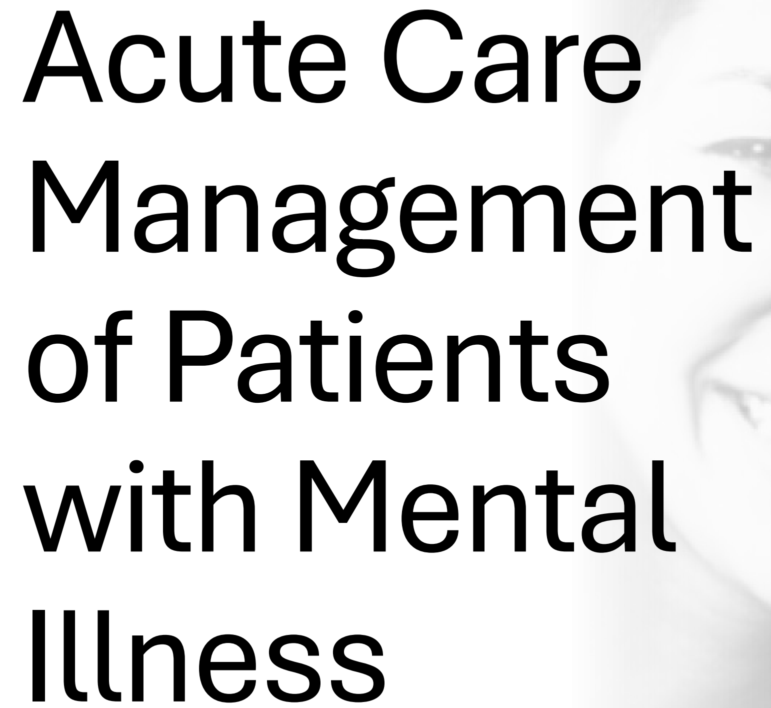
2024 EMERGENCY SERVICES FORUM

NEWPORT BEACH

What's Next for Behavioral Health in California

California Hospital Association



Acute Care Management of Patients with Mental Illness

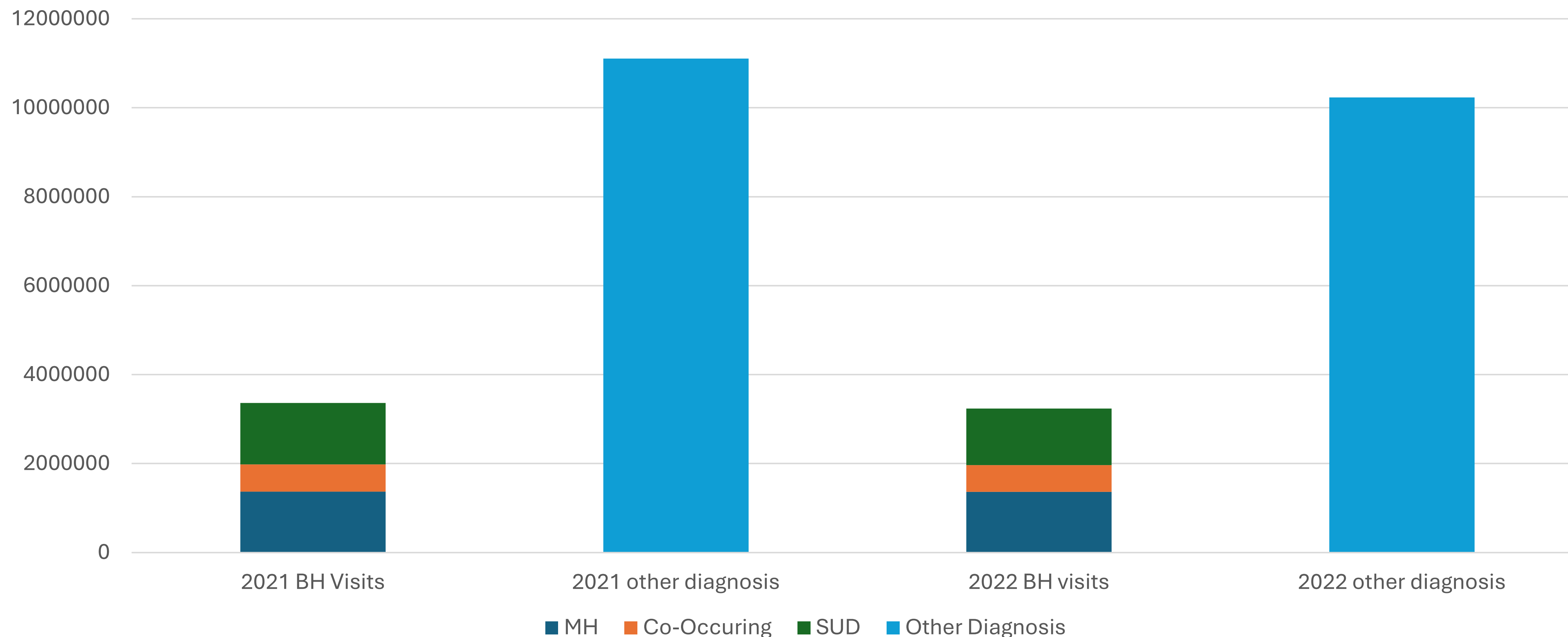
Aimee Moulin, M.D.

Objectives

- How to anticipate and meet the needs of your patient population
- Early treatment…early discharge
- Risk stratification for suicide
- Risk stratification for agitation
- Staffing for success

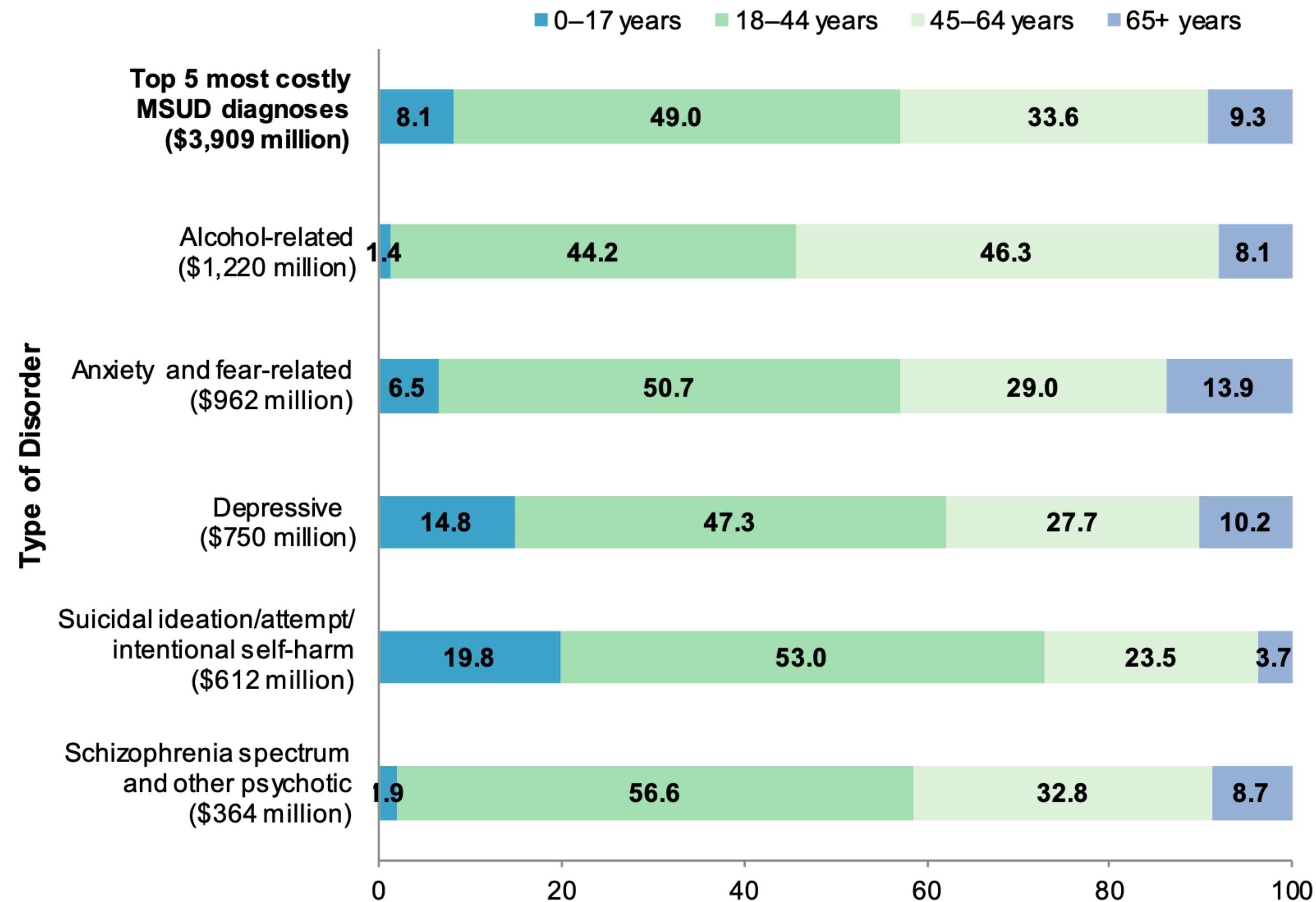
Meeting the Needs of Your Population

California Behavioral Health Visits



https://hcai.ca.gov/visualizations/inpatient-hospitalizations-and-emergency-department-visits-for-patients-with-a-behavioral-health-diagnosis-in-california-patient-demographics/

Estimating health care costs



Unstable housing and health care needs

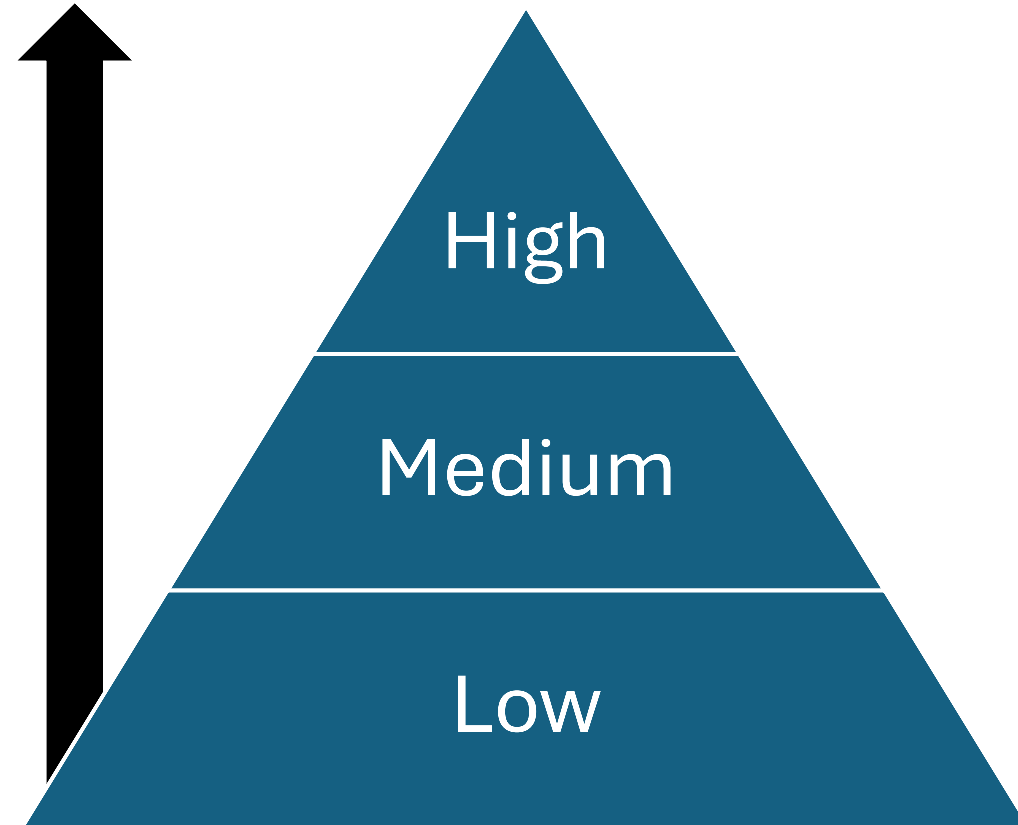
- 49% Substance use
- 38% Depression
- 36% Alcohol use
- 29% Psychosis
- 28% Hypertension

our plan…

Patients at Risk for Agitation

Risk Stratification

- Broset Violence Checklist
  - 6 item score
  - Low/Medium/High Risk
  - Used in mental health facilities, EDs, and inpatient units
  - Developed by nursing staff



Verbal De-escalation

1. Respect personal space
2. Don’t provoke response
3. Establish verbal contact
4. Be concise
5. Identify need wants/feelings

6. Listen

7. Agree or agree to disagree
8. Set clear limits
9. Offer choices and options

Managing Agitation

Broset score: linked to actions

Low score: Quiet room, limited vitals overnight

- Moderate: Verbal de-escalation, redirection, prn medications
- Lorazepam 2 mg prn q4h, Olanzapine 5-10 mg q6h
- High score: restraints, IM medications

Preventing Agitation (po)

ANTI-PSYCHOTICS

Olanzapine (Zydis) 5-10mg po onset 15-45min

Risperidone (Risperdal M-tab) 1-2mg po onset 30-60min

Haloperidol (Haldol) 5mg po onset 30-60min

BENZODIAZEPINES

Lorazepam (Ativan) 1-2mg po onset 20-30min

Diazepam (Valium) 5-10mg po onset 20-40min

Treating Agitation (IM/IV)

ANTI-PSYCHOTICS

Droperidol 2.5mg-5mg 3-30min

Haloperidol (Haldol) 2.5-10mg 5-60min

Olanzapine (Zyprexa) 5-10mg 15-45min

Ziprasidone (Geodon) 10-20mg 15-30min

BENZODIAZEPINES

Midazolam (Versed) 2.5-5mg 3-20min

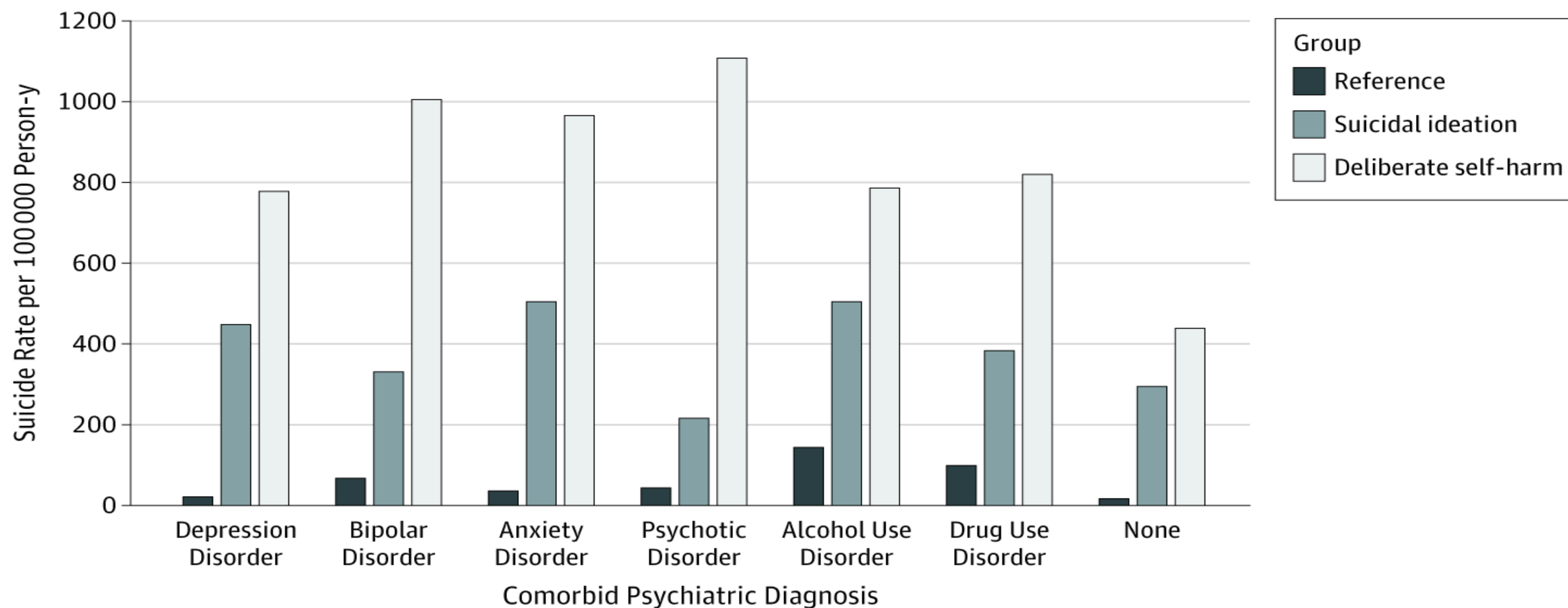
Lorazepam (Ativan) 1-2mg 5-30min

Patients at Risk for Suicide

ED visits and suicide

- 10.7% of people who die by suicide have an ED visit within six weeks of their death
- 20-30% of fatal drug overdoses estimated to be suicide deaths
- Occult suicidality: 11% ED patients screen positive 2% report plan and intent

What is the risk of suicide post ED visit?

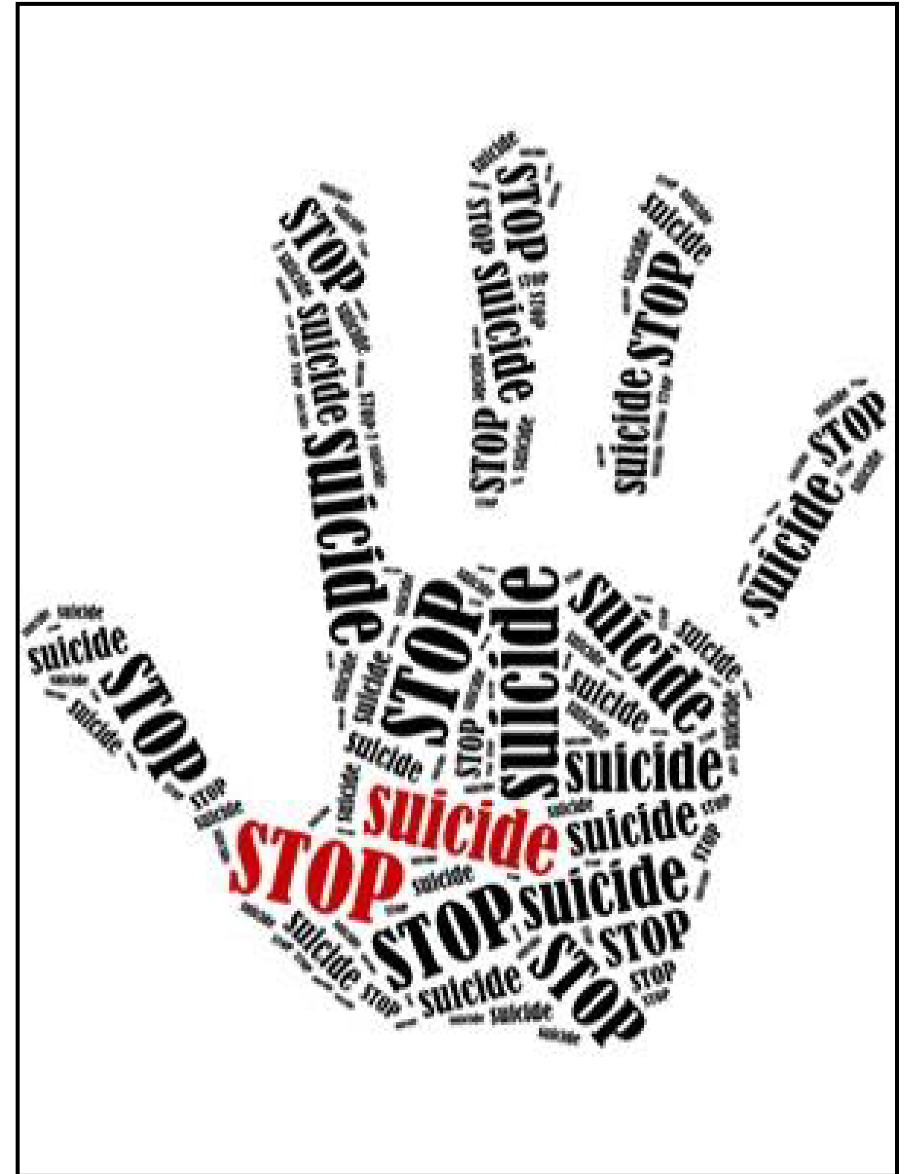


Suicide Rates Within 1 Year of Emergency Department Visit Stratified by Comorbid Psychiatric Diagnosis and Patient Group

- JAMA Netw Open. 2019;2(12):e1917571. doi:10.1001/jamanetworkopen.2019.17571

ED-based interventions

- Patient education/safety planning
- Rapid Referral
- Caring contact post discharge



Follow up…

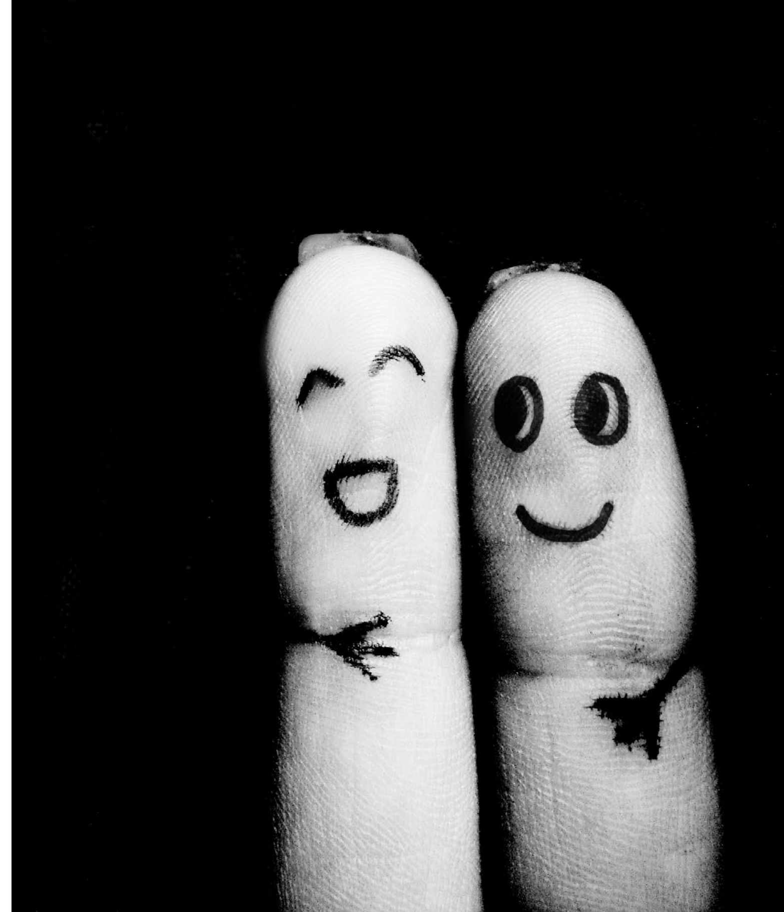
Direct linkage to outpatient care

- 22% increased rate of engagement in treatment
- 3.5% reduced rate of suicide attempts

Doupnik SK, etal. Association of Suicide Prevention Interventions With Subsequent Suicide Attempts, Linkage to Follow-up Care, and Depression Symptoms for Acute Care Settings: A Systematic Review and Meta-analysis. JAMA Psychiatry. 2020

Caring Contact post-discharge

- Increased post-discharge treatment engagement
- Decreased depression and frequency of suicidal thoughts
- Decreased suicide attempts



Staffing for Success

CRISIS TEAM

SOCIAL WORKERS

Divide up and delegate tasks

- Mental Health Workers
- Social Workers
- Community Health Workers
- Peer Support Specialists

Patient navigators

Comparison of case management to no case management in a large suburban hospital

Case management group had **39%** reduction in combined ED and inpatient length of stay over a year

The program resulted in **178** fewer patient days in the hospital

Patient Navigation reduces length of stay

1 Grover, et. al., 2018 Case Management Reduces Length of Stay, Charges, and Testing in Emergency Department Frequent Users
2 Seaberg, et al., 2017 Patient Navigation for Patients Frequently Visiting the Emergency Department: A Randomized, Controlled Trial

Substance Use Navigators

- Support patients transition to treatment
- Assist patients with treatment resources, help with housing/placement and transportation

Mental Health workers
Psychiatric technicians

- Staff trained in working with patients with mental health crisis
- Skilled at verbal de-escalation
- Provide assistance with daily activities and monitor patient conditions
- Non-uniformed response first

Early Treatment…Early Discharge

Fix the easy stuff

- Calm, quiet space
- Food, drink and access to a bathroom
- Respect circadian rhythms
- Allow personal autonomy when possible

Screen and anticipate withdrawal syndromes

- Nicotine patches
- Alcohol withdrawal
- Opioid withdrawal
- Meth/Stimulant withdrawal

Start treatment early

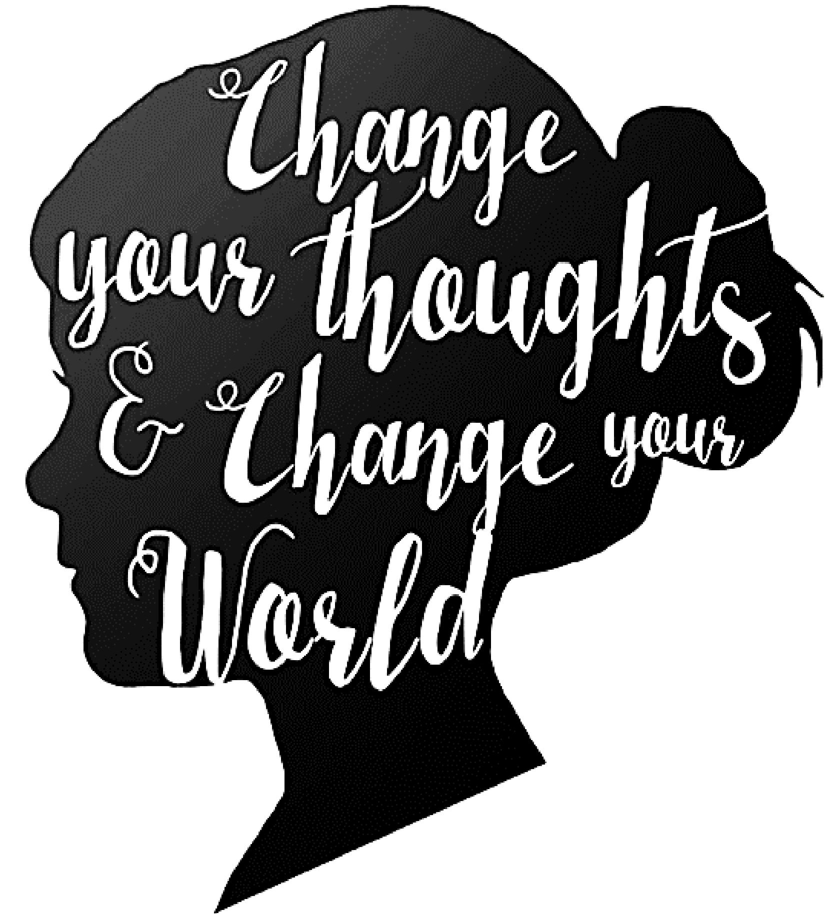
- Restart outpatient medications early
- Early treatment of symptoms of mental illness. Do not need a formal diagnosis to treat symptoms (anti-psychotics, benzos)
- Early psychiatric evaluations
- Medical clearance/evaluation concurrent with psychiatric evaluations

EmPATH Behavioral Health Units

- Quiet therapeutic spaces
- Prompt psychiatric assessment and treatment
- Milieu rooms, planned activities
- Reduced need for physical restraints and forced medications.

Our plan for treatment of MH patients

- Meet the needs of your patient population
- Risk stratification for suicide
- Risk stratification for agitation
- Staffing for success
- Early treatment…early discharge



State Policy Updates on Behavioral Health

Kirsten Barlow, MSW
Vice President, Policy, CHA

California Hospital Association

Outline

- **Newly Enacted Laws to Implement**
- **Active Legislation this Year**
- **What's on the Horizon?**

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Newly Enacted Laws to Implement

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SB 1338 (Umberg) The CARE Act

A **court-supervised process** to prevent more restrictive conservatorships or incarceration for individuals ages 18+ who have a diagnosis of **schizophrenia spectrum or other psychotic disorder** and who are **all** the following:

- Currently experiencing a severe and persistent mental illness that may cause behavioral functioning which interferes substantially with primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning.
- Not currently clinically stabilized in an ongoing voluntary treatment program.
- Either:
  - Unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating, OR
  - In need of services and supports to prevent a relapse or deterioration that would likely result in grave disability or serious harm to the person or others.

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The CARE Act (cont.)

Hospitals may petition the county superior court to evaluate an individual that might be eligible.

- Judicial Council CARE-050-INFO (About the CARE Act for Petitioners)
  https://www.courts.ca.gov/documents/care050info.pdf
- Judicial Council CARE-100 (Petition to Commence CARE Act Proceedings)
  https://www.courts.ca.gov/documents/care100.pdf

Save the date!
May 10 Webinar
for CHA Members

County implementation deadlines vary.

- October 2023: Glenn, Orange, Riverside, San Diego, Stanislaus, Tuolumne, San Francisco
- December 2023: Los Angeles
- December 2024: Remaining 50 counties

Additional Information

- Judicial Council – https://www.courts.ca.gov/48654.htm
- Resource Center – www.CARE-Act.org

SB 43 (Eggman)

Changes the definition of "gravely disabled" for involuntary holds and treatment, effective January 1, 2024, in the Lanterman-Petris-Short (LPS) Act.

- A condition in which a person, as a result of a mental health disorder, *a severe substance use disorder, or a co-occurring mental health disorder and a severe substance use disorder,* is unable to provide for *their* basic personal needs for food, clothing, ~~or shelter.~~ *shelter, personal safety, or necessary medical care.*

- A condition in which a person, as a result of impairment by chronic alcoholism, is unable to provide for their basic personal needs for food, clothing, ~~or shelter.~~ *shelter, personal safety, or necessary medical care.*

Counties may delay implementation until 2026.

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Implementing SB 43: Many Local Considerations

- What local entities could be impacted? (At least 20!)
- Who will respond, and how will they identify this new population?
- Where will the individuals go for an initial evaluation and assessment?
- What options exist for (involuntary) substance use disorder treatment?
- What new skills or professionals are needed to evaluate and treat the population?
- How can local coordination among agencies be established?

Ask your county!

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AB 2242 (Santiago)

Prior to release from involuntary care under the LPS Act, all individuals must receive a care coordination plan.

- Developed by the individual, the county behavioral health department, the health care payer (if different than the county), and any other individuals designated by the person as appropriate, with input and recommendations from the facility.
- 1st follow-up appointment.
- Health plan, county mental health plan, primary care provider, or other appropriate provider to whom the person has been referred shall make a good faith effort to contact the individual at least 3 times by email, telephone, mail, or in-person outreach.

Statewide "model" care coordination plan under development.

- Must be in place in all LPS designated facilities by August 1, 2024.

Ask your county!

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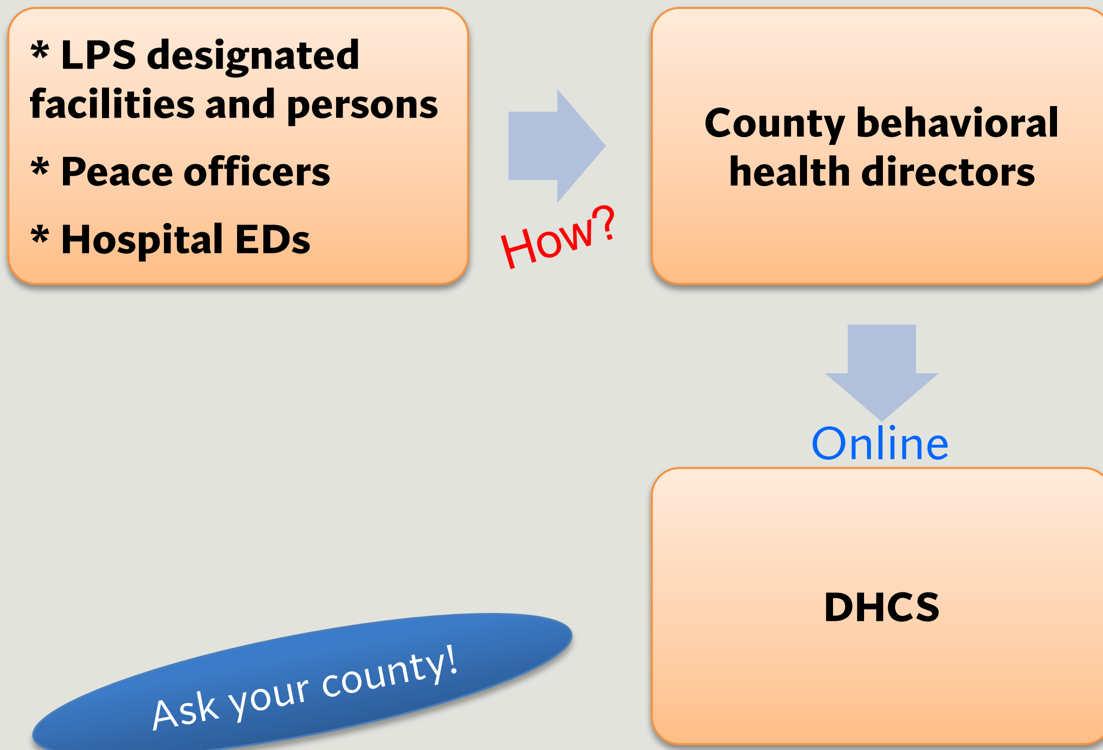
SB 929 (Eggman)



DHCS must annually publish expanded data regarding treatment provided pursuant to the LPS Act.

- Demographics
- Sequential holds
- Numbers of county-contracted beds
- Clinical outcomes*TBD
- Services provided or offered *TBD
- Waiting periods*TBD

Plans of correction and/or civil money penalties if counties and facilities do not submit data timely.

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New Data Elements (Counts of Unique Individuals)

- Condition for each detainment and by each type of involuntary treatment admission
  - Danger to self
  - Danger to others
  - Grave disability – mental health disorder
  - Grave disability – severe substance use disorder
  - Grave disability – both
- Age (by age groups)
- Race, ethnicity
- Primary language
- Sex, gender identify, and sexual orientation
- Veteran status
- Housing status
  - Stably housed
  - Imminent risk of homelessness
  - Literally homeless and sheltered
  - Homelessness unspecified
  - Jail/correctional facility
  - Unknown or declined to state
- Summary of sequential holds in a quarter
  - 1 admission or detainment
  - 2 to 5
  - 6 to 8
  - More than 8

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Active Legislation this Year

AB 1316 (Irwin) – CHA Sponsored Legislation

- Requires Medi-Cal managed care plans reimburse hospitals for emergency department care provided to Medi-Cal beneficiaries experiencing a mental health crisis.

- Ensures people who need access to a mental health inpatient hospital bed can be transferred promptly to the most appropriate care setting, even if they are on an involuntary hold.

- "No Wrong Door for Mental Health Services"

  https://www.dhcs.ca.gov/Documents/BHIN-22-011-No-Wrong-Door-for-Mental-Health-Services-Policy.pdf

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AB 2700 (Gabriel) – CHA Supports

- Promotes expanded use of behavioral health facilities, rather than emergency departments (EDs), for individuals with behavioral health needs.
- Requires the state Emergency Medical Services Authority to publish descriptions of all local agencies that are serving as, or could serve as, alternatives to hospital EDs (psychiatric health facilities, psychiatric hospitals, sobering centers, crisis stabilization units, etc.).
- Requires each local emergency medical services agency (LEMSA) to develop protocols for transporting individuals to alternate destinations.

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SB 1238 (Eggman) – CHA Supports

- Would expand the definition of a “designated facility” in the LPS Act
  - Has appropriate services, personnel, and security to safely treat individuals being held involuntarily
  - Is licensed or certified as a skilled-nursing facility, mental health rehabilitation center, or a facility capable of providing medically monitored or managed intensive inpatient treatment for substance use disorders (SUDs)

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SB 1300 (Cortese) – CHA Opposes

- Extends the notice period for proposed closures or eliminations of inpatient psychiatric or maternity services from 90 days to 120 days.

- Requires the facilities to provide an impact analysis report (paid for by the hospital) to the Department of Health Care Access and Information.

    - Must include a "good faith estimate of the impact of the closure on the county, including potential increased annual costs to the county for providing additional inpatient psychiatric care or maternity care, and on the continuum of care capacity in the county."

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AB 2154 (Berman) – CHA is Neutral

Would require hospitals to provide a copy (could be digital) of the state-published *Patients' Rights Handbook* to certain family members, with the consent of individuals on involuntary psychiatric holds.

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What's on the Horizon?

Medi-Cal Community-Based Mobile Crisis Intervention

- New statewide Medi-Cal benefit managed by counties, effective 2023.
- Community-based de-escalation and relief at home, work, school, or in the community. (Excluding hospitals)
- **Goal to reduce unnecessary law enforcement involvement and emergency department utilization.**
- Multidisciplinary team.
- Coordinated crisis care 24/7, 365 days per year.

Ask your county!

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Behavioral Health Continuum Infrastructure Program

“BHCIP” has provided 6 rounds of competitive grants ($2.2 billion in total) to construct, acquire and rehabilitate real estate assets, or to invest in mobile crisis infrastructure, to **expand the community continuum of behavioral health treatment**.

Please check out CHA’s collection of fact sheets organized by county to make the information easier to read. Hospitals are encouraged to reach out to local organizations that received grants and learn more about new behavioral health treatment options being developed.

https://calhospital.org/wp-content/uploads/2024/02/BHCIP-Awards-by-County-FINAL.pdf

Note: Proposition 1 will extend BHCIP with new bond funding.

Example BHCIP Fact Sheet: Orange County

Ask your county!

Type of Facility to Be Developed & Name of Grantee	Estimated # of Beds /Annual Slots	Estimated Award Amount
Community Mental Health Clinic		
Orange County Health Care Agency	2,626	$ 27.6 M
Adolescent Residential for Substance Use Disorders		
Orange County Health Care Agency	32	27.6 M
Perinatal Substance Use Disorders Residential		
Orange County Health Care Agency	24	27.6 M
Crisis Stabilization Unit		
Be Well Irvine	8,760	10.1 M
Sobering Center		
Be Well Irvine	7,008	10.1 M

Passage of Proposition 1

- Placed on March ballot via SB 326 (Eggman) & AB 531 (Irwin)
- Renames the law to the "Behavioral Health Services Act"
- New county spending rules, with a large **community input process**
  - 35% for full-service partnerships
  - 30% for housing interventions
  - 35% other behavioral health services
- Target population includes people with **substance use disorders**.
- $6.38 billion bond for 10,000 **new beds and housing** for veterans and others
  - Half of the bond is earmarked for infrastructure ("BHCIP"), to which hospitals could apply.

Ask your county!

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BH-CONNECT Demonstration Waiver

- Would bring in new federal Medicaid funds to counties when paying for short-term stays in freestanding acute psychiatric hospitals.

Ask your county!

- 5-year demonstration: 2025–2029.

- **Counties must opt-in** and agree to cover a full array of enhanced community-based services and evidence-based practices.

- **A goal is to reduce ED visits and improve post-ED follow-up care.**

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Medi-Cal Rates for Behavioral Health

Last year's state budget commits $300 million in 2025 and 2026 in Medi-Cal managed care organization (MCO) tax funds to promote Medi-Cal provider participation in hospital and institutional long-term care settings for individuals with behavioral health conditions – improving "behavioral health throughput."

This November, a ballot initiative, the "Protect Access to Healthcare Act of 2024," would maintain $200 million annually to supplement the Medi-Cal rates for inpatient psychiatric services.

California Hospital Association

Questions?

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