State of the Art Conference
VA Emergency Medicine (SAVE)

Emergency Care for Acute Mental Health Conditions Work Group

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This is a draft and may not represent the final recommendations that will be forthcoming.

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Evidence Synthesis: Effectiveness of Mental Health Interventions in the Emergency Department

- Multicomponent interventions for suicidality (risk assessment, safety planning, follow-up care coordination, other components) appear effective in ED/UCC settings. However, effects are not sustained over time.
- Barriers to MH screening and assessment have been identified, e.g., insufficient time, privacy, challenges with integration into ED/UCC workflows.
- Interventions for opioid overdose appear to have limited evidence.
- Paucity of literature on non-opioid substance use and psychosis management in the ED/UCC setting.

Key Issue #1

Improve Access to Emergency Mental Health Care for Veterans

- How can we best facilitate implementation of evidence-based practices?

Evidence

-- Good evidence for multicomponent interventions for suicidality that span within- and post-ED/UCC care.

-- Some evidence that telemental health approaches may improve MH care access in ED/UCC settings.

-- Little evidence suggesting brief interventions for substance use are effective in ED/UCC settings.

Policy Recommendations

- Enhance and support implementation of telemental health modalities in ED/UCC settings to increase access to care both during- and post-ED/UCC visits.

Research Recommendations

-- Improve understanding of barriers, facilitators, harms, and benefits associated with telemental health modalities and their impact during- and post-ED/UCC MH care.

-- Identify workforce development models to improve emergency mental health care: workflow analysis, embedded MH staff, retention and recruitment, regional differences (e.g., rural, urban), role (e.g., Peer Specialist, social worker).

-- Determine mechanisms impacting effectiveness of brief substance use interventions in ED/UCC settings to inform implementation.

Data Needs

- Real-time characterization of the VHA emergency mental health workforce for identifying effective organization strategies for enhancing ED/UCC MH capacity.

- Monitoring of existing initiatives and their effectiveness within ED/UCC settings (e.g., Integrated Care Coordination, Opioid Safety Initiative, SPED, SBOR).

Key Issue #2

What evidence-based policies or interventions should be implemented to improve care of Veterans presenting with mental health symptoms in the ED/UCC?

Goal: Implement evidence-based care strategies for Veterans with mental health conditions in ED/UCCs

A. Triage and screening
B. Symptom management
C. Care coordination

A. SCREENING

Policy Recommendations

-- All ED/UCC patients with mental health symptoms should be screened for suicidality, alcohol use disorder, and drug use (including prescription drug misuse).

-- All ED/UCC providers should be trained on how to recognize and de-escalate psychosis- or substance-induced aggression and agitation.

A. SCREENING

Research Questions

-- How should screening that is patient- and provider-centered be implemented? That is,

a. Screening seen as relevant to patient's concerns by patients and providers.

b. Screening is incorporated into the workflow.

c. Positive screens are reliable and lead to appropriate care.

-- Would screening for other mental health conditions in the ED, especially anxiety, enhance patient outcomes?
(Anxiety is in the top 3 of MH conditions seen in VA EDs.)

B. SYMPTOM MANAGEMENT

Policy Recommendations

-- All ED/UCC patients with identified suicidality or substance use concerns should receive an intervention that includes components of safety planning, brief counseling (to reduce symptoms/use and/or to seek help), linkage to subsequent care, and follow-up to ensure care was initiated.

-- All ED/UCC patients with alcohol or opioid use disorders should be offered medications for those disorders. All patients with opioid overdose and/or use disorder should receive naloxone.

B. SYMPTOM MANAGEMENT

Research Questions

-- How can bundled interventions be incorporated into the workflow and implemented?

(Facilitators: More ED MH staffing, more staff role responsibility for intervention delivery;

Barriers: scope of practice [“it’s not in my skillset”], no feedback on patient outcomes and successes; lack of prescribing capacity for MOUD)

-- Which components of bundled interventions are cost-effective?

-- Should bundled interventions for mental health be tailored to patients’ co-occurring problems such as medical conditions, trauma history, and life context (e.g., housing and food insecurity)?

B. SYMPTOM MANAGEMENT

Research Questions continued

-- What is the most effective mix of tele/video and in-person care to deliver these interventions? What are efficient models to deliver tele/video mental health intervention components, e.g., regional, national hubs?

-- Evaluate the potential for Peer Specialists to facilitate protocols for screening, counseling, linkage, and follow-up.

C. CARE COORDINATION: WITHIN VA, WITH COMMUNITY

a. Among providers during the ED episode
b. With post-ED providers

<u>Policy Recommendations</u>

--Implement centralized, comprehensive, and collaborative longitudinal care management for mental health patients that includes the ED as one care setting.

--Continue to improve VA-community information sharing pre-, during-, and post-ED/UCC care for patients with mental health/substance use conditions.

(Facilitator: Use of Health Information Exchanges)

C. CARE COORDINATION: WITHIN VA, WITH COMMUNITY

Research Questions

-- What are the most effective and cost-effective models of longitudinal care management delivery? What are the facilitators and barriers to implementing LCM?

(Facilitators: low-barrier access to post-ED services)

-- What are the acceptability and feasibility of enhancing VA-community ED/UCC mental health coordination via innovative strategies, e.g., community ED provider training, telehealth consultations, community-embedded VA MH providers, Peer Specialists, linkage from community back to VA MH?

In particular, how can Veteran patients seen in community EDs for mental health concerns be repatriated to VA care?

RESOURCE NEEDS

Real-time data on variations across VA emergency care settings on processes of mental health care, e.g., what screenings are being conducted? are patients with OUD receiving naloxone? what do VA EDs do to link patients to post-ED care?

Better methods for stakeholders to share VA dashboards and other initiatives, e.g., multiple mental health care coordination initiatives are occurring; how can they be better coordinated and disseminated so they can be used to improve patient care?