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ABOUT ME

- 30 years experience as a clinician
- 17 years in a Level I Trauma Center ER doing assessments on night shift
- Current Sr. Behavioral Health Director for global technology company
- Former NAMI National Board of Directors, State ED, Lobbyist
- Gulf Vet, Married, Mom, Grandma
- Technology, data and research academic
- Catalyst for change
- Humanitarian

CHALLENGES

- Many ER's are not physically designed for BH clients
- Even with crisis stabilization units opening – many messages refer to ER's
- If substance misuse is an issue they encourage the ER as a first stop
- Utilization review by Medicaid often blocks co-occurring admissions until the person tests negative for the substance
- If a youth is sent from a psychiatric hospital for aggressive behavior placement becomes even more challenging
- ER's are 24 hours so discharges can occur in the middle of the night
- An assessor may not have the luxury of finding and placing in the best fit for the patient sometimes it who has the bed.

CHALLENGES

- Many times folks run out of meds and often try to get refills in ER's
- Conversely, Many folks come to ER's asking to start meds and may not meet 27-65 criteria.
- The gray space of "they are just not sick enough to meet imminent criteria"
- Restraints mechanical or chemical often become a have to use for everyone's safety.
- Hospital security is often not skilled in de-escalation
- Hospitals often have to hold patients on 27-65 holds for days due to lack of inpatient facilities.
- Individuals with IDD, transgender or specific charges sex offender, arsonist or violence make placement to inpatient units very difficult.

OPPORTUNITIES

- We could consistently induct suboxone and warm hand off to outpatient care
- We do not use Peer Coaches in most ER's they can provide a great deal of insight, empathy, and resources
- We do not always have transportation to get a patient from point a to b if they are uninsured
- In the middle of the night there are not often opportunities for warm hand offs, by the time MHC's or STP's are open your night shift is home in bed. Being able to talk to a Metro Crisis Services person that is responsible for hand off could be huge.
- Having a standard order set for prescribing based on best practices could be helpful for getting medications started.

OPPORTUNITIES

- Incentivizing nurses to take BH related CEU's to increase cultural competency of ER staff of individuals with BH related issues
- Place a unstaffed kiosk in ER's that are preloaded with resources from everything from housing, food, clothing, treatment resources that could be printed and taken by the patient or their family or support system
- Educate all levels of ER providers on BH advance directives so they have a place to start
- Showers and grooming kits
- Peer follow up after discharge via phone to ensure folks connected to services and patient satisfaction surveys verifying they received quality care while in ER.

HOW DO WE ADDRESS THESE?

- Rules and rule making tied to hospital licensure or 27-65 designation
- Practice Act revisions
- Figuring out how to pay for Peers in ER's to show cost benefit to hospital systems may need to be a contracted service
- Legislation- should criteria for 27-65 hold be changed
- Carrots- If funding is made available to ER's would that incentivize change
- Could Kiosks be bought by state and provided through ARPA funds or Block grant
- Could we use technology to provide more services

QUESTIONS, COMMENTS, OR COUNTERPOINTS
LET'S DISCUSS….