2022 BEHAVIORAL HEALTH CARE SYMPOSIUM RIVERSIDE

Update on EmPATH: Expanding an Effective ED Boarding Solution

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Update on *EmPATH*

The Missing Link in Crisis/Emergency Behavioral Healthcare

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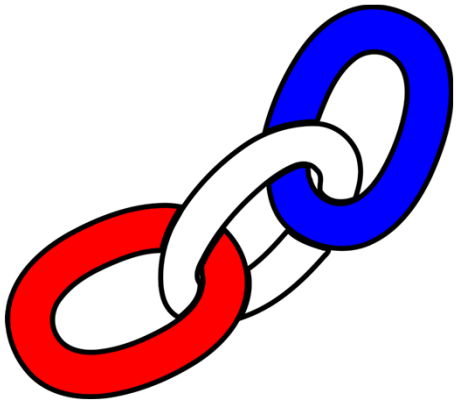

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Psychiatric Emergencies are Medical Emergencies!!

- 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

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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 and in California, 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 HAS BEEN OVERLOOKED IN STATE/COUNTY IN MENTAL HEALTH PLANNING AND FUNDING.
- ***CRISIS CARE SHOULD NOT END AT THE EMERGENCY DEPARTMENT DOOR!***

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Many wonderful community crisis programs have been created with the hopes of reducing ED use for psychiatric patients – but here's why these often don't solve everything, and many emergency psychiatry patients still come to the ED:

1) **These programs tend to be set up for mild-to-moderate severity patients**
2) **They have exclusion algorithms for the more acute patients, which resort to 'send to the ED' or 'call 911"**

Common Exclusion Criteria for Community Crisis Centers

- ✓ Patients who are currently agitated/aggressive or history of violence
- ✓ Patients with profound symptoms of psychosis/disorganization
- ✓ Patients with severe suicidal ideation or a serious suicide attempt
- ✓ Patients with active substance/alcohol intoxication or withdrawal
- ✓ Patients on involuntary status or with active criminal charges
- ✓ Patients pronounced comorbid medical issues, incl overdose, self-injury
- ✓ Patients with vital signs abnormalities
- ✓ Patients with serious developmental disabilities/neurologic issues
- ✓ Patients who have utilized the crisis program too frequently/recidivists
- ✓ Patients who refuse indicated medications

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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)

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Bottlenecks and Inefficiencies

Psychiatric patients spend **3x longer** than other patients in the ED

Longer LOS of psychiatric patients

Operational
and
Financial Impacts

Prevents 2.2 Bed Turnovers

Boarding of psychiatric patients

Financial Loss
$2,264 per patient

The Impact of Psychiatric Patients Boarding in Emergency Departments, B Hicks, DM Manthey, Department of Emergency Medicine, Wake Forest University Health Sciences, Winston-Salem, NC 27157, USA, June 2012

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Coordinating Care in the ED

Today's Challenges

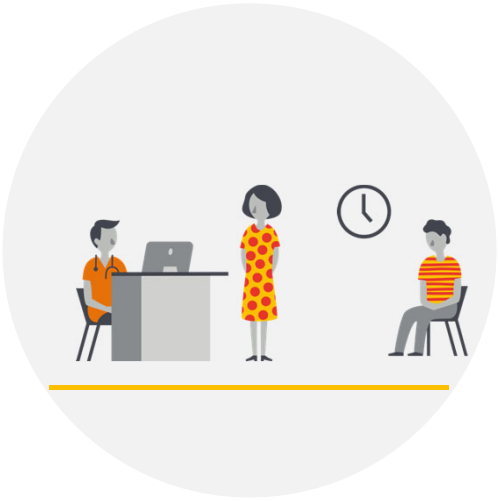
Patient capacity concerns while mental health crises on the rise

Patient throughput and bottlenecks in a disruptive ED environment which can worsen patient symptoms

ED teams lack the right personnel and space to provide effective care for this population

Concerns of safety and overcrowding

Still defaulting to long-held approach of medical clearance and refer to inpatient psych facility



Tackling The Mental Health Crisis In Emergency Departments: Look Upstream For Solutions, Mara Laderman , Amrita Dasgupta , Robin Henderson , Arpan Waghray , January 26, 2018, Doi:10.1377/hblog20180123.22248

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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

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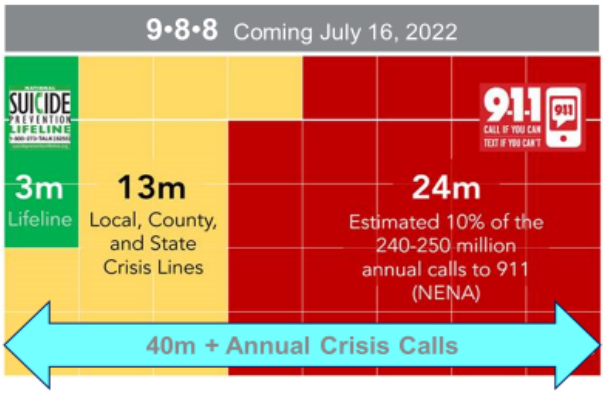
988: The new Nationwide 3-digit number for behavioral health emergencies



- Replaces the current National Suicide Prevention Lifeline 1-800-273-TALK
- Phone, Text, and chat functions
- Geolocation
- National standards
  - SAMHSA oversight
  - single national administrator
    Vibrant Emotional Health: www.vibrant.org
- People with BH emergencies now have an alternative to calling 911
- More info: https://www.samhsa.gov/988

Credit: Margie Balfour, MD PhD, Connections Health Solutions

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Boarding Solutions Suggested in the Past

- Most suggestions – even ideas that include community-based drop-in care and mobile crisis units – still follow concept that virtually all ***emergency*** psychiatric patients need hospitalization as the only possible 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%-20% of such patients get hospitalized)

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Wrong Solutions: A Destination, not Solving 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?***

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Transforming Emergency Psychiatry

The EmPATH Model

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

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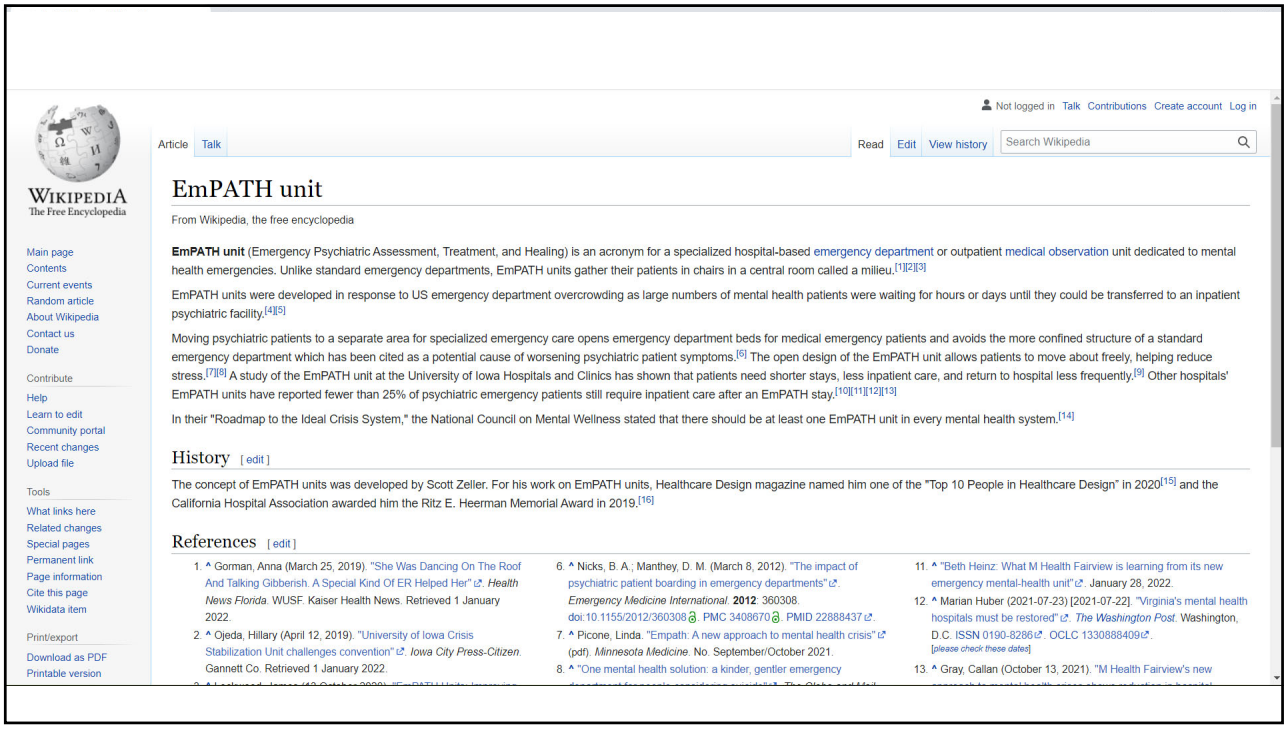

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EmPATH unit

From Wikipedia, the free encyclopedia

EmPATH unit (Emergency Psychiatric Assessment, Treatment, and Healing) is an acronym for a specialized hospital-based emergency department or outpatient medical observation unit dedicated to mental health emergencies. Unlike standard emergency departments, EmPATH units gather their patients in chairs in a central room called a milieu.[1][2][3]

EmPATH units were developed in response to US emergency department overcrowding as large numbers of mental health patients were waiting for hours or days until they could be transferred to an inpatient psychiatric facility.[4][5]

Moving psychiatric patients to a separate area for specialized emergency care opens emergency department beds for medical emergency patients and avoids the more confined structure of a standard emergency department which has been cited as a potential cause of worsening psychiatric patient symptoms.[6] The open design of the EmPATH unit allows patients to move about freely, helping reduce stress.[7][8] A study of the EmPATH unit at the University of Iowa Hospitals and Clinics has shown that patients need shorter stays, less inpatient care, and return to hospital less frequently.[9] Other hospitals' EmPATH units have reported fewer than 25% of psychiatric emergency patients still require inpatient care after an EmPATH stay.[10][11][12][13]

In their "Roadmap to the Ideal Crisis System," the National Council on Mental Wellness stated that there should be at least one EmPATH unit in every mental health system.[14]

History [edit]

The concept of EmPATH units was developed by Scott Zeller. For his work on EmPATH units, Healthcare Design magazine named him one of the "Top 10 People in Healthcare Design" in 2020[15] and the California Hospital Association awarded him the Ritz E. Heerman Memorial Award in 2019.[16]

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1. ^ Gorman, Anna (March 25, 2019). "She Was Dancing On The Roof And Talking Gibberish. A Special Kind Of ER Helped Her". *Health News Florida*. WUSF. Kaiser Health News. Retrieved 1 January 2022.
2. ^ Ojeda, Hillary (April 12, 2019). "University of Iowa Crisis Stabilization Unit challenges convention". *Iowa City Press-Citizen*. Gannett Co. Retrieved 1 January 2022.
6. ^ Nicks, B. A.; Manthey, D. M. (March 8, 2012). "The impact of psychiatric patient boarding in emergency departments". *Emergency Medicine International*. **2012**: 360308. doi:10.1155/2012/360308. PMC 3408670. PMID 22888437.
7. ^ Picone, Linda. "Empath: A new approach to mental health crisis" (pdf). *Minnesota Medicine*. No. September/October 2021.
8. ^ "One mental health solution: a kinder, gentler emergency
11. ^ "Beth Heinz: What M Health Fairview is learning from its new emergency mental-health unit". January 28, 2022.
12. ^ Marian Huber (2021-07-23) [2021-07-22]. "Virginia's mental health hospitals must be restored". *The Washington Post*. Washington, D.C. ISSN 0190-8286. OCLC 1330888409. [please check these dates]
13. ^ Gray, Callan (October 13, 2021). "M Health Fairview's new

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Zeller's Six Goals for Emergency Psychiatric Care

1. Exclude medical etiologies and ensure medical stability
2. Rapidly stabilize the acute crisis
3. Avoid coercion
4. Treat in the least restrictive setting
5. Form a therapeutic alliance
6. Formulate an appropriate disposition and aftercare plan

Zeller, *Primary Psychiatry*, 2010

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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

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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

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A Calming, Comfortable Environment

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Diverse Professionals Staffing the Unit

EmPATH is an academic term, not copyrighted or licensed, and each unit differs

Multidisciplinary Team Approach

- Psychiatrists/Psychiatric Providers
- RNs
- Social Workers
- Psychiatric Assistants
- LVNs/ LPTs
- Peer Support Specialists

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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%

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Hospital Benefits

EMTALA-Compliant
for both voluntary and involuntary mental health crises

ED Capacity Creation
Alleviate volume pressure in the ED and reduce psychiatric holds and boarding

Reimbursement Options
Among CMS and private payers

Eliminate Unnecessary Admissions
While reducing payer denials for inpatient psychiatric units

Cost-Effective Implementation
by remodeling available, unused hospital spaces

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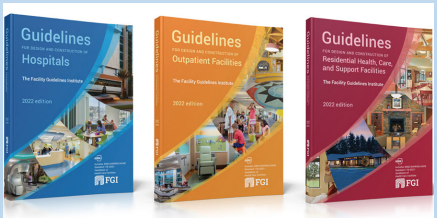
FGI 2022

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



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

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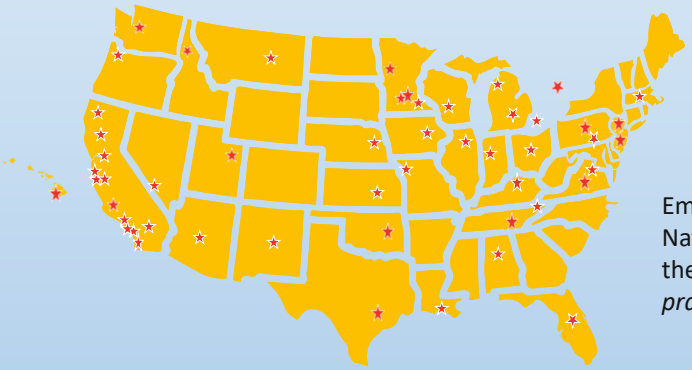
The Model is Expanding Across North America



EmPATH units should be considered a National Best Practice, and we will take the EmPATH unit knowledge back as a *best practice to Joint Commission Central*…

- Joint Commission Surveyor

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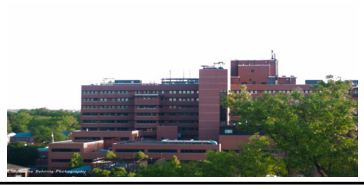
Academic Emergency Medicine
A GLOBAL JOURNAL OF EMERGENCY CARE

Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) Unit Decreases Hospital Admission

Published: 17 August 2021



- Reduced ED length of stay from an average of 16.2 hours to just 4.9 hours (70% reduction!)
- Reduced inpatient psychiatric admissions by 53%! *(from 57% of patients to just 27% of patients)*
- Improved the outpatient follow-up of patients from 39.4% to 63.2% (60% improvement!)
- Reduced 30-day psych patient return to ED (recidivism) by 25%
- Added $861,000 to ED bottom line in first year by moving BH patients out of the ED to more targeted, timely, better care!
- Reduced inpatient lengths of stay for patients admitted from EmPATH

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M Health Fairview's new EmPATH approach to mental health crises shows 58% reduction in hospital admissions to just 17% overall !

KSTP.COM EYEWITNESS NEWS

In six months, Minnesota's first EmPATH unit has treated nearly **1,100 people** experiencing a mental health crisis while reducing unneeded hospital admissions.

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Billings Clinic, MT – Psychiatric Stabilization Unit

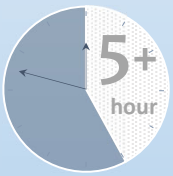
12-chair adult EmPATH unit and 5-chair youth EmPATH unit, opened Spring 2018

$784K funding support from Helmsley Charitable Trust

Readmissions Reductions

37% **decrease in psych 30-day readmission** from 19% to 12%

51% **decrease in overall readmission** from 57% to 28%



Reduction in ED ALOS for psychiatric patients

0.2% **seclusion or restraint** thousands of patients treated

50%

Reduced recidivism rates for ED psychiatric patients by nearly 50%

$1.7M **Annual Cost Savings** for public and private insurers

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Providence Little Company of Mary EmPATH, Los Angeles

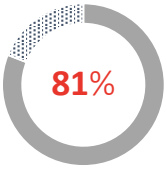
12-Chair EmPATH Unit (opened November 2017)

Featured on CNN

Solution

- ✓ Board-certified onsite psychiatrists and telepsychiatrists
- ✓ Nursing leadership
- ✓ Psychiatric nursing education
- ✓ Collaboration to enhance patient experience & operational efficiency

Results



Patients Discharged
To home or community programs

16 hours

Average LOS

>3,500

Annual Visits

0.2% Restraints
0.1% Patient injury

Safety

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Dignity Mercy San Juan EmPATH, Carmichael, CA

Collaboration between Hospital and **Sacramento County** - Opened Sept. 2019

Celebrating the Early Wins

- ✓ Baseline boarding time for psych patients in the ED FY '19 was 32.9 hours – in the first month this fell to 19 hours, by December the average was 7.6 hours (**77% reduction**)
- ✓ Since opening, restraints have only been used **one time** (January 2020)

FY 2021 Impact (July – Oct)

- ✓ Avg ED Length Of Stay before transfer = 6.3 hours (median = 4.3 hours)
- ✓ From Medical Clearance in the ED to CSU Acceptance = 1 hour
- ✓ 80% of patients discharged home
- ✓ Patient Satisfaction = 85%
- ✓ ED Recidivism = declined 30%

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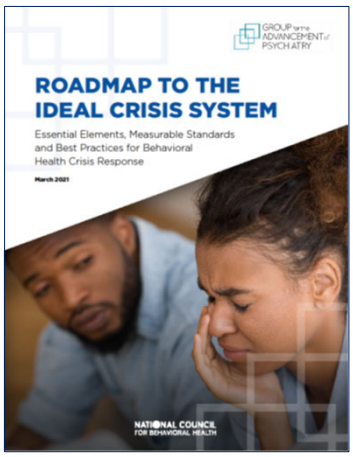
EmPATH Units complement community crisis programs, for the highest-acuity patients

- *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"



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Financial Benefits of EmPATH units for Mental Health Medicaid reimbursement

- On average, **EmPATH units stabilize 75% of the involuntary patients they see** – in a typical ER, 100% of these patients by definition would be sent to inpatient hospital beds. Therefore, EmPATH units avoid an expensive inpatient hospitalization in three out of every four patients!
- Typical inpatient stay cost to Medi-Cal: $12,500
- Typical EmPATH unit Medi-Cal reimbursement: $2,500
- Thus: for every four patients at $2,500 = $10,000, EmPATH units save Medicaid the cost of three inpatient stays at $12,500 = $37,500.
- **For every $10,000 Medicaid pays for EmPATH care, they avoid $37,500 in inpatient payments – documentable savings!**

Sacramento EmPATH estimates it has saved the County Medi-Cal over $45 million to date while providing better and more timely care in their three years of operation.

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California Announces $20 million grant program for hospitals to *specifically build EmPATH units*

CALIFORNIA ALL

MHSOAC
Mental Health Services
Oversight & Accountability Commission

RFA will go live on December 12, 2022, for any general hospital in California who is currently treating mental health patients in their medical emergency departments, **to create a new EmPATH unit, by name.**

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Tom Orrock, MA, LMFT
Chief of Community Engagement and Grants, MHSOAC

- Background of Mental Health Wellness Act
- Commission's Commitment to Mental Health Crisis Prevention and Intervention
- Funding Opportunity: RFA Release Date **December 12, 2022**

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Questions

California Hospital Association

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Thank You

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