vituity®

At the heart of better care.

The Transformation of Behavioral Health Care Begins in the ED

How supply and demand is intensifying our psychiatric crisis and what leading hospital executives are doing about it.

It is a well-known fact that the growing number of patients presenting to hospitals with psychiatric emergencies represents a major challenge for emergency departments. Sadly, there is little relief in sight as research indicates our behavioral health crisis continues to worsen.

To better understand how today's behavioral health trends are impacting hospitals, and more importantly how hospital leaders are preparing to deal with them, we invited executives from leading health systems to join us for Vituity's first *Behavioral Health Executive Roundtable*.

At the root of the conversation was a simple and fundamental question: how to balance Supply and Demand while responding to new and evolving pressures? There was quick and unanimous agreement that the transformation of behavioral health care in our hospitals must begin in our EDs and all were passionate about transforming psychiatric care to improve the lives of patients.

"If we can just dial that part [the ED] in, everything will improve down the line."

To understand the best way to balance this supply and demand tension, our conversations explored the real issues that are driving the increase in demand as well as the industry evolution that is creating the supply constraints. We also discussed the regulatory pressures that are building and putting increased strain on hospitals ability to operate. To wrap up the conversation, the executives at the table shared insights with each other related to how they are working to address this problem in their own facilities. Sharing these insights with you is our way of extending and inviting you into the conversation.

Sincerely,

Scott Zeller, MD
Vice President Acute Psychiatry, Vituity

Growing Demand

More patients are presenting to EDs with psychiatric emergencies.

Demand for emergency services has been steadily rising across the country and EDs have seen a sharp increase in behavioral health-related visits. Just how many more are we talking about? For that, we can let the data tell the story.

Consider this, 10 years ago, behavioral health (BH) patients were <5% of ED volume; now they often account for 8–15%. Some of the executives at our table suggested they are aware of areas that are seeing 20–25% or more patients with behavioral emergencies.

To compound this, two recent studies have shown that more than 40% of adults and children in the ED have undiagnosed mental illness which suggests the situation may only worsen.[1]

DECODING THE
Terminology

Behavioral Health Emergency
Also called a *behavioral crisis* or *psychiatric emergency*.

Behavioral Health and **Mental Health** are often used as interchangeable term. They have unique differences.

Behavioral Health includes both mental health and substance abuse

Factors contributing to the rise in behavioral health-related ED visits:

Suicide Rates are rising, and 90% of people who attempt suicide have a mental illness.

Approximately 1 in 4 individuals with serious mental illness also have a **Substance Use Disorder** (SUD).

Opioid-related ED Visits visits more than doubled between 2005 and 2015.

Comorbidity is prevalent with 70% of behavioral health patients also dealing with a chronic medical condition.

Over 60 % of **adolescents in community-based SUD treatment programs** also meet diagnostic criteria for another mental illness.[2]

Dwindling Supply

There are significant shortages of both behavioral health providers and inpatient psychiatric beds.

The U.S. is experiencing an acute shortage of qualified psychiatric providers that is projected to grow over the next decade.

According to a November 2016 analysis by HHS' Health Resources and Services Administration, the nation needs to add up to 10,000 providers each to seven separate behavioral health professions by 2025 to meet the expected growth in demand.

The shortage of trained psychiatric professionals creates a gap greater than that in nearly every other clinical specialty.[3]

Factors contributing to the physician shortage

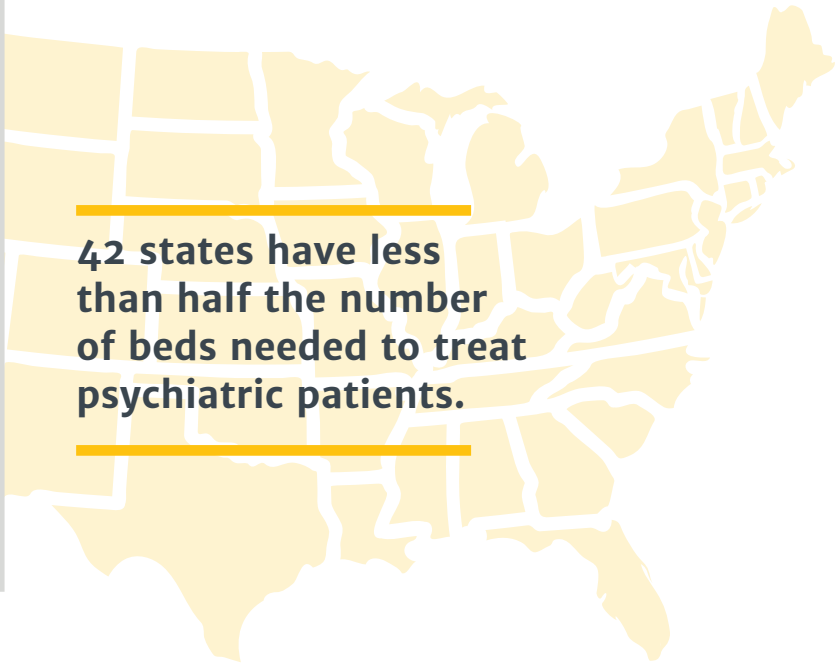
Mental health providers frequently are reimbursed less than physical health providers, leaving some institutions struggling to cover salaries[4]

More than 60% of practicing psychiatrists are over the age of 55—**one of the highest proportions among all specialties**[5]

Severe Bed Shortage

The number of public inpatient psychiatric beds has decreased by 17 percent since 2010. This translates to only 12 public beds per 100,000 people nationwide.

A consensus of experts notes that 50 public psychiatric beds per 100,000 people is the minimum number a community can bear. However, one report showed that 42 states of the 50 states had less than half the minimum number needed.[6]



42 states have less than half the number of beds needed to treat psychiatric patients.

The Consequences

The supply and demand struggle impacts patient safety, quality of care, hospital efficiency, and the bottom line.

The impact on patients and the community:

Behavioral health patients wait longer and have poorer outcomes

BH patients wait on average 11.5 hours for admission, three times longer than the average for all patients.

Result: Patients board in ED for hours or days awaiting disposition and specialized treatment.

ED boarding reduces physical capacity and consumes staff resources.

Result: Reduction of care quality for all ED patients.

Chaotic ED environment is stressful for patients in behavioral crisis.

Result: Symptoms exacerbate and agitation increases.

When patients act out, **staff may restrain them or use forced sedation.**

Result: Poorer outcomes, loss of trust, decreased patient satisfaction, and longer ED stays.

The impact on the medical staff and hospital:

Behavioral health emergencies increase risk and costs for hospitals

ED staff lack access to trained physicians to respond to psychiatric emergencies.

Agitated patients are at a higher risk of aggressive behavior (like assaults on providers and staff).

Without appropriate proactive management, patients are more likely to experience exacerbations and crises that require additional emergency care.

Boarding has enormous financial implications for hospitals. One executive's large national health system loses 90,000 bed hours per year to ED psychiatric boarding. This translates into $200 million in opportunity.

Added Pressures

New quality measures from CMS and the Joint Commission.

Beginning in October 2017, hospitals must report ED length of stay for psychiatric visits to CMS. Public reporting on this measure will begin July 2018 and will include data going back to October 2017. This was news to many executives.

In addition, CMS and the Joint Commission recently introduced several new measures related to transitions of care and readmissions which will have a direct impact on how the public views patient care and how sites are reimbursed. Some notable examples:

- **Suicide Screening Protocols in the ED**
- **Follow-up After Hospitalization for Mental Illness**
- **30-day all-cause readmissions following a psychiatric hospitalization**
- **Assessment of Patient Experience of Care**

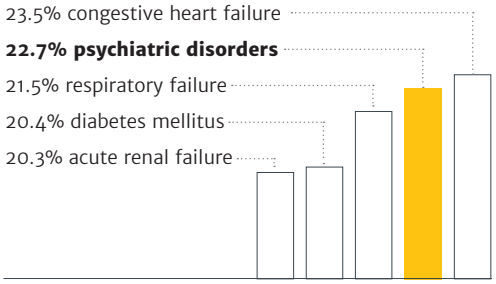
These changes increase the pressure on hospitals to improve the quality of emergency behavioral health care. Failing to do so could have financial implications down the road. As one participant noted, "When CMS starts reporting on something, reimbursement usually follows."

The result of the supply and demand constraints and increased pressure is a resource and financial drain on hospitals that affects the whole community. In turn, many hospitals face an uphill struggle to fulfill their missions. As one participant put it:

"Part of my day job is meeting with families who've lost a loved one or have had a bad outcome after desperately trying to get help in an ED. The pain is palpable. We simply owe it to everyone we serve to do better."

The result of the supply and demand constraints and increased pressure is a resource and financial drain on hospitals that affects the whole community. In turn, many hospitals face an uphill struggle to fulfill their missions.

Psychiatric Disorders
Second Highest Readmission Rate



Striking The Balance

How leading executives are finding relief for this crisis.

Supply and demand leads to a quantity conversation but the reality is this isn't a capacity issue. Rather, the executives at our table agreed that we need to be innovative and more thoughtful about which psychiatric patients need to be admitted and how we address their acute care needs in the emergency department.

Early intervention is critical. Experience shows that the vast majority of psychiatric emergencies resolve within 24 hours. Hospitals can therefore decrease admission rates by shifting the paradigm toward early intervention in the ED. The sooner a patient is evaluated and treated, the better their chances of preventing hospitalization and the sooner they begin healing.

> "If we hospitalized every patient who came in with chest pain, we wouldn't have any med-surg beds left either."
>
> —Scott Zeller, MD
> Vice President of Acute Psychiatry, Vituity

These innovative approaches promote early intervention

Telepsychiatry

Outpatient Psychiatric Emergency Units

Clinical Education

Telepsychiatry

Providing more access to emergency psychiatrists.

During a mental health crisis, on-demand video consults can provide an expert evaluation in minutes. Access to an Emergency Psychiatrist via telepsychiatry can aid with diagnosis, treatment, and disposition planning in the ED.

Participants from some states reported that licensing was still a major hurdle. One potential solution is the Interstate Medical Licensure Compact, which has streamlined the licensure process among its 22 member states.

Reimbursement can also be a thorn, though the situation is gradually improving. Some participants reported that their telepsychiatry programs had never received a cent from payers. Medicare currently reimburses for telehealth under specific circumstances (in rural areas, for example). Many states are considering parity laws that would require payers to reimburse telehealth and in-person visits at the same rate.

Participants were passionate about advocating for more favorable telepsychiatry regulations and reimbursement. "I really think this is an issue where providers need to stand together and pressure our oversight agencies to do the right thing," one said.

STUDIES SHOW TELEHEALTH PROGRAMS

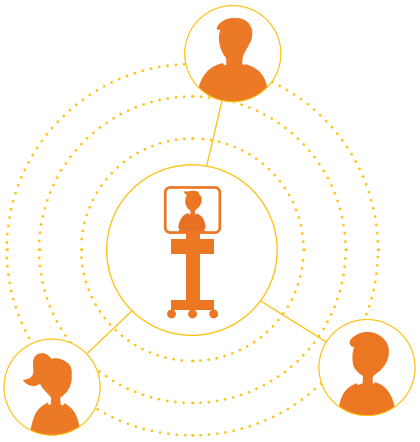
Reduce Readmissions and Save Money

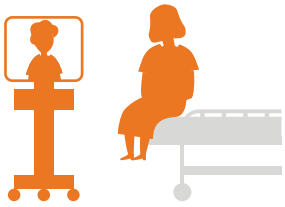
Readmissions reduced by as much as 62%

Cost Savings $1,000–$1,500 per patient

Healing Our Many Underserved Populations

Many of our executives are leveraging telepsychiatry across their EDs. Some are developing hub-and-spoke models to reach underserved populations, including incarcerated violent offenders and people in rural areas.





TELEPSYCHIATRY

Patient Satisfaction

—

Executives say it's not always easy to get buy-in for telepsychiatry. Some stakeholders worry that patients will resent this approach to care. However, research suggests that telepsychiatry doesn't hurt patient satisfaction, and that many psychiatric patients actually prefer it to live consults.

Outpatient Psychiatric Emergency Units

Improve patient experience and reduce unnecessary admissions.

Executives at some health systems were developing outpatient psychiatric units adjacent to their EDs to improve the care setting for these patients and prevent unnecessary admissions.

Vituity's Dr. Zeller pioneered the first such unit in Alameda County, CA. Today, Vituity calls this model of care the EmPath Unit (short for *emergency and psychiatric assessment, treatment and healing.*) Other common names include crisis stabilization units, psychiatric EDs, and observation units.

FINANCIAL

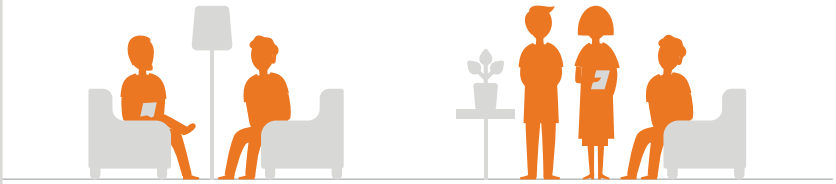
Benefit

—

One participant worked in a county that had opened a regional EmPath unit. Within nine months, his hospital had recouped$1 million in boarding costs.

Exploring an EmPath Unit

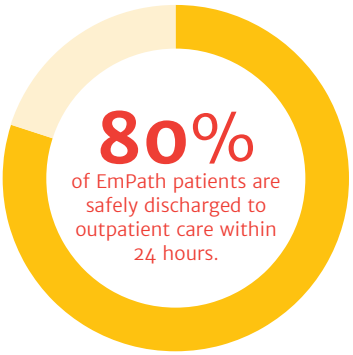
After medical clearance in the ED, the patient is transferred to the EmPath unit and evaluated on arrival by a psychiatrist. The patient can then relax and begin treatment in a comfortable, homelike setting. Staff mingle with patients and provide ongoing evaluation.



Benefits for hospitals

EmPath units benefit hospitals by preventing unnecessary admissions and resultant payer denials.

This approach also decreases the need for ED boarding which in turn, increases contribution margins by freeing capacity to care for medical patients.



Clinical Education

Training and education are additional tools to effectively address this crisis.

In addition to expanding psychiatric services, several executives are focusing their efforts on additional training and education.

De-Escalation: Training frontline personnel in calming and de-escalation techniques can significantly reduce agitation, aggression, the risk for violence, and the need for forced sedation and/or restraints. Improved de-escalation can also assist in throughput, bed turnover, disposition options, and improved outcomes.

A Trauma-Informed Approach: Staff would also benefit from education on a trauma-informed approach to mental health care, and the benefits of avoiding traumatic or triggering encounters for patients.

Expand the Circle: In addition to updating the physicians and nurses in contemporary psychiatric medication management, extend training to address pre and post acute psychiatric care support by engaging EMA and first responders as well as other community partners.

Design Better Processes: Design administrative processes and policies/protocols to empower the entire staff to treat all patients in accordance with state laws.

Conclusion

Solving the crises starts with the ED.

The participating executives recognized the enormous challenges facing their hospitals and behavioral health patients. They also believed they had a growing number of tools to meet these challenges and were cautiously optimistic about the future.

Many participants emphasized the benefits of a proactive approach. Responding early — before ED volumes reach crisis levels — can save money down the road while improving staff satisfaction.

Participants also say they're seeing a new level of executive focus on and commitment to behavioral health care.

"Fifteen years ago, I don't think we'd have had a meeting like this," said one participant. **"To be together discussing it in a beautiful room with a view, that's progress."**

About Vituity

As a physician-led and -owned Partnership, Vituity places clinical expertise and patient outcomes at the center of our practice. Our acute focus and compassionate care are the driving forces that have placed us **at the heart of better care.**

Scott Zeller, MD, leads Vituity's Acute Psychiatry Solutions division. Dr. Zeller is internationally recognized as a leading researcher, advocate, consultant, author, and speaker in the field of emergency psychiatry. He has helped hospitals and communities around the world to implement patient-centered delivery models that promote dignity and improve clinical outcomes.

Get in front of the crisis in emergency psychiatry.

Partner with Vituity to create a plan today. To learn more, visit vituity.com

vituity®
At the heart of better care.

2100 Powell Street
Suite 900
Emeryville, CA 94608
510.350.2777
vituity.com

1 Downey LV, Zun LS, Burke T. Undiagnosed mental illness in the emergency department. J Emerg Med. 2012;43(5):876–82.

2 Hser YI, Grella CE, Hubbard RL, et al. An evaluation of drug treatments for adolescents in 4 US cities. Arch Gen Psychiatry. 2001;58(7):689-695.

3 Merrithawkins 2017 report

4 MILLIMAN RESEARCH REPORT Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates. 2017

5 AAMC 2015 data

6 The Shortage of Public Hospital Beds for Mentally Ill Persons A Report of the Treatment Advocacy Center E. Fuller Torrey, M.D.* Kurt Entsminger, J.D.** Jeffrey Geller, M.D.* Jonathan Stanley, J.D.** D. J. Jaffe, B.S., M.B.A.*