

## **Ensuring Effective Triage of Psychiatric Patients in the Emergency Department: Community Collaboration Handles Mental Health Emergencies ‘from A to Z’**

*“In the first year we started publicizing our services to providers, there was a 9 percent decrease in unnecessary psychiatric presentations in both major EDs in the county.”*

– Leonetta Rizzi, Manager, McHenry County Crisis Services,  
Centegra Memorial Medical Center, Woodstock, IL

### **Hospital and Community**

Centegra Memorial Medical Center in Woodstock together with Centegra Northern Illinois Medical Center in McHenry make up Centegra Health System, a two-hospital, 342-bed health system, which employs more than 3,100 associates and serves McHenry County and parts of Lake and Kane counties in Illinois, and Walworth County in Wisconsin.

Suburban McHenry County, which is part of the Chicago metropolitan area, has been one of the fastest growing counties in Illinois. As of 2002, its population was 276,000, of whom 95 percent were white and 8 percent were Hispanic. About 62 percent of the county works in traditionally white-collar professions, including sales and management positions, and the median income is \$69,299 per household. Six percent of the county lives below the poverty line.

### **Program Overview**

The McHenry County Crisis Center Program is the central point of access for all behavioral health emergencies in McHenry County. Beginning in 1981, the crisis program has provided emergency mental health services, upon request, to all McHenry County residents.

The program is primarily funded by the McHenry County Mental Health Board, which was established by referendum in 1969 as a result of Illinois House Bill 708. This bill provides for counties and other units of local government to allocate tax dollars for the provision of mental health services to its citizens. Within this mandate, the nine-member Mental Health Board also has the responsibility to initiate, monitor, and review all aspects of mental health service delivery for McHenry County residents.

McHenry County uses a property tax levy for the majority of the Mental Health Board’s \$10 million budget. About \$3 million comes from a block grant provided by the Illinois Department of Human Services’ Division of Mental Health, Department of Children and Family Services, Department of Rehabilitative Services, and other federal grants. In total, about \$357,000 of the county tax money and \$119,000 of the state block grant go to crisis services annually. Centegra Health System also contributes to the crisis program’s operating expenses, and a small portion of the expenses is covered by client fees.

The crisis program's primary goals are to provide prompt, compassionate, and effective mental health help during any personal, family, or community emergency. The two main

components of the program are a 24-hour crisis line and its unique 24-hour onsite response team.

The crisis line serves as the first point of contact for callers in need of immediate assistance. Crisis line professionals help people cope with personal issues and support them as they explore options. Targeted referrals are given, linking the caller to appropriate services. If the caller needs more than the services of the crisis line, the caller can be referred for a face-to-face assessment through the crisis onsite program.

The McHenry County Onsite Crisis Program provides face-to-face assessments when comprehensive and immediate services are necessary. The program is available 24 hours a day, 7 days a week, and is staffed by qualified mental health professionals (master's level). The mobile team is dispatched through the crisis line and will meet with patients anywhere that is needed: emergency rooms, schools, police stations, even in people's homes. Members of the mobile team serve on an on-call basis and can usually be with the patient within 30 minutes. The primary goals of the Onsite Crisis Team are to assess and stabilize the crisis situation, and link individuals and/or families to the least restrictive level of care needed.

### **Reducing Unnecessary Psychiatric Visits to the ED**

In 1992, when Centegra Memorial Medical Center took over administration of this county program, previously administered by the Family Service Agency, the response team saw 958 cases. Last year, in 2004, they saw 3,347 cases. Leonetta Rizzi, manager of the McHenry County Crisis Center Program, has 23 associates – two-thirds are master's-level professionals who serve on the mobile crisis team and one-third provides staffing for the crisis line and dispatches the mobile team.

Ms. Rizzi points to the comprehensive services offered through the program, "We take any mental health emergency and deal with it from A to Z." To accomplish this, the program partners with all three hospital emergency rooms in the county, the police departments, social service agencies, schools, a domestic violence group, a senior abuse and neglect prevention agency, and the Youth Services Bureau, for which the crisis program handles runaways, lockouts, and more. Several of these agencies also use the program as an after-hours provider of services for their organization; when they close, they reroute their phone lines to the toll-free 24-hour crisis number.

Among its other responsibilities, McHenry County Crisis Services also does all the screenings for state-operated mental health facilities and provides Critical Incident Stress Debriefing services in the event of a disaster. Ms. Rizzi is also responsible for the operation of the county's mental health disaster plan and has lined up 80 professionals who can show up to help out in the event of a large-scale emergency.

Because the crisis services program is funded through the McHenry County Mental Health Board and is not a "feeder" to any organization, Ms. Rizzi says, "We work for the patient." Even though there is competition among some of the partners, all are invested in not duplicating crisis services.

All partners have also become interested in minimizing unnecessary presentations to emergency rooms. “If it’s not a medical issue,” according to Ms. Rizzi, “it’s best for everyone if the patient is seen outside of the ED.” She estimates that a psychiatric presentation in the ED takes 4-6 hours, given that the patient must be evaluated by triage, nursing, a physician, and a crisis worker. On the other hand, a psychiatric presentation through the crisis line with the mobile team outside of the ED takes about 2½ hours.

Since Centegra Memorial Medical Center became responsible for administration of Crisis Services, data collected from the overall services and from the mobile teams has been analyzed since 1992. The teams determined that about half of the “psychiatric emergencies” presenting at the ED were not emergencies, but simply a way for many county residents to access mental health care. By checking who was referring people to the ED, the Crisis Services team was able to identify which providers should be targeted with information about the services available.

In 2000, the crisis program focused on psychiatrists and agencies that told patients to go to the ED when they need behavioral health services after hours or in emergency situations. When the tide started to turn as more psychiatrists and social service agencies were discovering and using the toll-free number, the program shifted its focus to police. Historically, police had tended to “drop” most mental health cases at the ED. Ms. Rizzi conducted police trainings that included information on the need for police officers to complete a petition for each patient if they dropped them off at the ED, as opposed to just calling the crisis line and arranging for the crisis team to meet with the patient (no forms to fill out unless there were behaviors that only the police had witnessed). Police involvement in the program increased. In 2004, Ms. Rizzi marketed crisis services to primary care physicians, and this year, she plans to market directly to the public through newspaper, radio, and television advertising.

In the first year they started publicizing services to providers, Ms. Rizzi reports a 9 percent decrease in unnecessary psychiatric presentations in both major emergency rooms in the county. The following year, the trend continued with an additional 9 percent drop at Centegra Northern Illinois Medical Center’s emergency department and “a whopping 21 percent decrease” at Centegra Memorial Medical Center’s ED. Despite some fluctuations at Northern, unnecessary psychiatric presentations at Memorial’s ED has continued to decrease from 925 in 2000 to 661 in 2004. The percentage of mobile team visits seen outside of the ED jumped 40 percent in 2001 and continues to grow.

### **Obstacles Faced, Success Factors, Lessons Learned**

#### *Obstacles faced:*

- Data was not being captured indicating how many psychiatric presentations were and were not actually emergencies. Reviewing several years of paperwork – going through random samples – was a daunting task for Ms. Rizzi and her staff. They found that half of the psychiatric visits to the ED were in fact not emergencies but just attempts to access mental health care.

- Most psychiatrists, police, therapists, agencies, etc. were accustomed to sending people needing behavioral health care to the ED. The change process has involved targeting each group and making sure they understand how sending these people to crisis services is better for everyone.

*Success factors:*

- Collaborating with existing community resources, including the county mental health board, area hospitals, schools, and many local agencies.
- Communicating with local providers in an effort to change their behavior of inappropriate ED referrals of patients with behavioral health issues.
- Getting (and continuing to work at getting) buy-in from different segments of the community – therapists, psychiatrists, group homes, police, primary care physicians, etc. To appeal to this last group in 2004, Ms. Rizzi held several in-services, spoke at meetings, and sent mailings.

*Lessons learned and advice to others:*

- Collaborate with existing community resources. If there is a county mental health board, draw it into the planning phase of the program.
- Credential mobile teams to do assessment and disposition to the appropriate level of care. “If emergency department nurses and doctors have to process cases on their own without social services support,” Ms. Rizzi contends, “it leads to a ‘revolving door.’ The ED staff don’t have the expertise nor time to triage these cases properly due to the high volumes of medical emergencies we’re also seeing in our EDs.”
- Include a 24-hour access number of some kind. If your hospital has a psychiatric unit, you might be able to use the Behavioral Health Central Intake Department as a resource. “Most central intake departments are 24 hours and have a 24-hour line,” Ms. Rizzi says. “So they might be willing to develop initiatives similar to ours to help clients avoid the ED and instead access a more appropriate level of behavioral health care through them. The challenge and goal are to prevent psychiatric patients from inappropriately utilizing the ED when a different level of care would be more effective. Therefore, if we can change the old paradigm and create a culture in one’s community that advocates and supports 24-hour behavioral health access outside of our EDs, then everyone, especially the patient, is a winner.”

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