How to Setup and Manage an Observation Unit for Psychiatric Patients in Crisis: The Sinai Experience

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Learning Objectives

- To understand admission criteria for psych patients
- To review the psychiatric observation/crisis stabilization units
- To exam the Sinai CSU

What is a Mental Health Crisis?

US HHS: Practice guidelines: Core elements in response to mental health crises. www.samhsa.gov.

- Personal distress
  - Anxiety, depression, anger, panic, hopelessness
- Obvious change in function
  - Neglect of personal hygiene, unusual behavior
- Catastrophic life events
  - Disruption of personal relationships, support systems or living arrangements
  - Loss of autonomy or parental rights
  - Victimization or natural disasters

Admit or Discharge 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

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
- Alternatives to inpatient stay

Observation Models

- Emergency department
- Observation unit
- Psychiatric emergency service
- Comprehensive Psychiatric Emergency Program
- Psych ED

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

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Overnight Observation in VA Medical Center

Francis, R, et al: Utilization and outcome in an overnight psychiatric observation program at a veterans affairs medical center. Psych Services 200;51:92-95.

- Designed to avoid unnecessary admissions
- 92 pts in 1996, came through ED
- Characteristics
  - 80% unemployed, 41% homeless
  - 55% suicidal or homicidal ideation
  - 49% intoxication, 77% substance use
  - 88% referred to outpatient
- 9.8 inpatient days before and 2.7 days after
- No variables to determine inpatient care

Comprehensive Psychiatric Emergency Program

Sullivan, AM and Rivera, J: Profile of a comprehensive psychiatric emergency program new York city municipal hospital. Psych Q 2000;71:123-138.

- By law emergency psych eval, tx and dis, extended OBS to 72 hours
- 20% brought by police, self/family 63%
- Dx
  - Schizophrenia 27%
  - Drug and alcohol 14%
  - Bipolar 13%
  - Depression 11%
- Inpatient 43%

Comprehensive Psychiatric Emergency Program

Sullivan, AM and Rivera, J: Profile of a comprehensive psychiatric emergency program new York city municipal hospital. Psych Q 2000;71:123-138.

- 16% Kids
- Presenting complaint
  - Violent behavior 25%
  - Agitation 24%
  - Suicidal 26%
- Dx
  - Conduct disorder
  - Adjustment disorder
  - Depression
- Admission rate 22%

Acute Stabilization

Breslow, RE, Klinger, BI, Erickson, BJ: Crisis hospitalization on a psychiatric emergency service. Gen Hops Psych 1983:15:307-315.

- Functions
  - Allows time for diagnostic clarity
  - Develop alternatives to admission
  - Respite function
  - Denies dependency needs
- Patient types
  - Schizophrenics
  - Personality disorder
  - Suicidality
  - Substance use disorders
- 41% of total patients seen

Regionalization of Acute Psychiatric Care

Ashkenazi-Shira, N, Stone, A: Effects of regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Em 2014;15:1-6.

- 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

Benefit of Psych OBS

- Reduction in admissions
- Gain in earlier functional independence
- More immediate use of community resources
- Higher level of patient satisfaction
- Promoted better coordinated care

Patient Types

- Who Benefits from Psych OBS
  - Situational depression
  - Wiling to continue therapy after discharge
- Who does not benefit?
  - Suicidal
  - Danger to others
  - Severity of psychiatric symptoms
  - Diagnosis of psychotic disorder

Benefits

Laurer, M: Replacing the revolving doo. J Psychosocial Nursing 2008;46:25-32.

- Appropriate level of care
- Reduced elopement
- Reduced restraint use
  - From 3.7 patients per month to 0.7
- Psychiatric inpatient stay
  - 43% decline

Patient Outcome in Psych OBS

Admass, CL , El-lallakh, RS: Patient outcome after treatment in a community based crisis stabilization unit. J Beh Health Ser and Res. 2009;36:396-399.

- 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 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

Clinical Profile

Thinn, DSS, et al: The 23 hour observation unit admissions within the emergency service. Prim Care Companion.2015;17:1-11.

- 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. .

Requirements of Psych OBS

- Security and safety measures
- Restraint and/or seclusion
- Therapeutic setting
- Available mental health resources

Physical Plant

- Location
- Furniture
  - Lounge chairs
- Physical plant safety
  - Wiring
- Safety search
  - In the ED
  - Outside the ED
- Design
  - Living room style
  - Interview rooms
  - Medical evaluation rooms

Staffing

- Psych RNs
- Mental Health worker
- Advanced practice providers
- Psychiatrist
- Annual in-service on verbal desecration and hands on management of the violent patient

Model Cost Estimate

	Hourly rate	FTE	Dollars
Psychiatrist	$82	.5	$85,280
Nurse Practitioner	$41	2.5	$213,200
Psych RNs	$32	5.5	$366,080
Mental Health Tech	$16	5.5	$183,040
Public safety officer	$12.5	5.5	$143,000
Total			$990,600

Model Revenue Estimate

	Rate	Patients/Day	Total
Professional Fee			
MD	$20	6	$43,800
APN	$130	6	$284,700
Allied health	$174	6	$381,060
Hospital Fee			
OBS for < 8 hr.	$942	6	$2,062,980
OBS for 8-23 hrs.	$87/hr.		
Total			$2,772,540

Appropriate for Psych OBS Severity of Illness

Severity	Description	Suicidal	Disposition	Need for Obs
Stable	Functional, works	None	Outpatient	No
Low level	Had medical or psych stressor	Mild	Outpatient	Yes
Moderate	Decompensated, agitated	Moderate	Psych consultation	Yes
Severe	Severe decompensation	High	Inpatient care	No

Static and Dynamic Factors for Suicide to Determine Risk Levels

- Static
  - Age, gender, medical problems, psych illness, substance use
- Dynamic
  - High risk suicide attempt
    - Use of highly lethal means (guns-hanging)
    - Planned and or rehearsed ahead of time
    - Efforts to not be discovered-going to remote site
    - Suicide note-putting affairs in order
  - Moderate risk
    - Use of limited # of medications or substances of abuse
    - High likelihood of being discovered or calling for help
    - Suicide note overtly manipulative or designed to gain attention
    - Ambivalence about lack of success
  - Low risk attempt (gesture)
    - Taking a small number of pills
    - Attempt in front of another person
    - Happy that the attempt was not successful or feels "stupid"

Treatment Protocols

- Depression
  - Need for safety and eval of self-destruction
- Agitated
  - Intensive treatment
- Psychotic patient
  - Antipsychotic +/- benzo
- Manic
  - Antipsychotic +/- benzo

Alcohol and Substance Use

- Psych patients have high rate of substance use disorder
- Differentiate substance use from psychiatric illness
- Observation of intoxication
- Treat minor withdrawal
- Start Suboxone
- Need for SBIRT

OBS Treatment

- Most primarily focused on medications
- Need to involve social work, case management and discharge planer
- Few provide any non-meds treatment
- Family involvement
- Provide peer support services
- Safety planning
- Connection to other services

Interventions

- Brief intervention Fleishmann: Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries Bull WHO 2008;86:703-709.
  - International study of 8 EDS
  - Brief intervention and enhanced follow up
  - Reduced number of deaths
- Enhanced Intervention Rotherham-Borus: The 18-month impact of an emergency room intervention for adolescent female suicide attempters J Consulting & Clinical Psych 2000;68:1081-1093.
  - 18 month study of female Hispanic patients
  - Soap opera video, family therapy, and staff training
  - Reduced suicide re-attempts and ideation

Reimbursement

- Medicaid
  - All inclusive bundled billing around $100 per patient per hour, up to a max of 20 hours.
  - No pro fees or other charges
  - Crisis stabilization code S 9484
- Medicare
  - Unscheduled psych eval-very poor reimbursement
- Private insurers
  - Negotiated per-diem rate
  - ACOs

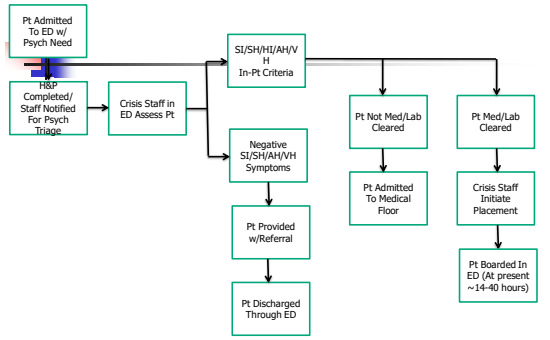
Sinai CSU

- Establish pilot to determine the best practice
- 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 utilization of ED resources/beds
- Increase pt access to psych services/tx
- Earlier psych consult & meds
- Increase pt connection with outpatient services
- Initiate psych assessment earlier in process

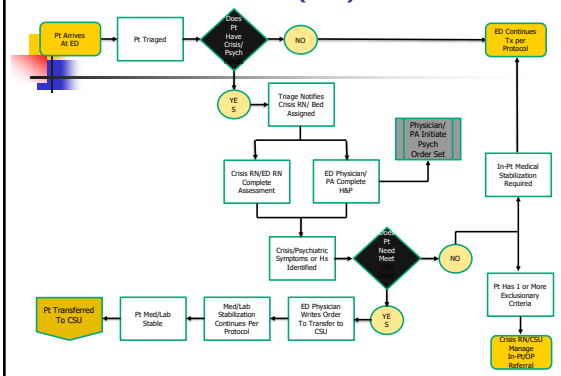
Sinai CSU
Process Objectives

- Decrease pt boarding time in ED
- Increase utilization of ED resources/beds
- Increase pt access to psych services/tx
- Provide safe/low stimulation environment
- Complete psych consult/begin meds when appropriate
- Increase pt connection/participation with outpatient services
- Initiate psych assessment earlier in process

Current Process Flow



CSU Process Flow (ED)



How do we reconcile the differences in the literature? Protocol for the Emergency Medicine Evaluation of Psychiatric Patients:

Zun, , LS, Leiken, JB, Scotland, NL et. al. Protocol for the emergency medicine evaluation of psychiatric patients (letter), Am J Emerg Med, 14:329-333, 1996.

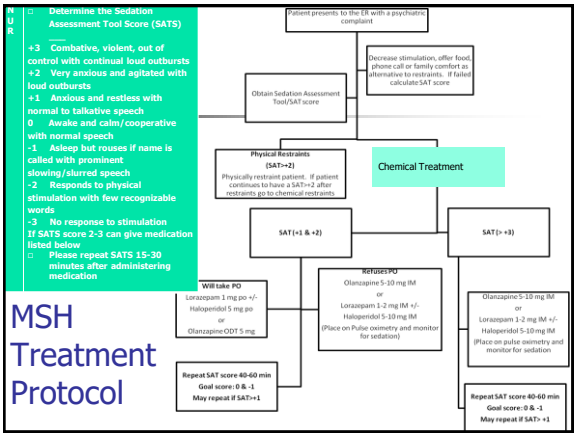
Medical Clearance Checklist

	Yes	No
1. Does the patient have new psychiatric condition?		
2. Any history of active medical illness needing evaluation?		
3. Any abnormal vital signs prior to transfer?		
4. Any abnormal physical exam (unclothed)?		
5. Any abnormal mental status indicating medical illness?		

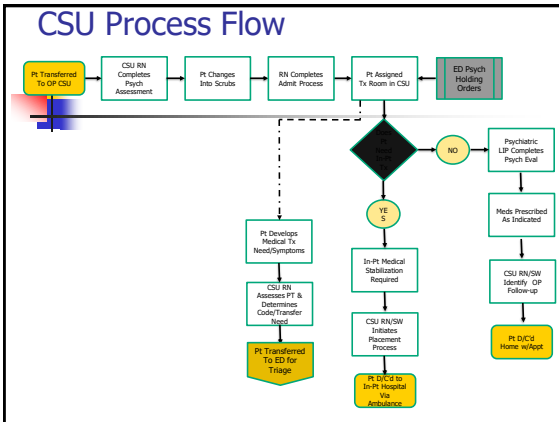
If no to all of the above questions, no further evaluation is necessary.

If yes to any of the above questions, tests may be indicated.

MSH Treatment Protocol



CSU Process Flow



Sinai CSU

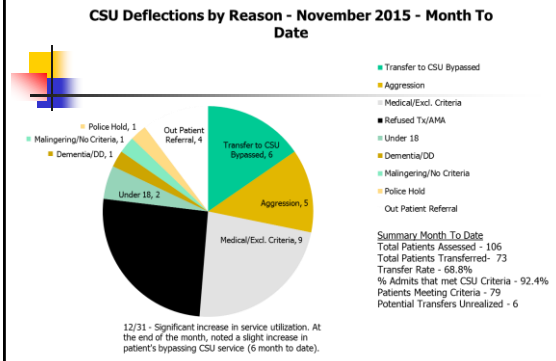
- Size
  - 1800 sq. feet
  - 12 beds/treatment spaces
- Staffing
  - RN 2 per shift
  - Techs 3 per shift
  - Security 1 per shift
- Type of patients
  - Suicidal
  - Depression
  - Psychotic
  - Substance use disorder co-occurring)

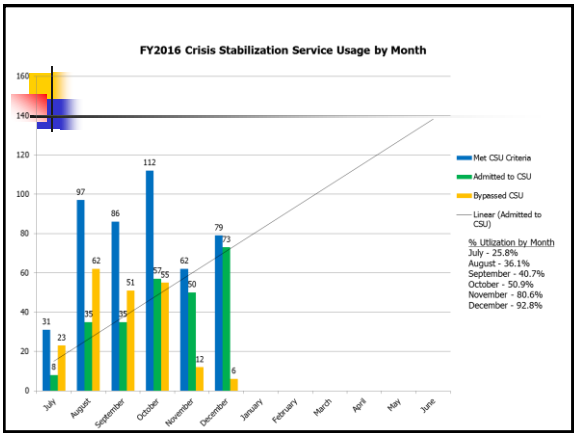
Sinai CSU

- Psych assessments
  - ED
  - Q 4 hours
- Current Volume
  - 5-7 pts per day
  - Percent admitted – 47% target 25%
- Current Throughput time
  - ED 7 hours
  - CSU 15.2 hrs.

Sinai CSU

- Therapy
  - Talk therapy
  - Disease process education
  - Coping skills
- Adverse events
  - 1 patient had SZ transferred to ED
- Restraint use
  - 2 of 239 pts





Challenges

- Timeliness of evaluations
- Treatment protocols
- Collaborate with county sheriff, Chicago police
- Increase volume
- Peer program
- Psychiatrists used to different model of care
- Patient satisfaction assessment
- What department is it under

Take Home Point

- If done right, a psych OBS unit can reduce or eliminate psychiatric boarders
- Psych OBS can improve patient care environment, patient safety and reduce admission rate
- Important to establish patient flow process, evaluation and treatment protocols
- Financial benefit is somewhat tenuous

SINAI
Sinai Health System

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