STROUDWATER

IMPROVING OUTCOMES FOR PATIENTS WITH BEHAVIORAL HEALTH AND/OR SUBSTANCE USE DISORDER IN RURAL EMERGENCY DEPARTMENTS

June 2025

LEARNING OBJECTIVES

1. Review the current challenges to caring for patients with behavioral health needs in rural emergency departments
2. Understand best practices to improve care for this population
3. Identify 1-2 ideas to bring back to your hospital or health system
4. Learn about a new offering to help rural ED teams improve care for patients with behavioral health needs

CURRENT STATE

RISING RATES OF BEHAVIORAL HEALTH IN THE EMERGENCY DEPARTMENT

More than 20% of adults in the US have some form of mental health disorder.

As of 2025, nearly 10% of all visits to rural emergency departments involve mental health or substance misuse.

More than one-third of the US Population lives in mental health professional shortage areas (2024).

The lack of mental health professionals in rural areas can delay treatment and contribute to longer ED stays.

RURAL MEDICINE BEHAVIORAL HEALTH CHALLENGES

More than 60% of rural areas lack psychiatrists, and half lack psychologists.

Rural residents often face challenges related to geographic isolation and the need to travel long distances to access care.

Financial barriers to mental health care reduce access to necessary treatment.

In rural areas, there may be greater concerns regarding social stigma that can prevent individuals from seeking help.

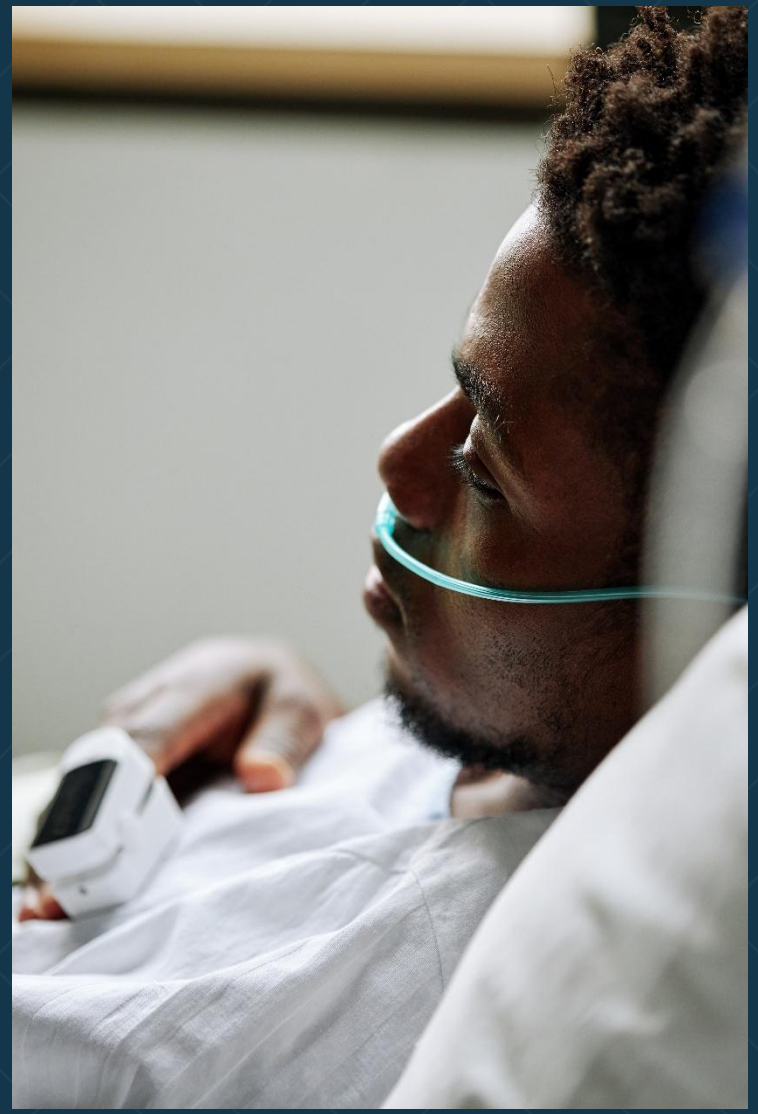
Source: https://www.commonwealthfund.org/publications/2023/feb/filling-behavioral-health-gaps-rural-communities

ED BURDEN

- **Variation in ED expertise and mental health training** can lead to inadequate care and negative patient and staff experiences.
- The average ED length of stay for psych patients is double that of non-psych patients (median 5.5 hours), exacerbating ED overcrowding.
- Proposed changes to Medicaid eligibility are likely to increase the burden on rural and urban ED settings.

In a survey of over 300 ED medical directors:

- 79% of the respondents said psychiatric patients were boarded in their EDs, with a third of the patients boarded for 6 hours or more; ***62% said these patients received no psychiatric services while they were being boarded.***
- A survey of 1,333 emergency physicians found that only 7% say a psychiatrist sees their patients in the ED.
- 11% of all ED patients are boarded, but 21.5% of all psychiatric ED patients are boarded.
- Psychiatric patients are more likely to be readmitted within 30 days.



JOINT COMMISSION: ED BOARDING

Characteristics of Boarded Patients:

- Likely to have severe and persistent mental illness
- May not be covered by insurance
- Have less social support and community connections

Therefore, patients boarded in the ED are often those most in need of care.

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The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

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FROM THE EDITORS

The Joint Commission Journal on Quality and Patient Safety Adds New Editors to Team
D. Shearer; D.W. Baker

EDITORIALS

No More Useless Band-aids that Fail to Solve America's Emergency Department Boarding Crisis
R.J. Cooper; D.L. Schriger

Screening for Suicide Risk Is Predicting the Future, Not Diagnosing the Present
R.C. Rossom; G.E. Simon

ORIGINAL ARTICLES

Clinicians' Insights on Emergency Department Boarding: An Explanatory Mixed Methods Study Evaluating Patient Care and Clinician Well-Being
D.E. Loke; K.A. Green; E.G. Wessling; E.T. Stulpin; A.L. Fant

A Proposed Approach to Allegations of Sexual Boundary Violation in Health Care
W.O. Cooper; J.J. Foster; G.B. Hickson; A.J.R. Finlayson; K. Rice; S. Sanchez; J.C. Smith; I. Dees; J. Adler

Does Suicide Risk Screening Improve the Identification of Primary Care Patients Who Will Attempt Suicide Versus Depression Screening Alone?
C.J. Bryan; M.H. Allen; A.O. Bryan; C.J. Thomsen; J.C. Baker; A.M. May

Long-Term Sustainability and Adaptation of I-PASS Handovers
S.L. Ryan; M. Logan; X. Liu; D.M. Shahian; E. Mort

Improving Diabetes Screening in the Primary Care Clinic
E. Tseng; Y.-J. Hsu; C. Nigrin; J.M. Clark; J.A. Marsteller; N.M. Maruthur

Key Strategies to Publishing Your Quality Improvement Work
R. Suttle; G. Armstrong; L. Headrick; R. Miltner; G. Ogrinc

IMPROVEMENT BRIEF

Improving the Format, Content, and Writing Process of Outpatient Clinic Letters Within a Musculoskeletal Therapy Department
C. Horler; E. Eve; R. Turner

INNOVATION REPORT

Learning from Latent Safety Threats Identified During Simulation to Improve Patient Safety
K. Congenie; L. Bartjen; D. Gutierrez; L. Knepper; K. McPartlin; A. Pack; K. Sava; L. Smith; H. Watts

SENTINEL EVENT ALERT

Sentinel Event Alert 67: Preserving Patient Safety After a Cyberattack

LETTER TO THE EDITOR

Survey of Perioperative Nurses Regarding Their Experience with Operating Room Fires
E. Mlaver; J. Sharma

The Joint Commission

IMPROVING CARE DELIVERY

What are the general principles used in ED improvement that can be used to care for psychiatric patients?

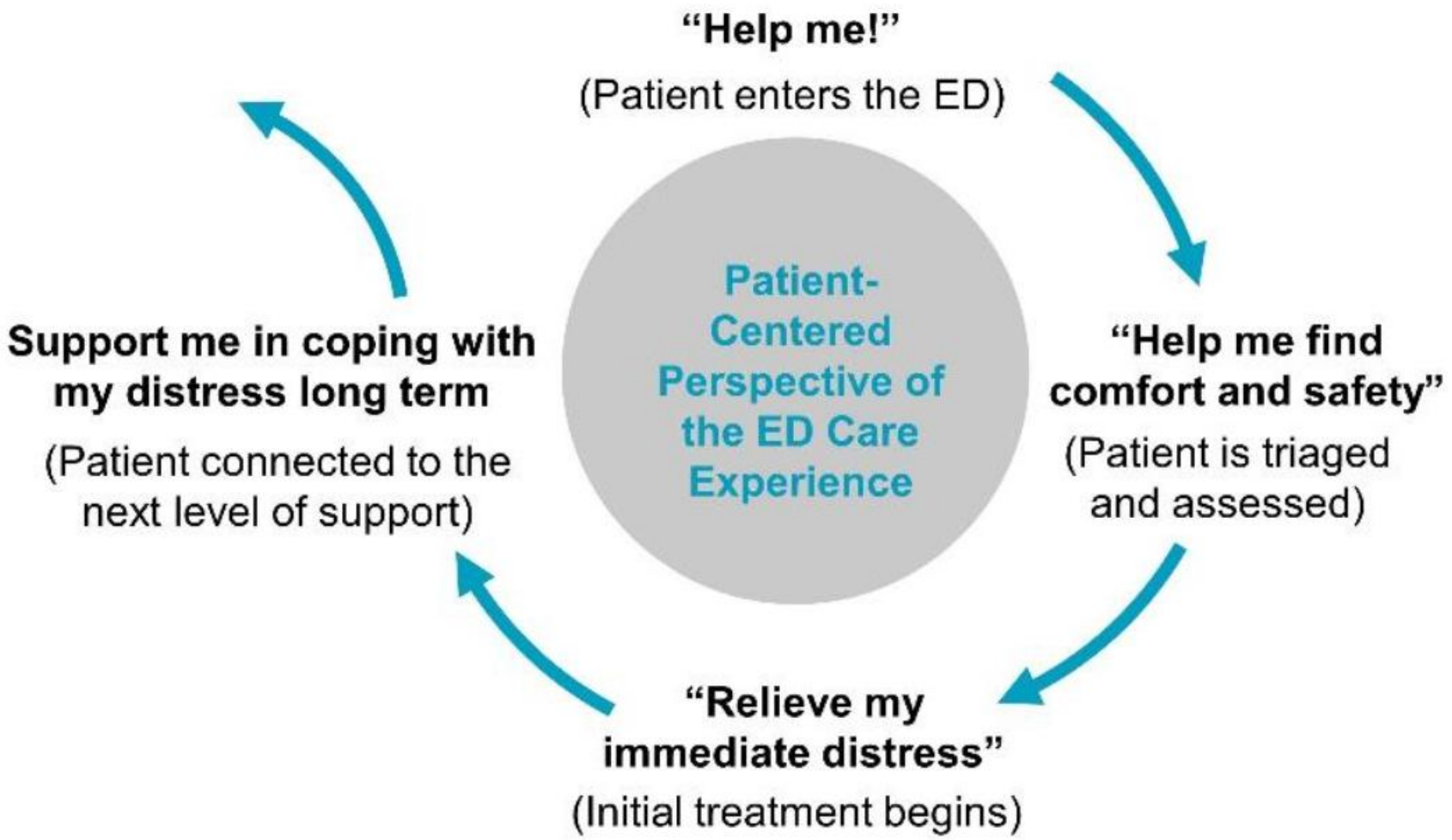
How can we all help each other with the patient at the center?

IHI PAPER WITH A DIRECTION FOR IMPROVEMENT

Improving Behavioral Health Care in the Emergency Department and Upstream

Institute for Healthcare Improvement, 2022

PATIENT-CENTERED PERSPECTIVE



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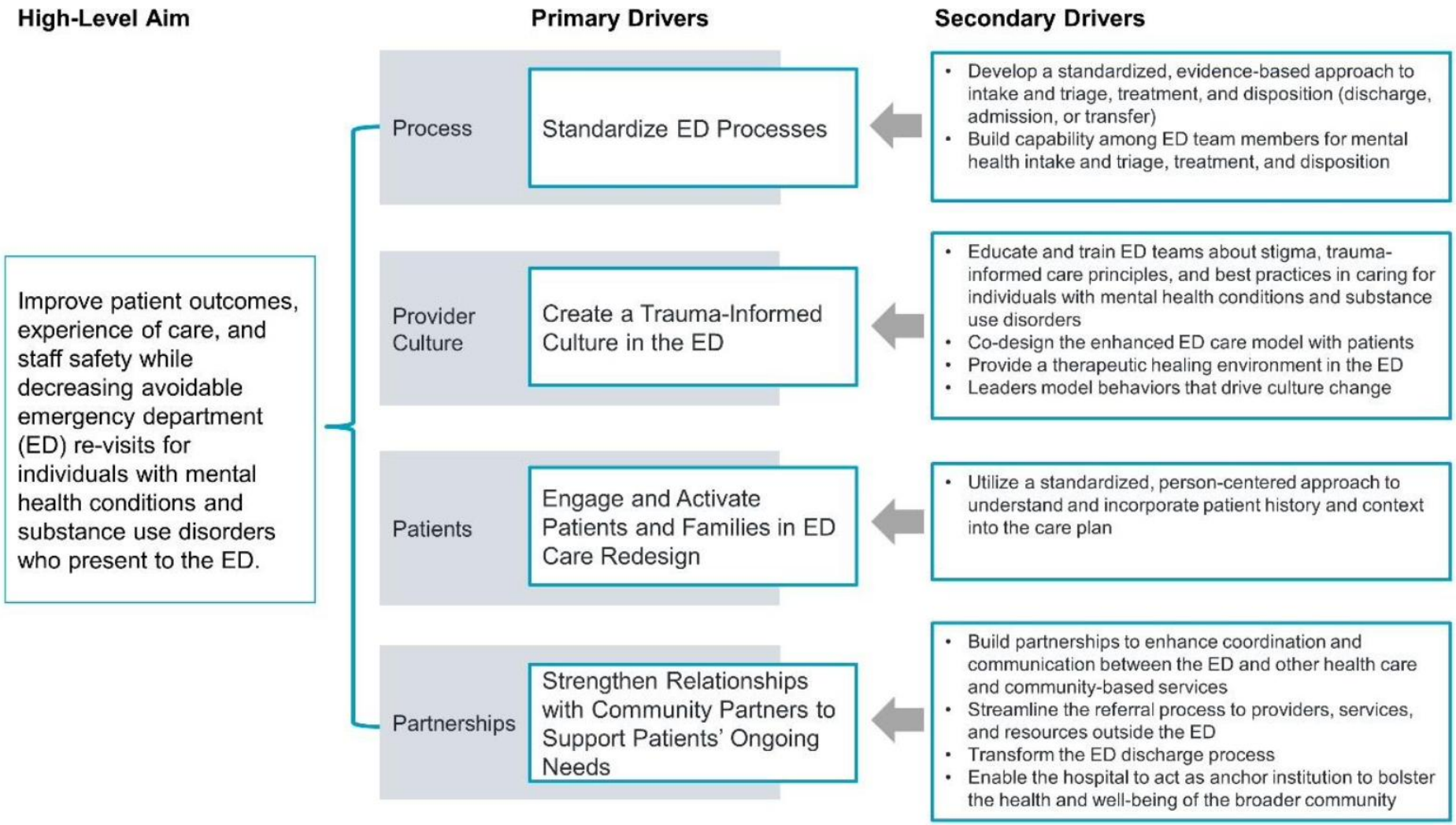
DRIVERS OF CHANGE



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WHAT OTHER GROUP OF PATIENTS WOULD BE ISOLATED & NOT ACTIVELY TREATED?

NEW PARADIGM: STANDARDIZE ED PROCESSES

Move from “sedate and wait” to “triage, assess, and initiate treatment.”

EARLY MEDICATION ADMINISTRATION

Worked with our psychiatrists to get agreement on standard diagnosis-based medications for patients.

Obtained agreement that all patients in the ED over 8 hours would get a nuanced medication assessment.

Set a goal with the ED staff for arrival to medication administration of under 30 minutes for most patients.

Found that patients who were treated early had less agitation, higher discharge percentage, and lower total length of stay if hospitalization was needed.

SMART Medical Clearance Form

Suspect New Onset Psychiatric Complaint?.....if "**NO**" continue ☐

Medical Conditions that Require Screening?.....if "**NO**" continue ☐

- Diabetes (FSBS > 250)
- Possibility of pregnancy
- Other complaints that require screening

Abnormal:.....if "**NO**" continue ☐

- **Vital Signs?**
  - Temp: > 38.0℃ (100.4℉)
  - HR: < 50 or > 110
  - BP: BP < 100 systolic or > 180/110 mm Hg (≥ 2 consecutive readings)
  - RR: < 8 or > 22
  - O_2 Sat: < 95%
- **Level of Consciousness?**
  - Cannot answer name, month/year and location
  - If inebriated HII score ≥ 4 (see next page)
- **Physical Exam (unclothed)?**

Risky Presentation?..... if "**NO**" continue ☐

- Age < 12 or > 55
- Possibility of ingestion
- Eating disorders
- Significant traumatic injury, prolonged struggle or "found down"

Therapeutic Levels Needed?..... if "**NO**" continue ☐

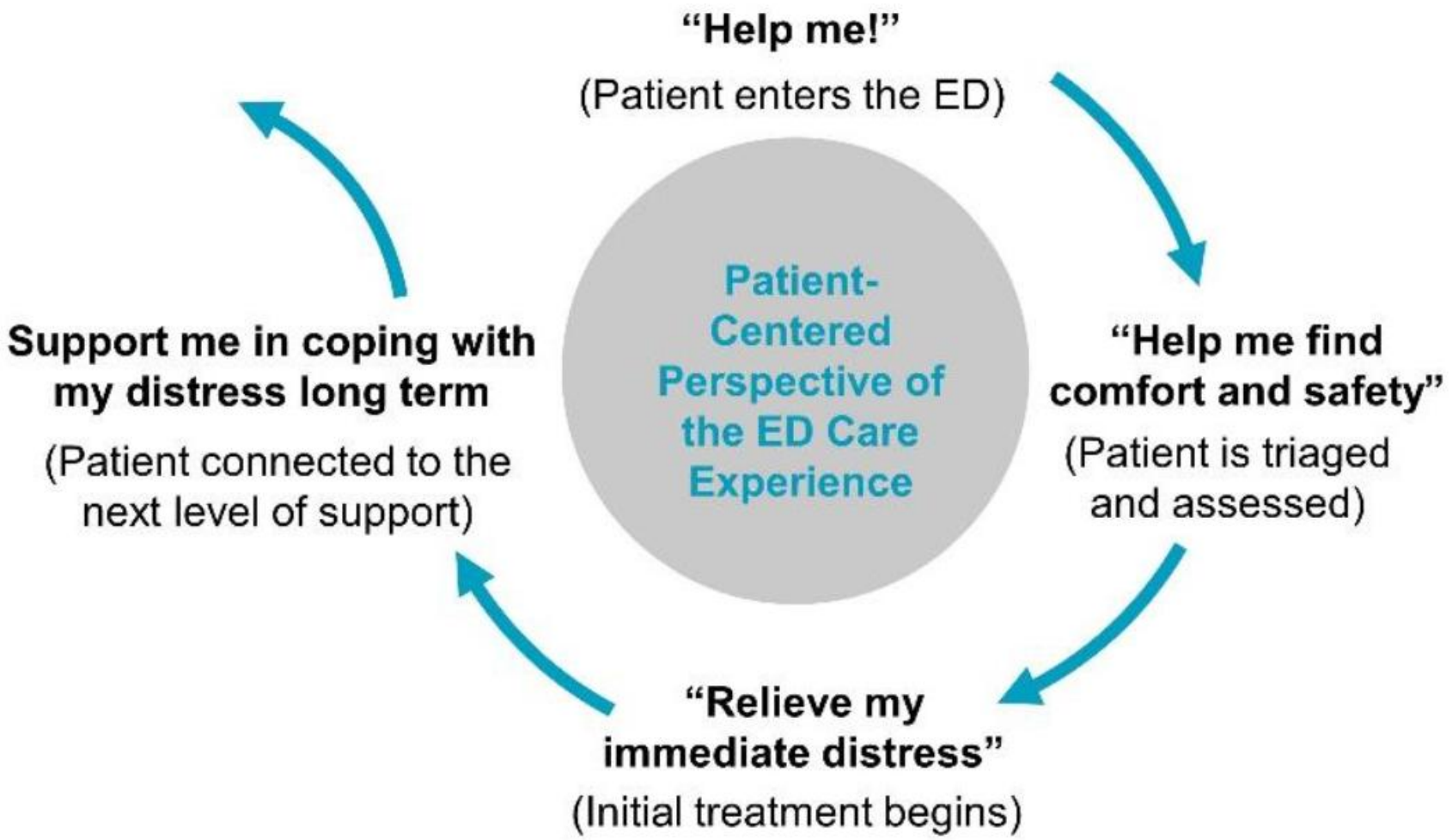
- Dilantin
- Lithium
- Digoxin
- Coumadin

☐ **If ALL SMART categories CAN be answered with "NO" then the patient is considered medically cleared and no additional testing is indicated.**

☐ **If ANY SMART category CANNOT be answered with "NO" then appropriate testing and/or documentation of rationale for medical clearance must be reflected in the patient's chart.**

Completed by: _____ _____**, MD/DO** **Date:** _____
Signature Print

PATIENT-CENTERED PERSPECTIVE



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YOUR STEPS TO WELLNESS

Step 1: Assessment

- You will be evaluated by the medical and behavioral health teams.
- You may require lab work to be completed and/or medications.

Step 2: Individualized Treatment

- **Case Management:** We will obtain information from you, your family, friends, caregivers and/or community partners, as needed, to help plan for your care.
- **Goal Setting:** We will work with you to develop individualized goals for reaching and maintaining wellness.
- **Treatment:** We will offer you classes and educational support groups to help support your steps toward wellness.
- **Release Planning:** We will work with you, your family, friends, physicians and/or caregivers to establish resources and continued treatment to help maintain your state of wellness.

Step 3: Release/Transfer

- We will work with you to help facilitate your release plans or possible transfer to a higher level of care.

KAISER PERMANENTE®

BEST PRACTICES

- Tele-psychiatry to leverage staff (be sure reassessment and treatment are incorporated)
- Community engagement to increase clinic capacity and delivery of medications to the homeless
- Low-cost collaboration: Community mental health clinicians can train ED staff in the management and care of patients
- Look for every community resource
- Work with law enforcement
- Community paramedicine

Dr. David Selander, MD, MBA

Executive Medical Director of Acute Care and Emergency Medicine with Providence Swedish Medical Center in Seattle, WA

Providence SWEDISH

Standardizing Our Approach to Behavioral Health Patients

David Selander, MD MBA – Swedish Executive Medical Director of Acute Care and Emergency Medicine

Providence-Swedish, Seattle, WA

Background:

Providence-Swedish has 7 EDs in Seattle and the surrounding urban areas

Environment at Swedish in 2020:

- BH population steadily growing with increase in severely agitated patients with violent behavior
- Increased workplace violence (WPV)
- Lack of standardized treatment
- Cultural concerns around care of this challenging patient population

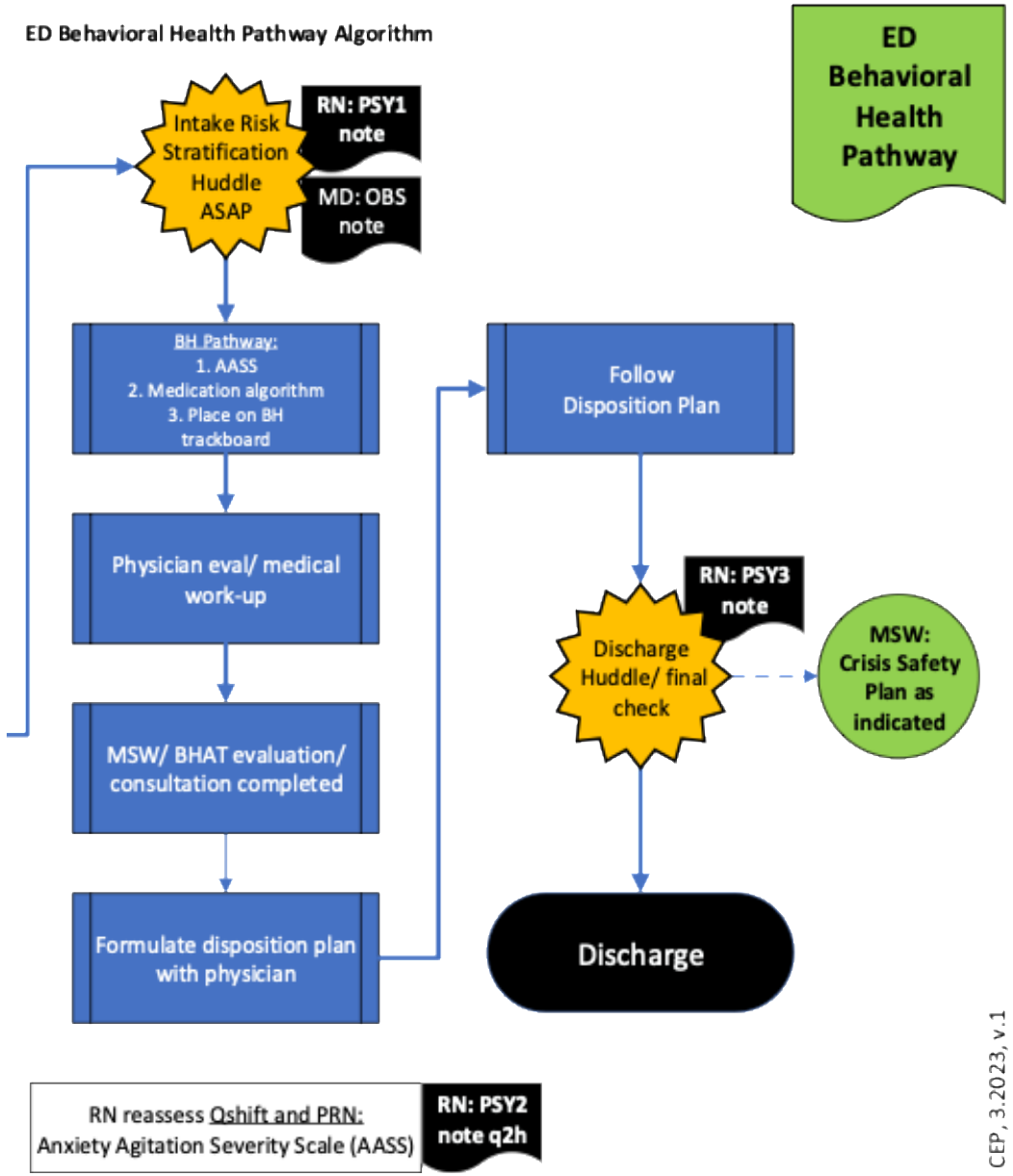
Swedish ED BH Pathway:

In 2020, a pathway was created to standardize early and aggressive treatment of BH crises:

- Early huddle promotes communication and gets everyone on the same page
- Objective score-based treatment of agitation
  - Track treatment efficacy
  - Intervention/medication algorithm based on score
- Social Work/BH Assessment Team workup
- Admit/Discharge decision
- Discharge huddle to ensure a safe discharge plan

Concurrent focus on WPV reduction:

- Enhanced reporting and tracking
- AVADE hands-on training
  - Decreased WPV incidents
  - 400% decrease in injury from a WPV incident



CEP, 3.2023, v.1

Providence SWEDISH

Agitation Anxiety Severity Scale (AASS)

- Score based on 17 observable patient behaviors
- Broad Scope - assesses both agitation and anxiety
- Detailed and Nuanced Scoring – captures subtle variations in severity and progression to influence less restrictive treatment measures
- Less opportunity for implicit bias than other scores
- Better Treatment Guidance - de-escalation, comfort measures, anxiolytics vs. anti-psychotics

Assessment findings indicate patient is a candidate for early medication administration as part of stabilization treatment. Nurse completes the 17-item Agitation Severity Scale Decision Scoring Grid and selects the appropriate medication based on the scores

Agitation Severity Scale	Scoring	Criterion: Anxiety	Agitation	Results/Criterion		Action
Spitting	4		x	0-1	Anxiety	reassess per routine
Red in the Face	4		x	2-3	Anxiety	medicate mild anxiety
Darting Eyes	1	x		4+	Anxiety	medicate mod. anxiety
Yelling, louder than baseline	2		x			
Demanding	2		x	0-1	Agitation	reassess per routine
Speaking more quickly than baseline	1	x		2-3	Agitation	medicate mild agitation
Angry tone of voice	2		x	4+	Agitation	medicate mod. agitation
Persistent disruptive verbalizations	4		x			
Physical violence towards self or others	4		x			
Violating Self or Others	3		x			
"In your face"	3		x			
Decreased self-control, impulsiveness	4		x			
Puffed up, chest out, threatening posture	3		x			
Tapping, clenching, involuntary movement of hands	1	x				
Restless	1	x				
Confrontational	2		x			
Unable to be calmed	2	x				

Results:

- Increased comfort with and standardized treatment of ED patients in BH crises
- Increased use of timely and appropriate medications
- Decreased workplace violence
- Decreased violent restraint use
- Improved regulatory compliance

Advice:

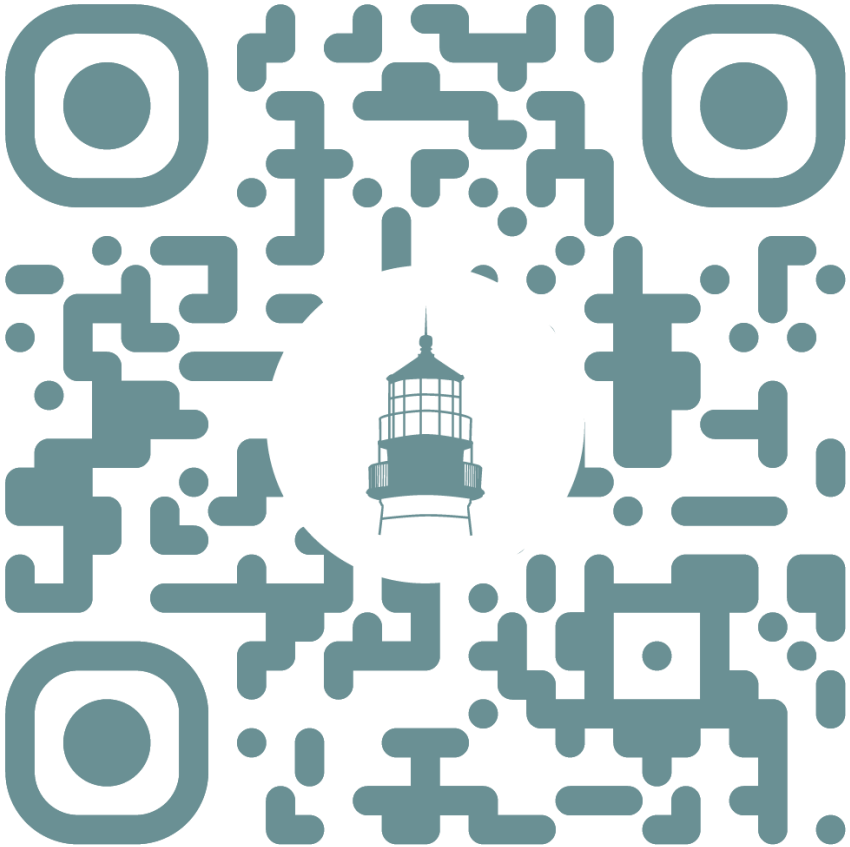
- Start with **culture**
- Set expectations around care with **standardized treatment pathways**
- Focus on **workplace violence reduction** initiatives

DISCUSSION WITH DR. SELANDER

UPCOMING PROGRAM TO DRIVE CHANGE

BEHAVIORAL HEALTH IN THE RURAL EMERGENCY DEPARTMENT: IMPROVEMENT 'SPRINT'

- Ten-week virtual program designed to support your CAH's improvement goals with a combination of content, coaching, and on-site improvement.
- Features content experts from across the country.
- Opportunities for individual CAHs or whole-system participation.
- **Next open-enrollment cohort launching in September 2025!**



STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

Thank you!

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