

# Improving Access to Inpatient Care for Socioeconomically Disadvantaged Psychiatry Patients

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## Learning Objectives:

- Identify the primary cause of health care disparity related to inaccessible mental health care for psychiatric patients.
- Discuss successful strategies to achieve more equitable transfer rates between public/uninsured and privately insured psychiatric patients

## Project Overview

Psychiatric patients in the Emergency Department who are publicly insured or uninsured are nearly six times less likely to be accepted for transfer to another facility despite EMTALA law requiring facilities to accept patients regardless of ability to pay. This project highlighted the compounded marginalization of an already stigmatized patient population within the health system. In line with Stanford's Mission and Values for Diversity, Equity and Inclusion, we believe this project represents how to be at the forefront of a commonly known, but previously seldom-addressed issue.

## Background

Stanford's Psychiatric Consult Service to the Emergency Department sees 1500 patient encounters for an urgent mental health need every year. When Stanford's inpatient psychiatric unit is at capacity, patients must board in the ED while our transfer center attempts to find an open bed at a local psychiatric hospital, which can take as long as 3 days. From a six-month range spanning Nov 2020 to April 2021, an average of 40% of privately insured psychiatric patients were accepted for transfer from our ED to another hospital, in contact with only 8% of all MediCal, MediCare and Uninsured patients. When we evaluated our own admission practices, we found no similar disparity for patients admitted to Stanford psychiatry. Not only was there significant disparity with the type of insurance, but with race and ethnicity as well. Forty percent (40%) of the public and uninsured population is an underrepresented minority group, in contrast to only 10% of the privately insured patients. This means that African American and Latin X patients with emergency mental health needs are most affected.

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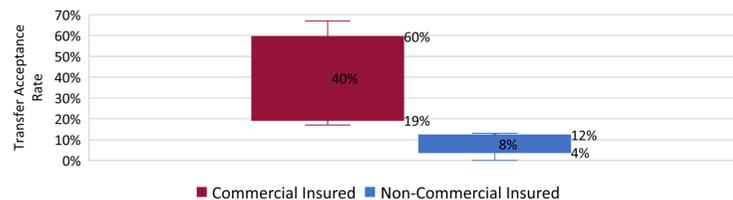
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The authors have no relevant financial relationships to disclose.

## Disparity of Private vs Public/Uninsured Transfers

### Psychiatric Patient Transfer Acceptance Rate Range

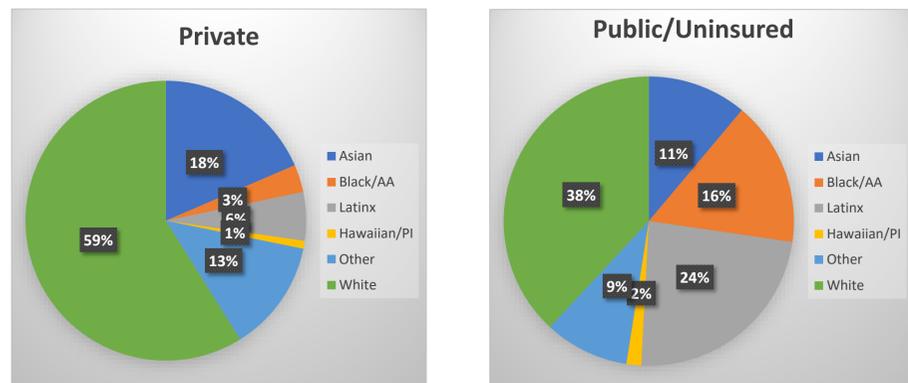
Nov 2020 - Apr 2021



~40% of private insured patients are accepted for transfer

~8% of public/uninsured patients are accepted for transfer

## Demographics by Insurance Type



## Intervention Detail

Using the A3 problem solving methodology, a process map was initially developed to show the workflow from the time the patient is evaluated by psychiatry in the ED, to the time they get transferred to another facility. Multiple root causes were identified, and key drivers were developed. Timely and complete transfer packets sent to the transfer center from the ED is a key element in the transfer process. Updating the list of required documents and streamlining the process of sending a "psych out" request packet to the transfer center, clarifying all the team member's roles and responsibilities, and developing a unified source of communication across 4 departments during the entire transfer process helped mitigate delays. Optimizing outside facility acceptance of public/uninsured EMTALA requests was done by developing a new fax cover sheet that clearly displays a psychiatric EMTALA request, withdrawing insurance information, and by empowering the transfer center staff with verbiage to remind outside facilities that the request falls under EMTALA law. A process was also developed in identifying, escalating, and reporting potential EMTALA violations.

## Stanford MEDICINE Improving Equitable Access to Inpatient Care for Socio-Economically Disadvantaged Psychiatry Patients

**Problem Statement:** Psychiatric patients with public insurance are rarely accepted for EMTALA transfer to outside hospitals from the SHC ED when there are no beds available on our inpatient psychiatric unit, resulting in significant delays in care. Of the patients with commercial insurance, 43% were accepted for transfer, while only 5% of non-commercial insured patients were accepted for transfer during the same sample period of about 6 months.

**Background:** SHC ED patients with emergency psychiatric needs and Medi-cal or public insurance are noted to have disproportionately long wait times in the SHC ED while waiting for transfer to an inpatient psychiatric unit. These wait times result in significant delays in care. When patients meet criteria for psychiatric admission and the SHC psychiatric unit is full, a transfer to an outside hospital psychiatric unit is attempted. SHC ED patients with emergency psychiatric needs, and Medi-cal or public insurance are noted to have disproportionately long wait times in the SHC ED while waiting transfer to an inpatient psychiatric unit. Most often (90% of the time), they are not accepted for transfer and either receive all their psychiatric care in the ED and eventually discharge or are admitted to our unit when a bed opens. The wait times range from 1 day to up to 5 days. During this time, patients are in relative isolation in a non-therapeutic environment, lacking in the structure and group/therapeutic programming that is found on inpatient psychiatric treatment units.

**Target State: SMART Goal:** Increase the percent of non-commercially insured patients accepted for transfer from the ED from 10% to 20% by September 2021. Longer term goal is to achieve 45% (or equitable rate to commercial patients) by September 2022.

**Current State: Identify Target / Actual / Gap**

**Key Drivers:** Timely and complete packets to the Transfer Center; All teams have consensus on roles/responsibilities during the transfer process; Optimize outside facility acceptance of non-commercially insured EMTALA transfers (clarify); Standard process for identifying and reporting concerns about EMTALA violations.

**Interventions / Countermeasures:** One list/source of updated information of patient disposition in Epic available to Psych/ED/Transfer Center/Complex CM (2); Psych CM/SW update TC daily by 11am on patient disposition (1); Resident education course on issues of call (emails, chief meetings, peer-to-peer feedback, resident education course) (2); Daily audit of using correct TC form and provide peer-to-peer feedback (1) Joe (6/24); request SW to also involve in checking 7/15; Opportunities to automate packet – speak to EPIC about current capabilities – (3) Madeleine (7/15; explore free text box); Clarify role of ED clerk to ensure packet complete (2) Ana (6/24); Fax cover sheet clearly identifies "Psych EMTALA" transfer request – (2) Sharon (6/10); Reach out to select OSH facilities to open line of communication, education about this initiative and give opportunity to review process (create culture) – (1) Andrea (Date); Remove insurance information from face sheet – (2) Ana/Sharon (7/19) - how to measure "success"

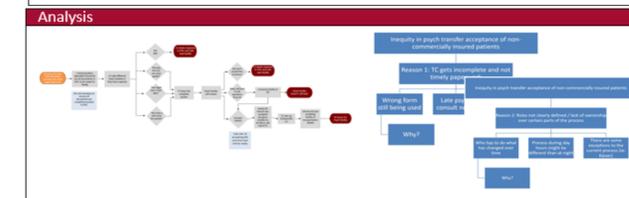
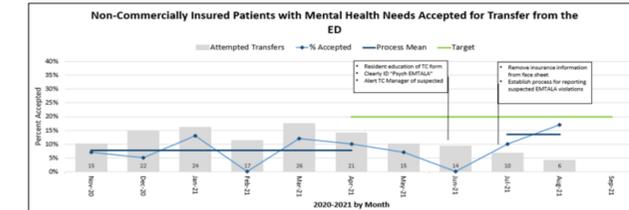
**Sustain Plan:**

Activity to sustain	Owner	Sustain method and frequency	Report to
Maintain and develop empathy amongst affected SHC staff by Report out – # violations flagged, # reported to CDPH, progress of violation reporting, violations by institutions	Psych ED CL	In a regularly occurring meeting with ED MD/RN, quarterly, TC Manager TC Vis Wall, Staff Meetings	TBD
Continued committee to meet qMonthly to review outcomes, process, and areas that require modification (TC, ED, Psych)	Psych ED CL	In a regular occurring meeting with TC & Psych ED CL & G2P/H2	ACNO?
Random audit of TC sheet & Unit Clerk check-in	Psych ED APP	Report out at Monthly Psych ED CL Meeting	Psych Department Leadership Psych CL Leadership

**Reliability Level:** (1) Individuals: Feedback, checklists, training, basic standards; (2) Procedures: Embedded standard work, reminders, constraints; (3) Systems: Process design, fail safes, physical layout, built-in feedback, automated systems, concentration of responsibility

**Maturity Bars:** 0: Untested idea; 1: Early tests / PDCA; 2: Multiple PDCA; 3: Early implementation; 4: Working well in operation

**Process / Barrier:** Progress (0-4 bars), Barrier (Red X)



## Interventions

**Improved Transfer Form:** Adult Psychiatry ED EMTALA Transfers

**EHR Handoff for Communication:** EMTALA - Psychiatric Care

**Fax Cover Sheet:** EMTALA - Psychiatric Care

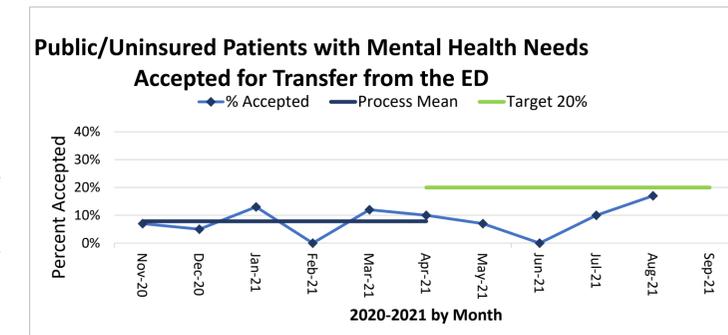
**Process for Reporting Suspicion of EMTALA violation:** Potential EMTALA violation identified → Documentation & recording collected → Evidence demonstrates possible violation → Submit to Compliance Office → Compliance Office & ABL report to CDPH

## Outcomes and Impact

The initiative has shown a light to the impact of this disparity to our healthcare workers and health system. The prolonged boarding times of psychiatric patients in the Emergency Department, during which time patients cannot receive the optimal level of care they desperately need, led to burnout and moral distress of our healthcare staff. It also impacts 240 public/uninsured patients per year, which translated to a cost of \$2000 per patient, per day in our institution. Focusing on process improvements within our internal workflows showed some movement towards our goal in decreasing disparity.

After 4 months, our data showed the uninsured and publicly insured patient transfers increased from only 8% to 17% within 4 months. However, we also acknowledge that a systemic change needs to happen from both within and outside of our institution to achieve a sustainable goal of a more equitable access to mental health care issue.

## Results



## Next Step / Improvement opportunities

- Continuous education of stakeholders of the developed processes
- Engage and collaborate with other facilities and open a dialogue with regards to this issue.