD MCAID: 51%
- Medicaid: 13%
- Medicare: 12%
- Commercial: 13%
- MGD MCARE: 8%
- Self-pay: 3%
When Do Patients Most Commonly Present To The PES?

Provider and CIS in triage
PES Seclusions

Count of Events and Avg Length
February - December 2017

- Events: 6, 13, 20, 41, 23, 19, 22, 28, 32, 24, 9
- Avg Length: 3.83, 3.88, 4.52, 5.22, 6.21, 4.86, 3.40, 4.04, 4.15, 3.46, 2.03

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# PES Restraints

## Count of Events and Avg Length

February - December 2017

<table>
<thead>
<tr>
<th>Month</th>
<th>Events</th>
<th>Avg Length</th>
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<tr>
<td>Feb</td>
<td>3</td>
<td>3.57</td>
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<tr>
<td>Mar</td>
<td>4</td>
<td>0.90</td>
</tr>
<tr>
<td>Apr</td>
<td>5</td>
<td>1.20</td>
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<tr>
<td>May</td>
<td>9</td>
<td>2.08</td>
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<tr>
<td>Jun</td>
<td>5</td>
<td>2.46</td>
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<tr>
<td>Jul</td>
<td>2</td>
<td>0.54</td>
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<tr>
<td>Aug</td>
<td>0</td>
<td>0.00</td>
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<tr>
<td>Sep</td>
<td>5</td>
<td>1.57</td>
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<tr>
<td>Oct</td>
<td>5</td>
<td>1.61</td>
</tr>
<tr>
<td>Nov</td>
<td>2</td>
<td>4.22</td>
</tr>
<tr>
<td>Dec</td>
<td>2</td>
<td>1.25</td>
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What Is The Disposition of Patients Presenting To The PES?

- Discharge: 71%
- Admit: 23%
- LWBS: 4%
- Transferred to Another Facility: 2%
Percent of Patients Transferred From Other Facilities Admitted To Inpatient Unit
How Long Do Patients Stay In The PES?
What Is The Likelihood That Patients Return To The PES?

7289 Total PES Visits

- 2363 Repeat Visits (32%)
- 4926 Individuals (68%)
### Where Do We Go From Here?

- Improving patient flow
- Increasing direct transfers to the PES and decreasing ER boarding time
- Developing scholarly/research aim
- Continue to create PES culture
- Expanding staff wellness and resiliency efforts
- Decreasing barriers to Trauma Informed Care
Trauma Informed Care

Barriers Identified by Staff

- Time, 15
- Workload, 6
- Staffing, 4
- Inexperience/Training, 4
- Money, 3
- Understanding, 3
- Email, 2
- Fatigue, 2
- Disruptions/Interruptions, 2
- Management, 2
- Resistance, 2

Created by Juliana Wallace, LCSW
Thank You!

Questions?