Hospitals: Where Full Integration Begins

One-third of hospital stays are related to mental health diagnoses.[1] And in acute or emergency settings, such as the emergency department (ED), individuals often experience lengthy wait times; in one survey, 10% of EDs reported that individuals stayed several weeks in the ED for a mental health issue.[2]

IDENTIFICATION AND INTERVENTION ACROSS SPECIALTIES

While mental health is a common comorbidity with other physical health or medical conditions, it frequently goes undiagnosed — increasing costs and worsening outcomes. Further, hospitalization provides another point of contact with individuals for identifying needs — one that should be leveraged. This is especially true in suicide prevention, where hospital contacts have been found to be an effective entry point for preventing suicide.

ACTION ITEMS

- The federal government should ensure that hospital payment models and quality programs **incentivize assessing mental health at every interaction as a vital sign,** and not only during well visits. This should include integrating screening and treatment into episode-based payment models for health conditions for which there are frequent mental health comorbidities, such as cardiovascular diseases, cancers, and pulmonary diseases.
- The federal government should **increase incentives for reducing readmissions for mental health problems** over longer timeframes and provide seed funds for safety net hospitals to have the necessary resources to perform well on these new incentives.
- **Suicide and mental health crises should be included as part of hospital safety initiatives** and evidence-based strategies should be integrated into federally funded hospital quality improvement programs, such as the Zero Suicide program.

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1 "Pain in the Nation Update" (Trust for America's Health and Well Being Trust, March 2019).

2 T. C. Halmer et al., "Health Policy Considerations in Treating Mental and Behavioral Health Emergencies in the United States," Emerg Med Clin North Am 33, no. 4 (November 2015): 875–91, https://doi.org/10.1016/j.emc.2015.07.013; Beth Kutscher, "Bedding, Not Boarding. (Cover Story)," Modern Healthcare 43, no. 46 (2013): 15–17.

WELL BEING TRUST
HEALING THE NATION: ADVANCING MENTAL HEALTH AND ADDICTION POLICY

Hospitals: Where Full Integration Begins

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INTEGRATING CARE IN EMERGENCY DEPARTMENTS

Many mental health crises lead to interactions with the Emergency Department (ED), but many EDs are not well equipped to handle mental health crises. Integration remains key to improving the quality of emergency care on three levels:

- Integrating mental and physical care within the ED;
- Integrating care between Emergency Medical Services (EMS) and EDs;
- Integrating ED care with community-based treatment.

Studies indicate that developing more integrated models may provide the least restrictive, most continuous care.[3]

ACTION ITEMS

- The federal government should invest in **piloting and scaling innovative information technology solutions to improve the successful triage and coordination of care** for individuals with mental health conditions who present to EMS or the ED,[4,5] including connections with social services.[6]
- The federal government should provide funding or centralized administration to **expand the availability of online "bed boards"** that allow clinicians to find available psychiatric beds in other hospitals and transfer patients to those facilities, with the caveat that these beds are not geographically prohibitive from a person having access to their family or caregiver.[7]
- The federal government should fund the development and dissemination of **evidence-based training and continuing education materials** on mental health for ED staff.
- The federal government should **establish a three-digit suicide prevention lifeline number.** The FCC has recommended that 9-8-8 be designated as the new lifeline number, and dollars should be appropriated to allow for local call centers to support ongoing services from the call line.

3 D. Coates, "Service Models for Urgent and Emergency Psychiatric Care: An Overview," Journal of Psychosocial Nursing and Mental Health Services 56, no. 8 (August 1, 2018): 23–30, https://doi.org/10.3928/02793695-20180212-01.

4 Z. F. Meisel et al., "Optimizing the Patient Handoff between Emergency Medical Services and the Emergency Department," Ann Emerg Med 65, no. 3 (March 2015): 310-317.e1, https://doi.org/10.1016/j.annemergmed.2014.07.003.

5 Kutscher, "Bedding, Not Boarding. (Cover Story)"; M. Moore et al., "The Role of Social Work in Providing Mental Health Services and Care Coordination in an Urban Trauma Center Emergency Department," Psychiatr Serv 67, no. 12 (December 1, 2016): 1348–54, https://doi.org/10.1176/appi.ps.201500469.

6 Moore et al., "The Role of Social Work in Providing Mental Health Services and Care Coordination in an Urban Trauma Center Emergency Department."

7 Crisis Bed Registries to Assist People with Urgent Mental Health Needs. https://www.samhsa.gov/newsroom/press-announcements/201901240130