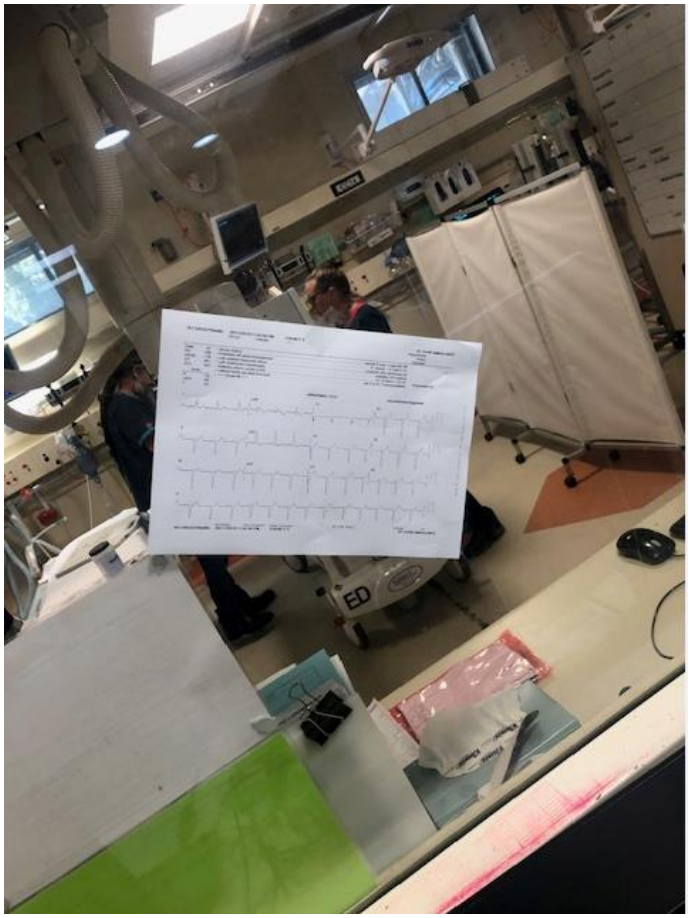
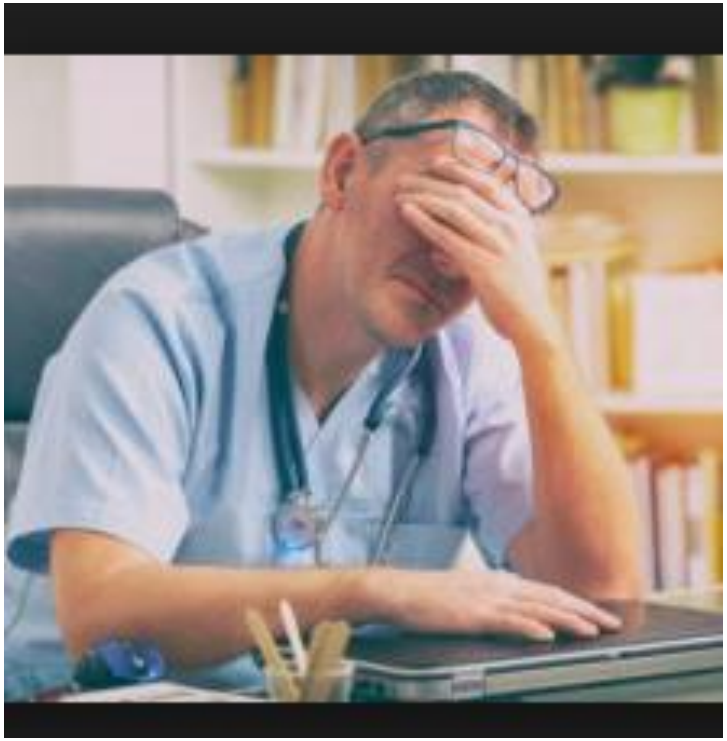
Taming the ED Frequent Flyer

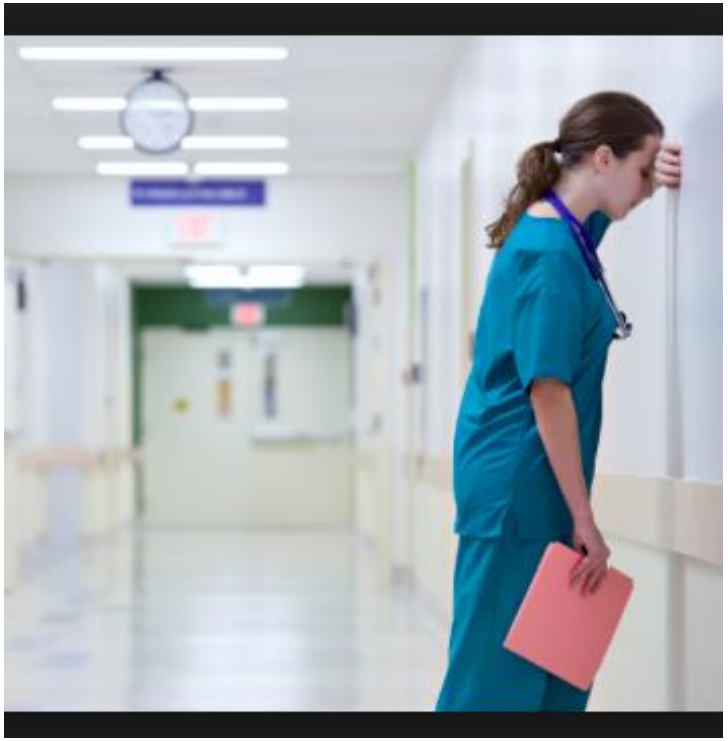
Dr Amanda Stafford
"The Whisperer"

Tough times ahead…..

A historical perspective..







The ED Super-User

- Generally 10+ ED presentations per year
- 0.4% of US adults
- Can use ED as their primary care source
- High overall users of health care

- Vinton, D. T., Capp, R., Rooks, S. P., Abbott, J. T., & Ginde, A. A. (2014). Frequent users of US emergency departments: characteristics and opportunities for intervention. Emergency Medicine Journal, 31(7), 526-532.

Why does it matter?

- Effects on staff – how they make us feel
- Effects on patient- what happens to them
- Effects on the healthcare system – cost
- Find the holes/gaps in the "system"

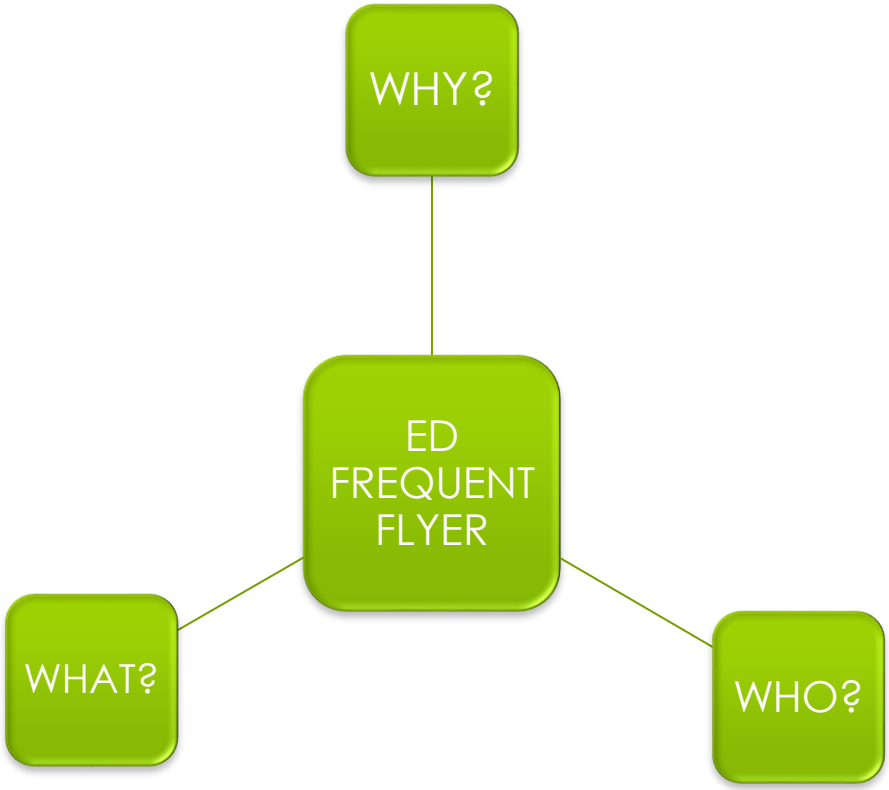
What we do

- Spend too much
- Spend too little
- Treat social problems with medical paradigm
- Complain but do nothing

My FF Journey…..


STOP
DO NOT
ENTER

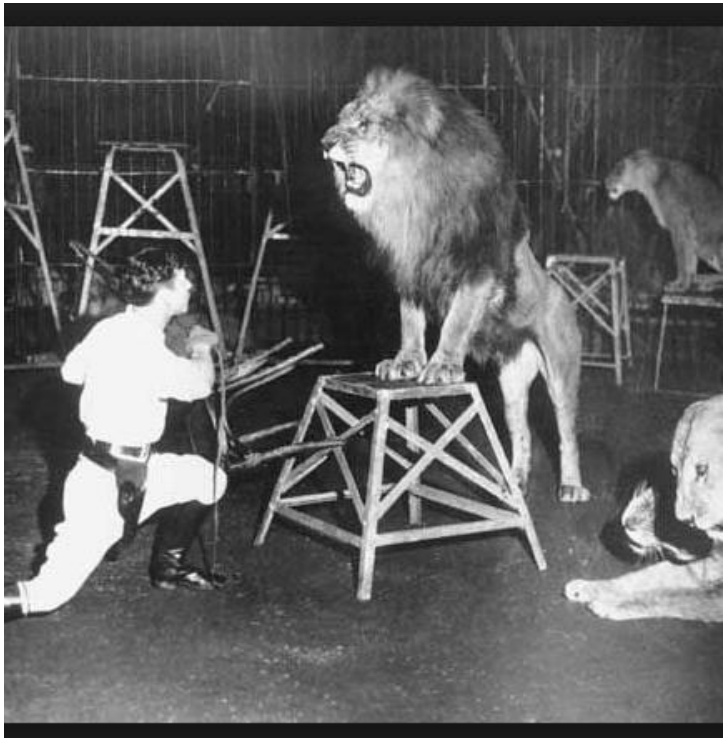

Diverted
traffic
Diverted
Traffic
Diverted
traffic


WHY?
ED FREQUENT FLYER
WHAT?
WHO?

Why do FFs come to ED?

- Unmet need

  - What is missing?



Frequent Flyer Whisperer

GOOD

- Curious
- Problem solving
- Improves care
- Risk comfortable

BAD

- Angry
- Problem creating
- Denial of care
- Risk averse/risky

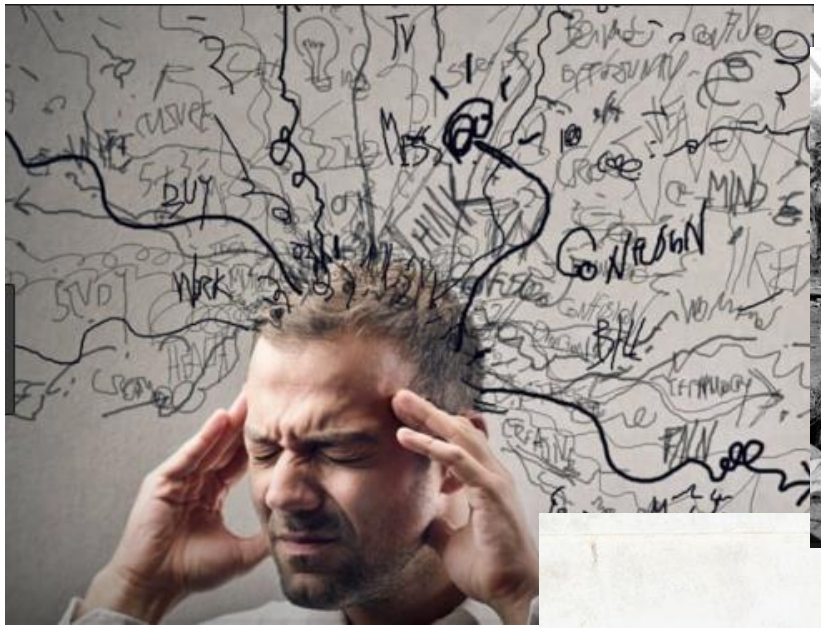
Who are they? Measure..

RPH ED PRESENTATIONS JULY TO SEPTEMBER 2018

1		168	17/01/1980	PO	VI		24
2		001	28/03/1979	CO	NA		21
3		128	25/12/1956	JO	FR		19
4		001	11/06/1987	AL	ZA		17
5		453	23/05/1960	O'N	AD		17
6		650	27/05/1960	TID	MA		15
7		757	22/02/1984	GO	TA		15
8		900	15/01/1988	FR	BR		13
9		942	17/09/1980	FA	JU		13
10		190	15/12/1992	BE	NA		13
11		023	23/12/1966	LIT	AL		12
12		397	20/07/1975	KE	MI		11
13		804	31/12/1989	OX	GA		10
14		423	31/12/1985	YC	MA		10
15		566	21/07/1937	JU	AN		10
16		648	12/10/1966	MI	SO		10
17		1255	16/01/1968	LIT	KE		10
18		092	3/10/1985	MA	SU		9
19		312	7/02/1964	RO	KA		9
20		1268	5/11/1970	KE	RI		9
21		514	4/05/1983	SL	AU		9
22		2022	16/06/1961	FO	CH		9
23		770	27/06/1942	KA	NA		9
24		8679	17/09/1976	MC	CA		9
25		9950	17/06/1978	PE	JA		9
26		3819	25/08/1961	GC	RO		9

RPH TOP 100 ED PRESENTATIONS JAN TO OCT 2018

1		143	11/06/1990		54
2		001	11/06/1987		53
3		023	23/12/1966		51
4		53	23/05/1960		47
5		68	17/01/1980		45
6		50	27/05/1960		42
7		24	23/07/1975		42
8		092	3/10/1985		40
9		255	16/01/1968		36
10		001	28/03/1979		33
11		67	27/02/1930		31
12		757	22/02/1984		31
13		022	26/08/1971		31
14		498	8/09/1984		28
15		05	17/12/1965		28
16		268	5/11/1970		26
17		760	23/06/1992		26
18		666	21/07/1937		26
19		169	16/12/1999		25
20		588	20/03/1964		24
21		128	25/12/1956		24
22		512	2/02/1986		24
23		293	24/12/1999		24


DUI
CONFUSION
MIND
WORK
BILL

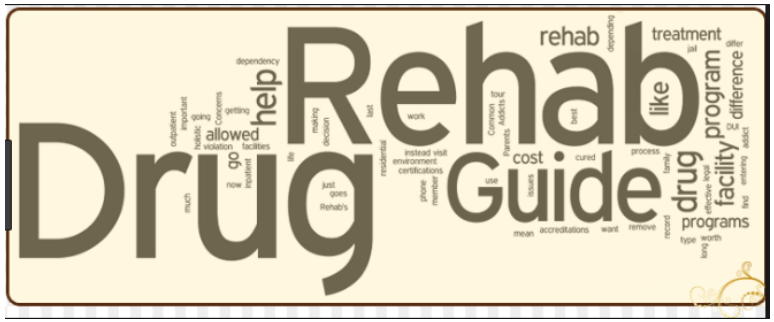
Get the Facts! Where?

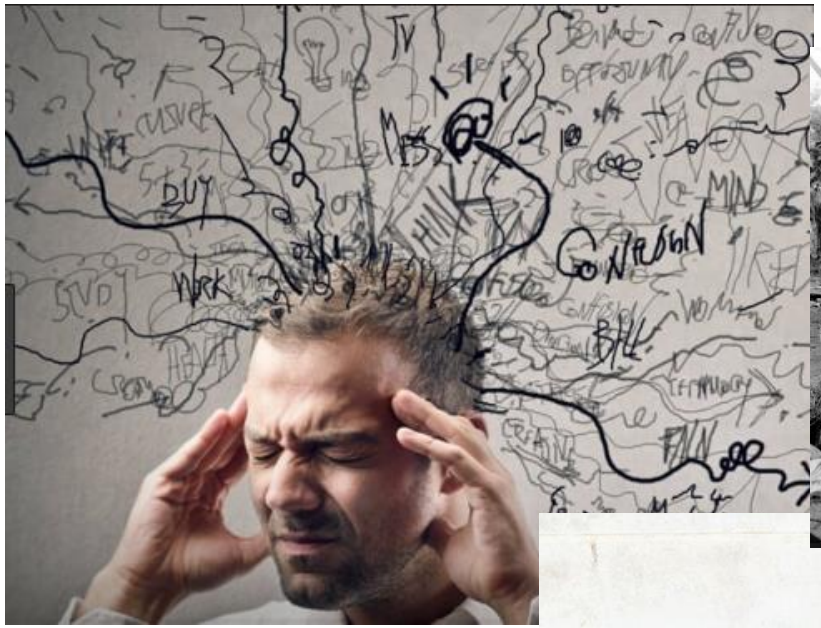
The Tool Box

Individual FF strategies:

- Solve the problem
- Connect the patient to better solutions
- Get a consistent plan of management
- Watch, wait, give up…

Build Networks and Resources

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CONFUSION
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WORK
BILL

The most help is found…

Frequent Presenter Program:
Each month, an EDIS search for RPH ED's most frequent presenters is carried out to identify the Top 20 ED presenters in the preceding 3 months. This systematic and proactive identification of frequent presenters activates a detailed case review and acts as an early warning system and an opportunity for intervention. This might be:

- An ED management plan with more rational and consistent ED management.
- Case management of complex patients via the Complex Needs Coordination Team (CoNeCT) to provide more appropriate care in the community eg via GP, outpatient clinics or community support organisations.
- Collaboration with the RPH Homeless Team for homeless patients who require community support to obtain housing and support as well as specialist Homeless Medicine GP services.
- Intervention on unresolved diagnostic, medical, surgical, psychiatric, substance abuse, pain or social issues via consultant level consultation and collaboration.

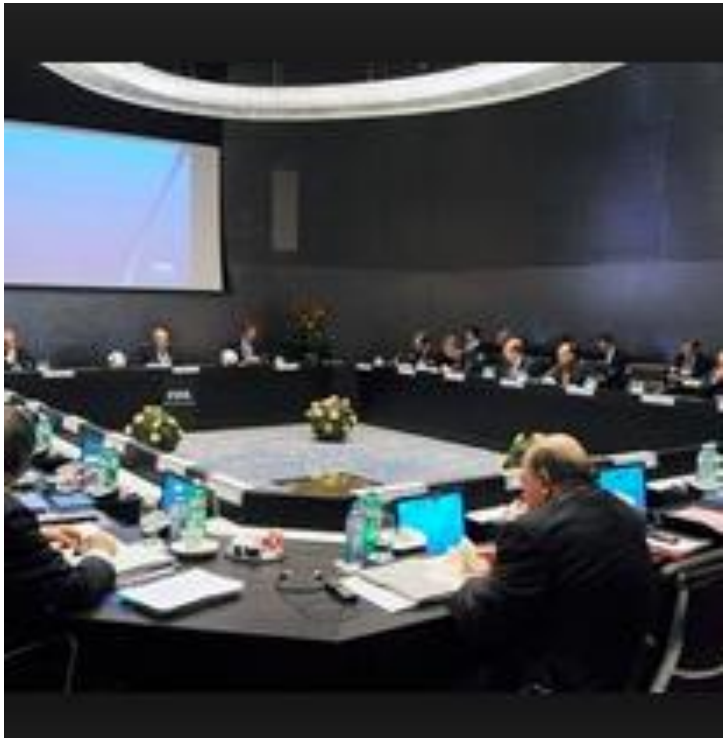
The ED Management Plan

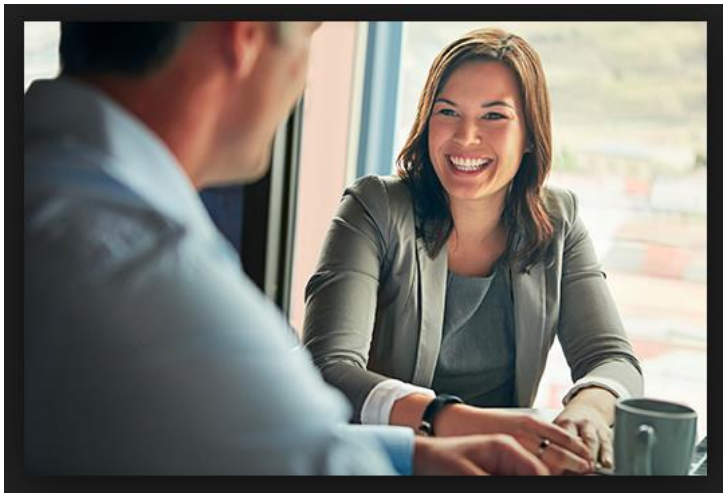
Aims of Management Plans

- Increased staff safety
- Improved patient care
- Improved use of healthcare resources

OVERALL BENEFITS:

1. Early information to ED staff about complex patients presenting to ED.
2. Early warning to ED staff about patients who represent a potential threat to ED safety to allow preventative action and suitable precautions to be taken.
3. Clinically appropriate management plans for patients who are frequent presenters to ED and those who have complex needs.
4. Multi-disciplinary plans for complex patients to improve their care in ED and beyond.
5. Improved ED staff morale/competence in dealing with complex patients and those who present frequently to ED.
6. Facilitate the development of new departmental protocols in response to difficulties in dealing with certain groups of patients.





Patient Management Plans -the General Format

- The **Problem/s**
- The background
- What's already in place
- What to do: **Action/s**
- General
- eg senior review
- Specific

- **PROBLEM:**
- Recurrent RPH ED presentations, generally with alcohol intoxication, suicidal ideation, injuries due to assaults or falls and complications of alcoholism such as pancreatitis.
- He has a history of serious aggression and violence, especially when intoxicated but this issue has faded with time with no evidence of this now for about 2 years. This change is likely due to the effects of prolonged homelessness and alcoholism such that he now presents a much reduced risk to staff and other patients and is more often on the receiving end of injuries.
- His most pressing need is stable accommodation.
-
- **ACTION:**
- Alert security on arrival if he is agitated or aggressive.
- Recognise that his homelessness and alcoholism put him at high risk of injury and illness so manage accordingly.
- He should have standard management for alcohol dependence/withdrawal eg IV thiamine and multi-vitamins.
- He can be admitted to EMW if a risk assessment based on current behaviours is favourable.
- He should be seen by the Homeless Team where possible (9-3pm M-F) or Choices 4pm-8pm M-F and 8am-8pm weekend and PH days) or Social Work re accommodation options.
- It is preferable to discharge him from ED when sober and in daylight hours.
- Put problems

- **ACTION:**
- Alert security on arrival and ask them to attend there is aggressive behaviour or threats to staff.
- To be seen only by senior ED staff given the risk of aggression and complex social and drug dependence situation.
- It is prudent to offer early, liberal sedation if there is agitated behaviour or if he needs to remain in the ED for any prolonged period to reduce the risk to staff.
- Will need to receive usual CPOP suboxone treatment if remains in the ED/hospital for a duration which precludes him obtaining it from the community pharmacy.
- Not suitable for QUAC given risk of aggression.
- Any decision to admit to EMW requires an assessment regarding the risk to other patients and staff because of the frontal lobe syndrome.
- Should be charged by the police for any offences committed against person or property while in the ED.
-

- **ACTION:**
- Be aware of the above complex history, especially with regard to factitious shoulder dislocations. The laxity of her shoulder ligaments is such that she will be able to subluxate them at will. Xrays should only be taken if clinically necessary and with the shoulder held in the position described above in 1.1. She can normally be discharged promptly from ED with no Xrays and no attempt at re-enlocation if the above advice is followed.
- Should ONLY be seen by senior medical staff- consultant (if possible) or registrar in order to facilitate early senior decision making regarding investigations and management. NO RMOs to see her.
- Each presentation should be judged on it's own merit as Munchausen's patients may have genuine pathology, albeit self induced although this has not been her pattern to date.
- IVC insertion and investigations should ONLY be performed for clear clinical indications.
- NO opiates to be given unless there are clear clinical indications and not for recurrent pain issues as per above where there is no objective evidence of illness eg claims shoulder dislocation or ovarian torsion.
- She has a history of seeking care from multiple EDs for her various complaints. In particular she is NOT to be given **any** opiate medication as she has a history of opiate addiction.
- Expect prompt self discharge and verbal abuse when her demands are not met.

Current Categories:

1. Frequent ED presentations requiring coordinated/consistent approach to care.
2. Violence/aggression/assault
3. Carrying concealed weapons
4. Drug seeking behaviour
5. Stealing and other crimes committed in ED
6. Chronic psychiatric illness requiring special management
7. Personality disorders requiring special management
8. Drug and alcohol abuse where these impact significantly on ED presentations
9. Munchausen's syndrome
10. Complex medical needs
11. Special needs related to physical or intellectual disability
12. Difficult intubation
13. Precarious/vulnerable social situation
14. Chronic pain management plans

CURRENT DATA: 20/07/2018

Total number of PMPR patients: 275

Breakdown of patient numbers by All Reasons for Management Plan:

Category: Any Reason: can be in more than 1 category	No. of patients	% of total patients
ED Frequent Presenter	38	14%
Violence/aggression/staff assault	142	52%
Carrying concealed weapons	37	14%
Drug seeking behaviour	38	14%
Stealing/other crimes in ED	21	8%
Chronic psychiatric illness requiring special management	53	19%
Personality disorders requiring special management	71	26%
Drug and alcohol abuse where these impact significantly on ED presentations	123	45%
Munchausen's syndrome	17	6%
Complex Medical Needs	53	19%
Special needs related to physical or intellectual disability	28	10%
Difficult intubation	1	<1%
Precarious or vulnerable social situation	75	27%
Chronic pain management plans	16	6%
Total Patients	275	Not applicable Can be in more than one category

Patient Management Plan Register

- Plans easily accessible but safe
- Plans seen early in the ED visit
- Regular review process
- Governance structure – how/why

Medicolegal Risk with PMPs

- Curious
- Problem solving
- Improves care
- Risk comfortable

Frequent Flyer Groups

Find the Cracks

Homelessness
Alcoholic
Methamphetamine abuse
Complex psychiatric
Complex social
Complex medical
Elderly
ATSI
Specific ethnic groups

Top Groups RPH ED

2014

- Alcoholism 80%
- Homelessness 70%
- ATSI 50%

2018

- Anxiety 50%
- Homeless/ATSI 40%
- Alcoholism 25%

FF Group Strategies:

- Improve/expand hospital response
- In-reach services – bring in new services
- Reach out- link to outside programs
- Start new initiatives


Royal Perth Hospital
Homeless Team
A REPORT ON THE FIRST 18 MONTHS OF OPERATION
Royal Perth Hospital
Homeless
THE UNIVERSITY OF
WESTERN AUSTRALIA

Baclofen Treatment Program

FULL TEXT ARTICLE

Baclofen for the treatment of alcohol use disorder: the Cagliari Statement

Article in Press: Corrected Proof

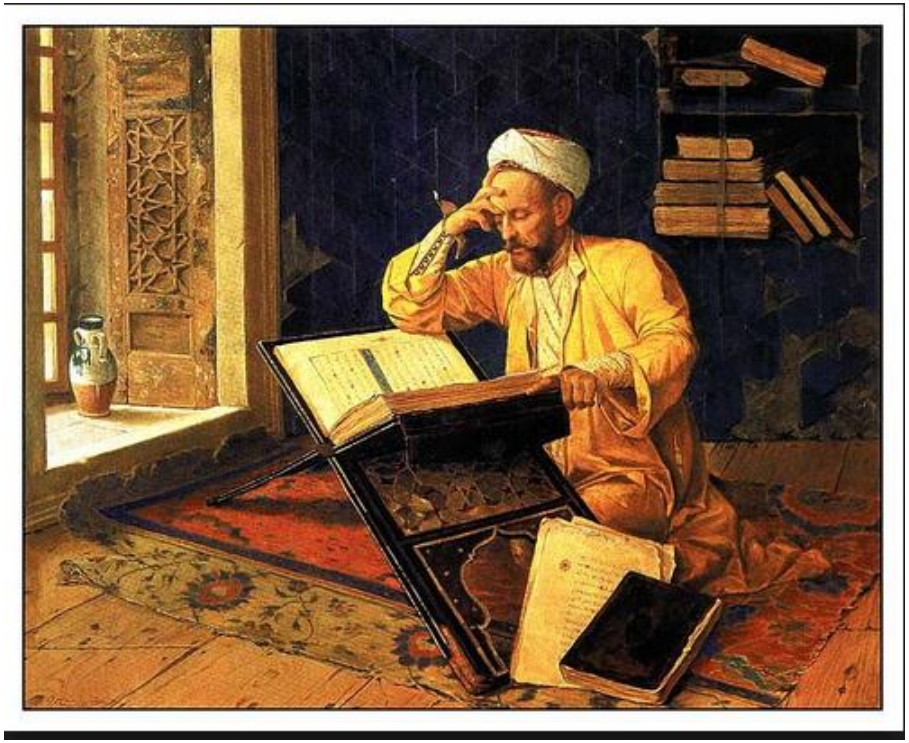
Roberta Agabio, Julia MA Sinclair, Giovanni Addolorato, Henri-Jean Aubin, Esther M Beraha, Fabio Caputo, Jonathan D Chick, Patrick de La Selle, Nicolas Franchitto, James C Garbutt, Paul S Haber, Mathis Heydtman, Philippe Jaury, Anne R Lingford-Hughes, Kirsten C Morley, Christian A Müller, Lynn Owens, Adam Pastor, Louise M Paterson, Fanny Pélissier, Benjamin Rolland, Amanda Stafford, Andrew Thompson, Wim van den Brink, Renaud de Beaurepaire and Lorenzo Leggio

Lancet Psychiatry, The

Mental Health in ED

Be Bold and Go to New Places

Keep thinking and learning



Thank you