Reducing Wait Times in Emergency Departments for Vermonters Experiencing a Mental Health Crisis

The Designated Agency and Specialized Services Agency Perspective ~ February 2017

Vermont Care Partners

Vermont Care Partners

Executive Summary

Vermont Care Partners and its network of designated agencies and specialized services agencies are deeply concerned about the crisis of long wait times in hospital emergency departments (EDs). We are in agreement with those in crisis, their families, their advocates, hospitals, and other stakeholders: emergency department settings can heighten, rather than lessen, mental health symptoms. Long waits in EDs for those in crisis represent an egregious violation of the principle of mental health parity, and a form of discrimination for the most vulnerable Vermonters.

Our network of designated agencies and specialized services agencies have the infrastructure, expertise, track record, and willingness to be part of the solution for addressing problems in our system of care.

We are committed to working with others to identify effective solutions. Vermont Care Partners has taken a leadership role, in conjunction with the Department of Mental Health, on addressing this issue by inviting stakeholders to work together collaboratively on a work group to focus on solutions to this problem. This workgroup will dive deeper into a cost analysis, data review, and evaluation of possible options to redress this problem. Pending further recommendations, Vermont Care Partners proposes:

1. **Raise reimbursement rates for the designated and specialized services agencies so that salaries are on par with state employees and other health professionals to reduce vacancies and turnover of staff at all levels of care.**

2. **Increase capacity for people with geriatric and psychiatric ("geropsychiatric") needs.**

3. **Designated hospitals should be required to accept high acuity patients, as well as patients who are in Emergency Departments outside their catchment area.**

4. **Designated agencies, designated hospitals, EDs, and care management should develop a set of communication protocols to track those waiting for hospital placement and those waiting for discharge. These protocols should include internal and system-wide operations.**

5. **There needs to be a comprehensive analysis of current costs to the system for ED wait times so that we can identify opportunities to shift financial resources to more preventative, community-based care.**

A more detailed discussion of each of these points can be found on page five, as well as additional recommendations.

Overview of the Crisis

There are a variety of complex factors that are contributing to this problem. As a network we provide a continuum of services and hold a range of ideas about how to address this issue. The following summary offers an analysis of the root causes of this problem and sees opportunity for redress in three areas: resources, accountability, and flexibility. We are committed to an inclusive process with all stakeholders focused on how to work towards these solutions.

Wait Times in Emergency Departments: Who is Waiting and Why

Designated agencies report that the acuity and volume of people presenting at the ED in mental health crisis is high. Vermont has effectively developed a community-based system of care with minimal use of institutional settings, as a result more people who are experiencing severe mental illness are living in the community and have periodic need for crisis supports. In addition, opiate abuse is adding to the complex presentation of people presenting in EDs. An increase in collaboration between emergency screeners and police has been a positive development in terms of integrated care, but has led to more referrals for people with more complex presentations for crisis mental health care in the Emergency Department, including referrals intended to protect public safety. Crisis teams provided 6225 services in fiscal year 2016, up more than 50% from fiscal year 2009, when 3767 crisis services were provided.[1]

Some people frequently reappear in the emergency room for care. These people may have a history of assaulting hospital staff; refuse medication, and/or have a diagnoses such as borderline personality disorder which impact their ability to ability to get care quickly. In addition, some people who have needed the most acute (or "Level One") beds in the past often have difficulty shedding this history of needing Level One care. Designated agency crisis beds do not typically accept referrals for those whose primary presenting issue is homelessness but are not experiencing a mental health crisis; as a result, these people can end up in the ED.

Crisis teams report that at least half of those presenting in crisis are not currently active clients of the designated agencies. Crisis teams believe that clinicians in private practice, as well as a variety of community service providers, are increasingly likely to refer clients to the ED when risky symptoms arise.

When designated agency crisis teams meet with someone in crisis, they engage in assessments, often called "screenings," to determine the level of psychiatric crisis the person is experiencing and to support them in getting help. Some people are able to return to their homes and communities with safety plans. Others voluntarily accept a referral for inpatient psychiatric care at a hospital or

[1] Vermont Department of Mental Health. 2017. *Emergency Services: # served by ES.* Retrieved from https://app.resultsscorecard.com/PerfMeasure/Embed?id=101266&navigationCount=1.

crisis bed. Still others meet criteria for involuntary treatment based on the acuity of their symptoms. The process to become an involuntary patient involves an emergency examination by the screeners and a psychiatrist, and judicial approval. At this time, the department of mental health only tracks those people who are involuntarily waiting for inpatient hospital care. If someone is found to warrant involuntary care, current EMTALA [Emergency Medical Treatment and Labor Act] rules do not allow people to receive services anywhere else besides a hospital setting, such as a crisis bed.

A culture of risk aversion in both hospital settings and community services, compounded by recent high-profile cases of violence, is likely contributing to ED doctors and psychiatrists recommending inpatient care. Designated agency crisis teams report that the recent Vermont Supreme Court decision (referred to as the Kuligoski decision) which creates a duty to warn caregivers about the risks of the patient towards self and others has not changed practices regarding emergency examinations.

Staffing shortages for crisis teams is another relevant factor. Emergency Screeners have difficult jobs, with unconventional hours and compensation that hasn't stayed competitive. Low salaries have led to significant turnover, which has led to staff vacancies. Some crisis programs are down 40-60% of their crisis teams. Vacancies are typically filled by those who are new to the work. Short-staffing and inexperience, combined with significantly higher volume, may be factors in increased ED referrals and resulting emergency examinations, as opposed to de-escalation and safety planning in the home or community.

Why is a person asked to wait in the Emergency Department for inpatient care?

When those in crisis are asked to wait in the Emergency Department, crisis teams, DMH care managers, and ED staff all work tirelessly actively seeking a hospital placement. From the perspective of designated agencies, the following reasons may contribute to the lack of inpatient capacity:

- The hospital beds are at 100% census.
- Hospitals are at capacity, but there are some people who might be ready to discharge but they are unable to discharge due to lack of a discharge setting or plan.
- Hospitals are concerned about the impact of the potential behavior of those with acute symptoms on other patients, and therefore decline to accept these patients. This may be due to their past experience of acuity, violence, refusal to take medication, or reputation for all of the above. In some cases hospitals inform emergency departments that they will accept certain patients when they have started taking medications.

- Hospitals may choose not to accept a person who is homeless or who has significant medical needs for fear that the discharge planning based on those factors will be extremely challenging.
- The only hospital that treats children and youth expresses concern about accepting those who are too acute or who have medical needs such as diabetes or seizure disorders.
- Many designated agency crisis teams report that hospitals will refuse to accept a person who is waiting for treatment if they are outside the hospital's catchment area, instead holding the place for someone within the hospital's catchment area.

Why are there challenges in discharging from the hospital?

People in mental health crisis get important and valuable care and stabilization in inpatient hospital facilities throughout the state. Developing a responsible discharge plan has become increasingly challenging, and as a result, beds intended for those with acute mental health needs are being filled by those who are unable to be discharged. In a best-case scenario, people are discharged through a collaborative process and plan with a familiar community-based treatment team from the designated agencies. This might involve "stepping down" to a crisis bed or intensive residential setting. A variety of factors impede effective discharge:

- Nursing homes and residential care facilities can be averse to accepting elderly clients with behavioral and medical needs, because CMS quality scoring penalizes those facilities for factors such as high utilization of psychotropic medications and staff undertrained in mental health interventions.
- There are not enough alternative resources to meet the demand for elderly people with the need for both medical and behavioral support.
- Workforce challenges in the designated agency system, such as vacancy rates, staff turnover, short-staffing, variation in staff experience, and increased staff stress due to complexity of the system can all be barriers to successful discharge planning.
- Designated agency stepdown facilities may not accept referrals due to high acuity in relation to staffing capacity.

Possible Solutions

Vermont Care Partners supports the process of the multi-stakeholder workgroup focused on how to address this problem. Ongoing collaboration between those who access services and service providers will be crucial to tracking and resolving this crisis. In the meantime, our network sees

solutions in the following areas: resources, tracking and accountability, and improving flexibility in the flow.

A. Resources Needed

The chronic underfunding of the community mental health system, especially around reimbursement rates and lack of COLA adjustments has stripped the solid, community-based infrastructure to its bare bones. The result has had an impact on quality of care, including care for those in crisis.

1. **Raise reimbursement rates for the designated and specialized services agencies so that salaries are on par with state employees and other health professionals to reduce vacancies and turnover of staff at all levels of care.** Outcomes: greater capacity in crisis and stepdown facilities; higher quality and better treatment available in the community to prevent hospitalizations (i.e. case management, outpatient therapy, and community supports); higher capacity for quality crisis interventions in the community to prevent ED visits.

Next Step: Vermont Care Partners requests that DMH raise reimbursement rates.

2. **Increase capacity for people with geriatric and psychiatric ("geropsychiatric") needs.** This could be done by developing a tiered rate system that incentivizes nursing homes to accept people with geriatric and psychiatric needs; increased coordination and shared care management between Choices for Care and DAs; and/or additional funding to establish nursing and/or primary care staffing in designated agency long term residential care homes. Outcome: More capacity for people with geropsychiatric needs will open up Level One beds for those waiting in Emergency Departments.

Next Step: Workgroup subcommittee on geropsych needs will likely evaluate all options and provide recommendations.

B. Tracking and Accountability Needed

1. **Designated hospitals should be required to accept high acuity patients as well as patients who are in Emergency Departments outside their catchment area.** A centralized admissions process would allow for inpatient units to provide input on concerns about accepting a high-acuity client, but will ensure that all available inpatient beds are available to be accessed. Outcome: better dispersal of people in need of hospital-level care to available beds.

Next Step: DMH should work with designated hospitals to embed these expectations into contracts.

2. **Designated agencies, designated hospitals, EDs, and DMH care management should develop a set of communication protocols to track those waiting for hospital placement and those waiting to discharge. These protocols will include internal and system-wide operations.** This group should give consideration to including those waiting for voluntary as well as involuntary treatment. Outcome: by increasing awareness of clients stuck in ED or inpatient hospital settings among direct care staff, case management, and leadership, the instinct to protect against risk will be balanced by a culture of accountability and risk-sharing at all levels of the system, reflecting an attitude of zero tolerance for long waits in Emergency Departments.

Next step: Workgroup subcommittee should work on developing a communication protocol.

3. **There needs to be a comprehensive analysis of current costs to the system for ED wait times that we can identify the financial resources that could potentially be shifted to more preventative, community-based care.** Outcome: In a climate where limited resources exist, this information will allow the system to have the information needed to distribute resources to the most cost-efficient and client-centered services, and potentially reduce costs for all.

Next Step: AHS should gather information across divisions to provide this analysis.

C. Increased Flexibility to Improve Flow Needed

It is inevitable that people have long waits in the Emergency Departments if most people identified as experiencing a crisis are directed to go there. Finding a way to provide evaluation and crisis services outside of the ED will reduce the wait for others.

1. **EMTALA statute should be reviewed and alternative statute explored to allow for the possibility of evaluation and short-term treatment outside of the ED. If it were possible to provide evaluations in a different setting, more resources would be needed to support these additional settings.** Outcome: fewer people in crisis waiting in ERs. Some may be able to stay in a crisis bed setting, discharge back to the community, or transition to an inpatient bed without going through the ER.

   Next Step: Workgroup subcommittee will review EMTALA statue and possibility for alternative language in conjunction with study of non-ED crisis centers.

2. Designated Agencies, along with the workgroup on wait times, will also explore the following options:

- **Increase individual supported housing options, such as Mypad; increase "lilypad" approach to housing where people can return to supported housing for short-term stays** Outcome: prevention of emergency room visits by high-frequency adult users, and therefore reduction in wait times.
- **Increase preplacement visits to community settings to support discharge transition.** Outcome: this may promote faster discharge.
- **Increase funding for palliative psychiatric care in Emergency Departments or home-based settings for children.** Outcome: better care for those waiting for emergency placements.
- **Monitor the impact of the new hospital diversion program for children and youth in the southern part of Vermont.** If this new capacity in the system reduces wait times for children and youth, explore whether additional programs may be helpful. Outcome: information on efficacy of hospital diversion for children and youth in reducing wait times.

Next Step: Workgroup will be delegating and review different approaches and solutions with recommendations in approximately six months.

Note on increase in proposal for inpatient psychiatric beds:

Many people who provide care for those waiting in hospital emergency departments have called for increase in inpatient hospital beds as a solution. Vermont Care Partners' network of designated agencies and specialized services agencies is committed to addressing this problem, but is not prepared to endorse this suggestion at this time. We believe directing current resources and/or additional resources towards upstream interventions and more discharge options to divert people from institutional or hospital settings will benefit those in crisis and be a more cost-effective use of resources.

Conclusion

Vermont Care Partners and our network agencies are committed to working with all possible stakeholders – those in crisis, families, hospitals, nursing homes, AHS divisions, and others – to reduce the number of people waiting and the length of wait times in Emergency Departments. We believe that mental health care is most effective when it is provided by cohesive treatment teams in the least restrictive setting possible. It will take a thorough understanding of the complexity of the problem, a bolstering of the community mental health system, creative and flexible thinking, and a

collaborative approach, and we look forward to supporting our clients and community partners in this endeavor.