DPM NEWS

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BHACC

At the bottom of this page Dr. Cushman explains some of the benefits and criteria for an alternative destination for mental health patients which could benefit the patients and the system.

Purpose of Training

On *page 3,* Dr. Galton breaks down his thoughts on the state and purpose of mandatory training.

Geriatric Teleconsult

Dr. Cushman explains an initiative in place to allow EMS to treat certain patients in place without transport on *page 4*.

RT = a + b log2 (n) is the formula for Hick's Law which describes the relationship between an individual's reaction time based on the number of inputs or stimuli. Basically, the more choices you have, the longer it takes to make a decision. Publication of the newsletter is late this edition in part due to my inability to complete any of the articles I started which included: a juxtaposition of the wrongful death criminal convictions of nurse RaDonda Vaught and police officer Kim Potter, a cautionary article on medicine vs advocacy, a lament on risk assessment, and a muse about whether the time has come for body worn cameras in medicine. Fortunately, other contributors had much better follow through than I and their articles can be found below.

Please take special note of the articles on use of the BHACC and Geriatric Teleconsult. Anything we can do to help alleviate the burden on our local emergency departments helps our EMS system and our patients. These are two initiatives that can help us incrementally work towards these common goals.

Eric Rathfelder
Editor-In-Chief

Why Use the BHACC?

Jeremy T. Cushman, MD, MS, EMT-P, FACEP, FAEMS

The Rochester Regional Health Behavioral Health Access and Crisis Center (BHACC) is an outstanding, but under-utilized resource in our community. Currently open 7 days a week from 9am to 9pm, it provides a multitude of services for individuals in crisis. Given the overcrowded ED's and Psychiatric Evaluation Units, the BHACC received authorization last year to be an alternative destination for EMS and law enforcement agencies for patients in crisis – whether voluntary or under MHL 9.41 provided they meet certain criteria (See Advisory 22-02 at https://www.mlrems.org/GetFile.aspx?fileID=27238). Those criteria are designed to assure the patient's safety while at the BHACC and reduce the chance of secondary transfers. In fact, for those brought to the BHACC since the program started,

Upcoming Events

Melinda Johnston

For more information about any event listed below, please visit the training calendar at MLREMS.org

April

11 - EMS Journal Club

18 - REMAC Meeting

18 - Regional M&M Conf

29 - Peds Cardiac Arrest

24 - REMAC Case Conf

May

15-21 Happy EMS Week

16 - MLREMS Council

16 - MLREMS Awards

only one that was appropriate for BHACC according to the Advisory required subsequent transport (many hours later) to another facility. That's a phenomenal safety profile and dramatically helps optimize resource use while improving the services provided to an individual.

A common concern amongst EMS practitioners that I have heard is that the criteria are too long and too restrictive. I get it. Valid complaint. I would have preferred they be much shorter, however there were a lot of stakeholders involved in this project, including the state, as this is the FIRST time anywhere in the state something like this is being done. As a result, there was appropriately some level of concern and a "conservative" approach. Use your best judgement within the criteria, for example, "Intoxication" specifically means that the individual is clinically intoxicated (staggering, slurring words, can't hold themselves up, altered, etc). It does not mean that someone that had a couple beers, is alert, oriented, coherent, and in crisis (despondent, suicidal, etc) cannot be considered for the BHACC.

Since you know who is eligible to be transported, now you are probably asking why. The reason is simple: The BHACC can provide crisis services to address our patient's needs, often much more effectively than an over-crowded ED. Specifically, the BHACC provides immediate crisis intervention, assessment, supportive counseling, peer services, care management, and follow-up services for individuals and families facing various types of crisis. There are licensed clinicians on staff who can aid the individual in dealing with various situations including, but not limited to:

- Thoughts of self-harm
- Relationship problems
- Depression and anxiety
- Substance use concerns
- Problems following up with mental health & care providers

The BHACC provides behavioral health services to those 18 years and older and they will experience a comfortable, relaxed environment, without the wait of an ER, and are free to come and go as they please (if not under MHL 9.41).

Please take the opportunity to review the inclusion criteria for transport to the BHACC and consider it as a care option for your next person in crisis – not only will you be less likely held in a hallway awaiting your patient to be received, but the environment and care may be just what your patient needs.

Let's Focus Education on Improving Patient Outcomes

Christopher Galton MD, NRP, FP-C

I just got back from a great vacation to Arizona where we visited some of our immediate family members. Nine days of time with my wife and kids (and I still love them) was a great break from the day-to-day grind. I got to see the Grand Canyon with six inches of snow. I witnessed hundreds of tractor trailers locked up on Interstate 40 because they were not prepared for the conditions, which were laughably uninteresting from our perspective. There was a big orange orb in the sky and it made me feel warm and happy. Hopefully this wonderful orange orb in the sky will come visit us sometime soon...

Then I opened my computer up to find an inbox full of polite content encouraging me to jump onto various company sponsored websites to complete "mandatory" on-line courses. I dread this time of year. Since you are EMS people, I know you all have multiple jobs and each agency has their own version of the annual blood-borne pathogens beat down, the how to properly don your PPE videos, etc. After being at this gig for over 25 years now, I have sat through, or now clicked through, far more information about making sure I don't recap a needle, improperly decontaminate a stretcher, and get my hep B vaccine, than I needed to.

When I look back on all the time lost for this type of content, it makes me sad. I start to wonder what I could have done with myself if I had all that time back. I also get easily frustrated that I have to take a different version of the same content for each different agency. What makes it worse it that we are taking these classes because of some state or federal mandate, or so that the agency can lower its insurance rate. These mandates come from some "knee jerk" type rules because one person did something silly and now we are all paying for it. I just spoke with a colleague who has something to do with assigning this content and it really causes him a lot of heartburn since these type classes are pressed upon us as education. It's not education, it's punishment being brought down upon us by people that don't believe that we should have down time, see our families, or do something for our community. What would our world be like if we took all the hours that each employee puts into this mandatory content and used that to volunteer our time in the community cleaning up roadways, working at a food bank, or building a house with Habitat for Humanity?

When is the last time you truly learned something from annual mandatory classes. In most cases, the person leading the session is lucky if 50% of the room is still awake five minutes in. For on-line classes, I think employees take bets on who can click the boxes the fastest without regard to how many times they have to take the quiz at the end. Hypothetically speaking, I bet you could pay your tech savvy 11 year old daughter to take all those classes for you. Those of us older folks should thank the "we are not allowed to fail" generation for making all these tests repeatable with no penalty.

Now that I have plead guilty to speeding through mandatory education, or at least being willing to provide below minimum wage employment to underage immediate family members, I'll make my pitch. Let's transition away from mandatory education. I'm sure those of you who get assigned to put this content together do not look forward it. For those of you responsible for paying employees to sit through the content, let's find better ways to allocate those resources. For the rest of us that have to choke this stuff down, why don't we ask for content that will actually provide some benefit to the patient's we serve? Employers can provide benefit to the communities we serve and employees can feel good about doing more for their communities.

For all the human resources and office type people that are currently getting chest pain reading this, I accept that there are certain topics that government agencies require training. Knowing that, what can we do to limit the topics that require maintenance training and spend more time and capital on dialing in education for our staff that will improve the morbidity and mortality of our patients? The patients are the reason we all have and will continue to have jobs for the foreseeable future. Being forced to sit through mandatory red bag disposal content but having voluntary respiratory distress training is just about criminal in my mind. I don't know any red bags whose lives need to be saved by a bunch of good hearted EMS personnel.

Thanks for continuing to do what you do best by taking care of the wonderful people of Upstate NY. I'll keep up the fight against the overwhelming tide of mandatory time wasting. If you have any comments on this column, feel free to email me at chirstopher_galton@urmc.rochester.edu.

Why Use the Geriatric Teleconsult

Jeremy T. Cushman, MD, MS, EMT-P, FACEP, FAEMS

In the midst of COVID, we worked with the Geriatricians to find ways to help keep their patients in their living environment and not get transported to an ED. At first that was just for asymptomatic COVID positive residents, but expanded to any presenting condition that did not obviously require transport to the Emergency Department. Despite that guidance and service still being in place for UR Medicine patients (See Advisory 22-03 at https://www.mlrems.org/GetFile.aspx?fileID=27252), it remains vastly underused.

So why talk to a geriatrician? This is a great resource when you have a patient that A) Wishes to refuse transport but you have a concern; B) Has a minor condition that you don't believe may require an ED visit, or C) Staff is indicating that they need to go but the patient would rather not and you aren't finding anything concerning on the exam either. Here's two big benefits in using the Geriatric Teleconsult when indicated according to the Advisory:

First, the geriatric group that covers that facility either knows the patient, or knows the physician that knows that patient. That means they can help by knowing what is normal or not, arrange a followup visit by phone, telemedicine, or in-person if necessary, and be able to advocate for the patient in ways that standard medical control can't (since we at the end of the med control phone don't have that type of relationship with the patient).

Second, and most importantly, the individuals at the facilities that are eligible for Geriatric Teleconsult are often truly right on the precipice of requiring a higher level of care, despite wanting to live as independently as possible (who wouldn't?!). Transporting to an ED does have risk: The incidence of delirium as a result of an ED visit or hospitalization is remarkably high and can exceed 80% in some subpopulations! This shouldn't be surprising: lights are always on, vital signs being taken, no sense of day or night, medication and meal disruptions, social isolation, etc. Did I mention being on a gurney in a hallway for a day or two (or three)? In some cases, transport to the ED for a condition that could have been managed in the outpatient setting may result in them never coming back to that living environment.

In short, as we in EMS start doing more than "you call, we haul," we will increasingly have the opportunity to direct a patient through the healthcare system in ways to better meet their needs, and reduce risks in ways that don't always incur the default outcome of a simple sign-off or transport to the ED. Familiarize yourself with the Geriatric Teleconsult criteria and earmark the facilities you may be able to use it in – it may be exactly the medicine your patient needs.

From the MLREMS PIER Committee

Thank you everyone for submitting your nominations for this year's 2021 MLREMS EMS Awards! Awards will be presented at our May 16th MLREMS Council Meeting at 4pm at Livingston County EMS (3360 Gypsy Lane, Mount Morris, NY 14510).