Asking the Right Questions the Right Way of the Right People to Learn the Right Answers.

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INTRODUCTION

Approximately four years ago, South Carolina began to feel the loss of private and public psychiatric hospital beds. As many as 225 beds were lost due to budgetary issues. The bed closures contributed to the fast growing problem of over utilization of hospital emergency departments (EDs). (See Appendix A for a legend of terms and operational definitions.) EDs were not prepared for this influx of psychiatric and substance abusing patients. For the purpose of this document, the term psychiatric patient will refer to emotionally distressed, mentally ill, and chemically abusing patients. The physical layouts of the EDs were not suited for the care of increased number of psychiatric patients; the staffing patterns did not address the growing needs of the psychiatric population; and the actual ED staff was not adequately trained to handle the needs of the psychiatric population. Many EDs did not even have psychiatrists on staff. As a result of the ED overcrowding around the Nation, many states began to look at the development of psychiatric EDs to ease the burden on the "regular" EDs. The prevailing wisdom supporting a specific ED for Psychiatric patients is made up of the following beliefs:

- A psychiatric ED would be staffed with mental health staff and psychiatrists on site who would be well trained in assessment, crisis intervention, pharmacological treatment, and outpatient options.

- As a result of the above benefits, the average ED length of stay (LOS) would be

shortened.

- As a result of a shorter LOS, law enforcement, the group who often transports these patients to and waits with them in EDs, would be able to get back on "the street" faster, hereby performing their public safety role.

South Carolina hospitals and the South Carolina Department of Mental Health decided to investigate the development of psychiatric EDs in South Carolina. Data were gathered in an effort to determine the need for a psychiatric ED in Charleston County. Once the data had been collected and analyzed, it was determined that the data was not comparable from ED to ED. The collection methods were different; the questions asked and answered were different; the collection points were different. No operational definitions even existed. As a result of this finding, it was decided that a data collection tool and a stakeholder needs assessment survey needed to be developed. Therefore, this paper will discuss all dimensions associated with the creation and use of these tools.

LITERATURE/INFORMATION REVIEW

Although significant amounts of data had been gathered and reviewed from other states such as Texas, New York, North Carolina, and Washington, no clear data existed that proved the need for the creation of a psychiatric ED in Charleston County, South Carolina. The American Psychiatric Association Task Force on Psychiatric Emergency Services report also provided comprehensive data that demonstrated a need for and extolled the virtues of psychiatric EDs in general. Unfortunately no data specifically related to the counties of Charleston, Dorchester, and Berkeley (i.e. the Tricounty area) existed.

Several local agencies began presenting anecdotal pieces of data. Multiple ED staff cited week long stays of psychiatric patients tied down to gurneys in ED hallways while ED physicians dodged these gurneys to deal with patients having heart attacks. Law enforcement personnel also declared that they spent hours in EDs with psychiatric patients who sat waiting in seclusion until an ED physician found the time to come either to perform an assessment or call in a mental health professional with whom the hospital contracted to provide these assessments. Although these reports were believed to be true, no data existed to support the reports. It was unknown if these reports were the exception rather than the rule.

Various agencies and organizations decided to collect data that many thought would clearly support the anecdotal reports. The South Carolina Budget and Control Board reported data for the year 2002 reflecting that there were 34,311 unduplicated psychiatric patients visiting EDs around the state. This data also showed that 74% of the psychiatric patients visiting

EDs around the state were individuals unknown to SCDMH. This fact leads to the following questions:

- Who were these patients?
- Where had they been seeking treatment previously?
- Why weren't they being served by SCDMH?
- Was this population's ED usage new or had these patients always sought care at EDs?

SCDMH did not have baseline data to answer these questions. Although this data seemed to reflect that the recent increase in ED usage was not the result of SCDMH's closure of state psychiatric beds, the data was not conclusive.

In October 2003, the South Carolina Department of Mental Health (SCDMH) began to collect a "weekly snapshot" of psychiatric patients waiting for a psychiatric hospital bed in EDs around South Carolina. Charleston/Dorchester Community Mental Health Center (C/DCMHC) staff called the eleven EDs in the Tricounty area every Monday morning at approximately 9:00am to learn how many psychiatric patients were awaiting a psychiatric hospital bed at that moment. From that data collected in the Tricounty Area, from September 2003 – October 2004, 63 weeks of weekly snapshots showed that only fourteen patients had met the criteria sought in the snapshot. The snapshot also asked for the wait time in hours. The longest LOS for those patients waiting in the stated time frame was

eight hours, a far cry from the report of seven to eight days. Why was there a disparity in the perceived problem and the collected data?

The Charleston County Sheriff's Department Therapeutic Transport Team, the team of deputies designated to transport psychiatric patients who are being either transported to an ED or mental health facility to be evaluated for emergency involuntary hospitalization or those patients who have already been evaluated and subsequently committed involuntarily to a psychiatric hospital, was asked to collect data from January 2004 – September 2004 that reflected the following:

- How many patients they transported
- To which EDs or facilities they transported
- Whether the individual was on emergent psychiatric papers or chemical dependency papers
- The LOS for individuals on psychiatric papers vs. the LOS for those on chemical dependency papers
- The LOS by facility

These data reflected that the LOS was significantly shorter at a dedicated mental health facility;however, the data only reflected information for a very specific group of psychiatric patients, those involved at some point with Probate Court commitment proceedings. (See Appendix B.)

Finally, C/DCMHC initiated a quarterly meeting with all stakeholders in the Tricounty area concerned with ED usage. This coalition, called the ED Utilization Committee, included ED directors from every ED in the area, command staff from all law enforcement agencies in the area, EMS command staff, administrators from both psychiatric hospitals in the area, administrators from other relevant human service agencies, representatives from consumer advocacy groups, and even the local newspaper's health writer. The specific stakeholders are as follows:

- C/DCMHC
- Berkeley County Mental Health Center
- The Medical University of South Carolina's Institute of Psychiatry
- Palmetto Lowcountry Behavioral Health
- The Care Alliance (St. Francis and Roper Hospital System)
- East Cooper Hospital
- HCA Trident/Summerville Hospital System
- Charleston, Dorchester, and Berkeley Counties' Departments of Alcohol and other Drug Addiction Services (DAODAS)
- Charleston, Dorchester, and Berkeley Counties' Departments' of Disabilities and Special Needs

- Tricounty United Way
- 211 Hotline
- Charleston County DHEC
- Charleston County Probation and Parole
- Charleston, Dorchester, and Berkeley County Sheriffs' Offices
- Mount Pleasant, Charleston, North Charleston, Summerville, Sullivan's Island, Isle of Palms, Folly Beach, Hanahan, and Goose Creek Police Departments
- Charleston, Dorchester, Berkeley Counties' Emergency Medical Services
- Post and Courier Health Reporter
- Charleston Area National Alliance of the Mentally Ill

This extensive coalition developed a data collection form in July 2002 for use in EDs in an attempt to gather local data relevant to the use of EDs by psychiatric patients. This form included date of admission, age of patient, diagnosis of patient, patient's county of residence, patient's funding source, and patient's treatment disposition. The coalition mistakenly assumed this form would collect the needed data in a uniform fashion. The coalition was wrong.

Because no operational definitions were provided, terms were subject to individual interpretation. Some facilities routinely collected data; others did not. Some answered all

of the questions; others did not. Also, the coalition determined that the form did not collect enough data. Important pieces of information were missing. Time of admission and time of discharge were significant missing pieces of information.

After reviewing data from all of the mentioned sources, it became obvious that inclusive, comprehensive, valid, reliable, and comparable data was needed. Although various data had been collected by ED staff, law enforcement, and SCDMH, "apples to apples" were not being compared and clearly needed to be. The coalition still did not have the data required to determine the need for a dedicated psychiatric ED in the Tricounty area.

The coalition created an ad hoc committee made up of three ED directors, two representatives from law enforcement, one representative form EMS, one representative from each psychiatric hospital, and two representatives from each of the involved mental health centers to continue the investigation into the need and development of a psychiatric ED in the Tricounty area. It was thought that a smaller group dedicated to this specific issue could better define and implement the process. The ad hoc committee identified the need to "start form scratch" and start gathering "apples to apples" data. A data collection form and a stakeholder needs' assessment was warranted.

Method

The literature was reviewed for an example of a needs assessment survey and for a data collection form related to the creation of a psychiatric ED in order to avoid "reinventing the wheel." After an extensive search as indicated in this document's bibliography, surprisingly, none were found.

A draft of a data collection form was designed for use in the EDs and was reviewed by several individuals who would be involved in the collection, collation, and interpretation of the data. The ad hoc committee believed that the unsuccessful attempts at useful data collection provided the coalition with the knowledge of the questions it really needed to ask. Simply speaking, who, when, where, why, and how were the questions that needed to be asked and answered.

It was also recognized that a survey of the four main stakeholders in this enterprise, the existing EDs, law enforcement, EMS, and most importantly the patients and their families, was needed. The coalition needed to know if the stakeholders saw a need, a financial benefit, and a clinical benefit from the creation of a psychiatric ED. The coalition also needed to know the stakeholders' concerns.

Apparatus (or Research Instruments/Tools)

ED Data Collection Form. (See Appendix C as an email attachment).

Hospital Survey. (See Appendix D)

Law Enforcement/EMS Survey. (See Appendix E)

Advocate, Patient, and Family Survey. (See Appendix F)

Procedures

The data collection form is being translated into an EXCEL document with dropdown boxes and is being emailed to designated, identified staff in every ED in the Tricounty Area by the executive director of the C/DCMHC. These staff are then being asked to complete

the form for four distinct periods of time in order to allow for all anomalies of psychiatric patient presentation to EDs such as day of the week, week of the month, season of the year, etc. The form is to be completed with data from the first week in March 2005, the second week in May 2005, the third week in July 2005, the fourth week in September 2005. The completed form is then to be emailed to the executive assistant of the C/DCMHC for input into the created database for this project. A report will be completed by the Information Technology staff of the C/DCMHC and will be given to the Executive Director of the C/DCMHC for distribution to the ad hoc committee, the coalition, and all stakeholders. The C/DCMHC has memorandums of agreement (MOAS) with all of the agencies being asked to complete the data collection form and with all agencies being asked to complete the surveys. All agencies and stakeholders are invested in the project and have all agreed to participate in the data collection process.

The stakeholder surveys are being emailed to the administrators of each of the agencies and facilities by the executive director of the C/DCMHC on February 15, 2005, and will be emailed or faxed back to the executive assistant of the C/DCMHC for collation. The patient and family surveys will be given to patients of the mental health centers involved who are known to have used EDs to address their psychiatric issues. It is recognized that the surveys will not be gathering data from the 74% of psychiatric patients utilizing EDs who are unknown to the SCDMH. Due to the complicated logistics of such data collection, the ad hoc committee could not determine a reasonable process for gathering data from that specific group of patients. The patient and family surveys will be presented in person to the patients by their respective case managers. The case managers will explain the survey as needed, will collect the completed form from the patient, and will then send it to the

executive assistant of the C/DCMHC for collation. The executive assistant will then forward the report to the executive director of the C/DCMHC. The results of the all the surveys with then be shared with the ad hoc committee, the entire coalition, and, finally, with all of the stakeholders. The ad hoc committee will then make recommendations to the coalition on future actions.

Results

Obviously, there are no results to report at this time as the revised data collection and survey administration has not yet begun. The coalition hopes that the forthcoming results yield enough information with which a decision can be made concerning the development of a psychiatric ED in the Tricounty area.

Summary and Conclusions

Originally, this project was to examine all relevant data that existed to determine the need for and benefits of a psychiatric ED in the Tricounty area of South Carolina. As the data was gathered and reviewed, what became clear was the need for more comprehensive, valid, reliable, and uniformly understood data. The closer the existing data was examined, the more useless it appeared. The project then had to "go back to square one." As no valid conclusion could be drawn from existing data, the project logically evolved into the creation of a data collection form and needs assessment that would actually collect useful, meaningful, valid, and reliable data.

This project's value has been twofold. A valuable lesson was learned – simply because an abundance of data exists concerning a specific topic, the relevance and usefulness of the data cannot be assumed. This project has resulted in the creation of a data collection form and needs assessment survey that actually collect necessary data relevant to the topic. As no such form and survey were discovered in the existing literature, perhaps these documents could be used in other communities, particularly in South Carolina as communities attempt to deal with the current crisis of overcrowding in the state's emergency departments.

Appendices

Appendix A: Operational Definitions

1. Prisoner – person in custody of law enforcement who has been charged with a crime, but not booked into a detention center (pre-booking custody)

2. Inmate – person in custody of law enforcement who has been charged with a crime and has been booked into a detention center (post-booking custody)

3. Emergency Protective Custody (EPC) – law enforcement custody for protective purposes only, not criminal purposes. EPC invoked at discretion of law enforcement officer at scene. Typically, officer must witness injurious behavior or believe it has occurred or will imminently occur. Often used with mentally ill individuals. Some agencies must call Adult Protective Services (APS) when invoking EPC as a part of their Standard Operating Procedure (SOP).

4. Person in Custody – could be a prisoner; could be someone in EPC; could be an inmate

5. Deputy – In the Tri-County area, law enforcement personnel employed by a Sheriff's department

6. Law Enforcement Officer – In the Tri-County area, law enforcement personnel employed usually by a local jurisdiction or Public Safety

7. "10-96" – one of the "10 Codes" used by some law enforcement agencies that means mentally ill subject

8. Therapeutic Transport Team ("1096 Team") - specialized team of Charleston County Sheriff's Office deputies who take into custody persons thought to be mentally ill or chemically dependent for whom a Probate Judge has issued an *Order of Detention* or for whom a licensed physician has certified involuntary emergency hospitalization necessary.

9. *Application for Involuntary Emergency Hospitalization for Mental Illness or Chemical Dependency (Part I)* – a legal document completed by anyone in the community with knowledge that an individual is at imminent "risk of harm to self or others." This document may be sent to the Probate Court for review and may result in an *Order of Detention*. It may also be given directly to a licensed physician who'll then evaluate the individual for said imminent risk. This evaluation will result in a *Certificate of Licensed Physician Examination for Emergency Admission.*

10. *Order of Detention* – a legal document issued by a Probate Judge that allows "any officer of the peace" to take a person into custody against his/her will and transport that individual to a physician to be evaluated for imminent "risk of harm to self or others" as a result of a mental illness or a chemical dependency or to a hospital after having been evaluated and having been found in need of involuntary emergency hospitalization. An *Order of Detention* follows an *Application for Involuntary Emergency Hospitalization for Mental Illness or Chemical Dependency.*

11. *Certificate of Licensed Physician Examination for Emergency Admission (Part II)* – a legal document detailing the physician's evaluation of the individual brought before him/her on an *Order of Detention or an Application (Part I)*. This evaluation will either result in the person being certified for involuntary admission to a hospital and being admitted or will result in non-certification indicating that the individual does not need involuntary emergency hospitalization.

12. "White Papers" – law enforcement/mental health profession slang for Part I and Part II for mental illness

13. "Pink Papers" – law enforcement/mental health profession slang for Part I and Part II for chemical dependency

14. Mobile Evaluation Team (MET Team) – masters level clinicians employed by Palmetto Behavioral Health who perform psychiatric evaluations in all of the Roper/St.Francis EDs, East Cooper ED, and all of the Trident Hospital System EDs through a contract with Palmetto and said EDs

15. Assessment/Mobile Crisis - an emergency response team employed by the Charleston/Dorchester Community Mental Health Center, responds in the community, not to EDs

16. Medical Clearance – term used when individual has already been certified for involuntary emergency hospitalization, but may have some medical complication that the admitting hospital would like checked out by ED staff prior to admission

DiNovo, 2/2/05

Appendix B: ED UTILIZATION BY CCSO THERAPEUTIC TRANSPORT TEAM "1096"

1/1/04 – 9/23/04

Location	total	White Papers	White Paper Avg. ED Wait – in hours	Pink Papers	Pink Paper Avg. ED Wait – in hours
CMH	53	24	3.5	29	3.5
One West	1	1	1	0	0
2100 Charlie Hall – A/MC	28	28	1.5	N/A	N/A
St. Francis	32	19	3.5	13	3.3
Roper (downtown)	9	2	3.75	7	2.5
E. Cooper	5	1	5	4	3
VA	3	1	3	2	3.25
Trident	1	1	4.5	0	0

Longest wait was 9.5 hours at St. Francis; white. Shortest wait was .5 hours at A/MC, white; St. Francis, pink & white; Roper, pink. Thompson, DiNovo, 9/28/04

Appendix C: sent as an attachment as format was in landscape

Dinovo, 2/2/05

Appendix C: EMERGENCY ROOM PSYCHIATRIC PATIENTS DATA COLLECTION FORM

(Please Email To Toni Doyle at add70@scdmh.org - Or fax to 727-2083)

Date completed:	Hospital Reporting:

PET* – Psychiatric Eval. Team of any name, ie. MET, IOP Team, Etc.

Day/ date	**Pt. Time in**	**Age**	**Race**	**Sex**	**County of Res.**	**Presenting Issue** (SI, HI, Panic, DTs, OD, Etc.)	**Brought in by** (EMS, Law, Self, family, Etc.)	**Eval by ED staff or by PET**	**Time PET* called**	**Time PET* arr.**	**Time PET* eval over**	**Pt. Time out**	**Final Disposition** (TCSC, Inpt. psych., Inpt. Med., Home, Etc.)	**If Inpatient: Invol. or Vol.?**	**All Dx** (psych., AOD, medical	**Medical complica-tions: Please list**	**Funding source:** (medcaid, medicare, pvt.ins. self, DMH, Etc.)	**Required seclusion or 1:1 – yes/no**

DiNovo
2/2/05

Appendix D: PSYCHIATRIC EMERGENCY DEPARTMENT NEEDS ASSESSMENT for HOSPITALS

FEBRUARY 2005

Name of Hospital: _____

Name and Title of Representative: _____

Date Form Completed: _____

Please report data representative of 7/1/04 – present.

Psychiatric patients include psychiatric/Alcohol and other Drugs/Dually Diagnosed patients.

Questions 3 – 10 require two answers, one for the psychiatric population and one for the non-psychiatric population.

1. **Total** # (non-psychiatric and psychiatric) of patients utilizing the Emergency Department (ED)? _____

2. # of psychiatric patients utilizing the ED? _____

3. Average LOS, in hours, per psychiatric/non-psychiatric patient in the ED? _____/_____

4. Average total ED charge per psychiatric patient/non-psychiatric patient per visit? _____/_____

5. Average ancillary charges per psychiatric patient/non-psychiatric patient per visit? _____/_____

6. # of psychiatric patients/non-psychiatric patients of funded by Medicaid? _____/_____

7. # of psychiatric patients/non-psychiatric patients funded by Medicare? ____/_____

8. # of psychiatric patients/non-psychiatric patients funded by private insurance? _____/_____

9. # of psychiatric patients/non-psychiatric patients who were self pay? _____/_____

10. # of psychiatric patients/non-psychiatric patients involved in Adverse Incidents (injury to patient/personnel, damage to property)? _____/_____

11. # of psychiatric patients funded by DMH? _____

12. Please estimate what % of psychiatric patients utilizing your ED would be medically stable enough to divert to a specific psychiatric ED? _____

13. What concerns do you have about the creation/utilization of a psychiatric ED?

_____

_____

_____

DiNovo, 2/2/05

Appendix E: PSYCHIATRIC EMERGENCY DEPARTMENT (ED) NEEDS ASSESSMENT for LAW ENFORCEMENT/EMS

FEBRUARY 2005

Name of Agency:_____

Name and Title of Representative:_____

Date Form Completed:_____

Please report data representative of 7/1/04 – present.

Psychiatric subjects include psychiatric/Alcohol and other Drugs/Dually Diagnosed patients.

1. What is the total number of psychiatric subjects transported by your personnel to an Emergency Department (ED)? _____
2. How many psychiatric subjects were transported on "white" papers?_____
3. How many psychiatric subjects were transported on "pink" papers?_____
4. How many psychiatric subjects were transported in Emergency Protective Custody (EPC)?_____
5. What was the average wait, in hours, for your personnel in an ED with EPC'd subjects?_____
6. What was the average wait, in hours, for your personnel in an ED with subjects on White Papers?_____
7. What was the average wait, in hours, for your personnel in an ED with subjects on Pink Papers?_____
8. What was your average personnel cost per hour?_____
9. What was the impact to the community for having your personnel wait in an ED – specific incidents?
   _____
   _____
   _____
10. How many Adverse Incidents (damage to property, injury to subject/personnel) occurred with psychiatric subjects during transport and ED wait time?_____

11. What percentage of psychiatric subjects were transported to EDs in shackles, cuffs, or belly chains?_____

12. What concerns do you have about the creation/utilization of a psychiatric ED?

_____

_____

_____

Dinovo, 2/2/05

Appendix F: PSYCHIATRIC EMERGENCY DEPARTMENT NEEDS ASSESSMENT For PATIENTS AND THEIR FAMILIES

Date Form completed: _____

1. How many times have utilized an emergency department in the past year to address your psychiatric needs?
   1 - 4 times____5 – 8 times_____9 – 12 times_____ more than 12 times_____

2. Who usually brings you to the emergency department?
   Self____ family/friends____ case manager____ law enforcement____ EMS____

3. What was your shortest length of stay in an emergency department?_____

4. What was your longest length of stay in an emergency department?_____

5. Overall, how satisfied have you been with your treatment in an emergency department?
   not satisfied at all____ somewhat satisfied____ satisfied____ very satisfied___

6. Would you use a psychiatric emergency department?_____

7. What concerns do you have about using psychiatric emergency department?
   _____
   _____
   _____
   _____

Dinovo

2/2/05

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