Provider Bias Towards High Utilizers in the Emergency Department

A Lethal Case

Kelley-Anne Klein MD[1], Steven Runyan DO[2], and James Kimball MD[3]

1 Vermont Department of Mental Health
2 Department of Psychiatry, University of Vermont
3 Department of Psychiatry, Wake Forest

Introduction

Providing mental healthcare in the emergency setting comes with a certain level of risk. Upwards of 10% of people presenting to emergency departments have recent suicidal ideations or even recent suicidal behaviors. (1, 2) A recent statistical brief by the Healthcare Cost and Utilization project found that 8.7% of presentations to emergency departments in 2017 were found to have a diagnosis indicative of self-harm. (3) Determining level of risk for these individuals is one of the greatest challenges an emergency provider will face.

Many emergency providers report confidence in screening for suicidal ideation but less comfort in assessment. (4) Provider factors that can affect assessments include but are not limited to: time constraints, level of training, counter transference and provider bias.

A particular subset of patients that are subject to a high level of provider bias are high utilizers of the emergency department.

Bias

Blindspot →
seeing oneself as less bias than others

Choice-Supportive Bias →
Tendency for the decision-maker to more readily recall the facts that support the decision they have made

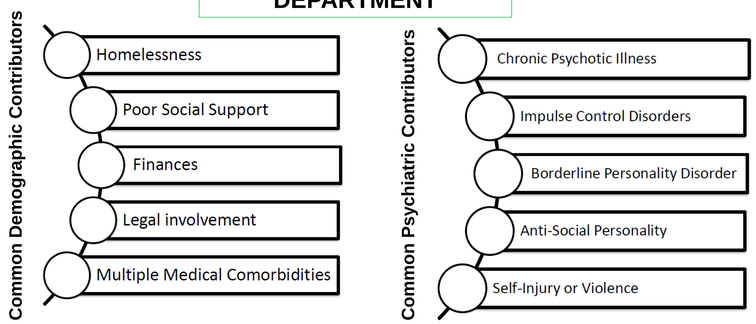
Confirmation Bias →
The tendency to select or value information that supports ones already established view

Conservatism Bias →
The tendency to cling to established views at the expense of acknowledging new information

VS.

Instant Countertransference (iCT)
An opinion formed in the blink of an eye. Relates to patient behaviors and characteristics.

HIGH UTILIZERS: 4+ ANNUAL VISITS TO THE EMERGENCY DEPARTMENT



Case Report

- Demographics: Young woman, divorced with no children. Living independently. High level of education (was working on masters). Was once employed but is now unemployed. Dwindling social support.
- Historical presentation:
  - First 6 years: scattered visits for depression, emergence of cutting behaviors, and one suicide attempt via low dose overdose
- Recurrent presentations:
  - Year 1: 9 ED visits and a new diagnosis of dissociative identity disorder
  - Year 2: 41 ED visits
  - Year 3: 40+ ED visits, moved out of state and back
  - Final 3 days: 5 ED visits (1 visit with no mental health intervention, 1 visit without psychiatric evaluation). Newly homeless, without medications, no longer connected to services.

→ 36 hours after being discharged presented unresponsive and vomiting after apparent ingestion of 1,000 tablets of 200mg ibuprofen

→ Intubated quickly, CT head negative

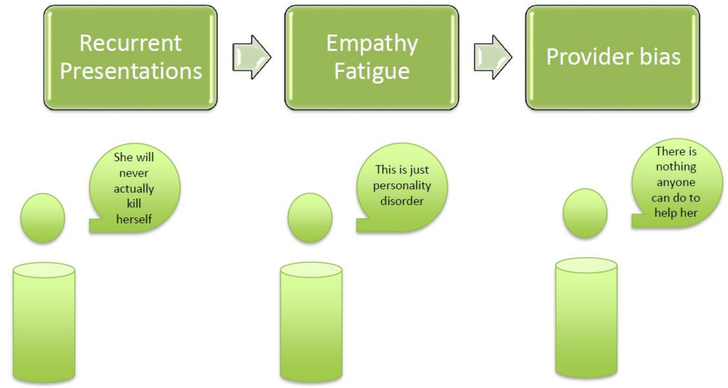
→ Given charcoal approximately 2 hours after arrival, started on levophed

→ Admitted to MICU

→ Renal failure, started on continuous renal replacement therapy

→ Progressive hypotension despite max pressor

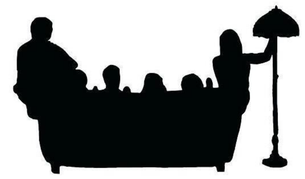
→ Terminal extubation 24 hours after presentation



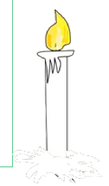
Sentinel Event Review and Outcome

- Institution wide review
- EMTALA requires a unique assessment for every presentation of suicidal ideation
- Choose your own adventure style training of iCT and

Avoiding the iCT Trap



- **The one where you walk away**: recognize feelings of anger, frustration and remove yourself from the situation for a breather
- **The one where you follow standard of care**: remove the patient's name from your plan, determine what you would do for a patient who walked through the door with the same issue → make that the plan for this patient
- **The one where you realize you don't care**: feelings of apathy are more difficult to face and more difficult to admit to ourselves. First step → get a second opinion. Second step → talk to a mentor, start asking the difficult question of why.



References

1) Ilgen MA, Walton MA, Cunningham RM, et al. Recent suicidal ideation among patients in an inner city emergency department. Suicide Life Threat Behav. 2009;39:508–517. [PubMed] [Google Scholar]
2) Claassen CA, Larkin GL. Occult suicidality in an emergency department population. Br J Psychiatry. 2005;186:352–353. [PubMed] [Google Scholar]
3) Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2008, 2010, 2012, 2014, 2016, and 2017
4) Betz ME, Sullivan AF, Manton AP, Espinola JA, Miller I, Camargo CA Jr, Boudreaux ED; ED-SAFE Investigators. Knowledge, attitudes, and practices of emergency department providers in the care of suicidal patients. Depress Anxiety. 2013 Oct;30(10):1005-12. doi: 10.1002/da.22071. Epub 2013 Feb 20. PMID: 23426881; PMCID: PMC4350671.
5) Moukaddam N, Tucci V, Galwankar S, Shah A. In the blink of an eye: Instant countertransference and its application in modern healthcare. J Emerg Trauma Shock 2016;9:95-6.