Issue Brief: Behavioral Health Crises

Hospital Emergency Department Coordination with Tribes and Indian Health Care Providers

Background

American Indians/Alaska Natives (AIAN) are disproportionately impacted by health disparities including those resulting from opioid use disorder. Data indicates that AIANs are disproportionally diagnosed with opioid use disorder, have less access to the full spectrum of best practices for treatment of OUD, and suffer from higher rates of fatal and non-fatal opioid overdoses. At the same time, Tribal and Urban Indian health providers are leaders in providing comprehensive, effective, innovative, and culturally grounded prevention and treatment approaches. These approaches draw on ancestral knowledge and protect future generations.

Problems and Concerns

Indigenous people are residents of Washington and deserve access to behavioral health crisis services. Indian Health Care Providers (IHCP) serve dual roles as providers and as health authorities for their sovereign nations. Hospital Emergency Departments serve a specialized regional role in communities across the state as part of a broad network of state services for behavioral health crises. Tragedy results when Native people are denied care, hospital ERs decide to release someone happen without full information or refuse to share information with IHCPs.

The following are core concerns for hospital emergency departments coordinating with Tribes and Indian Health Care Providers close to, during and immediately following a mental health and/or substance use crisis.

> *Care Coordination breakdowns*: Policies and processes don't honor health home model; hospitals won't share decision making on treatment and discharge, refuse to recognize IHCP expertise and role.
>
> *Communication breakdowns*: Frequency; amount of information; improper citing of HIPAA; informing families; informing police, first responders, and BH providers who are representatives of Tribal governments.

Recommendations

1) Hospitals should **sign Care Coordination Agreements (CCA)** with Indian Health Care Providers. CCA includes provisions for sharing information and coordinating care between a patient's primary care provider and the referred or emergency services needed.
2) Hospitals should **update their electronic medical record system** to be able to identify American Indian/Alaska Native patients and Indian Health Care Provider primary care points of contact. Early identification and robust inclusion policies will increase communication between hospitals and Indian Health Care Providers.
3) Hospital Emergency Departments should **update policies and procedures** for attending physicians and hospital social workers to include coordinating decision making with tribal providers.
4) Hospital Emergency Departments should **train staff and providers annually on HIPAA compliance**, especially coordinating with outpatient health providers. Hospital Emergency Departments should also **train staff, providers, contractors, and partners on Indian Health**

Delivery Systems 101: staff and leadership should understand that Indian Health Care Providers are both equal system peers and health authorities for sovereign nations.

Points of Contact

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Background Examples:

- *Refusal to coordinate care:* Calls to the hospital emergency department were not returned and hospital staff have cited HIPAA as a reason to not let the Tribe know the status of a client. One workaround has been for the police department to follow up and get an update on status. However, this type of follow-up adds steps to the process, a provider-to-provider direct contact is best.
- *Unclear decision making:* When the hospital emergency department and social worker do not call the Tribe nor the county DCR, it is unclear which information they use to determine the severity of a crisis. After the fact quality assurance checks have revealed that the hospital did not use all the information available and released the patient before they were ready. Even shared electronic health records has only limited improvement on information sharing.
- *Delayed intake slows first responders:* Both police officers and fired department/EMS responders often transport clients to the hospital emergency department. First responders have commented that they may end up waiting for the client to complete the intake process for up to three hours. This delay causes the responders to be unavailable for other emergency calls.
- *Involving DCR earlier in the process:* DCRs can and should assess patients in the field, however in the last year several issues have delayed that process: families and first responders taking patients to hospital before DCR involved, calls to regional crisis line aren't timed correctly (person released from hospital, person in hospital), 911 routes BH calls to police (bypassing crisis line and DCRs). Several hospitals have refused to call the county DCR and the DCR feels they cannot access the patient without the invitation from the hospital.
- *Need to notify a Tribe:* In one review of a tragic case, our workgroup found that the person had been seen by two hospitals, the VA, and police within about a week of completing suicide. Not one entity communicated with the Tribe.