St. Joseph Hospital of Orange
Psychiatric Emergency Hospitalist Team Model

2018 HASC Annual Meeting
04/12/18
Should anything be different in this picture?

- 3.1% of the population has experienced "serious psychological distress" within past 30 days (CDC, 2014)
  - 2018 U.S. Population = 326,210,591
  - 3.1% = 10,112,598 (over 3x OC population)

- National Alliance on Mental Illness (NAMI) rates U.S. as a nation a "D" for mental healthcare, their measures include:
  - Health Care integration with emphasis on wellness
  - Innovation/best practices and process improvement
  - Data tracking with metrics, is what you do effective?
  - Is there adequate public insurance coverage to reach most people?
  - Are there adequate support services: housing, employment, transportation, clinics and other ‘wrap around’ services available in the community?

- Yet, only 6% of all U.S. healthcare dollars are spent on mental health treatment
GENERAL OVERVIEW

- There’s a severe shortage of general and specialized psychiatric beds in OC
- There are very few housing/long-term residential aftercare treatment options
- OC does not operate a County Hospital, 10 bed ETS center
- Only 31 adolescent beds (17/College & 14/UCI) and no child beds in OC
- 2 Grand Jury Reports—“Crisis in behavioral health service in Orange County”

SPECIFIC BACKGROUND

- SJO Psychiatric/Behavioral Health Programs:
  - highest volume ED in OC for behavioral health visits
  - Behavioral Health Payors: 80% MediCal, M/C, 10% self-pay, 10% private ins
  - longest running psychiatric program in Orange County (OC)
  - strong foundation outpatient treatment (bipolar, PPD)
- Commitment to care of poor and vulnerable as part of underlying mission
- Integrated solution for highly reliable/safe care for medical and BHS patients
## Psychiatric Emergency Hospitalist Team Model

**Timeline**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>Jan 2014</td>
<td>Opened ECDU, plan to have it serve as hub for reverse engineering programs to address the lack of behavioral health services for patients experiencing mental health crisis</td>
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<td>Nov 2014</td>
<td>Obtained first grant to help fund a pilot program using psychiatric nurse practitioners and psychologists to help reduce length of stay for behavioral health/psychiatric patients</td>
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<td>Nov 2015</td>
<td>Obtained additional grant support, fully implemented psych NP, psychologist and added social work to the team. Began searching for emergency psychiatrists to lead the team</td>
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<td>Mar 2016</td>
<td>Implemented telepsychiatry support program while recruiting psychiatrists due to lack of psychiatrists in local community. Recruited and began using psychiatrists mid-2016, implemented rapid screening and medication protocols</td>
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<tr>
<td>April 2017</td>
<td>Fully implemented the emergency clinical decision unit psychiatric emergency hospitalist team model</td>
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Psychiatric Emergency Hospitalist Team Model, cont’d

Actions for the journey (2013 to 2018)

• Create physical space to improve safety, function and capacity
  – Remodel/renovate, start small, OSHPD flex variances,
  – **END POINT**: Quiet space, well monitored <not dedicated, just preferred>

• Recruit new and align current staff to provide specialized care
  – Train ED nurses, create STPs, add Psych NP/Psychologist or LCSW
  – **END POINT**: Some comprehensive level coverage (F-2-F or Telepsych)

• Develop “out-of-the-box” funding and key stakeholder activities
  – Private donations, state/county funds, pilot projects to show outcomes
  – **END POINT**: Show some impact in a short time for direct or indirect ROI

• Align an operational strategy with a core mission
  – Start with end in mind, reverse engineer, define failure and create system
  – **END POINT**: Reduce hopelessness and helplessness.. one sacred encounter at a time…
### Hub-Emergency Clinical Decision Unit...

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<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
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<tbody>
<tr>
<td>Total ED Volume</td>
<td>80,914</td>
<td>78,991</td>
<td>80,256</td>
<td>80,686</td>
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<td>LWBS Volume</td>
<td>3.6%</td>
<td>3.9%</td>
<td>3.3%</td>
<td>3.3%</td>
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<tr>
<td>EMS Diversion</td>
<td>5.0%</td>
<td>4.3%</td>
<td>5.6%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Total BHS/Psych volume (low acuity ED only + crisis ECDU)</td>
<td>4,004</td>
<td>4,644</td>
<td>4,856</td>
<td>5,111  (avg 14/day)</td>
</tr>
<tr>
<td>Total ECDU BHS/Psych volume (crisis ECDU only)</td>
<td>2,973</td>
<td>2,708</td>
<td>2,901</td>
<td>2,306  (avg 6.3/day)</td>
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<tr>
<td>90th percentile (10% of the patients in ECDU stayed at least this amount of time or greater) for their length of stay</td>
<td>297 patients stayed 25hrs (1 day) or longer in ECDU. Longest single patient max stay was 9 days</td>
<td>270 patients stayed 25hrs 8min (1 day) or longer in ECDU. Longest single patient max stay was 5 days</td>
<td>290 patients stayed 23hrs 54min (1 day) or longer in ECDU. Longest single patient max stay was 5 days</td>
<td>230 patients stayed 20hrs 9min (little under 1 day) or longer in ECDU. Longest single patient max stay was 2 days</td>
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<tr>
<td>Number of staff assaulted by patient in crisis (ED &amp; ECDU combined)</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>1</td>
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<td>Percentage of restraint usage (ED &amp; ECDU combined) after protocol started</td>
<td>N/A</td>
<td>N/A</td>
<td>baseline</td>
<td>19% combined (ED &amp; ECDU) reduction in restraint usage</td>
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Healthiest Communities

How does this help us move toward healthier communities?

• **Psychiatric Emergency Hospitalist Team** (right process)
  Reverse engineer - failure to success, crises to whole person health

• **Enhance limited behavioral inpatient capacity** (right patient / right place)
  Improved psychiatric/behavioral health care continuum

• **Improve crisis stabilization time** (right provider / right time)
  Rapid emergency behavioral assessment, timely protocol initiation

• **Maintain staff & patient safety** (right care / right outcomes=process)
  Improved care for behavioral and non-behavioral [medical] patients

• **Build sustainable, supportive, wrap-around infrastructure** (right service)
  Hub (Emergency) and Spoke (Inpt, Outpt, C/L, Sub Abuse, Soc skills)

• **Other**
  NAMI grading system to assess effectiveness, indirect/direct ROI KPI’s
Thank You!

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