IMPROVING YOUR PRACTICE:
Chapter Launches Mental Health Toolkit
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Improving psychiatric care has been a priority for the Chapter, especially since 2015, when we co-sponsored legislation to reform the Lanterman-Petris-Short (LPS) Act, which concerns the involuntary commitment of persons to a mental health institution in California.

In 2017, we sponsored and passed AB 1119 (Limón) to clarify that providers do not need to obtain patient consent to share mental health information for treatment of these patients in emergencies.

Then in 2018, we sponsored and passed AB 2099 (Gloria) to clarify that a photocopy of a 5150 application is a valid version of the 5150 application. The same year, we sponsored and passed AB 2983 (Arambula) which clarified that hospitals cannot require that a 5150 hold be placed as a condition for transfer for patients who seek voluntary psychiatric care.

As you have likely read in previous issues of Lifeline, we are taking up the fight to improve mental health in the Legislature again this year by sponsoring AB 451 (Santiago) to apply EMTALA to stand-alone psychiatric facilities and AB 774 (Reyes) to require hospitals to report boarding times to the Office of Statewide Health Planning and Development (OSHPD), all to help us with the issue of psychiatric patients’ lengthy stays in our emergency departments (ED).

Despite numerous legislative successes that improve access to care for our patients, we know all too well that patients presenting with a mental health condition still face great barriers to accessing timely treatment. It takes us next to no time to medically clear these patients, but we all know there’s more we can do to help these patients. That’s why the Chapter felt we needed to supplement our efforts with a non-legislative approach as well.

In 2016, former California ACEP Board Member, Dr. Valerie Norton, created an anti-psychotic medication table for her ED that she shared broadly with our members in Lifeline. Since then, we continue to see these patients in enduring volumes, and their prolonged boarding has become commonplace in many of our EDs. We medically clear these patients and wait for our psychiatric colleagues or county evaluation teams to manage or transfer these patients.

As newer anti-psychotic agents have become more available, many of our fellow emergency physicians have gained experience with and more confidence in using these medications while these patients board in the ED; whether it be to continue their usual psychiatric meds while boarding or to restart meds for patients who are non-compliant but know which anti-psychotics worked for them in the past. Not all of
these patients need psychiatric admission, but we fear many may not follow up with a psychiatrist on an outpatient basis.

Through efforts in her ED, Dr. Norton found that the non-compliant patients showed significant improvement with re-starting their medication in the ED. They were no longer psychotic or suicidal by the time they got evaluated by the psych team several hours later. She also found that patients with methamphetamine-induced psychosis often improved rapidly with an anti-psychotic agent and also could be safely discharged home in a few hours.

Inspired by Dr. Norton’s efforts, the California ACEP Mental Health Work Group decided to look at Dr. Norton’s medication table again and update it with the latest evidence. These anti-psychotic medications have varying side effects and drug-drug interactions. Sorting out these specifics while on shift taking care of these patients may be confusing and difficult. That’s why we’ve created the pocket medication guide found on the page following this article.

This pocket guide will be mailed to California ACEP members this year when they renew their membership and will also be available for download on the California ACEP website (www.californiaacep.org) under the Improving Health tab. There you will also find de-escalation techniques and helpful scripting that the Work Group assembled to help you take care of your agitated or psychotic patients. A copy of the de-escalation tips and scripting can also be found in this issue of Lifeline.

<table>
<thead>
<tr>
<th>Name</th>
<th>Usual Oral Dosage</th>
<th>Usual IM Dosage</th>
<th>Common Side Effects</th>
<th>Drug-Drug Interactions</th>
<th>Pediatric Dosing (5-11 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone</td>
<td>initial 0.25-1 mg</td>
<td>N/A orthostasis</td>
<td>sedation</td>
<td>Increase dose if taking cytochrome P450 inducers, decrease dose if taking cytochrome P450 inhibitors</td>
<td>0.1 mg/kg PO/IM Risk of paradoxical reaction</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>initial 12.5-50 mg</td>
<td>sedation (++)</td>
<td>orthostatic hypotension</td>
<td>Increase dose if taking cytochrome P450 inducers, decrease dose if taking cytochrome P450 inhibitors</td>
<td>0.1 mg/kg PO/IM Risk of paradoxical reaction</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>initial 1.5-5 mg</td>
<td>N/A</td>
<td>sedation (+), anticholinergic, sedation, seizure (1%)</td>
<td>Increase dose if taking cytochrome P450 inducers, decrease dose if taking cytochrome P450 inhibitors</td>
<td>0.1-0.03 mg/kg PO/IM Risk of paradoxical reaction</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>initial 20-40 mg</td>
<td>orthostasis, can increase QTc</td>
<td>Avoid with other drugs that prolong QTc</td>
<td>0.01-0.03 mg/kg PO/IM Less preferred in children due to risk of extra-pyramidal symptoms</td>
<td></td>
</tr>
</tbody>
</table>

**EPS: Extra-Pyramidal Symptoms**

Cytochrome P450: Typical inducers: rifampin, anti-epileptics. Typical inhibitors: protease inhibitors, azole antifungals, fluoxetine

Use all agents with caution in the elderly and start at lower doses, especially those causing hypotension and prolonged QTc (quetiapine, ziprasidone).

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Adapted from a table created by Valerie Norton, MD, FACEP March 2016
I especially want to thank the members of the Mental Health Work Group, Drs. Genevieve Santillanes, Valerie Norton, Aimee Moulin, Larry Stock, Cameron McClure, Catherine Ferguson, Marc Futernick, Haley Manella, Jim Hardy, and Kevin Jones for all of their work on this project. We need and welcome evidence-based and thoughtfully crafted tools, like the ones they have created, that help us take better care of our patients. Please share these tools with your department and, while you’re visiting our website, please take some time to look at our other toolkits on Medication Assisted Treatment and much more. As we make headway in sponsoring legislation to help our mental health patients and your practice, we hope our efforts with these toolkits will help you change the course of your patients’ care and dispositions from the ED.

Thank you for all you do for ALL of our patients,

Chi Perlroth

http://www.californiaacep.org

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**GENERAL GUIDELINES FOR AGITATED PATIENTS**

- Ensure a safe environment for the patient and staff—remove potential weapons from area.
- Reduce noise, lights & crowding as much as possible.
- Offer oral medications early—ask patients what has worked in past and ensure they are not missing home doses of medication while in the ED.
- Attend to physical comfort (food, drink, blanket).
- Express sympathy for what the patient is going through.
- Be respectful. Treat the patient as you would want a family member treated in the ED.
- Involve patient in treatment decisions when possible.

**TEN DOMAINS OF VERBAL DE-ESCALATION**

1. Respect personal space
2. Do not be provocative
3. Establish verbal contact
4. Be concise
5. Identify wants and feelings
6. Listen closely to what the patient is saying
7. Agree or agree to disagree
8. Lay down the law and set clear limits
9. Offer choices and optimism
10. Debrief the patient and staff

**DE-ESCALATION TECHNIQUES USEFUL IN THE ED:**

Acknowledge them politely and respectfully. “Hi, Mr. Smith, I’m Dr. Jones. I’m sorry you have to be here today. I’m going to take report from the officers and then I’ll get the full story from you.”

Offer patients things to make them more comfortable: “Would you like something to eat or drink? Some Tylenol? A blanket?”

Offer medical therapy for psychiatric symptoms: “I’d like to help you with the scary thoughts you’re having and give you something to make you less anxious. May I give you something to help calm you down?”

Involve them in decisions about their treatment: “What has worked for you in the past?” Have you tried Zyprexa or Risperdal or other psychiatric medications?”

Address their non-psychiatric needs: “Are you having any physical health problems today that we can help you with? Do you need… (a breathing treatment? something for pain? etc.)”

Give the patient choices: “Do you want the lights on or off?” “Would you like your medication in pill form, or would it be better to give you a shot?”

Express sympathy for what they’re going through: “I’m so sorry this has been so tough for you.”

Appeal to their better nature: “There are children and sick people all around us—do you think you could lower your voice a little? That would be really helpful.” “You’re scaring my staff—could you please stay in your room? I know you don’t want to scare anyone.”

Explain consequences: “I need for you to calm down and stop yelling. I want to help you, but if you can’t stop spitting (hitting/yelling/etc.), we’re going to have to sedate you.”

Smile. Use a soothing voice. Imagine the patient is your child/parent/sibling.
Mayor Steinberg spoke at length about the importance of expanding access to mental health care, with an emphasis on improving access when symptoms of mental illness first present to improve outcomes. He acknowledged that the fight to improve mental health treatment and access to care has been a long one but offered his thoughts on why he believes now is the time to make substantial changes. “There’s a hidden constituency. Every family deals with [mental health] in some way. People want to address this.”

During his speech, Mayor Steinberg also discussed why, when it comes to mental health and homelessness, “we must change the system from a process-based system to an outcomes-based system that provides better care”. That system includes better crisis stabilization services and community mental health resources to connect emergency department patients to quickly. Mayor Steinberg thanked the emergency physicians in attendance for the work they do for their homeless and mentally ill patients and acknowledged that more must be done to improve care and resources for mentally ill patients who present to the emergency department.
KEY LEGISLATION

Once LLC attendees left for the Capitol, they began lobbying for this year’s Chapter-sponsored bills and other important legislation:

AB 451 (Santiago) – Patient Access to Psychiatric Care (Sponsor)

After an evaluation by an emergency physician some patients need additional psychiatric services and require transfer to a different facility to receive a higher level of mental health care. A fundamental principle of our emergency care system is that facilities must provide emergency services regardless of a patient’s race, gender, immigration status, or ability to pay. These principals are protected by the federal Emergency Medical Treatment and Labor Act (EMTALA). Similarly, California law prohibits patient dumping and ensures that everyone who comes to an emergency department (ED) is treated for their emergency medical condition. Because not all hospitals have the capability – due to lack of available specialists or capacity – to treat every condition, this law also requires hospitals to accept transfers of patients with emergency medical conditions from another hospital.

Hospitals are expected to accept an appropriate transfer of an unstable patient and cannot ask about payment until the patient is both medically and psychiatrically stabilized. AB 451 ensures that this important patient safety protection also applies to acute psychiatric hospitals.

State Budget Allocation for Certified Drug and Alcohol Counselors (Sponsor)

We are sponsoring the one-time allocation of $30 million to place certified drug and alcohol counselors (CDACs) in EDs. This one-time budget allocation would create a pilot program for hospitals to apply for a grant to place a CDAC in each of the roughly 325 EDs throughout California. EDs encounter patients with substance use disorders regularly, yet lack the resources to adequately address their needs for treatment and recovery. This pilot program is a critical step to developing an effective and innovative solution to treating patients with substance use disorder.

The UC Davis Medical Center ED received a grant to employ a CDAC to provide interventions in their ED and showed impressive results in patient outcomes and cost savings. Over a 12-month period, the Medi-Cal insured patients who received a brief intervention and referral to treatment experienced a 60% decline in ED utilization after the intervention. Based on an average cost to Medi-Cal per ED visit, not factoring in reduced hospital admissions costs, for every $1 spent on a CDAC, Medi-Cal saved $7. The results were so compelling after the grant expired, the UCD Medical Center hired the CDAC full time.

Placing CDACs in California’s EDs will allow them to connect with patients in need, turning a crisis into the catalyst needed to seek and receive treatment.

AB 890 (Wood) – Nurse Practitioner Independent Scope of Practice (Oppose)

AB 890 would allow a nurse practitioner to practice medicine without supervision or oversight by a physician if the nurse practitioner meets certain requirements, such as practicing under the supervision of a physician for a certain number of hours. California ACEP is deeply concerned about the impact of this proposed change on patient safety. Nurse practitioners are an important part of health care delivery in conjunction with supervising physicians. Nurse practitioners, however, do not have sufficient education and training to examine and diagnose completely independent of physicians and such a practice puts patients at risk.

There is a significant distinction between the amount of education and training received by physicians and that by nurse practitioners. As recently as 2017 the Legislature passed SB 798 strengthening even further the requirements for physician training; beginning 2020, physicians must receive 3 years of residency training beyond medical school before they can receive a medical license. This recent more stringent standard is in direct conflict with the efforts of this bill to loosen standards which ensure patient safety.

While there is a legitimate concern created by the lack of access to care which currently exists, we are opposed to a solution which would have patients treated by persons without adequate education and training to do so.

The Chapter is currently tracking hundreds of bills in addition to these. Please contact us at info@californiaacep.org if you have any questions about our advocacy efforts.
CALIFORNIA ACEP CELEBRATES 30 YEARS OF LLC
CALIFORNIA ACEP CELEBRATES 30 YEARS

2019 CALIFORNIA ACEP BOARD OF DIRECTORS ELECTION
ONLINE • MAY 15-31, 2019

Cast Your Vote!
A Set-up for High Emergency Department Utilization

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Ethan J. Evans, PhD†
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INTRODUCTION: Frequent users of emergency departments (ED) account for 21–28% of all ED visits nationwide. The objective of our study was to identify characteristics unique to patients with psychiatric illness who are frequent ED users for mental health care. Understanding unique features of this population could lead to better care and lower healthcare costs.

METHODS: This retrospective analysis of adult ED visits for mental healthcare from all acute care hospitals in California from 2009–2014 used patient-level data from California’s Office of Statewide Health Planning and Development. We calculated patient demographic and visit characteristics for patients with a primary diagnosis of a mental health disorder as a percentage of total adult ED visits. Frequent ED users were defined as patients with more than four visits in a 12-month period. We calculated adjusted rate ratios (aRR) to assess the association between classification as an ED frequent user and patient age, sex, payer, homelessness, and substance use disorder.

RESULTS: In the study period, 846,867 ED visits for mental healthcare occurred including 238,892 (28.2%) visits by frequent users. Patients with a primary mental health diagnosis and a co-occurring substance use diagnosis in the prior 12 months (77% vs. 37%, aRR [4.02], 95% confidence interval [CI] [3.92-4.12]), homelessness (2.9% vs 1.1%, odds ratio [1.35], 95% [CI] [1.27-1.43]) were more likely to be frequent users. Those covered by Medicare (aRR [3.37], 95% CI [3.20-3.55]) or the state’s Medicaid program Medi-Cal (aRR [3.10], 95% CI [2.94-3.25]) were also more likely to be frequent users compared with those with private insurance coverage.

CONCLUSION: Patients with substance use disorders, homelessness and public healthcare coverage are more likely to be frequent users of EDs for mental illness. Substance use and housing needs are important factors to address in this population. [West J Emerg Med. 2018;19(6)902-906.]

INTRODUCTION

Mental illness is widespread and has high medical and socioeconomic costs. Emergency department (ED) visits for mental healthcare are growing in the United States (U.S.). Many patients continue to face significant barriers to consistent mental healthcare. ED visits increase when mental health services are unavailable or uncoordinated. Nationally, frequent ED users for all diagnoses account for 3–8% of all ED patients and 21–28% of all ED visits. High ED utilization is often seen as a marker of unmet healthcare needs as well as an opportunity to decrease healthcare costs and improve resource utilization. Yet prior research on frequent ED users found that these patients have multiple chronic conditions and high rates of primary and specialty care outside the ED. Studies of patients with high ED use for any diagnosis show that they have insurance coverage and are more likely to have private insurance or Medicare insurance.

Patients with mental illness face barriers to consistent outpatient care. Mental health services tend to be difficult to access and poorly integrated with primary care. Studies on ED utilization in patients with mental illness have focused on large urban populations and may not be generalizable to broader areas. Studies have evaluated ED utilization by patients with mental illness but are limited by the sample being either a single hospital or across a single urban area. A study of ED visits in San Diego by patients with psychiatric diagnosis found that frequent users were more likely to have lower socioeconomic status, homelessness, and co-occurring substance use disorders.

Our study examined ED utilization for patients with a primary mental health diagnosis over a six-year period across California, using data that included the geographic and socioeconomic diversity of the entire state. We hypothesized that patients with mental illness covered by Medicare or Medi-Cal (the state’s Medicaid insurance program), those who were concurrent substance users, and homeless patients would be more likely to have high ED utilization. Understanding factors associated with high ED utilization across a large, diverse state has clinical and policy implications as systems attempt to address ED utilization and healthcare costs.
METHODS

We conducted a retrospective analysis of all adult ED visits to acute care hospitals with a primary mental illness in California from 2009–2014 using a cohort defined from patient-level data for all ED visits, reported to California’s Office of Statewide Health Planning and Development (OSHPD). Each patient discharged from inpatient admission or ED treatment encounter in a licensed hospital in California is included in the OSHPD data. Our analysis included data on all ED visits from patients discharged or admitted through the ED from 2009–2014. These data do not represent a sample but rather surveillance with 100% coverage. The University of California Davis Institutional Review Board Administration as well as OSHPD’s Committee for the Protections of Human Subjects approved this study.

Data used for the study included a unique patient identification number, patient demographic information to the level of Zip Code, date of service, expected source of payment, disposition, and up to 25 International Statistical Classification of Diseases and Related Health Problems, version 9 (ICD-9) diagnosis codes. We defined a surrogate marker for ED encounters of patients with a primary mental illness diagnosis as visits with mental health diagnosis in the first diagnosis position, using ICD-9 codes. Patients with a substance use disorder were defined as patients with a substance use diagnosis using ICD-9 codes in any one of the 24 secondary diagnosis positions. We defined patients with four or more ED encounters for a primary mental illness diagnosis in a 12-month period as frequent ED users. In the OSHPD database patients who were “homeless” were specifically assigned a zip code of “ZZZZZ.” This designation is distinct from patients with an unknown Zip Code reported as “XXXX” and patients who do not reside in the U.S. reported as “YYYY.”

We calculated descriptive analyses of patient demographic and visit characteristics (Table 1). Multivariate log-linear model with Poisson distribution was used to assess the association between patient factors such as age, sex, payer, homelessness, substance use disorder, and classification as an ED frequent user. We used adjusted rate ratios (aRR) to account for variations in person/time using the Poisson log-linear model. aRR and 95% confidence interval (CI) are reported in Table 2. Data analyses were performed using SAS (V9.4) software.

RESULTS

During the study period, a total of 846,867 visits were made to California EDs by adult patients with mental illness and a valid record linkage number. This total includes patients admitted, transferred, or discharged from the ED. Mean age was 54.0 (standard deviation 21.1) and 55.8% were male. Insurance status was 20.4% Medi-Cal, 31.5 Medicare, 12.4 private insurance, 10.2 % self-pay and 25.5% other (Table 1). Overall 238,892 (28.2%) of ED visits for mental illness were by frequent users.

**TABLE 1. DESCRIPTIVE STATISTICS FOR MENTAL HEALTH EMERGENCY DEPARTMENT USERS.**

<table>
<thead>
<tr>
<th>Patient characteristics</th>
<th>LESS THAN 4 VISITS/YEAR</th>
<th>4 OR MORE VISITS/YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>607975</td>
<td>71.8</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>238463</td>
<td>50.1</td>
</tr>
<tr>
<td>Female</td>
<td>237502</td>
<td>49.9</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-25</td>
<td>55992</td>
<td>11.8</td>
</tr>
<tr>
<td>26-30</td>
<td>52316</td>
<td>11.0</td>
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<tr>
<td>31-35</td>
<td>47057</td>
<td>9.9</td>
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<tr>
<td>36-40</td>
<td>42947</td>
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<tr>
<td>41-45</td>
<td>47306</td>
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<tr>
<td>46-50</td>
<td>51478</td>
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<td>51-55</td>
<td>47985</td>
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<tr>
<td>56-60</td>
<td>36224</td>
<td>7.6</td>
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<tr>
<td>61-65</td>
<td>24586</td>
<td>5.2</td>
</tr>
<tr>
<td>66+</td>
<td>70074</td>
<td>14.7</td>
</tr>
<tr>
<td><strong>Payer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal*</td>
<td>116373</td>
<td>24.4</td>
</tr>
<tr>
<td>Medicare</td>
<td>119080</td>
<td>25.0</td>
</tr>
<tr>
<td>Other</td>
<td>106354</td>
<td>22.3</td>
</tr>
<tr>
<td>Private</td>
<td>54571</td>
<td>11.5</td>
</tr>
<tr>
<td>Self pay</td>
<td>79587</td>
<td>16.7</td>
</tr>
<tr>
<td>Homeless</td>
<td>5079</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Substance use in past 12 months</strong></td>
<td>176147</td>
<td>37.0</td>
</tr>
</tbody>
</table>

*Medi-Cal is the Medicaid healthcare program serving low-income people in California.*
Frequent ED users with mental illness had different characteristics than non-frequent users. Patients with a primary mental health diagnosis and a co-occurring, substance use diagnosis in the prior 12 months (77% vs. 37%, aRR [4.02], 95% CI [3.92-4.12]), homelessness (2.9% vs. 1.1%, odds ratio [1.35], 95% CI [1.27-1.43]) were more likely to be frequent users. Those covered by Medicare (aRR [3.37], 95% CI [3.20-3.55]) or Medi-Cal (aRR [3.10], 95% CI [2.94-3.25]) were also more likely to be frequent users compared with those with private insurance coverage.

**DISCUSSION**

Frequent users with mental illness had different characteristics than non-frequent users. Patients with a primary mental health diagnosis and a co-occurring, substance use diagnosis in the prior 12 months (77% vs. 37%, aRR [4.02], 95% CI [3.92-4.12]), homelessness (2.9% vs. 1.1%, odds ratio [1.35], 95% CI [1.27-1.43]) were more likely to be frequent users. Those covered by Medicare (aRR [3.37], 95% CI [3.20-3.55]) or Medi-Cal (aRR [3.10], 95% CI [2.94-3.25]) were also more likely to be frequent users compared with those with private insurance coverage.

In our analysis concurrent, substance use diagnoses had a strong association with frequent ED visits for mental illness. This association between substance use disorders and mental illness highlights the importance of medical treatment that addresses both disorders. According to the Substance Abuse and Mental Health Services Administration’s 2014 National Survey on Drug Use and Health, 7.9 million American adults have co-occurring, substance use disorders and mental illness. Twenty percent of individuals with a serious mental illness develop a substance use disorder in their lifetime, yet only 7.4% receive treatment for both disorders and 55% receive no treatment at all. Studies looking at single institutions have found high ED utilization in patients with co-occurring, substance use disorders. Such dual-diagnosed patients have low rates of access to treatment for their substance use disorders. Despite evidence that integrated treatment is considered best practice, there are barriers to widespread adoption. Given the high demand for mental healthcare and substance use treatment identified in this study of California, future research should assess availability and impact of integrated mental health/substance use treatment programs.

Although less strong than the association between co-occurring, substance use disorders, we also found an association between homelessness and frequent ED visits for mental illness. Homeless patients had higher rates of ED visits and hospitalizations than non-homeless patients for all diagnoses, and they reported barriers accessing outpatient care. Interventions designed to address homelessness such as supportive housing have shown to impact healthcare utilization and expenditures.

### TABLE 2. ADJUSTED RATE RATIO FOR HIGHER MENTAL HEALTH EMERGENCY DEPARTMENT USE.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Adjusted Rate Ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male vs female</td>
<td>1.25</td>
<td>1.22-1.28</td>
</tr>
<tr>
<td><strong>Payer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal vs private</td>
<td>3.10</td>
<td>2.94-3.25</td>
</tr>
<tr>
<td>Medicare vs private</td>
<td>3.37</td>
<td>3.20-3.55</td>
</tr>
<tr>
<td>Self pay vs private</td>
<td>1.43</td>
<td>1.35-1.51</td>
</tr>
<tr>
<td>Other vs private</td>
<td>1.62</td>
<td>1.54-1.71</td>
</tr>
<tr>
<td><strong>Age</strong></td>
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<tr>
<td>20-25 vs 51-55</td>
<td>0.97</td>
<td>0.93-1.01</td>
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<td>26-30 vs 51-55</td>
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<td>36-40 vs 51-55</td>
<td>1.11</td>
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<td>41-45 vs 51-55</td>
<td>1.08</td>
<td>1.03-1.12</td>
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<tr>
<td>46-50 vs 51-55</td>
<td>1.04</td>
<td>1.00-1.09</td>
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<tr>
<td>56-60 vs 51-55</td>
<td>0.91</td>
<td>0.87-0.96</td>
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<tr>
<td>61-65 vs 51-55</td>
<td>0.81</td>
<td>0.77-0.86</td>
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<tr>
<td>66+ vs 51-55</td>
<td>0.32</td>
<td>0.30-0.35</td>
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<tr>
<td><strong>Homeless</strong></td>
<td>1.35</td>
<td>1.27-1.43</td>
</tr>
<tr>
<td><strong>Substance use in past year</strong></td>
<td>4.02</td>
<td>3.92-4.12</td>
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CI, confidence interval.
National databases have shown that Medicaid recipients have a high prevalence of psychiatric disorders, and psychiatric disorders are a driver of healthcare costs. Indeed, we found a high proportion of patients entering the ED with mental illness were covered by the state’s Medicaid program Medi-Cal. This finding is consistent with other studies that have noted that patients covered by public insurance are more likely to use the ED when compared with those covered by private insurance. Additionally, California extends its Medi-Cal eligibility to the largest extent feasible under federal law. Yet barriers to consistent primary care or lack of access to regular outpatient mental healthcare could explain the higher ED visit rates.

**LIMITATIONS**

Studies that rely on retrospective data can be subject to a set of limitations such as selection, misclassification, and other forms of bias and confounding. Because our data cover the complete, documented population of ED visits in California, selection bias is mitigated. However, this study was dependent on diagnosis codes assigned by the ED provider and was subject to misclassification bias within and across the many hospitals from which patients were included. Further, choosing to identify those visiting the ED for mental health concerns by those with a mental health diagnosis in the first position served only as a proxy and risked missing patients. While individual chart review might have produced less concern, the volume of records made that infeasible. Prior work on ED populations and undiagnosed mental illness suggest that undercounting is more common. We report on healthcare utilization, but the data cannot speak to health outcomes nor can we definitively identify the causes of high ED utilization. Despite its shortcomings, this study reports and identifies important characteristics of patients who visit EDs for mental illness frequently across a large, diverse population, information that suggests areas for further study.

**CONCLUSION**

Patients with substance use diagnoses, patients who are homeless and those who are covered by Medi-Cal, the state’s Medicaid program, are more likely to be frequent users of the ED for mental illness. This suggests substance use and housing needs are important factors to address in patients with high ED use for mental health needs.

**REFERENCES**


17. LaCalle E, Rabin E. Frequent users of emergency departments: the myths, the data, and the policy implications. *Ann Emerg Med*.


YOUR LIFE IN EMERGENCY MEDICINE

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The inaugural Diane K. Bollman Chapter Advocate Award was given to California ACEP's executive director Elena Lopez-Gusman.

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September 20, 2019 | Garden Grove, California

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More information at californiaacep.org/event/AdvancED2019
For more information on upcoming meetings, please e-mail us at info@californiaacep.org; unless otherwise noted, all meetings are held via conference call.

### MAY 2019

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>5th–8th</td>
<td>ACEP Leadership and Advocacy Conference</td>
</tr>
<tr>
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<td>Washington, DC</td>
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<tr>
<td>14th at 9 AM</td>
<td>Reimbursement Committee</td>
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<tr>
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<td>Conference Call</td>
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<td>15th–31st</td>
<td>Board of Director Elections</td>
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<td>16th at 10 AM</td>
<td>Government Affairs Committee (GAC)</td>
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### JUNE 2019

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<tr>
<td>6th at 10 AM</td>
<td>Board of Directors Meeting</td>
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### JULY 2019

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<thead>
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<td>2nd at 9 AM</td>
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<td>4th</td>
<td>Independence Day</td>
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<td>Chapter Office Closed</td>
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<tr>
<td>18th at 10 AM</td>
<td>Government Affairs Committee (GAC)</td>
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<tr>
<td></td>
<td>Conference Call</td>
</tr>
</tbody>
</table>
FULLERTON, CALIFORNIA: Join our ED team in beautiful north OC at St Jude Med Center. Our 36 bed ED serves >70K pts/yr with 54-60 hrs MD, 44 hrs PA and 100% scribe coverage per day, 9-10 hr shifts. We have held this stable contract for >36 years, have excellent back-up, 24hr in house Critical Care, OB, neonatologist and hospitalists. We are a STEMI receiving center, “Advanced Comprehensive Stroke Center” and provide excellent compensation with night differential. Partnership track negotiable. EM BC/BE mandatory.

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Web: www.compliance-training.com

**CSUS Prehospital Education Program**
Thomas Oaks, Program Director
3000 State University Drive East, Napa Hall, Sacramento, CA 95819-6103
Office: (916) 278-4846
Mobile: (916) 316-7388
Email: thomasfr@stboglobanet
Web: www.ccs.csus.edu

**EMS Academy**
Nancy Black, RN, Course Coordinator
1170 Foster City Blvd #107, Foster City, CA 94404
Phone: (666) 577-9197
Fax: (650) 701-1968
Email: nancy@caems-academy.com
Web: www.caems-academy.com

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Toll-Free: (800) 700-8444
Fax: (831) 477-4914
Email: mthomas@emergencytraining.com
Web: www.emergencytraining.com

**Loma Linda University Medical Center**
Lyne Jones, Administrative Assistant
Department of Emergency Medicine
11234 Anderson St., A108, Loma Linda, CA 92354
Phone: (909) 558-4344 x 0
Fax: (909) 558-0102
Email: L.LJones@ahs.llumc.edu
Web: www.llu.edu

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James Peterson, EMT-P
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Fax: (707) 644-1784
Email: jpierson@medicambulance.net
Web: www.medicambulance.net

**Napa Valley College**
Gregory Rose, EMS Co-Director
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Phone: (707) 256-4596
Email: grose@napavalley.edu
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Web: http://www.phialmedical.com

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Email: Chris.Wade@rocklin.ca.us
Web: www.rocklin.ca.us

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Web: www.rmetro.com

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Phone: (831) 426-9111
Web: www.defibthis.com

**Verihealth/Falck Northern California**
Ken Bradford, Training Coordinator
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