Mercy San Juan Behavioral Health Crisis Services Collaborative EmPATH Unit

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Slides on EmPATH in collaboration with Dr. Scott Zeller, M.D.

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Psychiatric Emergencies are Medical Emergencies!!

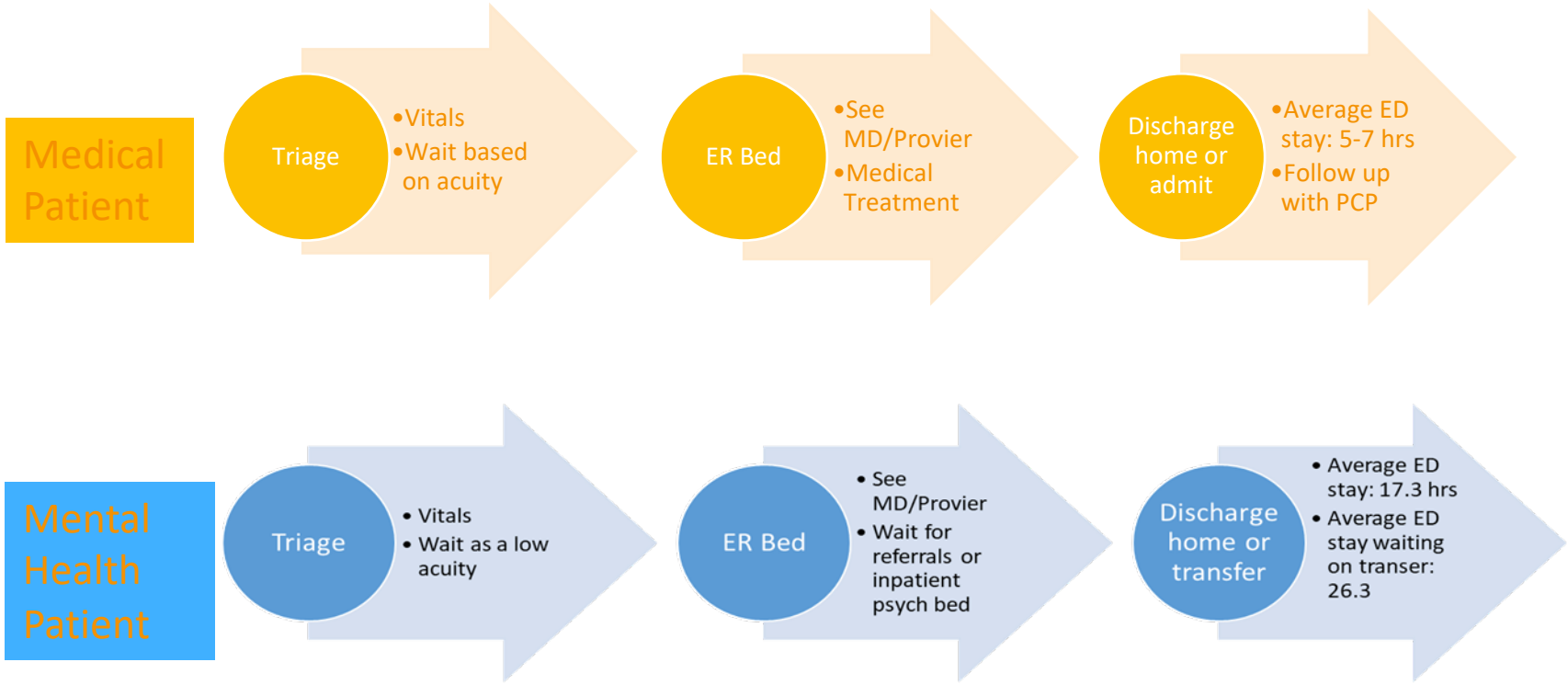
- Federal EMTALA Laws already designate psychiatric emergencies as equivalent to heart attacks and car accidents – time to start intervening with the same urgency and importance as medical emergencies

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

Credit: Dr. Scott Zeller Slide

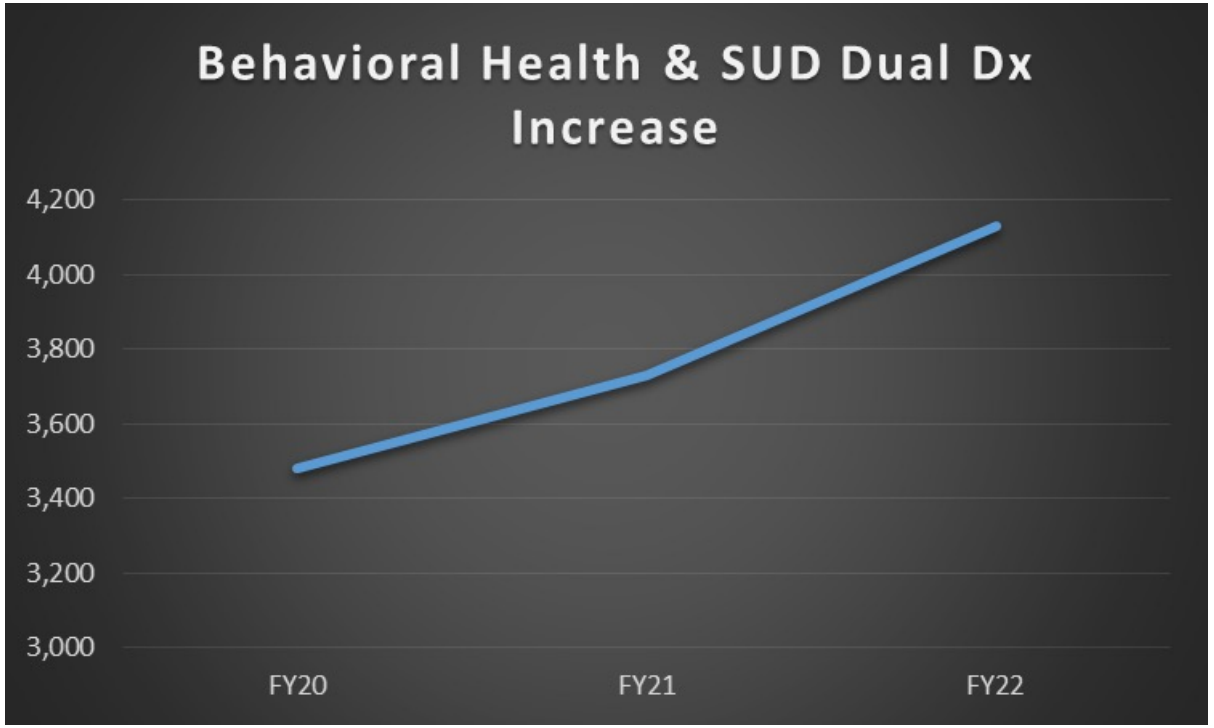
Traditional Path through the Emergency Room

- Access for a medical patient vs Access for a patient in Mental Health Crisis



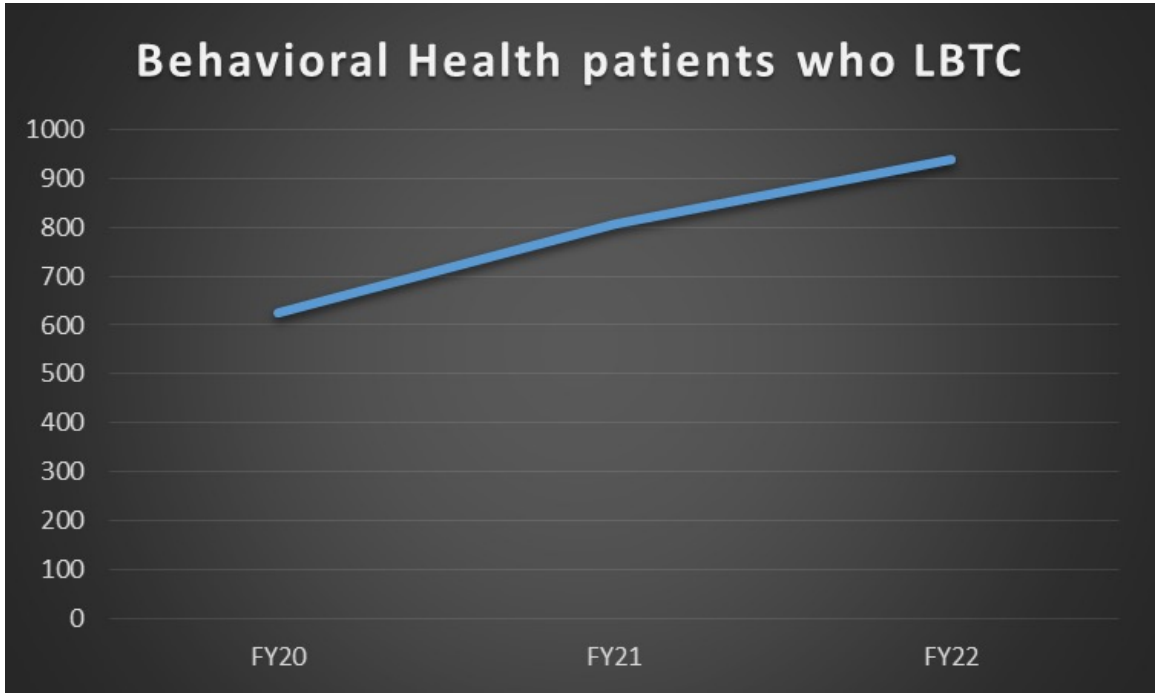
Navigating the System—Access to Emergency Psychiatric Care

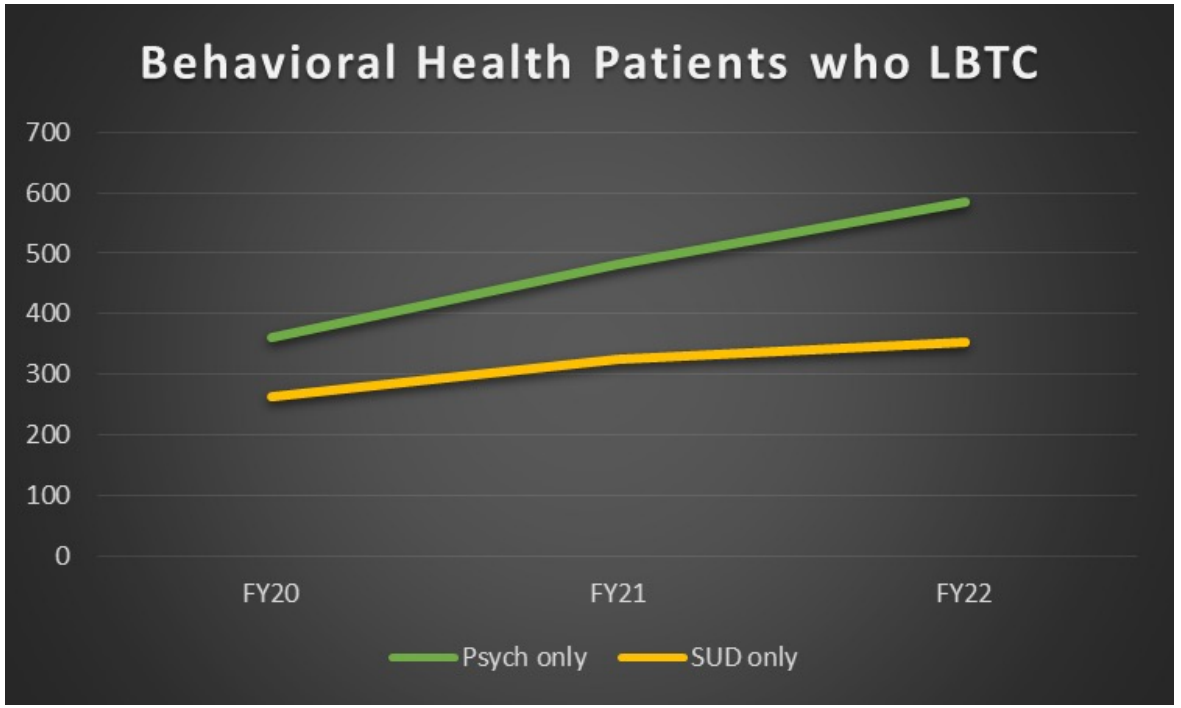
- Navigating the health care system is challenging
- Getting appointments in a reasonable timeframe
- Self-medicating with other substances is easier for the consumer



Navigating the System—Access to Emergency Psychiatric Care

- Having patience to wait for mental health crisis services??
- Are the voices from the chaotic ER?
- Confined to a small space?
- Elopement in less than 6 hours





Focus for the past decade has been on community-based crisis solutions, with a goal of reducing the numbers of patients going to hospital ERs

- But the number of behavioral health patients coming to hospital emergency departments has only INCREASED during the past 10 years

- Behavioral emergencies are now 1 in every 7 patients in hospital ERs nationwide! Nationally, ER BH stays often *average* over 30 hours.

- **HOSPITALS NO LONGER LOOKING TO EXCLUDE, NOW REALIZE "THESE ARE OUR PATIENTS TOO" AND ARE WILLING TO ENGAGE WITH QUALITY, TIMELY CARE. BUT TOO OFTEN, HOSPITAL CRISIS CARE IS OVERLOOKED IN STATE/COUNTY IN MENTAL HEALTH PLANNING AND FUNDING. *CRISIS CARE SHOULD NOT END AT THE EMERGENCY DEPARTMENT DOOR!***

Credit: Dr. Scott Zeller Slide

ERs always accept ALL with no discrimination!

- Emergency Departments have long been at the forefront for equity impacting racial, ethnic, LGBTQ and other populations, catering to everyone in need immediately
- Federal law* states legally ERs cannot turn anyone away, must evaluate all people who request help, for presence of emergency medical conditions, and then attempt to stabilize, without consideration of ability to pay
- Federal law* defines psychiatric emergencies as medical emergencies
- Suggesting behavioral emergency patients “don’t belong” in ERs and should be only seen in community stigmatizing, discriminatory, “wrong door”

*Emergency Medical Treatment and Active Labor Act (EMTALA)

Credit: Dr. Scott Zeller Slide

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
- ED environment itself can often make crisis patient symptoms worse

Credit: Dr. Scott Zeller Slide

Common reasons for Boarding—Catch 22 on exclusions for Inpatient Psych & many Community Crisis Centers

- Common reasons for boarding are the exclusionary criteria for inpatient psych admission:
    - Current Substance intoxication – need to metabolize
    - Medically complex patients
    - Patients who are currently agitated/aggressive or history of violence
    - Severe suicide ideation or a serious suicide attempt
    - Criminal charges or sexual offenses
    - Vital sign abnormalities—including those who's blood sugars never run in the "normal" range
    - Frequent utilizers

Wrong Solution: Treating to a Destination, not at 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?***

Credit: Dr. Scott Zeller Slide

Transforming Emergency Psychiatry

The EmPATH Model

- EmPATH is a generic academic acronym well established in the literature for a specific model of hospital-based Crisis Stabilization Unit (CSU), not a trademark nor copyrighted!

Credit: Dr. Scott Zeller Slide

EmPATH

Emergency **P**sychiatric **A**ssessment **T**reatment **H**ealing

Research shows that 75% or more of severe psychiatric emergencies can be **stabilized within 24 hours**

What makes the EmPATH Approach Different?

- Designated destination for all medically-cleared patients in crisis prior to determination of disposition or IP admission; not viewed as an alternative destination but *THE* destination
- Designed and staffed to treat all emergency psychiatric patients – philosophy of “no exclusion”
- Immediate patient evaluation and treatment by a psychiatrist, constant observation and re-evaluation
- Provides a calming, healing, comfortable setting completely distinct from the Medical ED
- Wellness and Recovery-oriented approach

Credit: Dr. Scott Zeller Slide

Physical Space Design

Calming, healing environment that prioritizes safety and freedom

Large, open ‘milieu’ space
where patients can be together in the same room – high ceilings and ambient light, soothing decor

Designed to facilitate
socialization, discussion, interaction and therapy

Per chair model
outfitted with fold-flat recliners

Space recommendation
80 sq. ft. total per patient, which includes 40 sq. ft. patient area around each recliner

Open nursing station w/instant access to staff
No ‘bulletproof glass fishbowl’ separate from the patients

Voluntary Calming Rooms
Avoids locked seclusion rooms or restraints

Credit: Dr. Scott Zeller Slide

Patient Benefits

Trauma-informed Unit, a home-like care setting different from a chaotic ED; relaxation, movement, recreation encouraged

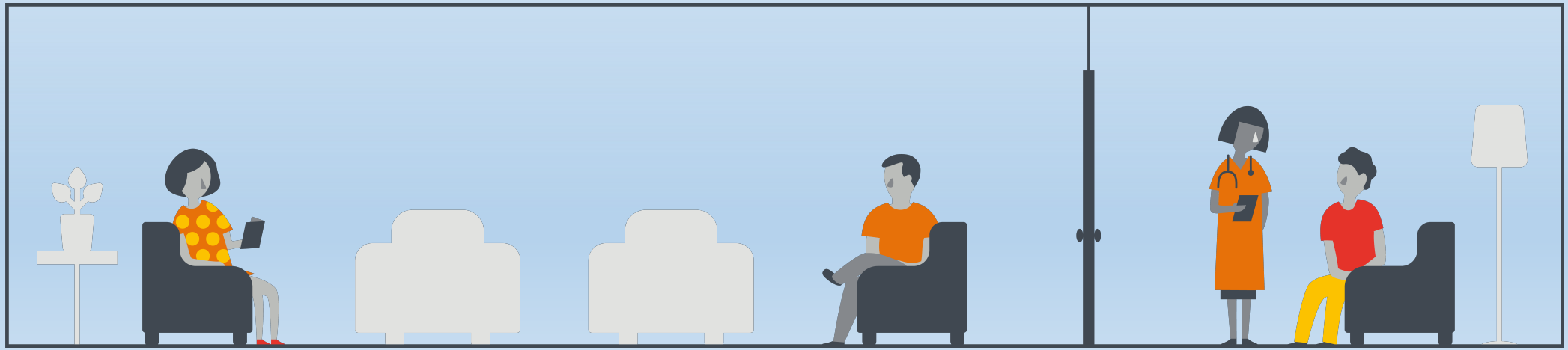
Calming Environment that best meets patients' needs, can serve themselves snacks, beverages, linens

Multi-disciplinary Treatment Team involved from arrival to disposition

Constant Observation & Re-evaluation leads to much higher diversion from hospitalization

Rapid Evaluation by Psychiatrists, ensuring care integration with comprehensive care plan development

Restraint Elimination Typically far less than 1%



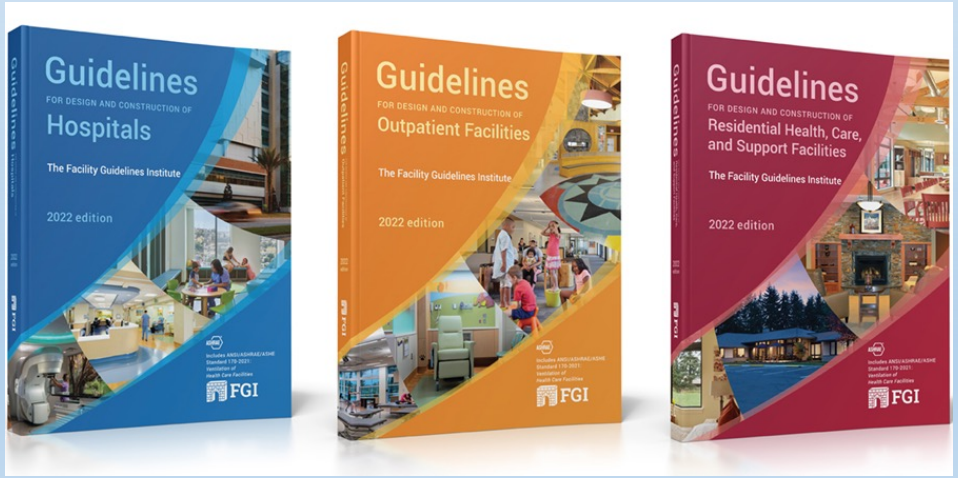
Credit: Dr. Scott Zeller Slide

FGI 2022

A2.2-3.2 Behavioral health crisis unit. This unit is a dedicated emergency services unit to serve behavioral and mental health patients presenting in a state of crisis. Advantages of this unit are that services and staffing can be tailored to the needs of this population, and the physical environment can be controlled to help alleviate stressors for patients and staff.

2.2-3.2.2.3 Multiple-patient observation area (aka EmPATH Unit)

*80 square feet total space per patient
*One restroom for every 8 patients
*Can be inside ED, accessible to ED, or elsewhere on hospital campus
*Can share requirements with ED spaces



Compare to traditional individual observation rooms, which must be 100 sq ft each, and need constant monitoring

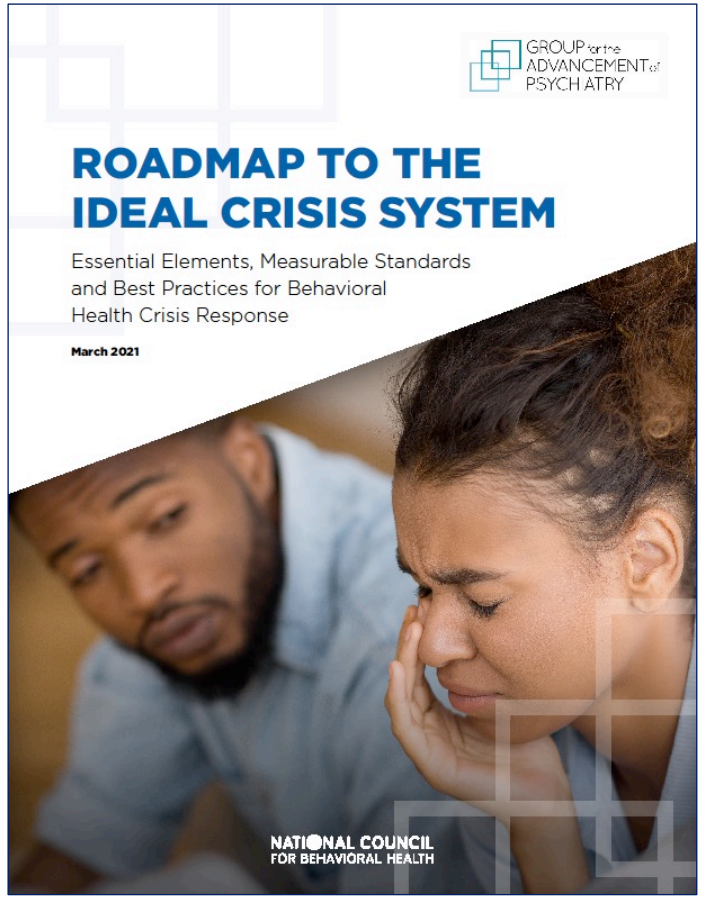
Credit: Dr. Scott Zeller Slide

EmPATH Units complement community crisis programs, for the highest-acuity patients

- *National Council for Mental Wellness*, ***"Roadmap to the Ideal Crisis System"***: specifically cites EmPATH units in their recommendations, saying that there

"should be *at least* one

in every mental health system"



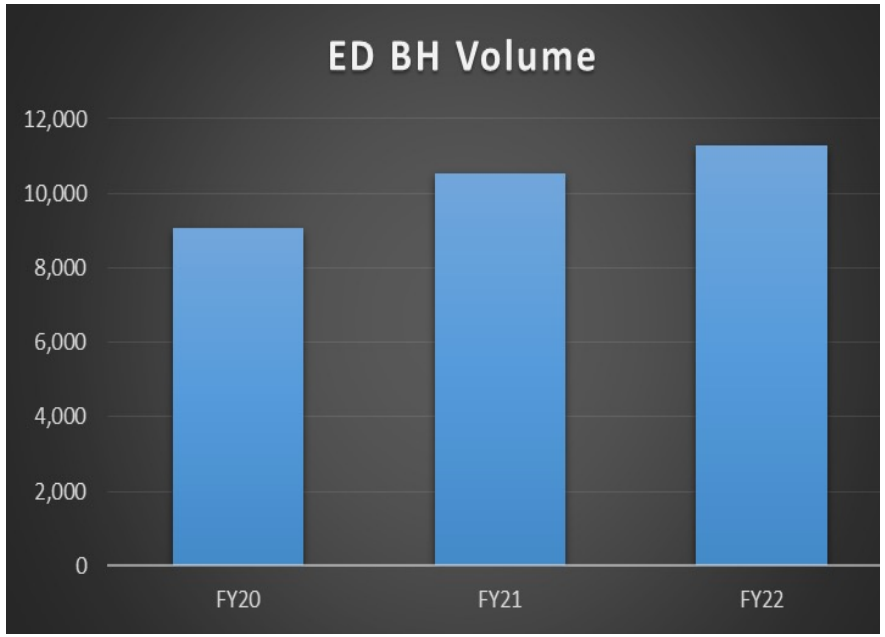
Credit: Dr. Scott Zeller Slide

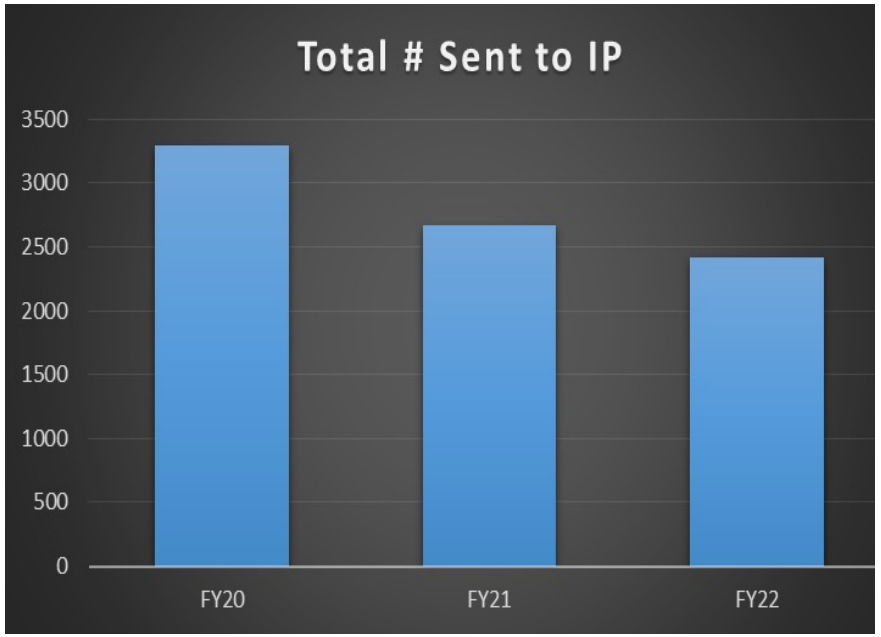
Mercy San Juan Medical Center- BHCSC EmPATH Unit

- Partnership with Sacramento County
- Access to appropriate care in an appropriate timeframe
- Quality of care
- Least Restrictive alternative

Mental Health Post Pandemic

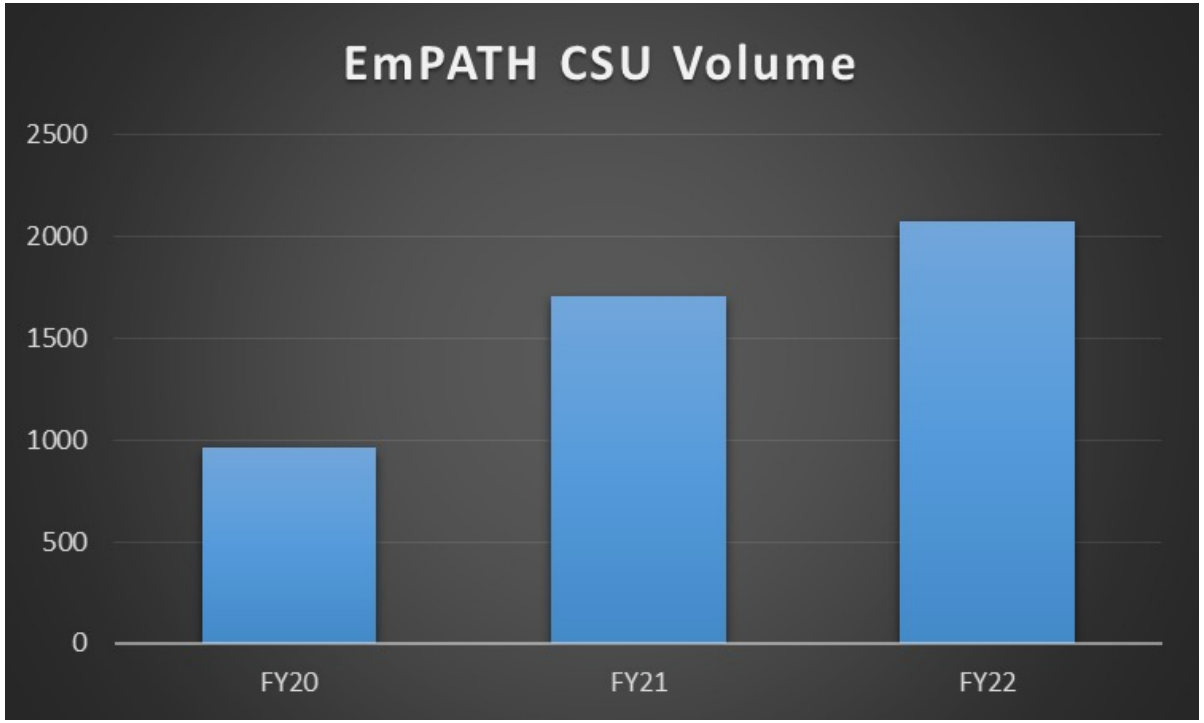
- 1 in 5 adults experienced mental health that had a significant negative impact on them during the pandemic. 45% of those with mental illness, 55% had serious mental illness (NAMI mental health stats, 2020)
- Even with ED behavioral health volume increasing by 25%, with the help of the EmPATH unit, we decreased our transfers to inpatient psych facilities by 27%





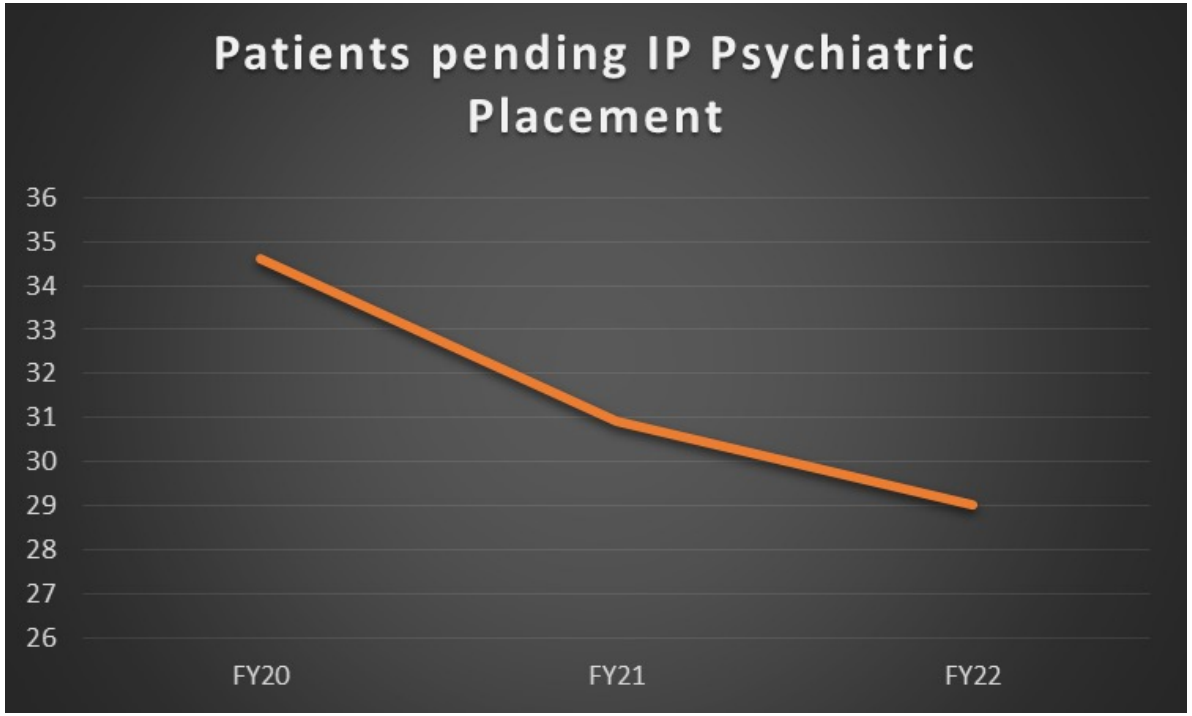
Access to appropriate mental health care services

- September 2019 Mercy San Juan Behavioral Health Crisis Services Collaborative (EmPATH CSU) opened as a Partnership with Sacramento County
- Prior to the EmPATH unit opening, patients would be lined up in gurneys in the hallway
- MSJ has an average of 13 new behavioral health patients per day, not accounting for the patients who have been waiting in the ED over 24 hours for an inpatient psychiatric bed
- Since opening over 5,477 patients have received treatment in the EmPATH CSU



Emergency Room length of stay for the Patient in Mental Health Crisis

- Average length of stay includes those who are complex as well:
  - Includes those dropped off from CPS, APS, Board and Care's for developmentally delayed, who may be presenting with behavior problems as well as acute psychiatric crisis
  - Will still have some with longer ER length of stays due to complexities or ages that the EmPATH can't accommodate, yet now those can be placed quicker at the Inpatient PHFs



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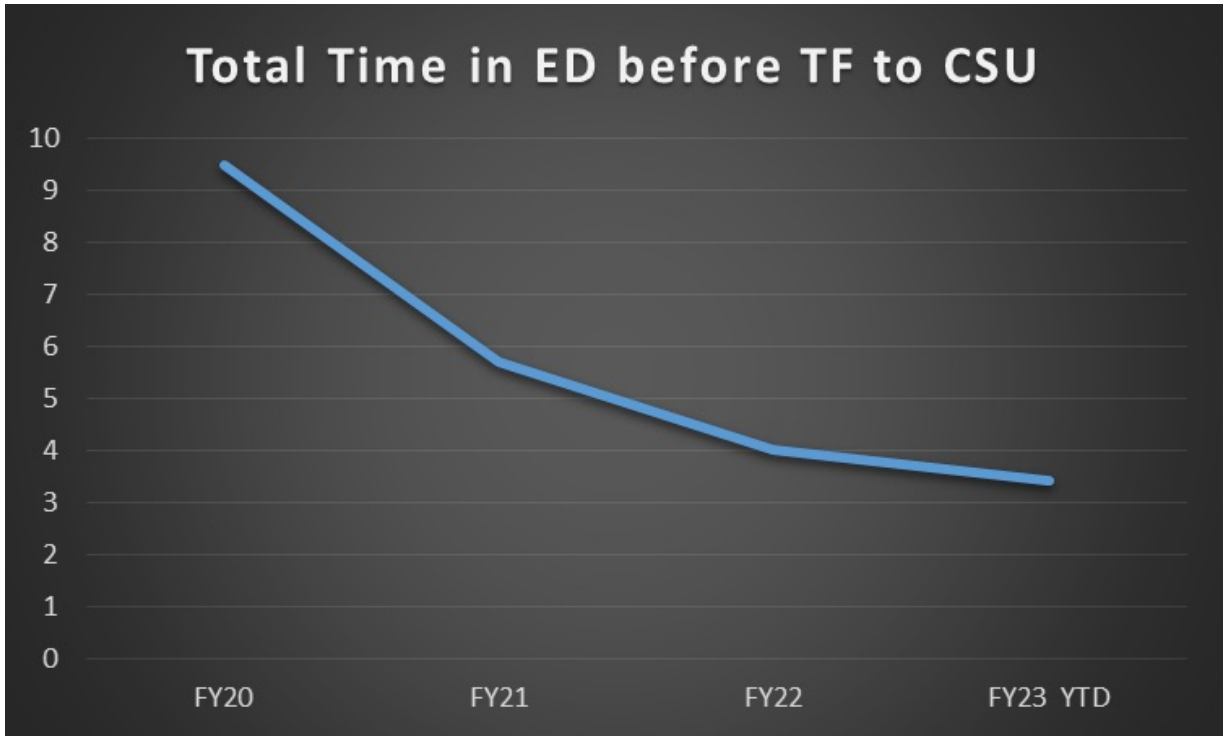
Quality of Care for the Patient in Mental Health Crisis

- Time from ED medical clearance to acceptance to MSJ EmPATH CSU is under 2 hours
  - 1.6 hours FY22 and FY23 YTD
- Hours spend from initial triage at MSJ ED to **transfer to EmPATH CSU**: 3.4 hours
  - Prior to the EmPATH CSU, the average length of stay (pending an Inpatient Psychiatric bed) was 33 hours in the ED
    - 9.5 hours in first yr of CSU
    - 3.4 hours in FY23
    - October was 2.6 hrs



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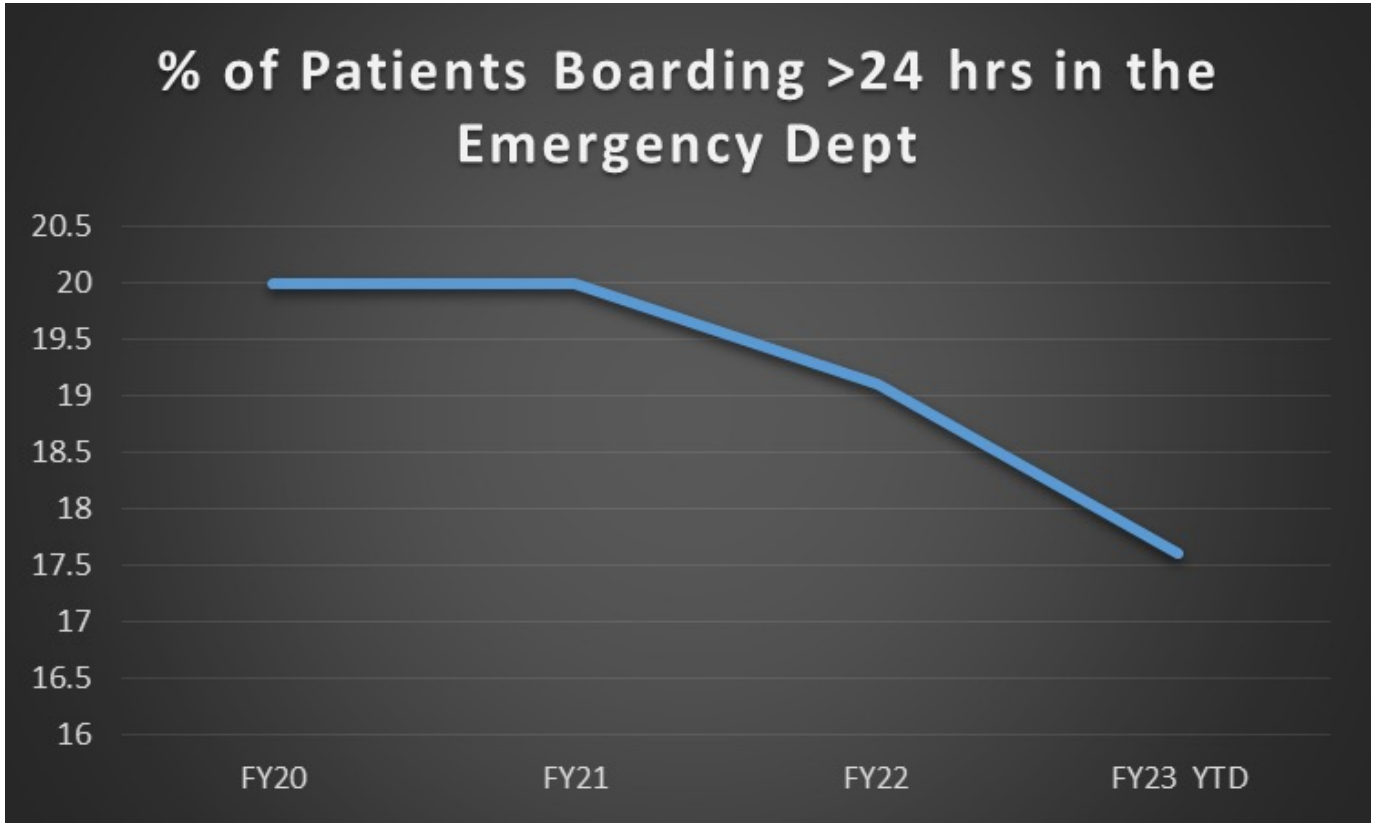
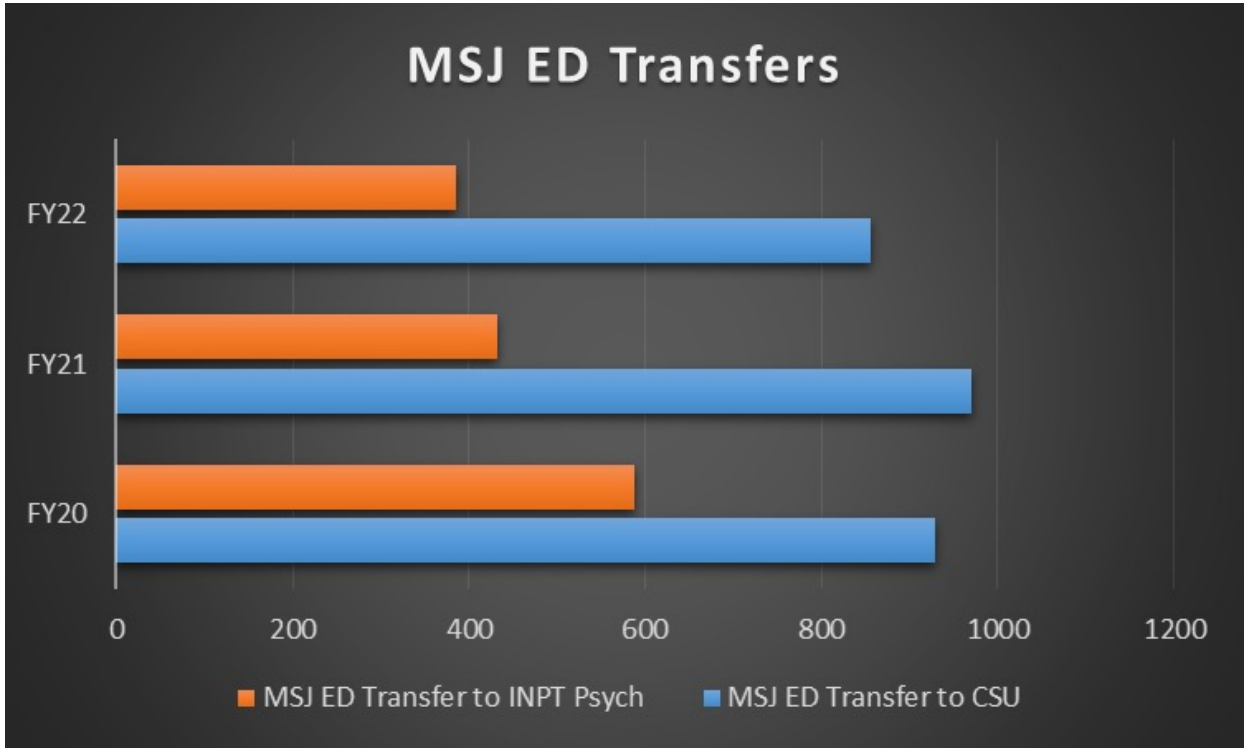
Boarding Concerns

- A 2012 Wake Forest University Health Sciences study also showed that psychiatric patients who are waiting in ERs remain there 3.2 x longer than non-psychiatric patients
- The Joint Commission reports ED boarding lengthens the inpatient stay for those admitted
- MSJ EmPATH CSU opens up more beds in the inpatient psychiatric facilities to treat those in need



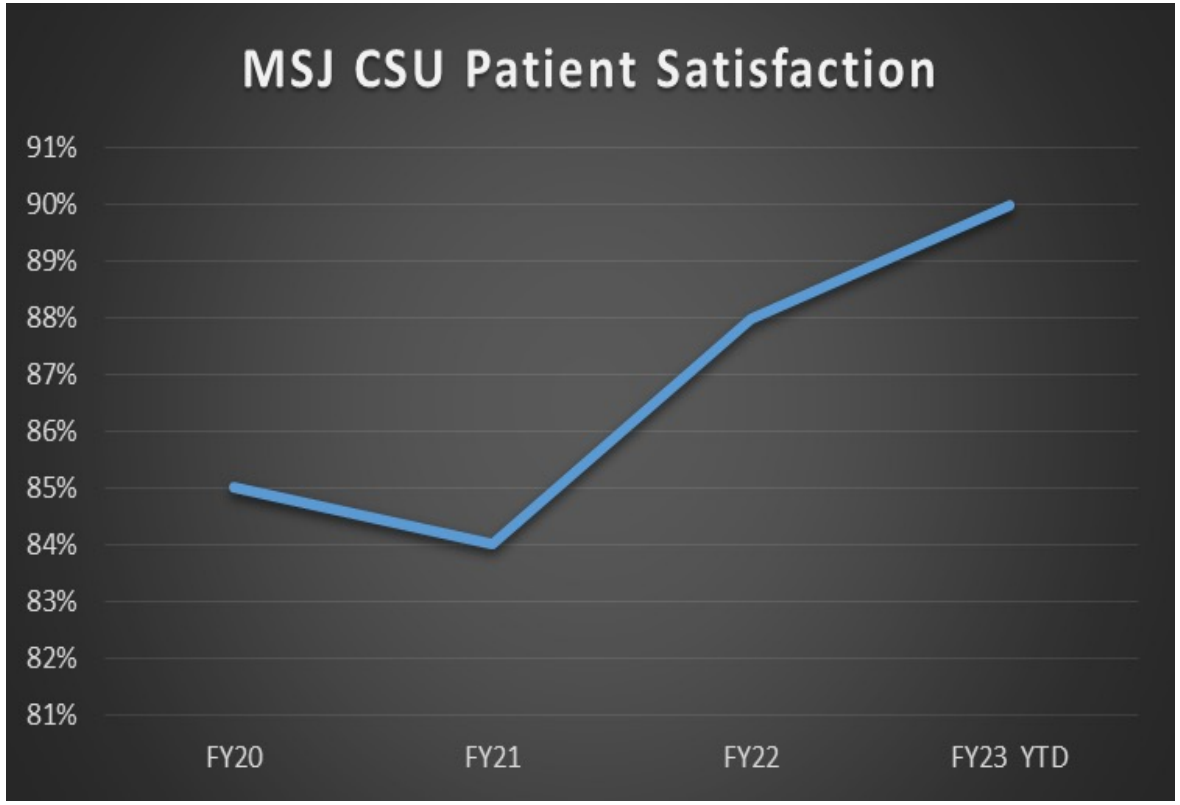
EmPATH CSU vs Inpatient Psychiatric Admission

- More patients are going to the EmPATH CSU than to inpatient psychiatric facilities—the back hall has not had a line of psychiatric patients on gurneys since 2019
- Moderate acuity (moderately high/moderate/moderate-low) patients who may not necessarily need a longer inpatient psychiatric stay at an inpatient psychiatric facility are now getting their needs met more efficiently



MSJ Behavioral Health Crisis Services Collaborative

- Average LOS for patients in the EmPATH CSU:
  - 24 hours
- Median LOS for patients in the EmPATH CSU:
  - 22 hours
- Patient Satisfaction Rate FY23 YTD
  - 90%
- BH Recidivism
  - 30 day ED Recidivism: 6%
  - 90 day CSU Recidivism: 3.8%



Thank You

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