Reducing Psychiatric Readmissions

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Objectives

- To identify patients types who are at risk for readmission
- To address issues in the Emergency Department to prevent readmissions
- To address issues in the inpatient setting to reduce readmissions
40%-50% of Psychiatric Patients are Readmitted within 1 Year
Risk Factors for Psychiatric Readmission

- Low level of schooling
- Younger age
- Schizophrenia
- Personality disorders
- Psychoactive substances
- Males
- Time for complete recovery
- # of prior hospitalizations
- Condition of living
- Admitted prior year
- Receiving disability
- No discharge plan for PCP
Factors Associated with Psych Hospitalization from ED


- **Factors**
  - Increased age
  - Arrival by EMS
  - Longer LOS
  - Uninsured
  - Lack of community based mental health

- **Disorders**
  - Schizophrenia
  - Suicidal
  - Affective disorders
  - Dementia
  - Personality disorders
  - Impulse control

- Recommend increased community based psychiatric services
Patient Subsets
Suicide admissions

- Elderly with substance use disorder
- Personality disorder
- Prior psych admission
- Unemployed
- Receives social benefits
Patient Subsets

Elderly with Substance Use Disorders

- Risk for readmission
  - Prior hospitalization for substance use disorder
  - Psychiatric comorbidities
  - Poisoning
  - Adverse drug reactions
  - Falls

- Recommendation
  - Focus intervention on women with psychiatric illness and accident risk
Patient Subsets
Involuntary Admissions

- Lower patient satisfaction
- Living with others
- Lower economic status
- Country of origin
- Poor global functioning
Patient Subsets
Pediatric Inpatient Admission


- Usually within 90 days
- Factors
  - Conduct problems
  - Harsh parental discipline
  - Disengaged parents
  - Parents stress level
There were a total of 214 participants in the study:
- 106 medical and 108 were psychiatric
- Took on average between 2 to 6 meds/day

There was no significant difference between the two groups:
- Psychiatric pts. were more likely to get admitted (50%) than medical pts. (31%)
Before Patient Arrives at the Emergency Department

- Review of frequent readmissions from the ED
  - By patient
  - By diagnoses
  - By ED MD
- Action plan to reduce ED/hospital use
  - Social worker in ED
Inappropriate Admissions from the ED

- Legal and liability of sending patients home
- Secondary utilizes such as police, group homes, nursing homes and families
  - Send to ED to resolve issues
- Lack of appropriate assessment
  - Difficulty in contacting provider
  - Need for collateral information
  - Problem with obtaining old medical records
- Lack of outpatient resources
  - Housing
  - Medication
  - Care givers
ED Treatment

- Tendency to keep patient in the ED with limited, if any, treatment
  - Not medicated or in therapy

- Alternative
  - Involve psychiatry in the patient care (Consultation & Liaison service)
  - Role of telepsychiatry
  - Begin other therapeutic interventions
  - Medicate in the ED
ED Treatment Interventions

- **Brief intervention**
  - International study of 8 EDS
  - Brief intervention and enhanced follow up
  - Reduced number of deaths

- **Enhanced Intervention**
  - 18 month study of female Hispanic patients
  - Soap opera video, family therapy, and staff training
  - Reduced suicide re-attempts and ideation
ED Treatment
Interventions

Rapid response


- Suicidal adolescents in a pediatric ED
- Rapid response team psychiatrist & RN with assessment, meds & community follow-up
- Lower hospitalization rate

Psychiatric service provided in ED


- Psychotherapeutic approach
- Counseling of patient and family
- Reduced voluntary hospitalizations 19.5% and increased outpatient consultations 14.4%
In ED Crisis Intervention in UK


- Psychiatric service provided in ED
- Psychotherapeutic approach to considering the crisis an event
- Counseling of patient and family
- Before and after cost and reduction of hospitalizations
- Reduced voluntary hospitalizations 19.5% and increased outpatient consultations 14.4%
Medication

- Re-start prior meds
- Start new medications
  - Psychiatry via telepsychiatry
  - Assistance from C and L service
- Medications to start in ED
  - Antidepressants
  - Antipsychotics
  - Mood stabilizers
  - Benzodiazepines
ED Discharge

Set up follow up appointments

- 62,746 COPD patients, 66.9% had PCP follow up
- Patients who follow up visit reduced the risk of an ED visit and readmission

Begin case management

- Involve social work and pharmacy
- Set up home health services
- Med reconciliation and F/U phone calls

Communicate with PCP

- Hand off to primary care
For Discharged Patients
ED’s Role

- Clear, detailed discharge plans tailored to patient, family, clinicians, case managers and payers
  - Teach self-care
  - Improved instructions and instruction process
  - Patient read back
  - Encourage self-management

- Telehealth technology to monitor at home
- ED physician/nurse/social worker phone calls
- Assign a patient navigator
Does the Psych Patient Need to Be Admitted

- Admission criteria
- Telepsychiatry
- Suicide risk assessment
- Diversion programs
Psychiatric Patient Admission Criteria
Does the Patient Need to Be Admitted?

- Not always an easy decision
- Use of admission criteria or guidelines for many conditions
  - Risk to self, Risk to others, Unable to care for self
- Improved assessment for admission
  - Telepsychiatry
  - Diversion programs
  - Suicide risk assessment
- Alternatives to inpatient stay
Admission Criteria


- Decision support tool
- Criteria
  - Suicide potential
  - Danger to others
  - Severity of symptoms
- Predicted 73% of the admissions
Crisis Triage Rating Scale


- Scores three categories 1-5
  - A. Dangerousness
  - B. Support system
  - C. Ability to cooperative

- Scoring
  - 9 or more – outpatient/crisis intervention
  - 8 or less - admit
# Admission Determination

<table>
<thead>
<tr>
<th>Severity</th>
<th>Description</th>
<th>Suicidal</th>
<th>Disposition</th>
<th>Need for Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable</td>
<td>Functional, works</td>
<td>None</td>
<td>Outpatient</td>
<td>No</td>
</tr>
<tr>
<td>Low level</td>
<td>Had medical or psych stressor</td>
<td>Mild</td>
<td>Outpatient</td>
<td>OBS</td>
</tr>
<tr>
<td>Moderate</td>
<td>Decompensated agitated</td>
<td>Moderate</td>
<td>Psych consultation</td>
<td>Yes or OBS</td>
</tr>
<tr>
<td>Severe</td>
<td>Severe decompensation</td>
<td>High</td>
<td>Inpatient care</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Mobile Crisis Units and Telepsychiatry

**Mobile Crisis Units**

  - Comparison of mobile unit to ED admission rate
  - ED admitted 3x more than mobile units

**Telepsychiatry**

  - High provider and patient satisfaction
  - Wide variety of diagnosis, age and complaints
  - Consultations, diagnostic assessment, medication management, family and patient psychotherapy
Determination of Suicide Risk

Myths

- All patients who want to harm themselves or others need admission
- Alcohol and substance intoxicated patients need admission even if they change their mind when they are not clinically intoxicated
- All teenagers with suicide gestures or thoughts need admission
- Maybe not
Suicide Risk Determination

- Needs to include static and dynamic factors, protective elements and means.
- Suicide risk assessment is a clinical judgement.
- Tools may augment the judgement.
- It is an imprecise science.
Medical treatment not needed
No prior suicidal attempt
No actively suicidal
Adult in house with good relationship
Adult agrees to monitor
Adult will move guns and medications
Whom to contact for deterioration
Follow up arranged
Agreement to plan and recommendations
Chronically Mentally Ill in Crisis

Other Options

Emergency Department

Mental Health or Community Mental Health

Psychiatric Home Care
Living Room

Crisis Phone Service
Crisis Mobile Units

Integrated Services

Crisis Stabilization Unit
Observational Care

Inpatient Care

Psychiatrist Mental Health Worker
Community Service

Psychiatric Urgent Care

Day hospital
Crisis Oriented Residential Treatment


- For acutely distributed chronic patients
- For acutely decompensated patients that might need acute hospitalization
- Highly structured
- Group and individual therapy
- Therapeutic activities
- Expectations of appropriate behavior
- Cost effective
- Reduction of hospital admissions
**Brief Admission Programs**


- **Functions**
  - Acute treatment
  - Brief intensive therapy
  - Long term supportive re-socialization or rehabilitation

- **Day hospital**
  - Usually 5 days a week for 2-3 months
  - Mon-Friday

- **Patient types**
  - Not suicidal, homicidal or assaultive
  - Psychotic patient & substance use disorders
Role of Community Mental Health Center

- Specialized clinics for specific disorders
- Early intervention and teams

Assertive community treatment teams
- Multidisciplinary approach to intensive services in the community (home or work)
- Psych, nursing, social work, substance abuse tx, employment

Alternative forms of occupational and vocational rehabilitation
Day Hospital vs. Crisis Respite Care


- Voluntary patients in need of acute psychiatric care
- Compared day hospital/crisis respite program to inpatient stay
- Programs were equally effective
- Average cost savings of $7,100 per patient
Psychiatric nurses, social workers, home health aides, and occupational therapists to work at pt’s home.

CMS allows all physicians to sign a Medicare psychiatric plan of care.

Results in significant reduction in both hospitalization admission and recidivism rates.
Involuntary Out-Patient Commitment


- Compared hospital release to hospital discharge to outpatient commitment
- 57% fewer hospitalizations
- 20% fewer hospital days
- Non-affective psychotic disorders had highest rate 72% reduction
Observational Care

Appropriate use of OBS units for psychiatric patients

- Psychosis
- Suicidal
- Depressed
- Anxiety
- Alcohol and drug intoxication/withdrawal
- Social situation

Requirements

- Provides adequate stability and containment
- Availability of consultation liaison service
Crisis Stabilization Units


- Functions
  - Allows time for diagnostic clarity
  - Develop alternatives to admission
  - Respite function
  - Denies dependency needs

- Patient types
  - Schizophrenics
  - Personality disorder
  - Suicide
  - Substance use disorders

- 41% of total patients seen
Clinical Profile

- Young males
- Stress related, anxiety, affective spectrum psychotic disorders
- CGI-S improved
- Inpatient admission from OBS associated with self-referral, older, lower GAF scores and < improvement

The Clinical Global Impression – Severity scale (CGI-S) is a 7-point scale that requires the clinician to rate the severity of the patient's illness at the time of assessment, relative to the clinician's past experience with patients who have the same diagnosis.

The Global Assessment of Functioning (GAF) is a numeric scale (1 through 100) to rate subjectively the social, occupational, and psychological functioning of adults, e.g., how well or adaptively one is meeting various problems-in-living.
Patient Outcome in Psych OBS


- Patient outcome in CSU BPRS changed from moderately ill to mildly ill
- Beck’s depression scale improved greatly

The Brief Psychiatric Rating Scale (BPRS) is a rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behavior.

The Beck Depression Inventory (BDI) is a 21-item, self-report rating inventory that measures characteristic attitudes and symptoms of depression.
Regionalization of Acute Psychiatric Care

- Prior 30 day period efforts have focused on increasing inpatient beds
- Alternative is prompt access to treatment
- Evaluate and treatment patients in a given area and take patients from EDs
- 30 day period examined all patients from 5 EDs on voluntary holds
- 144 patients had average boarding time of 1 hour and 48 minutes
- 24.8% were admitted
Sinai CSU

- Treatment safe/low stimulation milieu to rapidly assess, stabilize and discharge patient
- Population adults 18-64 self-preservation & ADLs
- Capable of decrease pt. boarding time in ED
- Increase pt. access to psych services/tx
- Earlier psych consult & meds
- Increase pt. connection with outpatient services
- Initiate psych assessment earlier in process
Inpatient Issues

- Use of feedback of psychotherapy
- Peer mentor program (.89 vs. 1.53)
- Community mental health (20% lower)
  - Assertiveness Community Treatment (58% lower)
- Home visits
- Discharge readiness assessment
- Medication alternatives like long acting IM meds
- Multifaceted inpatient psychiatric approach
Inpatient Issues

- Weekly readmission rounds
- Readmission focus in discharge rounds
- Teach back method
- Outpatient follow up in 3 days
- Family engagement focus
- Post discharge phone calls
- Improving community linkages
Pediatric Inpatient Reduction

- Focus on initial hospital stay
- Complex treatment needs of conduct disorders
- Improve child-parent relations
Enhanced Integrative Strategies


- Medical home
  - Embedded medical, substance use & psychiatric services in clinics

- Condition education
- Family involvement in care

- Patient communications
  - Frequent communications
  - Phone, web or text

- Supportive services
  - Peer mentor
  - Community healthcare worker
  - Patient navigator

- Medications
  - Medication reconciliation
  - Depot meds

- Assertive Community Treatment (ACT)
  - Homeless SMI population
  - Multidisciplinary team

- Non-traditional services
  - NAMI
  - Help phone lines
Review of 15 studies without overlapping interventions

- Pre and post discharge patient psychoeducation
- Structured needs assessment
- Medication reconciliation/education
- Transition managers
- Inpatient to outpatient communication
- Outpatient follow-up
- Regular consultations
- Attendance at activities
Take Home Point

- **Emergency Department**
  - Look for ED deflection programs such as mobile crisis teams and law enforcement for those that do not need an ED
  - Some patients can go home after ED evaluation with or without telepsychiatry
  - Consider admission options such as observation, short stay or crisis respite

- **Inpatient**
  - Need for aftercare communication, instructions, appts
  - Follow up with the patient
  - Use long acting medication
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