

Joint Study Committee
on
Mental Health Access
(House Resolution 502)

11:00 a.m. – 1:00 p.m.
October 25, 2013



Northeast Georgia Health System Welcomes:

Jason Bearden
Rep. Katie Dempsey
Rep. Pat Gardner
Judge Stephen Goss
Garry McGiboney

Sen. Josh McKoon
Sen. Jesse Stone
Rep. Kevin Tanner
Sen. Kurt Thompson



AGENDA

- House Resolution 502
- NGHS and Behavioral Healthcare
- Where we were
- What we found
- Where we are now
- Where we want to be
- Where we need your help



HR 502

- Tragedies occur in schools and communities impacting innocent people.
- Many of these tragedies are committed by individuals with mental illness.
- People with Mental Illness are not receiving adequate treatment.
- The state MH system is transitioning to a community based model



HR 502 (continued)

- Incarcerated individuals have untreated Mental Illness exacerbated by drug abuse.
- “HELP” courts are new and developing
- Efforts need to be undertaken to ensure the safety of our schools and communities, without the loss of our Constitutional Liberties
- **This committee shall undertake a study of these conditions, needs, issues and problems, and recommend appropriate actions or legislation**

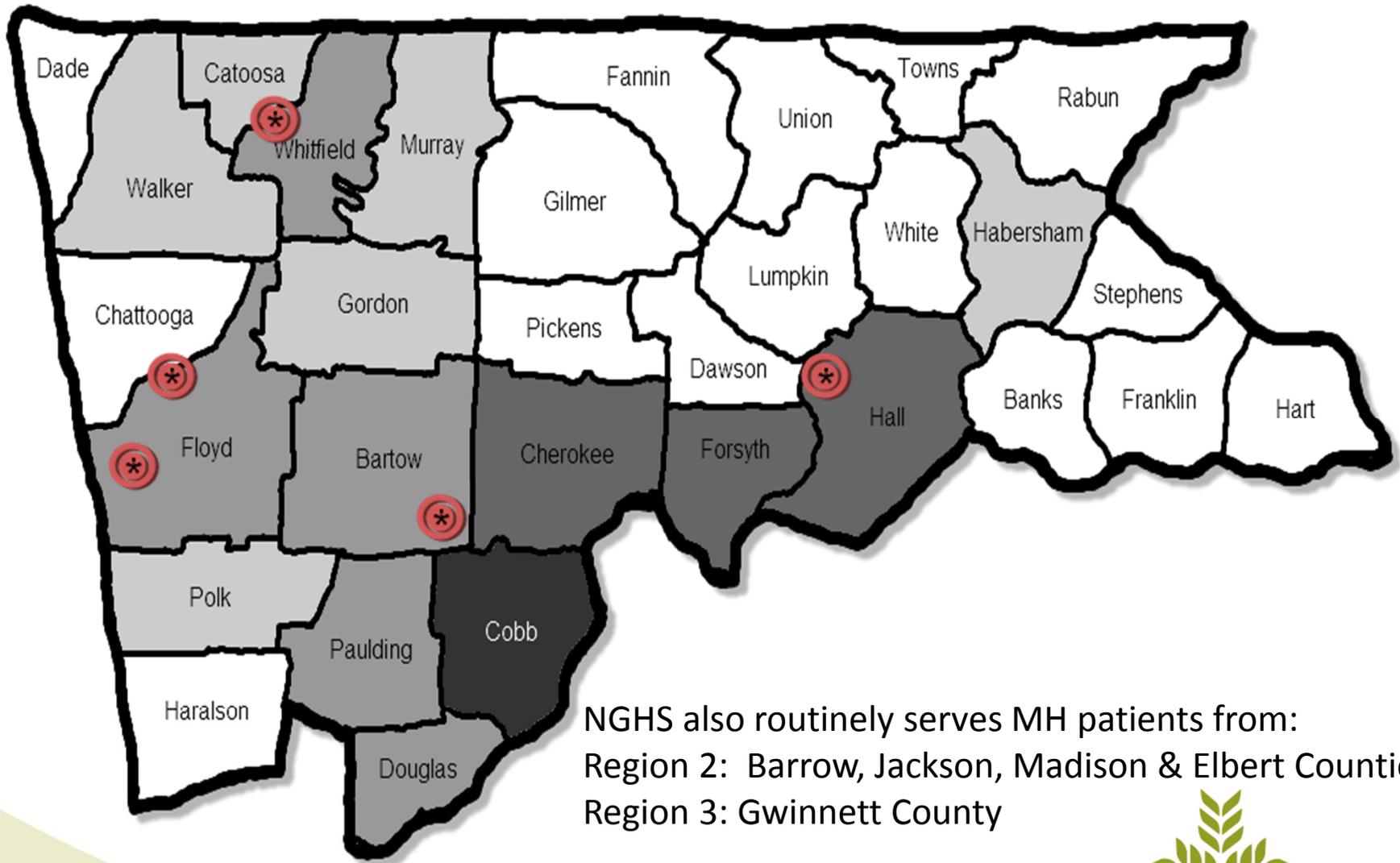


NGHS and Behavioral Health

- NGHS has always been committed to the care of Mental Health patients in our community.
 - Designated IP unit within the hospital pre 1988
 - Laurelwood 1988 – present
 - Mobile Assessment services in ER's in Forsyth, Franklin, Habersham, Lumpkin, Rabun, Stephens, Towns and Union Counties.
 - Northeast Georgia Physicians Group Psychiatry with seven employed Psychiatrists.
- Provided all Inpatient Treatment for AVITA from 1999 – 2011.
- State overflow contract for Region 1 since 2011



Region 1 Adult Crisis Stabilization Units July 2013



NGHS also routinely serves MH patients from:
Region 2: Barrow, Jackson, Madison & Elbert Counties
Region 3: Gwinnett County

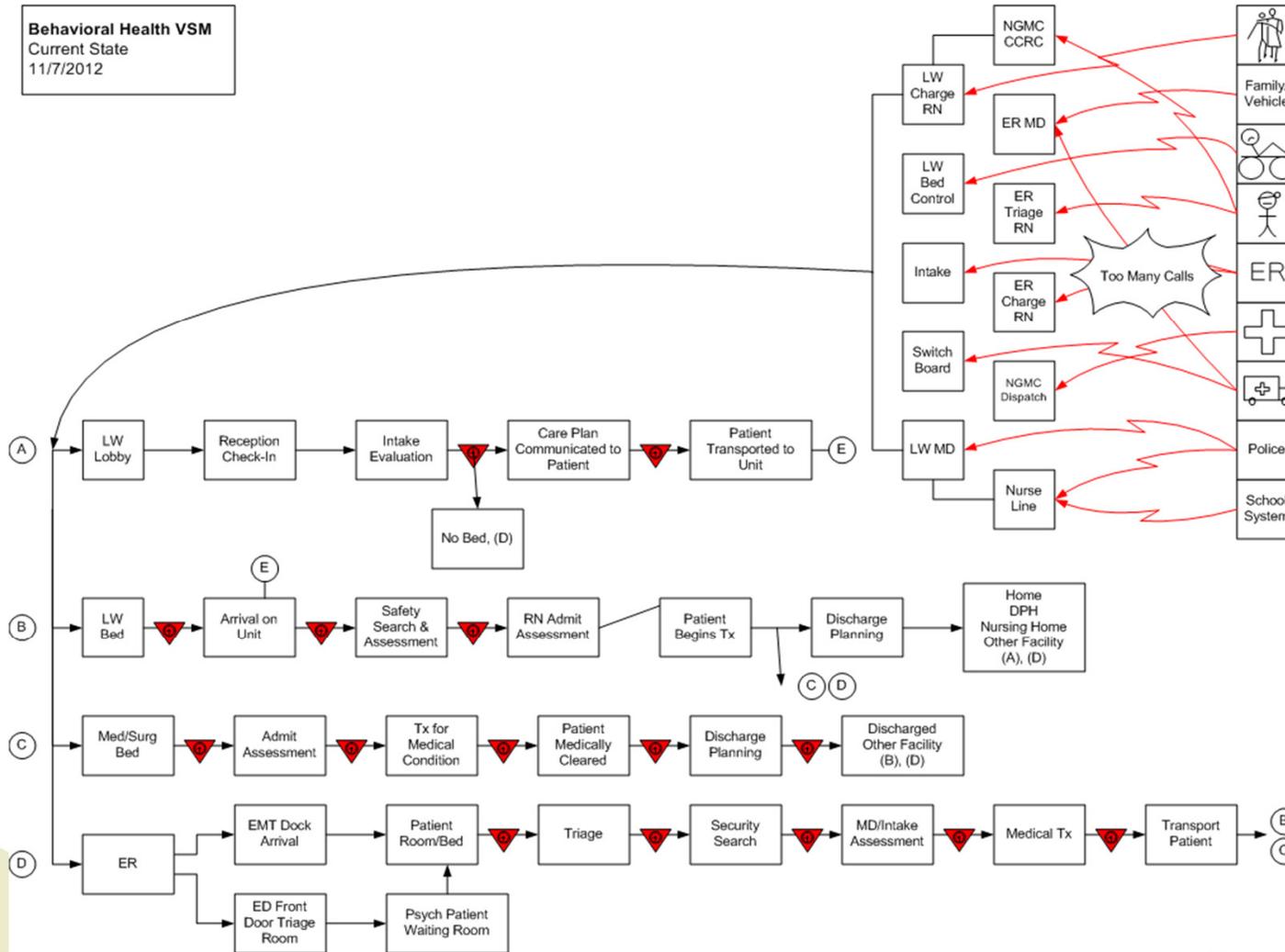
The Problem

Current standards do not exist across Northeast Georgia Health System in how we care for behavioral patients. Confusion exists among the care staff on the appropriate destination and level of care received by the patient.....



Where we were.....

Behavioral Health VSM
Current State
11/7/2012



What we found

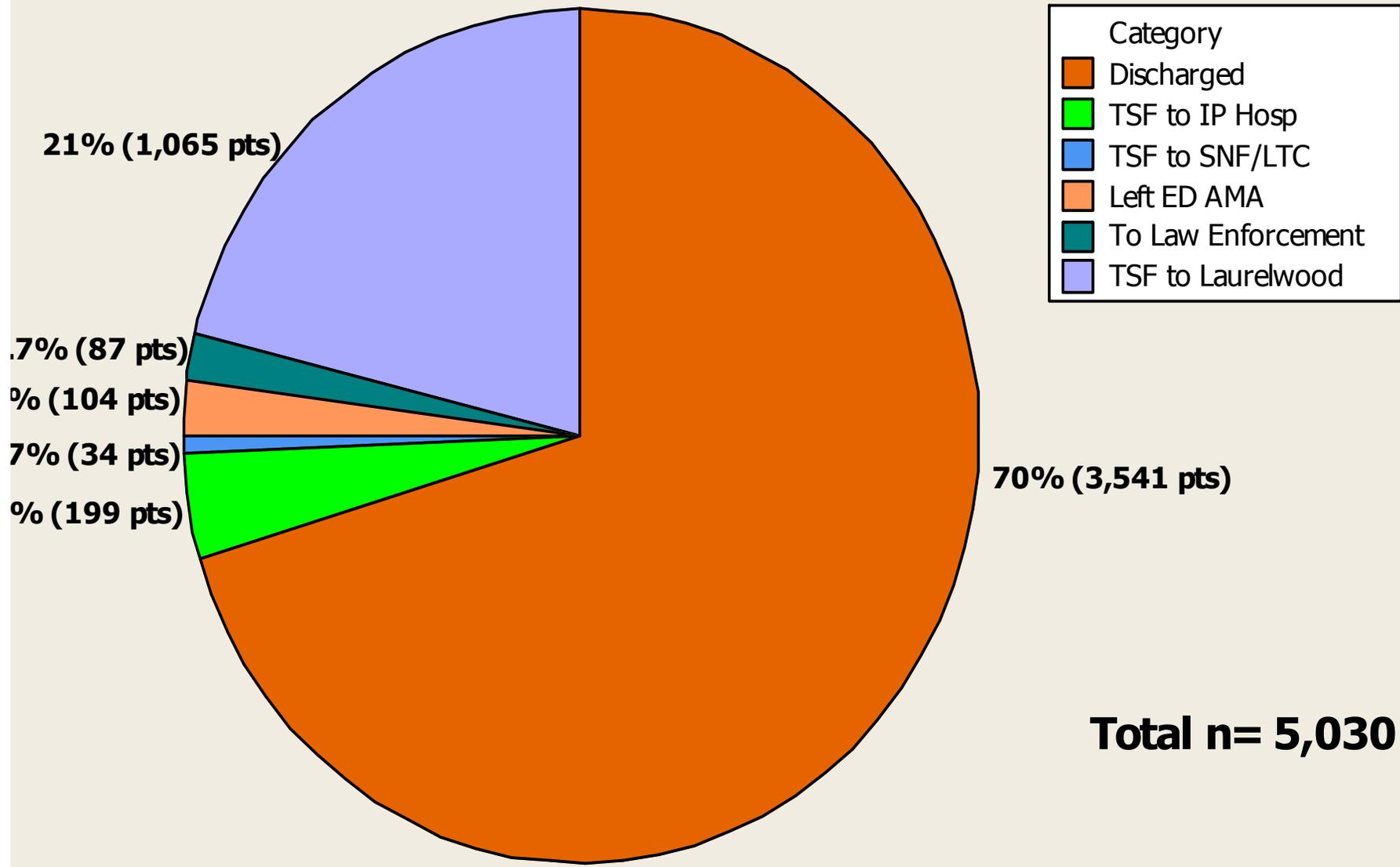
- Multiple entry points to system
- Dozens of phone calls to figure out where patient is coming from, or no communication
- No standard for medical clearance
- No control over disposition to state beds
- For some patients, we have limited resources to treat
- Patients circulated throughout the system

What we found

- Multiple safety hazards for staff, visitors and patients
- Lack of staff training specific to BH population
- One inadequate seclusion room in main campus
- Holding -vs- treating patients (*our Emergency Psych Holding area was insufficient in size and location*)

Disposition of ED Patients: Behavioral Health Diagnosis

Jan 2011 - Aug 2012



Total n= 5,030

Does Not include post acute Tx (GSW, Self Inflicted Wounds)

Daily Impact

- 84 Treatment Bays with “flex” to 126
- 23 camera access rooms (14 main, 9 in “F”)
- 3 Safe rooms
- 300 + patients/day –avg. 15 behavioral/day
Excludes acute medical needs, GSW, ODs, etc.
- Stays of 8 to 96 hours
- Treatment....???? Safety & Sedation



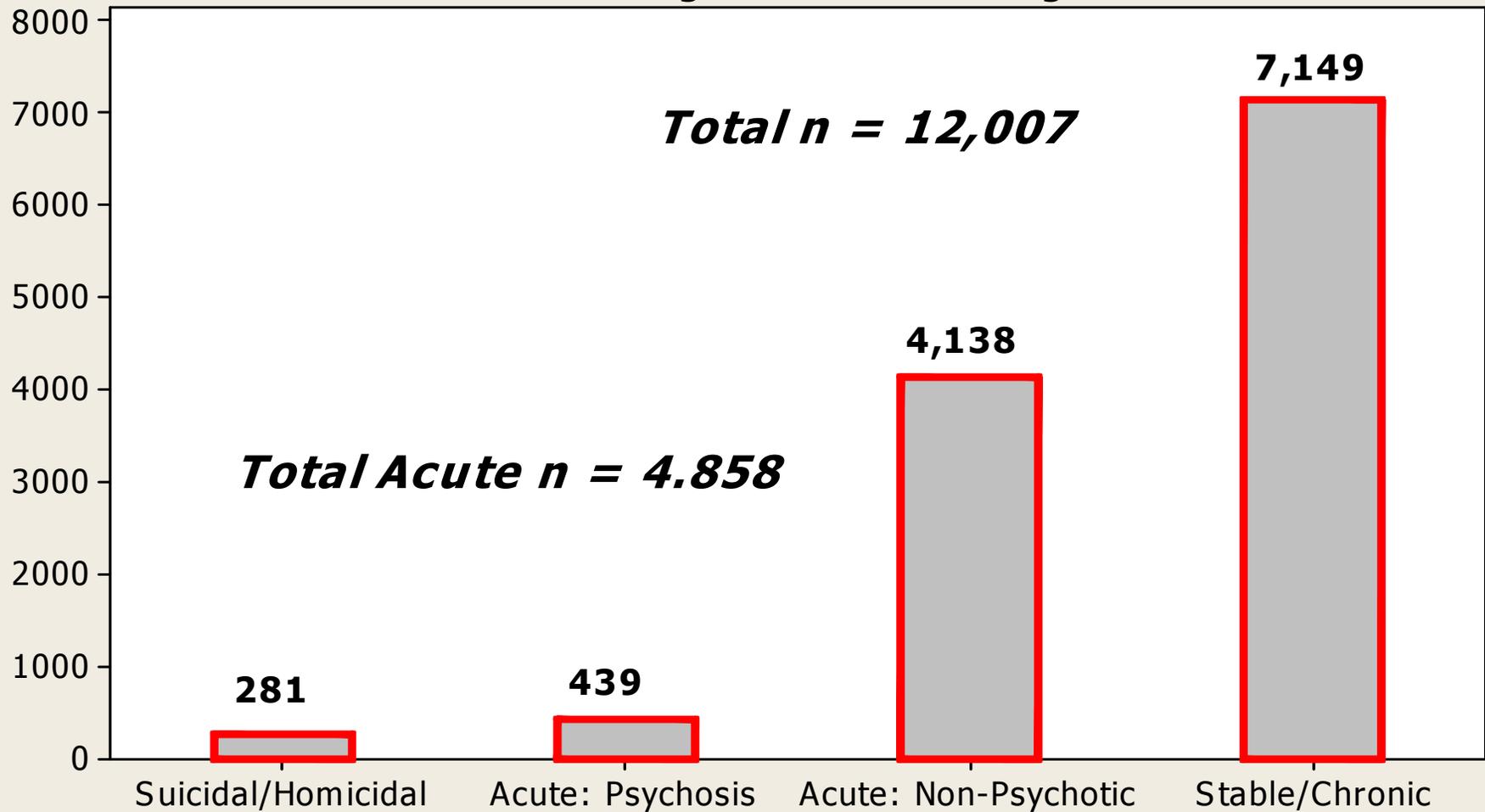
Patient Story (Child)

- Patient presented to the ER:
 - 9 year old with autism and schizophrenia
- Transferred to inpatient Pediatric unit after 22 hours in ER
 - Abandoned by mother
- Spent 16 hours on the inpatient Pediatric unit waiting for state placement
- Patient exhibited no behavior which indicated treatment

What did we learn?

- 26 different staff members provided patient care during ED stay (22 hours)
- No placement for 9 year old within our system
- ED not equipped for inpatient care
- No reimbursement
- 2.5 hour transfer to Macon

Acute & Chronic Behavioral Health Diagnosis in Acute Med Surg Setting Jan 2011 - August 2012 Discharges



Sitter costs for Behavioral patients on Medical floors is approximately \$550,000/annually.



MH Transport

- Law Enforcement will no longer provide transportation of an involuntary patient, although the law still mandates.
- Specially equipped MH transport Vehicles
- Specially trained MH transporters (2 required for all transports)
- Trips across the state, dependent on the CSU where a patient is placed by GCAL/BHL (availability)
- 223 Trips greater than 100 miles
- Total of 116,000 miles traveled transporting MH patients
- Annual cost for MH Transports \$400,000



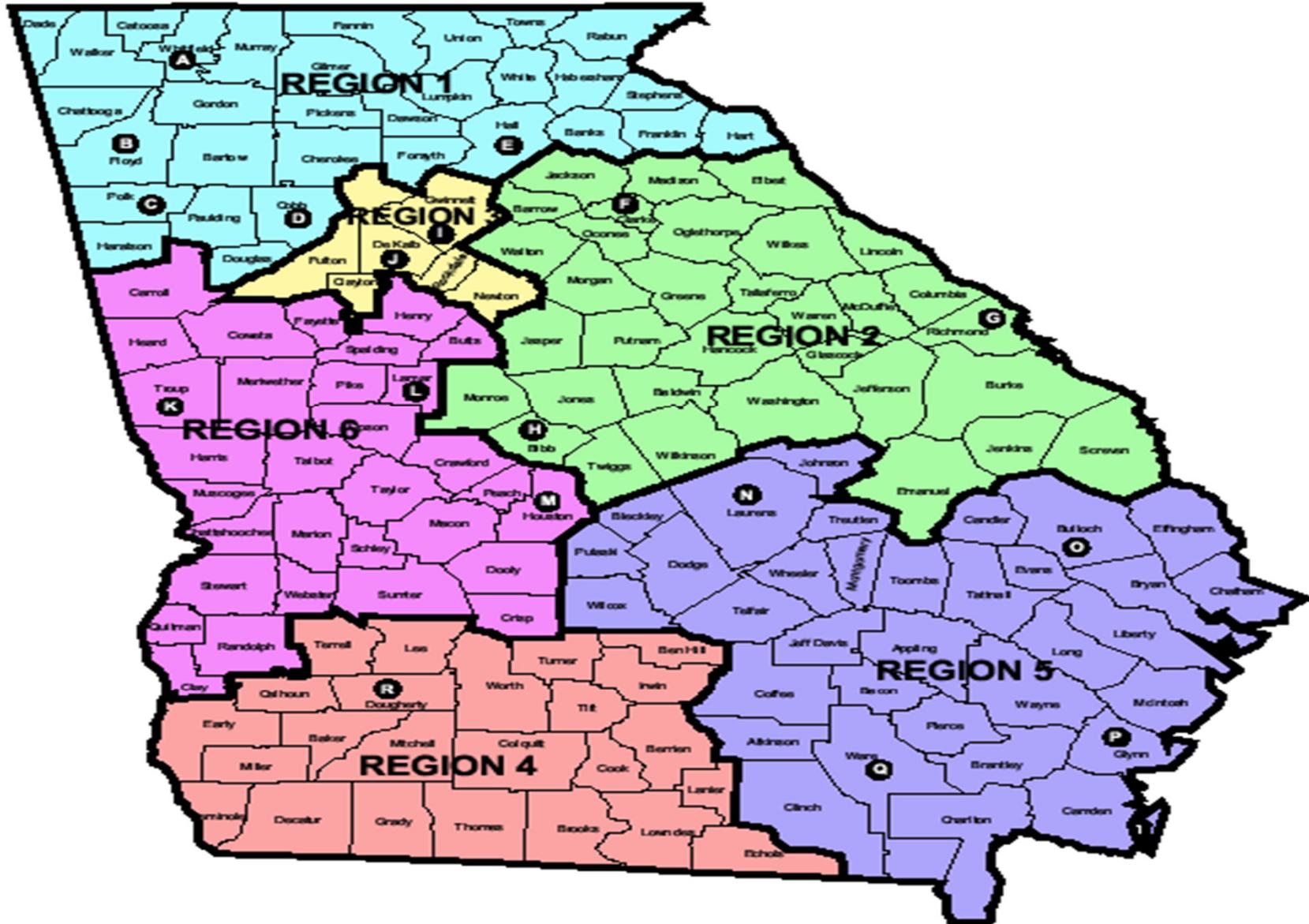
MH Transport Vans





for excellence

Adult Crisis Stabilization Units

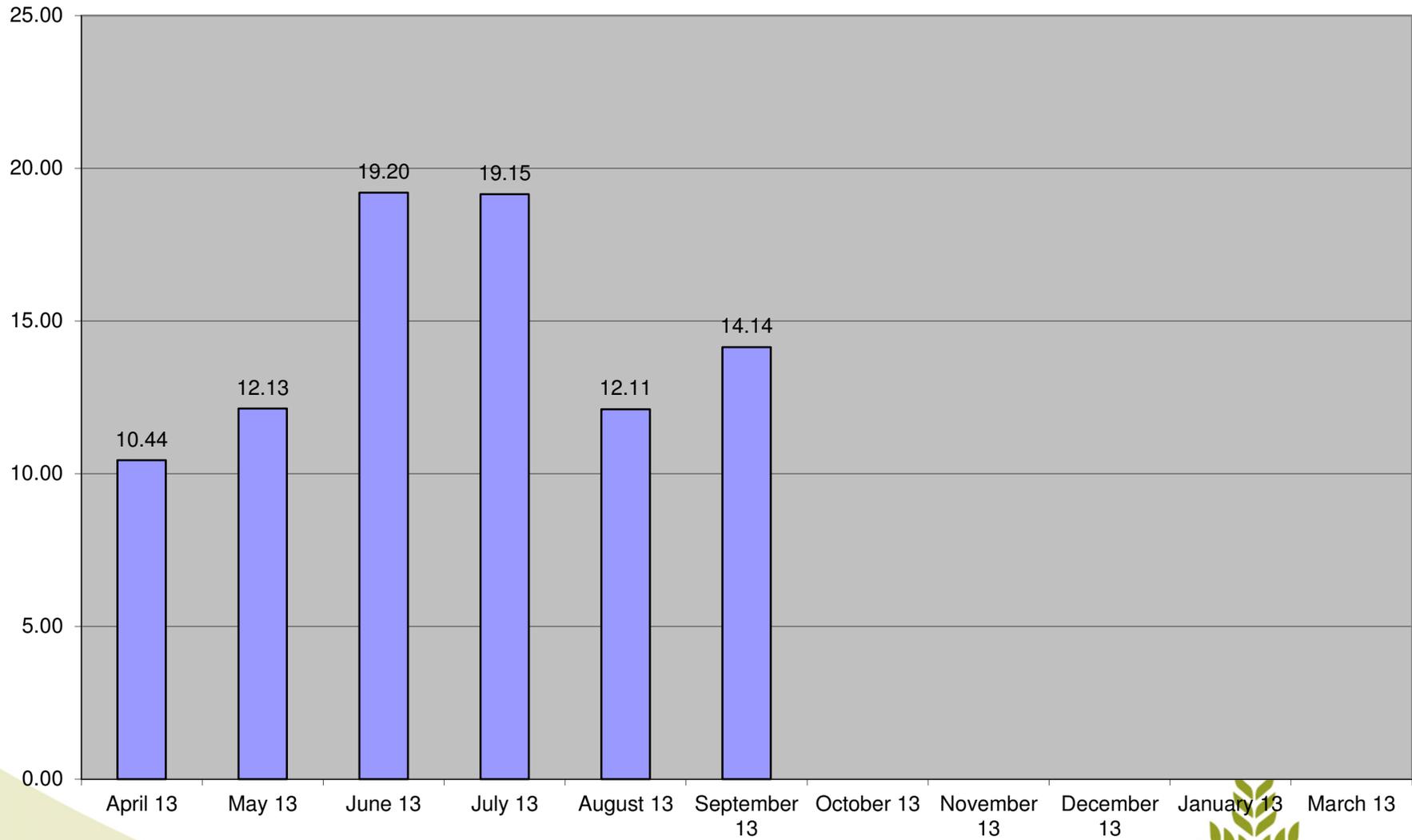


Where we are Now

- Conducted a Behavioral Health Process and Service Analysis
- Two, week long Performance Improvement Focus Groups were conducted (\$25,000 in staff costs)
- Relocation of Intake for single point of entry, and consistent psychiatric and medical clearance of all patients.
- Relocation of Emergency Psych Holding from Laurelwood to the ED “area F”, with renovation costs of \$300,000 to create 7 private psych holding rooms, 2 seclusion rooms, and a controlled environment



GCAL/BHL Wait Times (average) by Month



A Normal Day

- **MH pts in the ED @ 2100 on 10/22: (11 patients)**
- C20 - (4.5hrs) Pt #1 - faxed to U4 @2000
- C21- (8.5 hrs) Pt #2 - given o/p referral (mother refuses to pick up 17 yr old pt, defacs involved)
- C29 - (4.5) Pt #3 - Parf submitted @1929
- E41 - (6 hrs) Pt #4 - o/p referral - med admit (**referred for OP services**)
- E45- (7.5 hrs) Pt #5 - pursinging changing seasons
- F52 - (5.5 hrs) Pt #6 - parf submitted @ 1934
- F53 - (6 hrs) Pt #7 - parf submitted @ 1956
- F54 - (10 hrs) Pt #8 - faxed to Avita @ 1957
- F55 - (3 hrs) Pt #9 - GCAL when clear
- F56 - (5.5 hrs)) Pt #10 - parf subitted @2046 (region 3 substance abuse)
- F58 - (4 hrs) Pt #11 – LWD U3 when Medically clear



A Normal Day (continued)

- **MH pts in the ED @ 0100 on 10/23: (1 referred OP/5 placed/5 still awaiting placement)** (ALL Under 12 hrs)
- Pt #1 was admitted to LWD U4 @ 2150 **(5 hr stay)**
- Pt #11 was admitted to LWD U3 @ 2340 **(6.5 hr stay)**
- Pt #7 was transferred to Avita CSU @ 2340 **(8.5 hr stay)**
- Pt #5 was medically admitted to NGMC after declined by Changing Seasons @ Chestatee Hosp. @ 2300 **(9.5 hrs)**
- Pt #2 was discharged to DFACS custody @ 2400 **(11.5 hrs)**
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- **MH pts in the ED @ 0600 on 10/23: (5 still awaiting placement)**
- F51 Pt #3 13.5 hrs received an **APS#** @ 0500 pending N2N with LWD U2 **(15.5 hr stay)**
- F52 Pt #6 14.75 hrs pending **GA Regional Atlanta** **(23.5 hr stay)**
- F54 Pt #8 19 hrs **delaying transport to Avita CSU 0700 per their request** **(20.5 hr stay)**
- F55 Pt #9 11.5 hrs pending GCAL multiple issues with new PARF submission **(24 hr stay)**
- F56 Pt #10 14.5 hrs pending GCAL **Region 3** primary substance abuse **(46 hr stay)**



Considerations when placing patients

- Behavioral/Violence
- Age
- Gender and Gender Identity
- Sex offenders
- Handicapped/Special Needs (Vision, hearing)
- Medical Needs
- Infection Control Issues
- Rooms shut down due to damage
- Family



Safety and Security of Staff, Patients and Visitors

- “Rendering Safe” – Patients, Visitors and Staff
- Hostility ‘Flash Points’
- Code CHARLIE – Standard Response
- Repeat Offenders
- Law Enforcement Coordination Challenges
- Documentation is critical



Contraband entering the ED



FY 13 Statistics for Security

- 108,473 - identified and logged visitors in ED
- 30,432 - calls for Security Services
- 4,006 - requests for Patient assistance
- 2,092 - requests for combative MH Patients
- 48 - MH Patients were classified “Extremely Violent”



How it could work!!

STEMI



S-T Elevation Myocardial Infarction

2013 - 100% D2B in 90 minutes or <
D2EKG- Avg. 4 minutes

CVA –TIA



Cerebral Vascular Accidents

2013- 100% D2CT 8 minutes or <
D2tPA- 60 minutes of <

Trauma



2013- 100% D2ICU 3 hours or <

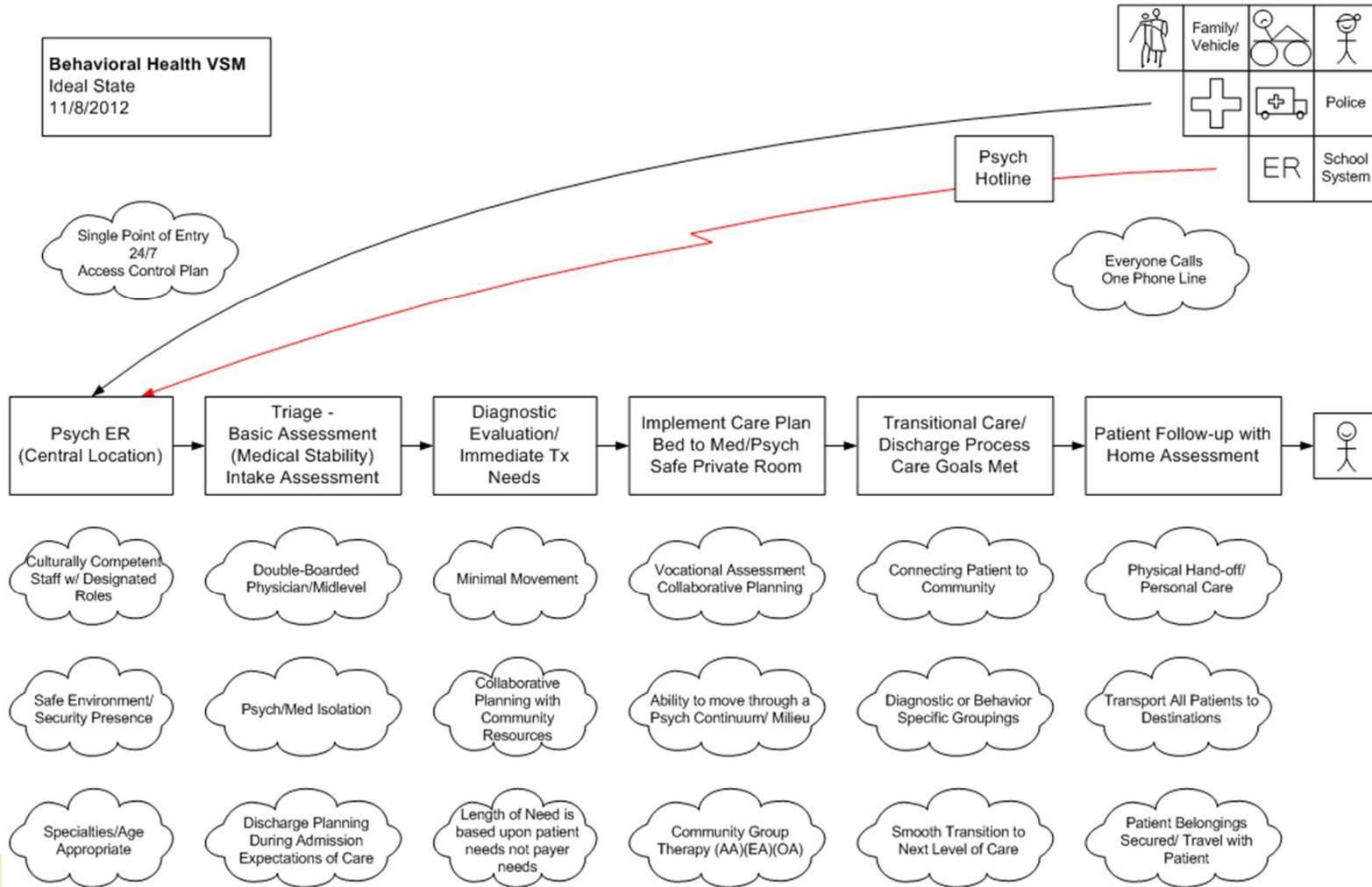
90% D2 off Backboard 20 minutes or <

A Change of Mindset



- A Behavioral Health Crisis IS an emergency!
 - * Danger to self and others....
- Illness requiring treatment
 - * Can't just "snap out of it..."
- Time sensitive like STEMI, CVA and Trauma
 - * Only population we measure success in HOURS, not minutes
- Crosses all boundaries
 - * Elderly, Children, Male, Female, all races.....
- Not all drug-seekers

Where we want to be



Where we need your help

- Sharing of MH information electronically
- Child Inpatient Services
- Emergent placement for Developmentally Disabled patients
- Services for the Violent Psychiatric Patient
- Timely placement of patients from all Regions, not just Region 1
- Service provision/placement of Addictive Disorders



Where we need your help

- Community based Psych Emergency Department (as is being explored in other areas of the state)
- Clear parameters on non personal care home, residential providers
- Improved wrap around services (ACT teams)

