



**From Crisis to Recovery: Strategic Planning for Response, Resilience and Recovery**

## **Emergency Department Length of Stay**

# **Action Plan**



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**ACKNOWLEDGMENTS**

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## CHAPTER 1: INTRODUCTION

### EXECUTIVE SUMMARY

The North Carolina Department of Health and Human Services instructed the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services in partnership with various stakeholder groups, to consider and advise on actions that would address the following issues:

- Reducing the number of people entering the Emergency Department with mental illness, intellectual developmental disabilities, and/or substance abuse disorders by promoting early intervention systems and strategies.
- Reducing the length of stay for individuals with behavioral health issues admitted to hospital emergency departments.
- Linking consumers to housing, services, and supports to prevent future Emergency Department admissions.

To effectively address these issues in North Carolina, the Division of MH/DD/SAS, in collaboration with its stakeholders, developed an Action Plan. The plan describes goals and action steps that will continue to strengthen and improve North Carolina's crisis service system. The Action Plan is intended to serve three major functions:

1. To serve as a **roadmap** to guide our immediate priorities, as well as priorities over the next several years, with flexibility to respond to unanticipated opportunities and challenges.
2. To act as a **communication tool** to share our plans with consumers, partners and the public, and engage wider support in achieving these goals.
3. To provide a list of priority solutions showing how additional funding could improve the system of care to individuals with mental illness, intellectual developmental disabilities, and/or substance abuse disorders.

The recommendations contained in this Action Plan are multi-layered, and some not easily resolved. However, actions can be taken to make a significant difference in improving emergency department care for people with mental health issues, reduce demand on emergency departments and first responders, and strengthen the capacity of the community mh/dd/sas system to address issues before they become acute. Most of the recommendations are supported by data; however, **all** recommendations are supported by the experience of consumers, state organizations, and service providers working to improve care for the people in our communities.

There are four primary goals and associated actions steps that comprise the framework of this plan, which are described in more detail on the following pages. The framework is organized into phases of emergency care: Pre-Crisis, Pre-Emergency Department, Emergency Department, and Post-Emergency. The plan details our recommendations under each goal and shows those which can be done quickly and within available resources, and those that might require additional time and/or resources. An important component of the Action Plan is an evaluation to determine if the recommended actions, if taken, have the desired outcome. Please refer to the charts for a summary of the goals and recommendations and the following pages for more detailed information.

**SUMMARY OF ACTION PLAN GOALS AND RECOMMENDATIONS**

**PRE-CRISIS GOAL:** To promote early intervention systems and to prevent crisis events through a collaborative effort.

<b>Recommendations:</b>	1. Develop and provide crisis prevention/de-escalation training.
	2. Require enhanced crisis reduction plans for high risk, high volume consumers.
	3. Increase provider accountability for consumer outcomes.
	4. Convene critical care conferences for individuals who have high utilization of crisis services.
	5. Develop funding and planning to provide transportation.

**PRE-EMERGENCY DEPARTMENT GOAL:** To reduce the number of people entering the Emergency Department with behavioral health issues.

<b>Recommendations:</b>	1. Enhance the effectiveness and efficiency of Mobile Crisis Management Services.
	2. Augment the role of Facility Based Crisis Centers (FBC) and 24 hour Walk-In Clinics.
	3. Work with Law Enforcement.
	4. Enhance accountability in First Responders.
	5. Develop consistent Screening, Triage, and Referral (STR) procedures.
	6. Use non-emergency department resources for medical clearance evaluations.
	7. Work with magistrates.
	8. Provide care coordination.
	9. Diversify and strengthen workforce.

**EMERGENCY DEPARTMENT GOAL:** To reduce emergency department length of stay for individuals who present with behavioral health crises.

<b>Recommendations:</b>	1. Implement a computerized psychiatry bed registry.
	2. Develop protocols and practice guidelines to standardize /utilize best practices for services the emergency department.
	3. Clarify and support the role of LMEs with regard to emergency department behavioral health crisis admissions.
	4. Reduce legal obstacles.
	5. Enhance disposition options for individuals with behavioral health crises in the emergency department.
	6. Engage individuals with substance use disorders earlier and link to treatment services.

**POST-EMERGENCY DEPARTMENT GOAL:** To link consumers to housing, services, and supports to prevent future Emergency Department admissions.

<b>Recommendations:</b>	1. Ensure available housing and essential benefits are available in order to help the person remain successfully in the community and out of emergency departments.
	2. Develop a Uniform System of Care Coordination.
	3. Implement Assertive Engagement statewide.
	4. Schedule appointments with-in 48 hours prior to discharge.
	5. Establish local relationships among all stakeholders to facilitate seamless coordination of care.

## **BACKGROUND AND PURPOSE**

There is an emergency in the Emergency Departments (EDs) of North Carolina's hospitals. Too many people with mental illness and/or substance abuse disorders are ending up in our state's Emergency Departments, where they often wait for hours or even days to receive appropriate care. The long wait times affect not only consumers and their family members, but the law enforcement officers who wait with them, and the hospitals, whose EDs are overfilled with patients awaiting psychiatric assessments or placement.

Persons with mental illness, intellectual developmental disabilities, and/or substance abuse disorders end up in the ED for a variety of reasons, and decreasing their numbers and wait times in the ED will require a variety of solutions. They may be experiencing crises that could be prevented through early intervention. They may be more appropriately routed to crisis service alternatives than to the ED. Once in the ED, there may be actions, policies, and procedures that can be implemented to reduce their wait times. Following discharge from the ED, there may be actions that can be taken to reduce the probability of their future admission to the ED.

To address the issues mentioned above, a work group led by the NC Division of MH/DD/SAS Medical Director, Dr. Nena Lekwauwa, was charged with the task of developing an action plan to reduce wait times for persons with mental illness, intellectual-developmental disabilities, and/or substance abuse disorders in our state's EDs. This work group contained representatives from a myriad of stakeholder groups, including advocates, providers, LME representatives, the hospital association and hospital staff, and magistrates, as well as the Division of MH/DD/SA, the Division of Medical Assistance, and DSOHF staff. The result was a carefully considered plan that addresses all aspects of this problem.

This plan recognizes both the urgency of the problems, and the limited resources available to implement solutions. Therefore, solutions that are practical and actionable, (i.e., can be implemented immediately, and at little or no cost) will be highlighted. However, the plan also recognizes that quick and no cost solutions may not completely address this problem. Longer term solutions that require both time and resources to implement may be necessary, and those are also presented in this plan.

Finally, there is a need for continuing study. The Division of MH/DD/SAS will need to know more about why people with mental illness, intellectual-developmental disabilities, and/or substance abuse disorders languish in our EDs. Also, the Division will need to continue to gather, analyze, and report on data to assure that our efforts to solve these problems have the desired effect.

Solving the problem of long wait times in EDs will not occur in a vacuum. The actions we are recommending are consistent with and complement those already underway to improve our mental health, developmental disabilities and substance abuse service system. The Division of MH/DD/SAS is confident that taking the steps we recommend in this plan will not only improve wait times in the ED for our consumers, but will help our entire MH/DD/SAS system function more effectively and efficiently for our most vulnerable citizens. The Division looks forward to working in partnership with our stakeholders to achieve this goal.

## CHAPTER 2: PRE-CRISIS

- **GOAL: TO PROMOTE EARLY INTERVENTION SYSTEMS AND TO PREVENT CRISIS EVENTS THROUGH A COLLABORATIVE EFFORT.**

### Introduction:

If all mental health crises in North Carolina could be prevented, there would be no need for an ED wait time work group. While it is unrealistic to believe that all mental health crises could be prevented, substantial reductions in numbers of people appearing in psychiatric crisis in our emergency departments might be achieved by preventing crises through early and effective intervention. A subcommittee of the ED wait time work group composed of providers, LME staff, and DMH/DD/SAS staff, met to determine what action steps might be taken to prevent psychiatric and behavioral crisis events among our most vulnerable citizens. Their recommendations, presented in order of their projected impact, are as follows, along with a discussion of how each of these recommendations could be implemented:

**Recommendation # 1:** Develop and provide **crisis prevention / de-escalation training** for group home, adult care home staff, law enforcement, consumers, family members, providers, and other stakeholders in crisis response / prevention.

The pre-crisis workgroup believes that many crises could be prevented, if persons first responding to consumers in distress were better trained in de-escalation skills. All too often, first responders do not know how to effectively assist consumers in distress, and their ineffective actions result in “the consumer in crisis.” First responders believed to need crisis de-escalation training include group and adult care home staff, law enforcement officers, family members, providers, and others.

### **What can be done quickly and within available resources?**

A variety of crisis de-escalation trainings are currently being delivered to first responders across the state. For example, law enforcement agencies across the state are receiving Crisis Intervention Team (CIT) training to help them learn to more effectively assist people in crises. More than 3,000 officers from more than 250 law enforcement agencies in North Carolina are now CIT certified. The UNC Center for Excellence in Community Mental Health has developed the Group Home Employee Skills Training (GHEST) for group and care home staff to prepare them to work more effectively with consumers with mental illness to reduce their symptoms, prevent crises, and decrease psychiatric hospitalizations. Although recently developed, more than twenty-five (25) managers from fifteen (15) agencies in North Carolina have completed GHEST training. Mental Health First Aid is another crisis intervention / prevention training program being delivered in various counties throughout North Carolina to first responders, including to persons with mental illness and their families. The Mental Health First Aid website lists sixteen (16) trainers in North Carolina, eight (8) of whom are employees of

LMEs. The North Carolina Systemic, Therapeutic Assessment, Respite and Treatment program (NC START) is a specialized crisis prevention program for adults who have a developmental disability and challenging behaviors, often with a co-occurring mental illness. The crisis prevention component of NC START includes providing technical assistance, consultation, and support to providers working with NC START consumers with the aim of preventing crises, reducing hospital admissions, and inappropriate use of emergency departments for crisis intervention.

Although all of these crisis prevention trainings and programs are currently being delivered in North Carolina, they are not readily available in every county of the state. We recommend that these trainings be promoted and expanded to make them available throughout North Carolina. Fortunately, all these programs, except NC START and GHEST, can be expanded within available resources. Crisis Intervention Team (CIT) programs have partnered with community colleges throughout the state to provide this training free of charge to law enforcement. Costs of CIT training are further reduced by reliance on mental health and other professionals who volunteer as instructors. Remaining costs are paid for through a continuing allocation of state funds to support CIT's development. The GHEST program's cost is similarly reduced through reliance on volunteer instructors who are mental health professionals to provide this training. In addition, both GHEST and Mental Health First Aid training would help fulfill current requirements for 5600a group homes to have staff trained in the population they are serving. Therefore, any cost to providers for these trainings would not necessarily be greater than their current costs to meet licensure requirements.

### **What might require additional time and / or resources?**

Expansion of NC START and/or GHEST to all areas of the state, and to all eligible consumers, would likely require an infusion of additional funds. Also, current rules do not specify the amount of training that group and care home staff must receive, and a rules change, along with additional funds, may be needed to require that all group home and care home staff receive the level of training provided through the GHEST program.

### **What evidence will indicate progress?**

Progress towards implementing this recommendation might be tracked by measuring numbers of CIT, GHEST, and Mental Health First Aid trainings held, numbers of agencies participating in these trainings, and numbers persons trained for each of these different types of training. Progress towards expansion of NC START could be measured by numbers of consumers receiving NC START assistance. Further evaluation of the impact of these trainings could be assessed by examining the relationship between implementation of crisis prevention / de-escalation training for group home and care home staff, and the resulting change in crisis episodes among the consumers they serve. Similar data could be examined to demonstrate the impact of NC START consultations and technical assistance interventions on numbers of consumer's crisis events.

**Recommendation # 2:** Require an **enhanced crisis reduction plan** for high risk, high cost consumers that is accessible to all necessary personnel (provider, consumer, LME, call centers, etc.) and provides all necessary information to help prevent a crisis event, or intervene quickly and effectively, if a crisis occurs.

Crisis plans are currently a component of every consumer's Person Centered Plan. However, current requirements for crisis plans do not indicate they need to be immediately available to staff intervening in a crisis, and they do not require all the information needed to identify impending crises, or to intervene effectively when they occur. Crisis plans are an essential component of services for certain people with serious mental illness. In its 2010 guide for people with mental illness/substance abuse disorders, the Council on Quality and Leadership also noted that each person's plan must contain an individualized crisis response plan. Requiring more robust crisis plans for those individuals will lead to more effective intervention with them, and a reduction in crisis events requiring emergency room or hospital admission. We therefore propose requiring an enhanced crisis reduction plan on high risk, high cost consumers that is immediately available to all persons needing it, including after hours responders, and that contains all the guidance needed to intervene effectively in a crisis.

Developing a detailed, highly personalized crisis plan that can provide sufficient guidance in a crisis requires time, significant effort, and knowledge of the consumer with whom the plan is written. For example, one must know a consumer well enough to understand and identify the signs of a consumer's impending crisis in order to intervene effectively and decisively to prevent it. It may not be practical to require such detailed plans on every consumer served by our public mental health system. However, enhanced crisis plans are most critical for those frequent users of our crisis services systems. Developing enhanced crisis plans for consumers who are at demonstrably high risk of crisis events would be most practical and beneficial, and would enable mental health professionals the opportunity to provide a swift and decisive response to avert crises and subsequent emergency room visits or psychiatric hospitalizations.

### **What can be done quickly and within available resources?**

Requirements for enhanced crisis plans on high risk, high cost consumers of crisis services will need to be determined. What constitutes "high risk, high cost" has been defined, as well as a process for identifying them. However, a system for making crisis plans available to all who need them and have permission to access them will need to be developed. Finally, it will be necessary to train providers and others on these requirements, and to monitor their quality to assure they are adequate. Training on writing high quality crisis plans will be among the trainings required for implementation of the 1915 b/c waiver. Monitoring may be performed by clinical staff at the LME and/or Program Accountability section. At the PBH Local Management Entity (LME) / Managed Care Organization (MCO), development of an enhanced crisis plan for high risk, high cost consumers of crisis services is underway. Once completed, it will be adopted as a requirement by DMH/DD/SAS for other 1915 b/c waiver programs.

### **What might require additional time and / or resources?**

Funds may be needed to pay for technical expertise to develop a system and process where crisis plans are uploaded to a central server and made available to all who would have the consumer's permission and a need to access it to assist the consumer in crisis. Local Management Entity (LME)-Managed Care Organization (MCO) staff may need to recruit staff with clinical expertise to enable them to evaluate the adequacy of an enhanced crisis plan.

### **What evidence will indicate progress?**

Once criteria are established for who needs an enhanced crisis plan, and a repository for those plans is created locally, then progress would be measured by the proportion of consumers requiring an enhanced crisis plan to those actually having an enhanced crisis plan uploaded to a local repository where it could be downloaded by all who would have permission and the need to access it in a crisis. This repository could be located with and maintained by the LME, Critical Access Behavioral Health Agency (CABHA), or other service provider.

**Recommendation # 3:** Increase **provider accountability** for consumer outcomes.

Until recently, there has been little incentive in our MH/DD/SA system for providers to improve consumer outcomes. Providers whose consumers showed significant positive improvements and outcomes were rewarded no more or less for their success than providers whose consumers had poor outcomes. Any willing provider was allowed to serve consumers of our public mental health system, regardless of the outcomes of the consumers they served, as long as the provider met minimal requirements to become a provider in our system.

We believe that providers need to be accountable for the outcomes of the consumers they serve, and holding providers accountable for their consumer's progress will provide incentives for them to provide care that can prevent crises from occurring, or prevent them from escalating.

### **What can be done quickly and within available resources?**

Increased provider accountability will be accomplished through implementation of the 1915 b/c waiver and the creation in the LMEs of a closed network of providers. A closed network of providers would allow the LME to contract only with the most reliable providers of highest quality services. Selection of higher quality providers for inclusion in this network would provide incentives to providers who do provide higher quality care that leads to better outcomes for consumers.

### What might require additional time and / or resources?

Time will be required for implementation of the 1915 b/c waiver, and to establish quality standards and measures of quality of providers. Consideration should be given to providing tiered rates based on provider's performance.

### What evidence will indicate progress?

Progress will be evident in the quality of the providers in the LME's network. Specific measures of quality will need to be determined.

**Recommendation # 4:** Convene **critical case conferences** with involvement of CABHA medical and clinical director, IDD providers, direct care staff, and all relevant persons involved (LME staff, mobile crisis, law enforcement, hospital staff, etc.) for individuals who have high utilization of crisis services.

High utilizers of emergency psychiatric services tend to have certain characteristics that put them at risk of repeated crisis events. They tend to lack social support, are more likely to be homeless, have personality disorders along with more serious psychiatric diagnoses, and are more likely to have co-occurring substance abuse problems or developmental disorders, and generally have more complex service needs than persons with psychiatric disorders who do not frequently use crisis services. Pasic and colleagues found that these individuals had six times more visits to psychiatric emergency rooms than other persons receiving emergency psychiatric care. Reducing their disproportionate use of emergency psychiatric services requires meeting their complex service needs – often by providing more intensive services than they were receiving.

Critical case conferences can help determine the adequacy of the care and supports these individuals are receiving to determine if they are sufficient to meet the person's needs. Critical case conferences can also examine precursors to crises to determine if there are patterns to them or triggers that might be identified, and interventions that could be designed to address these patterns or triggers. Critical case conferences should include all persons and agencies involved in the person's care (including the consumer, whenever possible) in order to have as broad a perspective as possible in planning the consumer and family's care.

### What can be done quickly and within available resources?

Some Local Management Entities (LMEs) and Critical Access Behavioral Health Agencies (CABHAs) are already convening critical case conferences for consumers who are demonstrably at high risk of crisis events. Others could easily develop criteria and protocols for convening such critical case conferences, based upon those being used by other LMEs or CABHAs. Critical case conferences are time and staff intensive events. However, the time and resources necessary to hold critical case conferences may be more than offset by decreased use of crisis services, the resulting reduced cost burden on the mental health system, and most importantly, by the reduced potential for harm to the consumer.

### What might require additional time and / or resources?

If people who are experiencing multiple and frequent crisis events requiring emergency psychiatric care are not receiving services and supports of the type or intensity sufficient to meet their needs, then additional resources may be required in order to provide them supports and services that will ultimately result in their decreased use of psychiatric emergency resources. More intensive services, such as Assertive Community Treatment Teams (ACTT) may need to be offered to these individuals. However, the cost of providing these more intensive and appropriate services may, in the long run, be offset by the reduction in their use of psychiatric emergency services

### What evidence will indicate progress?

Evidence will include the establishment of protocols for convening critical case conferences in all LMEs, including clear criteria for the threshold that would trigger the need for holding a critical case conference. To facilitate progress towards this goal, the Division of MH/DD/SAS could produce a model protocol that the LMEs could chose to adopt. In addition, a survey could be made of each LME's highest utilizers of psychiatric emergency services, and the proportion of those for whom critical case conferences were held.

**Recommendation # 5:** Develop **funding and planning to provide transportation** to outpatient appointments and for prescription pick up or delivery to certain at risk, eligible consumers.

For services to be effective, consumers need to be able to access them, and transportation to services poses a significant practical barrier to treatment for many consumers, particularly those in rural areas who have little access to public transportation. It is clear that providing reliable transportation by car, van, or contracted transport can significantly improve consumer's adherence to treatment, although providing transportation vouchers or funds for public transport may not have this same beneficial effect. The impact of the lack of transportation to treatment can be seen in our emergency departments, where these consumers are taken for treatment of psychiatric crises that could have been averted, if only they'd been able to access transportation to their routine appointments or to pick up medications.

### What can be done quickly and within available resources?

People who have Medicaid may qualify for Medicaid-funded transportation services, but Medicaid funded transportation is reported to be unreliable and inconvenient. Medicaid recipients often must schedule for transportation at least a week in advance, and Medicaid transportation services are frequently late or off-schedule. Persons receiving services such as ACTT, may have transportation provided by their ACT team. However, transportation is not a benefit of many services, and even when it is permitted (such as with case management), stringent limitations on hours of service authorized

per month makes case management an impractical transportation option.

**What might require additional time and / or resources?**

Providing transportation to treatment free of charge to all consumers of mental health services would require a significant infusion of funds that is unlikely to be forthcoming, given the state's current fiscal challenges. However, it may be possible, with limited funding, to develop a pilot program to determine the cost effectiveness of providing transportation to treatment for certain eligible consumers who would otherwise end up in psychiatric crisis. This pilot program might help us determine for which consumers, and under what circumstances, it would be more cost effective to provide transportation. The results could help shape a policy concerning the provision of transportation of consumers to treatment that would, in the long run, both reduce emergency department use and save costs by removing a barrier to effective treatment for these "at risk" consumers.

**What evidence will indicate progress?**

Evidence of progress could include a plan to pilot and study the cost effectiveness of a transportation program for consumers of mental health services.

**SUMMARY AND CONCLUSIONS**

The increase in psychiatric emergency department visits is a national trend that is a consequence a variety of factors, including deinstitutionalization, increasingly limited outpatient resources, increased substance abuse problems among persons with mental illness, few resources for people with substance abuse disorders, and difficulties meeting the needs of complex and challenging consumers who are not easily engaged in treatment. The increased demand upon our emergency departments is a reflection of our limited resources to meet the needs of our consumers in the community. While it is clear that increased resources are needed to address this problem, steps may be taken that would better enhance the efficiencies of our system, and decrease the number of crisis events that need psychiatric emergency room care. The most cost effective crisis interventions are typically those that can occur earliest in the crisis event, or even prevent the crisis from occurring. We have attempted to delineate those steps that can be taken at the pre-crisis stage that we believe will most effectively reduce usage of emergency departments for psychiatric crises. The following portions of this plan will provide recommended steps that can be taken during a crisis, in the emergency departments, and following a crisis to further reduce the use of emergency rooms for psychiatric crisis intervention.

## CHAPTER 3: PRE-EMERGENCY DEPARTMENT

- **GOAL: TO REDUCE THE NUMBER OF PEOPLE ENTERING THE EMERGENCY DEPARTMENT WITH BEHAVIORAL HEALTH ISSUES.**

### Introduction:

Reducing the number of individuals with behavioral health crisis presenting to the ED requires an effective and efficient crisis system that includes appropriate alternatives to emergency rooms for crisis services. This approach is consistent with the overall goal of NC's public system of services and supports for individuals with mental illness, developmental disabilities, and substance use disorders which is to provide appropriate, high quality services in the least restrictive setting possible. Adhering to this philosophy allows for services to be delivered as close to the individual's home or community as possible and no more intense than needed to meet consumers' needs. This is often referred to as "the right service, at the right time, in the right amount, and at the right cost." Recommendations, which reflect these values, are as follows, along with a discussion of how each of these recommendations could be implemented:

**Recommendation # 1:** Enhance the effectiveness and efficiency of Mobile Crisis Management Services.

Mobile Crisis Teams (MCTs) provided 15,544 services to consumers in the 6 month period from July to December, 2010. While Mobile Crisis Teams provide important services in the ED to assess consumers, facilitate transitions in care, and provide linkages to community services, there are some services provided in the ED when safe and appropriate alternative sites for evaluation are not available, particularly after hours. Mobile Crisis Management services should be provided in the home whenever possible. It is therefore, the opinion of the pre-emergency department workgroup, that consumers should be able to receive mobile crisis services in a setting that is as close as possible to the consumer's home/natural environment, including evening and after hours whenever possible. In addition, alternative non-emergency department sites that provide privacy, confidentiality, and safety for clients should be available for use when clinically indicated and desired by the consumer.

A number of clinical services that are provided by Mobile Crisis Teams could be enhanced by using staff with specific qualifications. For example, law enforcement may take custody of an individual when there is concern that the individual is dangerous to self or others. When law enforcement takes custody and believes that an emergency exists, a first commitment evaluation is required. Working to establish linkages between law enforcement and mobile crisis teams will be more effective and efficient if the mobile crisis team can reliably respond with a provider qualified for first commitment evaluations. The workgroup supports improved matching of staff qualifications to functions, including use of licensed staff for initial evaluations, inclusion of first commitment evaluators, and structured inclusion of psychiatrists in workflow activities as measures that would enhance the effectiveness of mobile crisis services.

As first responders involving people with behavioral health crises, law enforcement officers are important in determining how and where consumers access services and first commitment evaluations. Some communities in NC have been successful in establishing protocols that assist law enforcement in determining how and where clients should access services based on the individual's circumstances. Establishment of formal linkage agreements and procedures between Mobile Crisis Management Teams, Law Enforcement (LE), and Screening, Triage, and Referral (STR) is expected to improve patient flow, communication, and efficiency between these critical partners in crisis services. Linkages may provide for MCTs responding to law enforcement for evaluation of consumers in alternative sites as well as requests from MCT to LE to assist in non-emergency department settings when indicated by the MCT safety risk assessment.

A formal linkage with NC START is recommended to improve the efficiency and effectiveness of the partnership between Mobile Crisis Management (MCM) and NC START in caring for individuals with Intellectual -Developmental Disabilities (I/DD).

In addition, consistent monitoring of compliance with the MCM service definition is recommended to support the provision of high quality services.

### **What can be done quickly and within available resources?**

With the exception of use of licensed staff and first commitment evaluators for initial evaluations, these recommendations are expected to be able to be implemented within currently available resources. Risk assessment tools to assist Mobile Crisis Teams in determining safety risk factors related to providing services in consumers homes are available. It is probable that public sites can be developed for use by Mobile Crisis Teams at low cost or no cost; however, it is important that alternative sites allow for privacy, confidentiality, and safety for clients. Forming linkages with Law Enforcement and NC START does not require additional resources and may provide additional efficiencies for all parties. Psychiatrists are currently mandated to be part of the staffing pattern for mobile crisis teams; therefore, structuring the inclusion of psychiatrist in workflow should be low cost or no cost.

### **What might require additional time and / or resources?**

Although some mobile crisis teams currently utilize licensed staff and first commitment evaluators for initial evaluations, there is typically a subsidy from the LME that supports the enhanced staffing. Therefore, use of licensed staff and first commitment evaluators by more mobile crisis teams will require additional resources to support mobile crisis services. Development of alternative sites for use by Mobile Crisis Management, particularly those used in the evenings and after hours will require additional time. Use of public facilities as an alternative site for evaluations is likely to mitigate the cost associated with use of additional facilities. Building relationships between the LMEs and local law enforcement is needed as a foundation for development of protocols that include linkages between LE and MCM teams and this may require additional time.

### **What evidence will indicate progress?**

Provision of effective and efficient mobile crisis services in the non-emergency department setting would be expected to result in a decrease in individuals presenting to the ED. Progress towards implementing this recommendation might be tracked by measuring the number of individuals presenting to the ED. In addition, one would expect to see more Mobile Crisis Services delivered in the home and/or natural setting. It is important to recognize that a linkage between emergency departments and community services is also important and mobile crisis often plays a role in this important relationship; therefore, many mobile crisis teams will have to balance the settings in which they provide care according to the needs of the community that they serve. Use of the psychiatrist in Mobile Crisis workflow can be tracked through mobile crisis clinical documentation. Effective linkages with law enforcement can be tracked through the development of memoranda of agreements and development of protocols for the Standard Operating Procedures (SOP) manual. Linkages with NC START can be tracked through NC START reporting requirement and completed contracts.

**Recommendation # 2:** Augment the role of Facility Based Crisis Centers (FBC) and 24 hour Walk In Clinics .

The pre-emergency department workgroup thinks that having 24 hour facilities with high quality crisis services that serve as an alternative to the emergency department, might reduce numbers of individuals with behavioral health crises presenting to the emergency department. Consumers, families, and law enforcement may turn to the emergency department when trying to determine where to access comprehensive crisis services that are available 24/7.

One model recommended by the American Psychiatric Association has demonstrated success in Harris County, Texas. Seventy-eight percent of adults and seventy one percent of children assessed there during 2006-7 could be adequately treated there and did not require hospitalization. A key component of this model is the 24/7 availability of psychiatric emergency services.

Some communities in North Carolina have Facility Based Crisis Services in place, but there is variability in a number of characteristics including hours of operation, In-voluntary Commitment (IVC) designation, qualifications and ratios of staff, availability of medical evaluation and/or medical clearance services, and policies regarding walk in that may limit their effectiveness as alternatives to emergency departments. There are currently 21 facility based crisis centers available across the state and the workgroup has a series of recommendations designed to enhance the effectiveness of Facility Based Crisis Services in NC as follows:

- All FBC facilities should meet staffing qualifications, staff to client ratios, and other requirements necessary to be designated as IVC facilities.
- There should be an economic impact analysis to determine which regions have the population and geography to support additional Facility Based Crisis Centers and expanded hours for Walk In Crisis Centers.

- FBCs should consistently allow walk-ins 24/7/365 except when over capacity requires them to close temporarily.
- Have a system for non-ED medical clearance which meets medical clearance policy requirements of DMH/DD/SAS and DSOHF.
- Require 1<sup>st</sup> commitment evaluators at FBC and WIC during operational hours.
- Implement State Plan for Child FBC.
- Increase access to FBC for individuals with IDD via service definition changes and clarification.

### **What can be done quickly and within available resources?**

Most of the recommendations related to enhancing the number and effectiveness of Facility Based Crisis Centers will require additional resources. Many existing facility based crisis centers are located in urban areas, and an economic impact analysis is needed to determine whether additional centers are sustainable and have the population density to support these services. Medical clearance may be able to be supported through linkages with local hospitals that may make non-emergency department medical clearance resources available when needed.

### **What might require additional time and / or resources?**

Funds will be needed to pay for new facilities as well as increased staffing requirements and expanded hours of operation. Additional time is needed to do an economic impact analysis. Planning and building new facilities and hiring and training additional staff all require additional time. Embedding medical services into facility based crisis centers will take additional financial resources. Also additional research is needed regarding Facility Based Crisis Services. For example, anecdotal information indicates proximity to ED has an impact on Facility Based Crises Utilization

### **What evidence will indicate progress?**

A decline in the number of individuals presenting to emergency departments with behavioral health crises would be an expected outcome. In addition, the number of individuals in the ED who have been referred for hospital admission and who are put on a wait list would be expected to decline. The total number of clients served by facility based crisis centers and the number of clients who require transfer to emergency departments can also be used to assess progress.

**Recommendation # 3:** Work with Law Enforcement.

As first responders in many crises involving people with mental illnesses/substance abuse disorders, law enforcement officers can play an important role in preventing the escalation of a situation involving a psychiatric patient and can thus make inpatient care unnecessary. Training these officers to manage mental health crises, linking officers to STR and MCM teams, and giving officers information about custody orders, appropriate use of local mental health services, and sites for evaluation, including first commitment evaluations, can keep some psychiatric patients out of the emergency department.

Development of procedures utilizing a security risk assessment tool may reduce law enforcement waiting time in non-emergency department settings and provide incentives for law enforcement to use alternative sites. This tool allows for a collaborative determination of when it is safe for law enforcement to leave the individual under the supervision of facility based security, walk in clinics, and/or the mobile crisis team.

It is recommended that the custody order form be revised to provide clearer communications to law enforcement.

### **What can be done quickly and within available resources?**

Protocols and memoranda of agreements that allow STR and/or MCM to assist the officer in managing the crisis and to communicate the options and services for appropriate and available sites for consumer evaluations should be available within existing resources. Additional CIT training for officers is covered in the Pre-crisis section of this report and will not be repeated here.

### **What might require additional time and / or resources?**

Building relationships between the behavioral health community and local law enforcement is needed as a foundation for development of protocols that include communication and assistance from STR and MCM teams. The provision of security staff by behavioral health agencies will require additional financial resources. Revision of the custody order form involves multiple agencies and may take additional time. In addition, there are costs associated with revising and printing new forms and training.

### **What evidence will indicate progress?**

Progress can be measured through the number and use of agreements and/or protocols developed between LMEs and local law enforcement agencies. The number of officers trained with CIT can be measured.

**Recommendation # 4:** Enhance accountability in First Responders.

On-going, coordinated care can be an alternative, trusted point of care that can divert consumers in crisis from emergency departments or facilitate discharge planning when clients do access emergency departments. CABHA agencies have an obligation to perform "first responder" crisis response 24 hours a day, 7 days a week, 365 days a year to all consumers accessing CABHA services. It is recommended that the system be designed to ensure that this response is robust and that Residential Homes (including TCM-IDD) are also accountable for responding appropriately to clients in crisis as follows:

- Monitor First Responders for compliance with crisis response requirements.
- First responders and residential homes should develop robust crisis plans for high risk consumers or those who are experiencing a crisis.
- Evaluation should be provided in the client's home or as close to their home as possible following a risk assessment and if desired by the consumer.
- Use licensed providers to assess clients of enhanced services when called for crisis assessment.
- Notify NC START for early signs of crisis and admissions to ED.
- Consider legislation or develop consequences to prohibit abandonment of consumers in the ED by residential providers.

### **What can be done quickly and within available resources?**

A number of systems could be used to implement a performance monitoring system for crisis response. Use of billing data, provider reported data, NORTH CAROLINA - TREATMENT OUTCOMES AND PROGRAM PERFORMANCE SYSTEM (NC TOPPS), Mobile Crisis Management reports, and the LME crisis tracking system are all possible sources of monitoring for compliance. LMEs currently have access to data from one or more of these sources. Some requirements for monitoring could be written into DMH/DD/SAS-LME performance contracts which would follow the contract cycle and may take up to 12 months.

### **What might require additional time and / or resources?**

Development of legislation designed to prohibit abandonment of consumers in the emergency department will require legislative action and will take additional time. Evaluation of which data sources provide reliable monitoring and development of systems to capture and report the desired data elements may take additional time.

### **What evidence will indicate progress?**

The percent of clients enrolled in services with first responders and/or residential providers utilizing the ED whether measured by billing data, consumer report, provider report, MCM report, or through the LME crisis tracking system would be expected to decline.

**Recommendation # 5:** Develop consistent Screening, Triage, and Referral (STR) procedures .

For crisis services to be effective, consumers and responders need to be able to reliably receive information about how to respond to clients in crisis, understand what services are available, where the services are, and how to access them. STR serves as an important hub in assessing the needs of the individual and caller and communicating key information. The workgroup recommends that each STR line provide the following functions:

- Retain and communicate a list of available evaluation sites to law enforcement, magistrates, schools, and other community based resources so that the consumer can make an informed choice.
- Use licensed staff for Emergent/urgent Screening, Triage and Referral calls and those involving LE.
- Require crisis plans to be submitted and available for high risk consumers.
- Develop a protocol that is consistent (standardize information that is provided to the client by LE as well as the information retrieved from LE and what is given such as whether the client is known to the system).
- Respond quickly, efficiently, and reliably to each user to promote use of the STR function by key stakeholders such as law enforcement and magistrates.

### **What can be done quickly and within available resources?**

Licensed staff is currently available in LMEs. Workflow and procedures would need to be altered in some LMEs. Communication and training of staff and stakeholders around STR protocols and processes should be available within existing resources.

### **What might require additional time and / or resources?**

Development of systems for accepting and retrieving crisis plans may take additional time. If additional licensed staff is required, additional financial resources will be required.

### **What evidence will indicate progress?**

Progress can be measured by the presence of protocols in place in each LME. Mystery callers can be utilized to determine if STR services are being provided in an effective, reliable, and consistent manner.

**Recommendation # 6:** Use non-emergency department resources for medical clearance evaluation.

The Emergency Department often serves as a resource to obtain medical evaluations and medical clearance for individuals being referred for inpatient psychiatric hospitalization and/or those being treated in a crisis center. Once the individual is admitted and evaluated in the Emergency Department, a complex interplay of factors may prevent the individual from subsequently being transferred to a setting of care that better matches the individual's behavioral health needs. One example of a non-emergency department medical resource is an urgent care center. Because medical evaluation and clearance requires a medical assessment and often requires obtaining laboratory studies, these services are not often available in outpatient behavioral health settings. Use of urgent care centers for medical evaluation and medical clearance could be explored for individuals who do not require the higher level of medical services available in the emergency department. Embedding medical resources

into behavioral health settings of care for individuals in crisis would resolve the problem of access to medical services as well as the logistical problems associated with transportation and communication between medical and behavioral health systems of care. Payment mechanisms are a barrier to use of non-emergency department medical evaluation resources. Methods of payment for medically indigent consumers and Medicaid patients who are being treated in crisis centers will need to be developed.

#### **What can be done quickly and within available resources?**

The workgroup recommends that community hospitals be included in conversations about accessing non-emergency department medical evaluation resources.

#### **What might require additional time and / or resources?**

A number of individuals who require medical evaluation and clearance do not have the financial resources to access services outside of the emergency department. Crisis centers will require additional financial resources to access services from urgent care centers, contract for medical services, or to provide them on-site at the crisis center.

#### **What evidence will indicate progress?**

Identification and utilization of alternative sites for medical evaluation and clearance can be used as a measure of progress.

**Recommendation # 7:** Work with magistrates.

Magistrates serve an important role in protecting individuals' constitutional rights. Family members and others concerned for the safety and welfare of individuals may present to a magistrate for a petition seeking a court order to take the individual into custody for an examination to determine if the individual is dangerous to self or others.

When custody orders are granted and a first commitment evaluation is needed, the site of evaluation is often the emergency department. Working with magistrates to communicate availability of a MCT or other evaluation service prior to proceeding with a petition may provide an opportunity to treat the individual in a less restrictive environment and potentially avoid an involuntary hospitalization. Communication of the availability of evaluation services prior to the custody order is consistent with the philosophy that involuntary commitment and court-ordered treatment should only be used as a last resort and only when it is believed to be in the best interests of the individual.

#### **What can be done quickly and within available resources?**

This recommendation can be implemented within existing resources.

### **What evidence will indicate progress?**

An increase in the number of referrals from magistrates to MCTs can be used as a measure of progress.

**Recommendation # 8:** Provide care coordination.

The Agency for Healthcare Research and Quality (AHRQ) has defined key goals for care coordination to include coordinating transitions of care, reducing hospital readmissions, communicating medication information, and reducing preventable emergency department visits. All of these goals are also goals for individuals served in North Carolina's Public Behavioral Health Crisis System.

Individuals often go through a series of transitions of care as they enter and proceed through the crisis system interfacing with community crisis providers, law enforcement, magistrates, primary providers, and others. Coordinating, communicating, and tracking the care of individuals from the earliest time of entry into the crisis system may afford opportunities to utilize available community resources and resolve the crisis before the consumer's crisis necessitates an ED visit or hospitalization. In addition, once a consumer reaches an ED, poor coordination of care between the mental health system and the emergency department has been identified as a factor in psychiatric boarding.

### **What can be done quickly and within available resources?**

Utilization of Care Coordinators residing in the LME or as designated by the LME, such as a MCT provider agency or a primary mental health home, can be implemented within existing resources.

### **What might require additional time and / or resources?**

Coordination of care functions involving significant numbers of consumers may benefit from data systems that allow tracking of the individual within the crisis system as well as communication and coordination of client information and needs between multiple agencies. Development of information systems that support care coordination activities may take additional time in LMEs that do not currently have existing systems.

### **What evidence will indicate progress?**

Definition of the system of care coordination in each LME can be used to evaluate progress. In addition, stakeholder satisfaction surveys can be used to gauge the effectiveness of care coordination services.

**Recommendation # 9:** Diversify and strengthen workforce.

In 2009, the Substance Abuse and Mental Health Services Administration (SAMSHA) identified key principles to ensure that important values common to all crises can be enacted. Included among these 15 key principles is the need for crisis responders to have a comprehensive understanding of the crisis, for peer support to be available, and for crisis services to be trauma-informed. Peer support services can provide personal experiences that can reduce the isolation and fear associated with crises. In addition, when it is not feasible for someone to stay in their natural setting, consumer managed crisis residential services can be an effective alternative to hospitalization. With these principles in mind, the workgroup recommends:

- Striving to have first response include peers and familiar staff, and
- Consumer-managed crisis residential service, and
- Appropriate training and competency of crisis responders, including workforce development for trauma-informed crisis response.

#### **What can be done quickly and within available resources?**

Development of consistent training and core competencies that reflect the key principles of crisis response can be implemented within existing financial resources.

#### **What might require additional time and / or resources?**

The development of a system for demonstrating core competencies and the implementation of a state-wide system for competencies will take additional time. Inclusion of peer support staff into crisis response services and development of consumer-managed crisis residential services may require additional financial resources.

#### **What evidence will indicate progress?**

Measurement of the percent of crisis responders who complete training utilizing required state-wide curriculums, and measurement of the percent of crisis responders who demonstrate required competencies can be used to gauge progress. Tracking the number of crisis responders who include peer support staff and functions in their workforce can be used to assess progress towards making peer support available to consumers in crisis.

## CHAPTER 4: EMERGENCY DEPARTMENT

- **GOAL: TO REDUCE EMERGENCY DEPARTMENT LENGTH OF STAY FOR INDIVIDUALS WHO PRESENT WITH BEHAVIORAL HEALTH CRISES.**

### Introduction:

Over the past decade, emergency department (ED) utilization for any cause has been increasing nationally, with similar trends noted in North Carolina (Institute of Medicine, 2006; Tang et al., 2010; NCDETECT 2007, 2008, 2009). During State Fiscal Year 2009-2010, a total of 4,279,499 individuals were admitted to local EDs in the state of North Carolina. Of that total, 135,536 (3.2 percent) were individuals who had a primary diagnosis of a mental health, developmental disability or substance abuse disorder and were seen in the ED for a behavioral health crisis.

Figures 1 and 2 provide information on the number of ED admissions with a primary behavioral health diagnosis for each quarter for the time period of January 2009 through June 2010. Data show that while the number of behavioral health admissions are rising steadily, it is in keeping with the rise in the number of overall ED admissions.

**Figure 1. Number of admissions for All Causes and with a Primary MH/DD/SA Diagnosis by Quarter**

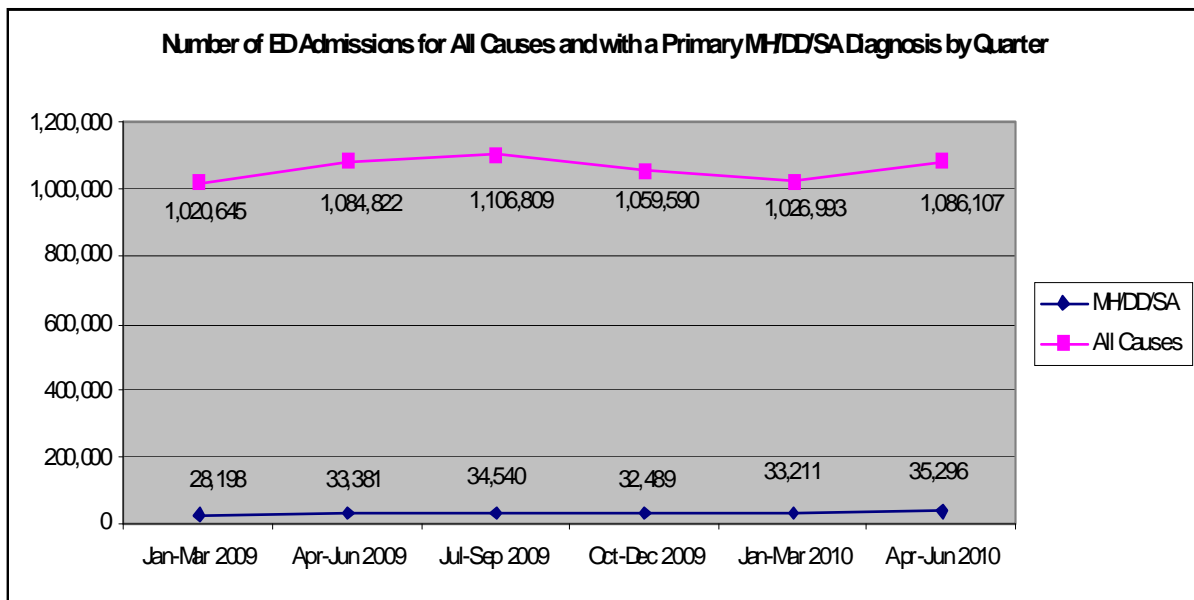
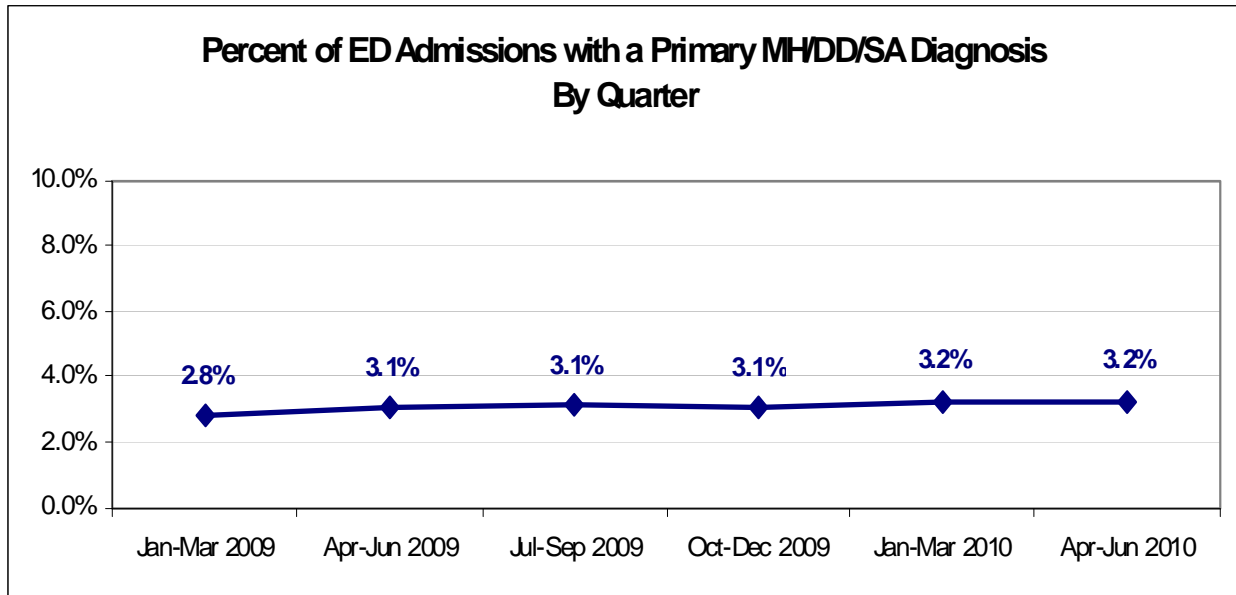


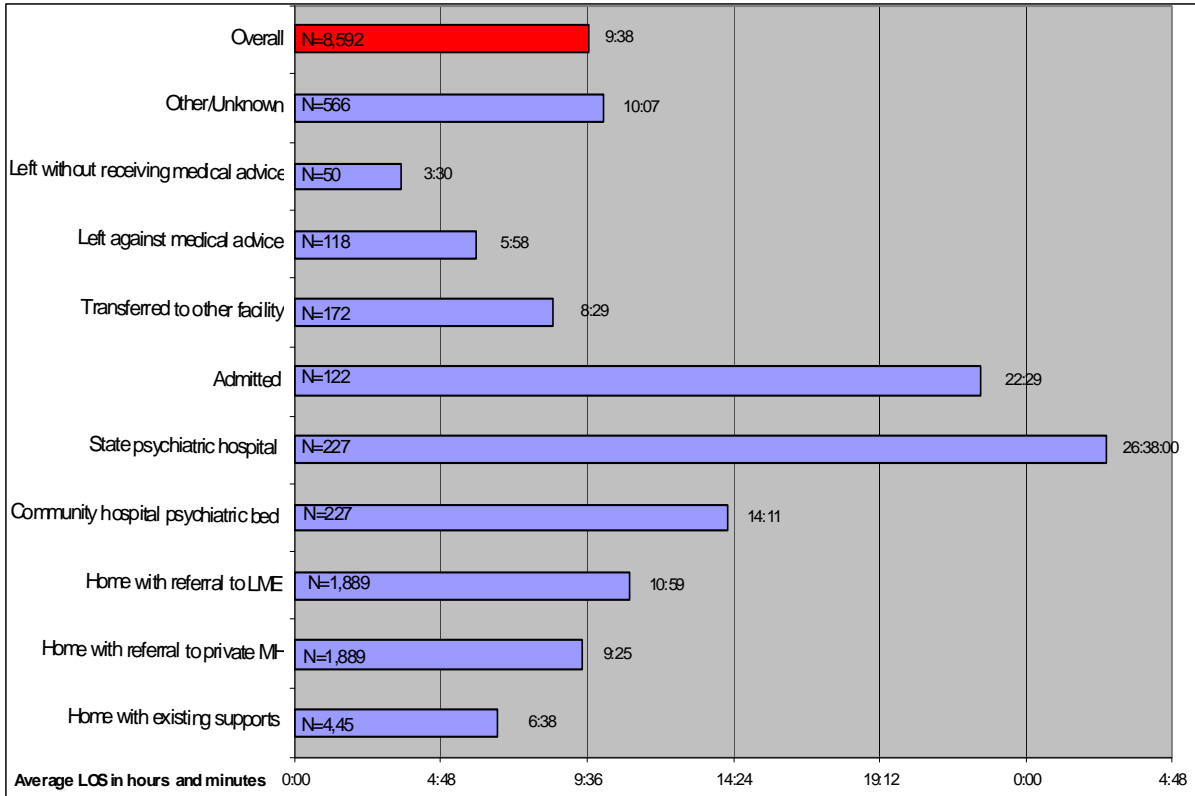
Figure 2. Percent of Emergency Department Admissions with a Primary MH/DD/SA Diagnosis by Quarter



ED Admission Data Source: NC DETECT provided to NC DMH/DD/SAS

This increase in ED utilization has been thought to lead to an inevitable increase in ED length of stay. Research has also shown an increase in length of stay for those with mental health-related visits and longer ED length of stay for individuals who require psychiatric hospitalization and/or transfer to other psychiatric facilities. North Carolina data supports this assertion (North Carolina Department of Health and Human Services, 2011). A recent study showed that those with behavioral health crises presenting to EDs who were discharged to a home setting had, on average, an ED wait time ranging from six hours and 38 minutes to 10 hours and 59 minutes. Those who were admitted or transferred to another facility had an average ED wait time ranging from eight hours and 29 minutes to 26 hours and 38 minutes, depending upon the facility type (See Figure 3 on the next page).

**Figure 3. Average Emergency Department Length of Stay for a Behavioral Health Crisis by Disposition**



There are many reasons other than increased ED utilization that are thought to contribute to increasing ED wait times. Research has shown that legislation such as Emergency Medical Treatment and Active Labor Act (EMTALA), cost shifting, hospital organizational factors, a nationwide reduction in state psychiatric hospital beds, and a reduction or limitation in behavioral health community services also contribute to increased ED LOS for individuals with psychiatric crises.

North Carolina, like many other states, faces issues with psychiatric boarding. Psychiatric boarding is defined as the process of holding psychiatric patients in emergency departments until an inpatient bed is available. Some states such as Georgia, report average boarding times of 34 hours with many patients waiting several days for an inpatient bed in a state psychiatric hospital. The state of Maryland reports some emergency rooms boarding up to a dozen psychiatric patients for days at a time. A report by the United States Office of Disability, Aging and Long-Term Care Policy on psychiatric boarding provides many reasons for increased length of stay including lack of inpatient hospital capacity, closure of state psychiatric hospital beds, insurance status or delays in pre-authorization, placement or transfer issues, insufficient community resources, necessity of medical clearance and EMTALA issues.

A review of North Carolina data suggests that the phenomenon of psychiatric boarding does occur with individuals who are admitted to psychiatric beds or transferred to other facilities for psychiatric care, with individuals who are awaiting transfer to a state hospital waiting for over 26 hours, on average.

**Recommendation # 1:** Implement a Computerized Psychiatric Bed Registry (Bed Board) which would include access to:

- State hospitals
- Community based hospitals
- Facility-based Crisis (FBC)
- Mobile Crisis Management Team (MCM)
- LMEs

One problem contributing to lengthy emergency room wait times is the difficulty in getting information necessary for appropriate disposition. Hospital emergency room staff report that a large portion of staff time is devoted to placing calls to other facilities to see if inpatient psychiatric beds are available and hospitals are willing to accept individuals needing beds. Multiple calls are often made through out the day and at each shift change. Other states, such as Virginia, have implemented statewide web-based data systems that allow facilities to post up to date information about their available psychiatric beds (<http://www.vhi.org/beds2/default.asp>). This database also allows registered hospitals to determine quickly where available beds may be located that are appropriate to specific individual needs. North Carolina is currently piloting a similar “bed board” for the Eastern region of the state.

### **What can be done quickly and within available resources?**

It is recommended that the Eastern region bed board be expanded to include information about psychiatric beds on a statewide basis. Additionally, it is recommended that the bed board information be made available to personnel at facility-based crisis (FBC) centers, mobile crisis management (MCM) teams, local management entities (LMEs) and the North Carolina Systemic, Therapeutic Assessment, Respite and Treatment Program (NC START) which provides regionalized 24 hour crisis response and consultation for adults with intellectual and developmental disabilities.

### **What might require additional time and resources?**

The Eastern region bed board was developed by personnel at Walter B. Jones Alcohol and Drug Treatment Center (ADATC). Additional funds may be required for staffing to assist with additional programming needs, maintenance and training needs as the program expands.

### **What evidence will indicate progress?**

Progress for this goal can be evidenced by a fully operational bed board.

**Recommendation # 2:** Develop **protocols and practice guidelines to standardize/utilize best practices for services** in the EDs. Guidelines should address the following:

- Improving the treatment and engagement of patients while waiting in EDs and crisis centers for inpatient care.
- Clarifying the role of MCM teams in the ED.
- Clarifying the role of the MCM team psychiatrist.
- Clarifying and supporting the role of MCM team providers in assessing and reassessing patients who remain in EDs for longer than 72 hours as well as the role of the mobile crisis provider with regard to final disposition.
- Legal and funding aspects of MCM in EDs clarified.
- Standardized data elements for MCM/NCSTART/NCDETECT reports.

Currently, each of the 23 local managing entities (LMEs) has mobile crisis management (MCM) teams that provide a variety of services to individuals in crisis. Mobile crisis teams are designed to provide 24 hour access to evaluation and referral to behavioral health services to individuals who meet eligibility criteria. MCM teams are designed to be a second level service, providing back up to the first responder or primary mental health provider. However, MCM teams function differently across the state. For example, some programs deliver the majority of their services in the emergency department, while others focus on diverting individuals with behavioral health crises from the ED. Also, it is reported that the role of the psychiatrist varies across MCM teams. It is perceived that a standardized best practice model that outlines the role of the MCM in the emergency department would have an impact on service delivery in the ED and thereby decrease ED length of stay for individuals with behavioral health crises.

#### **What can be done quickly and within available resources?**

In an effort to improve effectiveness of MCM services, ensure access to crisis services, and further solidify the working relationships of MCM teams and community hospital staff, the Division of MHDDSAS recently worked with key external stakeholders to form a MCM workgroup. The workgroup drafted guidelines addressing the functions that are clinically appropriate to be provided by MCM team staff in a hospital ED among and also drafted guidelines for enhancing oversight and provision of clinical activities. This workgroup will continue to meet to consider next steps for the draft guidelines and will also consider strategies designed to meet additional objectives for MCM as delineated in the chapter on Pre-Emergency department recommendations.

#### **What might require additional time and resources?**

Development of standardized data elements and clarification of funding aspects will require additional time.

### What evidence will indicate progress?

The availability of published protocols and guidelines would indicate progress for this goal. Additionally, progress towards this goal could be measured through on-site monitoring or an implementation fidelity review. An implementation fidelity review could provide information on how closely MCM teams are following guidelines and adhering to the program intent.

Progress for this recommendation could also be assessed by analyzing the incidence of ED visits of individuals with behavioral crises as well as analyzing ED length of stay. An ED length of stay study would likely require additional resources as well as the cooperation of community hospital EDs as there is no existing data source to capture that information.

**Recommendation # 3:** Clarify and support **the role of LMEs with regard to ED behavioral health crisis admissions** including the following:

- Assisting EDs and the crisis continuum through tracking of consumers in the ED.
- Holding meetings with each ED to address issues.
- Providing training to EDs on mental health, substance abuse and intellectual/developmental disability issues.
- Maintaining an expectation that LMEs assist with consumers who have been in the ED longer than 24 hours.
- A review of existing policies and guidelines regarding LME role in the ED should be conducted to see if revisions are needed. This would also include a review of the Division contracts with the LMEs and a review of performance measures.

As with MCM teams, the LMEs role in the local ED can vary. Some LMEs have staff assigned to meet regularly with local community hospital staff to develop local strategies on how to decrease ED utilization and ED wait times for individuals with behavioral health crises. Some LMEs have staff assigned to community hospitals who call local EDs daily to assist with individual disposition planning and provide consultation.

### What can be done quickly and within available resources?

Many LMEs already provide support to local emergency departments in a variety of manners. Additional efforts, such as the development of statewide workgroups to develop policy guidelines for LMEs, should be made to identify best practices and standardize efforts across the state.

### **What might require additional time and resources?**

Additional time and funds are required to disseminate and provide training around policy guidelines.

### **What evidence will indicate progress?**

Progress could be measured for this recommendation through the following: 1) the existence of a policy which is publically available; 2) a measured reduction in ED length of stay for individuals with behavioral health crises; and 3) an overall decrease in ED visits for individuals with behavioral health crises. An additional study of ED length of stay would need to be conducted and would require the cooperation of community-based emergency departments in North Carolina.

#### **Recommendation # 4: Reduce legal obstacles.**

- Clarify EMTALA issues, pursue alternative resolution(s).
- Clarify outpatient commitment issues.

There are many laws in place that protect the rights of individuals who are in a behavioral health crisis. However, the legal aspects of treating individuals with mental health, developmental disability and substance abuse diagnoses can be unfamiliar to emergency room doctors. One such law is the Emergency Medical Treatment and Active Labor Act (EMTALA) which was enacted by congress in response to concern that emergency departments were refusing to treat indigent and uninsured patients or inappropriately transferring them to other hospitals. EMTALA requires hospitals receiving federal funds (e.g., Medicare and Medicaid) to provide a medical screening exam, stabilizing treatment and an appropriate transfer, if needed.

EMTALA impacts ED wait times in two ways. In North Carolina, as well as many other states, ED wait times are impacted if an appropriate receiving hospital bed is not available to accept the transfer. EDs are legally required to board the individual until an appropriate place is located. This can take days or even weeks for some complex psychiatric cases. Also, the term "stabilizing treatment" in the EMTALA legislation has not been very well defined. It can be difficult for ED doctors to determine appropriate stabilizing treatment for some complex psychiatric patients. Hospital EDs are very cautious in treating individuals with behavioral health crises due to high fines for EMTALA violations. This can also lengthen the time individuals with behavioral health crises spend in EDs.

Another law which impacts ED length of stay is the involuntary outpatient commitment law. This law is a legal intervention that can require individuals with severe mental illness to comply with specified outpatient treatment. If the individual under commitment fails to comply with treatment, the responsible clinician may request law enforcement to transport the individual to an outpatient facility where mental health clinician attempts to persuade the individual to comply with treatment. Research has shown that outpatient commitment can improve treatment outcomes, such as hospital readmissions, when the court order is sustained and combined with intensive outpatient treatment.

In North Carolina a substantial number of individuals discharged from state hospitals are put on outpatient commitment; however, there are currently many factors such as uneven follow-up on the court order and variances in follow-up treatment offered that make the outpatient commitment process less effective than it would otherwise be. Also, outpatient commitment is perceived to be underutilized by many emergency room doctors. It is perceived that due to liability issues, ED doctors tend to use inpatient commitment when outpatient commitment procedures would be clinically appropriate.

**What can be done quickly and within available resources?**

Training and educational resources regarding how to treat individuals with behavioral health crises under EMTALA and outpatient commitment can be provided immediately and at low cost to emergency room doctors.

**What might require additional time and resources?**

Smart phone applications are being used increasingly in the medical profession to help aid treatment decisions. These applications can provide up-to-date information for ED physicians regarding best practices for individuals with behavioral health crises and assist them in navigating EMTALA and OPC issues.

**What evidence will indicate progress?**

Progress could be measured by the number of training events provided to ED physicians and staff. Additionally, progress could be measured by the total number or rate per population of outpatient commitments conducted in North Carolina on an annual basis.

**Recommendation # 5: Enhance disposition options** for individuals with behavioral health crises in the emergency department. Options include:

- Temporarily opening additional state psychiatric hospital beds until wait time for state psychiatric beds are reduced.
- Maintain or increase funding levels for three-way beds.

Lack of appropriate disposition options can increase ED length of stay for individuals with behavioral health crises. A recent study of ED length of stay for individuals with behavioral health crisis in North Carolina indicates the disposition decisions greatly impact the length of time an individual waits in the ED. Individuals deemed to need state psychiatric hospital level of care waited on average for over 26 hours- 17 hours longer than the average wait time (North Carolina Department of Health and Human Services, 2011).

One strategy North Carolina has used to ameliorate lengthy ED wait times and to off-set the decrease in available state psychiatric beds is three-way contracts. During SFY2010-2011, DMHDDSAS and 15 LMEs had contracts in place with 21 hospitals across the state to provide up to 121 psychiatric beds. These three-way contracts utilized state funding to serve indigent individuals who required inpatient psychiatric care. These beds have provided services in private hospitals to those who would otherwise have received services from the state psychiatric hospital. During SFY11, the three-way contract beds were well utilized.

#### **What can be done quickly and within available resources?**

The Department could use existing staff and resources to research and evaluate the appropriate number of psychiatric beds for North Carolina's present and projected population. Additionally, a review of the utilization of the three-way beds could be conducted to ensure maximization of those resources.

#### **What might require additional time and resources?**

The state psychiatric hospitals currently have unused bed capacity that could be utilized for additional psychiatric beds; however, additional funding would be needed for staff to provide direct care.

#### **What evidence will indicate progress?**

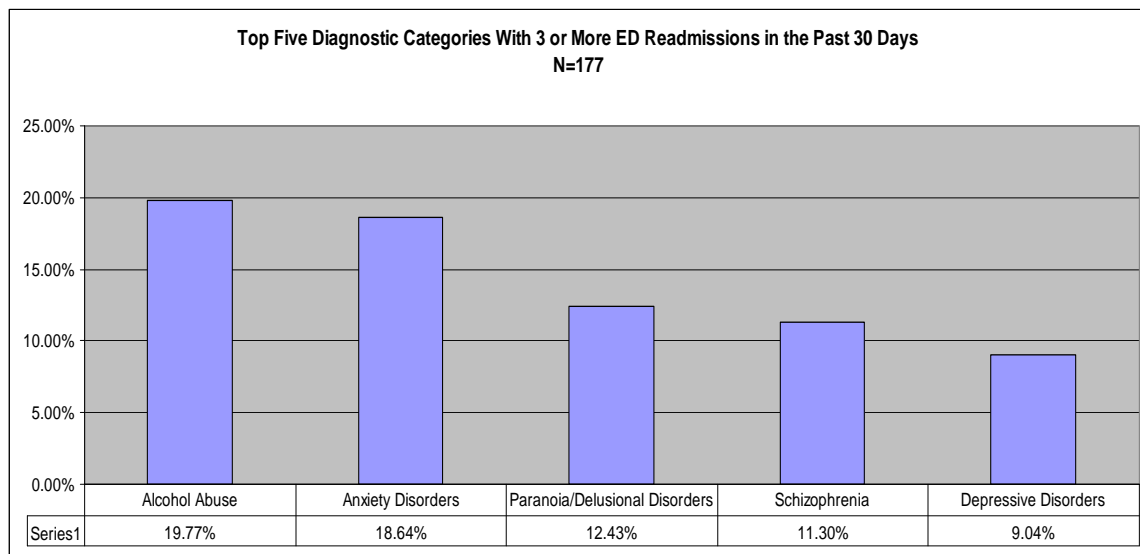
There are several mechanisms for measuring the success of this recommendation. Conducting a study of ED length of stay, with a specific focus on the wait time for individuals waiting for state psychiatric beds would be important. Additional ways to measure progress for this recommendation include a study on the appropriate number of psychiatric hospital beds for the state and the feasibility of the maintenance of funds for three-way beds.

**Recommendation # 6:** Engage individuals with substance use disorders earlier and link to treatment services.

- Linkage of patients to substance abuse treatment earlier from the ED or from medical detox.
- Outreach by ADATCs to EDs and Medical Detox to engage consumers.

North Carolina data from the EDs show that alcohol abuse is the leading diagnostic criteria for individuals with 3 or more ED readmissions in 30 days. Research has clearly shown that detoxification alone does not support long-term sobriety or recovery and that individuals benefit from ongoing substance abuse treatment following initial detoxification.

In order to improve access and reduce recidivism for individuals with high acuity needs that experience a behavioral healthcare crisis and reach out for services through an ED, linkage to substance abuse treatment services from the ED is important. The Alcohol and Drug Abuse Treatment Centers (ADATCs) play an essential role in the service continuum for individuals with substance use and co-occurring mental health disorders.



**What can be done quickly and within available resources?**

In order to engage people to address their substance use at this moment of crisis, the ADATCs should be considered as the first referral for individuals who need inpatient substance abuse treatment. Additionally, in situations where an individual is admitted to a community hospital bed for stabilization, the ADATCs should be considered as a primary discharge option for those people who need ongoing treatment in an inpatient setting.

Strategies to improve communication and engagement with ADATCs include:

1. Educate EDs in each of their regions, to inform of ADATC services and the referral process to access beds.
2. Create a referral protocol, specific to their regions needs, involving the EDs and authorizing LMEs.
3. Provide outreach to hospitals with three-way bed contracts to create a referral protocol for individuals who have a primary substance use disorder and may need prioritization for direct ADATC admission post-stabilization in a three-way bed.
4. Upon request, regularly report available beds for possible placement of candidates awaiting ADATC services.
5. Initiate collaboration with social workers on medical units in local acute care hospitals to identify individuals who may have been admitted to the hospital due to a primary medical condition that is caused by substance use (e.g., pancreatitis). The goal would be to educate hospital discharge planners to use ADATCs as a discharge option for ongoing substance abuse treatment.
6. Achieve ADATC accreditation as opioid treatment programs (OTPs) in order to meet the needs of individuals requiring methadone detoxification.

#### **What might require additional time and resources?**

Achieving accreditation as opioid treatment programs (OTPs) to meet the needs of individuals requiring methadone detoxification or maintenance initiation in a hospital setting will require some additional time. Development of these resources will also address the need for pregnant opioid dependent women in need of methadone initiation as the standard of care.

#### **How can we measure progress?**

Each of the strategies designed to improve communication and engagement is measurable and can be used to gauge success in implementing this recommendation.

## CHAPTER 5: POST-EMERGENCY DEPARTMENT

- **GOAL: TO LINK CONSUMERS TO HOUSING, SERVICES, AND SUPPORTS TO PREVENT FUTURE EMERGENCY DEPARTMENT ADMISSIONS.**

### Introduction:

After consumers with behavioral health crises have been discharged from the emergency department, it is essential to quickly link consumers to housing, services, and supports to prevent future emergency department admissions.

The North Carolina DMH/DD/SAS, in conjunction with the NC Hospital Association and 78 hospitals in the state, conducted a survey of emergency department admissions during the month of November 2010. This report found that almost 28 percent of individuals admitted for a behavioral health crisis had been previously admitted to an ED within the past 30 days. Elsewhere, Manderscheid and colleagues found that approximately ten percent of people discharged from state psychiatric hospitalization have been readmitted within 30 days, and over twenty percent have been readmitted within 180 days.

Studies have shown that homelessness, unemployment, psychotic disorders with co-occurring substance abuse, previous inpatient hospitalization, and Medicaid insurance coverage are associated with repeated visits to emergency departments for psychiatric crisis. Among the general population, frequent admissions to emergency departments has been attributed to social problems of homelessness, poverty, alcohol abuse and chronic illness.

In order to achieve the goal of the Post-Emergency Department subcommittee, the group focuses on two general areas of need;

- The first one is the need for stable housing for persons who frequently use emergency departments for health care.
- The second area in our recommendations was the need to quickly link persons who are discharged from emergency departments, to services and supports in their communities.

These areas of need are the basis for the five recommendations listed below.

**Recommendation #1:** Establish housing options and benefits in order to help people remain successfully in the community and out of emergency departments.

Housing and essential benefits are two of several keys to remaining successfully in the community and out of emergency departments. Consumers should not be discharged into homeless shelters. If temporary housing and step-down services are needed, consideration should be given to discharge consumers, when appropriate, from emergency department to Facility Based Crisis, mental health respite, transition beds, or supported transitional housing, rather than homeless shelters.

In order to facilitate access to long term, stable housing, it is often necessary to connect eligible consumers to applicable benefits. Benefits, such as Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) can provide consumers the regular income needed to be able to afford housing. However, the application process can be very daunting and the results often unsuccessful. Programs exist, however, to assist consumers with SSI/SSDI and other applications for benefits. One such program, SOAR, has been very successful in guiding consumers through the application process. SOAR's high rate of success with benefits applications has helped to bring over \$2 million in income in 11 months, providing opportunity for savings to the state, which could be re-invested into housing.

There is also an additional barrier in that special assistance dollars are required to be used only for licensed facilities. This is a barrier for individuals with behavioral health crisis who would benefit from staying in their own homes.

The issue of appropriate housing for individuals with psychiatric crises has been well studied in North Carolina. A 2011 Task Force on Alternatives to Hospitalization for Frequent Users of Psychiatric Hospitals in North Carolina released a report entitled, "Supportive Housing as an Alternative to Psychiatric Hospitalization". Although the report focused on individuals being discharged from psychiatric hospitals rather than being discharged from emergency departments, many of the recommendations from the report are pertinent to this discussion as well as indicated in the responses below.

### **What can be done quickly and within available resources?**

Temporary housing/step-down services, such as Facility Based Crisis, mental health respite, transition beds, and supporting transitional housing constitute existing resources that could be employed.

Transitional housing is usually thought of as temporary supported housing; that is housing with services where individuals or families live during the time they receive intensive stabilization services that prepare the household for independent living. A limited transitional phase allows for adequate medical stabilization, but also improves outcomes in an individual's transition to permanent housing arrangements.

Increasing the availability of transitional housing options such as Oxford Houses, would be relatively inexpensive in relation to the benefits. Per the Taskforce Report, "Oxford Houses lease existing housing stock where residents collectively pay the rent and expenses. Residency is not time limited. Each group recovery home operates under a charter from Oxford House, Inc., the 501(c) (3) nonprofit umbrella organization that oversees home development and continuing operations. Oxford House staff provides 24-hour on-call services, support services such as coordinated outreach to associated treatment providers, drug courts, 12-step groups and other community supports that the residents need." Oxford Houses are just one example of transitional housing options that already exist and could be expanded upon.

### What might require additional time and resources?

Expanding workers dedicated to assisting consumers in applying for benefits will require additional resources, but could be implemented quickly once the resources are allocated.

Another recommendation that will require additional time and/or resources is to increase the availability of permanent supportive housing as defined by SAMHSA: “Decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under State and local landlord tenant laws and is linked to voluntary and flexible support and services designed to meet tenants’ needs and preferences.” One potential model would be to expand upon the Community Alternative for Supportive Abodes, Inc., model, more often referred to as CASA. Per the taskforce “CASA business model is based on purchase, rehabilitation, and construction funding obtained through HUD, NCHFA, county, city, and/or town funds. It is necessary that a portion of funding come from up front grants to minimize mortgage related development costs. Funding for supportive services comes from local governments as well as Medicaid. Income from the properties supports CASA operating expenses. CASA’s operating expenses include some support services, which include a half time psychiatrist and other professionals.”

The Taskforce on Alternatives to Hospitalization made the following recommendations in regards to securing funding for supportive transitional and long-term housing. Although these recommendations might take some time to get into place, they certainly apply to efforts to reduce emergency department visits.

- 1) Consistent and level funding for the NC Housing Trust Fund is critical to provide the most flexible financing for affordable supportive housing across North Carolina. It leverages federal affordable housing funding streams and provides opportunities in communities that would otherwise go unmet.
- 2) Consistent appropriations of DHHS Operating Subsidy must be made available to fill the gap between what an individual at 30% of Area Median Income (AMI) or SSI income can afford to pay for housing and what is needed to properly maintain the housing. The use of this in the Key Program makes supportive housing available while SOAR activities take place and while waiting for Section 8 to become available (“bridging the gap between when federal source become available and when housing is needed). This in turn brings in additional federal dollars allowing release of those state dollars to help the next person. The appropriation must include administrative costs to cover the operation and oversight of the program and consider that with each new unit the amount of recurring appropriations grows.
- 3) The Housing and Homeless Office within the Department of Health and Human Services is vital and necessary to coordinate housing efforts across DHHS and to provide one point of contact for NCHFA and other housing developers. This allows one office to coordinate all the disability specific needs with disability neutral housing providers, complying with the Fair Housing Act and the Olmstead decision. Additionally, this office promotes best practice policy across housing referrals systems, housing development, and housing assistance.

- 4) Continue and increase funding for the NC Interagency Council for Coordinating Homeless Programs (NC ICCHP). This will continue the Balance of the State Continuum of State application and allow for the population of emphasis identified in this report to remain a top priority.
- 5) Securing technical assistance to create sound funding and development options is critical due to the complexity of funding streams and housing development. Additionally, the ICCHP and the Housing Coordination and Policy Council should share each other's knowledge to allow further understanding of supportive housing initiatives across the State.

### **What evidence will indicate progress?**

Progress will be indicated by the reduced number of people discharged to homeless shelters and the increased number of people living in stable housing on long term basis. Also, there will be reduced repeat visits to emergency departments.

#### **Recommendation #2:**

Develop a Uniform System of Care Coordination.

LME Care Coordinators should be assigned for all Medicaid and indigent individuals when they present to the ED for behavioral health crises. Upon discharge, the LME Care Coordinators should link individuals to appropriate services and benefits, as well as update individualized crisis plans.

In addition, Intensive Case Management should be provided for consumers who are identified as having high intensive mental health and substance abuse service needs (as indicated by frequent use of crisis services), which result in high costs. This recommendation includes the employment of peer support specialists on intensive case management teams.

#### **Focused Care Coordination:**

The Durham Center has recently reported reduced state psychiatrist hospitalization of consumers, and attributed that decrease, in part, to the agency's focused care coordination initiative. ([http://www.durhamcenter.org/uploads/docs/publications/ED\\_Report.pdf](http://www.durhamcenter.org/uploads/docs/publications/ED_Report.pdf)).

- **Focused Care Coordination (Implemented in 2007)**  
Individuals being discharged from State psychiatric facilities are receiving more focused discharge planning and coordination of services and resources before they are discharged. Once discharged, these individuals' providers are contacted to ensure appointments were kept and to determine if there were any barriers at discharge. On average, 62% of individuals discharged from State psychiatric hospitals are seen within seven days for a follow-up appointment.

**Intensive Case Management:**

Okin and colleagues found that case management appeared to have a desirable cost-effective impact on the problem of frequent use of Emergency Departments, by decreasing acute hospital service use and psychosocial problems among the population studied.

Similarly, The Durham Center Local Management Entity attributed significant reductions in the frequency of Emergency Department usage by consumers with mental health and substance abuse crises to a panoply of changes, including but not limited to, case management of individuals with medical needs.

- **Case Management of Individuals with Medical Issues (Implemented in 2010)**

TDC has hired a case manager to coordinate integration of behavioral and medical care for individuals accessing the Durham Center Access Crisis Facility. This involves connections with a primary care provider and the behavioral health clinical home. This is a partnership with the Durham Community Health Network to provide collaborative support to individuals who over-utilize local hospital emergency departments.

**What can be done quickly and within available resources?**

With the implementation of the 1915 b/c Waivers, the approved LMEs are required to employ care coordinators. Their responsibilities will include, but are not limited to: connecting with consumers who have been served in local and state hospitals and their Emergency Department, and linking them to community services.

**What might require additional time and resources?**

Intensive Case Management, with the inclusion of Peer Support Specialists, will require additional funding for the employment and training of Peer Support Specialists.

**What evidence will indicate progress?**

**Progress will be indicated by** reduced utilization of crisis response services, reduced repeat visits to the ED, and timely access to services/supports post-discharge.

**Recommendation #3:**

Implement alternative service, Assertive Engagement statewide to facilitate transition to needed services/supports.

Seven Local Management Entities are currently approved to implement the state-funded Assertive Engagement service. Of those, six LMEs have utilized the service, serving a total of 3,093 consumers since October 2008. Assertive Engagement could be an effective mechanism statewide, along with care coordination, and intensive case management (noted in Recommendation #2)) for linking persons, who have been discharged from emergency departments and hospitals, into community services.

Assertive Engagement is a state-funded service wherein behavioral health staff contact, communicate with, and encourage the participation in treatment/services of individuals with severe and/or serious mental illness/substance abuse disorders, co-occurring mental illness and substance use disorders, and/or developmental disabilities, and who have not sufficiently engaged in treatment for the disorder (s). Assertive engagement is an initial step in the process of effectively treating these illnesses. It is intended to promote engagement and retention in treatment/services and decrease the need for crisis services, and reduce readmission to more intensive and unnecessary emergency care. It is suggested that DMH/DD/SAS study the effectiveness and impact of Assertive Engagement on emergency department admissions/readmissions in the catchment areas of LMEs that have utilized this alternative service, before committing additional resources to it.

### **What can be done quickly and within available resources?**

If requested by LMEs that have not already been approved to bill for Assertive Engagement, DMH/DD/SAS could quickly approve this service definition for the remaining LMEs. For LMEs that are or will become approved as 1915 b/c Waiver entities, it is suggested that those LMEs consider including Assertive Engagement as a B3 service; that is funding for the service could come from savings generated by implementing managed care.

### **What might require additional time and resources?**

For those LMEs that do not receive approval as a 1915 b/c waiver entity, state funding for Assertive Engagement may be delayed due to national and statewide economic downturns.

### **What evidence will indicate progress?**

Progress would be indicated by reduced repeat visits to EDs and increase percentage of access to post-discharge service.

**Recommendation #4:** Implementation of appointments for follow-up care in the community within 48 hours post discharge. Discharge and follow-up medications to be affordable and consistently available.

Prior to discharge, appointments for comprehensive clinical assessment and medication management and peer support need to be scheduled to occur within 48 hours after discharge. Appointment options may include: CAHBAs or other provider; private psychiatrists; utilize Walk-In Crisis clinics; Mobile Crisis Management psychiatrists; primary care. Medications should be affordable and consistently available (this applies to both ED prescriber and post-ED prescriber).

### What can be done quickly and within available resources?

With relationships established between local emergency departments and LMEs, appointments should be able to be made during business hours so that persons discharged from the emergency departments could be receive follow-up treatment/services from community service providers within 48 hours.

LMEs and the local emergency departments in their catchment areas could develop mutual understandings regarding the prescribing of less expensive and more readily available psychiatric medications for persons who are discharged from the emergency departments.

### What might require additional time and resources?

During after-hour visits to local emergency departments, LMEs may not currently have the technological capacity to schedule appointments within their provider network. It is not known at this time what fiscal and technological resources would be needed to ensure immediate appointment scheduling after normal business hours.

### What evidence will indicate progress?

Progress would be indicated by reduced repeat visits to EDs, an increase in percentage of appointments scheduled within 48 hours of emergency department discharge, an increase in percentage of identified low-cost discharge psychiatric medications, and an increase in the rate of refills of those medications over a six-month period following discharge.

**Recommendation #5:** Establish local relationships among all stakeholders (e.g., consumers/family members, ED doctors, community hospital workers, LMEs, MCM, WIC, law enforcement, state facilities, jails, etc.) to facilitate seamless coordination of care.

### What can be done quickly and within available resources?

LMEs can continue to establish and strengthen their relationships and understandings or agreements with local stakeholders.

### What might require additional time and resources?

No additional time nor additional resources are needed.

### What evidence will indicate progress?

Progress will be indicated by reduced repeat visits to Emergency Departments.

## **CHAPTER 6: CONCLUSION**

The development of this action plan presented an opportunity for numerous stakeholders that plan, fund, deliver, support and receive mental health, developmental disabilities and/or substance abuse services to work collaboratively to assess needs and identify gaps in crisis services and resources. The process itself was an important tool for identifying system issues and barriers and subsequent recommendations. The North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services recognizes the challenges this created for those individuals and organizations, and commends all involved for their openness, willingness to work together, and ability to look at their work and their position in the system with a critical eye. It is the Division's hope that this Action Plan initiates a continued and longstanding process of collaboration across all stakeholders. The Division will continue to partner with its stakeholders in developing a process that will ensure initial and ongoing education regarding the implementation and monitoring of this Action Plan.

The NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services acknowledges that no single plan can tell the entire story of a state's populations in need, the services required, or the barriers that exist to meeting those needs. Furthermore, no single action plan can be as detailed as stakeholders might like for issues of interest. However, the information in this action plan and the process by which the information was developed has provided an impetus to initiate prompt action in order to achieve meaningful outcomes.

The Division remains steadfast in its commitment to emphasize continuous quality improvement to ensure that the crisis system in place today will grow increasingly stronger in the years to come. Therefore, ongoing refinement and adjustment of the action plan may be necessary due to new findings, lessons learned, and emerging best practices.

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