EMTALA and Mental Health

Good day. I speak as both a board certified emergency physician who practices in a high volume emergency department at a Level One Trauma Center and as board certified subspecialist in Emergency Medical Services, functioning as the Director and Medical Director for the Wake County Department of EMS in Raleigh, North Carolina.

My work in the hospital offers what I will refer to as the traditional EMTALA perspective – standing the in the hospital and looking out into the community. From this perspective, we see patients who are delivered to our institution for EMTALA covered care for a variety of conditions. The trauma patient presents either directly from the streets or in referral, and a wide array of trauma services are offered. A trauma patient who has a highly acute or unique injury beyond the capabilities of my trauma center are rapidly and efficiently transferred to specialized centers for burns, aortic surgery, etc, all with EMTALA-covered care. Heart attack patients are whisked to the cardiac catheterization lab, septic patients to the ICU, stroke patients to the CT scanner, and patients in labor to the obstetrical suite. Yet, when the patient with mental health crisis and/or substance abuse presents, I have no specialized admission center/floor/area to offer. In many of these cases, these patients simply remain in the emergency department with a sitter by their side, waiting for hours and hours for placement in a psychiatric facility. In my institution, the average boarding time for these patients is 14 hours. Perhaps more importantly, these patients are boarding in a facility that has offered no significant intervention or treatment for their condition.

My perspective as an EMS physician provides the view from the community, looking toward all of the potential avenues of care. As the EMS subspecialty has developed, we have incorporated the concept of Mobile Integrated Healthcare into our practice of medicine [1]. By way of brief background, it is important to note that EMS systems were designed in the late 1960s to early 1970s to respond to traffic accidents on the interstate highway system [2]. Thus, EMS was envisioned as a conveyance for trauma victims and thus was logically considered a transportation benefit [3]. Today, however, between 5 and 10% of the population summons EMS via the 9-1-1 system on annual basis, seeking access to healthcare for a variety of conditions, including mental health and substance abuse issues. It has been suggested that the EMS mission should evolve from the colloquial "you call, we haul, that's all" mentality that directs all patients reflexively to a hospital emergency department (as was appropriate for victims of trauma on the interstate highway) to a model that navigates patients to the appropriate locus of care, including not only emergency departments but also primary care medical homes, mental health facilities, home health, evaluation by telemedicine, and a variety of other patient-centered approaches [4][5].

Thus, experience from within an EMTALA governed facility whereby mental health and substance abuse patients are often boarded for many hours after not receiving any significant treatment as well as knowledge of other facilities in the with more appropriate patient treatment modalities were available lead to the development of a novel patient navigation program. This program allows Advanced Practice Paramedics to evaluate patients on-scene and, based upon protocol,

determine the most appropriate locus of care and offer treatment options to patients. This program was recently highlighted in the New York Times and I will take this opportunity to briefly describe the initiative [6].

Alternative Destination for Mental Health and Substance Abuse Patients

Our program involves several reproducible, protocol-driven evaluation steps. Before we go into details, please allow a few introductory remarks regarding the over-arching governance and philosophy. First, all treatment protocols and evaluations go through three levels of review prior to implementation. Thus, the program discussed here was reviewed by our Deputy Medical Director and myself, then by the Wake County EMS Peer Review Committee, and then by the North Carolina Office of EMS Medical Advisor[7] . Second, patients retain the right of choice and great care is taken for those who may have diminished capacity. Individuals evaluated under this protocol are evaluated in manner similar to all other patients in our EMS system, with choice of destination offered to those who demonstrate capacity. We have simply expanded the choice to include facilities that specialize in psychiatric and substance abuse treatment. Appropriately, some may question whether a patient with acute suicidal ideation may retain capacity. It is worth noting that every EMS system routes patients with decreased capacity to pre-designated centers on a daily basis (e.g., the unconscious trauma patient who is taken to the trauma center). Thus patients who demonstrate capacity are given choice in their treatment while those with potentially diminished capacity are transported to a facility that can immediately monitor and care for them. Finally, patient safety and outcomes are part of the on-going quality assurance process. We

have on-going working relationships with each of the sites that receive patients via this program.

Practically, then, the program functions in the following way. Patients are identified for screening in two ways. First, if the chief complaint to the emergency medical dispatcher includes psychiatric complaint and/or overdose, an APP is automatically dispatched to evaluate the patient. Additionally, if EMS personnel on scene identify a patient with a psychiatric or substance abuse compliant, the APP may be summoned (regardless of the complaint which spawned the original dispatch from the 9-1-1 center). In either case, the patient is evaluated utilizing the "well-person check" and the "alternative destination screening" criteria (attached). If the patient passes all criteria, then the APP contacts the appropriate facility or facilities to determine capacity/bed availability. If there is capacity at an alternative facility, then transport to that site is offered to the patient. If the patient declines the alternative site, then transport to the emergency department is offered. If the patient accepts, transport is coordinated with law enforcement. In either circumstance, EMS personnel provide a patient report to personnel at the receiving facility.

Between July 1, 2012 and July 1, 2013, 1503 patients were evaluated for alternative destination. 514 (34.2%; CI95 31.8-36.6) met diversion eligibility criteria, and 315 (61.2%; CI95 57.0-65.4) of those eligible agreed to be transported to an alternative destination instead of the local ED. Of these, the vast majority were transported to WakeBrook, the public mental health crisis center, with the remainder being transported for detox at faith-based facilities. Only 4 (2.0%; CI95

0.5-4.0) patients transported to WakeBrook were referred back to the ED within 90 minutes of arrival, none of whom subsequently required medical intervention. Among those patients who received alternative destination, 199/315 patients (63.2%; CI95 57.8-68.3) were treated and discharged home with mental health follow-up[8].

Conclusion:

A county-wide APP program for acute mental health issues allowed a significant number of patients to be diverted to a community mental health setting instead of the ED. Successful broader implementation of such a program could have a big impact on the volume of patients seen in the ED with acute mental health disorders while providing improved health and improved healthcare.

References:

[1] Beck E et al. Mobile Integrated Health Practice: A Healthcare Delivery Strategy to Improve Access, Outcomes, and Value. Modern Healthcare, December 2013. Accessed on March 9th at http://info.modernhealthcare.com/rs/crain/images/Medtronic_Download_12-9.pdf

[2] National Academy of Sciences. Accidental Death and Disability: The Neglected Disease of Modern Society. 1966. Accessed on March 9, 2014 at http://www.nap.edu/openbook.php?record_id=9978

[3] http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf

[4] Munjal K and Carr B. Realigning Reimbursement Policy and Financial Incentives to Support Patient-Centered Out-of-Hospital Care. JAMA 2013;309(7):667-8.

[5] Alpert A. et al. Giving EMS Flexibility in Transporting Low-Acuity EMS Patients Could Generate Substantial Medicare Savings. Health Affairs;2013(12):2142-48.

[6] Creswell J. ER Costs for Mentally Ill Soar, and Hospitals Seek a Better Way. New York Times. December 26, 2013, pages A1 and B4.

[7] 10A NCAC 13 P .0408 EMS Peer Review Committee for EMS Systems (membership based upon NC GS 131E-155(6b).

[8] Glickman S et al. An Advanced Practice Paramedic Program Can Safely and Effectively Divert Acute Mental Health Patients from an ED to a Community Mental Health Center. SAEM Mid-Atlantic Regional Conference, February 21, 2014 [oral abstract presentation].