HB 3090 Report

Emergency Department Release Survey of Hospitals

March 2019

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Oregon Health Authority

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Emergency Department Release-Survey of Hospitals

March 12, 2019

Background and Methodology

ORS 441.053 (HB 3090) was meant to reduce suicides for people 14 years of age and older. The law requires hospitals with emergency departments to adopt policies for the release of patients from emergency services following treatment for a behavioral health crisis. People in "behavioral health crisis" is a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate treatment to prevent serious deterioration in the person's mental or physical health. Adoption and implementation of policies for the supportive release from the hospital's emergency department includes suicide prevention measures. The bill also required hospitals to share progress on these policies with the Oregon Health Authority. Oregon Health Authority-Health Analytics conducted an online survey of hospitals with emergency departments in the first two months of 2019. This report summarizes the findings from that online survey.

For a review of these regulations see these links:

https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/HB3090/Enrolled

ORS 441.196, ORS 441.015-441.063:
https://www.oregonlegislature.gov/bills_laws/ors/ors441.html

A request to complete a Survey Monkey questionnaire was sent by email with three separate reminders to the listed contacts at each hospital in Oregon. This list of emails is maintained by Oregon Health Authority's Division of Public Health. Recipients of the email were asked to complete a survey on "details about your emergency department discharge policies and protocols" (Reference OAR 333-520-0070). The email message asked that the questionnaire be completed by the Emergency Department Administrator most knowledgeable about hospital protocols. Participation was described as taking no longer than 10-15 minutes. Appropriate links to the statute and house bill were provided in addition to a contact if there were any further questions. Fielding of the survey was closed in the second week of February, 2019. Every question with item responses is provided in the Appendix.

Key Findings

There are 59 hospitals in Oregon with emergency departments (represents the number of hospitals submitting acute/emergent discharge information to OHA.) We calculate the response rate based on 21 responses from 59 hospitals. This represents a 36 percent response rate. Hospitals represented all regions of the State including Portland metropolitan area, Eastern Oregon, and West of the Cascades outside the Portland metropolitan area.

- Hospitals reported that the most common suicide risk screener is a form of the *Columbia Suicide Risk Screener.*

- Most hospital ED administrators reported their standardized ED release protocols were updated in the last half of 2018 or were in process of being updated. However, 8/21 (38%) either did not know when their policy had been updated or had a protocol over three years old.
- Close to two thirds (13/21) of hospital ED administrators reported they were able to schedule behavioral health appointments for over half of their patients within seven days of release from the ED which is stipulated as part of ORS 441.196. However, this was not true of the other third of respondents, making them out of compliance with the rule. Typical challenges given for timely scheduling of these appointments primarily had to do with scheduling logistics such as when releases occurred at night and availability of information about coverage, qualifications for visits, as well as, willingness of the patient to seek services.
- Over half (52%) of hospitals said that most patient releases received caring contacts within 48 hours of release. Although close to 20% said none of their patients get caring contacts at all.
- Less than half of hospitals (43%) reported that ALL patients with suicide ideation were released with a suicide safety plan. Most hospitals reported an estimated rate roughly half or more of their patients receive a suicide safety plan at release.
- Most respondents (42%) said that lethal-means counseling was conducted by a behavioral health clinician with other professionals such as "Social Worker" and "Nurse" being identified as well. Yet, 11% indicated that they had no specific professional assigned to this counseling.
- All hospitals reported an estimate of a group of patients with suicidality who had spent more than 23 hours in the emergency department before release. Close to half of the respondents (48%) reported their estimates to be between a quarter and three fourths of their patients with suicidality had spent more than 23 hours in the emergency unit.

Summary Conclusions

There were several notable findings in the release of patients with suicidality. For example, many hospitals reported the use of a common standardized screener and many hospital administrators reported their protocols had been updated because of the new laws. In addition, a high percentage of caring contacts were said to be taking place within 48 hours of release. Nevertheless, gaps in compliance with the law remain, particularly in the use of suicide safety plans upon release. The fact that 64% of the emergency departments in Oregon did not respond is also of concern because their nonresponse could be an indication of compliance issues. OHA is taking steps to work with the hospital association to ensure that future surveys will experience better contact strategies to raise the response rate for a more complete picture of compliance with the law. Ongoing monitoring will be required because several hospitals indicated their policies were in the process of changing, possibly as a result of the new laws.

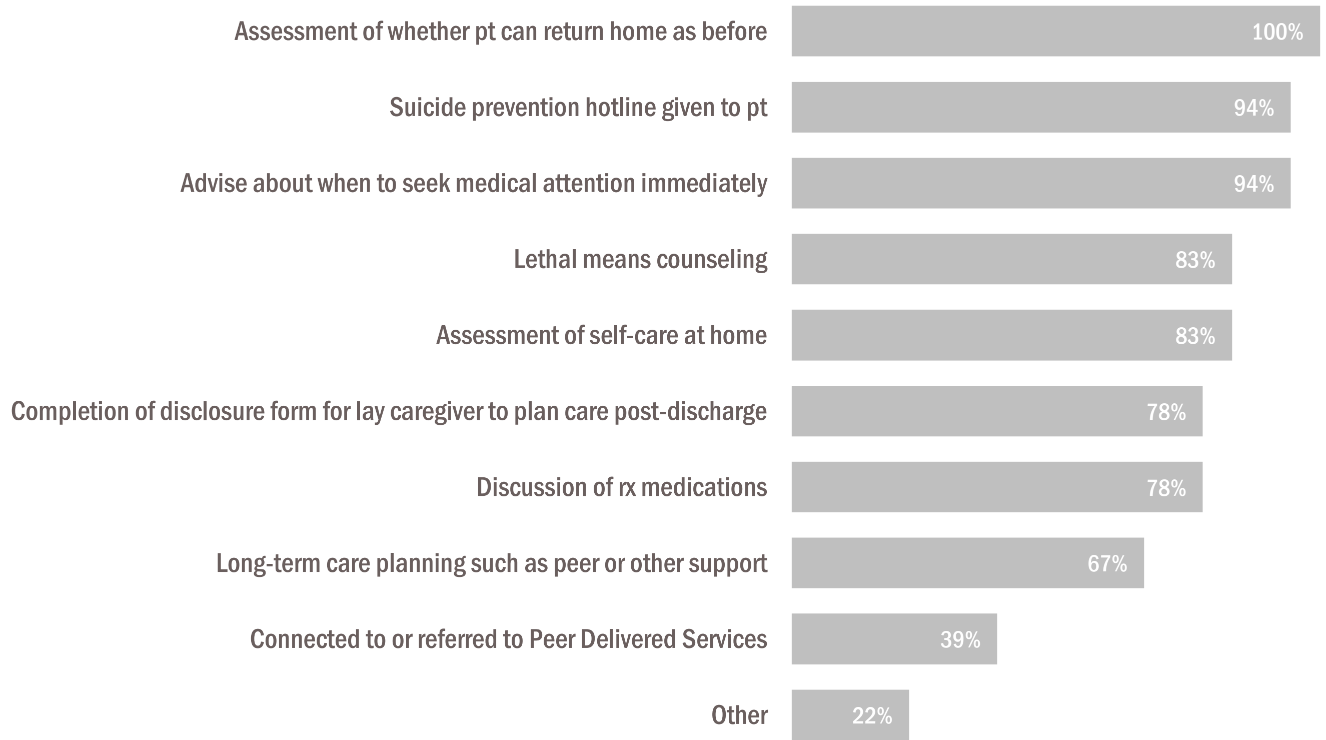
Appendix: Survey responses

When a patient presents to the ED with suspected suicidality or serious and persistent mental illness, what type of assessment is completed?

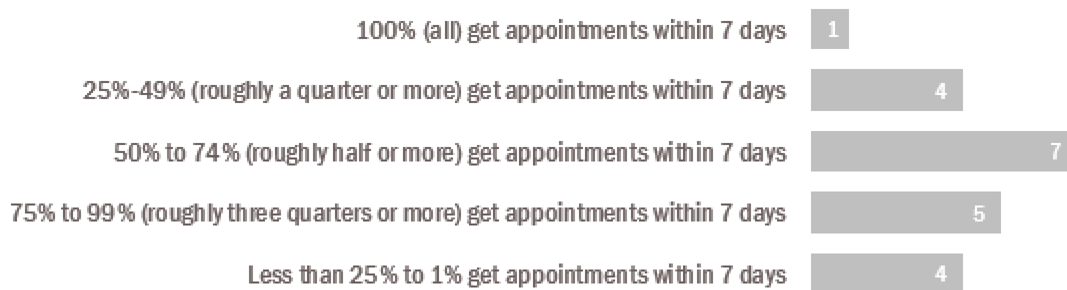
- Columbia Suicide Risk Scale   13 hospitals
- Other Reponses Given:
- Three assessments are completed as required by HB3090. 1) Behavioral Health Assessment (BH Assessment - Mental Status); 2) Risk Assessment (Suicide/Self Harm Risk Assessment); and 3) Long-term Needs Assessment (CM/SW Screening/Discharge Planning)
- Full psych assessment including a suicide risk assessment and safety planning
- The CIS completes our BH assessment
- A full mental health exam completed by a social worker is completed and documented.
- Medical Screening Exam by ED provider and Behavioral Health Crisis Assessment by Yamhill County or George Fox
- Medical assessment by ED Provider (MD, DO, or FNP). Then evaluation by QMHP.
- Complete suicide assessment by RN and/or Social Worker with complete ED evaluation by Physician.
- Psychosocial assessment

What was the date of last change of your standardized suicide ED release protocol or policy that is followed by physicians and nurses?

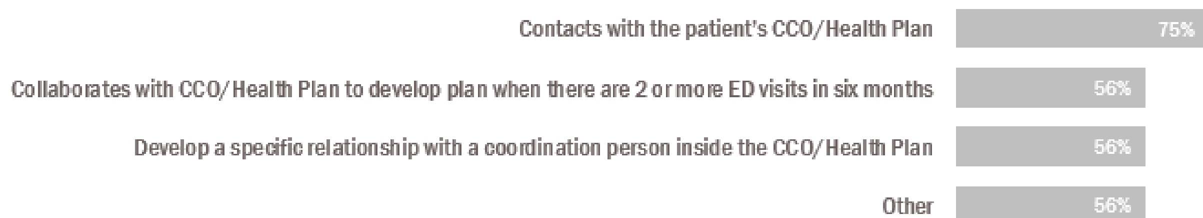
Please check ALL that apply from this list if it is part of your written discharge protocol/policy for patients presenting with serious and persistent mental illness or suicide ideation.



Please estimate the level of your success your hospital has had scheduling behavioral health appointments within seven days of the patient's release?



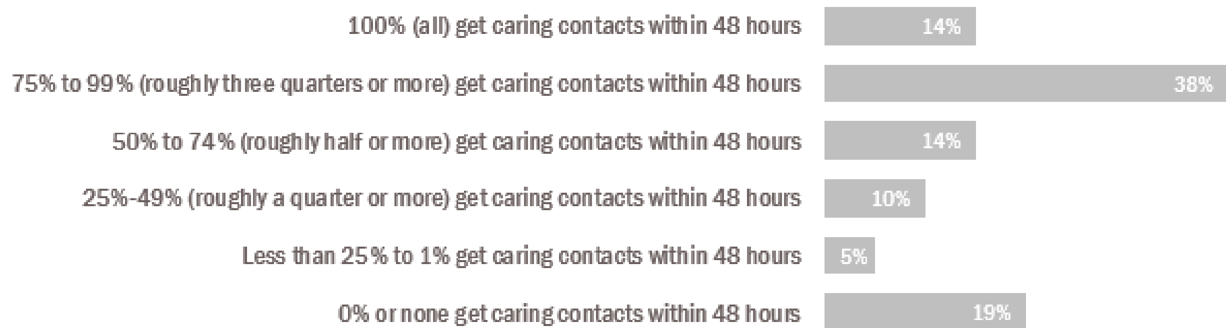
Please select the strategies used to connect released patients to services. Check all that apply:



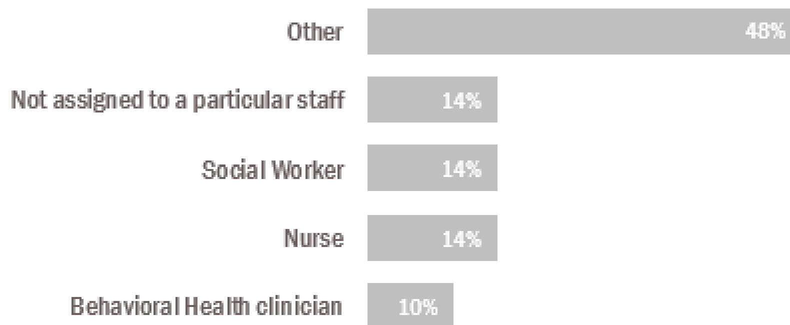
What are the typical barriers or challenges of scheduling appointments for the patient within 7 days of discharge? Multiple Answers Allowed

- Access/Provider Availability (13)
- Patient's insurance has no available appointments (6)
- Timing of discharges nights/weekends/holidays (5)
- Patient compliance (5)
- Logistics of Insurance and Information Exchange (5)

Please estimate the number of caring contacts conducted through your hospital with patients presenting with suicide ideation within 48 hours of release?



Who on the staff does these caring contacts?

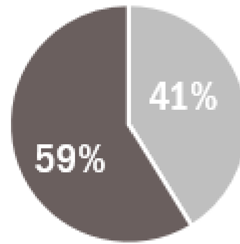


For "other" people answered:

- CCOs coordinate the care (1)
- It depends on the patient (1)
- CMHP (1)
- Contracted 3rd party crisis provider (3)
- In progress (2)
- ED Outreach Specialist (1)
- Case Managers (1)
- Do not know (1)

Is there an option for the patient to receive multiple caring contact calls after discharge?

No, we typically do not make attempts to contact patient by phone after release.



Yes, we make attempts to contact patient by phone after release.

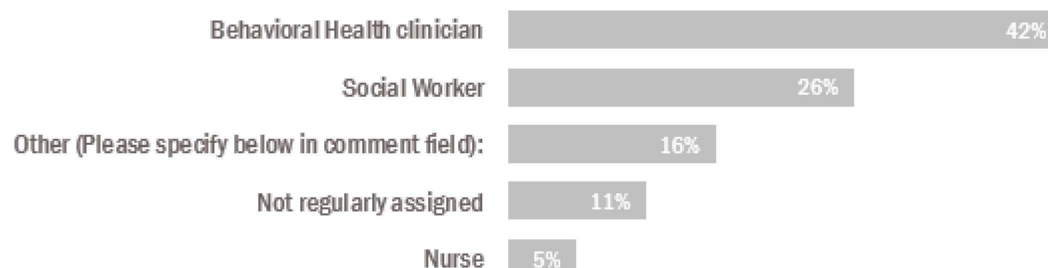
If the patient receives several attempts, what is the typical, estimated number of attempts received before stopping?

- There is a warm handoff to the outpatient provider, who facilitates the caring contact and attempts to contact the patient.
- Our contractor makes all contact attempts
- Policy in development. Historically follow up contact from the ED has not been part of the ED CIS role.
- This writer is not aware of cap on calls. Lines for Life, I believe, continues to call until contact made.
- 4 Attempts
- Two to three depending on the estimated need of the patient.

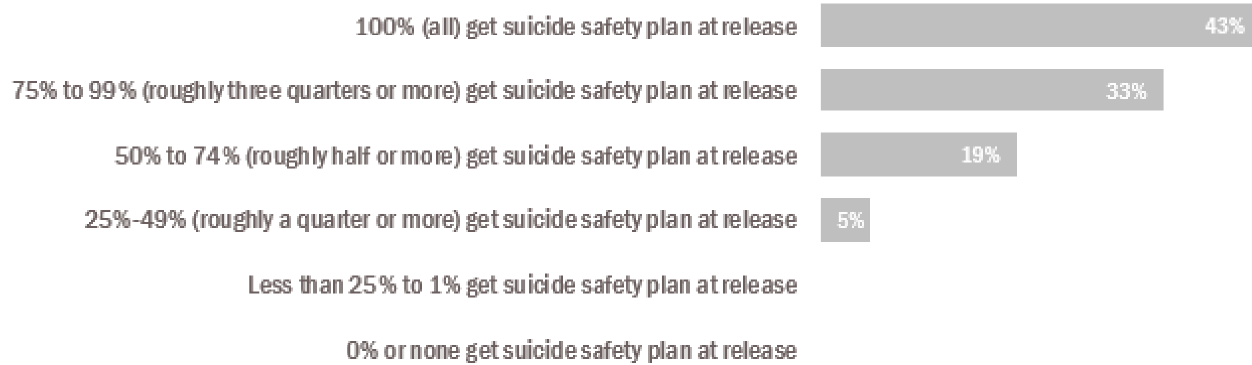
What event/situation stops the patient contacts from occurring?

- Staffing shortage (5)
- Contact information wrong (3)
- Unknown/Not Done (3)
- Nonspecific (3)

If lethal means counseling is being done at release for patients who present with mental illness or suicide ideation, who on the care team typically performs the counseling?



In your opinion, for patients presenting to ED with suicide ideation, what would be your estimate for the number of released patients that have a suicide safety plan?



In the last 12 months, what is your estimate for patients that spent over 23 hours before release that presented to your ED with serious and persistent mental illness or suicide ideation?

Please include any comments or other information that you would like us to have here.

- More geriatric psychiatric services (inpatient and outpatient) are needed with our aging population.
- Contact given for hospital
- Our CMHP facilitates scheduling follow up appointments and those are not routinely documented in our EMR   Also, any follow up is completed through CMHP, not coordinated by hospital staff
- Patients who present to the ED with suicide ideation and meet criteria have a safety plan. Estimated, not scored on actual data
- This survey does not adequately capture the work and interventions already in place and we are working to develop a stronger more thorough plan to ensure patient safety, support and stabilization.
- Assuming you are referring in to mod-severe suicidal pts, then they DC with IOP next day or stay for admission. We contract through Line for Life to contact patient within 24 hours; outreach and chemical dependency workers will also attempt contact

- Providers refuse to see OHP pts as the paperwork for billing is too complicated and not worth payment
- We are a pediatric ER seeing patients under 18. We are currently working on caring contacts. Our policy is being updated to comply with HB3090.
- We did not have a written policy before the passing of HB 3090, and it's currently in process.
- Well intentioned legislation, but difficult to enact with limited community resources for mental health
- Regs and laws need funding attached

Who responded to this survey?

21 respondents

From:

- Portland (5)
- Salem (2)
- Albany
- Baker City
- Bend
- Clackamas
- Corvallis
- Hillsboro
- Lakeview
- Lebanon
- Medford
- Milwaukie
- Newberg
- Prineville
- Roseburg
- Seaside

Representing:

- Administrator or Management (62%)
- Emergency Department Nurse (5%)
- Emergency Department Physician (5%)
- Other Clinician (10%)
- Other Role (10%)