MICHIGAN BEHAVIORAL HEALTH CAPACITY IN EMERGENCY DEPARTMENTS

Research Findings and Recommendations

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Executive Summary

Individuals experiencing a behavioral health crisis are presenting to emergency departments at an increasing rate and with progressively more complex, co-occurring conditions. Those in a crisis require adequate and timely access to care. But when emergency departments (EDs) are ill-equipped to handle these challenges, individuals are left waiting for days or sometimes weeks to receive appropriate treatment referrals.

The Michigan Department of Health and Human Services, commissioned TBD Solutions to survey EDs from across the state with funding from the Michigan Health Endowment Fund. By leveraging their knowledge and peer relationships with other national experts in the United States, TBD Solutions was able to offer an array of potential solutions to these complex problems.

Through surveys and interviews, the results depict a familiar story: Most emergency departments are ill-equipped to address the challenges of individuals in a mental health crisis, including the complexities of their co-occurring substance abuse, health conditions, and/or developmental disabilities. Limited community behavioral health capacity also increases the strain on the emergency department and exposes their deficiencies in providing comprehensive behavioral health treatment. Innovative practices are happening in pockets of the country, but improvements often require administrative buy-in and/or legislative mandate, neither of which is happening with any regularity.

Based on the analysis conducted, the following are offered as recommendations for consideration:

- Changes to state policy and regulations to increase access to telepsychiatry services within EDs
- Increase peer support services within EDs and allow peers to bill for services
- Establish statewide intake protocols to assess for suicidal ideations and substance use
- Increase access to and education about viable alternatives to psychiatric inpatient hospitalization, such as Crisis Residential Units, Crisis Stabilization Units, and Peer Respite programs
- Establish a metrics portfolio for assessing access to behavioral health services, clinical outcomes, cost savings, and patient satisfactions, and develop benchmarks for optimal performance
- Create an electronic bed registry for psychiatric hospital beds and other crisis services

Introduction

In 2017, the Michigan Department of Health and Human Services (MDHHS) convened the Michigan Inpatient Psychiatric Admissions Discussion (MIPAD), a group of stakeholders gathered to address barriers to accessing inpatient psychiatric services within Michigan. The efforts of the workgroup and its subcommittees resulted in the Final Workgroup Report[1], released in February 2018.

In 2018, as part of its efforts to address the recommendations from the MIPAD report, MDHHS commissioned TBD Solutions to complete a thorough analysis of the behavioral health service capacity within Hospital Emergency Departments (EDs) across the state of Michigan, supported by funding from the Michigan Health Endowment Fund. This report describes the methodology, findings, and recommendations resulting from this extensive analysis.

Emergency Departments and Behavioral Health Emergencies

There are approximately 175 hospitals in Michigan, 134 of which have an Emergency Department[2]. People in crisis situations are taught to call "9-1-1" or instructed to go to the nearest "emergency room". These systems and public messaging were appropriately created to properly guide people to receive emergency medical care, engaging a familiar and effective protocol for physical healthcare treatment. Unfortunately, ED protocols were not designed for the unique needs of people in psychiatric crisis. Subsequently, individuals with a behavioral health emergency such as suicidal ideations, severe depression, or psychosis, frequently seek assistance for those needs at the same location as they go to for emergent medical needs. However, most Emergency Departments are not properly equipped to address the growing and complex needs of these patients.

The MIPAD Workgroup Report found that substantial numbers of ED visits from people with a principal mental health diagnosis "created immense pressure on emergency departments and contributed to boarding of psychiatric patients[3]." The report also cites the lack of resources experiences by EDs to treat individuals in psychiatric crisis or even to keep them safe (Final Workgroup Report: Michigan Inpatient Psychiatric Admissions Discussion, p. 4, 2018).

Methodology

To conduct this analysis, TBD Solutions employed a comprehensive analysis of statewide practices, industry trends, emerging national best practices, and a review of research and literature related to behavioral health treatment in the Emergency Department.

TBD Solutions created a list of 134 hospitals in Michigan with Emergency Departments and invited these hospitals to complete a brief survey, communicating with them via postcard, email, phone, and the Michigan Health & Hospital Association email listserv to encourage completion of the survey. A select number of survey respondents engaged in a follow-up interview, either because of their progressive

[1] Available at https://www.michigan.gov/documents/mdhhs/MIPAD_WorkgroupReport_613570_7.pdf.
[2] See Appendix B for a list of hospitals with Emergency Departments in Michigan.
[3] Michigan Department of Health and Human Services. (2018). *Final workgroup report: Michigan Inpatient Psychiatric Admissions Discussion*. Retrieved from: https://www.michigan.gov/documents/mdhhs/MIPAD_WorkgroupReport_613570_7.pdf.

approach to behavioral health treatment or due to the ED's shared concerns articulated regarding unique aspects of crisis psychiatric care.

National subject matter experts and innovators were interviewed to detail the prevailing attitudes of community mental health care, environmental factors, impetus for change, and community relationships that contributed to sustained improvements.

Literature Review

For over 10 years, considerable attention has been given to the problems of keeping people with a mental health crisis waiting for inordinate amounts of time in the Emergency Department until the appropriate treatment referral becomes available, a process referred to as "ED boarding". According to a 2008 survey of the American Association of Emergency Physicians, approximately 80 percent of ED medical directors believed that their hospitals "boarded" psychiatric patients[4]. Their survey report also referenced the piqued interest, collaboration and data sharing from other concerned organizations such as the American Psychiatric Association, the National Alliance for the Mentally Ill, the Mental Health Association (previously the National Mental Health Association) and the American Medical Association.

Dr. Scott Zeller, past president of the American Association for Emergency Psychiatry, identified six major types of psychiatric emergencies: suicide attempt or ideation; agitation, violent, or disruptive behavior; psychosis leading to dangerous behavior or thoughts; mania; intoxication states; and anxiety[5]. He also identifies six treatment goals of emergency psychiatry:

- Exclude medical causes for symptoms
- Rapid stabilization of acute crisis
- Avoid coercion
- Treat in the least restrictive setting
- Form a therapeutic alliance
- Appropriate disposition and aftercare plan

Addressing these symptoms and achieving these goals can be exponentially difficult without adequately trained or specialized doctors and clinicians.

Likewise, the issue of ED boarding has remained a priority for both the American Association of Emergency Psychiatry and the American College of Emergency Physicians[6].

Some journal articles focus on effective treatment interventions[7], embracing the perspective that individuals with psychiatric symptoms will almost always present to the ED, while others highlight the

[4] American College of Emergency Physicians. (2008). *ACEP psychiatric and substance abuse survey 2008*. Retrieved from: http://newsroom.acep.org/download/ACEP+Psychiatric+and+Substance+Abuse+Survey+-+April+2008.pdf
[5] Zeller, S. L. (2010). Treatment of psychiatric patients in emergency settings. *Primary Psychiatry*, *17*(6), 35-41.
[6] Nazarian, D. (2017, July). *ACEP refines its clinical policy on psychiatric boarding*. Retrieved from https://www.acepnow.com/article/acep-refines-clinical-policy-psychiatric-boarding/
[7] Nazarian, D. J., Broder, J. S., Thiessen, M. E., Wilson, M. P., Zun, L. S., & Brown, M. D. (2017). Clinical policy: critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department. *Ann Emerg Med*, *69*(4), 480-98.

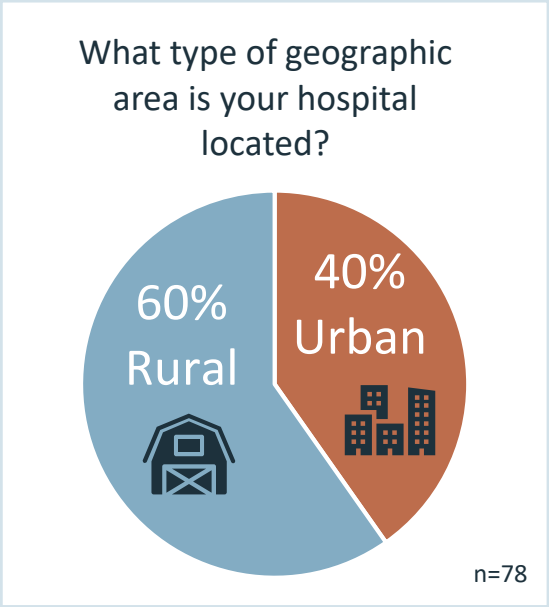
importance of community collaboration to divert individuals from the ED[8,9]. While most journal articles highlight the extent of the problem, the subject matter expert interviews provide much of the information around the solutions, as these solutions are not well-documented in controlled trials.

Results

Survey

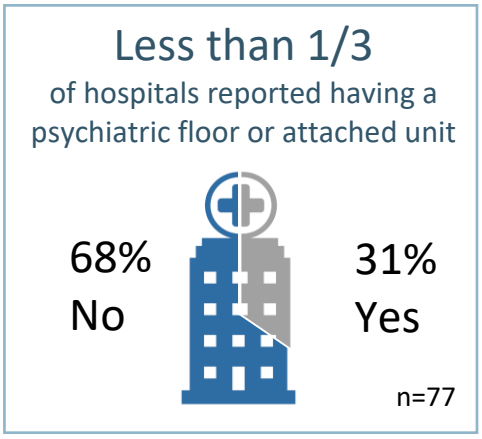
For this study, 80 of the 134 Michigan hospitals with emergency departments (ED) responded to the survey (60%) between August and October 2018[10]. Survey respondents were primarily ED supervisors, nurse managers or medical directors.

Sixty percent (60%) of respondents are located in a rural area and forty percent (40%) are located in an urban area (0% of Michigan EDs are located in what is formally defined as a "frontier area").



Access to Behavioral Health Staff

Over 51% of respondents have access to a behavioral health clinician, split evenly (25.7% for each) between clinicians that are directly employed by the hospital and those contracted from community mental health providers. The remaining 48.6% have no behavioral health clinicians in their EDs (n=74).



Only 14% of emergency departments surveyed have a psychiatrist on their team (n=78). Of those emergency departments, 73% reported having access to a psychiatrist 16- to 24-hours per day, while 18% reported having access 0 to 8 hours per day.

Less than 8% of EDs reported using telemedicine to provide psychiatric services. (n=78)

[8] Alakeson, V., Pande, N., & Ludwig, M. (2010). A plan to reduce emergency room 'boarding' of psychiatric patients. *Health Affairs*, *29*(9), 1637-1642.

[9] Zeller, S., Calma, N., & Stone, A. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *Western Journal of Emergency Medicine*, *15*(1), 1.

[10] While 80 hospitals responded to most questions in the survey, some did not respond to all questions. Each visualization contains an "*n*" value to show the actual number of respondents informing the measure. Some hospitals skipped questions which is why some values are less than 80. Five hospitals also had two representatives complete the survey. In instances where survey results were consistent, only one response was included and counted, and when responses were conflicting, both responses were not included in the analysis. Narrative responses were included in analysis provided they did not result in conflicting information.

Only 8% of EDs reported having peer support specialists as part of their team (n=78). "Peer support specialists" are people with lived experience with a mental illness who have achieved a level of stability in their recovery to be able to support others in their recovery journey. Similarly, "recovery coaches" are people with lived experience with a substance use disorder who provide support in the same capacity. Peer support specialists and recovery coaches are both paid positions.

Co-located Psychiatric Hospital

Twenty-five percent (25%) (n=77) of EDs reported having a connected psychiatric unit in their hospital, while six percent (6%) reported having a freestanding psychiatric hospital on their campus.

Psychiatry Access by Population

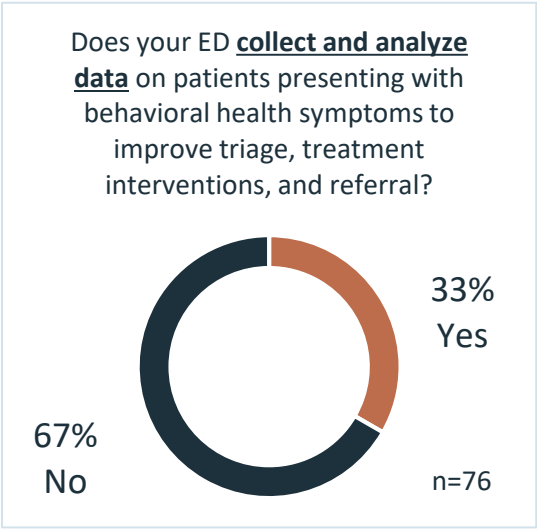
Of EDs that reported psychiatry services available to any population, psychiatric services for specific populations occurred at the following rates (n=39):

- Adults—100%
- Children—64%
- Geriatric—66%

Collecting and Analyzing Data

Only 1/3 of the EDs surveyed report collecting and analyzing data on patients presenting with behavioral health symptoms to improve triage, treatment interventions, and referral (n=76). Examples of data utilization include:

- Analysis of treatment denials at monthly meetings with community partners
- Advocating for additional staff such as emergency department technicians, clinicians, and psychiatrists
- Understanding throughput data to create process improvement plans for arrival-to-disposition times
- Ensure better safety practices and process for rapid transport to a higher level of care
- Determine adherence to medical criteria through review of ICD-10 data by behavioral health experts



Michigan ED Interviews

A handful of emergency department representatives were interviewed based on their responses to the survey. Summaries of the interviews from Ascension Health Hospital, Metro Health, Bronson Lakeview Hospital, and Spectrum Ludington Hospital provide useful insights.

Ascension Health Hospital (Madison Heights)

Ascension Health provides intake support 16 hours per day, five days per week, and 12 hours per day on weekends to serve people with mental illness and substance use disorders. They have also recently added telehealth capability for behavioral health evaluations. One supervisor reported their biggest challenges when treating patients with mental health symptoms are the volume, managing aggressive behavior, and the individual's length of stay in the ED.

The staff reported that placement and treatment of ED patients with psychiatric disorders has been an issue for at least 10 years, with increasing volume and mounting struggles to place individuals with intellectual and developmental disabilities. Telehealth was added because of the considerable volume of patients which is exceeding the capacity of the ED intake workers.

Metro Hospital (Grand Rapids)

To provide quality behavioral health access and referral, Metro Hospital embeds case managers and social workers into its ED. All staff are trained in non-violent crisis intervention through the Crisis Prevention Institute (CPI), and any staff who encounter patients with a mental illness receive disease-specific training.

The most pressing challenges facing Metro's ED include placement of patients requiring inpatient hospitalization and the inability of the outpatient treatment system to adequately provide follow-up and continued care post discharge. Staff seeking placement for these Western Michigan patients have often sought treatment options on the other side of the state, Indiana or Ohio. Many patients return to the ED after unsuccessful attempts to access outpatient care. Staff also see an extreme need for basic resources such as housing, finances, food, and transportation.

Metro Health utilizes a number of data sources to inform the assessment of timely and quality care for patients, including walk-in volume, emergency medical services (EMS) arrival time and methods of arrival, types of complaints, number of patients transferred out, frequency of extended ED visits (36+ or 48+ hours), patient experience, and average length of stay. Metro Hospital has identified a significant increase in volume, leading to increased burden placed on staff across the ED. They have effectively turned this data into enhanced social work and case manager coverage, treatment room modifications for safety, and increased collaborative efforts with local psychiatric providers. In addition, they have outfitted two observation rooms specifically for patients with behavioral health symptoms, and they have retrofitted other rooms to meet the level of need.

One supervisor identified an opportunity for improvement in relationships with the neighboring CMHs, acknowledging that some clinicians can take 8-12 hours from the time a patient arrives at the ED to assess and refer them for treatment. Because these delays affect patient care and overall performance metrics, the social work manager will reach out to the CMH to inform them of the delay and troubleshoot solutions for more expedited assessment processes.

Bronson Lakeview Hospital (Paw Paw)

Bronson Lakeview identified several efforts to assess, treat, and refer people with mental illness and substance use disorders. Bronson maintains an active partnership with Van Buren Community Mental Health. Bronson participates in a multi-disciplinary ED behavioral health advisory group to look at how the area EDs manage individuals in a mental health crisis in order to evaluate resource utilization and identify opportunities to share resources. Bronson Lakeview is currently evaluating assessment tools for use during the intake process, although all patients in the ED are universally screened for suicidal thoughts. Each quarter, a multidisciplinary group meets to review any patient presenting with mental health symptoms with an ED length of stay greater than 24 hours.

All patients presenting to Bronson Lakeview are screened for alcohol and substance abuse. The Severity of Ethanol Withdrawal Scale (SEWS) tool is administered for patients at risk for alcohol withdrawal. Patients with substance abuse issues are referred to community resources, although they are limited in their community.

A representative from Bronson Lakeview identified efficient adolescent patient referrals and placement as a primary issue. When a person identifies as being suicidal, they are immediately placed on one-to-one observation, resulting in a strain on staffing levels in the rest of the ED. With limited hospital resources locally and no Crisis Residential alternatives (Van Buren CMH's Crisis Residential Unit closed in 2016), patients will sometimes be sent as far as Detroit, or across state lines to psychiatric hospitals in Indiana.

Bronson Lakeview has been able to utilize data on ED patients with behavioral health concerns to advocate for increased staffing, which resulted in the addition of a second ED technician during peak volume times. They are also analyzing length-of-stay data and examining ways to decrease throughput time in the ED. Bronson Lakeview has also developed a standard work document for managing violent or potentially violent patients, some of whom are mentally ill.

Spectrum Ludington Hospital (Ludington)

Spectrum Ludington recognizes the relationship between length of stay in the ED, safety risk and issues with patient management. They track the following data:

- Length of stay from time of arrival to discharge
- Length of stay to acceptance at a facility
- Length of stay between CMH assessment and acceptance at a facility
- Length of time in restraints
- Number of restraint events

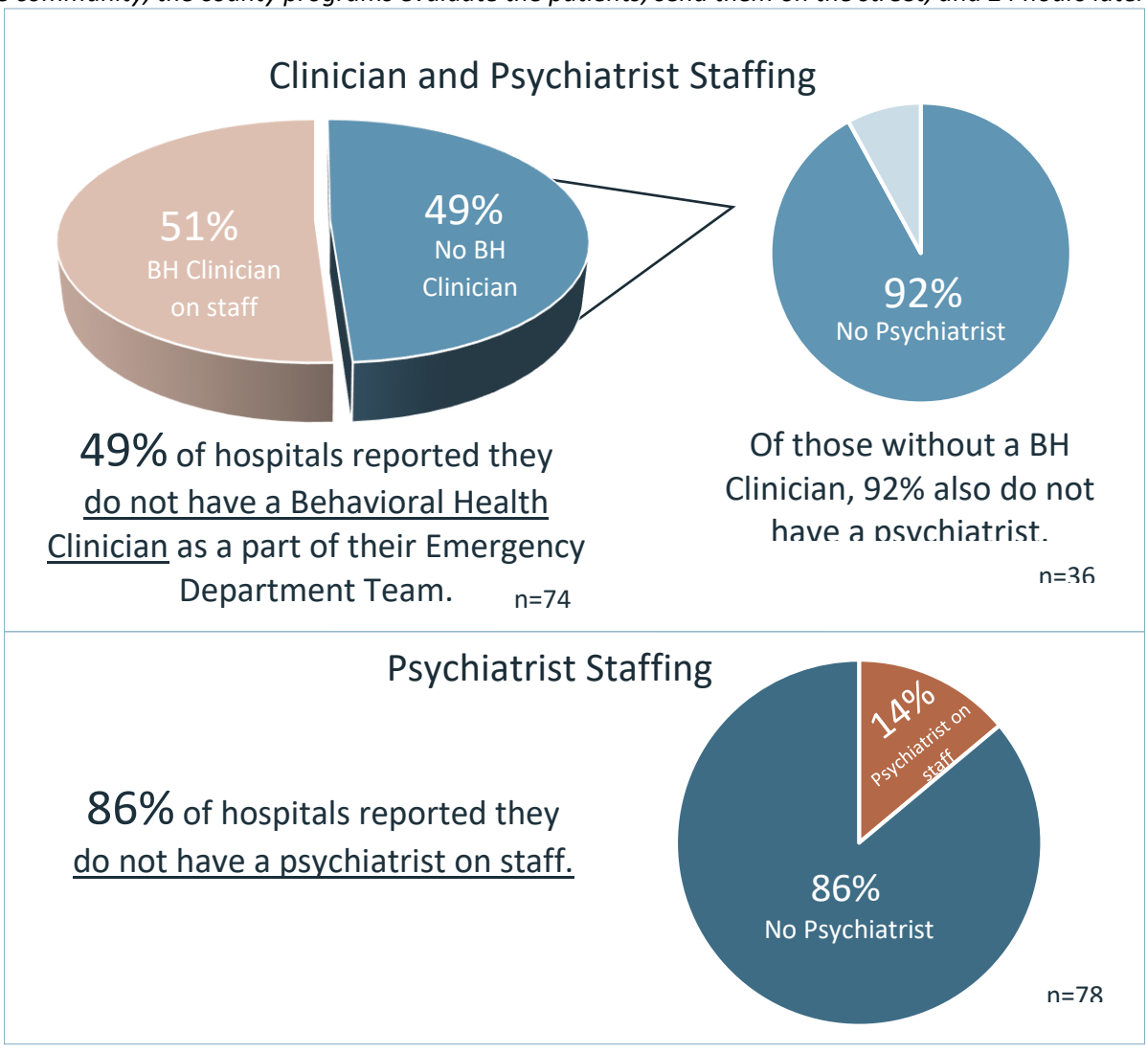
These data reports are reviewed by the supervisor who will bring them to other departments to seek answers to perplexing questions affecting throughput and quality of care. Spectrum Ludington's data capturing methods have been identified as a best practice by Det Norske Veritas (DNV) Healthcare, Inc., an accreditation body for hospitals.

Other Notable Quotes

The following comments made in response to the survey are also worth noting:

"I think we are on the right track to develop a standardized approach to these patients, as well as looking at it from a system perspective. I am hopeful this may lead to resource sharing, especially during "off shifts" when our small critical access hospital has limited staffing. I am also hopeful that this approach will lead to increased education for staff and increase the comfort level of staff caring for these patients."

"I don't think anything is working—the entire state of Michigan's mental health system is broken. We're not providing good care in the ED—we're just housing them and giving them meals. I think that out in the community, the county programs evaluate the patients, send them on the street, and 24 hours later



they're back in the ED again. There's nowhere to go and get what they need. With a 3- to 6-month wait, there's not enough psychiatrists to see these patients."

"This is an extremely complex and difficult population to treat. There is an extreme lack of inpatient capacity for these patients. Placement of these patients takes an extended amount of time and resources. Placement is often found long distances away and outside of the individuals' community. A

lack of standardization for care protocols and medical clearance leads to a significant amount of waste in the system and duplication of testing."

National Expert Interviews

Several national subject matter experts were interviewed about their experiences in creating effective systems to treat individuals in a psychiatric emergency presenting to the emergency department.

Dr. Scott Zeller, MD

Dr. Scott Zeller is the Vice President of Acute Psychiatry at Vituity, a partnership of physicians and industry professionals striving to assist communities in developing better models of psychiatric care.

Dr. Zeller posits that communities believe once a person gets to the ED their job is done, as people are instructed to go there for any type of emergency. The prevailing thought among treatment professionals is that if someone arrives at the ED, they need to be hospitalized. Dr. Zeller states that it is insulting and stigmatizing to tell people presenting at the ED that they went to the wrong place, yet many EDs are not equipped to handle the behavioral health problems that are funneled through their doors[11].

Through his national consultation of crisis systems, Dr. Zeller reports seeing a variety of approaches, including increasing mental health staff within the ED or forming external collaboration with behavioral health providers and specialists. Fewer communities want to create a separate unit or section of the ED for patients with behavioral health concerns. He suggests that the typical evolution of ED behavioral health capacity might be 1) retraining ED staff; 2) adding telepsychiatry services; and 3) developing additional units or centralized units for behavioral health assessment.

Dr. Zeller advocates for treatment interventions that do not rely heavily on sedation, stating that treatment professionals can be more helpful if patients are coherent to complete an assessment and resolve the reasons that they came in.

Dr. Zeller observes that ED physicians greatly value turnaround time, or throughput time. Patients with a mental health concern typically have a length of stay three times as long as someone with a medical concern, so the average psychiatric patient could have had 2.2 patients in their bed in the same amount of time. Using restraints also causes a person to stay in the ED longer. He refers to this informed approach as "convincing people, with numbers, that compassion works."

Dr. Zeller believes it is ambitious to expect people in a behavioral health emergency to stop presenting at EDs altogether and go to a psychiatric ED or other alternative, so educating and equipping ED staff to treat behavioral health emergencies is essential regardless of the presence of other psychiatric treatment programs.

Dr. Leslie Zun, MD

Dr. Leslie Zun is the president of the American Association of Emergency Psychiatry (AAEP), an organization dedicated to promoting "timely, compassionate, and effective mental health services for

[11] S. Zeller, personal communication, June 28, 2018.

persons with mental illness…in all crisis and emergency care settings[12].” He is a professor and chair in the Department of Emergency Medicine at Chicago Medical School.

Dr. Zun stated there are not a lot of good examples of well-built, hospital-based emergency services to meet the needs of individuals in a crisis. He referenced Dr. Zeller’s Alameda Model[13] as a promising practice, as well as the collaboration in Bexar County in San Antonio, TX, that is providing a cohesive network of services. He mentioned that most communities struggle to align resources. And while all community stakeholders might recognize the seriousness of the issue, it is challenging to get all parties to agree on a direction and commit to changes[14].

Dr. Jennifer Peltzer-Jones, PhD

Jennifer Peltzer-Jones is a Senior Staff Psychologist in the Level 1 Trauma Center Emergency Department at Henry Ford Health System in Detroit, MI. Dr. Peltzer-Jones, as a member of the ED team, attributes the success of their emergency department to her ability to analyze data, and create safe and efficient processes to effectively treat individuals presenting to the ED with a psychiatric emergency. This ED has a dedicated area for patients being treated for mental health symptoms. The hospital has established policies and procedures for how to handle individuals in a mental health crisis. They maintain a six-to-one patient-to-staff ratio (nurses and nurse techs). They also have installed security cameras and voice activated alarms that signal for elopement without restricting movement.

Dr. Peltzer-Jones reports that their ED admits less than 50% of presenting behavioral health patients to a psychiatric hospital, instead sending many people to lower levels of care such as outpatient clinics or crisis residential facilities. She indicates that many of the psychiatric hospitals do not have the resources to care for the sickest patients.

[12] AAEP. (2018). *About AAEP.* Retrieved from https://www.emergencypsychiatry.org/about-aaep
[13] The Alameda Model is a regional solution to the issue of mental health patients boarding in emergency departments. The Western Journal of Emergency Medicine outlines the Alameda Model in their February 2014 journal article, “The Alameda Model: An Effort Worth Emulating,” at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3935789/.
[14] L. Zun, personal communication, June 22, 2018.

Upon analyzing their data on individuals who present to the ED with a psychiatric crisis, she describes the most common features of people who stay longer than 24 hours are:

- Aggression
- Individuals with an intellectual and/or developmental disability
- Individuals that have Medicare with no lifetime psychiatric benefit
- Individuals with medical problems

Dr. Peltzer-Jones stated that a lack of a universal voluntary admission form causes all people who are hospitalized to be admitted on involuntary status. There is also variance in procedure from one county to the next and within each of their court systems. She also referenced a health insurance plan that will keep individuals in the ED all weekend or overnight until payment can be secured. Patients that need a private room or increased staffing resources put a strain on the rest of the system, preventing more people from accessing high-quality behavioral health care. She relates that Henry Ford ED is also willing to begin medications while a patient is waiting for a placement bed[15].

Steve Miccio

Steve Miccio is the Chief Executive Officer for PEOPLe, Inc., a peer support and peer respite provider in upstate New York. The Rose House model was one of the first peer respite homes in the United States and its model has been adapted by other providers across the United States and parts of Europe.

Around the year 2000, PEOPLe, Inc. reached out to the local hospital to advocate for the use of peer supports in the Emergency Department. Hospital administration was initially resistant but slowly began to see their value, as violence in the ED decreased and they noticed patients giving better self-reports of their presenting issues. The peer supports also provided follow-up support once the person left the ED, much to the delight of the hospital who did not have the capacity to perform this follow-up function.

Assuaging the skeptical hospital leadership required numerous meetings around role clarifications and job descriptions. Hospital staff were concerned that the peers were merely “planted there” to observe and report what the ER staff were doing wrong. As trust developed, both sides functioned more like a cohesive team.

Initiated in part due to a hospital tragedy, Steve Miccio started another peer support initiative around 2010 at King County Hospital in Brooklyn, NY. In both instances, Mr. Miccio impressed the importance of training hospital staff and the function and utility of peer support specialists, as well as trauma-informed care.

Mr. Miccio sees peer supports in Emergency Departments as one of the most helpful, complimentary services that a hospital could offer. Having people with lived experience talking with others, finding out they’re not alone, and talking through their trauma helps patients to be more credible reporters in the ED.

[15] J. Peltzer-Jones, personal communication, July 11, 2018.

Mr. Miccio stated that identifying performance indicators for the efficacy of peers is limited and challenging, as there are many uncontrolled variables that contribute to outcomes[16].

Sharon Raggio, MBA, MS

Sharon Raggio is the CEO at Mind Springs Health & West Springs Hospital in Grand Junction, CO. In 2015, Mind Springs Health worked to bring peer support specialists into the local emergency departments. The community mental health center provided training to staff on the function and utility of peers. The hospitals participated in interviews for these positions, and the newly hired peer support specialists were trained in hospital policies in addition to their community mental health training.

The results of embedding peer support specialists into the emergency departments included:

- Reducing the cost of sitters at the hospital (which the hospital greatly appreciated)
- Acting as a translator and advocate to increase fluency between the individual presenting at the ED and the clinical team
- Increased referrals to appropriate services and appointment scheduling

Mind Springs Health has also noticed a reduction in length of stay in the ED, but they identify the greatest value in the impact on culture and morale inside the hospital, and the improved throughput.

To Ms. Raggio, the value of peer supports in the EDs is obvious. “The doctors couldn’t live without the peers. They look at the peers as really being a part of their team. They have connections to other mental health services, and they give hope to the patients, and translate their needs.”

Ms. Raggio advocates that peer supports be employed by the community mental health center instead of the hospital because it creates a connection to a whole variety of other services that people can more easily be connected with and improves appropriate follow-up.

Because of the number of small critical access hospitals in their county area, Mind Springs Health hopes to bring peer supports into telehealth to support people accessing the ED[17].

Deb Dettor, MS

Deb Dettor is the Director of Anchor Recovery, a peer recovery support organization in Warwick, RI. In June 2014, the state of Rhode Island funded a pilot to bring recovery coaches from Anchor Recovery into the EDs to meet with people and use the crisis they were experiencing to get them into the next level of care.

The success of the pilot caused the Anchor ED peer supports to become a state-funded program, with 24/7 coverage in the local EDs. The ED team is made up of approximately 25 recovery coaches who also spend time in prisons and with ex-convicts doing re-entry work. All recovery coaches (called *peer recovery specialists* in RI) must have a minimum of two years of sobriety and begin working towards state certification once they are hired.

[16] S. Miccio, personal communication, September 21, 2018.
[17] S. Raggio, personal communication, September 21, 2018.

Ms. Dettor identified staff turnover as a barrier to success in the ED, which is combated through intentional relationships, reiterating the training and experiences that recovery coaches possess, and consistency in work quality and approach from recovery coaches[18].

Ms. Dettor offered the following key points to successfully implementing recovery coaches in the ED:

> *"[Starting a new program] requires a lot of legwork, meetings, conversations, and to be the face and voice of recovery. There have to be people in the lead that can talk about being in recovery themselves, what it is we bring, and how we add value. Studies show that is already starting to happen."*

When doctors and clinicians see people in recovery on the other side of addiction, Ms. Dettor says, you start to see the opinions and preconceived notions of people with addictions begin to change.

Ms. Dettor referenced Rhode Island's governor's task force on opiates that started in 2015 emphasized the utility of recovery coaches in providing quality treatment for opioid addiction.

Shannon Jaccard, MBA

Shannon Jaccard is the CEO and co-founder of Ballast Health, a peer and family coaching organization based in California. She is also the past CEO of NAMI San Diego.

During her time at NAMI San Diego, Ms. Jaccard helped to develop a program called "Friends in the Lobby" to support families of individuals admitted to a psychiatric hospital[19]. Trained peer support specialists and family members of people with mental illness would make themselves available in the lobby during visiting hours to provide support and answer questions. They provided support to over 500 family members in the first two months, and it has since spread to other psychiatric hospitals via local NAMI offices.

The success of these programs led to the development of the "Peer Link" program in partnership with local emergency departments, where peer support specialists were offered to patients with a mental illness presenting to the ED. This program is precipitated on the need for people in a mental health crisis to receive immediate empathy and referral to available resources. The local county hospital expressed initial skepticism, but the helpfulness of a peer support presence has increased opportunities to provide therapeutic support, and they have seen the results through reduced ED stays, reduced law enforcement interactions, and increased use of other services in the crisis continuum.

Peer supports in these programs have maintained effectiveness by developing relationships with hospital staff and engaging in daily check-ins with nurses and clinicians. The extensive peer support training and consistent communication and educated allayed the fears of the hospital staff that peer supports might turn into psychiatric patients themselves under such conditions or be inclined to say something counterproductive to a person's treatment[20].

[18] D. Dotter, personal communication, October 15, 2018.
[19] For more information, visit https://namisandiego.org/services/friends-in-the-lobby/.
[20] S. Jaccard, personal communication, September 26, 2018.

Mindy Harrison

Mindy Harrison is the Peer Support Specialist Network Director at Amistad, Inc., a peer support and recovery organization in Portland, Maine. Amistad began embedding peer support specialists in the local EDs in 2002[21] through a contract with Maine Medical Center, but they now contract for ED peer services primarily with Mercy Hospital.

Amistad, Inc. enjoys a congenial relationship with their hospital partners, and Mindy attributes this to maintaining a consistent and collaborative presence in monthly department meetings within the hospital. These relationships precipitate from a supportive and bought-in leadership team at the hospital.

Ms. Harrison stated that with the turnover inherent in large hospital systems, relationships must continually be fostered and maintained. Like many other hospitals that have infused peer support specialists into their treatment teams, many staff were skeptical of the peer supports' abilities and their motives, and some staff would prevent the peer supports from working with patients[22].

When asked what advice she would give to communities starting an ED peer support initiative, Ms. Harrison identified communication as the fulcrum for success. Taking the time to educate individuals about what the model is, and reinforcing a person-centered, non-stigmatizing approach to behavioral health treatment makes for a health working relationship between peer supports and ED staff.

Peer Supports and Recovery Coaches in Emergency Departments

Many of the interviews in the previous section underscore the impact that people with lived experience with addiction or mental illness can have on individuals seeking treatment in the ED.

Delaware

Christiana Care Health System (CCHS) initiated Project Engage in 2008 as an initiative to help hospital patients struggling with drug or alcohol use[23]. CCHS integrates peer support specialists, referred to as Engagement Specialists, into the clinical team. Engagement Specialists have maintained a presence in two EDs in Delaware since 2013.

Georgia

A partnership between the Northeast Georgia Medical Center (NGMC), Georgia's Department of Behavioral Health and Developmental Disabilities, and the Georgia Council on Substance abuse has brought peer support specialists to individuals who have experienced an opioid overdose or any substance use disorder-related incident in NGMC's three emergency departments[24]. Peer supports are referred to as Certified Addiction Recovery Empowerment Specialists (CARES), and they provide both on-site and post-discharge support to assist in recovery and maintaining wellness.

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[21] For more on Amistad's partnership with Mercy Hospital ED, visit https://amistadinc.com/mercy-hospital/.
[22] M. Harrison, personal communication, September 19, 2018.
[23] Christiana Care Health System. *Project Engage*. Retrieved from: https://christianacare.org/services/behavioralhealth/project-engage/
[24] Georgia Council on Substance Abuse. *Northeast Georgia Community Connections.* Retrieved from: https://www.gasubstanceabuse.org/cares-in-emergency-departments

A specialized group of CARES staff are trained to support parents in the Neonatal Intensive Care Unit who struggle with addiction. The recovery coaches answer question and assist with identifying treatment options, and they also maintain contact after discharge to provide any needed support in the person's recovery.

Maryland

In October 2018, the Queen Anne's County Department of Health launched the Peer On Call program to provide peer support to people who have overdosed and are presenting at the Emergency Department[25]. These peer supports are on-call 24/7 at the request of the local hospitals.

Massachusetts

In 2016, Massachusetts State Senator Eric Lesser announced a pilot project between the state of Massachusetts, The Center for Human Development, Behavioral Health Network, and Baystate Hospital to embed recovery coaches in the Baystate Emergency Departments[26]. The state earmarked $120,000 to fund two full-time recovery coaches to provide support to individuals presenting to the Emergency Department with a substances use disorder.

New Jersey

In October 2018, Horizon Blue Cross Blue Shield of New Jersey, the largest commercial insurance provider in the state, announced it would make trained peer counselors available to its members who are receiving treatment for a substance use disorder[27]. These services are being made available 24/7 via telehealth platforms. Horizon BCBS cited the considerable effectiveness of peer support programs in justifying the offering of these services.

North Carolina

In May 2018, six hospitals in North Carolina received a combined $1.37 million in grant funding through the North Carolina Department of Health and Human Services to embed certified peer support specialists into their emergency departments to serve patients presenting with problems related to opioid addiction[28]. At least two peer supports are being hired in each hospital, with training and technical assistance provided by the North Carolina Healthcare Association.

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[25] (2018, September). "'Peer On Call' overdose response program launching October 1st". *Queen Anne's County News*. Retrieved from: https://www.myeasternshoremd.com/qa/extras/purple/peer-on-call-overdose-response-program-launching-oct/article_3604a5f0-b982-5333-af8d-01b37608bce4.html

[26] Tuthill, P. (2016, September). State Funds To Pay For Addiction Recovery Coaches in ER. *WAMC Northeast Public Radio*. Retrieved from: https://www.wamc.org/post/state-funds-pay-addiction-recovery-coaches-er

[27] Washburn, L. (2018, October). NJ's largest insurer to offer free peer counselors for recovering addicts. *North New Jersey Record.* Retrieved from: https://www.northjersey.com/story/news/health/2018/10/18/nj-largest-insurer-offer-peer-counselors-recovering-addicts/1670585002/

[28] North Carolina Healthcare Association. (2018, May). *North Carolina Emergency Department Peer Support Pilot Project.* Retrieved from: https://www.ncha.org/north-carolina-emergency-department-peer-support-pilot-project/#1520025441845-4a899410-2ef1

Pennsylvania

The University of Pittsburgh Medical Center (UMPC) began a grant project in 2015 to hire peer specialists in their emergency departments to serve people struggling with addiction[29]. UMPC now boasts a Peer Navigation Department to serve people battling substance use disorders, as part of their Opioid Use Center of Excellence.

Vermont

Three Emergency Departments in Vermont currently have Peer Recovery Support Services available[30]. Their personal experience with addiction and their familiarity with the behavioral health system make them valuable assets for patients and staff.

Wisconsin

In August 2017, the Wisconsin Recovery Community Organization (WIRCO) received a grant from the University of Wisconsin to provide peer support to individuals in Emergency Departments, primarily as a response to the Opioid Crisis[31]. Since then, WIRCO has embedded peer supports into three EDs with 24/7 support.

Treatment Innovation in Michigan

Innovative practices in accessible and quality emergency psychiatric treatment are happening in Michigan, resembling the efforts of other progressive communities as described in the subject matter experts' interviews.

Psychiatric Emergency Services - University of Michigan, Ann Arbor

The University of Michigan has maintained a Psychiatric Emergency Services (PES) for several years. The University of Michigan Medicine website states, "PES provides emergency/urgent walk-in evaluation and crisis phone services available 24 hours a day, 7 days a week, for people of all ages[32]." Like the 23-hour Crisis Stabilization Unit model, individuals have access to a variety of brief intensive psychiatric services, including:

- Psychiatric evaluation
- Crisis intervention
- Screening for inpatient psychiatric hospitalization
- Screening for other mental health and substance abuse treatment services

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[29] Reid, L. (2016, August). Counselors Say Addiction Recovery Isn't About Putting the Drugs Down. *WESA: Pittsburgh's News Station.* Retrieved from: https://www.wamc.org/post/state-funds-pay-addiction-recovery-coaches-er

[30] Vermont Recovery Network. *Emergency Room Recovery Support.* Retrieved from: https://www.vtrecoverynetwork.org/peer-recovery-support-services/peer-recovery-support-services-emergency-room-recovery-support/

[31] Affo, M. (2018, February). Aurora Health Care hopes to cub opioid epidemic with coaching in Sheboygan, Two Rivers. *Sheboygan Press*. Retrieved from: https://www.sheboyganpress.com/story/news/2018/02/12/aurora-health-care-hopes-curb-opioid-epidemic-coaching-sheboygan-two-rivers/329588002/

[32] (2018). *Psychiatric Emergency Service.* Retrieved from https://medicine.umich.edu/dept/psychiatry/patient-care/psychiatric-emergency-service.

PES serves approximately 6,500 to 7,000 patients per year, or about 18 to 20 per day. Dr. Victor Hong, MD, is the Director of PES, and he stated that nearly 40% of patients are children, compared to about 10% in 2008. About 35% of the people who present to PES are admitted to the psychiatric hospital, and about 2/3 are transferred out, not because of medical complexity but because of capacity.

The increase in children's referrals has caused consistent overcrowding at PES. The waiting room has about 23 chairs, and on busy days there can be 23 *patients* in the waiting room, not including their family members. This leads to frustration and agitation from patients and staff, as they are standing or sitting on the floor. The average length of stay in PES for children is 13 hours, over twice as long it is for adults.

Because there is not court reciprocity between Washtenaw, Wayne and Oakland Counties, PES is not able to admit anyone from those counties with public insurance or an involuntary commitment.

Dr. Hong reported that PES will make referrals to Crisis Residential Units, but their capacity is limited. Synod Residential is the only CRU provider in Washtenaw County, with 6 beds for adults in a county of 345,000 people. He acknowledges a point of frustration in CRU admission criteria, as it is virtually identical to psychiatric inpatient hospitalization but serves as a distinct level of care[33].

While it took a long time to get the technological infrastructure in place to collect and analyze PES data, Dr. Hong reported that they are now able to measure a number of performance indicators. This data is used to determine patient acuity that informs staffing patterns, identify appropriate interventions for patients staying longer than 24 hours, and shortening length of stay by making visits more expedient and efficient.

Dr. Hong stated that PES maintains a healthy workplace culture with limited staff burnout. The local Emergency Departments show a great appreciation for PES and sees them as an important part of the crisis services continuum, but the current structure is not financially solvent. PES loses $1 million-to-$2 million per year, and resources are scarce. When Mott's Children's Hospital was rebuilt about 8 years ago, the only department that was not included in the new building was psychiatry. Children in a psychiatric crisis are subsequently still referred to PES for screening, assessment, and referral.

Dr. Hong advocates for more service options between inpatient psychiatric care and outpatient therapy, such as behavioral health urgent care or crisis clinics. The only psychiatric urgent care clinic is booked out for over a month. He also sees a lack of consistent quality care in the neighboring counties' psychiatric hospitals and Partial Hospitalization Programs, causing people to present back at PES after discharge.

Urgent Behavioral Health Center- Macomb County CMH, Clinton Township

Macomb County CMH developed its Urgent Behavioral Health Center (UBHC) (referred to as "Open Access" as of 10/1/18) to provide an open access model for people experiencing a behavioral health crisis, so that people could receive services as soon as they call or arrive. They have made some modifications to their model such as reducing their hours to 5 days per week and incorporating same-day discharge appointments at local outpatient clinics.

[33] V. Hong, personal communication, July 26, 2018.

The UBHC has collaborated with Henry Ford Hospital System to transfer discharging patients to UBHC on the same day, resulting in a decrease in recidivism, partly because more people have access to continuous medication.

Approximately half of people referred to UBHC don't show up to their intake appointments, whether they came through a post-hospital discharge referral or as a new client to services.

UBHC tracks hospitalization rates at 1-month, 3-months, and 6-months post-discharge. One of the peer support staff completes these measures by comparing against a Certificate of Need database or whether an individual was hospitalized.

Macomb County CMH plans to add three more open access clinics to ensure a location in each quadrant of the county.

Community Mental Health Partnerships

Many emergency departments maintain healthy and collaborative relationships with their local community mental health agencies. Much work has been done to establish, foster, and improve these relationships through consistent communication and alignment towards shared client goals. Representatives from Community Mental Health staff were interviewed to understand their relationship to local emergency departments.

CMH for Central Michigan

Population: 252,000

CMH for Central Michigan (CMHCM) covers a six-county region in northern-central region of Michigan's lower peninsula. CMHCM does not have any crisis workers staffed in the emergency departments but they do respond to requests for screening from the EDs. With seven EDs in their area, they do not have the capacity to provide clinicians at each of these locations while maintaining centralized teams responsible for answering crisis calls and other duties. In four of these EDs, CMHCM clinicians have a dedicated space outside of the ED to see individuals and work to avoid unnecessary ED admissions.

Beyond the EDs, CMHCM will send a clinician wherever they are requested, including to schools, universities, and other counseling centers. Some CMHs have an arrangement with the EDS to see patients with commercial insurance and are reimbursed by the ED at a per-case rate.

CMHCM has worked with hospitals and law enforcement to reduce the length of time that officers are waiting with individuals transported to the ED for assessment. By CMHCM taking on the responsibility of the individual's disposition, officers are able to return to their responsibilities of their shifts.

One of the biggest issues in the ED comes when a CMHCM clinician cannot find an available referral source for a person. If the problem goes on for hours or days, ED staff

might assume CMHCM is not doing enough to find a placement, so it requires intentional and consistent communication to let the EDs know exactly what activities have been undertaken to appropriately place this person in accordance with their medical necessity.

CMHCM maintains regular meetings with their local EDs, and the EDs are invited to community meetings facilitated by CMHCM. Crisis supervisors make themselves available to EDs to call at any time. Clinicians are proactive in their communication with the ED treatment team if the clinician determines a person is not meeting criteria to be hospitalized.

Network180

(the d/b/a of Kent County Community Mental Health Authority)

Population: 649,000

Network180 provides crisis assessments to individuals with Medicaid who are not otherwise open for services with one of their contracted behavioral health providers. Clinician presence in the ED is on an as-needed basis, as hospitals call the Network180 Access Center to request a screening at the hospital. Individuals who are open for behavioral health case management services receive a screening from the contracted provider. Network180 does not provide any screening and assessment services for the hospitals for individuals with commercial insurance.

Network180 has noticed an increase in the volume of patients presenting to the ED with a behavioral health crisis, as well as the frequency of substance abuse, and history of trauma. They also see more super-utilizers (people who access services frequently) presenting to the ED.

Recently MDHHS stated it would pay for mental health screenings via telehealth, and Network180 is developing a pilot project with Mercy Hospital to utilize this technology. Network180 facilitates a monthly meeting with Mercy Hospital to discuss issues related to timeliness and access of behavioral health services and screenings.

Soon Network180 will begin “Project Assert”, an initiative to insert recovery coaches into EDs. In addition to on-site support, they will provide follow-up to individuals who have recently overdosed on opioids. Project Assert will be under the purview of the Network180 Access Center.

North Country CMH

Population: 150,200

North Country CMH clinicians provide crisis assessments to five EDs and 6 jails across its 3300 square mile area. They also provide screenings for people with private insurance, however this impacts their ability to meet performance indicators around timeliness of assessment for individuals with Medicaid. Thus, commercial client support for individuals in crisis is only available during weekdays.

Because the distance is so great—it can take 90 minutes to drive from one hospital to the next—North Country CMH began piloting a telehealth solution in 2017 by doing assessments with clinicians via video. This telehealth service is now available from 4pm on Sunday to Friday at 5pm. The State of Michigan approved a Medicaid billable code for video screening to all EDs.

New clinicians receive emergency services training for two days, and then they are placed at the busiest clinic for a month, shadowing emergency service workers.

North Country CMH, the ED staff, and law enforcement have enjoyed a cohesive relationship, built upon strong communication and the mutual understanding of needing one another.

Saginaw CMH

Population: 192,00

Saginaw CMH established a behavioral health presence at Saginaw General Hospital following the closing of their psychiatric unit 30 years ago. Clinicians from Saginaw CMH were brought in to the ED as a safety measure and to provide consultation for the ED staff. During the building of St. Luke's Hospital, administrators gave consideration to Saginaw CMH clinicians by providing them a room to work out of.

To address the potential for stress and friction between community partners, Saginaw CMH created a First Responders Guide to Behavioral Intervention, a collection of community resources, contact information, and important guidelines for effective interventions.

Medical clearance and ED boarding are two of the major issues identified by Saginaw CMH. The elusive definition of medical clearance is a source of confusion between Saginaw CMH and its partnering EDs. New doctors and medical residents that are risk-aversive generally order more lab tests, prolonging the ED wait time and boarding individuals in a behavioral health crisis longer than they need to be while delaying treatment.

One hospital currently contracts with Saginaw CMH to screen individuals with commercial insurance.

Jail Diversion and Emergency Departments

TBDS interviewed Steven Mays, Liaison to the Mental Health Diversion Council and Diversion Administrator for MDHHS[34]. The Mental Health Diversion Council "aims to reduce the number of people with mental illness or intellectual or developmental disabilities (including comorbid substance addiction) from entering the corrections system while maintaining public safety[35]."

The Mental Health Diversion Council (MHDC) currently funds 11 pilot programs across the state to meet these stated objectives, and three of them have addressed emergency behavioral health access to meet these objectives.

- In Oakland County, two diversion facilities on opposite sides of the county were opened to provide a safe, "no-refusal" space for police to drop off individuals in as little as five minutes
- The MHDC funded a full-time police officer at Borgess Hospital in Kalamazoo to receive individuals coming to the ED so that the police officers bringing individuals to the ED could complete a handoff quickly and return to their patrols.

[34] S. Mays, personal communication, November 2, 2018.
[35] Mental Health Diversion Council. (2018, January). *Mental Health Diversion Council Progress Report*. Retrieved from: https://www.michigan.gov/documents/mentalhealth/Diversion_Council_Progress_Report_Jan_2018_611673_7.pdf.

- In St. Joseph County, the jail remodeled one of the areas in their space to create a diversion center. The remodel included adding two cells, a medical desk, clear glass walls, and telehealth health capabilities.

Mr. Mays suggested that a more enhanced Crisis Center model would include co-located assessment and treatment services that are convenient for officer drop-offs and efficient for people needing crisis services. When an environment is safe and secure, officers can rely on them for efficient transitions and easy access to care.

Community Benefit Dollars

Community Benefits are health care-related services that nonprofit hospitals provide—often with little or no compensation—to address critical needs in the community. They can include:

- Health services to vulnerable or underserved people
- Financial or in-kind support of public health programs
- Health education screening and prevention services
- Medical research projects
- Physician training initiatives

Hospitals may choose to spend community benefit dollars on behavioral health services.

IRS-990 forms of the 80 hospitals with an Emergency Department who participated in the survey were analyzed from the most recently available fiscal year to identify references to behavioral health as a priority spending area for a hospital's community benefit dollars. Much of this data resulted from a community needs assessment conducted by most hospitals.

To efficiently review the substantial amount of narrative data, a word analysis was conducted. Narratives that included phrases like "mental health", "behavioral health", or "substance use" were categorized and reviewed more thoroughly for specific references to programs or sub-populations.

Qualitative responses from Schedule H of the 990 forms were organized into three categories:

- **Green**: Mental health and/or substance abuse services are listed as a priority for the hospital's use of community benefit dollars, often with a detailed description of efforts and specific action items to address mental health concerns
- **Yellow**: Mental health and/or substance abuse services are mentioned but not as a primary concern, with no corresponding action items identified
- **Orange**: Mental health and/or substance abuse services are not referenced anywhere

Quantitative community benefit dollar expenditures were also collected when available, as hospitals indicated on the IRS-990 Schedule H form indicate their total operating expenditures and their total community benefit dollar expenditures.

Hospital	Location	Community Benefit Dollar Usage
Beaumont Hospital Grosse Pointe	Grosse Pointe	• Sponsors the American Medicine Chest Challenge to raise awareness about prescription drug abuse • Developed the Everybody Matters "I Am" Campaign to advocate for dignity and respect • Developed the program Noble to support children who are bullied using peer support
Eaton Rapids Medical Center	Eaton Rapids	• Increased behavioral health and mental health
Harbor Beach Community Hospital	Harbor Beach	• Provided courses on SUD to youth • Provided Mental health counseling to senior citizen
Henry Ford Allegiance Health	Jackson	• Made referral and supportive relationships for mental health services • Provided free mental health screenings
Marlette Regional Hospital	Marlette	• Planning to encourage providers to educate local schools on drugs and alcohol use and abuse and bullying
Mercy Health	Muskegon	• Expanded mental health services and added new providers • Implemented Recovery coaches • Planning to strengthen relationships with local mental heal services providers
North Ottawa Community Hospital	Grand Haven	• Promoted the "Be Nice" campaign • Planning to train primary points of contact in Mental Helath, Integrated ER Model, and create counseling partnerships • Planning to increase care coordination use • Planning to improve existing mental health information resources for internal staff to have access to
Oaklawn Hospital	Marshall	• Set a goal to increase proportion of people with access to medical and mental health services • Planning to provide transportation to access above mentioned services • Set goal to increase the proportion ofpeople who experience positive mental health • Planning to add new providers • Set a goal to reduce the overall use/abuse of substances • Planning to practice policies for reducing addiction
Providence Hospital	Southfield	• Set a goal to decrease youth risk factors for suicide, depression, and substance use by implementing Rapid Assessment, providing mental

		health education, providing counseling and referrals for youth in partnering school • Set a goal to decrease youth and adult risk factors for suicide, depression, and substance abuse by implementing Mental Health First Aid • Set a goal to decrease youth risk factors for PTSD by utilizing Trauma Symptoms Checklist for Children • Set a goal to prevent and reduce addition and mental illnesses in children, youth, and adults (across the lifespan) by utilizing Screening, Brief Intervention, and Referral Treatment (SBIRT) and providing education to those at risk for SUDs.
Sheridan Community Hospital	Sheridan	• Promotes mental health through advocacy and education • Collaborates with organizations and programs that offer mental health and substance abuse services
Spectrum Health United	Greenville	• Working with CMH to integrate behavioral health into primary care clinics • Investing in telepsychiatry options • Disseminating information on available resources • Improving processes to maximize effectiveness of limited resources
St. Joseph Mercy	Chelsea	• Contributes to improved access and integration of behavioral health services • Addresses access to care barriers to vulnerable populations • Educates primary care providers to address behavioral health needs • Engages social service organization through public-private partnerships that reduce duplication of services
St. Joseph Mercy Hospital	Ann Arbor	• Planning to increase access to resources for individuals who are homeless and living with a mental illness • Planning to improve processes of access to care to maximize effectiveness
St. Mary Mercy Hospital	Livonia	• Planning to expand behavioral health services to Westland residents through a FQHC • Provided substance use and alcohol use education to youth and families

			• Collaborated with local mental health to facilitate discussion with social workers and counselors to promote mental health awareness
	St. Mary's of Michigan	Saginaw	• Collaborations with local CMH to provide education on the management of mental illness to patients with specific needs
	Beaumont Taylor	Taylor	• Mental health was referenced in the supplemental information but not action items or goals were listed
	Bronson Battle Creek	Battle Creek	• Mental health and addiction prevention were referenced in the supplemental information but not action items or goals were listed
	Bronson Methodist Hospital	Kalamazoo	• Mental health was referenced in the supplemental information but not action items or goals were listed
	Covenant Healthcare	Saginaw	• Behavioral health was referenced in the supplemental information but not action items or goals were listed
	Deckerville Community Hospital	Deckerville	• Mental health was referenced in the supplemental information but not action items or goals were listed
	McLaren Bay Region	Baycity	• Behavioral health was referenced in the supplemental information but not action items or goals were listed
	Metro Health	Wyoming	• Mental health and substance abuse were referenced in the supplemental information but not action items or goals were listed
	MidMichigan Medical Center Gladwin	Gladwin	• Mental health was referenced in the supplemental information but not action items or goals were listed
	Munson Healthcare Otsego Memorial Hospital	Grayling	• Mental health and substance use were referenced in the supplemental information but not action items or goals were listed
	Sparrow Clinton Hospital	St. John's	• Mental health and alcohol use were referenced in the supplemental information but not action items or goals were listed
	Allegan General Hospital	Allegan	Mental health and substance abuse services were not referenced in Schedule H section of IRS-990 form
	Apirus Iron River Hospital and Clinics	Iron River	
	Aspirus Keweenaw Hospital	Laurium	
	Aspirus Ontonagon	Ontonagon	
	Beaumont Hospital	Royal Oak	
	DMC Huron Valley-Sinai	Commerce Township	

Genesys Regional Medical Center	Grand Blanc	
Hayes Green Beach Memorial Hospital	Charlotte	
Henry Ford West Bloomfield Hospital	West Bloomfield	
Hills and Dales General Hospital	Cass City	
Lakeland Hospital Watervliet	Watervliet	
Scheurer Hospital	Pigeon	
Sparrow Ionia Hospital	Ionia	
Spectrum Health Big Rapids	Big Rapids	
Three Rivers Health	Three Rivers	

Recommendations

Based on survey results, interviews and literature review of successful programs nationally, the following are offered as recommendations for consideration:

Advocate for changes to state policy and regulations to increase access to telepsychiatry services within EDs. While there is a well-documented national shortage of psychiatrists, many providers are turning to telepsychiatry to meet their needs. EDs will benefit from reframing the question of "Should we provide psychiatry services?" to "How should we provide psychiatry services?"

Increase access to and education about viable alternatives to psychiatric inpatient hospitalization, such as Crisis Residential Units[36], Crisis Stabilization Units, and Peer Respite programs. Risk management has historically played an influential role in decisions about placement, but it can no longer be the only factor considered. Psychiatric hospitalization should be the last choice considered after all other potential alternatives have been deemed inappropriate, so as to decrease the amount of people being placed in levels of care that are higher than their identified needs. These alternatives to inpatient hospitalization boast more than 40 years of published research of achieving Triple Aim objectives[37,38].

[36] Crisis Residential Units provide a critical component of a healthy behavioral health crisis services continuum, offering substantial benefits when compared to psychiatric inpatient hospitalization.

[37] Bola, J. R., & Mosher, L. R. (2003). Treatment of acute psychosis without neuroleptics: two-year outcomes from the Soteria project. *The Journal of nervous and mental disease*, *191*(4), 219-229.

[38]Adams, C. L., & El-Mallakh, R. S. (2009). Patient outcome after treatment in a community-based crisis stabilization unit. *The journal of behavioral health services & research*, *36*(3), 396-399.

Increase peer support services within the EDs and allow peers to bill for services. In California, Colorado, Delaware, Maine, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, and Wisconsin, communities and providers are proving that a peer presence in EDs has a substantial impact on patient experience, clinical outcomes, and reduced cost.

Establish statewide intake protocols to assess for suicidal ideations and substance use. Initial interventions for issues as important as suicide prevention and substance abuse should be standardized to best practices and not left to local practices or preference.

Establish a metrics portfolio for assessing access to behavioral health services, clinical outcomes, cost savings, and patient satisfaction, and develop benchmarks for optimal performance. As health care systems move away from fee-for-service payment models and towards pay-for-value arrangements, outcomes play a critical part in the assessment of each provider's effectiveness. While crisis services can be the most difficult to measure due to the complex factors contributing to a person's crisis, intentional and committed efforts must be made to move closer and closer to identifying the factors influencing effective treatment and prevention and reinforcing those efforts with progressive payment models.

Create an electronic bed registry for psychiatric hospital beds and other crisis services. The statewide and national crisis of ED boarding stems from a lack of availability of crisis services and a lack of awareness of their availability. Developing a bed registry inclusive of psychiatric hospital beds, crisis residential beds, and substance abuse residential beds will decrease ED throughput times and reduce costs while shedding light on the capacity vs. awareness issue[39].

Examine the overutilization of EDs for non-emergencies in collaboration with first responders and implement practices that direct all potential ED patients to the most appropriate level of care. In states like Texas[40] and Colorado[41], first responders have formed interdisciplinary teams of police officers, firefighters, and clinicians to prevent unnecessary ambulance utilization and ED utilization as well as addressing individuals with high utilization of emergency services. Because the Bureau of EMS, Trauma, & Preparedness requires an ambulance to transport a patient to an Emergency Department[42] (as do most health insurance plans), employ the use of telehealth, mobile

[39] National Association of State Mental Health Program Directors. (2017, September). *Psychiatric Bed Registries.* Retrieved from: https://www.nri-inc.org/our-work/nri-reports/nri-psychiatric-bed-registries-report/

[40] Gonzalez, M., Alqusairi, D., & Jackson, A. (2015). Houston EMS advances mobile integrated healthcare through the ETHAN program. *Journal of Emergency Medical Services*, *2*.

[41] Bronsky, S., Giordano, K., & Johnson, R. (2016). Mobile Integrated Healthcare Program Changing How EMS Responds to Behavioral Health Crisis. *Journal of Emergency Medical Services*. Retrieved from: https://www.jems.com/articles/print/volume-41/issue-10/features/mobile-integrated-healthcare-program-changing-how-ems-responds-to-behavioral-health-crises.html

[42] Michigan Bureau of EMS, Trauma & Preparedness (2004). *Michigan State Protocols, Section 8-3*. Retrieved from: https://www.michigan.gov/documents/mdhhs/Section_8_System_615670_7.pdf

crisis teams, and other early stage interventions to reduce unnecessary ambulance use, and subsequently, unnecessary hospitalization.

Limitations

There is not a comprehensive list of hospitals with emergency departments maintained by the State of Michigan. The list created for this report and its corresponding survey was informed by the 2018 Michigan College of Emergency Physicians' directory, the 2016 Michigan Certificate of Need Annual Survey, and TBD Solutions' own research. The Michigan Health & Hospital Association (MHA) was not able to share their list of member hospitals but forwarded the initial survey request to its email listserv of member hospitals.

Some hospitals reported limited data on behavioral health services within emergency departments because of changes in administration (ex: merging hospitals), platforms (ex: electronic health records), or other procedural changes.

Behavioral health services and interventions referenced in the Schedule H section of the IRS-990 forms was expansive and inconsistent between hospitals. Some hospital systems combined information about all of their hospitals into a combined Schedule H narrative without specifying where specific services or interventions were provided.

Funding

Even programs such as the University of Michigan's Psychiatric Emergency Services that are having a substantial impact on ED diversion, reducing psychiatric hospitalization, and reducing cost are not proving to be fiscally solvent. There remains a need to actualize cost savings into incentives in order to maintain sustainability of these programs. Contracts must be developed to reward the provider for actualized cost savings, such as a value-based purchasing arrangement, but this requires efforts to accurately calculate the total cost of care and the total cost savings in prevention.

Incentives

The hospitals, providers, community partners, and the individuals driving each of these organizations have all been incentivized to keep some iteration of the status quo with the systems in which they exist. These systems tend to omit the most important consideration: the person seeking services. Factors like hours of availability, throughput time/ED boarding, and comfort level of individuals and their family members must be prioritized to have the most promising outcomes.

Conclusion

Treating behavioral health symptoms within an emergency department is a complex objective requiring engagement from many health care professionals and community partners. Managing complex objectives is not a new challenge to any mature hospital system. From disease control to safety and prevention to addressing social determinants of health, Michigan emergency departments are poised to provide effective, person-centered, and cost-effective treatment, and there are great examples to draw from in other states. Effective execution of this work at a high level requires constant attention to the patient experience and a desire to place patient priorities over other incentives. When emergency

departments are successfully screening, treating, and referring people in a mental health crisis, transformative effects can be achieved for the rest of the health care delivery system.

TBD Solutions appreciates the opportunity to provide a thorough analysis of behavioral health service access in the Emergency Departments statewide. Please direct questions or concerns with this report to:

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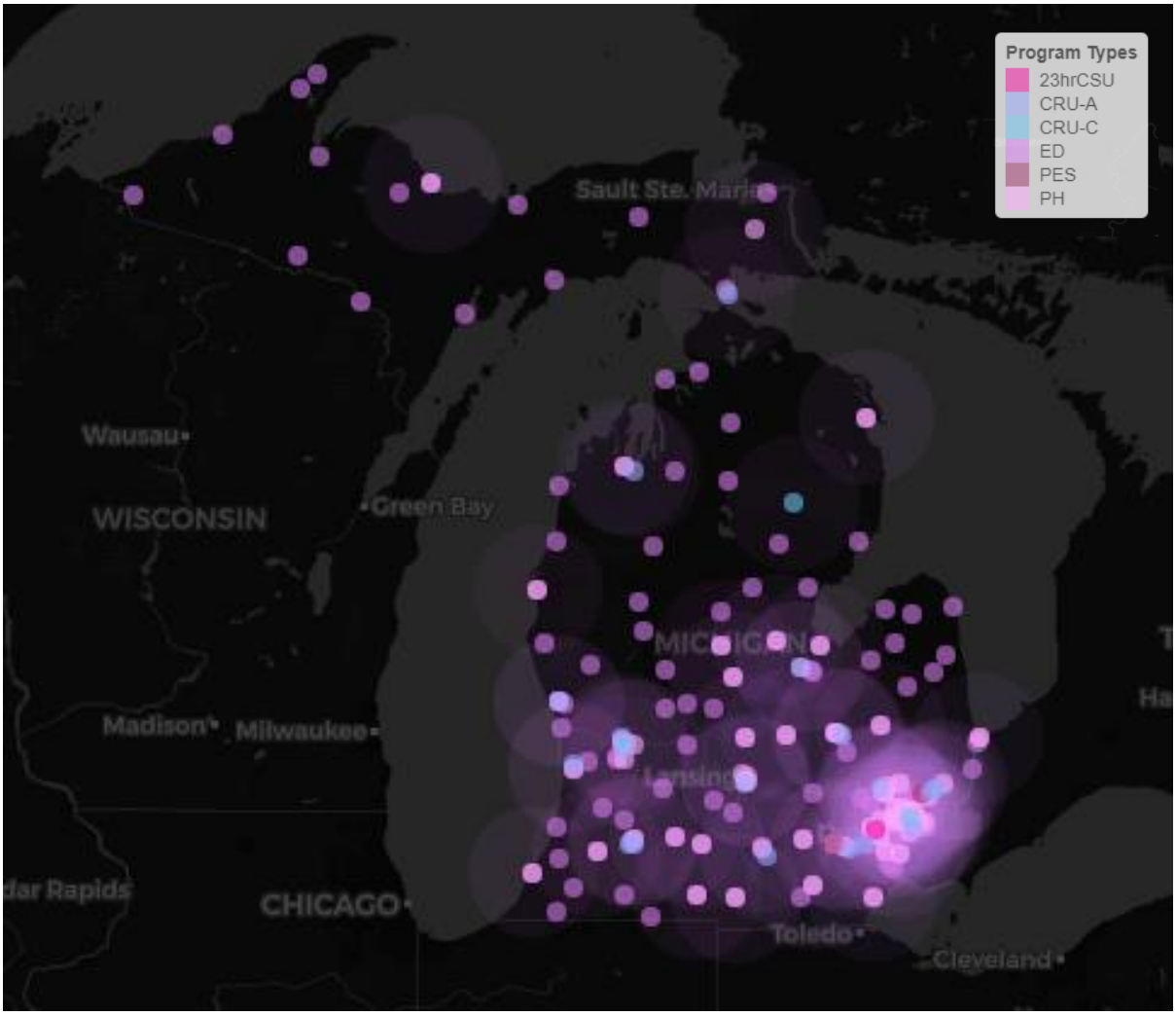
Appendix A: Map of Michigan Emergency Departments

These maps depict the emergency department services in the state of Michigan (represented in purple) and the emergency behavioral health services, including psychiatric hospitals (peach), adult crisis residential units (grey), youth crisis residential units (blue), psychiatric emergency services (brown), and 23-hour crisis stabilization units (red).

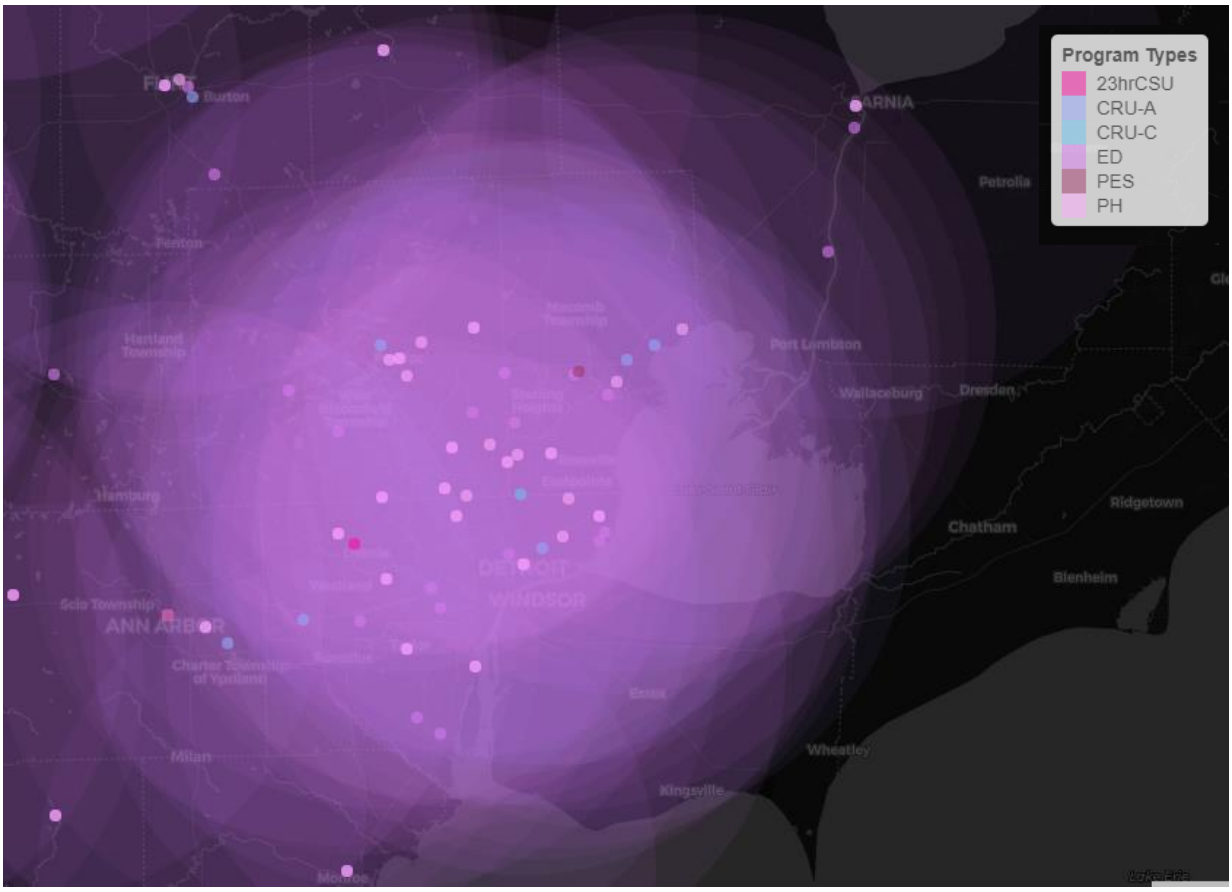
Each of the emergency behavioral health services has a shaded circle around it representing a 30-mile radius.

An interactive version of this map will be provided to identified staff at MDHHS.

State of Michigan



Metro Detroit



Appendix B: List of Michigan Emergency Departments

Below is a list of all hospitals with emergency departments in the state of Michigan. Hospitals whose names are in bold participated in the survey.

Hospital	City
ALLEGAN GENERAL HOSPITAL	ALLEGAN
ASCENSION CRITTENTON HOSPITAL	ROCHESTER
ASCENSION MACOMB-OAKLAND HOSPITAL	MADISON HEIGHTS
ASCENSION RIVER DISTRICT HOSPITAL	EAST CHINA
ASPIRUS IRON RIVER	IRON RIVER
ASPIRUS IRONWOOD HOSPITAL	IRONWOOD
ASPIRUS KEWEENAW HOSPITAL	LAURIUM
ASPIRUS ONTONAGON HOSPITAL	ONTONAGON
BARAGA COUNTY MEMORIAL HOSPITAL	L'ANSE
BEAUMONT HOSPITAL - CANTON	CANTON
BEAUMONT HOSPITAL - DEARBORN	DEARBORN
BEAUMONT HOSPITAL - FARMINGTON HILLS	FARMINGTON HILLS
BEAUMONT HOSPITAL - GROSSE POINTE	GROSSE POINTE
BEAUMONT HOSPITAL - ROYAL OAK	ROYAL OAK
BEAUMONT HOSPITAL - TAYLOR	TAYLOR
BEAUMONT HOSPITAL - TRENTON	TRENTON
BEAUMONT HOSPITAL – TROY	TROY
BORGESS MEDICAL CENTER	KALAMAZOO
BORGESS-LEE MEMORIAL HOSPITAL	DOWAGIAC
BORGESS-PIPP HOSPITAL	PLAINWELL
BRONSON BATTLE CREEK HOSPITAL	BATTLE CREEK
BRONSON LAKEVIEW HOSPITAL	PAW PAW
BRONSON METHODIST HOSPITAL	KALAMAZOO
BRONSON SOUTH HAVEN COMMUNITY HOSPITAL	SOUTH HAVEN
CHILDREN'S HOSPITAL OF MICHIGAN	DETROIT
CHILDREN'S HOSPITAL OF MICHIGAN- TROY	TROY
CHIPPEWA COUNTY WAR MEMORIAL HOSPITAL	SAULT STE. MARIE
COVENANT MEDICAL CENTER – HARRISON	SAGINAW
DECKERVILLE COMMUNITY HOSPITAL	DECKERVILLE
DETROIT RECEIVING HOSPITAL	DETROIT
DICKINSON COUNTY HEALTHCARE SYSTEM	IRON MOUNTAIN
EATON RAPIDS MEDICAL CENTER	EATON RAPIDS
EDWARD W SPARROW HOSPITAL	LANSING
GARDEN CITY HOSPITAL	GARDEN CITY
GENESYS REGIONAL MEDICAL CENTER	GRAND BLANC

HARBOR BEACH COMMUNITY HOSPITAL	HARBOR BEACH
HARPER UNIVERSITY HOSPITAL	DETROIT
HAYES GREEN BEACH MEMORIAL HOSPITAL	CHARLOTTE
HELEN NEWBERRY JOY HOSPITAL	NEWBERRY
HENRY FORD ALLEGIANCE HEALTH	JACKSON
HENRY FORD HOSPITAL	DETROIT
HENRY FORD MACOMB HOSPITAL	CLINTON TWP
HENRY FORD MEDICAL CENTER- BROWNSTOWN	BROWNSTOWN
HENRY FORD MEDICAL CENTER- COTTAGE	GROSSE POINTE FARMS
HENRY FORD MEDICAL CENTER- FAIRLANE	DEARBORN
HENRY FORD MEDICAL CENTER- STERLING HEIGHTS	STERLING HEIGHTS
HENRY FORD WEST BLOOMFIELD HOSPITAL	WEST BLOOMFIELD
HENRY FORD WYANDOTTE HOSPITAL	WYANDOTTE
HILLS & DALES GENERAL HOSPITAL	CASS CITY
HILLSDALE COMMUNITY HEALTH CENTER	HILLSDALE
HOLLAND HOSPITAL	HOLLAND
HURLEY MEDICAL CENTER	FLINT
HURON MEMORIAL HOSPITAL (now McLaren Thumb Region)	BAD AXE
HURON VALLEY-SINAI HOSPITAL	COMMERCE CHARTER TWP
KALKASKA MEMORIAL HEALTH CENTER	KALKASKA
LAKE HURON MEDICAL CENTER	PORT HURON
LAKELAND COMMUNITY HOSPITAL WATERVLIET	WATERVLIET
LAKELAND HOSPITAL NILES (As of 10/2018- Spectrum Health)	NILES
LAKELAND HOSPITAL ST. JOSEPH	ST. JOSEPH
MACKINAC STRAITS HEALTH SYSTEM, INC.	ST. IGNACE
MARLETTE REGIONAL HOSPITAL	MARLETTE
MCKENZIE MEMORIAL HOSPITAL	SANDUSKY
MCLAREN - CENTRAL MICHIGAN	MT. PLEASANT
MCLAREN - GREATER LANSING	LANSING
MCLAREN BAY REGION	BAY CITY
MCLAREN CARO REGION HOSPITAL	CARO
MCLAREN FLINT	FLINT
MCLAREN MACOMB	MOUNT CLEMENS
MCLAREN NORTHERN MICHIGAN HOSPITAL	PETOSKEY
MCLAREN OAKLAND	PONTIAC
MCLAREN PORT HURON HOSPITAL	PORT HURON
MCLAREN-LAPEER REGION	LAPEER
MEMORIAL HEALTHCARE HOSPITAL	OWOSSO

MERCY HEALTH MUSKEGON - HACKLEY CAMPUS	MUSKEGON
MERCY HEALTH MUSKEGON - MERCY CAMPUS	MUSKEGON
MERCY HEALTH PARTNERS, LAKESHORE CAMPUS	SHELBY
MERCY HEALTH SAINT MARY'S	GRAND RAPIDS
MERCY HEALTH SOUTHWEST CAMPUS	BYRON CENTER
METROPOLITAN HOSPITAL	WYOMING
MIDMICHIGAN MEDICAL CENTER - GLADWIN	GLADWIN
MIDMICHIGAN MEDICAL CENTER ALPENA	ALPENA
MIDMICHIGAN MEDICAL CENTER CLARE	CLARE
MIDMICHIGAN MEDICAL CENTER- GRATIOT	ALMA
MIDMICHIGAN MEDICAL CENTER-MIDLAND	MIDLAND
MOTT'S CHILDREN'S HOSPITAL	ANN ARBOR
MUNISING MEMORIAL HOSPITAL	MUNISING
MUNSON HEALTHCARE CADILLAC HOSPITAL	CADILLAC
MUNSON HEALTHCARE CHARLEVOIX	CHARLEVOIX
MUNSON HEALTHCARE GRAYLING	GRAYLING
MUNSON HEALTHCARE MANISTEE HOSPITAL	MANISTEE
MUNSON MEDICAL CENTER	TRAVERSE CITY
NORTH OTTAWA COMMUNITY HOSPITAL	GRAND HAVEN
OAKLAWN HOSPITAL	MARSHALL
OTSEGO MEMORIAL HOSPITAL (Now Munson Healthcare)	GAYLORD
PAUL OLIVER MEMORIAL HOSPITAL	FRANKFORT
PENNOCK HOSPITAL	HASTINGS
PORTAGE HOSPITAL, LLC (now UP Health System)	HANCOCK
PROMEDICA BIXBY HOSPITAL	ADRIAN
PROMEDICA COLDWATER REGIONAL HOSPITAL	COLDWATER
PROMEDICA HERRICK HOSPITAL	TECUMSEH
PROMEDICA MONROE REGIONAL HOSPITAL	MONROE
PROVIDENCE HOSPITAL AND MEDICAL CENTER	SOUTHFIELD
SCHEURER HOSPITAL	PIGEON
SCHOOLCRAFT MEMORIAL HOSPITAL	MANISTIQUE
SHERIDAN COMMUNITY HOSPITAL	SHERIDAN
SINAI-GRACE HOSPITAL	DETROIT
SPARROW CARSON HOSPITAL	CARSON CITY
SPARROW CLINTON HOSPITAL	ST. JOHNS
SPARROW IONIA HOSPITAL	IONIA
SPECTRUM HEALTH BIG RAPIDS	BIG RAPIDS,
SPECTRUM HEALTH BLODGETT HOSPITAL	GRAND RAPIDS
SPECTRUM HEALTH BUTTERWORTH HOSPITAL	GRAND RAPIDS

SPECTRUM HEALTH GERBER MEMORIAL	FREMONT
SPECTRUM HEALTH KELSEY HOSPITAL	LAKEVIEW
SPECTRUM HEALTH LUDINGTON HOSPITAL	LUDINGTON
SPECTRUM HEALTH REED CITY HOSPITAL	REED CITY
SPECTRUM HEALTH UNITED HOSPITAL	GREENVILLE
SPECTRUM HEALTH ZEELAND COMMUNITY HOSPITAL	ZEELAND
ST. FRANCIS HOSPITAL	ESCANABA
ST. JOHN HOSPITAL & MEDICAL CENTER	DETROIT
ST. JOHN MACOMB OAKLAND HOSP- WARREN	WARREN
ST. JOSEPH HEALTH SYSTEM - TAWAS	TAWAS CITY
ST. JOSEPH MERCY ANN ARBOR HOSPITAL	YPSILANTI
ST. JOSEPH MERCY CHELSEA	CHELSEA
ST. JOSEPH MERCY LIVINGSTON HOSPITAL	HOWELL
ST. MARY MERCY LIVONIA HOSPITAL	LIVONIA
ST. MARY'S OF MICHIGAN HOSPITAL	SAGINAW
ST. MARY'S OF MICHIGAN STANDISH HOSPITAL	STANDISH
STURGIS HOSPITAL	STURGIS
THREE RIVERS HEALTH HOSPITAL	THREE RIVERS
UNIVERSITY OF MICHIGAN HOSPITALS	ANN ARBOR
UP HEALTH SYSTEM-BELL	ISHPEMING
UP HEALTH SYSTEM-MARQUETTE	MARQUETTE
WEST BRANCH REGIONAL MEDICAL CENTER (now MidMichigan Medical Center-West Branch)	WEST BRANCH