Data Driven Approaches to Engaging the Medically Disenfranchised

Emergence Health Network

Session Code 1002

DATA DRIVEN APPROACHES TO ENGAGING THE MEDICALLY DISENFRANCHISED

AKA:
MAKING THE FACTS YOUR FRIEND….

Emergence Health Network

Disclosure to Learners

37th Annual Texas Council Conference

June 17-19, 2024

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- Complete registration and sign in,
- Attend the entire event,
- Participate in education activities, and
- Complete the participant evaluation.

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TEXAS Health and Human Services

Texas Department of State Health Services

Continuing Education

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TEXAS Health and Human Services

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TEXAS Health and Human Services

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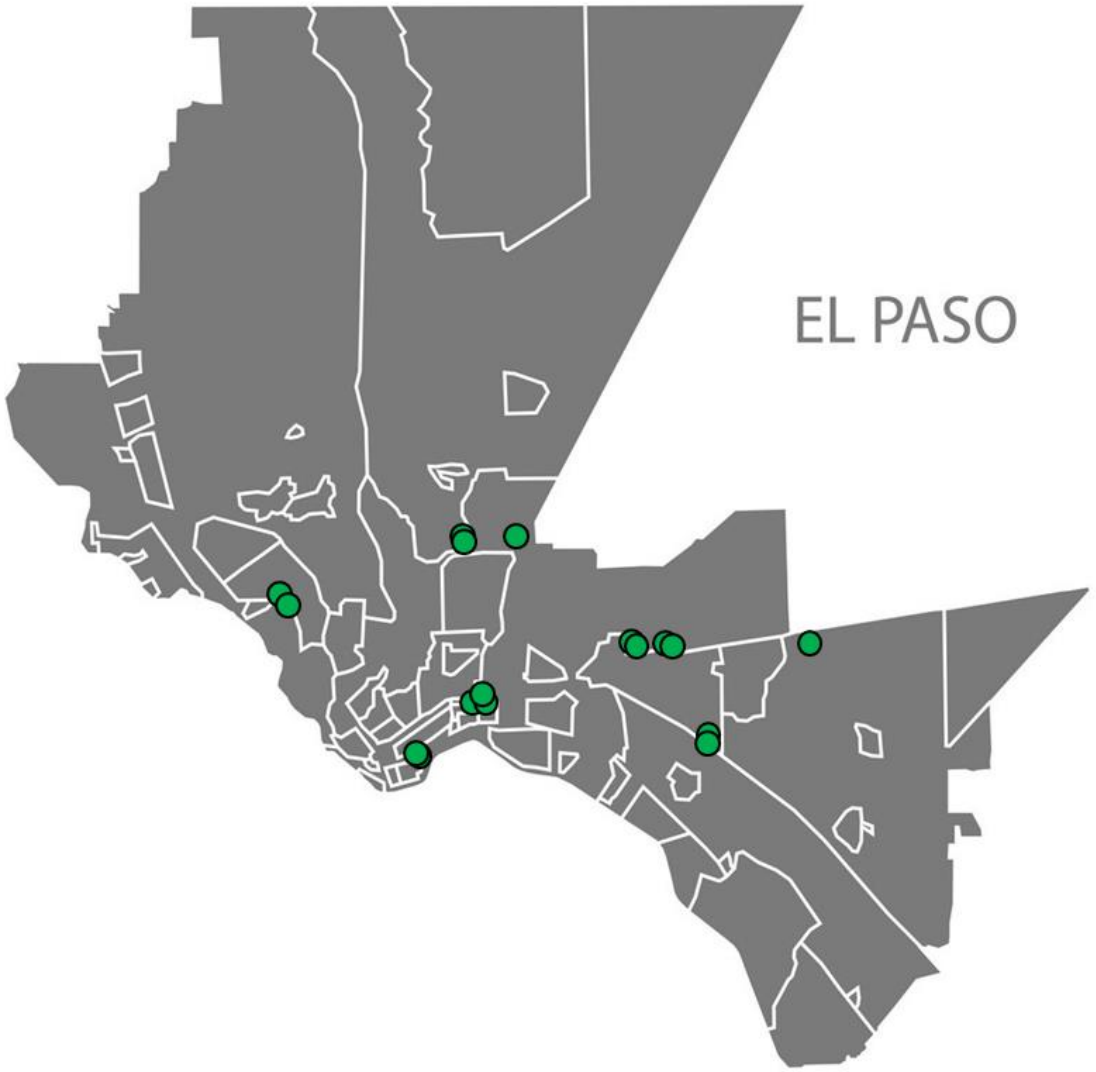


ABOUT US

- Emergence Health Network is the LMHA and the LIDDA in El Paso Country and far west Texas
  - We have 31+ service locations
  - Run 50 clinical programs:
    - Adult and Adolescent Bh Services
    - IDD Dayhab/group homes
    - Competency Restoration/BH in the jails
    - SUD support
    - Unhoused outreach/street medicine
    - Veteran's programs…to name a few….
  - Serve approximately 45K clients annually

WHEN THAT MANY PIECES ARE MOVING, AND THAT MANY LIVES ARE IN OUR HANDS – HOW DO WE BEST ASSESS AND IMPROVE PERFORMANCE?

DATA DRIVEN INITIATIVES!

OVERVIEW

- Implement approaches proven in other settings
  - SBAR Clear Comms
  - Safety Placards
- Partner with experts
  - UTEP studies
- Do your own research
  - Overview of the experience of clients with IDD in local emergency rooms.

PROBLEM:
CROSSED WIRES IN THE COMMS

- Jails are a complex working environment
  - Staff from different fields of expertise –
    - Correctional
    - Medical
    - Mental Health
    - Inmates
    - Attorneys
  - All with different priorities,
  - All speaking a different career-specific language (jargon)
  - If problems arise, chaos ensues because no one can communicate…

SBAR

Situation

Background

Assessment

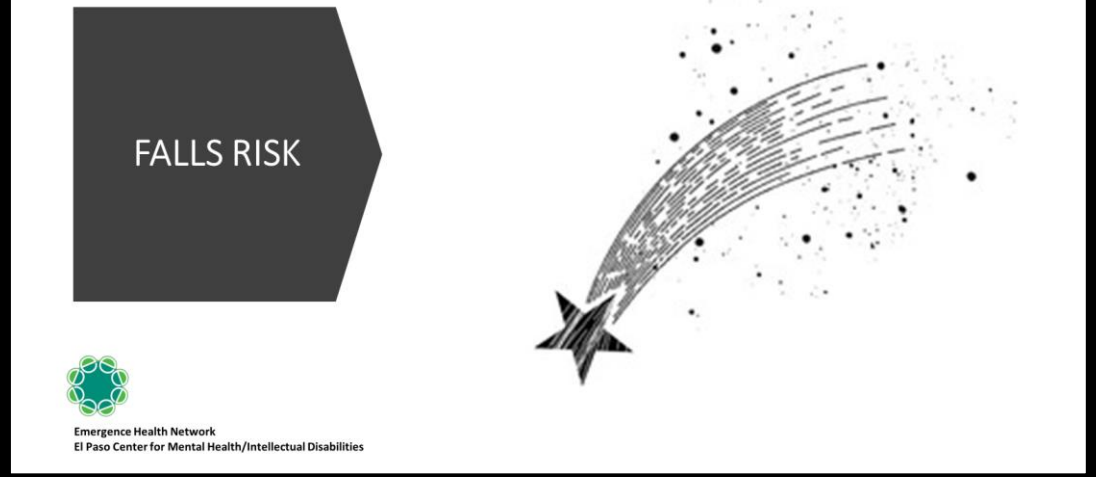
Recommendation(s)

Agency for Healthcare Research and Quality:

- Enhanced communication, clear & concise
- Vehicle to express concerns
- Frames and priotizes key concerns
- Brings team awareness

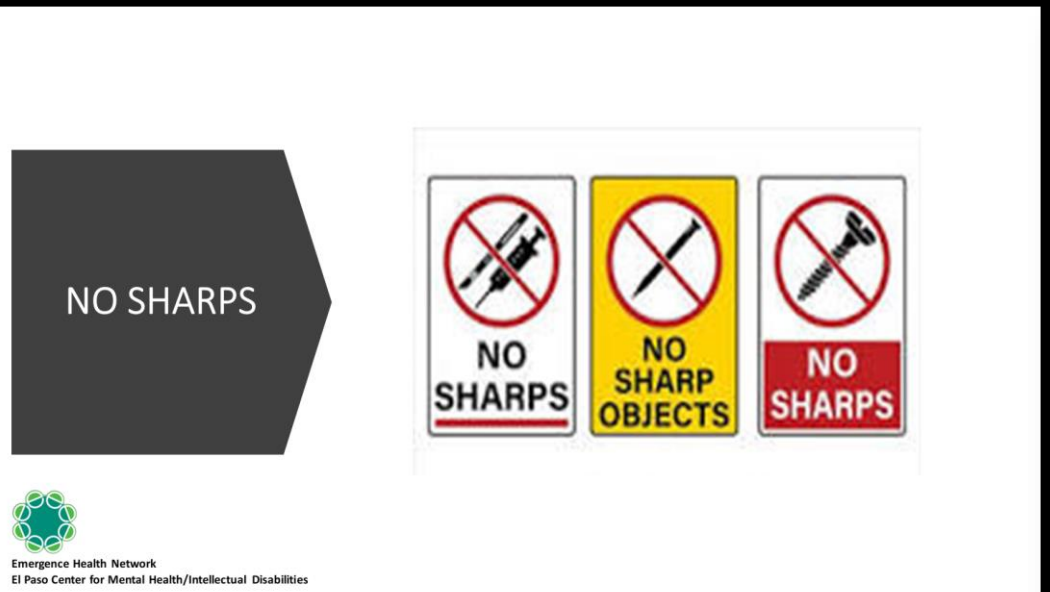
PROBLEM: SELF-HARM FREE FOR ALL AT SHIFT CHANGE

- Jails have sections set aside for “spec pops”
  - Gang related
  - Severe mental health concerns (SI, HI, psychosis, etc…)
  - Medical concerns/hospice
- Rash of self-harm incidents in spec pops: cutting, asphyxiation, assault, swallowing/inserting foreign objects
- Of note – SBAR discussions found that it tended to occur during shift changes
- Identified a breakdown in comms during staff turnover…



CELL-SIDE SAFETY PLACARDS

SAFETY PLACARDS



SAFETY PLACARDS

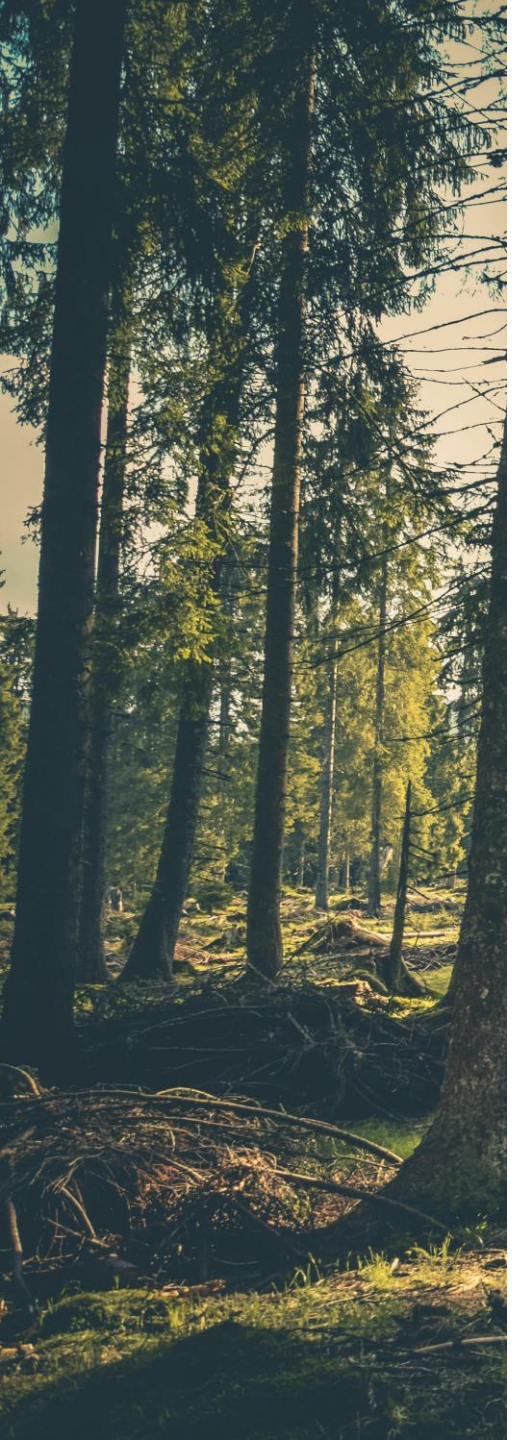
IS IT WORKING?

- In 2022 there were
  - 55 suicide/self harm attempts,
  - An average of 4.57/month
  - No completed suicides
- In 2023 there were
  - 21 suicide/self harm attempts
  - An average of 3.66/month
  - No completed suicides
- Thus far in 2024
  - 29 suicide/self harm attempts
  - An average of 7.25/mo
  - Did our study contribute to an increase!?!?!?
  - OF NOTE this year– no permanent harm, no hospitalizations required.
  - Staff are reporting earlier identification of concerns, allowing intervention prior to serious damage being done

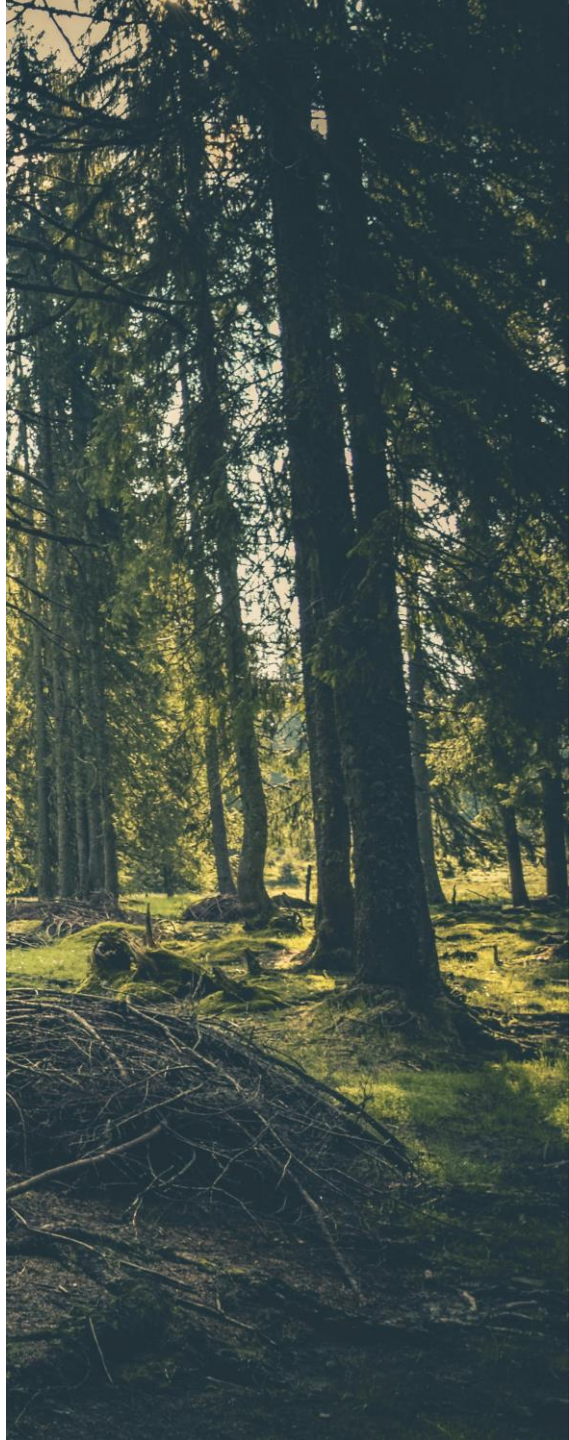
	Jan 2024	Feb 2024	Mar 2024	Apr 2024
Attempted Suicides	3	3	9	14
Suicides	00	00	00	00
Deaths in Custody	00	1	1	00

PROBLEM:
INCREASED PREVALENCE OF SHIVS

- More shivs being found on cell inspections, more self harm through cutting, more gang violence through stabbing injuries
- Of note – SBAR discussions indicated that the main component of these shivs was the fins being broken off of HVAC grates
- Once broken, grates then proved to be the highest source of sights for stabilizing ligatures in suicide by hanging attempts…probably need to change the grates….



Likelihood to Harm Inmate/Visitor/Staff	ITL	Limited	Pattern	Widespread
		VENTILLATION GRATES		
	High	• BUNKS IN SO UNITS HAVE SPACES THAT POSE LIGATURE RISKS	• PRIVACY PARTITIONS ARE FALLS, HANG AND CONCEALMENT RISKS	• BALCONIES AND STAIRWELLS POSE FALLS/HANG RISKS
	Moderate	• TV'S POSE HANG RISK, BROKEN PARTS USED AS SHIVS	• HANDRAILS FOR ADA – NOT SEALED	• SMOKE DETECTOR GRATES BROKEN/ PARTS USESD AS SHIVS • DOOR HANDLES POSE LIGATURE RISKS
	Low	• KIOSKS ARE OFTEN BROKEN, LEADING TO DECREASED ABILITY OF INMATES TO COMMUNICATE THEIR NEEDS	• TOILETS AND FAUCETS POSE LIGATURE RISKS • LIGHT FIXTURES ON WALLS POSE LIGATURE AND BREAKAGE RISKS • SEATS, STOOLS AND BENCHES POSE LIGATURE RISKS	• DOORS NEED PIANO HINGES, POSIBLE SLANTS TO LIMIT LIGATURE RISKS IN SO UNITS • TIOLET PAPER HOLDERS AND WALL HOOKS POSE LIGATURE/ IMPALE RISKS. • HOLES LEFT FROM OLD FIXTURES POSE LIGATURE RISKS



PROBLEM : NO SHOWS

- A missed appointment
  - Is a lost opportunity for that client
  - Is decreased responsiveness to other clients
  - Lost revenue
  - Lost overall access to care
- Review of our different clinics showed a range of 15—35% no-call/no-show
- Unsustainable, but how to engage?

BRING IN THE EXPERTS

- Made some cold calls and found the UTEP Faculty Fellow for Scholarship and Research in the Social Sciences
- Commiserated about the problem (absentee students a nice corollary)
- Identified research tools developed to analyze such concerns from the patient's perspective.
- Identified a target population – our Veterans
- Wrote a proposal, got funding, got IRB approval, developed consent forms, found a grad student, advertised to our clients and we're off!!!!

BRING IN THE EXPERTS

- If you enter such a partnership
  - DON'T BE A GOOD IDEA FAIRY!!!
  - DON'T BE A FLAKE!!!
  - DON'T BE "The Expert"!!!
  - DON'T GET COLD FEET!!!
- Instead
  - Realize this is an opportunity to learn and grow
  - Appreciate everyone at the table as subject matter experts in their own regard
  - Make sure it is a win-win for all involved
  - Celebrate through attribution and credit
  - Build a synergy that generates results none of you could have achieved on your own!!!

PROBLEM: WE DON'T KNOW WHAT WE DON'T KNOW

- Got a call my first month in office – acute change in a client with IDD
- Breakdowns in communication, delays in care, unfortunate outcome…
- Not sure what happened
- Hard to get anyone to own the problem
- Not willing to let it happen again, so now what?...
- THIS IS WHEN WE TAKE THE LONE WOLF APPROACH!

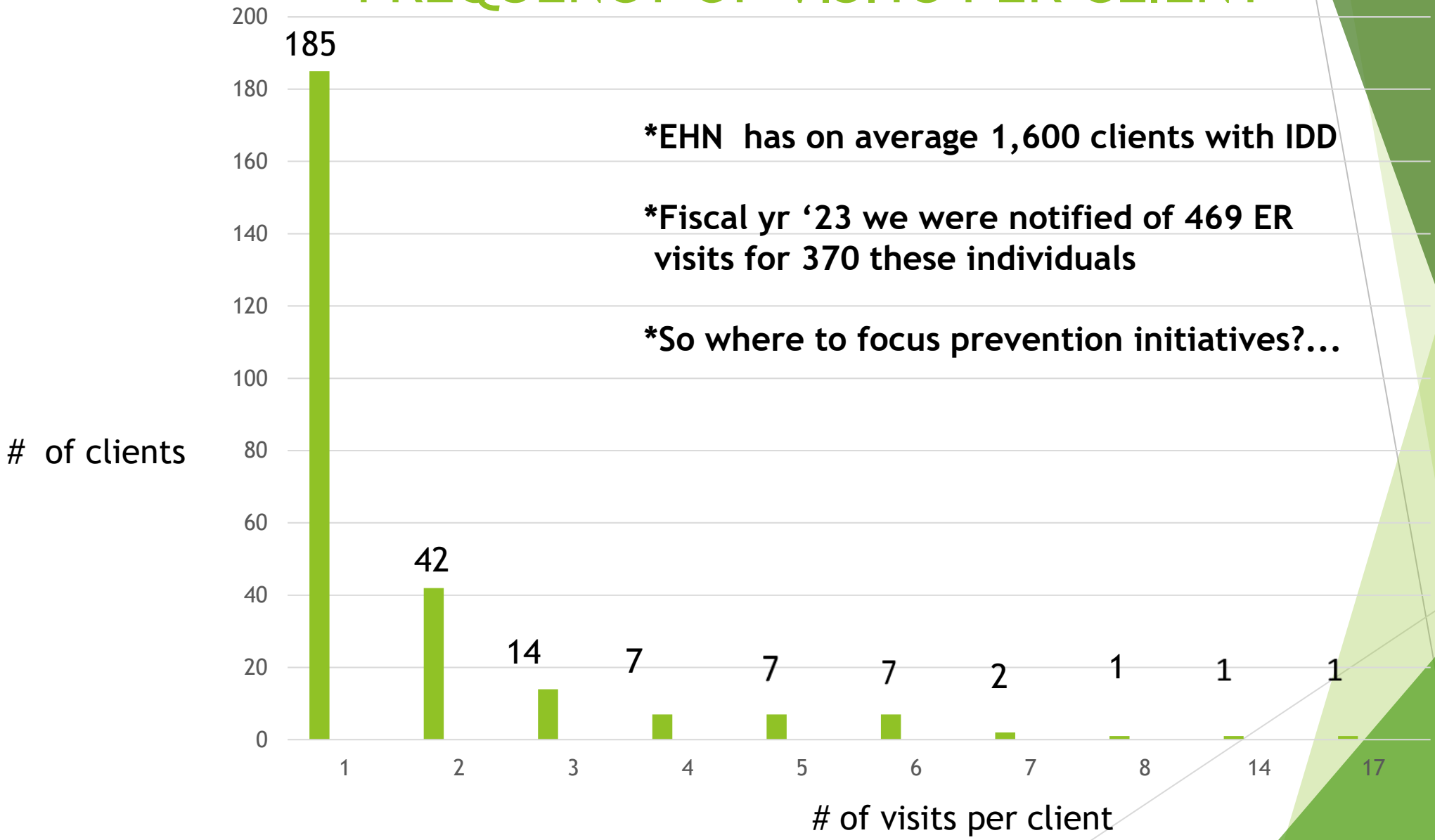
PROBLEM: WE DON'T KNOW WHAT WE DON'T KNOW

- Reviewed this case in depth
- Collaborated with PHIX
- Completed a comprehensive chart review of all risk management cases over the past year
- Collected as much data as could be found on all visits to the ER for our clients with IDD over the past year
- Identified the limitations of that data
- Started wading through the numbers…

WHY DO WE CALL IT THE LONE WOLF APPROACH?

- You need to figure out what you are looking for/looking at before you can start getting others involved
- You need to see what the initial data says and then verify that before you start laying blame/developing responses
- You most likely will poke a few hornet's nests in the process…

FREQUENCY OF VISITS PER CLIENT

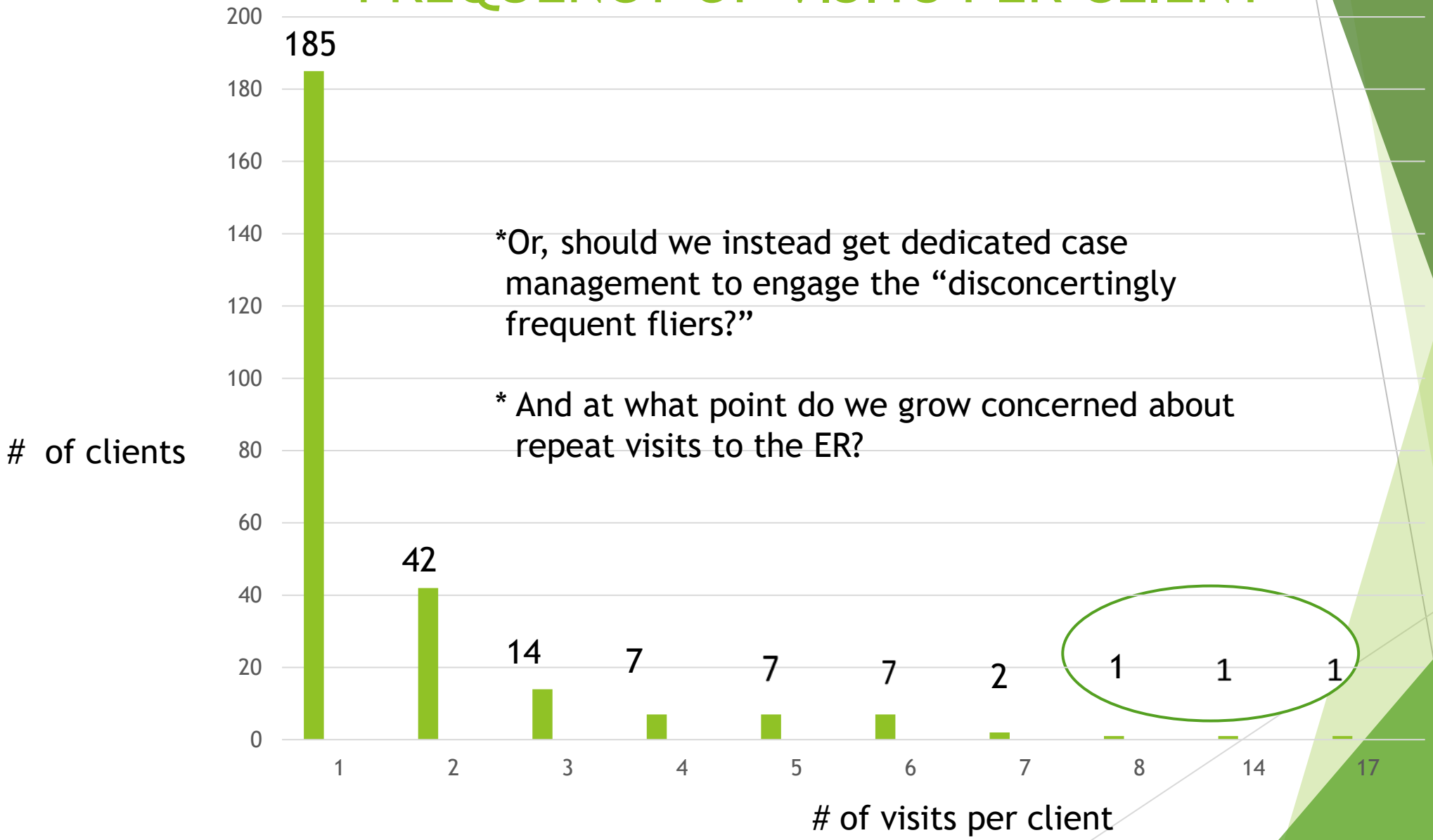


***EHN has on average 1,600 clients with IDD**

***Fiscal yr '23 we were notified of 469 ER visits for 370 these individuals**

***So where to focus prevention initiatives?...**

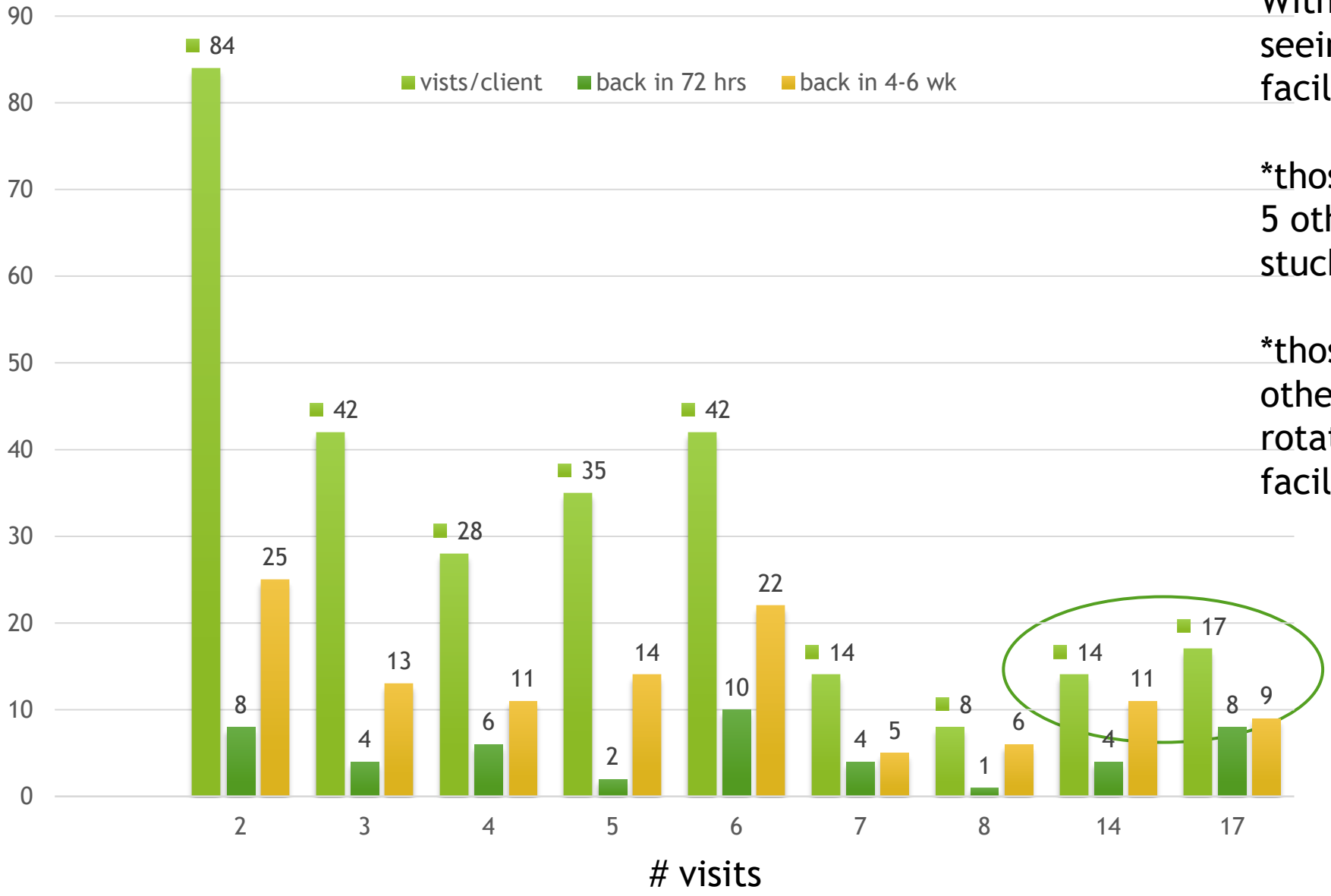
FREQUENCY OF VISITS PER CLIENT



*Or, should we instead get dedicated case management to engage the “disconcertingly frequent fliers?”

* And at what point do we grow concerned about repeat visits to the ER?

“bounce-back” data



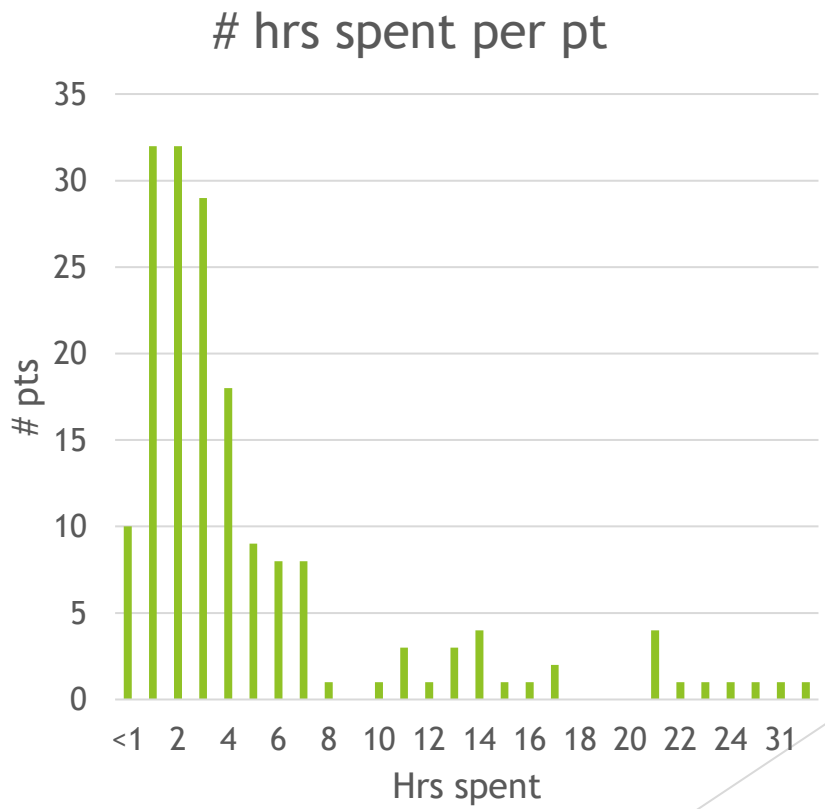
SIDE BAR – those With 2-3 visits tried seeing on average 2 other facilities.

*those with 4-7 saw up to 5 other facilities and then stuck with one.

*those with 8-17, saw 3 other facilities & kept rotating between the facilities they visited

Time…..

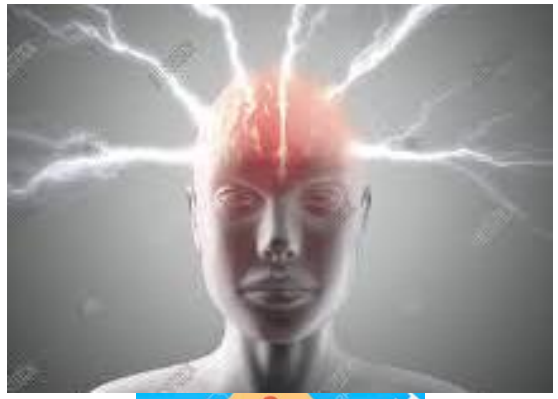
- According to the CDC report, on average, 41.8% of all patients seen in emergency rooms have less than 15 minutes with their care provider
- In this analysis:
  - Shortest time spent 14 minutes
  - Longest 48 hrs 55 min
  - Average 4 hrs 6 minutes
  - But in looking at frequency, the vast majority of these complex clients are seen in 2.5 hrs (mode)
- Total time : 952 hrs… or 39.5 days…



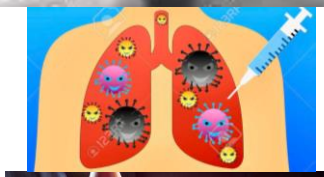
LMHA / LIDDA "perspective" on those with IDD

TENTATIVE DIAGNOSIS	# OF PATIENT
GENERAL	16
dehydration	1
pain	3
animal bite	1
hyponatremia	1
accidental overdose	1
not eating	1
generalized weakness	4
rash	2
hypoglycemia	2
GU	5
groin pain	1
renalith	1
pelvic surgery	1
removed own catheter	2
HEENT - ear injury/lesion/infection	3
HEMATOLOGY	1 (reported bruising due to blood abnormalities)

LMHA / LIDDA "perspective" on those with IDD

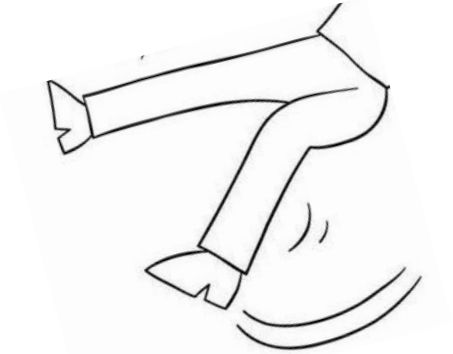


38%



8%

23%



21%

Plus 168 visits with no data

?

IF WE JUST LOOK AT THIS DATA…..

- From internal documentation,
  - The numbers indicate our PI projects need to be centered on:
    - 45 GI problems – preventing constipation
    - 42 Trauma – dynamic falls prevention program
    - 38 Dual Diagnosis (MH superimposed on IDD concerns) – engaged support of mental health in those with IDD
    - 36 Respiratory – work to prevent community acquired upper respiratory infections

- BUT
  - 168 – UNKNOWN, A key concern is the paucity of information
  - The impact of IDD on communication may limit client ability to convey accurate details
  - Family members may be unable/unwilling to share details
    - Limited medical literacy
    - Denial
    - Fear of abuse or neglect allegations
    - Actual abuse or neglect allegations
  - Social workers are not formal clinicians – most have learned, but they should not be expected to serve as adhoc medics in these cases

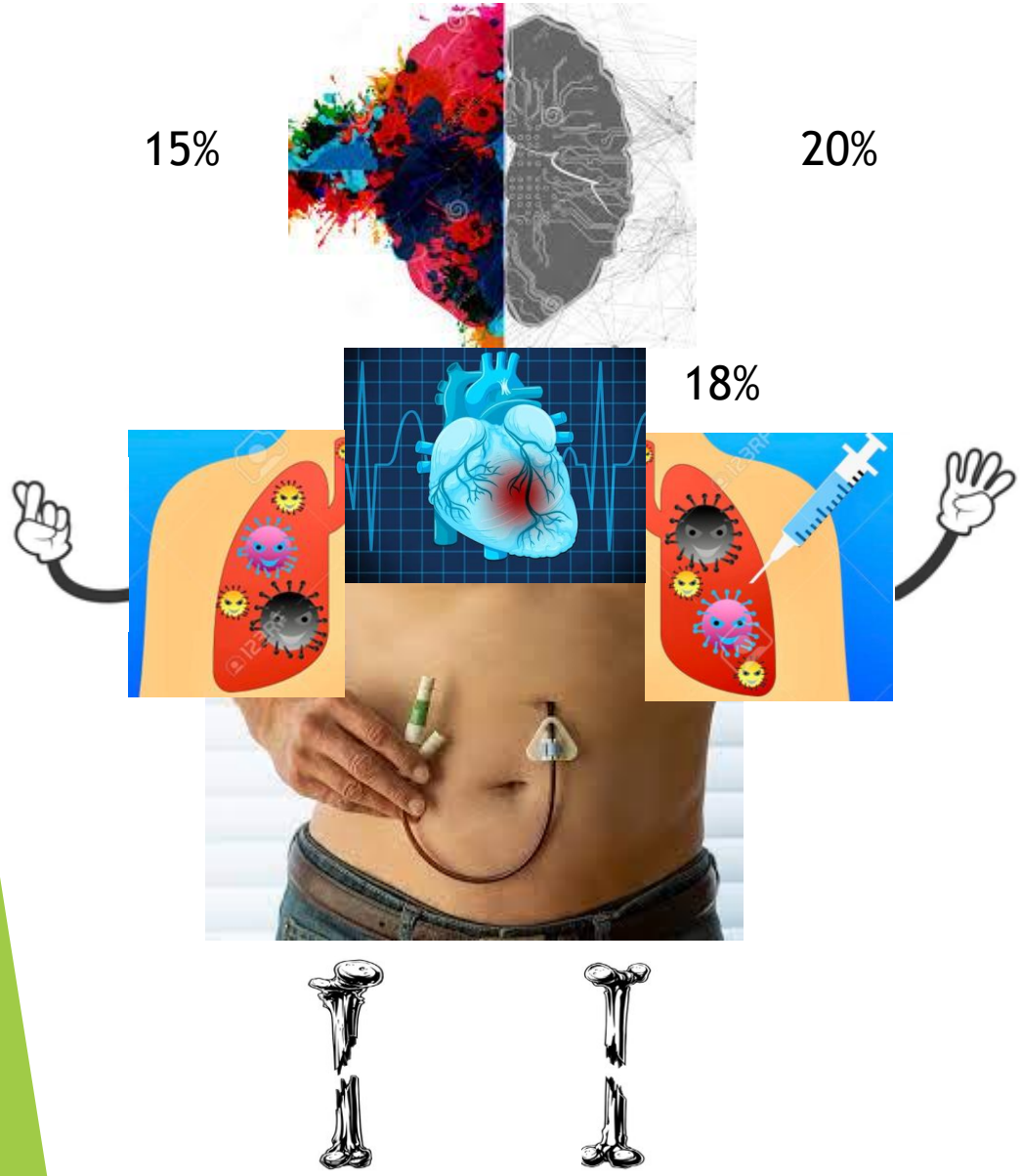
IF WE JUST LOOK AT THIS DATA…..

- AND –
  - This record is clearly incomplete
  - The data is frequently inaccurate
  - The data struggles with non-standardized terminology
    - Incorporation of ICD codes would:
      - Optimize accuracy of data comparison/contrast and analysis
      - Allow for epidemiological assessment
      - Facilitate cost analysis
      - Allow for comparison with medical literature from other communities and patient populations for further understanding

- But –
  - Reviewing just the clinical records that LMHA's have access to comes with it's own problems:
    - HIPPA
    - Access to medical records from different care facilities
    - Many electronic systems for health information exchange are "opt in" as opposed to "opt out"
    - "opt in" is mandated for those with SUD issues

TENTATIVE DIAGNOSIS	ER Data	LIDDA/LMHA DATA
GENERAL	12	16
dehydration	2	1
pain	x	3
animal bite	1	1
hyponatremia	1	1
accidental overdose	1	1
not eating	x	1
generalized weakness	1	4
rash	2	2
metabolic acidosis	1	x
electrolyte imbalance	2	x
GU	11	10
groin pain/ d/o of male genitalia	1	1
renalith	x	1
pelvic surgery/benign neoplasm	1	1
removed own catheter	2	2
urinary tract infection	2	2
dysuria	2	x
hematuria	2	3
cystitis	1	x
HEENT - ear injury/lesion	7	3
foreign object ear	1	x
otalgia/otitis	5	x
gingivitis	1	x
HEMATOLOGY	0 (reported abuse and neglect to CPS)	1 (reported bruising due to blood abnormalities)

ER “perspective” on those with IDD



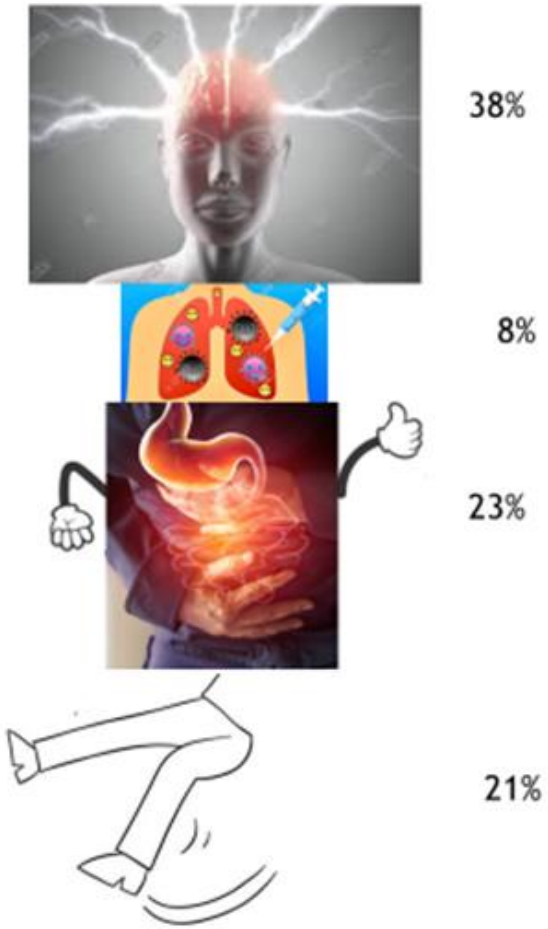
Plus 159 visits with no data, and 37 visits with no entry for medical clearance…

?

IF WE JUST LOOK AT THIS DATA…..

- From ER documentation, available on the Public Health Information Exchange
  - The numbers indicate our PI projects need to be centered on:
    - 57 GI problems – education re G-tube management/protection
    - 36 Neurological – optimize anti-epilepsy treatment regimens
    - 27 Psychological – confront limitations with respect to accommodating clients with IDD in local inpt BH treatment facilities
    - 23 Respiratory – advanced training in gauging ability to protect airways
    - 32 MSK injuries – bone density assessments in this pt population
    - 18 Cardiac – optimize cardiac risk factor management
- BUT
  - 159 with an unknown diagnosis, indicating a need for far more dynamic collaboration in the development of health information exchange for these clients
  - 37 with no diagnosis, as they were simply seen for medical clearance during BH crisis
    - Why not annotate the contributing factors to their IDD in order to better track data on this patient population
    - Why not annotate the type of BH crisis they are having, again, to better track data on this patient population
  - Clinicians are not trained social workers and thus may have less:
    - Awareness IDD concerns and the concept of dual diagnosis
    - Familiarity with social support “safety nets” in place for clients with IDD, and the gaps in those nets that allow many to fall through the cracks…
    - **TIME…** to meet these needs and those of every other patient in the emergency room

LMHA /LIDDA View



dual diagnosis - vs - neurology and/or psych*

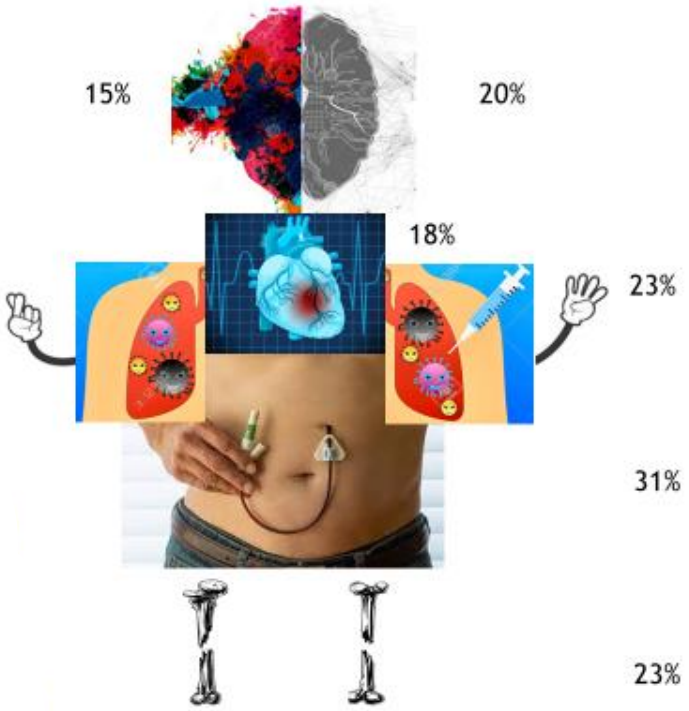
< appreciation for cardio

similar concerns for respiratory issues

> appreciation for GI concerns, especially peg tube care

falls become fractures

ER View



Next Steps?.....

SO WHAT HAVE WE LEARNED?

- It is good to ask questions, even better to get factual answers – be a constructive critic
- Review the literature and see if solutions already exist that can be applied to your setting
- Partner with community experts who have skills sets you need and can benefit from your engagement
- Give credit where credit is due
- Complete a dedicated, informed and accurate analysis of the data
- Use the resultant information to generate actionable solutions
- Test the solutions to make sure they are having the desired effects
- Focus on process improvement and share that vision throughout your agency

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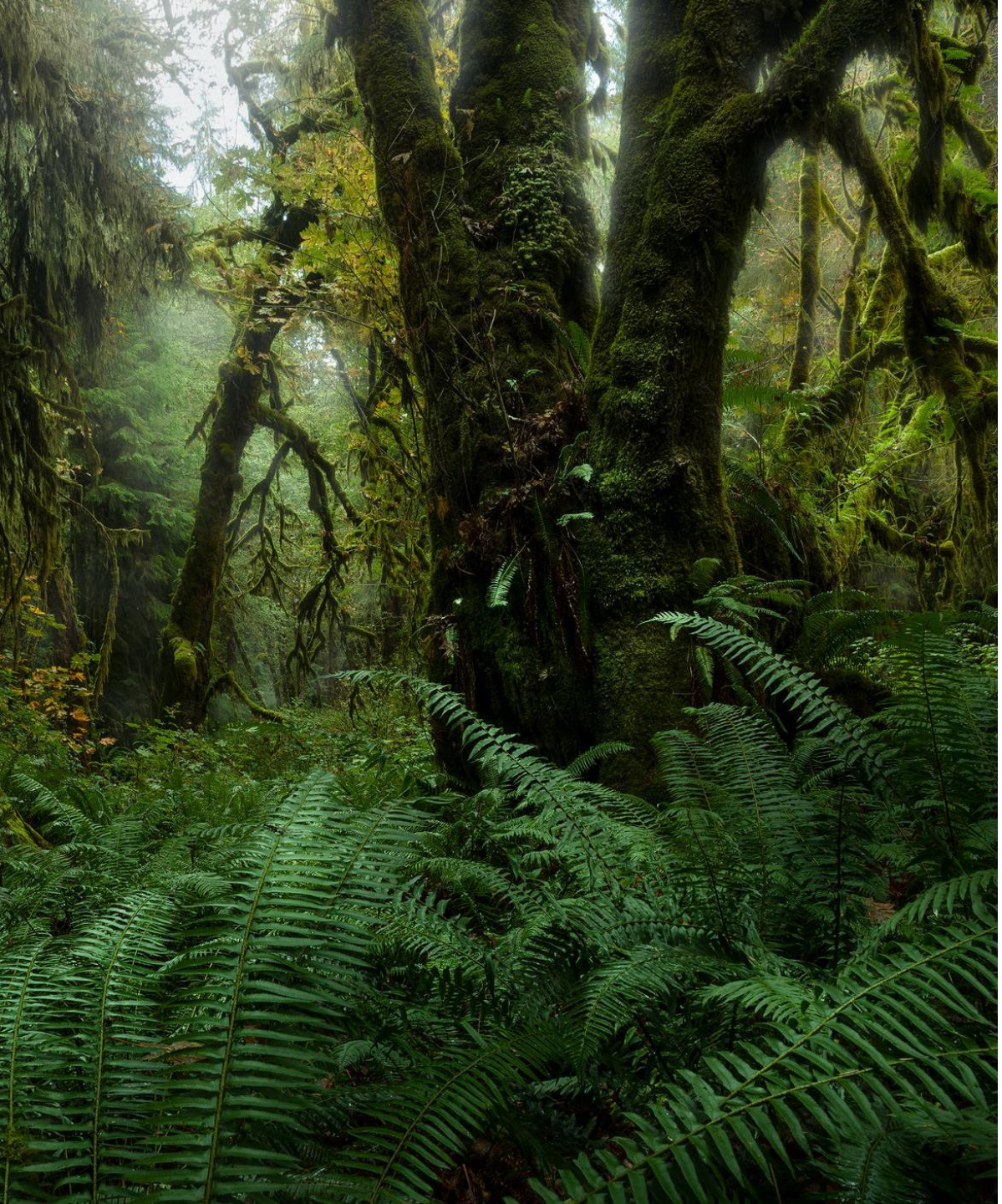

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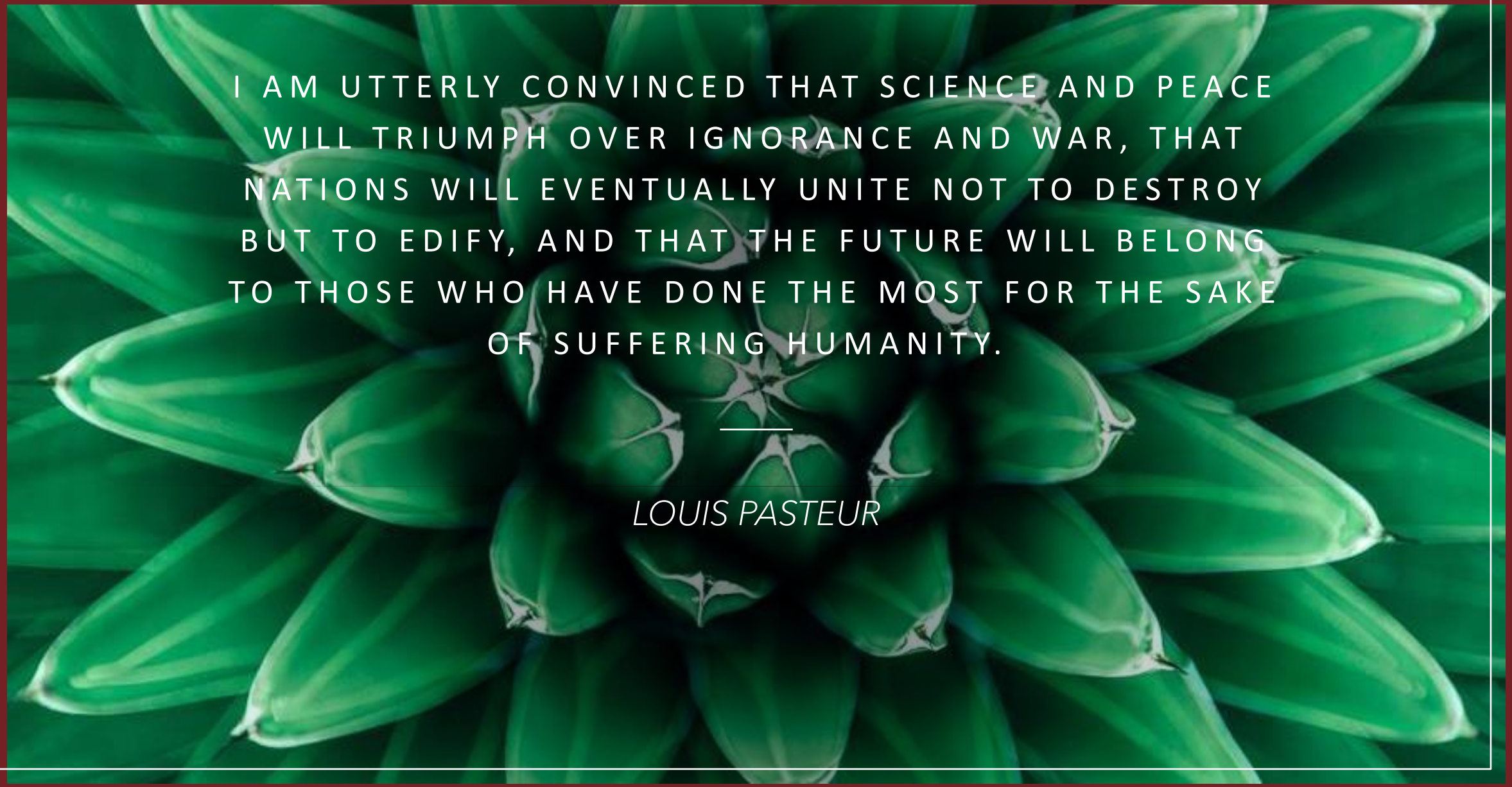
I AM UTTERLY CONVINCED THAT SCIENCE AND PEACE WILL TRIUMPH OVER IGNORANCE AND WAR, THAT NATIONS WILL EVENTUALLY UNITE NOT TO DESTROY BUT TO EDIFY, AND THAT THE FUTURE WILL BELONG TO THOSE WHO HAVE DONE THE MOST FOR THE SAKE OF SUFFERING HUMANITY.
LOUIS PASTEUR