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Policies that Support Emergency Department Staff in Providing Behavioral Health Care

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Abstract

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MS, Naval Postgraduate School, 1992

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Dissertation Submitted in Partial Fulfillment

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Abstract

A significant portion of individuals with a behavioral health (BH) condition return to emergency departments (ED) seeking care, resulting in reduced quality of care, and contributing to disproportionate healthcare costs. Care can be improved and return visits to the ED reduced where behavioral health care and follow-up care planning are provided as part of their treatment. However, policies expected to create declines in ED use for behavioral conditions are typically in short duration or are difficult to use given other funding and policy constraints. With little known about how policy is supporting the engagement of ED staff who are critical in providing this care, this qualitative case study provides an understanding of how policy is supportive of behavioral health care to reduce return ED visits. Through the theoretical lenses of the theory of reasoned action (TRA) and the theory of planned behavior (TPB), this study has identified where ED staff feel supported by processes and the related policies and are therefore more likely to engage in those activities. Through interviews with eight individuals who have provided for behavioral health care in an ED, processes were identified that supported provision of care. Using a thematic analysis and pattern coding to develop major themes based on participant attitudes and beliefs, corresponding policies were then identified through online document searches. This study has shown how policies support ED staff in the provision of behavioral health care so that policymakers may enhance and strengthen effective approaches for ED staff to improve care for individuals who enter an ED with a behavioral health need while also reducing healthcare costs for hospitals, and government and private health insurance payers.

How Processes and Policies Support Emergency Department Staff in the Provision of Behavioral Health Follow-up Care Planning: A Case Study

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Dedication

I am grateful for the support provided by family and friends and the strength and hope provided by God.

Acknowledgments

I am thankful for the continued support of my committee for the long process and the confidence and understanding provided by my student success advisor.

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Chapter 1: Introduction to the Study

Introduction

Emergency departments (ED) have become the default place where individuals with behavioral health (BH) conditions seek treatment due to lack of access to needed care (Kaltsidis et al. et al., 2021; Kumar & Klein, 2013; Ngo et al., 2018; Schmidt, 2017). Overuse of EDs by those with a BH condition, which includes mental illness (MI) and substance use disorders (SUD), is a critical issue increasing the volume of ED visits, (Kaltsidi et al., 2021; Kumar & Klien, 2013; McGuinty & Daumit, 2020). Overuse is resulting in a rise in overall unreimbursed hospital costs and increasingly detracting from the quality of care (Ngo et al., 2018; True et al., 2021; Weilburg et al., 2018;). Inadequate access to needed behavioral healthcare has been shown to lead to high utilization of EDs by those with a behavioral health condition, significantly contributing to increased healthcare costs in the United States (Alakeson et al., 2010; Kaltsidis et al., 2021; Nicks & Manthey, 2012; Sirotich et al., 2016). EDs are the default place of last resort for those with a behavioral health condition (Boudreaux et al., 2016). Thus, they are positioned to improve access to care and follow-up care planning so that behavioral health needs are better met toward reducing ED return visits (True et al., 2021; Vekaria et al., 2021). However, EDs have limited capacity to engage in providing follow-up care planning given existing funding policy so effective follow-up care planning practices not common (Ngo et al., 2018; Parasher et al., 2019; True et al., 2021; Wolf et al., 2015). It has been shown, however, that with adequate resources and funding, EDs can provide follow-up

care planning to reduce the volume of return ED visits (Nardone et al., 2014; Ward et al., 2018).

Policy Can Promote Effective Practices

Funding and other types of policy can be effective in improving follow-up care planning engagement by EDs for those who visit with a behavioral health condition (Nardone et al., 2014; Schall et al., 2020; Stewart et al., 2021). Demonstration projects and grant-funded programs have been effective in reducing return ED visits. These projects have included value-based approaches that improve incentives by allowing flexibility in payments to include non-traditional services, training, payment for clinician time and services, expedited triage, and development of a team-based ED approach to provide immediate and follow-on care (Knickman et al., 2016; Nourse, 2021; Rawson et al., 2019; Schall et al., 2020; Ward et al., 2018).

Two funding mechanisms that have enabled access to care through follow-up care plan development are: (a) funding that provided for adequate and appropriate staff and staff skill development, and (b) adequate reimbursements to assess, engage in triage, provide urgent care and ensure connection with a treatment plan (Carlo et al., 2019; Sawyer et al., 2006). One example of an effective demonstration project is the "Sustaining Healthcare Across Integrated Primary Care Efforts" pilot launched in 2012 that provided for global payments for team-based care approach rather than standardized payment systems established by broad-based policy (Ross et al., 2019). Programs that improve ED engagement in access to care and follow-up care planning have also been made possible through funding that developed a psychiatric fast track service in an ED

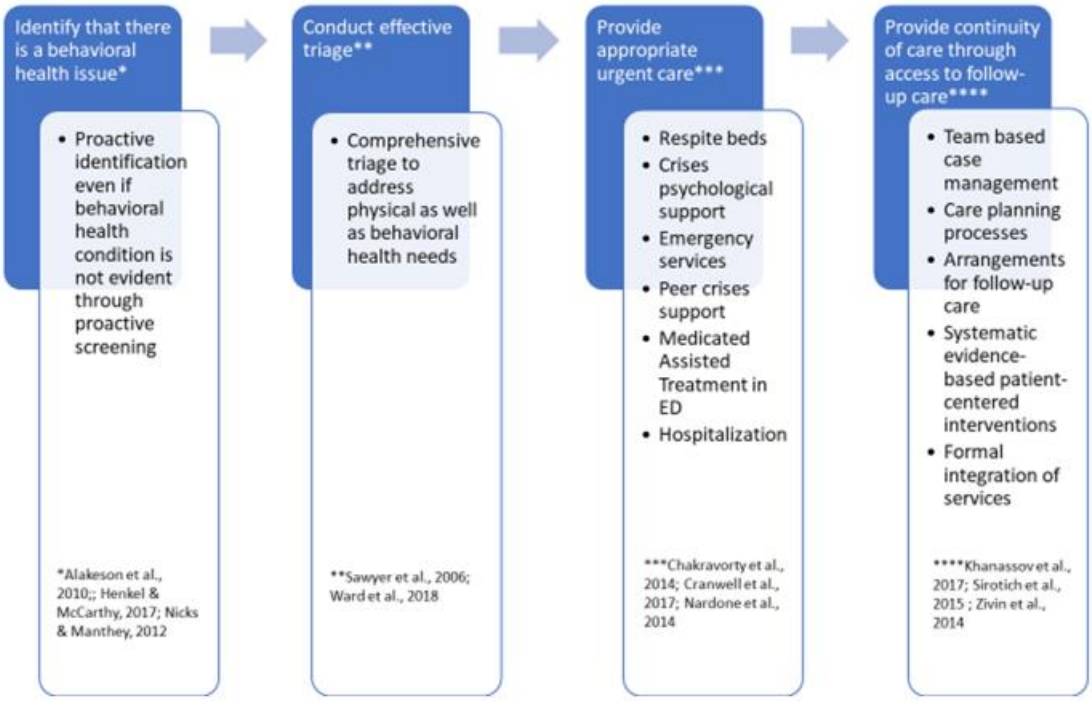
(Okafor et al., 2016). The “Psychiatric Fast Track” services improved adequate and efficient follow-up access to treatment for those who visited the ED with a BH condition (Okafor et al., 2016). Through this program, funding for appropriate interventions that included triage and disposition, in addition to added specialist care access in the ED and needed follow-up care planning, contributed to reduced ED utilization for those with a behavioral health condition. In order for EDs to ensure provision of a follow-up care plan to reduce return ED visits for individuals with a behavioral health condition, they needed to: (a) identify that the individual had a behavioral health condition (Langerman et al., 2019; Manton, 2021; Vekaria, 2021), (b) understand the immediate needs of the individual through triage (Cranwell et al., 2017; Manton, 2021), (c) provide urgently needed care (Manton, 2021), and (d) Provide access to a follow-up care plan to meet ongoing needs (Alakeson et al., 2010; Nardone et al., 2014; Stewart et al., 2021; True et al., 2021; Vekaria et al., 2021). These components are illustrated in Figure 1. Urgently needed care provided by EDs that is supportive of follow-up care planning may include:

1. Respite beds in the emergency department and ED staff supported stabilization (Brind’Amour, 2020),
2. Crises psychiatric professional support either in person or virtually through telemedicine (Brind’Amour, 2020; Fendrich et al., 2019) and emergency services crises teams that are on-call to the ED (Brind’Amour, 2020),
3. Peer crises support that is housed in or on-call to the ED (Stewart et al., 2021; True et al., 2021),

4. Medicated assisted treatment in ED or accessible to the ED (Stewart et al., 2021; Vekaria et al., 2021),
5. Hospitalization (Edwards et al., 2007; Peek CJ and the National Integration Academy Council, 2013; Rawson et al., 2019).

Figure 1

Processes in EDs Shown to be Effective for the Provision of Follow-up Behavioral Care



Despite the demonstrated effectiveness of providing the complete package of ED assessment, triage, urgent care, and subsequent BHCFUP for individuals with behavioral health conditions, such individuals continue to use emergency departments (EDs) at a greater rate than the general public and this is due to lacking follow-up care plans to meet their behavioral health needs (Kaltsidis et al., 2021; Medicaid., n.d.; Nicks & Manthey, 2012; Niedzwiecki et al., 2018).

Gap Between What is Known to be Effective and Practice

There is a gap between evidence-based clinical research and healthcare practice (Parashar et al., 2019; Samet et al., 2018; Stewart et al., 2021; Wolf et al., 2015). A continued disconnect between funding policy and needed support for implementation of BHCFUP highlights the value in policymakers' understanding what is working so that policies can be improved to increase engagement in the provision of BHCFUP to reduce return ED visits (McGinty & Daumit, 2020; Niedzwiecki et al., 2018). As these effective processes associated with policy are not commonly seen in EDs, a case study that is focused on a critical instance, also identified as a "critical case study" by Yin (2016), can provide specific, in-depth information from the point of view of those who have worked in EDs, or in collaboration with EDs, to explore where effective processes have occurred. In a critical instance case study, such as with this study, patterns, and trends of how these individuals are supported can then emerge when analyzed. Policies can influence the provision of healthcare through different levels that include the healthcare professional, health care groups, organizations that provide health care, or the larger healthcare systems (Eccles et al., 2005). At the healthcare professional level, staff attitudes, beliefs, and perceived ability to control the outcome across settings and for differing interventions mediate the effectiveness of the intervention, such as the provision of BHCFUP (Eccles et al., 2005; Schall et al., 2020; Wolf et al., 2015). As those who work in and with EDs are key to the successful provision of BHCFUP, their positive intentions or motivation to engage in those processes are a significant factor to explain how funding

policies can be effective to reduce return ED visits (Knowles et al., 2015; Manton, 2021; True et al., 2021).

Need to Understand How Processes Support Change in Behavior

To produce a desired change in behavior such as ED staff engagement in BHCFUP, it is important to utilize theories that explain how change can be affected through policy (Eccles et al., 2005). The use of theories can clarify how processes supported by funding policies are incentivizing ED staff engagement in the provision of BHCFUP (Ward et al., 2018). More information about the cognitive mechanisms that underlie staff behaviors is needed to improve behavior change efforts that target healthcare professionals (Godin et al., 2008). One way to study healthcare professionals' engagement in behaviors is to understand their intentions (Fleming et al., 2017). An individual's behavior is considered an action directed at a target that is performed in a given context or point in time (Eccles et al., 2005). The theoretical factors that underlie ED individual behavior can explain the processes and theoretical constructs that are important to ED staff support for BHCFUP (Eccles et al., 2005). Those theories that explain how to change individual behavior are the ones most likely to be useful in implementation efforts (Eccles et al., 2005). Theories regarding individual healthcare professional behavior are more relevant to understanding interventions related to ED staff than, for example, organizational change theories that are more appropriate for hospital interventions (Eccles et al., 2005). This study is therefore concerned with individual behaviors of ED staff (which includes for the purposes of this study individuals who

work in the ED), and the ways they are supported by processes, and corresponding policies to provide effective BH care in the ED.

This chapter provides a background of the study, a description of the problem, the purpose of the study, the research questions, the theoretical and conceptual framework for the study, the nature of the study, definitions, assumptions, scope, limitations, and significance of the study.

Background of the Study

Studies have shown that provision of BHCFUP can be effective to reduce return ED visits, have demonstrated types of funding that support BHCFUP, and have highlighted hospital staff perspectives related to perceived needs or barriers in the provision of BHCFUP (Fendrich et al., 2019; Stewart et al., 2021; True et al., 2021). However, there has been limited study. It is not clear how funding policy has motivated ED staff to engage in providing BHCFUP for those who enter the ED with a behavioral health condition (Powell & Beidas, 2016; Ward et al., 2018). This lack of information impedes acting through funding policy to motivate ED staff to support of BHCFUP. The Institute of Medicine (US) Committee on Crossing the Quality Chasm (2006) identified that improved understanding of how policies are incentivizing access to care through follow-up care planning could support the development of effective policies. However, there has been lacking exploration to understand the ED staff's attitudes and beliefs about processes and components that can support access to care through follow-up care planning for those who enter an ED with a BH condition (Cranwell et al., 2017). The social cognitive theories of theory of reasoned action (TRA) and theory of planned

behavior (TPB) have been used to predict individual intention to engage in behaviors. Intentions that are formed by attitudes and beliefs have been shown in multiple studies to be a predictor of behavior (LaMorte, 2019; Natan et al., 2009). According to TRA/TPB theory, if an individual intends to engage in a behavior, such as support for effective behavioral health care in an ED, in addition to being motivated, reflects how much effort they are willing to put forth and consequently the likelihood of engagement (Raudkivi, 2020). Understanding how processes and policies influence the likelihood of engagement through TRA/TPB theory can inform decision-makers where policy is positively influencing support for BHCFUP in EDs.

Studies have used TRA and TPB analysis to understand the motivations of healthcare professionals to predict and explain their engagement in practices of identification, assessment, provision of urgent care, or BHCFUP behavior (Knowles et al., 2015; Mullen & Westwood, 2010). Little is known, however, about the attitudes, social norms, beliefs, and perceived control beliefs of ED staff toward processes that enable the provision of follow-up care plans for those who enter the ED with a BH condition (Manton, 2021; Powell & Beidas, 2016; Romaire et al., 2018; True et al., 2021). Based on previous applications, TRA and TPB can serve as a lens to understand how the components of effective BHCFUP processes motivate staff. This understanding can then assist with identifying what funding policies are attributed to those components.

Problem Statement

Return ED visits by those with a BH condition contribute to high healthcare costs and reduced quality of care (Kaltsidis et al., 2021). It has been shown that EDs can be

effective in reducing return ED visits through processes that support BHCFUP. However, policies to promote those processes have been limited (McGinty & Daumit, 2020; Schall et al., 2020). Effective practices are limited given the predominant funding policies (Cross et al., 2020). Funding policy and the derived funding for differentials in reimbursements result from cultural, financial, and regulatory mechanisms creating barriers to equitably fund integration of behavioral health and clinical health through the provision of follow-up care planning (Carlo et al., 2019; Cross et al., 2020; Knickman et al., 2016; McGinty & Daumit, 2020). Inadequate follow-up care planning has been commonly seen in EDs, resulting in segmentation of care and rising ED use attributable to BH conditions (ACEP Emergency Medicine Practice Committee, 2014; Bluestein & Pruington, 2017; Nicks & Manthey, 2012). With the exception of specially funded demonstration programs, it is challenging for EDs to engage in the provision of follow-up care planning given existing state and federal funding policies (Kim et al., 2017; Malitt et al., 2017; Okafor et al., 2016). Policy development can increase ED support for processes that improve follow-up care planning and reduce return ED visits for those with a BH condition (Kaltsidis et al., 2021). ED staff engagement is key to successful implementation of processes that support BHCFUP (Wolf et al., 2015). The problem is that little is known about the attitudes, social norm beliefs, and perceived control beliefs that motivate ED staff engagement in processes to support BHCFUP. This understanding is needed to promote processes through informed policy development that motivate ED staff to provide BHCFUP toward reduced return ED visits. Through the TRA/TPB lens, if processes support ED staff intention to engage in BHCFUP, then the policy that drives

those processes can significantly impact how policy can be more effective (Knowles et al., 2015).

Purpose of the Study

The purpose of this case study is to discover and explore positive attitudes and beliefs of ED staff toward components that support BHCFUP to reduce return ED visits for those with a BH condition and how they are aligned with policy. By understanding what processes influence ED staff engagement and how they align with policy, policymakers can incorporate those factors into funding policy to improve outcomes of reduced return ED visits for those with a behavioral health condition. Examination of first-hand staff accounts for funding policies that have been supportive of ED staff attitudes, social norm beliefs, and perceived control beliefs, can improve policymaker understanding for how policies can encourage staff engagement and help to overcome barriers to reduce return ED visits (Ward et al., 2018).

Research Questions

The overarching research question for this study is: How are beliefs and attitudes of emergency department staff favorably influenced by processes to support behavioral health follow-up care planning for patients with a behavioral health condition who visit an ED? To answer this question, it will be necessary to identify the processes that lead to ED staff favorable beliefs and attitudes by investigating:

1. What processes do emergency department staff believe are supportive of behavioral health follow-up care planning toward reduced ED visits for those with a behavioral health condition?

2. How do the emergency department staff utilize the processes of identification, assessment, provision of urgent care, and connection with follow-up care plans, to support the provision of behavioral health follow-up care planning?
3. How do ED staff, administration, and key informants perceive that the processes considered favorable by ED staff toward behavioral health follow-up care planning align with policy?

Theoretical Foundation

Understanding how ED staff are supported by processes and policies requires an understanding of the theory behind how they are moved to action by processes and policies. Theories applicable to individual behavior change based in psychology may consider: (a) motivation to explain how individuals come to intend a change, (b) action to explain how individuals move from intention to behavior, or (c) stage theory that identifies a progression toward a behavior change (Eccles et al., 2005). This study seeks to understand the motivation to explain how ED staff come to intend engagement in BHFCUP. Additionally, interview analysis also provides some understanding for how staff move from intention to behavior and some understanding for the progression toward a behavior change, as they are not isolated processes. To be an appropriate theory to predict or explain individual motivation to engage in a behavior such as support for BHCFUP, the theory needs to: (a) explain behavior change for healthcare professionals in a variety of settings, (b) should explain the behavior through factors that are changeable such as beliefs and attitudes, and (c) should consider volitional, or control, factors (Bhalla, 2021; Eccles et al., 2005; LaMorte, 2019; Raudkivi, 2020). The TRA and Theory

TPB meet this criterion through the theoretical constructs of behavioral intention, which is framed by attitude toward the behavior, beliefs about the subjective norm, and perceived behavioral control by the individual (Bhalla, 2021; Eccles et al., 2005; LaMorte, 2019; Raudkivi, 2020).

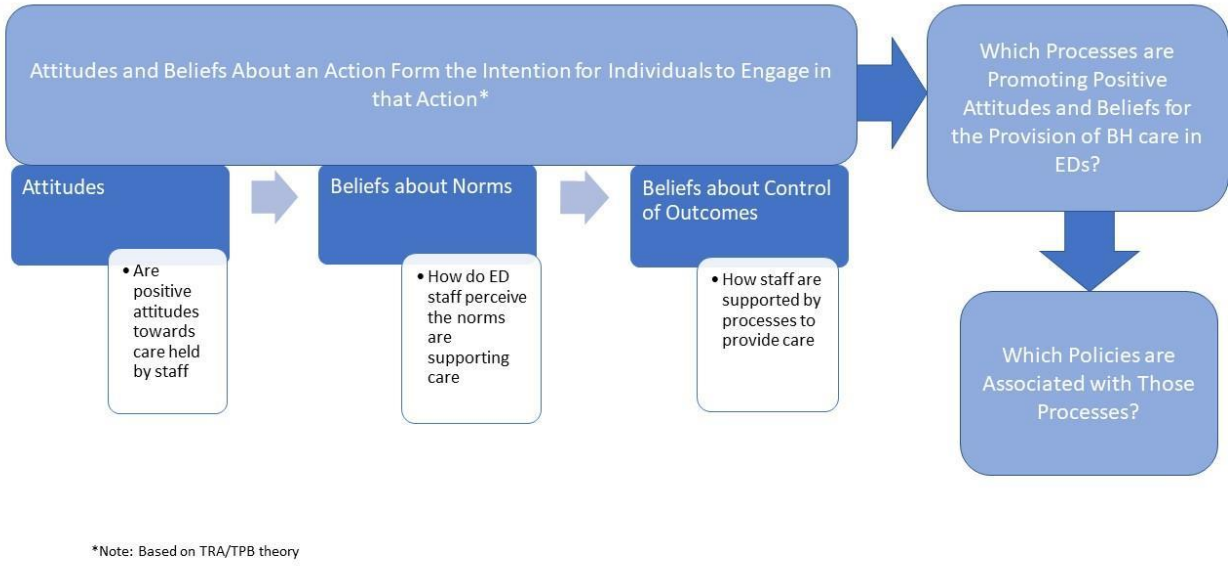
According to the TRA and TPB, theoretical approaches intentions are formed by attitudes, subjective norms, and behavioral beliefs (Ajzen & Fishbein, 1980; Bhalla, 2021; Fishbein & Ajzen, 1975; LaMorte, 2019; Raudkivi, 2020; Roberto et al., 2014). Through the lenses of TRA and TPB, an individual is likely to engage in behaviors to support, for example, BHCFUP, if in favor of doing something (their attitude), if feeling social pressure to engage in the behavior (subjective norm), and if they feel like they have control of the action or the perceived control over the behavior (Bhalla, 2021; Glantz et al., 2008; LaMorte, 2019; Raudkivi, 2020). Figure 2 illustrates these factors and their relationship to processes and policies and explains the linkage between ED staff beliefs and attitudes and their intention to engage in the behavior of support for BHCFUP (Bhalla, 2021). This study seeks to provide an understanding of how processes and policies positively influence staff attitudes and beliefs. The application of TRA and TPB theoretical approaches to this case study supports understanding to explain staff engagement in the provision of follow-up care planning for those with a behavioral health condition (Nilsen, 2015).

TRA and TPB have been shown to be preferable to specific health models (such as health belief model) as there is a greater alignment shown for general models for this study than specific health theories (Mullen & Westwood, 2010). Through TRA and TPB

studies, it has been found that intention is the single best predictor that an individual will engage in a behavior (Eccles et al., 2005; Knowles et al., 2015; Roberto et al., 2014).

Figure 2

Factors Affecting Engagement per TRA/TPB Theory in Relation to Processes and Policies



TRA and TPB can provide an exploration into the strength of beliefs related to processes, such as support for BHCFUP, and identify the beliefs that distinguish ED staff intention to engage in BHCFUP (Fishbein, 2008). TRA and TPB have been used widely to explain behaviors in healthcare that include both patient behaviors and healthcare provider practice behaviors. Fleming et al. (2017), Glantz et al. (2008), and Roberto et al. (2014) have suggested that study findings can help policymakers to understand how policy has motivated healthcare providers such as ED staff to engage in BHCFUP toward the reduction of return ED visits. The theoretical constructs identified for this study of

attitudes and beliefs that are supported by policy can be used to design interventions to enhance processes supporting change, such as policy development toward BHCFUP in EDs (Eccles et al., 2005). According to Eccles et al. (2005), theories can explain the appropriate targets of an implementation intervention to support, for example, BHCFUP in EDs to reduce return ED visits by those with a BH condition.

The social cognitive theories of TRA and TPB have been used in this study to capture the attitudes, social norm beliefs, and control beliefs toward ED staff engagement in the provision of follow-up care planning for those who visit the ED with a BH condition. These two theories have been applied to jointly highlight how policies are being used to support follow-up care planning toward reduced ED return visits by understanding the influence on ED staff behaviors. Through the TRA and TPB lens, this study has captured the attitudes, subjective norm beliefs, and perceived control beliefs of ED staff that explain their support for engagement in support for BHCFUP. According to the findings of TRA and TPB, these attitudes and beliefs drive intention to engage in the behavior (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975; Knowles et al., 2015). Further, it has been found that the intentions to engage in behavior, such as components that support BHUCP, are correlated with that behavior (Bhalla, 2021; Glantz et al., 2008; LaMorte, 2019; Nguyen et al., 2018; Raudkivi, 2020). Using TRA and TPB for this study required determination of the constructs of: (a) an attitude formed by behavioral beliefs, (b) subjective norm beliefs, and (c) control beliefs of ED staff related to BHCFUP (Mullan & Westwood, 2010).

An attitude formed by behavioral beliefs reflects the degree of ED staff favor for the action of engagement in BHCFUP and the outcomes of that action (LaMorte, 2019). Understanding ED staff attitude involves investigation about how they perceive engagement in BHCFUP components of identification, assessment, triage, provision of urgent care, and connection with BHCFUP (Glantz et al., 2008). These beliefs may be formed from many possible factors that include, for example, knowledge (Eccles et al., 2005; Knowles et al., 2015). A lack of knowledge, for example, may reduce the perceived value of a behavior by influencing the attitude toward that behavior; however, it is not a direct predictor of the formation of an attitude (Jove et al., 2014). Each of the factors, such as knowledge, may have some or little effect on influencing beliefs that form an individual's attitude, but other factors may be as likely to have an influence on forming the attitude (Eccles et al., 2005). This study goal was not to understand which factors or relevant influence those factors have on attitude, rather identify where positive attitudes are formed.

Subjective norm belief understanding involves discovering ED staff perception of their peers and others who are salient to the ED staff normative beliefs about a behavior (Glantz et al., 2008; LaMorte, 2019). Normative beliefs, or the beliefs about whether significant others approve or disapprove of the behavior, contribute to ED staff motivation to follow processes (Glantz et al., 2008; LaMorte, 2019). This study sought an understanding of the subjective norm beliefs that influence ED staff motivation to comply with engagement in support of BHCFUP. Subjective norm beliefs identified were based on what the ED staff expect their salient referents want them to do (Glantz et al., 2008;

LaMorte, 2019). The processes that occurred in the ED and were identified by the ED staff captured the subjective norm beliefs.

Control beliefs understanding involved identifying where support for BHCFUP was believed by ED staff to be associated with the attainment of BHCFUP and the attainment of reduced return ED use; and if ED staff believed they have control over the outcome (Glantz et al., 2008; Raudkivi, 2020). This volitional control can be supported or hindered through many factors that include skill development, presence or absence of needed resources, environmental or organizational support, or opportunities to engage (Eccles et al., 2005; Raudkivi, 2020). Understanding perceived volitional control involved learning if staff believe that their participation in those components contributed to BHCFUP and reduced return ED visits. The perceived volitional control was based on their judgments about different components that support BHCFUP and the perceived value ED staff attach to the outcome of BHCFUP and reduced return ED visits. Understanding volitional control involved uncovering if ED staff believed that they have power over situational and internal factors to support BHCFUP (Glantz et al., 2008; Raudkivi, 2020).

The theoretical foundation for this study will be addressed more extensively in Chapter 2. The constructs of TRA/TPB elucidated where positive beliefs and attitudes influence the intention of ED staff to engage in the provision of care for BHCFUP. An individual's intention is a relevant factor for policy development and implementation where intention has been used in studies to predict behavior (Bhalla, 2021; Knowles et al., 2015; LaMorte, 2019; Raudkivi, 2020). This study was not intended to measure TRA

and TPB model validity to predict behavior, which has been well documented, rather to uncover how funding policy driven components influenced behavior. Understanding the underlying theoretical concepts of attitudes and beliefs of individuals through the lens of TRA and TPB to explain intention helped to provide a view in the black box of where processes support ED staff engagement in BHCFUP.

Conceptual Framework

The conceptual framework for this study describes the relevance of needed components to support BHCFUP, the relevance of BHCFUP to reduced return ED visits, and how funding policy can support organizational interventions toward that desired behavior. This section describes how funding policy can support processes that enable behavioral health follow-up care planning (BHCFUP) in an ED and how BHCFUP can reduce return ED visits for those with a behavioral health condition. Funding that is flexible allows for organizational interventions to provide continuity of care that enables effective BHCFUP.

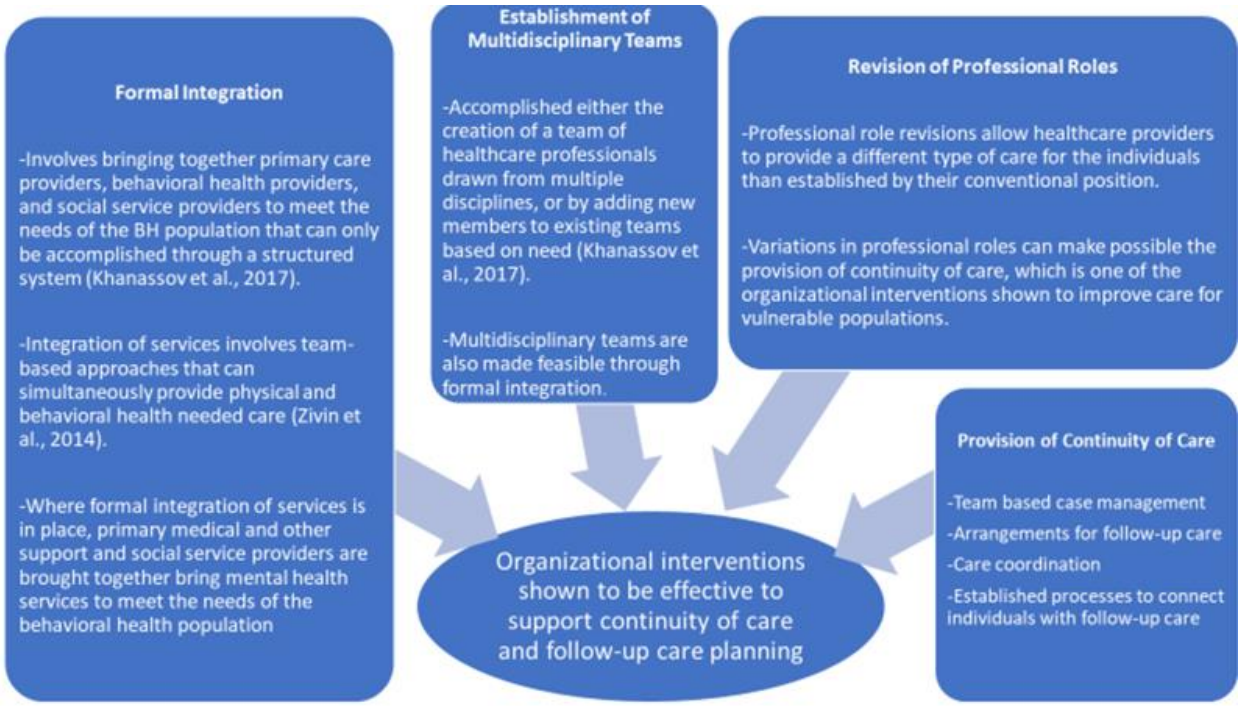
The Cochrane Effective Practice and Organization of Care Review Group (EPOC) identified effective, flexible funding and care interventions for complex patients such as those with a behavioral health condition (Khanassov et al., 2016). According to the EPOC group, effective, flexible funding provides an incentive or financial reward to an organization for specific actions. It provides for value-based or capitated payments that reimburse a set amount per patient (Khanassov et al., 2016; Stanek, 2014). Funding policies for financial interventions that include institution incentives and capitation allow for organizational interventions and processes to connect individuals with BHCFUP

(Carlo et al., 2019; Khanassov et al., 2016). BHCFUP that provides continuity of care can be achieved with funding flexibility that allows for shifting staff roles, institutional incentives, and capitation payments (Bhalla, 2021; Clark et al., 2015; Clark et al., 2014; Milton et al., 2020). Funding flexibility can support nontraditional services, training, pay for clinician time and services, expedited triage, and development of a team-based approach that allows for continuity of care to meet the needs of individuals with a behavioral health condition (Carlo et al., 2019; Knickman et al., 2016; Okafor et al., 2016).

An understanding of the supportive components and processes for BHCFUP is needed for this study to identify where ED nurses are engaging or utilizing those processes. Planned approaches to provide behavioral health care assist individuals with their behavioral change through the application of BHCFUP, thus reducing the need for those with a behavioral health condition to seek care in the ED (Zivin et al., 2017). Also termed seamless care, or shared collaborative care in the provision of behavioral health, it includes a variety of services to meet the full spectrum of medical needs for those with a behavioral health condition (Kroenke & Unutzer, 2017). Planned approaches through organizational interventions, as shown in Figure 3, that are supported by funding policy to bring these services together have been demonstrated to lay a foundation for the provision of needed care for vulnerable patients such as those with a behavioral health condition (Carlo et al., 2019; Khanassov et al., 2016). Those organizational interventions

Figure 3

Organizational Interventions Shown to be Effective to Support Continuity of Care



that are effective in supporting successful follow-up care planning include several key components: (a) formal integration, (b) the establishment of multidisciplinary teams, (c) professional role revisions, and 4) establishment of continuity of care avenues support successful follow-up care planning (Khanassov et al., 2016; McGinty & Daumit, 2020; Nourse, 2021; Rosen et al., 2019). The first of these organizational interventions, formal integration, involves bringing together primary care providers, behavioral health providers, and social service providers to meet the needs of the BH population that can only be accomplished through a structured system (Breslau et al., 2019; Chapman et al., 2017; Khanassov et al., 2016; McGinty & Daumit, 2020). Integration of services involves team-based approaches that can simultaneously provide physical and behavioral health

needed care (Breslau et al., 2019; Kroenke & Unutzer, 2017; Romaire et al., 2018; Zivin et al., 2017). Integration results when care is provided by a practice team of primary care and behavioral health providers in a systematic approach (Breslau et al., 2019; McGinty & Daumit, 2020; Vogel et al., 2017). Telepsychiatry services, an example of integrating services, has been shown to provide an avenue to connect individuals with behavioral health care in a collaborative way to compensate for shortages of psychiatric professionals (Farley et al., 2015; Kroenke & Unutzer, 2017; Romaire et al., 2018). Where formal integration of services is in place, primary medical and other support and social service providers are brought together to bring mental health services to meet the needs of the behavioral health population. The second organizational intervention shown by Breslau et al. (2019) and Khanassov et al. (2016) to improve care for vulnerable populations is the establishment of multidisciplinary clinical teams that is accomplished either through the creation of a team of healthcare professionals drawn from multiple disciplines or by adding new members to existing teams based on need (Khanassov et al., 2016; Rosen et al., 2019). These multidisciplinary teams are made feasible through formal integration.

The third organizational intervention shown in studies by Khanassov et al. (2016) and others to be effective is the revision of professional roles so that healthcare providers can provide a different type of care for the individuals beyond what is possible through conventional roles (Carlo et al., 2019; Esposito, 2019; Manton, 2021; Parashar et al., 2019). Variations in professional roles can make possible the provision of continuity of care. Provision of continuity of care is the fourth organizational intervention shown to

improve care for vulnerable populations by Brind'Amour (2020), and Khanassov et al. (2016). Continuity of care provided via case management, along with arrangements for follow-up care, has been shown in several studies to improve access to care for vulnerable populations such as those with a mental health or substance use disorder (Fendrich et al., 2019; Khanassov et al., 2016; Ngo et al., 2018; Raven et al., 2020). Continuity of care is created by applying evidence-based systematic patient-centered interventions (True et al., 2021; Zivin et al., 2017). Case management as a component of continuity of care can be effective if the care provided meets the complex needs of the individual along with formal integration of services (Kaltsidis et al., 2021; Parashar et al., 2019; Sirotich et al., 2016). Team-based case management involves counseling, coordination, crises intervention, assistance with entitlements and housing, ongoing community outreach support, and linkage to needed medical care providers (Sirotich et al., 2016). Intensive case management programs may include care coordination, crises intervention, counseling, and assistance with obtaining housing and income entitlement assistance along with making connection with medical providers, as well as other services (Kumar & Klein, 2013; Raven et al., 2020; Sirotich et al., 2016).

The provision of continuity of care is possible through follow-up care planning arrangements that are based on close follow-up, either when discharged or through care that was established on a planned schedule (Kaltsidis et al., 2021; Khanassov et al., 2016). Providing established processes that connect individuals with BHCFUP and subsequent continuity of care involves proactively identifying that there is a behavioral health issue, effectively conducting triage to determine what is needed, providing urgent

care, and arranging for access to follow-up care planning that is supported by organizational interventions (Brind'Amour, 2020). Follow-up care planning can be supported by EDs subsequent to the provision of urgent care (Kaltsidis et al., 2021). However, continuity of care is predominantly lacking in those ED settings that are without these processes, and they typically lack organizational interventions that flexible funding could facilitate (Parashar et al., 2019; Schall et al., 2020; True et al., 2021).

In summary, as staff are key to the successful implementation of BHCFUP, it is important to understand how policy is supportive of their engagement by understanding how the processes resulting from organizational interventions created through funding policy motivate their actions (Cranwell et al., 2017; Nardone et al., 2014). When supported by ED staff attitudes, these processes are more likely to succeed in ensuring the provision of BHCFUP.

Nature of the Study

This is a qualitative case study approach that is designed to understand how ED staff are supported by policies in the provision of behavioral health care. The framework for this case study is based on an ontological perspective that seeks to discover how selected emergency department processes and related policies are promoting the engagement of ED staff in support of BHCFUP. A research approach that involves eliciting salient beliefs through interviews and developing an understanding of the related funding and regulatory environment through document review and expert accounts, is the basis for understanding developed in this study (Fishbein & Ajzen, 2010). The nature of the study is a qualitative, case study approach to enlighten operational links between

policy and access to care through the provision of BHCFUP in EDs for those with a behavioral health condition. Little is known about how policy is supportive of the engagement of ED staff in follow-up care planning (Bystrek, 2010; Letvak & Rhew, 2015; Manton, 2013; Schmidt, 2017).

The definition of the "case" for this study is related to the research question, which is designed to understand how staff are supported to provide BHCFUP in EDs (Stake, 2006). The "case" is the provision of effective behavioral health care in U.S. emergency departments. A case study approach that identifies and examines perceptions of individuals who have previously or are currently working in an ED, and are engaged in support for BHCFUP, is appropriate for this study to seek understanding about how policy can be utilized in the United States. By discovering and exploring the positive attitudes and beliefs of individuals who have worked in or with EDs where policies support processes to provide access to care for those with a behavioral health condition, this study can provide illumination for how policy can be effective. Understanding how policies are conducive to those ED processes can inform policy development to promote improved BHFCUP and reduce return ED visits by those with a behavioral health condition.

Definitions

Attitude: This is related to a mental state that involves the beliefs, values, and feelings toward acting in specific ways. An attitude is both a function of an individual's beliefs about the behavior, their perception of how others value the behavior, and the individual's beliefs about the outcomes of performing the behavior (Glantz et al., 2008).

*Behavior***:** A behavior involves an action that is directed toward a target that is performed in each context and at a certain point in time (Fishbein, 2008).

Behavioral beliefs: The perception that some behavioral performance is associated with the attainment of specific attributes or performances and beliefs about positive or negative consequences of the behavior. An individual's behavioral beliefs contribute to their attitude and the evaluation of behavioral outcomes (Glantz et al., 2008).

*Behavioral health condition***:** Mental health and substance abuse disorders (Zivin et al., 2017).

*Behavioral health***:** Mental health and substance conditions (Zivin et al., 2017) and focuses on health behavior and the relationship to chronic medical illnesses and ineffective patterns of health care utilization (Vogel et al., 2017).

*Behavioral health integration***:** Care conducted in primary care and by behavioral health providers in the systemic provision of patient-centered care (Vogel et al., 2017; Zivin et al., 2017).

*Capitation payments***:** Fixed amounts of money paid in advance per patient based on the number of services estimated to be needed by the individual and are based on local costs and average utilization for the type of diagnosis of the individual (Alguire, 2019).

Case manager: Individual typically responsible for a range of services to include assessing care needs and developing care plans that involve collaboration between health care professionals and regular follow-up and liaison of services (Khanassov et al., 2016).

*Collaborative care***:** Ongoing relationship that is not fully integrated toward attaining a specific service (Kroenke & Unutzer, 2017; Vogel et al., 2017).

*Continuity of care***:** Case management focused on coordinating different medical and social services that include follow-up care planning (Khanassov et al., 2016; Ngo et al., 2018).

Control beliefs: Beliefs about the presence of factors that may facilitate or impede the performance of the behavior. Contributes to perceived behavioral control along with perceived power" (Glantz et al., 2008).

*Coordinated care***:** Organization of care between two or more providers involved in a patient's care. Exchange of information, treatment plans, and care, and case management can be used to enhance coordinated care (Ngo et al., 2018; Wagner et al., 1996).

Emergency departments: Also termed emergency rooms are facilities that provide acute or urgent care, typically addressing a wide range of illnesses and conditions. EDs may be the first point of care for populations with limited access to health care (Selby et al., 2018).

Evaluation of behavioral outcomes: Evaluation of behavioral outcomes are values attached to a behavioral outcome that reflect positive or negative judgments related to a behavior. An individual's evaluation of a behavioral outcome contributes to their attitude about a behavior (Glantz et al., 2008).

*External variables***:** External variables may include, for example, demographics that affect an individuals' attitude towards targets. Some behavioral scientists use the

terms "targets" when referencing TRA that are considered to be the adverse health outcomes of the behavior (Glantz et al., 2008).

*Follow-up care planning***:** Supports the provision of continuity of care through prearranged follow-ups or a preset defined frequency of care to ensure timely access to needed services Khanassov et al., 2016)

*Formal integration of services***:** Brings together all needed medical and social services to one point (Khanassov et al., 2016).

*Frequent ED user***:** Term most commonly defined as one who visits an ED at least four visits in twelve months (Hudon et al., 2016).

Implementation research: "…is the scientific study of methods to promote the uptake of research findings and hence reduce inappropriate care" and "includes the study of influences on healthcare professionals' behavior and methods to enable them to use research findings more effectively" (Eccles et al., 2005, p. 107).

Intensive case management: Can include care coordination, supportive counseling or crises intervention, in addition to assistance in obtaining stable housing or other entitlements to meet needs, and linkage to medical care providers and ongoing assertive community outreach and monitoring (Ngo et al., 2018; Sirotich et al., 2016).

*Intention to perform the behavior***:** Has been shown to be a direct indication of readiness to perform the behavior and is the most important predictor the desired behavior will actually occur. An individuals' intention is both a function of their attitude and their subjective norm towards a behavior (Glantz et al., 2008).

*Integrated care***:** Involves on-site team providers representing different fields and types of support including a unified care plan framed by both organizational and cultural integration (McGinty & Daumit, 2020; Wagner et al., 1996).

Normative beliefs: Beliefs about whether those whose opinion is valued by an individual approve or disapprove of their behavior. The normative beliefs contribute to their subjective norms, along with their motivation to comply with those expectations (Glantz et al., 2008).

*Psychiatric emergency***:** As defined by the American Psychiatric Association, is "an acute disturbance in thought, behavior, mood, or social relationship, which requires immediate intervention as described by the patient, family, or social unit" (Murtaza et al., 2018).

*Patient-Centered medical home***:** Comprehensive care that emphasizes a team-based approach connecting social services, community resources, and other resources (Wagner et al., 1996).

*Perceived behavioral control***:** The extent to which individuals feel that they are able to enact the behavior. It is a function of their control beliefs and perceived power with the behavior (Glantz et al., 2008).

Perceived power: The belief that an individual has regarding the power of both situational and internal factors that may inhibit or facilitate them to perform the behavior (Glantz et al., 2008).

*Psychiatric boarding***:** According to the American College of Emergency Physicians to be someone who is in an ED for four (4) or more hours after an admission decision has been made (Hsu & Chan, 2018; Murtaza et al., 2018; Tucci et al., 2017).

*Subjective norm***:** An individual's perception of the social norms or that of a peer or salient others' beliefs about a behavior. The subjective norm is a function of both the individual's normative beliefs and motivation to comply with beliefs (Glantz et al., 2008).

Social cognitive theory: According to Bandura (1986), "addresses the interaction between an individual and their environment, through a triadic reciprocal determinism." It includes factors that are related to the person, their behavior, and the environment that affects them (Bednarczyk et al., 2018).

Assumptions, Scope, Delimitations, and Limitations

Assumptions

An assumption for this study is that the study's sample population represents the general population of ED staff in the United States for how their attitudes and beliefs would be affected by funding policy-driven processes to engage in BHCFUP. Another assumption for this study is that an investigation of individual perceptions based on the TRA and TPB lenses applies to ED staff engagement in BHCFUP as demonstrated in other healthcare provider practice behavior studies that are not ED staff specific. This assumption that TRA and TPB behavior theory equally applies to ED staff and general medical or nursing staff is necessary due to limited studies that address the application of TRA and TPB to the specific population of ED staff.

The potential application for what is discovered by this study will be more robust where ED staff perception can be applied to policy development from a broad perspective. Representation is, therefore, a key assumption that is not explored or proven in this study due to the large volume of factors that would need to be considered to show general representation.

Scope

The focus of this study is to examine the attitudes and beliefs of ED staff related to positive engagement in BHCFUP. It does not include an investigation of attitudes and beliefs of other hospital staff, administration, or other involved entities regarding processes that support BHCFUP. The focus is on ED staff and how they are influenced by processes and policies to provide BHFUCP. However, investigation includes other key informant perceptions of which policies align with those processes. ED staff participants were identified through an initial questionnaire that clarified if potential participants had been involved in specific processes and components of the provision of BHCFUP in the ED. These key processes and components were identified through a literature search of other studies to compile what has already been identified as the key components of the provision of BHCFUP. The second aspect of the investigation includes ED staff views for what policies they perceive have supported their engagement, online document searches to expand upon supporting processes and policies identifies. Finally, there was additional inquiry with stakeholders to further investigate which policies might be supporting the indicated processes.

Potential Transferability

Transferability, has been supported for this case where others might transfer the results of this study to other situations or cases, can be strengthened through thick descriptions that gather information about a wide range of features around the cases(s). Through a collection of thick descriptions in this study, this study can increase applicability to other scenarios by giving the reader ample information about the case. A wide range of features about this case were be collected through two methods of data collection (document review and interviews) to capture information about state and federal funding, related regulations, reimbursement structures, the experience of conducting the interview, and the detailed information about processes and policies gathered through interviews. Information about payment and regulation structures, funding, regulatory hierarchy, public funding policies, and reimbursement structures from government and insurance providers will be gathered from internet searches and public government reports, provided by key informants, and verified or clarified with key stakeholders where needed. Information from reports and publications and information about the interview process providing thick descriptions include a robust and detailed account of the experience of surveying and interviewing ED staff and stakeholders or experts. This account will include, for example, descriptions of the interview process and ease of arranging interviews. By placing what participants express into the context of the surrounding social and cultural environment where the research study is framed through a description of attitudes and the environment of provision of care in EDs will better enable readers to make transferability judgments. Detailed information about the policies,

processes, and funding collected through the publications, reports, policy documents, and interview questions will include descriptions of those perspectives on funding and components that are in place and from staff who are engaged in supporting BHCFUP in EDs. By learning what processes staff find valuable through this framing of the criteria, readers may be able to apply what is learned about how ED staff use processes and supporting policy to engage in support of BHCFUP through the identification of similarities in organizations, staff behavior, or theoretical prepositions.

Limitations

TRA and TPB have been intensively applied in prior research. However, there is limited literature on how to use these models to change behavior through policy and related development of interventions. A TRA and TPB lens has more frequently been used to assess intervention effectiveness rather than used as a tool to develop the intervention (Nguyen et al., 2018). Though reviews of implementation research have shown that many interventions can achieve some improvement in healthcare delivery. these studies have not provided a rationale or theoretical basis or limited contextual basis for their intervention (Eccles et al., 2005). However, according to the UK Medical Research Council, the framework for the development of interventions should recognize the need to establish a theoretical basis for the interventions (Eccles et al., 2005). Applying appropriate theoretical constructs, therefore, can ameliorate this possible limitation of transferability of findings.

Rather than using interviews followed by a survey which has been the predominant approach to the utilization of TRA and TPB, this study utilizes a document

review and a qualitative interview approach absent a survey, raising a potential dependability limitation of this study. However, several studies have appropriately opted for interviews without surveys to inform the study findings through the TRA/TPB lens due to the level and type of information that is needed. As also supported by Khanassov et al. (2016), applying an interview-only approach based on the study constructs for this study can elucidate relevant themes in attitudes, normative beliefs, and control beliefs to help mitigate dependability limitations. As supported by Khanassov et al. (2017), this study used a qualitative interview approach to guide the development of interventions to improve primary health care for vulnerable populations. Identification of themes that can be discovered through interviews, and supported by document review and expert accounts, is more in line with the purpose of this study as described by Khanassov et al. (2016) due to the limited amount of information that is already known about staff attitudes. However, follow-on studies extending beyond document review and interviews to include surveys may serve later further to identify the relative strength of constructs and their influences. Future studies, using following surveys, could provide information about the relative strength for each of the constructs under the TRA and TPB models.

Another possible limitation is that the findings may be isolated to the specific situations or special funding studied which could have limited inference for other situations. Because the TRA and TPB focus on individual-level constructs such as the attitudes and beliefs of ED staff, findings are at the expense of comprehensive evaluation between the individual care and the broader constructs of the healthcare system (Bednarczyk et al., 2018). Generalizing the findings of this study to other ED

environments is problematic due to limited understanding of the characteristics of the intended behavior in other EDs (Eccles et al., 2005). To mitigate this possible limitation, participants have been selected based on meeting criteria for involvement in behavioral health care in EDs as established through a preliminary questionnaire.

My researcher bias includes a predisposed view based on previous community work that providing BHCFUP and integrated care is a difficult yet valuable effort. To mitigate this bias, I have used literature to formulate interview questions and standardized analytical approaches to uncover what is learned through interviews.

Significance of this Study

Patients with mental health needs and substance use disorders are expected to continue to utilize EDs seeking care due to lacking public funding for mental health and substance use outpatient services (Agency for Healthcare Research and Quality, 2017; Letvak & Rhew, 2015; Parashar et al., 2019; Williams et al., 2017). The growing prevalence of multiple chronic conditions has increased the importance of achieving better access to care for this patient population (Fryer et al., 2017). According to the American Hospital Association (2012), improved access to care that can occur through follow-up care planning for those with a behavioral health condition who visit an ED has cost implications impacting in all community sectors. The high prevalence of mental health disorders and SUDs and associated chronic complications, along with the negative impact of uncoordinated care on these populations, makes understanding what works to support access to BH care a priority (Ede et al., 2015). Improved access to care through follow-up care planning has been shown (through specially funded programs, such as the

Sustaining Healthcare and Psychiatric Fast Track) to reduce return ED visits, to produce significant social and economic cost reductions that extend to the community. These cost reductions in turn affect population health, social services, and productivity for whole communities and regions (American Hospital Association, 2012; Kaltsidis et al., 2021; Stewart et al., 2021). With an understanding of and an ability to predict motivational factors on the desired behavior, it is conceivable that those influencing the desired behavior can be modified to foster the desired behavior in healthcare providers (Evans et al., 2009).

There is a growing interest across programs to curb ED use by substance users and mental health patients with policies that create funding opportunities (Henkel & McCarthy, 2017). Populations with multiple chronic conditions are of interest for policymakers as this group is utilizing more health-related services with a disproportionate contribution to rising health care costs (Esposito, 2019; Fryer et al., 2017; Goldman et al., 2021; Wetzler et al., 2021). Improved understanding toward the reduction of return ED visits by those with a behavioral health condition is valuable to policymakers and administrators as a means to improve the provision of health care and reduce costs (Brind'Amour, 2020; Niedzwiecki et al., 2018). From the perspective of hospitals, payors, and patients, efforts to address ED overuse and sustain effective approaches are imperative (DeLay IV, 2017; Fryer et al., 2017).

States, institutions, and insurance or funding policymakers regulate the management of patients with a behavioral health condition, including evaluation, medical clearance, and disposition (ACEP Emergency Medicine Practice Committee, 2014;

Esposito, 2019). Policies implemented at various levels are intended to better manage care for those with a behavioral health condition (American Hospital Association, 2012; Breslau et al., 2019; McGinty & Daumit, 2020). However, despite policies that were anticipated to create declines in ED use, use has continued to grow (Greenwood-Ericksen & Kocher, 2019; Karaca & Moore, 2020; McGinty & Daumit, 2020; Theriault et al., 2020). This disconnect highlights a lack of understanding of what effective approaches can sustain improvements and describes a need to understand where policies are more broadly impacting outcomes. Due to the increasing numbers of patients with behavioral health conditions, hospital administrators and government agencies that are responsible for making policies have recognized the importance of improved quality of care and follow-up care planning in EDs (ACEP Emergency Medicine Practice Committee, 2014; Goldman et al., 2021; Niedzwiecki et al., 2018).

Clinical practice is also a form of human behavior that can be described by general theories that relate to healthcare providers and form the basis for a generalizable model (Eccles et al., 2005). A better understanding of how EDs are using policy to improve access to care through follow-up care planning can support further policy development toward reduced return ED visits through improved outcomes and systemic changes (Maruthappu et al., 2015). Informed policies about what is working in a complex policy environment are needed to address the prevalence and impact of behavioral health in the United States (American Hospital Association, 2012; Goldman et al., 2021; Niedzwiecki et al., 2018). Understanding how policy is sustaining improved access to

care, including follow-up care planning that decreases the arrivals into an ED, can highlight how policy influences improved outcomes (Murrell, 2017).

This study will contribute to positive social change by providing information to reduce the burden of BH conditions for individuals, communities, and EDs (Maruthappu et al., 2015). There is a growing interest in research regarding sustainability that spans disciplines and topics (Shelton et al., 2018). One factor in this interest is limited sustained initiatives over extended periods that commonly do not meet initial expectations (DeLay IV, 2017). Understanding how policies are being effectively utilized to sustain access to care through follow-up care plans can improve outcomes and reduce the impact of behavioral health conditions.

Summary

In this study, I seek to understand the attitudes, subjective norm beliefs, and perceived control beliefs of ED staff engaged in the provision of follow-up care planning as they relate to processes to help inform policy development. Exploration of positive attitudes and beliefs were conducted through interviews. The interviews focused on specific research questions to help to develop inferences about a general and abstract understanding of the formation of positive attitudes and beliefs of ED staff. Rather than an exploration of feelings or wholeness of the experience, this study was designed to be an exploration of understanding specifically how the ED staff respond positively to the processes that support BHCFU. Note that this is a different question than seeking to understand how and why. We are not seeking to understand the experience, such as how it makes the ED staff feel to support behavioral health care in the ED or what makes them

feel that way, as an example. Their feelings may or may not form their beliefs and attitudes, and feelings have not been shown to have a proven relationship with action or related to the behavior of interest in this study which is ED support for BHCFUP (Ajzen et al., 2011; Eccles et al., 2005).

Through the lenses of TRA and TPB, an understanding can be gained for how ED staff are motivated to engage in the processes to support BHCFUP for those in the ED with a behavioral health condition. These processes are identification, assessment, and provision of needed urgent care, and BHCFUP for those in the ED with a behavioral health condition (Glantz et al., 2008). Rather than a realist perspective, this study holds a relativist perspective where there is not a single reality rather that there are multiple realities that vary by participant perception (Ellinger, 2016). This study is based upon established TRA/TRB theory, which would predict that where participants feel supported to engage in BHCFUP, they are more likely to act on that belief. Examining the attitudes, subjective norm beliefs, and perceived control beliefs of ED staff to engage in these processes can capture their intention and likely engagement in those processes (Eccles et al., 2005). By understanding where the dependent variables of attitude and beliefs are resulting in the intention to engage in the desired clinical behavior of support for BHCFUP practices, it can thereby be understood where intention, theoretically mediates between the predictor variables and actual behavior that supports successful engagement in BHCFUP (Eccles et al., 2005). Understanding these perspectives of individuals who work in EDs can explain their engagement in support of BHCFUP, where funding policy has enabled evidence-based processes and the application of effective components.

Further exploration with individuals who work in EDs can also identify the funding policy they believe has empowered them to engage in support for the BHCFUP processes. Chapter 1 has introduced the problem of return ED visits for individuals with a behavioral health condition, described what is known about what has contributed to the problem, identified the gap in the literature that this study will address, and identified the underlying theoretical and conceptual framework that will guide this study. Chapter 2 will explain further what is known about these components including their basis in a review of the literature then articulate the theoretical and conceptual decisions made for this case study.

Chapter 2: Literature Review

Overview

Highly funded and otherwise well-resourced demonstration projects and grant-funded programs for specifically designated locations, including access to care services through follow-up care planning, have been shown to be effective to improve access to care and reduce ED utilization for those with a behavioral health condition (Nardone et al., 2014; True et al., 2021). The problem is that beyond specifically funded programs, EDs are not consistently supporting BHCFUP for those with a behavioral health condition due to funding policy barriers (Agency for Healthcare Research & Quality, 2017; McGinty & Daumit, 2020; Nicks & Manthey, 2012; Zun, 2016). Beyond specific programs, there is mainly funding policy misalignment between the services that are needed to improve access to care through follow-up care planning for individuals with a behavioral health condition and financial incentives for EDs and other entities involved in the care of those with BH conditions (Kunkle et al., 2020; McGregor et al., 2015). Funding policy often leads to reimbursement differentials and lacking appropriate funding for the provision of needed assessments, triage, and provision of urgent care and access to a care plan within EDs that would likely reduce return ED visits (Cross et al., 2020; McGinty & Daumit, 2020; Parashar et al., 2019; Sawyer et al., 2006). Segmentation of care commonly results from conflict between policies that contribute to budget constraints and implementation pressures for the care of those with a behavioral health condition (American Hospital Association, 2012; Maruthappu et al., 2015).

Consequently, best practices that have been shown to improve emergency department efficiency and reduce costs are not typically applied. Assessments and triage policies are weakly associated with identifying needs for adequate care for patients with a behavioral health condition (Agency for Healthcare Research and Quality, 2017; Alakeson et al., 2010; Zun, 2016). Despite evidence highlighting the potential benefits of collaboration necessary for BHCFUP and initiatives that have attempted to encourage it, it is not common practice in primary care or hospitals (Jove et al., 2014; McGrath, 2010; Schall et al., 2020). In this study, I seek to understand how funding policy supports ED staff engagement in BHCFUP in emergency departments (ED) by examining the attitudes and beliefs of ED staff that form their intention to engage in support for BHCFUP. The problem is that little is known about the attitudes, social norm beliefs, and perceived control beliefs to motivate ED staff engagement in processes supporting BHCFUP. Understanding is lacking for policy development that effectively motivates ED staff who are crucial to the provision of BHCFUP toward reduced return ED visits.

Overcrowding of U.S. emergency rooms continues with psychiatric patients waiting in hallways and areas in emergency rooms due to an inability to otherwise access care. With regulations that require hospital emergency departments to treat any who enter an ED, individuals who have unmet care needs are guaranteed by regulation to have some contact with healthcare providers in an ED. Kaltsidis et al. (2021), Kumar and Klein (2013), Liu et al. (2016), Weilburg et al. (2018), and Schmidt (2017) identified that ED users with psychiatric and substance disorder conditions comprise a significant portion of frequent ED users. Lacking access to care is manifested in U.S. emergency departments

as a last resort for those with a behavioral health condition and results in unmet care needs that are increasing ED use as well as hospital admissions (Kaltsidis et al., 2021; Letvak & Rhew, 2015; Nicks & Manthey, 2012). When overcrowding and psychiatric boarding occur in an ED, patients will often not receive treatment due to ED limitations (Hsu & Chan, 2018). Those behavioral health conditions such as psychotic symptoms, psychotic distress, and substance use have been found to have a strong association with repeat ED visits (Sirotich et al., 2016; Stewart et al., 2021). Overcrowding subsequently results in the ED when psychiatric and substance disorder diagnosis and provision of adequate follow-up care planning to address complex behavioral health issues are absent in an emergency room setting (Nicks & Manthey, 2012). Research has shown what components and funding policies can effectively support follow-up care planning. However, with limited application, it is valuable to understand how they are effective from the perspective of key stakeholders who are the ED staff.

In this chapter, I present a review of the literature describing what is known and not known about the issue of return ED visits and provision of BHCFUP through the lens of a conceptual and theoretical framework, the theoretical basis for the study, and include an overview of the literature search approach. Literature in this section describes what has been shown to contribute to the problem of return ED visits, the impact on care and cost, what has been shown to be effective to reduce ED visits to include the provision of BHCFUP, how funding policies have supported those processes, what is not known about approaches that provide for BHCFUP in an ED, and history and justification for the theoretical framework to address the gap in the literature in this study. Previous research

is summarized to identify the gap in the literature through insights into what has been studied.

Description of the Literature Search

Internet searches and Walden University online access were used. Journals were assessed in the areas of date, relationship to behavioral health, and applicability to provider care. Databases used included CINAHL, MEDLINE, Proquest, Science Direct, PubMed, EBSCOhost, JSTOR, and Sage. Google Scholar was to identify related search topics to include in consideration for the literature review search. The most commonly used keywords included behavioral health OR mental health OR substance abuse OR addiction, emergency departments OR rooms, access to care, care planning, integrated care, provider behaviors, theory of reasoned action OR theory of planned behavior, healthcare policy, and implementation supported theory search. The journals were assessed to explore the current and historical data related to ED visits by those with a behavioral health condition, contributing factors, barriers, trends, relevance to the constructive or theoretical theory application, and significance relative to the study components.

Theoretical Foundation

Social cognitive theories have established a perspective where individual cognitions or thoughts are viewed as processes that intervene between observable stimuli and response in real-world situations (Godin et al., 2008). A history of these underlying theories and their application to the behaviors of healthcare professionals in both predicting behavior and explaining behavior are provided in this chapter. Healthcare

provider attitudes and beliefs have been widely shown to align with practice behaviors through the lenses of the TRA and TPB social cognitive theories. TRA and TPB links attitude and beliefs to behavior (Bhalla, 2021; Knowles et al., 2015; LaMorte, 2019; Raudkivi, 2020). It has been shown that attitude, subjective norm beliefs, and perceived behavioral control beliefs shape an individual's behavioral intentions and subsequent behaviors (Bhalla, 2021; Fishbein, 2008; Knowles et al., 2015; LaMorte, 2019). Several hundred studies in healthcare have used behavioral science theories to understand and predict and change both patient and healthcare provider behaviors (Perkins et al., 2007). Millstien et al. (1996) and Perkins et al. (2007) argued that the theories that help explain patient behavior should also apply to physician behavior (Roberto et al., 2014). TRA, initially developed by Martin Fishbein and Icek Ajzen in 1980, was grounded in various theories that addressed learning and dissonance. Behavior under TRA has been shown to be a joint function of attitude in performing the behavior and beliefs about subjective norms (Knowles et al., 2015; LaMorte, 2019; Raudkivi, 2020; Roberto et al., 2014). Under TRA are two types of beliefs that include: (a) behavioral beliefs and (b) normative beliefs (Bhalla, 2021; Knowles et al., 2015; LaMorte, 2019; Raudkivi, 2020). In this theory, it is posited that related behaviors where an individual has a behavioral belief will follow (Bhalla, 2021; Knowles et al., 2015; LaMorte, 2019; Natan et al., 2009; Raudkivi, 2020). For example, findings have shown the applicability of TRA as a conceptual model for explaining counselor attitudes and intentions (Roberto et al., 2014). TRA has also served to guide substance abuse treatment providers' communications about evidence-based treatment strategies (Roberto et al., 2014). Normative beliefs that promote

behaviors are based on an individual's subjective evaluation of how others, which are significant to themselves, would want them to act (Knowles et al., 2015; LaMorte, 2019; Natan et al., 2009; Raudkivi, 2020). Influential groups, for example, may include regulatory agencies or patients (Fleming et al., 2017). Through the TRA lens, if a healthcare provider forms a personal belief about their action, it becomes their attitude toward engaging in that behavior (Jove et al., 2014).

Attitudes have been found to be the strongest predictor for healthcare professional behaviors (LaMorte, 2019; Perkins et al., 2007). Therefore, it is essential to understand ED staff perception of the usefulness of behavior as it affects their attitude and the underlying reason for their engagement in the context of, for example, BHCFUP (Jove et al., 2014; Schall et al., 2020). Research has found, for example, that beliefs about illegal drug use affect nurses' attitudes toward individuals who have substance use disorder (Natan et al., 2009). Results frequently found that negative, pessimistic beliefs affect their attitude toward individuals with a BH condition and affect their behavior in supporting that population (Natan et al., 2009).

Bandura’s concept of self-efficacy led to the development of TPB that expanded the TRA components to include perceived behavioral control (Bandura, 1986). The Theory of Planned Behavior (TPB) extends TRA to include the concept of perceived behavioral control (Bhalla, 2021; Mullan & Westwood, 2010). TPB was added to explore a direct link from the behavior to perceived behavioral control or the degree to which a person believes he or she can control the behavior. This extension of perceived behavioral control allows for predicting behaviors where there is strong control perceived

by the healthcare provider (Mullan & Westwood, 2010). Suppose the individual perceives that they have control of their environment or the applicable situation. They have the perception that they can carry out the behavior or overcome obstacles that are in the way of implementing (LaMorte, 2019; Perkins et al., 2007; Raudkivi, 2020).

The more favorable a healthcare professional's attitude toward the behavior, the stronger the subjective norm and the perceived control, and consequently the stronger the intention to perform the desired behavior of engagement in support for BHCFUP. Through the addition of TPB to TRA, the influence of individuals' volitional control perceptions on their behavior can be considered. Controllability refers to the external factors affecting the individual's belief that they can perform the behavior given the external influences. Volitional control factors such as skill and external factors influence the level of self-efficacy and controllability (Parashar et al., 2019; Roberto et al., 2014). Self-efficacy, or the perceived level of difficulty, forms, in part, an individual's belief about their ability to succeed or their control in performing the behavior.

TRA and TPB have shown that healthcare providers may choose behaviors based on attitudes and beliefs despite extensive training and research, even if contrary to the evidence (Evans et al., 2009; LaMorte, 2019; True et al., 2021). There has been consistent support for the ability of both TRA and TPB theories to predict intentions and resulting behavior (Bhalla, 2021; Knowles et al., 2015; Raudkivi, 2020; Roberto et al., 2014).

Application of TRA and TPB

Understanding why healthcare professionals implement research findings such as support for BHCFUP can be viewed similarly to finding out why people, in general, adopt a given behavior (Godin et al., 2008; Raudkivi, 2020). TRA and TBD had been used primarily to predict how likely individuals would engage in healthy behaviors. Additionally, TRA and TBD have been validated to predict primary care physician intention to engage in a behavior in practice, substance abuse counselor intention to tell their patients to use MAT, and pediatrician encouragement of parents to get their daughters vaccinated against HPV human papillomavirus (Roberto et al., 2014). TRA and TPB theories have been applied in varied settings to understand and change clinician behavior (Perkins et al., 2007). Perkins et al. (2007) identified nine studies that applied either TRA or TPB or both to healthcare providers on various topics. These topics included screening, intention to prescribe antibiotics, conducting an examination, referring patients to specialists, compliance guidelines such as handwashing, and counseling (Godin et al., 2008; Roberto et al., 2014). One study used TRA and TPB to identify positive attitudes, subjective norm beliefs, and perceived behavioral control beliefs toward encouraging parents to get their daughters vaccinated to predict engagement in that behavior (Roberto et al., 2014). One qualitative study explored the perceived usefulness of collaboration between general practitioners and community pharmacists, showing that the collaboration was perceived as advantageous (Jove et al., 2014; True et al., 2021). Collaboration was also considered beneficial to provide

integrated care, increased efficiency of the system, and resulted in participant increased job satisfaction and improved patient safety (Jove et al., 2014).

Most of the studies have been focused on primary care physicians. However, some have studied nurses' behaviors related to clinical practice, such as professional support for pain management and providing care to patients (Godin et al., 2008; Roberto et al., 2014). Other findings suggested that positive attitudes towards patients have an essential effect on the intention of nurses to provide evidence-based quality care to hospitalized patients addicted to drugs (Natan et al., 2009). Nursing behaviors such as care for HIV-positive patients or those with chronic pain have had similar predictions for behavior using the TRA and TPB factors (Perkins et al., 2007).

It has been shown that developing theory-based interventions using TRA and TPB can be a practical guide for provider practice or to explain attitudes and beliefs and consequently intentions (Eccles et al., 2005; Roberto et al., 2014). In one study, for example, the intentions of physician interns about the use of health promotion in practice along with identification of their attitudes and beliefs were used by applying TRA, and TPB constructs to predict physician behavior (Evans et al., 2009). TRA/TPB constructs have also been used to examine pharmacists' practice and develop a causal model for the delivery of pharmaceutical care (Perkins et al., 2007). TRA and TPB have been used to predict and explain engagement in sexual health education by school nurses (Mullan & Westwood, 2010). Studies have demonstrated that interventions targeting substance abuse treatment provider behaviors are effective when organized according to TPB constructs (Roberto et al., 2014).

Studies have also shown similar predictions to engage in a behavior for TRA and TPB except when there is a higher level of volitional control (Raudkivi, 2020; Roberto et al., 2014). This suggests that attitudes, social norm beliefs, and perceived control beliefs are equally likely to predict behavior when individuals feel they have control of the environment or can overcome obstacles. However, in multiple studies, the lens of TRA and TPB have shown that "intention to perform a behavior" is the best predictor of a person's behavior (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975; Raudkivi, 2020; Roberto et al., 2014). Further shown is that the best predictors of intention are attitude towards the behavior and how the individual thinks significant others would want them to behave (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975; Fleming et al., 2017; Roberto et al., 2014). TRA is considered superior to TPB, where there is less perceived control over the behavior resulting in higher volitional behaviors (Mullan & Westwood, 2010; Natan et al., 2009). Therefore, to determine the application of TRA or TBD or both, I needed to examine whether the behaviors are volitional or not (Mullan & Westwood, 2010; Roberto et al., 2014). TPB seems the most appropriate theory to predict behavior where TRA better captures the dynamic underlying intention (Godin et al., 2008).

The TRA and TPB theories have been applied to healthcare providers to determine intentions and behaviors in their practices (Evans et al., 2009) to inform policy on effective approaches to motivate healthcare providers. By understanding and predicting motivational influence, a policy can be modified to drive more positive health outcomes. If policymakers can understand and predict motivational influences on behavior, it is feasible that such influences can be modified to drive more positive health

outcomes such as engagement in BHCFUP (Evans et al., 2009). By identifying through TRA and TPB analysis how program design components support the ED staff behavior of engagement in BHCFUP, this study can provide a better understanding of how funding policy has helped to achieve reduced return ED visits. This understanding can inform funding policy for better engagement of ED staff and enhance state and local policymaker ability to create a future roadmap in promoting BHCFUP and reduced return ED visits.

Alternative Theoretical Approaches

Alternative theoretical approaches for why ED staff change was considered for use in this study include classical behavior and knowledge theories in addition to the integrative model of behavioral prediction (IM) (Burnes & Bargal, 2017). Classical theories that include Kurt Lewin's theory of change, Thomas Kuhn's paradigm shift theory, and Kant's philosophical basis for change were considered as foundations to explain why ED staff and hospital administration engage in follow-up care planning. Lewin's theory helps explain individual behaviors in the adoption of change and the factors related to making that change possible (Burnes & Bargal, 2017). Kuhns paradigm shift expands upon Lewin’s basic change adoption process with the perspective that behaviors are based on the presence of paradigms. As identified by Kuhn, the criteria to determine if there is progress, such as engagement in sustained change, relates to whether a new paradigm has developed and is viewed as a better process (Patton & Applebaum, 2003) and a better way to effectively conduct the work (Ward et al., 2018). Kant's theory explains how knowledge, understanding, and wisdom are attained (McLaughlin & Olson,

2012). The use of these approaches could consider the influence of funding policy on understanding and wisdom and the formation of paradigm perspectives to encourage staff engagement in the provision of BHCFUP (Stanek, 2014a). Knowledge, understanding, and wisdom can influence the formation of attitudes and beliefs that drive interventions but do not directly establish an intention to engage in a behavior (Cranwell et al., 2017). Interventions that provide more or different kinds of knowledge to change behavior have mostly not been proven in research to affect behavior directly (Eccles et al., 2005; Fishbein, 2008; Moore et al., 2009). One literature review study conducted in 2017 found that educational interventions were effective in healthcare provider professional development and helped to optimize prescribing or screening rates. However, many of those studies also incorporated evaluation and a comprehensive, multifaceted approach that included feedback and audit and increased knowledge (Chauhan et al., 2017). Knowledge, understanding, and wisdom are a few of many possible contributing factors in forming attitude. Other factors may mitigate each of these, or the individual may already have the appropriate level of knowledge, for example, to positively influence their attitude (Ajzen et al., 2011; Eccles et al., 2005; Fishbein, 2008; Knowles et al., 2015).

Another theoretical approach considered for this study was the Integrative Model of Behavioral Prediction (IM) approach could also be used to improve implementation. The IM approach has been used to help improve implementation success. By identifying needed skills and abilities, the IM approach developed in 2008 by Martin Fishbein expanded upon TRA, adding a focus on environmental factors, skills, and abilities to

moderate the intention-behavior relationship (Fishbein, 2008). This model provides a tool to explore the variables that are more likely to influence attitudes and beliefs to affect behavior (Fishbein, 2008). Understanding variables that influence attitudes and beliefs beyond the focus of this study may be of interest to further identify critical factors that influence ED staff attitudes and beliefs. An understanding can be developed in future studies for why those attitudes and beliefs have developed through the utilization of the IM approach. Conversely, the purpose of this study is to serve to identify how the positive attitudes and beliefs of ED staff that are supporting BHCFUP are related to policy. This study is first concerned with identifying attitudes, which may or may not have been influenced by knowledge and other factors, identifying perceived control beliefs that may have been influenced by skill development, and other environmental factors. This study aims not to understand underlying factors in forming attitudes and perceived control beliefs; rather how ED staff use policy.

With the foundational component of TRA, TPB has been found to be an appropriate theory to predict behavior rather than to capture the dynamics of the underlying intention (Godin et al., 2008). Identifying how program design components and processes support the ED staff behavior of engagement in BHCFUP through TRA and TPB analysis can provide a better understanding of how funding policy has helped to achieve reduced return ED visits. Understanding clinician attitudes, subjective norm beliefs, and perceived behavioral control beliefs and providing the necessary support are the keys to developing interventions that are most likely to impact behavior. This understanding can inform funding policy to better engage ED staff in promoting

BHCFUP and reduced return ED visits. By understanding the intention of healthcare providers to engage in BHCFUP, policymakers can better understand their decision-making processes (Fleming et al., 2017). They can provide information about factors impacting healthcare provider intentions and subsequently help to inform policy regarding the provision of BHCFUP components. Better understanding of how policy is being used by ED staff to improve access to care can support policy development that could be significant for healthcare improved outcomes and systemic changes. Using information gained through TRA and TPB qualitative study, policymakers can influence the relative impact of the three constructs on individuals' intentions to perform a given behavior without changing the constructs themselves (Jove et al., 2014).

By applying TRA and TPB, this study seeks to explain how the implementation of the provision of follow-up care plans succeed in relation to the attitudes and beliefs of ED staff and can increase understanding of how policies are utilized from a broad perspective toward sustained access to care (Nielson, 2017). This understanding provides an avenue to explain the findings of this case study with possible application across diverse settings (Birken et al., 2017). Using the TRA and TPB lens, the research questions can uncover what influences ED staff participation in BHCFUP practices driven by funding policy. Interview questions were developed to explore the TRA/TPB constructs of behavior intention that include attitude, subjective norms, and perceived behavioral control. The questions related to behavioral control will be further divided into TRA/TPB sub-constructs of self-efficacy and controllability. This approach is supported by Ajzen's principle of compatibility that clearly defines the three behaviors with the elements of

target, action, context, and time vignettes (or scenarios) that can assist in defining the intended context of the behavior (Knowles et al., 2015). A final section of interview questions will be included to assess staff perceptions of policy related to components or processes that they believe are supportive of BHCFUP.

Conceptual Framework

A review of literature showing what has historically contributed to the problem of repeat ED visits by those with a behavioral health condition, along with the impact on costs and patient care, lays a foundation for understanding the causes and significance of the problem of return ED visits for this population. The literature identified in this chapter further describes related funding policy and components that have been put in place when the desired outcome of reduced return ED visits due to the provision of BHCFUP is achieved.

The prevalence of behavioral health conditions in EDs are presented as a continuing issue with between 4% and 10% of ED visits directly attributable to a behavioral health condition where half of those patients have a history of diagnosed psychiatric illnesses, and a third are currently undergoing treatment (Cederbaum et al., 2014; Nicks & Manthey, 2012; Zun, 2016). The problem of ED overcrowding, as described by Greenwood-Ericksen and Kocher (2019), and Rosen et al. (2019) is directly associated with poor clinical outcomes that include delays in care and increases in mortality and morbidity, and reduced emergency bed capacity continue to burden hospital and healthcare systems in the United States. Lacking follow-up care planning and associated gaps in access to care for those who visit EDs have been identified by

Cederbaum et al. (2014), Nicks & Manthey (2017), True et al. (2021), and Zun (2016) to contribute to the problem. Inadequate access to care that includes lacking diagnosis, misaligned triage, and lacking treatment is commonly seen in EDs, resulting in segmentation of care and rising ED use attributable to BH conditions (ACEP Emergency Medicine Practice Committee, 2014; McGregor et al., 2015; True et al., 2021). The prevalence of behavioral health conditions combined with lacking access to care has been shown to increase ED visits, ED hospital admissions, and rehospitalizations (Bluestein & Pruington, 2017; Cederbaum et al., 2014; Murrell, 2017; Nicks & Manthey, 2012; Williams et al., 2017).

Key Statements and Definitions

Enhanced access to care that allows for integration, such as BHCFUP, has been shown to encourage a comprehensive approach to patient care and is more likely to: (a) address health inequalities, (b) reduce overtreatment waste, (c) reduce redundancy, (d) eliminate inefficiencies, and (e) control costs while providing higher-quality coordinated care (Breslau et al., 2019; Kaltsidis et al., 2021; Maruthappu et al., 2015; Press et al., 2017). To support access to care through follow-up care planning for individuals with a behavioral health condition, EDs may establish a care plan or arrange to connect the individual with an entity to establish a care plan that will reduce the likelihood that the individual will return to the ED (Doupe et al., 2016; Edwards et al., 2007; Fendrich et al., 2019; Peek & National Integration Academy, 2013). This follow-up access to care is made possible through integration that can be both horizontal and vertical, including

coordination between providers at the same level and different levels of care (Agency for Healthcare Research and Quality, 2017; Breslau et al., 2019; Tricco et al., 2014).

In order for ED staff to support follow-up care planning in an ED, the ED must first be engaged in the identification that the patient has a BH need and provide appropriate triage and urgent care (Brind'Amour, 2020; Chakraborty et al., 2014; Cranwell et al., 2017; Nardone et al., 2014). Urgent care may include the provision of respite beds, crisis psychological support, emergency services, peer crises support, medicated assisted treatment (MAT), or hospitalization (Brind'Amour, 2020; Chakraborty et al., 2014; Cranwell et al., 2017; Nardone et al., 2014). EDs are challenged to provide support for BHCFUP due to a predominant funding policy that creates a mismatch between funding and services needed by those with a BH condition who enter an ED (True et al., 2021).

Funding policy that hospital EDs may use to improve access to care has been shown to improve efficiency, quality of care, and reduce costs nationally (Carlo et al., 2019; Maruthappu et al., 2015). A financially sustainable service underpins attempts to improve access that meets the needs of the service population. When interventions are provided without appropriate financial support, interventions are usually not enough to change health care provider behavior (Boudreaux et al., 2016; Carlo et al., 2019; Perkins et al., 2007). The effect of financial interventions, which included institution incentives and capitation, was found in studies supportive of access to care for vulnerable populations with complex chronic conditions. Funding policies that have been shown to foster access to care include the following:

1. Funding that allows for skill development of existing staff or additional staff to engage in behavioral health access to care (Schall et al., 2020)
2. Funding or reimbursements that provides an incentive for EDs to engage in assessment, triage, and provision of urgent care and connection with a treatment plan for those with a behavioral health condition who visit an ED (Sawyer et al., 2006; Ward et al., 2018)
3. Funding that allows for adequate reimbursements so that staff may be funded to provide behavioral health support
4. Incentives for insurance providers to adequately reimburse hospital EDs to engage in access to care components
5. Adequate reimbursements for behavioral health professionals to provide crises intervention, counseling, peer supports, and mental health or substance abuse treatment (Brind'Amour, 2020; Williams et al., 2017)
6. Funding or reimbursements that compensates staff and meets technical needs for the establishment of care plans and following coordination of care
7. Reimbursements or funding that is based on effectively reducing the number of return ED visits (Sawyer et al., 2006; Ward et al., 2018).

The potential effect of specific programs and these types of funding to support access to care, including BHCFUP in EDs, is known. Improved access to care supported by these types of funding has been shown to improve health outcomes for individuals with BH conditions (Agency for Healthcare Research and Quality, 2017).

How BHCFUP has been Applied and Articulated in Previous Research

Cederbaum et al. (2014), Gross et al. (2013), Ku et al. (2014), Manton, (2021), Maruthappu et al. (2015), Perez and Schrag (2015), Pillow et al. (2013), and Schall et al. (2020) showed that shortages of care and inappropriate and costly medical care for ED high users can be attributed to lacking access to care that includes lacking identification and appropriate response to patients with complex social and behavioral health needs. Significant gaps exist between evidence-based behavioral knowledge and healthcare provider real-world practices (Knowles et al., 2015; Perkins et al., 2007; True et al., 2021). Viggiano et al. (2012) attributed poor transitions, associated with lacking follow-up care, to increased symptom exacerbation showing fewer than half of discharged mental health patients being connected to outpatient care within the widely accepted indicator standard of seven days from discharge. Viggiano et al. (2012) proposed nine core elements for interventions to address transition or follow-up care for those with a mental health need. Of these interventions, True et al. (2021); Raven et al. (2020); and Viggiano et al. (2012) found two broad categories of care transition interventions that are models related to either 1) the provision of general medical care or 2) care transitions that have been related to a mental health context. Transition interventions that allow for the provision or establishment of needed care plans for individuals with BH conditions have

been shown to be made feasible through organizational interventions (Kaltsidis et al., 2021).

Through a review of thirty-nine studies by Khanassov et al. (2016) as well as subsequent studies, it was found that organizational interventions that have been shown to target improved care for vulnerable patients include 1) formal integration of services, 2) establishment of multidisciplinary clinical teams, 3) shifting of professional roles, and4) follow-up care planning (Breslau et al., 2019; Fendrich et al., 2019; Press et al., 2017; True et al., 2021). Formal integration strategies shown in studies to support follow-up care planning and improve care for vulnerable populations include 1) bringing together primary care and secondary and tertiary services such as integrating specialists into primary care or the provision of a substance use disorders community service team and an alcohol abuse counselor, 2) establishment of brokers or community health workers that proactively identify the eligible patients in the emergency room, 3) development of a network with a single entry point such as 24-hour telephone access, and 4) integration that allowed virtual monitoring for complex conditions in primary care and hospital-based services (Breslau et al., 2019; Fendrich et al., 2019; Kaltsidis et al., 2021; Khanassov et al., 2016).

The research identifies a gap between practice and what is known about the reduction of ED visits for those with a BH condition. It has shown that common approaches such as offering lists of providers or direct referrals absent a care plan to support coordinated care for an individual with a behavioral health condition is ineffective toward reducing return ED visits (Chakraborty et al., 2014; Doupe et al.,

2016; Losonczy et al., 2017; True et al., 2021). There is lacking application of effective practices and funding policies that can be supportive despite what is known through research (Manton, 2021). By understanding through a literature review the value of follow-up care planning and components that conversely are supportive, a foundation to understand what is comprised of engagement in effective approaches enables exploration of how ED staff are engaging in those approaches for this study.

Studies Related to the Constructs of Interest and Chosen Methodology

Healthcare providers have been identified as key to successful implementation through engagement in behaviors that support evidence-based approaches such as BHCFUP. Healthcare providers' perceived barriers to implementation of BHCFUP have been identified where needed components are not in place or not effective. Studies have also explored how program designs have driven healthcare provider practice behaviors in other venues or with other objectives. Many studies describe behavior and behavior change, yet few explain the behavior change to identify, as in this case study, how policy has supported staff engagement in support for BHCFUP (Eccles et al., 2005). Studies have not been conducted to understand how program designs and components made possible through funding policy to provide BHCFUP have been a factor in driving positive ED staff behaviors. There is a gap in the literature to understand how program design components have supported ED staff engagement in BHCFUP.

Ways Researchers Have Approached the Problem and Strengths and Weaknesses

An increased number of studies have been seen since 2010 to support care model understanding for individuals with a behavioral health condition (Fendrich et al., 2019;

Garrity, 2016). Based on these studies, a collaborative care management model (CCM) for individuals with a behavioral health condition, as organized according to the commonly noted Wagner's Chronic Care Framework, showed that: (a) delivery system redesign, (b) patient self-management, (c) decision support, and (d) clinical information systems are needed to provide effective coordinated care for individuals with a behavioral health condition (Garrity, 2016; Kroenke & Unutzer, 2017; Parashar et al., 2019). The chronic care model (CCM) reflects both care transition interventions identified by Viggiano et al. (2012) and the organization interventions identified by Khassanov (2017). Many of the components of these categories align with Khassanov et al.'s findings in the literature (2017). Research centered on chronic care related to individuals with a behavioral health condition has primarily focused on identifying: (a) the value in follow-up care planning, (b) what components can be effective given specialized funding, (c) the importance of ED staff engagement in providing access to behavioral health follow-up care planning, and (d) identification of barriers to the provision of that care (Sullivan et al., 2021). However, research has not explored how ED staff utilize processes and components to provide access to behavioral health follow-up care planning and subsequently understanding related supportive funding policy.

Justification for Selection of Variables or Concept

According to the American College of Emergency Physicians, overcrowding in the ED and shortage of on-call specialists continue to be the most significant threats to patient safety and quality in emergency departments (Letvak & Rhew, 2015). BH is a leading contributor to ED overcrowding. Increased use of EDs by those with a BH

condition is associated with a related increase in poor health outcomes for individuals with a behavioral health condition over the last several decades (Garrity, 2016; Weilburg et al., 2018). This increase is partly due to siloed behavioral and physical health care systems (Garrity, 2016; McGinty & Daumit, 2020; Press et al., 2017). Access to BHCFUP approaches that involve the development of structural links between previously separate healthcare processes, and physical colocation, have been shown to be effective (Agency for Healthcare Research and Quality, 2017; Breslau et al., 2019; True et al., 2021). Programs that improve access to BHCFUP have been shown to reduce siloed care, increase efficient utilization of EDs, reduce hospital and payor costs and improve patient health outcomes (Parashar et al., 2019; Press et al., 2017; Stewart et al., 2021). Follow-up care planning that is accomplished through integrated behavioral health care brings all services together to one point that include (a) secondary and tertiary services, (b) proactive identification of individuals in need of BH care, (c) development of a network and (d) information-based integration to allow for telehealthcare (Kaltsidis et al., 2021; McGinty & Daumit, 2020; Press et al., 2017). Case Management has been shown to be a factor in 2015 and later review of studies to be a factor in reduced return visits (Fendrich et al., 2019; Ngo et al., 2018; Raven et al., 2020; Sirotich et al., 2016). Case management such as the CCM model has shown improved outcomes for those with a behavioral health condition by providing an assessment of symptoms, care managers, active follow-up for at least 16 weeks, involvement of mental health and primary care providers in follow-up care management, and regular supervision by mental health specialists (Garrity, 2016; Parashar et al., 2019). Case Management, however, lacks coordinated follow-up planning

that has been found to be more universally effective to reduce return ED visits for those with a BH condition. With needs related to psychiatric conditions having been shown to have the strongest association with repeat ED visits (Sirotich et al., 2016), follow-up care planning is a valuable approach to the provision of follow-up care planning.

Studies Related to Key Concepts

Poor transitions or lack of follow-up care planning has been found to detract from continuity of care, increasing symptom exacerbation (Viggiano et al., 2012). Based on a comprehensive study review, Viggiano et al. (2012) recommend several processes and components to improve transitions and follow-up care planning (see also Langerman et al., 2019). These processes and components include (a) identification of who is at risk, (b) assessment of urgent care needs, (c) engagement of caregivers and patents to identify follow-up care needs, (d) establishment of a client-specific plan, (e) establishment of care pathways that are specific to the needs of the individual, (f) linking caregivers and patients to providers, (g)) utilization of transition or follow-up care agents, (h) engagement of providers through clear roles and formal procedures, (i) monitoring and measurement of health status, and (j) shared accountability to include rewards through financial mechanisms (Kaltsidis et al., 2021; Langerman et al., 2019; Viggiano et al., 2012). Similarly, in another study conducted cited by Garrity (2016) where seventy-four studies were reviewed, it was found that (a) systematic identification and recruitment of individuals in need of BH care, (b) involvement of patients with chronic physical health conditions, (c) application of psychological interventions, and (d) established continued monitoring by care managers were effective (Fendrich et al., 2019).

Intensive case management that involves some of these components has been cited as an approach to reduce ED visits for those who frequently visit an ED for the general population; however, this approach alone has not been shown to be as effective for those with a psychiatric condition (Ngo et al., 2018; Raven et al., 2020; Sirotich et al., 2016; Stewart et al., 2021). Garrity (2016) identified sixteen studies involving care coordination for individuals with serious mental illnesses showing that care management and intensive case management do improve mental health symptoms. Only six studies involving care for substance use disorders were found by Garrity (2016). Yet, they too suggest that care management in addition to enhancement of collaboration and coordination of care, improves outcomes for that population. Fendrich et al. (2019) and True et al. (2021) also found that care management along with enhanced collaboration can be more effective.

These studies and reviews highlight what comprises effective follow-up care that is needed for follow-up care planning to be practical, useful, and ultimately effective. However, applying these effective processes and components is commonly lacking in practice due to financial and policy barriers, highlighting the importance of understanding where and how the financial policy enables implementers such as the ED staff to engage in follow-up care planning. What is not known is how ED staff use these processes and components to improve BHCFUP and consequently access to care to reduce return ED visits. Through the research questions developed for this study, a better understanding of how ED staff are supported by those processes and components enabled by funding policy.

Summary

Healthcare providers have been identified as key to successful implementation through engagement in behaviors that support evidence-based approaches such as BHCFUP (Perkins et al., 2007). The external variables that contribute to attitudes, subjective norms, and perceived control that include (a) demographic variables, (b) attitudes towards BHCFUP and those with a BH condition, (c) personality traits of hospital staff, and (d) other individual difference variables have been explored somewhat but not the specific beliefs toward intention to perform the behavior of engagement in the provision of BHCFUP in the ED. There has been little exploration to understand the perspectives of ED staff who are utilizing funding policy to provide BHCFUP for those who enter an ED with a BH condition (Cranwell et al., 2017). There has been some exploration to understand how integrated care processes can be supported through policy (Gross et al., 2013; Perez & Schrag, 2015). However, predominant research related to access to care has either focused on how or why there is resistance to change or what works given specific resources to achieve integrated behavioral health, but not the change process itself for provision of behavioral health support (Nilsen et al., 2012; Powell & Beidas, 2016). Little is known about how policy is being utilized to assess, refer, initiate treatment, & consider key characteristics of patients in order to access behavioral health follow-up care (Bystrek, 2010; Letvak & Rhew, 2015; Manton, 2013; Schmidt, 2017).

Studies have found that the most prevalent predictor of the behavior of healthcare professionals is the intention to engage in that behavior (Knowles et al., 2015; Mullan & Westwood, 2010). However, there is a gap between known evidence-based approaches

and what is done in practice that can be better understood by exploring healthcare provider intention (Godin et al., 2008; Perkins et al., 2007). Behavioral intention is described as an individual's subjective probability of engaging in specific behavior and has been found also to be a determinant of engaging in that behavior (Natan et al., 2009). Because individual decisions are fundamental to engagement in a clinical-related behavior, more information about underlying mechanisms that influence behaviors is needed to improve the effectiveness of interventions targeting behavior change for healthcare professionals (Godin et al., 2008). These healthcare professional adoption decisions are founded in sociology theory (Godin et al., 2008). More theory-based study is needed to inform policy or how interventions are designed to achieve the desired change (Godin et al., 2008). This critical instance study will help fill the gap of understanding one aspect of how policy is promoting follow-up care planning by developing an understanding for how funding policy is supporting processes and components that enable and motivate ED staff to engage in the desired behavior of support for follow-up care planning. This will be accomplished by identifying where support is occurring in EDs through the participation of staff in interviews and exploration of how policies and funding are related to those processes as identified in the Methodology for this study.

Chapter 3: Research Method

Methodology

The purpose of this case study is to discover positive attitudes and beliefs of ED staff toward processes that support BHCFUP to reduce return ED visits for those with a BH condition and to identify where policy has supported those processes. This chapter will describe the research design and rationale, the role of the researcher, the methodology used to identify and recruit the population of interest, data collection methods, and the data analysis plan. Trustworthiness that includes internal and external validity, dependability, confirmability, and reliability are also discussed in this chapter. This chapter concludes with ethical procedures and considerations for the study.

Research Design and Rationale

The overarching research question for this study asks how processes favorably influence the beliefs and attitudes of emergency department staff to support patients with a behavioral health condition who visit an ED. To answer this research question, it was necessary first to identify the processes that lead to ED staff favorable beliefs and attitudes by investigating:

1. What processes emergency department staff believe are supportive of behavioral health follow-up care planning toward reduced ED visits for those with a behavioral health condition
2. How emergency department staff utilize the processes of identification, assessment, provision of urgent care, and connection with follow up care

plans, to support the provision of behavioral health follow-up care planning

3. How ED staff, administration, and key informants perceive that the processes considered favorable by ED staff toward behavioral health follow-up care planning align with policy.

The central phenomenon of this study is the engagement of ED staff in support of the provision of BHCFUP. To support BHFCUP, EDs need to identify that an individual has a behavioral health condition, assess the individual's condition and needs, provide needed urgent care, and either establish a follow-up care plan or connect an individual with a follow-up care plan. The research tradition is a qualitative interview approach along with document review and expert input that is based on research that establishes qualitative approaches as a valid method to explore how or why ED staff are engaging in a behavior. This study seeks to understand how and why ED staff engage in support for the provision of BHCFUP and how the context of organizational influences and funding policy relate to the processes that occur in an ED to support BHCFUP.

A research approach that involves elicitation of salient beliefs through interviews in a case study and supported by documents review is the basis for understanding to be developed in this study (Fishbein & Ajzen, 2010). This study is not concerned with representativeness that may be identified through survey, instead, it is concerned with inferences about general and abstract theoretical principles that are more suited to the use of interview data and document collection methods (Gomm et al., 2000). Semi structured interviews and document reviews identified how the targeted group has responded to

examine the processes, motivations, and reasons for successful engagement in BHCFUP. An approach that uses semi structured interviews allows for space to discover additional knowledge during the interview process. Further, a survey approach could not readily investigate the phenomenon and the context due to the limitation on the number of questions and still fall within recommended degrees of freedom for the number of questions and people to be surveyed (Yin, 2014).

As the researcher had little or no control over the behaviors in EDs and the focus of this study is the phenomena of how and why staff are supporting BHCFUP, a case study approach was an appropriate choice for this work. Case study inquiries are suited for investigations where there are expected to be many more variables of interest than the data points as in this case study (Yin, 2014). This study sought to explore and understand the real-world perspective of ED staff and their involvement in the phenomenon of providing BHCFUP in an ED. In this study that seeks to understand how and why ED staff support BHCFUP, the context of organizational influences and funding policy are interrelated with the processes that occur in an ED to support BHCFUP. This study, which is concerned with many features for a unique case in a naturally occurring environment, meets the criteria for case study choice outlined by Gomm et al. in their introduction to "Case Study Method" (2000). In this study, I am focusing on a case to retain the real-world holistic perspective that is suggested by Yin (2014) to be appropriate for case study approaches.

Case Study Approach

Unlike in an experimental approach, in this study, which sought to understand how and why ED staff engage in support for the provision of BHCFUP, the context of organizational influences and funding policy are interrelated with the processes that occur in an ED to support BHCFUP. This focus on interrelationship is unlike an experimental approach, according to Yin (2014), that would rather distinguish between context and the phenomenon. Understanding of interrelationships can instead be gained in a case study approach through an understanding of how positive attitudes and beliefs are influenced by processes that is extruded through specifically designed interviews questions. Policies can then be identified that support those attitudes and beliefs.

According to Yin (2014), case studies have a contemporary focus, where behaviors are not manipulated and can be explored through direct observation and interviews in addition to a historical foundation established through a document or literature review. The historical foundation for this study has been established in the literature review and development of the conceptual framework. Interviews have been conducted with ED staff, supporting information has been accomplished through document searches and information from stakeholders. A case study approach is utilized for this study because a case study is a preferred approach when focused on understanding the 'how' or 'why' around contemporary events in real-world settings (Yin, 2012; 2014). The contemporary event is the provision of effective behavioral health care in the real-world setting of EDs in the United States. According to Ellinger (2016), case study research aims to explain, explore, or describe a phenomenon where there is interest

in further understanding. Yin (2009) further defines a case study as ‘an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not evident (Yin, 2009, p. 18). In this instance, a case study approach is supported as the phenomenon of motivation for staff support for behavioral health care in the ED, the context of EDs, and ED processes do not have clear boundaries. This study also aligns with Yin's definition of a case study in that it is an "empirical inquiry" that collects information through interviews and information attained through online document searches and from informed stakeholders that include healthcare administration, government officials, and BH support agencies (Yin, 2009). This empirical inquiry has a purpose to 'investigate a contemporary phenomenon which in this study the contemporary phenomenon is support for behavioral health: and is framed by a "real-life context" which in this study are the processes to support behavioral health care in emergency departments (Yin, 2009).

A single-case study approach is best suited to this study design as the case has been selected based on its representation of a critical test of the significant theory of how and why ED staff are engaged in supporting BHCFUP in an ED (Yin, 2014). The limits or boundaries for this case, which is BH care in EDs, was the defining factor of case study methodology choice (Merriman, 2009; Ragin & Becker. 1992; Stake, 1994; Yin, 2009). This case is the unit of human activity, which is the engagement of ED staff in BH that is embedded in some real-world framework which is EDs in the US. There is a merging of the context in this case where boundaries between the case, which is BH care, and the context, which is EDs in the US, cannot be clearly defined as separate units such

as individuals or institutions (Gillham, 2000). Per Yin, a single case study approach is appropriate where the case can represent a critical test of a significant theory and where the case represents an extreme or unusual case (Yin, 2014). The extreme or unusual case in this study is EDs in the US, where BHCFUP is supported through effective approaches. A single case study approach is best suited to this study design because the case has been selected based on its representation of a critical test of the significant theory of how and why ED staff engage in supporting BHCFUP in an ED. As there is a limited instance where successful support for BHCFUP in EDs has been documented, a study where this has occurred is a critical instance case that reflects processes that have not shown commonly documented barriers to the provision of BHCFUP. This critical instance or a single-case approach was used for this study by applying theory to understand ED staff engagement.

This study is a critical case, or critical instance type of case study, as it is concerned with an aspect that is of strategic importance for the general problem (Davey, 1991; Flyvbjerg, 2001). In this case study, I have sought what is common and what is particular about the case to define the boundaries of the case by considering: (a) the nature of the case, (b) the historical background of BH in an ED, (c) the physical setting of EDs in U.S. hospitals, and (d) other institutional and political contextual factors such as funding and government policy (Stake, 1994). This case study research has been defined by 1) the unit of analysis which is BH care in ED in the US; (a) the process of study that includes interviews, document search, and expert input; and (b) the outcome or end-product that is understanding how policy supports BH care in ED in the United

States (Merrimam, 2009; Stake, 1994). Conversely, phenomenological, or narrative research methodologies are used for other purposes, other types of information to be collected, and differing focuses for the unit of analysis (Yin, 2003). A case study approach is appropriate to achieve the purpose of this study rather than, for example, phenomenological or narrative approach.

Phenomenological or Narrative Approaches did not Apply to this Study

The focus in case study research such as this study is not predominantly on the individual ED staff or their personal stories such as with narrative or phenomenological research instead of on the issue of BH care in EDs to understand the issue. A description of the essence of the experience is not helpful to achieve the purpose of this study and make the case study assertions. Staff perceptions for how they are supported, along with documents and expert accounts, are significant to understanding the issue of BH care in EDs. However, understanding the ED staff perceptions concerning the daily environment and understanding the feelings of staff and underlying development of those feelings does not help to attain the purpose of this study. The conclusions of this study instead make study assertions about how behavioral health is supported in EDs in the US, not by describing the essence of the experience. Therefore, understanding the essence of the experience, as is done with a phenomenological approach, does not achieve the purpose of this study.

Case study research answers "how" or "why" questions rather than understanding the personal stories of individuals, such as in narrative research, or to attain insight into what experiences mean to individuals, such as in a phenomenological study (Yin, 2003).

The distinctive characteristic of case study research, as in this study, is that it is explanatory, answering how and why questions (Yin, 2014). Yin (2014) states that case study approaches are designed to answer how or why programs are working, such as behavioral health support in U.S. emergency departments, as in this study. As Yin states, case studies use multiple sources such as interviews, observations, documents, and artifacts for data procedures (Yin, 2014). For case studies, the focus is on the central features of the case. This study of how policies and processes support behavioral health care provides first an extensive description of the case followed by key themes or issues in the case. Thus, case study research studies an issue such as BH in U.S. EDs explored through a case which is BH care within a bounded system which is EDs in the United States (Denzin & Lincoln, 2005; Merrimam, 1998; Yin, 2003). According to Yin (2014), the case study method is relevant to support an investigation into research that seeks to answer the questions of "how" or "why" a phenomenon "works" and to provide an in-depth description of a social phenomenon (p. 4).

This study is therefore not designed to engage participants in developing the meaning of the experience. Consequently, this study explores how and why processes positively influence ED staff in a case study approach that uses interview questions, document reviews, and expert accounts designed to specifically answer how and why ED staff are positively influenced by policy. In whatever way staff attitudes and beliefs were formed, we would instead for this study like to know where there are positive attitudes related to processes. Although potentially helpful or of interest for some studies, understanding the feelings of ED staff does not contribute to understanding the processes

that influence ED staff through the lens of attitudes and beliefs, which are shown to have a linkage to the action of interest. Suppose a lived experience was explored through a phenomenological approach, much insight might be gained into the feelings and experiences of ED staff. However, it is unlikely that we would discover an understanding of what the specific study question is designed to attain.

Role of the Researcher

The role of the researcher is to identify and review relevant publications, reports, and policy documents, develop interview questions based on literature reviews, and conduct and interpret the interviews.). This researcher's previous work in community mobilization has included work with a few hospital CEOs and healthcare professionals to help them to identify the potential benefits of supporting behavioral health and how that may be accomplished in their hospital community. These interactions were only advisory without a power relationship formally or informally from the healthcare professionals or researcher. I am aware that my professional work has created a previous bias that there is a perceived need to address behavioral health needs in a tertiary environment such as hospital EDs. Additionally, researcher bias present is my belief that there is a need for coordination between community entities and healthcare organizations to address behavioral health needs. By utilizing research to validate these perceptions or to recognize that the research does not validate any bias I may have, I can approach this study to minimize the impact of those views. The value in addressing behavioral health in EDs is documented in research as well as primary care. By focusing on staff who have been involved in BHCFUP in EDs in this study, I am not discounting the potential value

of BHCFUP engagement in primary care, which has been studied, rather and focusing on the hospital ED potential benefit for this study. There are no known ethical issues to report.

Methodology

A single-case approach can explain how ED staff are supported to provide behavioral health care through the lens of TRA/TPB theory. Following Yin's (2014) recommendation, a single-case is best used to understand how something works through the lens of theory, whereas multiple-case studies consider replication logic approaches. This study is not a collective or multiple-case study, where the issue was selected and followed by the selection of multiple cases. An example of a multiple case study approach might be BH care in EDs in the United States and other countries (Creswell, 2012). For this study, my goal rather was to conduct a single-case study that involved participants who represented a variety of hospitals and locations in the United States to improve chances of findings that have transferability (Yin, 2014).

A broad criterion for selection was established that ED staff were engaged in any process or component of support for BHCFUP in the United States. Sample size calculations were not conducted as the sample size was limited to individuals who had some involvement in the provision of BHCFUP in the ED. By including participants from various locations, I have reduced the potential for artificial or unique conditions that would diminish the possible utility of findings (Yin, 2014). Participants who identified through a self-administered emailed questionnaire that they had been involved in the provision of effective behavioral health care in one or more U.S. EDs met the criterion

for participation in this study. Interviews were conducted until saturation of information was collected and repeating themes developed in responses. In total, eight individuals with experience working in EDs were interviewed.

Initially, participant recruitment methodology for this study involved accessing ED staff through hospitals that were identified as being involved in effective behavioral health care in EDs. Several hospitals were identified through experts and online data searches and were contacted. Four of these hospitals had indicated interest and expressed a willingness to proceed with a letter of cooperation to contact ED staff. However, with the pressures faced by hospitals to address COVID issues, they had indicated that they regretfully could not expend any attention to assist with participant recruitment at this time. In addition to providing ED staff access, this study intended to include hospital administration as one type of expert to support online document searches and identify policies that align with ED staff responses. Rather expert input was obtained from state, federal, and association professionals as initially planned but did not include hospital administration. With COVID challenges, approval was requested and granted to recruit participants directly through the university participant pool and related groups on social media sites. An introductory email and solicitation for participation were published on the participant pool and social media site. If the interest was expressed, an email address for the potential participant was obtained, and a consent form and the screening questionnaire were sent to the interested individual. A follow-up phone interview was scheduled if the potential participant responded with the consent form and the questionnaire indicating they met the criterion for participation.

This study is centered on first understanding the personal perspectives of ED staff where BHCFUP is supported. They were a primary population of interest, and specific hospital locations for their experience did not impact the purpose or validity of this study. The state, federal or regional laws and funding policies continued to be a relevant factor in identifying policies as initially planned in this study.

Instrumentation

Documents were used along with a questionnaire, interviews, and post-interview study design. A researcher-developed self-administered questionnaire was used to identify participants who met study criteria, interview protocol to collect data of focus, and interview protocol to validate analysis and findings. Instrumentation used that are researcher-developed questionnaires and interview protocols and voice recording methods, as well as documents and expert input included:

1. A questionnaire was used to identify participants that meet study criteria based on affirmative involvement in engagement in components of support for BHCFUP that include identification, assessment, provision of needed care, and connection with a behavioral health follow-up care plan. These components reflected what is needed for effective care from the literature search.
2. Semi structured interview question protocols were used to investigate positive ED staff attitudes, social norm beliefs, and control beliefs related to the provision of BHCFUP in the ED. A three-step qualitative synthesis approach was used to develop the interview questions.

3. Audio recording technology included linking from Android phone to laptop and utilization of Audacity software to record conversations. Transcription of audio conversations was then possible utilizing a Trint, a web-based transcription software support service.
4. Online document searches included public information from federal, state, and regional agencies and official reports and studies. Experts from official agencies or associations were then contacted to validate these documents' information and to provide any additional information where needed.

Following the qualitative study approach of Khanassov et al. (2017), I have used a three-step qualitative synthesis to develop interview questions (Khanassov et al., 2016). First interventions needed in an ED to support BHCFUP were classified. Second, classification of access dimensions and outcomes of the interventions were used, and finally, a dimensional pattern analysis related to desired outcomes was used to analyze interview responses (Khanassov et al., 2016). The interview questions were developed from a thorough review of the literature and gathering input from content experts. Interview questions to identify subjective norms, for example, were based on other studies that used TRA/TPB approaches (Roberto et al., 2014). The theories of TRA and TPB prescribe validity for the research methodology used supported by relevant specific links from actions that describe the behavior to the behavior. The interview questions were pretested for content validity with nurses with extensive ED experience and have been engaged in some components of BHCFUP and content. Interviews were recorded

and transcribed for analysis. Documents used included official publications and reports from governmental, other regulatory agencies, and funding agencies.

Procedures for Recruitment, Participation, and Data Collection

Data was collected through participant interviews, online document searches, and expert input. Participants were recruited via university participant pool and relevant group social media posts. The introduction and solicitation postings explained what the study is about, the purpose and the goal of the study, and the criteria for participant selection. The criteria used to determine the selection of participants include those who have been involved in behavioral health care in an emergency department. Where ED staff have been engaged in these components, it was possible to explore further what of these components or processes ED staff believe support BHCFUP in the ED and how the staff perceives these components align with policy. Reports and publications had been collected related to the funding and behavioral health policies that participants have indicated, and additional related documents have been identified by and collected from key informants.

The criteria used for participant selection was that they must have been involved in components that support BHCFUP in EDs. Participants for the case study included staff that have been involved in BHCFUP in EDs. ED staff engaged in components or processes known through literature to support BHCFUP also elucidated how policy supports their engagement. When interest was expressed on social media or from the university participant pool, a consent form and initial questionnaire were sent to potential participants who had expressed interest. If they indicated that they consented to

participate and completed and returned the initial questionnaire with an indication of some involvement in the areas of interest, a follow-on phone interview was scheduled. Interviews were limited to 30-minutes. Interview questions explored what processes the ED staff believe supportive of BHCFUP, how ED staff utilized the processes and components that support BHCFUP, and how ED staff perceived that the policy supports their involvement in BHCFUP. Questions specifically explored each of the components that support BHCFUP, including identification of BH need assessment, provision of urgent care, and connection with BHCFUP. Participants were asked to identify components or processes that support the provision of BHCFUP and invited to expand upon how those components are supportive. This approach allowed for a thick description of the influences on the provision of BHCFUP from the perspective of the ED staff. Saturation was achieved in this study in that the participants began to identify the same processes that they experienced and recurring themes for how they are supported in the provision of BHCFUP. Following data analysis, participants were provided with a synopsis of their responses as review and final validity check.

Following interviews, online searches were conducted to identify government and association official documents and reports to identify where policies supported processes identified by interview participants. Government and association experts were then contacted via email requesting validation, clarification, or edification for information obtained online to clarify additional policies that were associated with processes identified by participants.

Data Analysis Plan

Identification of themes that emerge through investigation of the contextual theories in support of BHCFUP, and how they are driven by funding policy through document review and the lens of social cognitive theories of TRA and TPB, can support analysis of emergency department experience toward an understanding for how and why these processes are working to positively influence the intention of ED staff. By describing the intervention and the real-world context in which it is occurring, this study has drawn generalizable theories about the process of ED staff engagement. The goal of the analysis was not to generalize the findings to other cases. Rather that the findings would be generalizable to the theoretical propositions related to supporting care in EDs in the United States. This concept is supported by Yin (2014), who states that case studies can be generalizable to theoretical propositions but not commonly generalizable to populations or universes. This case study was designed to be generalizable to theoretical propositions about the relationship between components to support BHCFUP in an ED and how ED staff engage in those processes. The analysis sought to support the approach of understanding how policy works rather than whether it works.

Through exploration of heuristic perceptions of ED staff for how their attitudes, normative beliefs, and control beliefs are positively influenced and aligned with policies that support those components, this study made sense of the participants' responses through themes that emerge in narratives and documentation. The generation of categories was inductive, as conducted by Jove et al. (2014). Themes were identified and coded through analysis (Jove et al., 2014). Subjective norm questions, for example, were

based on a goal to identify staff perception of support from influential groups to include regulatory groups and patients (as in Fleming et al., 2017). Triangulation of data occurs in this study by including collected information through documents, literature reviews, expert reviews of interview findings, and perceptions of policies that align with identified processes from ED staff and informed stakeholders. These stakeholders included administration, government, association, and partnerships that are invested in the provision of BHCFUP through EDs.

Issues of Trustworthiness

Trustworthiness is supported through the establishment of credibility, transferability, dependability, and confirmability. Credibility, or identifying meaningful operational measures, was established for this study by using multiple sources of evidence that include document review, the establishment of the chain of evidence, and involvement of key informants in analysis and report findings as recommended by Yin (2014). As prescribed by Yin (2014), the literature and document review was used to determine which questions are most pressing for the phenomena of interest in this study. Multiple sources of evidence used to triangulate information gathered (Yin, 2014) included documents review and expert accounts of governmental and other key informants and participants who have worded in EDs. Participant checks following the completion of interviews added to the credibility of the study. This methodological approach that incorporates multiple sources and the design for participant checks can lead to valid conclusions for both the sample and the context (Leung, 2015).

To support transferability, thick descriptions as described in Chapter 2 and supported by document review will be used to provide a rich account that includes the context of experiences, clear descriptions of sample strategies to include exclusion and inclusion choices, and collection of demographics (Korstjens & Moser, 2018). Additionally, including participants that were selected based primarily on engagement and awareness of processes of interest in multiple settings helped to provide a deeper understanding of the case.

Dependability was established through triangulation and audit trails to strengthen measures as outlined by Ajzen and Fishbeiin (1980). Multiple sources included literature reviews, publications, reports, and policy documents that provided historical and contextual information and were used to develop interview questions. Content expert validation was also used to validate that interview questions would capture the intended scope of the investigation. Further, participant and expert consultation and feedback from findings to validate interpretation support dependability. By gathering information from literature review and documents, content experts in government, and association, and partner organizations in addition to ED staff, multiple sources of information could be triangulated to support study finding dependability. Dependability is further supported in this study through audit trails that use a case study protocol and the creation of a database to document the case study process as described by Yin (2014). Dependability established through these means can ensure consistency in the analysis process (Korstjens & Moser, 2018).

Confirmability that is concerned with an aspect of neutrality and subjectivity was to be supported through the use of detailed notes and documents collected (Korstjens & Moser, 2018). Through the use of documents collected and detailed notes to maintain audit trails and audits by others, this study was designed to ensure that the interpretation of the data was not based on researcher preferences and viewpoints to minimize bias effect as much as possible. Respondent validation was to be conducted for the preliminary results comparing interpretation of the findings with the subjects who had participated (Jove et al., 2014). The analysis process involved a strategy to support conformability through an audit trail of decisions and review by outside third-party individuals. Keeping complete notes about decisions made during the research process can enable the third-party auditor to review the establishment of the findings (Korstjens & Moser, 2018). Notes included both decisions and reflective thoughts about the process, meetings, and sampling decisions, such as researcher responses to the setting and thoughts about the researcher's relationship with the interviewees (Korstjens & Moser, 2018). In addition to extensive notes, intracoder and intercoder reliability can be enhanced by establishing a chain of evidence where the evidence collected is considered and then defining a protocol question that led to the design used (Eamonn & David, 1999; Yin, 2014).

Ethical Procedures

Approval to conduct this study was obtained from Walden University IRB. Participation was voluntary and explicitly stated as well as the intention to publish non-identifiable results. By attaining consent, including the promise of confidentiality and a

member check following the interview, the researcher sought to reduce ethical concerns of any possible misrepresentation of participant responses. All data collected related to participant identification or responses were stored on a storage device kept safely in a fireproof locked safe in the researcher's home. Case study participant names were anonymous, with identification information removed from the study report.

Summary

This chapter has described the research design and rationale to answer the overarching research question of understanding how ED staff attitudes are favorably influenced by policy toward reduced return ED visits. This chapter has described how a qualitative critical instance case study research design can answer the how and why questions. The role of the researcher as a developer and analyst of interview data collected has been described, and the methodological approach to use a single case study method has been explained. Instrumentation development approaches and uses have been described. The procedures for recruitment of participants follow, and finally, the data analysis plan that was used and ethical considerations with respective confidentiality and permissions have been covered.

Chapter 4: Results

Results

This research approach that involved eliciting salient beliefs through interviews and supported by further investigation to include documents reviewed and input from key stakeholders was the basis for understanding developed in this study (Fishbein & Ajzen, 2010). By discovering and exploring where processes and policy support the positive attitudes and beliefs of ED staff, this study can provide illumination for how policy can be effective to support the provision of BHCFUP. Understanding how policies are conducive to those ED processes can inform policy development to promote improved BHFCUP and reduce return ED visits by those with a behavioral health condition (Grimshaw et al., 2005).

The purpose of this case study was to identify and discover where policy has supported discover and explore positive attitudes and beliefs of ED staff toward components that support BHCFUP to reduce return ED visits for those with a BH condition. This study has highlighted how staff can feel supported to provide care that is aligned with policy by answering the research question: How are beliefs and attitudes of emergency department staff favorably influenced by processes to support behavioral health follow-up care planning for patients with a behavioral health condition who visit an ED? Through interviews, the study has shown how, where positive staff attitudes are present and supportive processes in place, policy and funding can empower staff to support BHCFUP. This understanding was gained through the use of secondary questions to frame the non-structured interviews that explored:

1. What processes do emergency department staff believe are supportive of behavioral health follow-up care planning toward reduced ED visits for those with a behavioral health condition?
2. How do the emergency department staff utilize the processes of identification, assessment, provision of urgent care, and connection with follow-up care plans to support the provision of behavioral health follow-up care planning?
3. How do ED staff, administration, and key informants perceive that the processes considered favorable by ED staff toward behavioral health follow-up care planning align with policy?

This chapter describes the attitudes of participants and their experience at the time of the study, participant demographics, data collection methods, how participant interviews were analyzed, the collection of online supporting documentation, and the collection of information from governmental and organizational experts. The results for each research subquestion and a summary of how the findings for each subquestion relate to the overarching research question are presented, followed by edification that was provided through online data searches and expert inquiry.

Setting

The individuals who responded to participant requests had all worked in or with hospital EDs in the US. The participants shared experiences from various states that included Texas, Connecticut, California, Georgia, New York, Oregon, and Arkansas. Regulations, policy, and funding all varied by state, lending a variety of perspectives.

Demographics

Eight participants were interviewed. One was obtained via a university participant pool and the remaining seven through social media groups, and all had experience in emergency departments in the provision of behavioral health were all care. They all had experience in various areas related to the study. They had education, training, and certification levels that ranged from nurse practitioners to mental health counselors, psychologists, certified nursing assistants, social workers, registered nurses, and emergency room technicians. Experience mainly ranged from one to ten years, and one individual with over ten years of experience. Degree levels included up to bachelor's degrees and master's degrees with some variety of certifications. All participants were currently seeking an advanced degree and held varying certifications or degrees related to health care. Several indicated that they were pursuing a higher-level degree to be in a better position to change the outcomes of what they had experienced. The participants were all U.S. students who had been or were currently involved with behavioral health care support in emergency departments.

Data Collection

Document review and the lens of social cognitive theory of TRA and TPB identified themes that emerged through investigation of the contextual theories supporting BHCFUP and how they are driven by funding policy. Document review and the TRA/TPB lens also supported the analysis of the emergency department experience toward understanding how and why these processes and related policies positively influence ED staff intention. By describing the intervention and the real-world context in

which it is occurring, research has drawn generalizable theories about the process of ED staff engagement. The data collection and analysis goal was not to generalize the findings to other cases. Instead, the goal of this study was that the findings would be generalizable to theoretical propositions. This concept is supported by Yin (2014), who states that case studies can be generalizable to theoretical propositions but not commonly generalizable to populations or universes. This case study was designed to be generalizable to theoretical propositions about the relationship between components to support BHCFUP in an ED and the engagement of ED staff in those processes. The analysis sought to support the approach of understanding how policy works rather than whether it works. Through exploration of heuristic perceptions of ED staff for how their attitudes, normative beliefs, and control beliefs are positively influenced and aligned with policies that promote those components, this study made sense of the participants' responses by using themes that emerged in narratives and documentation. The generation of categories was inductive as conducted by Jove et al. (2014), and themes were identified and coded through analysis (Jove et al., 2014). For example, subjective norm questions, for example, were based on a goal to identify staff perception of support from influential groups to include regulatory groups and patients (as in Fleming et al., 2017).

Multiple Sources Including Interviews, Documents, and Expert Accounts were Utilized

The mix of methods used within a case study depends on what is feasible and what the researcher wants to find out (Gillham, 2000). The case study approach has been the primary method for this study with the sub-methods of interviews, online data

searches, and expert accounts. This data, accumulated by different methods but related to the same issue, frames a multi-method data collection approach for this study. Where they converge, it helps to frame the true picture (Gillham, 2000). This case study was an empirical inquiry investigating a contemporary phenomenon within its real-life context where the boundaries between phenomenon and context were not evident (Yin, 2009). Because it is not always possible to distinguish between the phenomenon and context in real-life situations, such as between ED staff support for BH care and provision of effective BH care in the ED, other characteristics may be helpful to define the case. The characteristic of the effect of policy and culture on behaviors is part of the technical definition of this case. Therefore, this case study inquiry explores many variables of interest and utilizes multiple sources of evidence including interviews with 8 participants and online searches and expert accounts and prior development of theoretical propositions such as TRA/TPB theory to guide data collection (Simons, 2009). Utilizing multiple sources of evidence goes beyond interviewing many participants, rather includes different kinds of evidence that can include documents and input from agency or authority representatives. These data collection methods have provided the needed chain of evidence to link key elements in this study to achieve its intended purpose (Yin, Case Study Research: Design and Methods, 1989).

As one of the essential sources for data in qualitative case study research, interviews can be corroborated and enhanced through documents and archival records, as done in this case study (Yin, 2018). This study methodology utilizes these multiple data

sources, including gathering data through interviews, sense-making or analysis of those interview responses, and the triangulation of multiple streams of data (Evans et al., 2009).

Documents used in case study research include letters, policy statements, guidelines, and regulations and have been collected in this case study as part of the data collection strategy. These secondary data sources are appropriate for this case, as it is recommended that documents are informative where the study is about a particular industry or area, such as in this case study which is behavioral health care in EDs in the United States. (Nilmanat & Kurniawan, 2021). Documents play an explicit role in case studies and are essential for case studies to corroborate and augment evidence from other sources such as the interviews. The documents in this study made it possible to make inferences for clues for further investigation. Where participants' responses have matched and are expanded upon by documents, a clear picture has been provided, however in some cases; the documents did not agree with participant perceptions, and additional clarification from experts was needed to assist with the development of triangulation (Gillham, 2000). The multiple data sources used in this study contribute to the collective understanding of the phenomena being studied. Looking at the different angles of divergence to include perspectives of ED staff, online data sources, and expert accounts enhances the complexity of understanding what has been found in this study (Simons, 2009). Other types of data collection, such as observation, did not apply in this study.

Triangulation

Triangulation was applied through multiple methods that included data sources, participants, and member checking to understand better the phenomenon of how BH care

can be supported in an ED. Using a triangulation of sources that included participants from varied venues and experiences across the United States. and collaborating these findings with what is known in the literature, this study has brought together a combination of perspectives and literature where findings agree. These multiple sources of data corroborated and shed light on the research findings. Each participant had brought their own world experiences and worldview to the study providing new dimensions to understanding how they were supported and identifying the commonality of experiences. Data triangulation using different data sources to understand the issues adds richness to the description verifies the significance of issues through different methods and sources. Investigator triangulation is helpful in team research, and teams or individuals can use theory triangulation in developing an understanding of the specific case (Simons, 2009). Triangulation of data occurs in this study by including the ED staff interviews, collected information through literature and document review, expert reviews of interview findings, and elucidation of policies that align with identified processes from ED staff interviews. Elucidation of policies was derived from online document searches and informed stakeholders that include healthcare involved administration, government officials, and BH support agencies involved in providing BHCFUP through EDs.

The reports, publications, and information about the experiences of ED staff provide descriptions of a wide range of features about the case, which are the processes and associated policies in support of behavioral health care in EDs. A wide range of features about the case have been collected through initial document review, interviews to capture detailed information about processes and policies and related funding, online

document searches, and information gathered from informed stakeholders. Information obtained from online searches and stakeholders provided elucidation about the related regulations and funding, regulatory hierarchy, public funding policies, and reimbursement structures. Detailed information about the policies, processes, and funding collected through the publications, reports, policy documents, and interview questions include descriptions of perspectives on funding and components in place and how the staff is engaged in supporting BHCFUP in EDs. Putting what participants express into the context of the surrounding social and cultural environment of the participant experiences better enable readers to make transferability judgments.

Observation as a Method of Data Collection Does Not Apply in this Study

Document analysis can reveal official or stated views of a program. Observation techniques conversely reveal what happens in each of the hospitals. However, the premise of the TRA/TRB theory for this study is that the perceptions of the ED staff for how processes support ED engagement in BH are critical, not the physical aspects in the formation of that perception. Observation would foster an in-depth understanding of the individual hospital situations and may help expand upon the participant perspectives of their environments. However, the focus of this study is the perspectives related to a larger setting that is the system of BH care of patients in EDs in the United States.

Understanding the context of the physical setting for each ED to validate participant interpretation does not apply in this study because it is not essential if the participant interpretation is correct. In this study, understanding the complexities of the case in a particular ED environment is secondary to understanding the insights into how

policy can support ED staff engagement in BHCFUP (Stake, 1994). Case studies instead focus on the naturalistic setting utilizing the objectivity of what the records show and include the qualitative element of the evidence, such as how the participants understand themselves and their engagement in BHCFUP (Gillham, 2000). In this case study approach, understanding physical and institutional descriptions would not have been sufficient to understand the case as a holistic system (Gall et al., 1995, 1998). Rather to understand the case as a holistic system data collection in this case needed attention to all components of the case context that included informative documents and expert accounts about policy related to ED staff engagement (Wimpenny & Savin-Baden, 2012). The case study method tends to focus on holistic description and explanation, and, as a general statement, any phenomenon can be studied by case study methods (Gall et al., 1995, 1998). Observation as a form of data collection may have afforded a comprehensive picture of a site. It could explore the specific sub-cultures of various hospital EDs and provide a better understanding of the interactions of each of those individual institutions with outside agencies and governments. Understanding how each institution functions is not central to understanding the provision of BH care in EDs in the United States in general. This study is not about understanding those institutions but rather the case of the provision of BH care in EDs in the United States.

Instrumentation

This study was not concerned with representativeness that may be identified through survey, rather concerned with inferences about general and abstract theoretical principles that are more suited to the use of interview data and document collection

methods (Gomm et al., 2000). Semi structured interviews, document review, and investigation with key stakeholders identified how the targeted group responded by examining the processes and associated policies that motivate ED staff for successful engagement in BHCFUP. The use of semi structured interviews, rather than surveys, allowed space to discover additional information from the study participants. Further, a survey approach could not have readily investigated the phenomenon and the context due to the limitation on the number of questions and still fall within recommended degrees of freedom for the number of questions and people to be surveyed (Yin, 2014).

Documents used were researcher-developed self-administered questionnaires to identify participants meeting study criteria and interviews of participants. Audio recordings and associated technology to capture interview responses were also included in the instrumentation. Details for each of these instrumentation methods include:

1. A questionnaire was used to identify participants that meet study criteria based on affirmative involvement in engagement in components of support for BHCFUP that include identification, assessment, provision of needed care, and connection with a behavioral health follow-up care plan.
2. A semi structured interview question protocol was used to investigate positive ED staff attitudes, social norm beliefs, and control beliefs related to the provision of BHCFUP in the ED.
3. Audio recording technology included linking from Android phone to laptop and utilization of Audacity software to record conversations. Transcription of audio

conversations was then possible utilizing a Trint, a web-based transcription software support service.

How Interview Questions Were Developed

Following the qualitative study approach of Khanassov et al. (2016), I have used a three-step qualitative synthesis to develop interview questions (Khanassov et al., 2016; Mariano et al., 2018). First interventions needed in an ED to support BHCFUP were classified. Second, classification of access dimensions and outcomes of the interventions were used, and 3) finally, a dimensional pattern analysis related to desired outcomes was used to analyze interview responses (Khanassov et al., 2016). The interview questions were developed from a thorough review of the literature and gathering input from content experts. Interview questions to identify subjective norms, for example, were based on other studies that used TRA/TPB approaches (Roberto et al., 2014). The theories of TRA and TPB prescribe validity for the research methodology used was supported by relevant specific links from actions that describe the behavior to the behavior. The interview questions were pretested for content validity with nurses with extensive ED experience and have been engaged in some components of BHCFUP and content. Interviews were recorded and transcribed for analysis. Documents used to develop these interview questions included fiscal publications and reports from governmental, other regulatory agencies, and funding agencies.

Selection of Participants

For this study, the goal was to conduct a single-case study to involve participants who have had experience in different hospital EDs and locations to improve chances of

findings that have transferability (Yin, 2014). A broad criterion for selection was established that ED staff were engaged in any process or component of support for BHCFUP. Sample size calculations were not conducted as the sample size was limited to individuals who had some involvement in the provision of BHCFUP in the ED. By including participants from various locations, this study has reduced the potential for artificial or unique conditions that would diminish the possible utility of findings (Yin, 2014). Explicit descriptions of sample strategies to include exclusion and inclusion choices for participants and collection of demographics were outlined in the literature review (Korstjens & Moser, 2018). Additionally, including participants that were selected based primarily on engagement and awareness of processes of interest in multiple settings helped to provide a deeper understanding of the case.

Procedures for Recruitment, Participation

A characteristic of good qualitative research across multiple paradigms that are the different EDs is the adequacy of data. According to Morrow et al. (2005), adequate amounts of evidence can be obtained by securing interviewees through a purposeful and criterion-based selection of participants who have in-depth experience with the phenomena under study, which is effective support for BH care in EDs in the United States. (The Counseling Psychologist, 2007). As this study is centered on first understanding the personal perspectives of ED staff where BHCFUP is supported, they were a primary population of interest. Participants were recruited via university participant pool and relevant group social media posts. In introductory and solicitation postings, the researcher explained what the study is about, the purpose and the goal of the

study, and criteria for participant selection. The criteria used to determine the selection of participants included those who have been involved in behavioral health care in an emergency department. Where ED staff have been engaged in these components, it was possible to explore further what of these components or processes ED staff believe support BHCFUP in the ED and how the staff perceives these components align with policy.

The criteria used for participant selection was that they must have been involved in components that support BHCFUP in EDs. Participants for the case study included staff that have been involved in BHCFUP in EDs. ED staff engaged in components or processes known through literature to support BHCFUP also elucidated how policy supports their engagement. When interest was expressed on social media or from the university participant pool, a consent form and initial questionnaire was sent to potential participants who had expressed interest. If they indicated that they consented to participate and completed and returned the initial questionnaire with an indication of some involvement in the areas of interest, a follow-on phone interview was scheduled. Interviews were limited to 30 minutes. Interview questions explored what processes the ED staff believe support BHCFUP, how ED staff utilized the processes and components that support BHCFUP, and how ED staff perceived that the policy supports their involvement in BHCFUP. Questions specifically explored each of the components that support BHCFUP, including identification of BH need assessment, provision of urgent care, and connection with BHCFUP. Participants were asked to identify components or processes that support the provision of BHCFUP and invited to expand upon how those

components are supportive. This approach allowed for a thick description of influences on provision of BHCFUP from the perspective of the ED staff.

Semi structured interviews were used to collect the data, which allowed participants to add information and thoughts as the interview progressed. Eight staff were interviewed who had been involved with behavioral health care in emergency departments. Five were hospital staff who had worked within the emergency departments. Three were contracted or support staff who provided behavioral health specialty or intensive care in cooperation with emergency departments. Interested participants were initially screened utilizing the brief questionnaire to determine if they had been involved in aspects of care that were relevant to the study. If the care they provided did not support processes shown to be effective for BHCFUP, then an interview was not conducted. Interviews were conducted with 8 participants. The original data collection plan had called for one hour in person or via phone interview. However, this was changed to 30-minute phone interviews due to COVID challenges, distancing restrictions, and difficulty with in-person access. The only unusual circumstance encountered in the data collection was that one interview needed to be shortened to 20 minutes as the participant had an emergent work conflict. Saturation was achieved in this study. The participants began to identify the same processes that they experienced and recurring themes for how they are supported in the provision of BHCFUP.

Data Recording

Each interview was recorded with the permission of the participant then transcribed from voice to text utilizing Audacity, Android, Microsoft, and Trint©

technology. Calls were routed through a laptop using Android and Microsoft technology. The internal Audacity microphone could record each response with enough clarity so that Trint technology could then transcribe the completed interview. Audacity's internal microphone made it possible for Trint to transcribe interviews with minor or few easily corrected errors.

The Iterative Process

The original plan for this study was to interview emergency department staff who would have been accessed via their hospital administration. However, due to COVID challenges, although several hospitals had expressed interest in supporting the study, they were ultimately unable to dedicate attention to the study at this time. ED staff were instead accessed utilizing the university participant pool and social media sites where members were typically involved in health care or related fields. Therefore, the responses, rather than reflecting participation from ED staff of institutions where some support for BHCFUP was indicated, were instead inclusive of participants from multiple EDs across the United States involved in BHCFUP. Therefore, identifying relevant processes, policy, and funding from various states was inclusive in this study, where they aligned with the participant responses. Primary, secondary, and tertiary coding was applied to responses. This process involved encoding, precoding, and recoding dependent upon the major category identified in responses. Different forms of coding were applied depending upon the type of information collected from the interview. Each coding stage provided greater depth and detail and increased understanding (Miles et al., 2014). In presenting data analysis, this study provided enough illustrative examples of coding

procedures in presenting data analysis, citing participant responses and transcript quotes to substantiate the organization and saturation of themes (Elliott et al., 1999).

Initial Coding

For the initial phase, the data was broken down into categories of interest based on the purpose of the study. The study purpose of discovering positive attitudes and beliefs and identifying where policy has been supportive, based on the theoretical framework, involves four natural categories: (a) the attitudes of staff, (b) the beliefs about norms or standard practices, (c) the beliefs about control of outcomes, and (d) the policies that support their beliefs.

Secondary Coding

Pattern coding was primarily used for secondary coding that allowed for the development of major themes and the collection of similar information (Miles et al., 2014; Saldaña, 2012). Each interview was analyzed through a continuous iterative process for new codes or themes for each category identified in the initial coding. Interviews were conducted until new codes no longer emerged. Each of the prior interviews was reviewed to determine if the emergent codes or themes were inclusive in those interviews (Auerbach & Silverstein, 2003; Miles et al., 2014).

Attitudes of Staff

To understand the Attitudes of staff, themes were developed with respect to what participants liked to see in support of individuals with a behavioral health condition. This "values," or "axiology," type of coding was used to reflect participants' attitudes and coding was useful to represent the participants' worldview toward understanding their

attitude (Miles et al., 2014; Saldaña, 2012). The participant values for improved care were centered on desiring quality or improvements in (a) staff ability or capability, (b) type of care, (c) utility of partnerships, (d) application of funding, and (e) a supportive environment for patients. Subcomponents for each of these themes were then identified to clarify what they would like to see for each area.

Beliefs About Norms or Standard Practices

Themes identified for the norms or standard practices that staff experience in support of behavioral health care was identified based on logical or conceptual sub-categories. Participants described the processes that they experienced in support of behavioral health care. This category is significant from a theological perspective in that the staff beliefs about norms or standard practices according to TRA/TRB influence the likelihood of individuals taking action. Coding for this category utilized a provisional coding approach where the coding begins with the contextual framework that had been generated by the researcher based on initial investigation and literature (Saldaña, 2012). The conceptual framework is significant for coding this category as norms identified by the participants reflected the processes identified in the literature review as effective approaches to support BH in emergency departments. The interviews validated what had been identified in the literature review and preliminary research as effective processes to support behavioral health care in an emergency department.

Staff Beliefs About Control of Outcomes

Staff beliefs about control of outcomes are also significant from a theoretical perspective. According to TRB, the staff's beliefs about how much control they have over

outcomes is another factor that influences the likelihood of individuals taking action. Axial coding was used for this category as this approach helps describe the category properties and how categories relate to each other (Saldaña, 2012). The properties related to control of outcomes centered on (a) hold and referral mandates, (b) help by key staff positions, (c) communication, (d) support available, (e) training for BH population care, (f) experience, (g) roles definition and (h) processes in place in the ED. These aspects of how staff felt supported to provide care operated within the processes and norms were also identified as part of the interviews. These properties related to control of outcomes are the nuances that staff believed allowed them to make a difference and what helped the institution to provide better care or what pressures allowed for the provision of better care. The coding further identified any sublevels for each of the properties.

Policies that Support Beliefs

Through interview questions, guided by the research question subquestion of: How do ED staff, administration, and key informants perceive that the processes considered favorable by ED staff toward behavioral health follow-up care planning align with policy, participants identified policies that supported the organizational processes and the policies that participants believed helped them to provide effective care. There were several types of policies identified and specific policies that were in effect in their region. Participants identified some policies that did not directly support BH instead allowed the staff to support care in some cases by omission. These policies were added as supportive of staff actions despite not being a direct organizational intervention.

Data Analysis

In the data analysis process, this study used a thematic analysis approach based on both the conceptual framework and the theoretical foundation that had been developed in this study. After transcription of the interviews utilizing Trint software, the transcribed responses were coded based on the purpose of the study, theological framework, conceptual framework, and research questions to explore the four categories of staff attitudes, beliefs or social norms, control of outcomes, and policy or funding. Each category was isolated for all of the interviews and compiled into common themes. No further interviews were conducted when coding patterns began to emerge that aligned with conceptual saturation for these themes. Miles and Huberman (1984, 1994) formal methodologies for qualitative data collection and analysis have been applied for conducting the interviews and coding of the data. Also, pattern matching and explanation building as identified by Yin (2014) and thematic analysis as identified by Merriman and Tisdell (2016) were utilized in interview analysis. Common themes and coding were captured in an excel spreadsheet. A table was developed to provide a snapshot of findings depicting the relative prevalence for each area of how/why staff feels control over outcomes.

The primary categories that were developed were centered on the purpose of the study to discover positive attitudes and beliefs and to identify where policy has been supportive, based on the theoretical framework, involves four natural categories (s) the attitudes of staff, (b) the beliefs about norms or standard practices (c) the beliefs about control of outcomes, and (d) the policies that support their beliefs. In identifying staff

attitudes, the first of these categories, the participant values for improved care centered on desiring quality or improvements in several common areas that included (a) staff ability or capability (b) type of care (c) utility of partnerships (d) application of funding and (e) a supportive environment for patients. To learn about the norms or processes that staff were experiencing, which was the second of these categories, a compilation of several themes emerged that included initial assessments by ED, working with BH partners, availability of previous information for care, safety measures in place, action taken to provide care, and follow-up care provided.

Trustworthiness

Trustworthiness is supported through the establishment of credibility, transferability, dependability, and confirmability. Credibility, or identifying meaningful operational measures, was established for this study using multiple sources of evidence including document review, the establishment of the chain of evidence, and involvement of key informants in analysis and report findings as recommended by Yin (2014). As prescribed by Yin, a literature review was used to determine which questions are most pressing for the phenomena of interest in this study. Multiple sources of evidence used to triangulate information gathered according to Yin included documents review and expert accounts of governmental and other key informants and participants who have worked in EDs.

This study has met the four components of trustworthiness in that credibility has been established, transferability is described, dependability is shown, and confirmability has been established, as discussed in this section (Pilot & Beck, 2014).

Credibility

Credibility is one of the four components of trustworthiness (Pilot & Beck, 2014) that can be expressed in terms of confidence in the data collected, the interpretation of the data, and the methods used to validate credibility for the study (Pilot & Beck, 2014). Providing credibility checks enhanced quality and rigor in this study's methods and analyses (Morrow et al., 2005). Participant checks following the completion of interviews added to the credibility of the study. This methodological approach that incorporates multiple sources and the design for participant checks can lead to conclusions that are valid for both the sample and the context (Leung, 2015). This respondent validation allowed individuals to see if they have been represented accurately and fairly and allowed readers to decide whether the interpretation was credible (Simons, 2009). After each interview, responses were checked with the interviewee for validation. Further, upon completion of the analysis, an overview of findings was sent to participants to determine their consensus and correct any errors or provide any additional information if needed.

The interview experiences and the detailed information about processes and policies gathered through interviews also contributed to the credibility of this study. A wide range of features about the case has been collected through initial document review and interviews to capture detailed information about processes, policies, and related funding. Elucidation about the regulations and funding, regulatory hierarchy, public funding policies, and reimbursement structures from government and insurance providers were gathered from internet searches and hospital and public government reports and were provided by key informants.

Creditability has been established in this study through validity and reliability checks and processes. Reliability in this study is based on document trail and analysis development. Interviews were recorded and transcribed utilizing Trint software. Also utilizing Trint, common themes were collected and categorized into three areas (a) the context of processes in EDs that support BHCFUP, (b) how/why staff felt like they had control of outcomes, and (c) policy or funding that supported those processes and staff control of outcomes. The processes captured in interviews mirrored processes that had been shown to be effective in the literature review section. These processes also served to describe the social norms shown through the TRA/TPB lens to support motivation and hence engagement in BHCFUP by staff.

Through interviews and document reviews, information was obtained about effective processes, related policies, and funding. Regulations and reimbursement mechanisms were not explored as this study did not focus on one or two EDs and information about specific funding was not available. Also, there is a broader representation of respondent experiences in this study's final approach for data collection. The participants were involved in a variety of locations beyond one or two individual hospital workplaces. This led to a perspective not limited to one or two operating systems and contributed to triangulation for this study.

Transferability

Exploring the case using multiple perspectives may help readers identify other hospitals EDs that may also be considered part of the "case," U.S. EDs where BHCFUP is supported. By identifying similarities in organizations as described by participants,

staff behavior readers can better apply what is learned about how ED staff use processes, and supporting policy, to engage in support for BHCFUP. By focusing on participant attitudes, beliefs, and experiences, thick descriptions have been provided for the reader to support transferability. Thick descriptions about participant interview responses provide sufficient detail so that readers can understand relevant characteristics and psychological variables that impact their participation. Adequately understanding the participants perspective as well as the context in which they are studied is provided so that readers may gauge the relevance of findings where BHCFUP is occurring in EDs in the United States (Suzuki et al., 2007 [TCP, special issue, part 3]).

Thick descriptions provide context that interprets the situation of provision of BH care in the ED for the participants (Ponterotto, 2006). It involves highlighting the thoughts, emotions, and perspectives of how the participants fit into the operating environment care provision in EDs for their hospital, the region, the state, and the nation (Ponterotto, 2006). By presenting enough detail about the context of the participant responses, this study gives the reader enough understanding so that the reader feels they understand the experience of providing BHCFUP (Denzin, 1989). As the adequate contextual description is required to understand the setting or context in which the case is revealed, in this study, the contextual description portrays through literature and previous studies the environment of provision of behavioral health in EDs. A thick description of ED staff engagement for this study has been achieved through ED staff descriptions that (a) give the context of engagement in BH care in ED (b) illuminates intentions and meanings (c) provide insight into the evolution and development of their action to engage

and (d) provides the text to the reader in a form that can be interpreted (Denzin, 1989). A thick description for this case presents the action of engagement in BHCFUP in the ED and the significance of that engagement (Ponterotto, 2006). The concept of thick descriptions was originally presented concerning direct participant observations (Geertz, 1973) and has since expanded to other qualitative data collection methods (Ponterotto, 2006). A thick description has been presented in this study by interpreting actions within the context of ED staff engagement in processes, by capturing and reporting thoughts and emotions of the ED staff with respect to their engagement, by assigning motivations and intentions for their engagement, and presenting their perceptions of the context for their engagement (Ponterotto, 2006). Results have provided a thick description by presenting the "voice" of participants through the incorporation of long quotes so that the reader can get a sense of the cognitive and emotional state of the participants.

As Denzin (1989, p. 83) described, a thick description for this case would convey the actions of ED staff, their voices, feelings, and meanings of interacting. Conveying to the reader interpretations of ED staff perceptions of the meaning of their circumstances and their motivations or strategies helps characterize the ED staff experience (Schwandt, 2001, p. 255). Thick descriptions would explore the underlying meanings of staff engagement in processes to support behavioral health in the ED (Holloway, 1997, p. 154). The "thick" description interprets the behavior within the context of the provision of care in an ED and reflects on what individuals are thinking and their present and future intentionality (Ponterotto, 2006). By providing a thickly described discussion section in the interview report, this study can successfully merge the ED staff perceptions and

experiences with researcher interpretations. These thick descriptions help the reader to decide if they agree with the interpretive conclusion as the researcher (Ponterotto, 2006).

Confirmability

Confirmability was attained through neutrality, and subjectivity was achieved by utilizing detailed notes in terms of interview transcriptions and documents collected that were maintained in an extensive, compiled database (Korstjens & Moser, 2018). The documents collected and detailed notes provide an audit trail where unbiased interpretation could be validated. Respondent validation was conducted to check the interpretation of the findings with the subjects who had participated (Jove et al., 2014). An analysis audit trail was identified for how analysis decisions were made and checked by outside third-party individuals. Complete tables of data and analysis are available to enable the third-party auditor to review the establishment of the findings (Korstjens & Moser, 2018). Additionally, intracoder reliability was established where the evidence collected, which was in part staff beliefs for how they have control of behavioral health outcomes, was considered, and then a protocol question was developed that would have led to the design used (Eamonn & David, 1999; Yin, 2014).

Confirmability concerned with neutrality and subjectivity was supported through detailed notes and documents collected (Korstjens & Moser, 2018). Through the use of documents collected and detailed notes to maintain audit trails and audit by others, I had planned to ensure that the interpretation of the data was not based on my preferences and viewpoints to minimize bias effect as much as possible. Respondent validation was to be conducted for the preliminary results comparing interpretation of the findings with the

subjects who had participated (Jove et al., 2014). The analysis process involved a strategy to support conformability through an audit trail of decisions and review by outside third-party individuals. Keeping complete notes about decisions made during the research process can enable the third-party auditor to review the establishment of the findings (Korstjens & Moser, 2018). Notes included both decisions and reflective thoughts about the process, meetings, and sampling decisions, such as my responses to the setting and thoughts about my relationship with the interviewees (Korstjens & Moser, 2018). In addition to extensive notes, intracoder and intercoder reliability were enhanced by establishing a chain of evidence where the evidence collected is considered and then defining a protocol question that led to the design used (Eamonn & David, 1999; Yin, 2014).

Dependability

Dependability was established through triangulation and audit trails to strengthen measures as outlined by Ajzen and Fishbiein (1980). Multiple sources included literature reviews, publications, reports, and policy documents that provided historical and contextual information and were used to develop interview questions. Content expert validation was also used to validate that interview questions would capture the intended scope of the investigation. Further, participant and expert consultation and feedback from findings were used to validate interpretation support dependability. By gathering information from literature review and documents, content experts in government, and association, and partner organizations in addition to ED staff, multiple sources of information could be triangulated to support study finding dependability. Dependability

is further supported in this study through audit trails that use a case study protocol and the creation of a database to document case study process as described by Yin (2014). Dependability established through these means can ensure consistency in the analysis process (Korstjens & Moser, 2018).

By applying an interview approach that is based on the study constructs elucidated relevant themes in attitudes, identified beliefs about norms, identified beliefs about staff control of outcomes to mitigate limitations on dependability that may be found with interviews alone (Khanassov et al. 2016). The identification of themes that were discovered through interviews reflected themes that had been identified in the literature review. Though there was limited information about staff attitudes, the literature provided a basis for the types of processes that had been found to be effective in providing BHCFUP.

In deciding which strategies to adopt for this study, I have chosen what is most appropriate for the kind of case study being conducted. I have considered the purpose of the study, the methods used, and the audiences sought to influence. I have striven to assure readers that the findings are accurate, credible, and trustworthy given what I am trying to help the readers understand about the particular contexts of the case (Simons, 2009).

Attitudes, Beliefs, and Policies Found

The purpose of this critical instance case study was to discover and explore positive attitudes and beliefs of ED staff toward components that support BHCFUP to reduce return ED visits for those with a BH condition and identify where policy has

supported these positive attitudes. As described by (Glantz et al.) 2008, attitudes are partly related to the mental state that involves values in acting toward specific ways. To achieve this purpose, the research question sub-questions were used to explore the staff's positive attitudes and beliefs and to identify associated policies. Findings for the overarching research question: "How are beliefs and attitudes of emergency department staff favorably influenced by processes to support behavioral health follow-up care planning for patients with a behavioral health condition who visit an ED?" fell into four categories. The three categories that evolved were theoretically founded with respect to TRA and TRB include (a) Attitudes of ED staff, (b) Staff beliefs about the norms or current processes, and (c) Staff beliefs of processes that support the feeling of control of positive outcomes. (d) Policies that support norms and enable staff feeling of control of outcomes.

Attitudes of ED Staff

According to TRA/TRB theory, where there are positive attitudes of ED staff, the more likely they are to engage in support for BH care in an ED. Interviews with study participants did reflect positive attitudes as evidenced by the support they expressed for effective behavioral health care. This expressed support by ED staff was organized into five areas: staff capability and ability, good care, effective partnerships, beneficial funding, and a supportive environment for individuals in need of BH in ED. Specific types of staff capability, care, partnerships, funding, and supportive environments valued by participants are shown in Figure 4. Additionally, most of the individuals who participated in this study indicated that they were more likely to do so because they had a

positive attitude about improved care for individuals with a behavioral health condition and a desire to help with research toward improving outcomes.

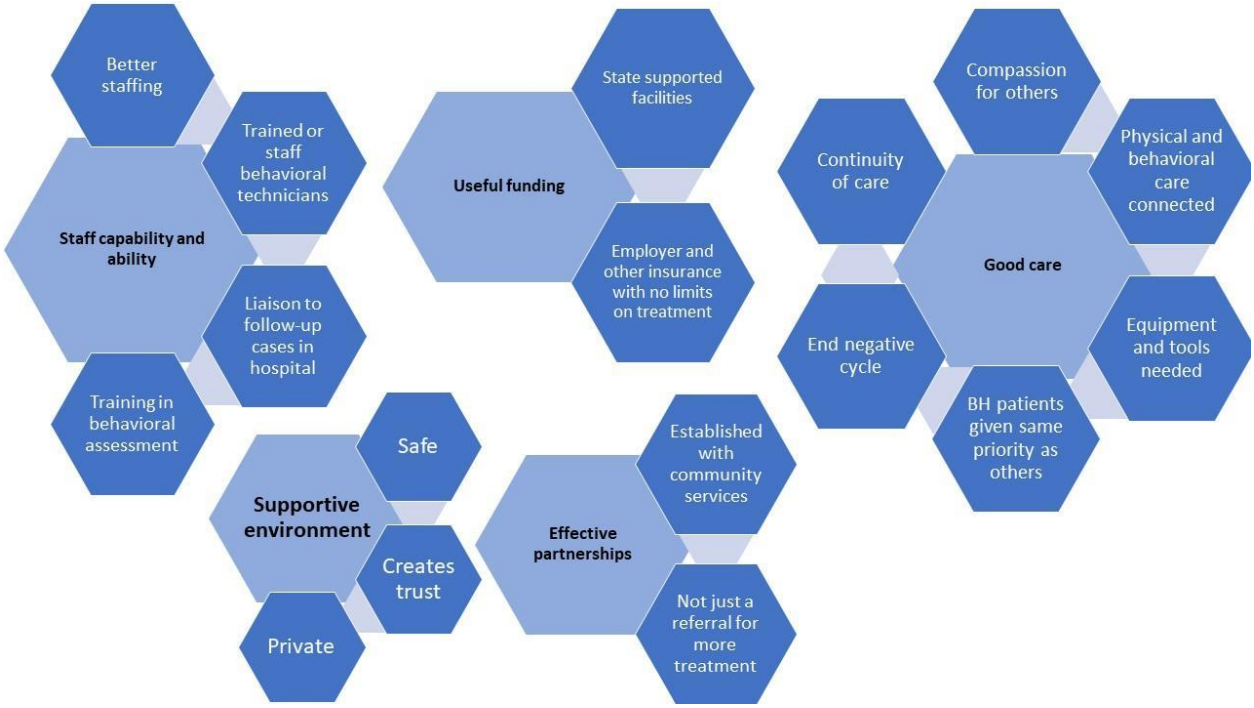
Examples of positive ED staff attitudes are reflected in the three participant quotations below:

> I think a lot of it was seeing people I knew in my patients and doing my best to not look at them as numbers that I need to move out of the emergency room and into another unit or something like that, and taking the time to know who these people were and ask questions not only about their personal history but about their family history, what their situation outside of the hospital was like. I guess looking at them holistically instead of just searching for pathologies.
>
> I think mental health in general, behavioral health anywhere needs help, but the frustration for us in my area at least, is not the emergency room care, because I think we do a very good job of identifying and stabilizing it once we get past that to [find the needed] inpatient treatment.
>
> I think just overall, as a culture in the facility that I work in, that we are really pushing towards viewing behavioral health, mental health, substance abuse as a disease process or an emergency, just like any other complaint would be.
>
> So there's one person who is dedicated specifically to that one area. And I believe that was a great step forward because now you have one technician who is there for their 12 hour shift working with these clients who are there. No behavioral health ER visit is a quick in and out. They're going to be there for a while, so you have that person working 12 hours building that rapport with their client, with the

patients and clients, getting to know them. So and I believe that was a great step forward.

Figure 4

Attitudes of Staff Types of BH Care Supported by Participants



Staff Beliefs About Norms or Current Processes

In answer to the subquestion: "What processes do emergency department staff believe are supportive of behavioral health follow-up care planning toward reduced ED visits for those with a behavioral health condition?" participants identified norms or processes that they experienced in the ED that they believed support behavioral health care. As part of the screening prior to conducting interviews, participants were asked to answer a brief questionnaire to indicate if they had been involved in effective processes and could therefore inform the study about those experiences. Participants identified processes that

they believed to be supportive of behavioral care is shown in Table 1. Below participant responses are examples of processes that ED staff believe are supportive of behavioral health care:

> I think typically when the individual is assessed by the nurse, once they get there, if they're identified as being someone who's experiencing a mental health emergency or something of that nature, they generally are placed in a specific area that they have reserved for that and then they be reassessed by a social worker.
>
> One thing that [our] County does is a thing called probably going to try and remember the department, it's I believe it's called triage connect. And what tirage connect does it's a 30 or it's a 30- or 60-day intensive case management that helps the clients that I've seen.
>
> So they do screening, sometimes it's apparent that we need to do the screening. So, for example, with the patient [that was described] they did go ahead and send him to the psychiatric room. And then once that happens, the nurse triages them and sends them over there. Then I do my assessment and then when the physicians come, I kind of give them a synopsis of why the patient is there…..and so the doctor will go and ask a series of questions and then they end up putting in a psychiatric consult.
>
> So basically, when we discharge people for the most part, we try to find them a place in the psychiatric treatment center and we always have the case management provide them with resources.

One of the great things about my county where I am at is they have an acute care facility within the hospital. And so once I do, the assessment I have to recommend them that I have to recommend them to the acute care for crisis stabilization.

Table 1 also shows how participant-identified supportive processes fell into the four effective categories which were identified in the literature review and preliminary research that includes assessment, triage, urgent care, and follow-up care planning.

Table 1

Alignment of Participant Responses with Types of Processes

Processes Identified by Participants	Assessment	Triage	Urgent Care	Follow-up Care
Comprehensive assessment by ED staff	X			
Mandatory suicide screening	X			
Triage to identify MH issues		X		
Assessment when patients come into ED and use checklists to conduct Triage		X		
BH screening is conducted on all who enter ED no matter what the complaint	X			
Social worker gathers information in ED		X		
Triage conducted in ED if individuals come in or brought in with a BH need		X		
Behavioral health screening part of intake	X			
Doctor screens for BH issue if some indication and requests a psychiatric consultation	X	X	X	
Social worker contacts BH professionals		X	X	
Social worker contacts BH professionals who come in to do an assessment.	X	X	X	
Social worker contact BH professional after individual placed in a safe environment			X	
If indicated ED may connect with BH professionals				X
Verbal communication between ED and BH providers assists with care			X	
Patients who need additional screening are identified and seen by BH team			X	X
Observation in ED where referrals to BH specialists were made to include MH professionals, substance use disorder medications (MAT), and outpatient support groups			X	X

Processes Identified by Participants	Assessment	Triage	Urgent Care	Follow-up Care
Contracted services for BH professionals with ED			X	X
Medical records available that shows previous BH consultations		X		
Background information available with shared data systems		X		
Information is included in a data base to identify past treatments and needs			X	
Mental health advocates have access to records				X
Staff assigned to front door	X			
Crises training provided for staff and utilization of a MH crises line with response from MH professionals within 2 hours			X	
Crises response within Previous information about patient available hours if contacted by ED			X	
Coordination with Police as a team to respond to individuals in crises			X	
Methadone or Suboxone available if needed for substance withdrawls or disorders			X	
Acute BH care facility within the hospital for crises stabilization and BH facility is contacted for follow-on support or outpatient hospitalization			X	X
Medication can be used for crises stabilization and referrals made to inpatient facilities (MAT)			X	X
BH professionals available 24 hours a day with MH professional visit within 12 hours.			X	
Specialized resources provided in ED			X	X
Screening done in ED and sent to psychiatric room if indicated	X		X	
Triage conducted for all with an indicated BH need and are placed in a safe location		X	X	
Individuals with a BH need are given the same priority as those who have a physical need.			X	
ED staff conduct initial screening and if BH need indicated then referral is made for a psychologist or experienced Nurse practitioner to see patient in the ED	X	X	X	
ED staff call BH department if indicated need and crises counselors will respond to the ED where they will check in with the social worker.	X	X	X	
Individuals are assessed by a nurse and if identified with a BH are placed in an area and reassessed by a social worker	X	X		
BH medication (MAT) treatments are continued in ED if they had already been prescribed			X	
Virtual or face to face BH professional support with individuals in ED			X	

Processes Identified by Participants	Assessment	Triage	Urgent Care	Follow-up Care
Treatment and transfers to BH facilities as needed				X
Physical assessment conducted where BH need is indicated in case they are transferred to a psychiatric facility			X	
Hospital connects individuals with follow-up care and continuation of BH medications				X
BH professionals called to ED and then connects them to services or outpatient care				X
Utilization of contacts on patients insurance lists				X
Variety of professionals are available to support those indicated to have a BH need including psychiatrists, registered nurses, and peer support providers			X	X
Coordination with BH professionals and follow up care planning that includes access to resources and supports				X
Crises services and outpatient services are available in the county and utilized				X
Coordination with specialists who assist individuals with getting to their appointments and assisting with such things as shelter and housing				X
Patients are discharged home or psychiatric facility and linked with MH advocates				X
BH facility links individuals to MH or other services				X
Contracted services to local agencies				X

Staff Beliefs of Processes that Support Feeling of Control Positive Outcomes

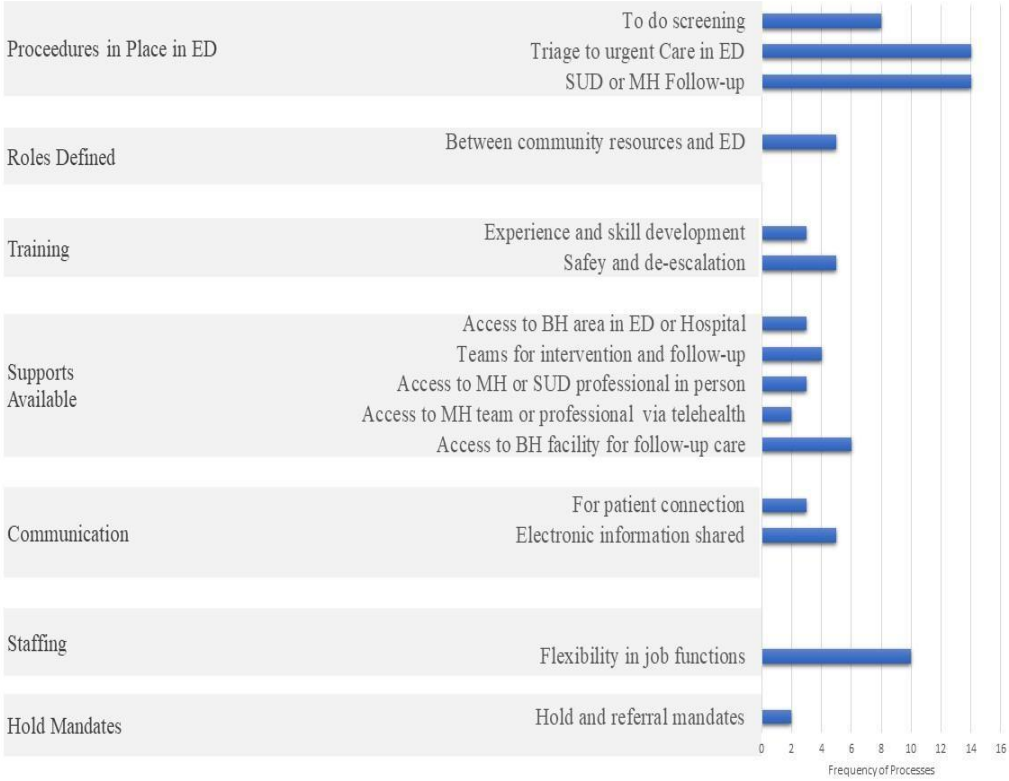
In answer to the subquestion "How do the emergency department staff utilize the processes of identification, assessment, provision of urgent care, and connection with follow up care plans, to support the provision of behavioral health follow-up care planning?" participants identified areas where they felt supported to provide care. Participants identified eight areas where they felt supported in their ability to provide BH care in the ED successfully. These eight areas included mandates, staffing, communication, supports available, training, experience, roles defined, and procedures in

place in ED. Each of these areas with the related specific processes that were identified is shown in Figure 5. Below are examples of participant responses for where they felt supported:

> But we are also all trained in ethics, and that goes beyond behavioral health. We're all trained in that to de-escalate and work with the patient, to kind of build the respect so that they know we are just trying to help.

Figure 5

Frequency of Processes Reported by Participants Supporting ED Staff Belief of Control of Outcomes



> Yes, sometimes our psychiatrists are literally right upstairs on the other floor and they'll still do it with tablets like. Well, then, for tell us, like we have to have the

patient sign a consent for the actual psychiatrist to come in, then the psychiatrist that comes in.

One of the great things about my county where I am at is they have an acute care facility within the hospital. And so once I do, the assessment I have to recommend them that I have to recommend them to the acute care for crisis stabilization. The acute care will refer them back to my agency. And I tell the client on their insurance plans and grant, if they have private insurers, but I tell them that you have your choice of agency, but where they are available and I'm recommending outpatient hospital, or what some of them need.

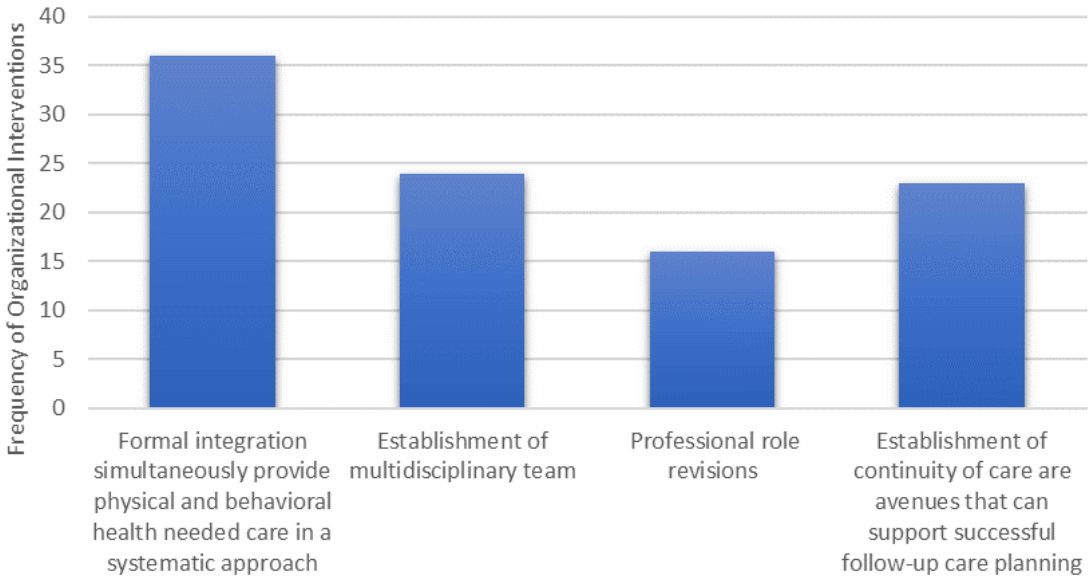
You know, I think it's just kind of a lot of cooks in the kitchen and finding a way to manage all that knowledge and just really focus it into one point.

Also, since the COVID epidemic began, actually, they are able to do it on zoom through their phone and so an ACT staff will show up to help them log on if they need that or like provide any level of support that's necessary to make sure that they attend those appointments.

The processes shown in Figure 5 align with the four organizational interventions identified in the literature review to provide for effective BHCFUP. The number of times participants identified processes related to each of these four organizational interventions is shown in Figure 6. These organizational interventions are driven by policy and funding that are addressed in the next section of this chapter. Participants also identified policies and funding that promote these processes and are addressed in the final section of this chapter.

Figure 6

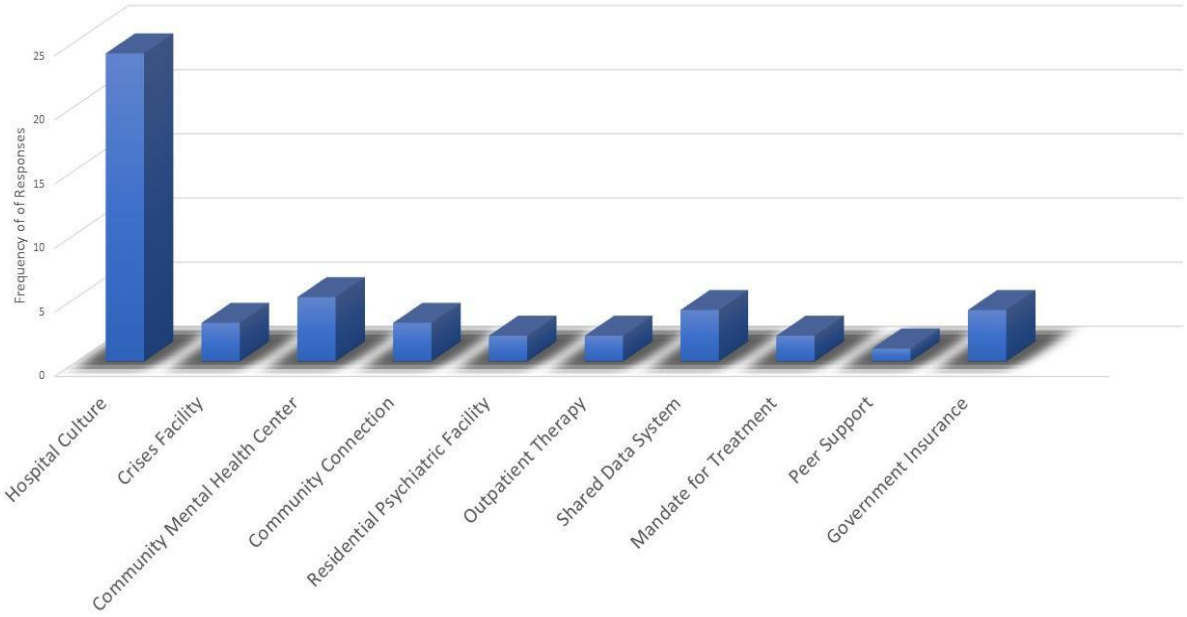
Organizational Interventions Identified by Participants to Support BH Care



In answer to the subquestion: How do ED staff, administration, and key informants perceive that the processes considered favorable by ED staff toward behavioral health follow-up care planning align with policy? The participants identified processes and could identify some policies that supported those processes. With an understanding of resources that have enabled supportive processes, as shown in Figure 7, related policies could then be identified through online searches and connections with experts.

Figure 7

Resources Supportive of Behavioral Health Care in the ED



Resources that enabled supported processes can be categorized as hospital culture, crises facilities, community mental health centers, community connections, residential psychiatric facilities, outpatient therapy, shared data systems, mandates for treatment, peer support, and government-funded insurance. Details for each of these categories are discussed below.

Hospital culture was the most significant resource as identified by ED staff. Hospital culture that was identified as supportive of behavioral health follow-up care in the ED included (in order of prevalence):

1. Focus on staff utilization to provide screening, assessment, and triage

2. Availability of mental health provider for crises assessment either physically or via telehealth
3. Availability of social worker to connect with other agencies or resources
4. Designated space in the ED for screening, assessment, and triage of individuals with a behavioral health need
5. Supportive climate and involvement of leadership
6. Training

A focus on staff utilization to provide screening, assessment, and triage was highlighted as the number one beneficial resource for ED staff to provide BHCFUP in an ED. Although mandatory screening and care are mandated by the Emergency Medical Treatment and Active Labor Act (EMTALA), as described later in this chapter, screening and care are commonly not adequate to identify, assess, triage, and provide urgent care for individuals with a behavioral health condition. The hospital staff involved in comprehensive and coordinated screening, assessment, and triage included medical assistants, social workers, nurses, doctors, and mental health professionals. Investigation into online sources revealed that funding policies that provide for staff involvement in these functions include private and public (Medicaid/Medicare) insurance reimbursements but frequently do not universally or adequately cover direct expenses for staff involvement in these processes. Hospitals often rather find that the kinds of screening, assessment, or triage that are provided for effective care are not adequately reimbursed by public or private insurances. In particular social workers, cited as most supportive of screening, assessment, and triage, provide care that has been shown to be

effective but is not billable in many cases by the hospital. Studies have, however, shown that social worker functions and involvement can be effective in improving care and reducing return ED visits and hospital costs. Hence, with limited reimbursements, hospitals are frequently funding these positions and roles "out of pocket" in many cases utilizing medical assistants or social workers wherever allowed by certification standards.

Access to a mental health provider for crises assessment either through physical co-location or via telehealth was cited as important for ED staff to provide an adequate assessment and determine the next steps in the provision of behavioral health care. Co-located mental health support was available at the larger hospital institutions facilitating coordination of care and ease of access to reimbursements through private and public insurers. Telehealth, specifically often referred to as "telepsychiatry: were related to mental health assessment and care, was found to be effective for staff, particularly in an environment where reduced restrictions and expanded funding was provided to support health care challenges during the COVID epidemic (Kanellopoulos et al., 2021). Specific information about telehealth funding policies, including allowances and changes, is shown in Appendix B. Increased access to mental health care through telehealth has been shown to improve access to care for individuals with a behavioral health condition by the increased availability and reimbursements provided. Some payment options are continuing to expand (Centers for Medicare and Medicaid Services, 2009). However, there are indications that there will be a decrease in availability due to future restrictions or reduced reimbursements. The details and implications for policymakers for this change in telehealth availability are discussed in chapter 5.

Availability of social workers to connect with other agencies or resources was cited as a means of connecting individuals with behavioral health conditions to follow-on resources was a significant factor for staff in the provision of BHCFUP. With this staff specifically designated to connect the individual with needed resources, other staff could turn their attention to the screening, assessment, triage, and provision of urgent care for other patients. Specific information about the roles and functions of social workers in a hospital setting and the types of reimbursements provided by private and public insurances are described in Appendix A. Implications for policymakers regarding reimbursement and funding for these roles and functions are discussed in Chapter 5.

A designated space in the ED for screening, assessment, and triage of individuals with a behavioral health need was highlighted by many of the ED staff, and although not all specifically mentioned this as a resource, there was likely a space set aside in the hospital environments to conduct the screening that took place. As shown in the literature review, having a safe and secure place in the ED to assess and provide triage for individuals with a behavioral health condition is essential to provide adequate screening. However, there is not a specific reimbursement for this type of expenditure beyond an occasional federal grant. Providing a safe space in the ED was more closely aligned with hospital culture and a commitment toward providing care for individuals with a behavioral health condition.

A supportive climate and involvement of hospital leadership seemed to empower the ED staff with a feeling of commitment by their leadership so that the ED staff's efforts were valued and supported in return. The policy associated with this supportive

climate is not based on reimbursements, or mandates, rather on a commitment to serve individuals with a behavioral health condition.

Training that the hospital mandated, or hospital policy that included safety training and de-escalation, was found to be valuable and reflected a commitment by the hospital administrations to serve the behavioral health population better. This training also is not reimbursed explicitly by payers and also takes time out of other staff duties. However, the ED staff expressed value in training offered and gave them an improved sense of ability to provide care.

Crises facilities available for urgent care that was cited by ED staff as helpful in the care of individuals who had been diagnosed with a behavioral health condition included a Detox facility, methadone treatment facility, or acute care facility. In addition to hospital policy that provides for and allows staff engagement to connect with these facilities, funding policy makes it possible for these resources to exist. Policy implications for policies supporting these resources are discussed in Chapter 5.

Policies and Funding that Promote These Supportive Processes

Online searches provided a deepened understanding of specific policies that supported these organizational interventions. Input from area experts, stakeholders, or government officials provided additional information and validation of what was identified by participants and online searches. The policies identified through further investigation supporting behavioral health care for ED staff are presented in the final section of this chapter. As shown in Table 3, processes supporting staff belief of control of outcomes toward improved care are supported by organizational interventions that

provide for the resources needed to support ED staff in providing behavioral health care in the ED. Table 2 below shows these relationships and how and what policies make these processes, organizational interventions, and resources possible.

Table 2

Relationship of Processes, Organizational Interventions, Resources Needed, and Policies that Support Those Processes in the Provision of Care

Processes Supporting ED Staff Belief of Control of Outcomes as Identified by ED Staff (Identified in figure 5)	Organizational interventions (Identified in figure 6)	Resources Needed (Identified in figure 7)	Policies that Support Processes (See policies section below. Each letter code refers to a policy section)
Procedures in Place to do Screening and Initial Assessment: Arkansas: Basic screening done by social worker; lead administrator promotes support for screening Georgia: Someone always at front door; every patient seen in ER within 10 minutes; screening policy in place Texas: Screening checklists utilized and during intake asked about BH history by medical assistants or nurses New York: Social workers do screening Oregon: Nurses conduct initial assessment followed by social worker further assessment California: Screening that includes social worker involvement	-Formal integration -Professional Role Revision	**Hospital Culture** -Supportive climate and involvement of leadership -Focus on staff utilization to provide screening, assessment, and triage involvement in screening	Hospital funding; out of pocket non-reimbursed B1, B2 Reimbursements for social worker, medical assistant, nurse, and doctor A1A, A1A1, A1A2
Procedures in Place to Conduct Triage and Urgent Care in ED Arkansas: Hospital administrator promotes support for triage and urgent care; in-depth assessment with MH professional provided through telehealth and contract with MH agency Georgia: Triage and urgent care policy in place; leadership participates in support for BH care in ED and promotes a philosophy of equal priority for BH and physical health; physical restraints are a last resort; telehealth with MH professional conducted for in-depth assessment and triage	-Establishment of multi-disciplinary teams -Professional Role Revision	**Hospital Culture** -Focus on staff utilization to provide screening, assessment, and triage -Availability of mental health provider for crises assessment either	Hospital funding out of pocket non-reimbursed B1, B2, I Reimbursements for social worker, medical assistant, nurse, and doctor A1A, A1A1, A1A2, B6, F

Processes Supporting ED Staff Belief of Control of Outcomes as Identified by ED Staff (Identified in figure 5)	Organizational interventions (Identified in figure 6)	Resources Needed (Identified in figure 7)	Policies that Support Processes (See policies section below. Each letter code refers to a policy section)
Texas: After screening nurse or physicians become involved for further assessment and triage; connection with psychiatric staff for triage and urgent care from hospital psychiatric floor or telehealth; doctor makes psychiatric consultations, CMHC contacted for in-depth telehealth assessment availability within 12 hours		physically or via telehealth -Designated space in the ED for screening, assessment, and triage of individuals with a behavioral health need -Supportive climate and involvement of leadership **Community Mental Health Center Accessible** -Community Mental Health Center to assist with assessment and triage	Behavioral health provider reimbursements A1, A1A, A1A1, A1A2, F State laws and funding for Telepsychiatry A1A, I Community Mental Health Center funding A1, A1A, C3A, F Psychiatric floor or staff in hospital A1A, A1A1, B4, C3A
New York: Counselors on staff and psychologist on staff to assist with triage and urgent care; telehealth utilized for screening and assessment since COVID			
Oregon: Many social workers on staff to support triage; telepsychiatry utilized for in depth assessment			
Connecticut: Staff perform unassigned roles to support triage			
Procedures in Place to Provide for SUD or MH Follow-up	-Formal Integration. -Establishment of multi-disciplinary teams -Establishment of Continuity of Care -Professional Role Revision	**Hospital Culture** -Availability of social worker to connect with other agencies or resources -Supportive climate and involvement of leadership **Crises Facility** Available	Hospital funding out of pocket non-reimbursed B1, B2 Reimbursements for social worker, medical assistant, nurse, and doctor A1, A1A, A1A2, B6, C3A, F Detoxification, or acute care facilities
Arkansas: Hospital administrator promotes support for triage and urgent care; in-depth assessment with MH professional provided through telehealth and contract with MH agency			
Georgia: Staff connect with mental health agency for follow-up			
Texas: Staff connect with methadone program in hospital for follow-up, with outpatient clinic in hospital system for follow-on counseling, and with psychiatric floor (or nearby facility)			
New York: Social workers contact CMHC for referral and follow-up; Medicaid pays for BH providers			

Processes Supporting ED Staff Belief of Control of Outcomes as Identified by ED Staff (Identified in figure 5)	Organizational interventions (Identified in figure 6)	Resources Needed (Identified in figure 7)	Policies that Support Processes (See policies section below. Each letter code refers to a policy section)
Oregon: CMHC utilized with a comprehensive team, detox facility 2 hours away			
California: ED contacts CMHC for follow-on coordinated care that may include utilization of "triage connect" 30–60-day intensive treatment available, and outpatient therapy that is sometime available same day		**Community Mental Health Center** to provide follow-up care	funded by grant or reimbursement A1, A1A, B3, B4, B5, B6, B7, C2A, C2A1
		Residential Psychiatric Facility in or associated with hospital	Community Mental Health Center funding A1A, A1A1, B3, C3A, D2
		Outpatient Therapy available	Behavioral health provider reimbursements A1A, A1A1, A1A2, B3, B4, B6, B7, C2A, C2A1, C3A
			State laws and funding for Telepsychiatry I
			Coordinated care program established A1A, A1A1, A1A2, C3A, F SUD or MH outpatient care reimbursement A1, A1A, B6, B7, C2A, C2A1, C3A
Supports Available - Behavioral Health Area Set Aside in ED		**Hospital Culture** -Designated space in the ED for screening, assessment, and triage of individuals with a behavioral health need	Hospital funding out of pocket non-reimbursed B1
Texas: Designated area in ED for BH assessment and triage	-Formal Integration		
Oregon: Separate area for further assessment			Reimbursements for redesign A1A, A1A2, C3A, E
California: Three rooms set aside for MH agency to go into hospital for deeper assessment, triage, and urgent care			

Processes Supporting ED Staff Belief of Control of Outcomes as Identified by ED Staff (Identified in figure 5)	Organizational interventions (Identified in figure 6)	Resources Needed (Identified in figure 7)	Policies that Support Processes (See policies section below. Each letter code refers to a policy section)
Supports Available - Teams for Intervention and Follow-up Texas: Peer support that goes into ED and connects with individuals statewide Arkansas: Social worker with Stepping Stones housing contacts MH agency; community crises center call line Georgia: Mental health agency allows for follow-up care through a team approach	-Formal Integration -Establishment of multi-disciplinary teams -Establishment of Continuity of Care -Professional Role Revision	**Peer Support** **Community Mental Health Center** Contract	Hospital funding out of pocket non-reimbursed B1 Peer and community support funding B6, C2A1, C3A Community Mental Health Center funding Service innovation funding A1A, C3A, D2
Supports Available - Access to MH Team or Professional in Person for Assessment Triage, or Urgent Care Texas: Access to psychiatric staff for triage and urgent care from hospital psychiatric floor California: ED contract with CMHC for follow-on coordinated care that may include utilization of "Triage Connect" 30-60 day intensive treatment available, and outpatient therapy that is sometime available same day	-Formal Integration -Establishment of Continuity of Care	**Hospital Culture** -Availability of mental health provider for crises assessment either physically or via telehealth **Community Mental Health Center** Contract	Mental health provider reimbursements A1, A1A Outpatient and intensive treatment available A1, A1A1, B6, C2A, C2A1, C3A Community Mental Health Center funding A1, A1A, C3A, D2 Psychiatric floor or staff in hospital B4 Coordinated care program established A1A1, A1A2, C3A

Processes Supporting ED Staff Belief of Control of Outcomes as Identified by ED Staff (Identified in figure 5)	Organizational interventions (Identified in figure 6)	Resources Needed (Identified in figure 7)	Policies that Support Processes (See policies section below. Each letter code refers to a policy section)
Supports Available - Access to MH Team or Professional via Telehealth for Assessment, Triage, or Urgent Care Texas: Contract for telehealth assessment, CMHC available 24 hours for triage and has 12 hours to respond Georgia: Telehealth utilized for crises assessment with MH professional through contract with Community Mental Health Center (CMHC)	-Formal Integration -Establishment of Continuity of Care	**Hospital Culture** -Availability of mental health provider for crises assessment either physically or via telehealth **Community Mental Health Center** Contract	Mental health provider reimbursements A1, A1A, A1A1 State laws and funding for Telepsychiatry I Community Mental Health Center funding A1A,C3A, D2
Supports Available - Access to BH Facility for Follow-up Care Arkansas: Access to county funded acute care facility and CMHC Texas: Methadone program in hospital available for follow-up appts and connections; outpatient clinic in hospital system available for follow-on counseling; psychiatric floor (or nearby facility) for referral Oregon: CMHC provides Medicated Assisted Treatment, RNs, care coordinators, substance abuse treatment specialist, and case managers California: CMHC for follow-on coordinated care that may include utilization of "triage connect" 30-60 day intensive treatment available, and outpatient therapy that is sometime available same day	-Formal Integration -Establishment of Continuity of Care	**Crises Facility** **Outpatient Therapy** **Residential Psychiatric Facility** **Community Mental Health Center** Contract	Detoxification, or acute care facilities funded by grant or reimbursement A1, B3, B6, C2A, C3A Improved Coordination for Care A1A, A1A1, C3A, D2 SUD or MH outpatient care reimbursement A1, A1A1, B3, B6 Residential psychiatric facility funding A1, A1A1, B3, B4 Community Mental Health Center funding B3, C3A, D2

Processes Supporting ED Staff Belief of Control of Outcomes as Identified by ED Staff (Identified in figure 5)	Organizational interventions (Identified in figure 6)	Resources Needed (Identified in figure 7)	Policies that Support Processes (See policies section below. Each letter code refers to a policy section)
Roles Defined Between Community Resources Arkansas: ED is familiar with roles of CMHC when contacted, Roles of CMHC for supportive housing referrals understooD) New York: Contact information for CMHC obtained from insurance list California: Response partnership program between police and CMHC provider; ED and CMHC have understanding and developed roles in process	-Formal Integration	**Community Mental Health Center** Contract **Community Connection**	Community Mental Health Center funding A1, C3A, D2 System Integration Development A1A, A1A2, C2A1, C3A Community collaboration developed A1A, A1A1, A1A2, D2
Experience and Skill Development New York: Experience for social workers helps to improve BH care; quality of training matters to be able to best provide care Connecticut: Would take advantage of any training offered for improved behavioral health care	-Professional Role Revision	**Hospital Culture**- Supportive climate and involvement of leadership -Training	Hospital funding out of pocket non-reimbursed Professional development
Safety and De-escalation Training Arkansas: Mental health agency contract provides for de-escalation training in CMHC Georgia: Safety training is a priority; safety and de-escalation training mandated in hospital; safety meetings everyday California: De-escalation policy for all staff	-Formal Integration	**Community Mental Health Center** **Hospital Culture**- Supportive climate and involvement of leadership -Training	Community Mental Health Center funding C3A, D2 Hospital funding out of pocket non-reimbursed
Communication for Improved Patient Connections Arkansas: There is a lot of communication between ED and CMHC California: Phone calls between ED and CMHC helpful, between police and CMHC Oregon-CMHC funded with broad range of specialties including care coordinator to improve connections	-Formal Integration -Establishment of Continuity of Care	**Community Mental Health Center** **Community Connection**	Hospital funding out of pocket non-reimbursed B1 Community Mental Health Center funding C3A, D2

Processes Supporting ED Staff Belief of Control of Outcomes as Identified by ED Staff (Identified in figure 5)	Organizational interventions (Identified in figure 6)	Resources Needed (Identified in figure 7)	Policies that Support Processes (See policies section below. Each letter code refers to a policy section
	-Establishment of multi-disciplinary Teams		Peer and community support funding B6, C3A
	-Professional Role Revision		Community collaboration developed A1A1, A1A2, C3A, D2 Improved Connections A1A, A1A2, D2
Communication for Electronic Information Shared		**Shared Data System**	Data system funding G
Georgia: EPIC data system provides shared information; GCAL Georgia crises and access line and data	-Formal Integration	**Community Connection**	Hospital funding out of pocket non-reimbursed G
Texas: With a large hospital more information is available about a patient's history if they had been treated within the hospital system			State and federal funding G
Oregon: Access to information through Community Crises line shared agreement and "Pre-Manage"			
California: Reliance town-wide shared database			
Hold Mandates		**Mandate for Treatment Available**	State mandate and laws and policies H
New York: Mandate with therapeutic community available	-Formal Integration		
Texas: 24 hour holds allowed by State law			
Oregon: 24 hour holds allowed by State law			
California: 24 hour holds allowed by State law			

In addition to funding policies, provision of care and licensing policies provide for the processes identified by ED staff as most supportive of their care for individuals who enter

an ED with a behavioral health condition. These processes as were shown in Figure 5 include:

1. Screening and initial assessment
2. Conducting triage and providing urgent care
3. Providing SUD or MH follow-up
4. Utilizing a separate area in the ED for individuals with a behavioral health condition
5. Having access to teams for intervention and follow-up
6. Access to a MH team or professional to conduct triage and assessment in the ED
7. Access to a MH team or professional to conduct triage and assessment via telehealth
8. Access to a behavioral health facility for follow-up care
9. Clear roles defined between ED and community resources
10. Having experience and skill development
11. Having safety and de-escalation training
12. Communication for improved patient connections
13. Access to patient history through a shared database
14. Hold mandates for observation and care

To identify the governmental policies and funding avenues that provide for these processes, an online data search was conducted and supported by validation of experts from various organizations and representing several states. Major categories of funding include Medicaid/Medicare payments as well as a variety of CMS funded projects to

states, federal block grants administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), programs, and supplements, payments for hospital staff by the hospital to achieve overall cost savings. Each section is coded to identify where it supports policies in Table 2.

Social Security Act A

Medicaid Creation A.1

Medicaid established in the 1960s Medicaid is a program that is jointly funded by CMS and the federal government and each individual State. This program established in the late 60s requires coverage for specific populations but also gives states flexibility to include others in eligibility and minimum standards of application. Medicaid is a government health insurance program that is administered by states and is jointly funded by states and the federal government. States are allowed the flexibility to choose how to provide payments under Medicaid within a framework established by federal statutes, regulations, and guidance. States determine specific benefit packages and provider reimbursement within limits established by CMS (Lane et al., 2020). Texas Medicaid funds for example provide for behavioral health services that include mental health case management, psychotherapy, inpatient psychiatric hospitalization, SUD treatment assessment, Medication Assisted Treatment, hospital-Based withdrawal management, residential withdrawal management, outpatient withdrawal management, and outpatient and residential SUD treatment (Texas Health and Human Services, 2019).

Section 1115 Wavier A.1A

Medicaid guidelines require some uniformity across states and authorize experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for permission to implement and test new approaches to administering Medicaid programs that are consistent with the overall goals of the program but are different from existing federal rules. Some states, such as Texas, have used section 1115 waiver authority to implement the delivery system reform incentive payment (DSRIP) programs. The overarching goals of the DSRIP projects are to improve the delivery system for "safety net" hospitals and other Medicaid providers through infrastructure development such as redesign of hospital spaces in ED and facilities to provide separate behavioral health screening, triage, and urgent care. Other areas of focus include service innovation and redesign of care such as coordination between Hospitals, including EDs and community or behavioral health resources, and improved payments to providers for behavioral health services. To improve overall health outcomes and lower costs many states sought to integrate physical and behavioral health services under the 1115 wavier that allowed for improved screening, triage, urgent care, and follow-up behavioral health care for individuals who visited the ED with a behavioral health condition. (Lane et al., 2020). Implementation of the Patient Protection and Affordable Care Act (Affordable Care Act, Pub.L. 111-148) of 2010 that provided states an option to expand Medicaid payments for low-income adults added some coverage that could be utilized in the PBHI programs. The Affordable Care Act, also required coverage for new beneficiaries under an Alternative Benefit Plan that included coverage for mental

health and substance use disorder services; however this legislation and related provisions have been subject to change (Lane et al., 2020).

States have also used Section 1115 demonstrations to promote Physical and Behavioral Health Integration (PBHI) by implementing delivery system reforms. States can use the additional flexibility to target specific benefits, develop managed care plans, improve delivery systems, or provide services not otherwise be available (Lane et al., 2020). A significant portion of the 1115 demonstration projects are hospital-led as the hospitals tend to have access to more resources needed to integrate behavioral health. As an example, California's PRIME primarily focuses on delivery system reform among hospitals.

Texas, another example, focused on utilizing 1115 wavier funding to support access to behavioral health services through increased access to behavioral health professionals, nursing services, physician services, and case management in support of behavioral health and SUD benefits. By increasing reimbursement rates for behavioral health contractors, the approach was designed to create better stability and sustainability of resources (Texas Health and Human Services, 2019a).

CMS has awarded funds, beginning in 2017, under a provision of the 1115 waiver section, to states that would provide reimbursements for psychiatric facilities that had not been eligible for reimbursement for individuals between 22 and 64. As part of this initiative, states were given the option to develop innovative approaches to coordinate with community-based care for improved access to inpatient and residential care for individuals with SUDs. A part of these reimbursements, residential facilities were

required to ensure that beneficiaries access Medicated Assisted Treatment (MAT) on-site or by facilitating beneficiaries' access to MAT off-site (CMCS Informational Bulletin, December 30, 2020). These facilities termed, Institutions for Mental Disease (IMDs), are facilities that provide residential inpatient psychiatric beds and have over 16 beds and over half of the patients provided for in that facility have a severe mental illness (Heisler & Tyler, 2014). As defined in section 1905(i) of the Social Security Act, and IMD is "primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services" (CMCS Informational Bulletin, December 30, 2020). Medicaid payments are typically excluded for those facilities. However, the Texas exception, for example, allowed for payments increasing access to follow-up care planning for emergency departments through expanded treatment options and expanded discharge options in the ED (Heisler & Tyler, 2014). Medicaid then covered the provision of MAT, counseling, and behavioral therapies provided in an IMD under this demonstration (CMCS Informational Bulletin, December 30, 2020)

Managed Care A.1.A1

The California application of Medicaid, called MediCal includes a subcategory of Managed Care Organizations (MCOs). MCO is a Medicaid reimbursement mechanism used in some states like California for individuals with more acute care conditions or higher needs. Managed care programs implemented by states under their Medicaid/Medicare payment authorization are aimed to create a unified benefit package for beneficiaries. (Lane et al., 2020). For example, many who meet designated criteria

(over 60% of MediCal covered individuals) are mandated to participate in this coverage in California. Approximately 60 percent of those covered by Medicaid (known as Medi-Cal in California) were enrolled in managed care organizations (MCOs) (Centers for Medicare and Medicaid Services, 2014).

However, Medicaid Managed Care in California does not typically include coverage for some of the most costly services (termed carved out) for managed care plans, excluding payments for mental health and institutional long-term care such as inpatient mental health or rehabilitation facilities. However, reimbursements are made for individuals with severe mental illness registered in Medi-Cal for behavioral health services, including crisis intervention, outpatient mental health treatment, case management, inpatient hospital mental health treatment, crisis intervention, and case management. However, if a Medi-Cal participant has been diagnosed with mild to moderate mental illness, reimbursement for services are more limited with coverage extended to only primary care providers (Centers for Medicare and Medicaid Services, 2014).

Arizona and New York, for example, have fully integrated managed care plans for individuals with complex behavioral health conditions. In New York, managed care programs provide care management of physical and behavioral health services, including beneficiaries with SMI or SUD conditions. (Lane et al., 2020).

For those registered in Medicaid plans (4 out of 28 million), Medicaid funds many behavioral health services in Texas. Medicaid reimbursements are made through Medicaid in Texas for assessment, triage, urgent care, and follow-up care for those who

enter an ED. These services include mental health targeted case management, mental health rehabilitation, psychotherapy, psychological and neuropsychological testing, psychiatric diagnostic evaluation, inpatient psychiatric hospitalization, psychotropic medications, SUD treatment assessment, (Medicated Assisted Treatment (MAT), hospital-based withdrawal management, outpatient withdrawal management, outpatient and residential SUD treatment, and screening, brief intervention, and referral (SBIRT). (Texas Health and Human Services, 2019a)

With over three-quarters of New York's Medicaid beneficiaries enrolled in a managed care program (2011), the statewide Medicaid Managed Care program covers acute, primary, specialty, limited long term care, and limited behavioral health through managed care organizations (MCO) for the majority of the New York Medicaid beneficiaries. The 2006 1115 waiver extension expanded mandatory enrollment in the MCOs for some high-need populations (Centers for Medicare and Medicaid Services, 2012).

DSRIP A.1.A.2

The Centers for Medicare & Medicaid Services (CMS) originally approved Delivery System Reform Incentive Payments Programs (DSRIP) for many states in the country beginning in 2011. DSRIP was provided under the CMS umbrella of the Healthcare Transformation and Quality Improvement Program 1115 Waivers, also known as the 1115 Transformation Waiver. (Texas Health and Human Services, 2019a). DSRIP payments provide for CMHC, SUD, and community-based behavioral health treatment services. In Texas, this funding totaled almost $11.5 billion over five years, providing

expanded Medicaid managed care payments. As part of the 1115 Transformation Waiver for Texas through the DSRIP funding pool, incentive payments were made to providers to make health care innovations and quality improvements. Extensions for DSRIP funding for Texas and other states in the country have been granted through 2021 and 2022. DSRIP funding in Texas and other states have been a significant catalyst for behavioral health projects to reinforce and improve the state behavioral health system. DSRIP payments providers for mental health and substance use disorder services for Texas are estimated to be over $900 million for two years. (Texas Health and Human Services, 2019a).

In California, care coordination is facilitated through their version of a care management program called CA PRIME Complex Care Management for High-Risk Medical Populations. The goals of that California approach are to improve the complex care management model in the State for targeted high-risk patient populations. Through improved coordination of the delivery of health care services, patient needs can be better met. Participating hospitals partnering with community housing can develop transitional housing for high-risk patients (Lane et al., 2020).

The Delivery System Reform Incentive Payment initiative (DSRIP) in New York provides reimbursement of a psychiatric assessment officer (PAO)integrated telepsychiatry program for three rural community hospital EDs. This program provides for psychiatric and behavioral health evaluations, brief crisis interventions, coordination of care, and direct psychiatric consultation for assessment and crises intervention. Staff reimbursement is provided for licensed behavioral health social workers, mental health

counselors, and psychiatric nurses to provide this service and care and are staffed during peak periods (Ross et al., 2021).

Funding or Mandate for Crises and Inpatient Mental Health and SUD Treatment B

Care that is not compensated by insurance payments B.1

It is estimated that over 40% of those who visit an ED are either uninsured or covered by Medicaid insurance. Through Medicaid and Medicare funding, the federal government is the largest payer for overall health care. Therefore, care for these individuals is not reimbursed for the uninsured or with compensation that is frequently less than that of private insurers for those covered by Medicaid and Medicare programs (Heisler & Tyler, 2014). When individuals who enter an ED with a behavioral health condition do not have private or government insurance for hospital reimbursement, the hospital pays from their funds or may be able to utilize government payments intended to compensate them for the unreimbursed care (Heisler & Tyler, 2014). The costs associated with hospitals providing unreimbursed, or partially reimbursed care have been defrayed by Medicare and Medicaid Under Medicare and Medicaid disproportionate share hospital (DSH) payments. DSH payments are made to hospitals that treat large numbers of low-income patients (Heisler & Tyler, 2014).

Social work in the emergency department (ED) uses a patient-centered approach to care that is commonly referred to as care coordination or case management that supports individuals' connections with community resources (American College of Emergency Physicians, n.d.).

Job functions of a social worker in the ED can include initial screening, a comprehensive psychosocial assessment, employing crisis intervention, potential mental illness identification, making referrals, promoting communication and collaboration among staff and for patients, and coordinating patient discharge and continuity of care planning (Ross et al., 2021). Social workers typically provide these services, but other clinicians and registered nurses can also successfully support ED case management. Peer counselors are also sometimes active in EDs as part of a successful case management team to promote ongoing patient engagement. In some cases, peer counselors are reimbursed through government or private insurance, or possibly through grants, and paid for by hospital resources. Case management in an ED, whether or not reimbursed, serve as a financial incentive in many instances to improve care and reduce overall costs (American College of Emergency Physicians, n.d.). Benefits from preventive social services has been shown to shift back to the hospital because less hospital utilization for unreimbursed care translates into less uncompensated care for the hospital (Gordon, 2001).

Although not usually fully funded by reimbursements, social workers have been demonstrated to provide improved support in the ED at a reduced overall cost. In the absence of social workers in the ED, it has been found, for example, that other medical staff would not have intervened in 25% of the cases for those needing services, and spent half of the time with physicians involved 25% of the cases and nurses involved in the remaining 75%. One study in Texas, for example, found that dedicated 24-hour social work staffing shows an immediate cost saving in large urban hospitals, is a break-even cost in medium hospitals, and is more costly in smaller hospitals. However, 24-hour

social workers on staff were found to be an overall economic benefit in any case when considering the savings of time realized by primary clinical staff such as physicians, nurses, and technicians to focus on patient care tasks and prioritize resources for emergencies. (American College of Emergency Physicians, n.d; Texas Health and Human Services, 2019a).

EMTLA – Screening, Provide Urgent Care, and Safe Discharge B.2

The Consolidated Omnibus Reconciliation Act (COBRA), passed by the United States Congress in 1985, encompasses mandates on emergency medical treatment as well as private pension plans, disability insurance, and group health plans (Ladd & Gupta, 2021). Under COBRA, the Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted in 1986 imposes requirements on any Medicare-participating hospital along with monetary sanctions against physicians or hospitals that do not comply. EMTALA requires these hospitals to conduct medical-screening examinations, provide needed stabilizing treatment to any patient seeking emergency medical care in an emergency department, and if not able to stabilize to transfer patients to facilities where they can be served (Kahntroff & Watson, 2009).

The screening (MSE) conducted under EMTALA requirement is that the screening must be conducted within the hospital's emergency department (Healthcare America, 2017). However, the type and depth of the screening provided are subject to interpretation. Screenings that show to be more successful for the care of individuals with a behavioral health condition may not be used and are not specifically required under this mandate. EMTALA provides clarification for who may conduct the screening where

specific licensure and credential requirements are more left to the States to define. In California, for example, screening may be conducted in the ED by a qualified physician, qualified licensed independent practitioners, or a qualified staff member operating within the scope of their license. These may include appropriately credentialed registered nurses and physician assistants (Healthcare America, 2017).

Mental Health Parity Act B.3

One of the laws enacted by Congress enacted designed to improve access to mental health and substance is the Mental Health Parity and Addiction Equity Act (MHPAEA) (State of New York Codes and Regulations, n.d.). This law (MHPAEA, Pub.L. 110-343) of 2008 required that "coverage for mental health and SUD services be no more restrictive than coverage available for medical or surgical conditions." By imposing equitable payments, this law is intended to prevent MCOs that provide behavioral health benefits from providing a less favorable benefit limitation for behavioral health care than those benefits on medical and surgical benefits. State governments, such as Texas, work with federal partners to monitor and improve parity for Medicaid payments and private insurances in support of behavioral health urgent care and inpatient and outpatient mental health and SUD services (Lane et al., 2020). The MHPA impacts the millions of Medicaid beneficiaries who participate in Managed Care Organizations and state alternative benefit plans (State of New York Codes and Regulations, n.d.).

Payment for Crises or Inpatient Psychiatric Facilities B.4

Although Medicaid payments have an IMD reimbursement exclusion for most populations, there are also several exceptions and other payments for short-term stays in IMDs. Medicaid payment is permitted for individuals aged 65 or older or under 21 for inpatient hospital services, nursing facility services, and intermediate care facility services. The hospital inpatient services may be furnished by a psychiatric hospital or a general hospital with a psychiatric program or maybe an accredited psychiatric facility, referred to a psychiatric residential treatment facility that meets certain requirements (CMCS Informational Bulletin, December 30, 2020).

When in an opioid treatment facility (OTP), federal regulation also requires that patients who receive treatment in an OTP also receive access to medical care, counseling, and other assessment and treatment services, in addition to prescribed medication (MAT). These individuals are covered for inpatient care; therefore, also are covered for needed medications for MAT, as well as the counseling and behavioral therapies. MAT and counseling and behavioral therapies can be furnished in inpatient and residential settings such as inpatient units in hospitals, psychiatric hospitals, or residential treatment programs, including in IMDs if an exception to IMD applies (CMCS Informational Bulletin, December 30, 2020).

Comprehensive Addiction and Recovery Act (CARA) B.5

Signed into law in 2016, CARA addresses the opioid epidemic through coordination of prevention, treatment, recovery, and overdose reversal. The Act endorsing medication-assisted treatment (MAT) for OUD amended the Controlled

Substances Act to raise the total number of patients a prescriber can have to dispense buprenorphine for up to 100 patients per year. In addition to expanding access to MAT, the Comprehensive Addiction and Recovery Act of 2016 (CARA) allowed nurse practitioners and physician assistants to qualify for a waiver providing increased access to MAT prescribers (CMS Informational Bulletin, December 30, 2020).

Support act B.6 - Increase Access to MAT, Requires State Medicaid Coverage *of Drugs for SUD*

The SUPPORT Act, signed into law on October 24, 2018, amended section 1902(a)(10)(A) of the Social Security Act to require state Medicaid plans to include coverage of MAT. Section 2601 of the Continuing Appropriations Act, 2021 and other Extensions Act, Pub. L. No. 116-159 further amended the SUPPORT Act to include rebate requirements that apply to any approved MAT drug (CMS Informational Bulletin, December 30, 2020). The Support Act provides greater flexibility in the provision of medication assisted treatment (MAT) and also extends prescribing privileges for buprenorphine to qualifying other practitioners "(Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetist (CRNAs), and Certified Nurse-Midwifes (CNMs)" until October 1, 2023. It also provides access to case-management services for patients that includes referral and follow-up services for programs (Substance Abuse and Mental Health Services Administration, 2018).

This Act added a requirement for state Medicaid plans to include MAT coverage for all eligible to enroll in the state plan or waiver of state plan (EMTALA California,

2017). Also, effective January 1, 2020, the Medicare program began covering and reimbursing OUD treatment services furnished by an Opioid treatment program (OTP) (CMS Informational Bulletin, December 30, 2020). Treatment services may include individual or group therapy, peer support services or recovery coach support, crisis intervention services such as evaluation, triage, and access to services and safe transition of individuals in acute crisis (CMS Informational Bulletin, December 30, 2020)

In a recent report on SAMHSA found that methadone is covered for MAT to treat OUD in 42 of the 53 states and territories (CMCS Informational Bulletin, December 30, 2020).

Controlled Substances Act (CSA) and Drug Addiction Treatment Act of 2018 Amendment B.7

The Controlled Substances Act (CSA) was amended by section 3502 of the Drug Addiction Treatment Act to permit physicians to receive a waiver of a CSA requirement for separate registration for prescribing and dispensing opioid medications to treat OUD (MAT). This legislation expanded access to OUD treatment by expanding the types of practitioners who are eligible to prescribe and dispense buprenorphine to treat OUD (CMS Informational Bulletin, December 30, 2020).

SAMSHA C

The federal government, through SAMSHA, supports efforts to increase access to behavioral health care that might reduce ED use. SAMHSA support includes grants to states and territories to support community-based mental health and substance abuse treatment and prevention services (Heisler & Tyler, 2014). Grants supporting behavioral

health include the State Targeted Response (STR) grant includes the State Opioid Response (SOR) grant, which also includes the (a) Targeted Opioid Response (TOR) grant, (b) Primary and Behavioral Health Care Integration (PBHCI) grant, (c) Emergency Grants to Address Mental and Substance Use Disorders During the COVID epidemic, and (d) grants under the 2021 American Rescue Plan Act; Consolidated Appropriations Act; and the Coronavirus Response and Relief Supplement Appropriations Act that may be expended through 2025.

STR Grant C.2

SAMHSA State Targeted Response (STR) provides funding for the State Opioid Response funding extension (Texas Health and Human Services, 2019a).

SOR Grant C.2.A

The State Opioid Response (SOR) grants aim to 1) increase access to MAT using FDA-approved medications for the treatment of opioid use disorders (MAT), 2) reduce unmet treatment needs, and 3) reduce opioid overdose-related deaths through prevention, treatment, and recovery efforts for opioid use disorder (OUD) (Substance Abuse and Mental Health Services Administration, 2020).

The Texas Department of Health and Human Services spends over $170M per year on SUD prevention, intervention, and treatment. Of those expenditures, over 75% is federal block grant funding administered by SAMHSA. Of the $1.5 billion that the State of Texas expends for mental health services in adults, over 83 percent is State funding. Just over 6 percent of the funds are from SAMHSA block grant funding, and just over 10% is from other federal funding. (Texas Health and Human Services, 2019). The grant period

is two years with an annual continuation that allows Texas to continue funding existing strategies established through TTOR and expand services (Texas Health and Human Services, 2019a).

TTOR Grant C.2.A.1

The SAMHSA Targeted Opioid Response (TOR) grant is used to increase access to MAT and improve SUD treatment access with strategies that span the behavioral health continuum of care, including funding 1) prevention activities, 2) treatment and recovery services, as well as 3) integrated projects (Texas Health and Human Services, 2020). The purpose of this grant was to increase access to medicated assisted treatment and reduce unmet treatment needs. Texas received over $27 Million for 2017 through 2019 in federal funding under the Texas Targeted Opioid Response (TTOR) grant. (Texas Health and Human Services, 2019). Funding under this grant in Texas allowed for increases in access to MAT in a variety of settings. Increasing the number of physicians approved to prescribe, creating a peer mentoring network, and expanding the network of state-funded treatment providers have enabled Texas to increase access to MAT throughout the State.

TTOR funded peer support expanded peer recovery support services throughout the State in various settings, including hospital EDs and provided opportunities for enhanced training in medication assisted recovery (MAT). Peer recovery support serves people at high risk for overdose with access to treatment induction, recovery support, community medical support, and overdose prevention services. Through this grant, individuals with a behavioral health condition also have improved access to Mobile Crisis

Outreach Teams and 24/7 and sobering centers (Texas Health and Human Services, 2020).

Emergency Grants to Address Mental and Substance Use Disorders During COVID epidemic C.3

This grant aims to support the approximate 57.8 million Americans (according to the 2018 National Survey on Drug Use and Health) living with mental and substance use disorders and the expected growth in those numbers with COVID epidemic challenges. With increased depression, anxiety, trauma, and grief, there is an expected rise in mental health needs and substance misuse. This grant allowed up to $2 million per State (and up to $500,000 per territory or tribe) to develop comprehensive systems to provide mental and substance use disorder treatment and crisis intervention services, as well as other related recovery supports (Substance Abuse and Mental Health Services Administration, 2020a).

Community Behavioral Health Clinic (CCBHC) and Community Mental Health Center (CMHC) grants C.3.A

Community Mental Health Center (CMHC) availability can reduce use of EDs (Heisler & Tyler, 2014). For example, an AHRQ-SAMSHA study found that counties with community mental health centers and inpatient psychiatric and SUD treatment facilities had fewer ED visits for mental health conditions (Heisler & Tyler, 2014). FY 2020 Certified Community Behavioral Health Clinics Expansion Grants (CCBHC-COVID), American Rescue Plan Act of 2021, Consolidated Appropriations Act 2021, and the Coronavirus Response and Relief Supplement Appropriations Act 2021 provided

support for CCBHCs and CMHCs through SAMHSA grant funding to increase access to and improve the quality of community mental and substance use disorder treatment services through the expansion of CCBHCs and CMHCs.

The FY202 CCBHC-COVID grant and subsequent grants have totaled over $1.27 billion in stimulus funding for CCBHCs. Included are $420 million in funding under the American Rescue Plan for expansion of CCBHCs, and at least $600 million for Certified Community Behavioral Health Clinics as part of the Consolidated Appropriations Act of 2021. Additionally, $250 million in funding was provided through the CARES Act to provide funding for 166 clinics. The goal of these grants were primarily to increase access to mental health and improve the quality of community mental health and substance use disorder treatment services (Office of Inspector General, 2021).

Certified Community Behavioral Health Clinics (CCBHCs) or Community Mental Health Centers (CMHC) provide 24/7 access to community-based mental health and substance use disorder services and treatment of co-occurring disorders, in addition to some types of physical health care in a single location (Office of Inspector General, 2021). The Certified Community Behavioral Health Clinics (CCBHC) expansion grant program, in addition to increasing access to community behavioral health centers, also is intended to improve the quality of community mental and substance use disorder treatment services. These funds are part of the $420 million explicitly appropriated for CCBHC expansion grants in the American Rescue Plan. It is expected that new services will be available through the development of new facilities and more robust service delivery in existing facilities. The more robust services include an increased ability to

provide coordinated and centralized, and more expansive care. These clinics usually coordinate and organize care activities among different services and providers and across various facilities, which is key to accessing improved treatment services throughout the community (US Department of Health and Human Services, 2021).

As part of $4.25 billion in funding from the Consolidated Appropriations Act, 2021 and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [PL 116-260]. In 2021 SAMHSA awarded almost $3 million in Certified Community Behavioral Health Clinics Expansion Grants (CCBHC Expansion Grants) and provided funding to strengthen Community Treatment Service (CTS) centers and provide support for the National Suicide Prevention Lifeline grant. In September 2021, SAMHSA announced a follow-on award of $825 Million to strengthen CMHCs with a distribution of funds to 231 CMHCs across the country. Some of the intended funds include:

1. Improve Telehealth capabilities
2. Increase outpatient services for individuals with a mental health or substance use disorder condition
3. Enhance clinical and recovery support services such as psychosocial rehabilitation, case management, and peer support
4. Provide training for staff to build competence in engaging in care for individuals with a behavioral health condition
5. Expand capacity and availability of crisis beds
6. Expand mobile crisis mental health services
7. Develop outreach strategies

8. Develop partnerships with housing authorities, Continuum of Care, hospital systems, peer-based recovery organizations, and substance use specific treatment providers, all of whom have a critical role in the crisis continuum
9. Develop a comprehensive 24/7 crisis continuum including screening and "assessment; mobile crisis response and stabilization; residential crisis services; psychiatric consultation; referrals and warm hand-offs to home- and community-based services; and ongoing care coordination."
10. Increase outpatient access that includes same-day or next-day appointments
11. Expand Assisted Outpatient Treatment (AOT) services
12. Expand and improve outpatient, intensive Crisis Stabilization Teams (Substance Abuse and Mental Health Services Administration, 2021a).

As a requirement under this program, CCBHCs must provide access to services, including 24/7 crisis intervention services for individuals with substance use disorders or serious mental illness. Through CCBHC services, access is created to stabilize people in crisis and provide the needed treatment and recovery support services. An integrated and comprehensive approach is provided through the engagement of these centers in the provision of services. Beginning in 2016 states were funded to develop CCBHCs through initial planning grants. Since 2016 expansion grants have been provided across the country.

Other Community Mental Health Center Funding D.2

States frequently include some level of funding for CMHCs in their state budget, such as in Texas, where the HB 13 Community mental health grant program was put in place to support community mental health programs. This program that established matching grants for the State serves to provide access to appropriate behavioral health services and access to timely treatment services (Texas Health and Human Services, 2019a). This program was designed to foster community collaboration, maximize existing community mental health resources, and strengthen continuity of care through improved network collaboration. for individuals receiving services through a diverse local provider network. The goal of this program that is financed with both state general revenue and local funding for grant recipients, is to support community programs providing mental health care services and treatment and improve coordination of MH services (Texas Health and Human Services, 2019a).

Behavioral Health Continuum Infrastructure Program (BHCIP) E

The Behavioral Health Continuum Infrastructure Program (BHHCIP) provides for expansion of infrastructure for behavioral health collaboration in California through competitive grants to entities in the State. This funding is provided to support the construction and acquisition of real estate assets and for investment in the expansion of the mobile crisis infrastructure in Texas. This State-funded grant serves to expand the community continuum of behavioral health treatment resources (Centers for Medicare and Medicaid Services, 2014). It also proposes to invest in the expansion of beds, units, or rooms by building new behavioral health continuum infrastructure and expanding

capacity. Expanded resources in the grant program in California serve to improve the continuum of services by "increasing capacity for short-term crisis stabilization, acute care, residential crisis care, community-based mental health residential treatment, substance use disorder residential treatment, peer respite, mobile crisis, community and outpatient behavioral health services, and other clinically enriched longer-term treatment and rehabilitation opportunities for persons with behavioral health disorders in the least restrictive and least costly setting" (Centers for Medicare and Medicaid Services, 2014). Similar types of funding with similar goals are in place in other states that are provided through state funds. Through state grant programs such as BHCIP, unnecessary hospitalizations can be reduced and improve outcomes for people with behavioral health conditions by expanding access to community-based treatment (Centers for Medicare and Medicaid Services, 2014).

Intensive Case Management F

In California, the Investment in Mental Health Wellness Act of 2013 originally provided grant funds to improve access to and capacity for mental health crisis services. Under this Act, funds are provided to California counties to increase capacity for 1) crisis intervention, 2) stabilization, 3) treatment, 4) rehabilitative mental health services, and 5) mobile crisis support teams. These services are designed to improve access to outpatient and crisis services and support reduced costs associated with expensive inpatient and emergency room care, and better meet the needs of individuals experiencing a mental health crisis. Through a currently funded program, the "Crisis Triage Connect Team" facilitates an individual's movement through the crisis continuum, assisting with

coordination of hospitalization placement as needed to include discharge planning, monitoring, and follow-up case management. Communication between psychiatric hospitals and EDs and transportation to and from psychiatric hospitals is included. The Connect Team follow-up services for every client are established upon discharge from a psychiatric hospital and include case management for up to 60 days.

In addition to the Connect Team grant, another California State grant, the 2018 Triage Grant, provides an opportunity to expand Mobile Crisis Team (MCT)s. The grant award of $514,743 over three years allows for a Mobile Crisis team to work with the Butte County Sheriff's Office to provide rapid response to crisis situations in the community through on-call access to mental health professionals. These professionals provide an on-call assessment of an individual's level of need in the community and coordinate placement as necessary and are included in the mobile crises team caseload for 30 days. Peer specialists who are individuals with lived experience with mental illness are part of this team and are able to provide support to the community member through emotional support a sharing of knowledge, teaching skills, providing practical assistance, and connecting people with resources (Butte County of California, n.d.).

Access to Patient History G

California, among many other States has adopted an Epic vendor electronic health record (EHR) approach to access patient history and care information. With more than 250 million patients included, EHR access improves care through more timely and historical information to improve care (Jason, 2019). An example of a federal grant was a SAMHSA award in 2016 to Community Mental Health Center, Inc. to improve their

ability to provide substance use services by enhancing the EHR infrastructure (Substance Abuse and Mental Health Services Administration, 2016). In addition to some historical funding for EHR development through federal grants, development is also financially supported through private grants such as the case for a Georgia health care system Good News Clinics (GNC) adoption of and EHR system that was provided the full cost of $100,000 through the R. Howard Dobbs, Jr. Foundation through The Medical Center Foundation (TMCF). Adoption of these systems serves to unite many services and locations on one system.

Included in the SAMHSA mental health block grant are allowances to fund improved information technology infrastructure that includes the availability of broadband and cellular technology for providers and the adoption and use of health information technology, such as electronic health records. Information technology grants are provided to improve access to and coordination of behavioral health services and care delivery through the development of digital platforms, such as Network of Care, which facilitate access to behavioral health services for persons with SMI-SED (Substance Abuse and Mental Health Services Administration, 2021a).

The Substance Abuse and Mental Health Services Administration (SAMHSA) has included a focus on promoting the development of technologies and standards that enable the exchange of behavioral health data while at the same time supporting privacy, security, and confidentiality. By promoting the adoption of electronic health records (EHRs) with behavioral health information capability for health care providers, SAMHSA is supporting improved treatment and recovery for behavioral health

conditions. Through a Service Continuity Pilot (SCP), individuals will be able to share a subset of their medical information with other OTP providers while maintaining the confidentiality of their sensitive health data

Substance Abuse and Mental Health Services Administration (n.d.a).

Mandatory Holds H

An emergency hold (also called a 72-hour hold or an involuntary hold) is brief involuntary detention in a hospital or secure facility of a person presumed to have a mental illness to determine the safety and whether the individual meets criteria (Hedman et al., 2016). Permitted by state psychiatric emergency hold laws, this involuntary admission to a health care facility of a person with an acute mental illness is used to observe and, in some cases, decide if a longer stay involuntary hold is needed in a psychiatric facility for the protection and safety of the patient. Every State and the District of Columbia have emergency hold laws; however state law varies with the allowed duration and who can initiate the hold. The extent of the judicial oversight and rights of the patient also vary. All but five states guarantee assessment by a qualified mental health professional (Hedman et al., 2016).

Telehealth I

Advance telehealth opportunities to expand crisis services for hard-to-reach locations, especially rural and frontier areas. Expand technology options for callers, including the use of texting, telephone, and telehealth (Substance Abuse and Mental Health Services Administration, 2021a). In 2018 nursing licensure changes increased the ability of Nurses to practice across state lines through telehealth through a cooperative

agreement that includes 29 states (Pauli et al., 2018). This was one step that improved access to care through telehealth. Significant changes, however took place following the COVID epidemic. Mental health providers in many states responded to the COVID emergency by rapidly transitioning to telehealth with the support that provided relief from preexisting regulatory and legislative barriers established before the COVID epidemic (Tse et al., 2021). Allowance and reimbursements for telehealth supportive of MH and SUD assessment and provision of MAT for urgent care have been significantly expanded since the beginning of the COVID epidemic (Nilsen & Levkovich, 2020). The Centers for Medicare & Medicaid Services (CMS) expanded the allowance for telehealth by allowing health care providers to offer telehealth services to patients in their homes and beyond previously designated rural areas (Nilsen & Levkovich, 2020). However, practicing across state lines is still subject to requirements set by individual states.

During the COVID Public Health Emergency, physicians could use telehealth for both new and established patients. Further, both audio and video are required; rather, visits could be conducted over the telephone (Nilsen & Levkovich, 2020). The Drug Enforcement Administration (DEA) also made changes related to prescribing controlled substances allowing a practitioner to prescribe using telemedicine. This provision allowed for qualifying practitioners to prescribe buprenorphine to new and existing patients with opioid use disorder based on a telephone evaluation. Cost-sharing obligations were also reduced or waived (Nilsen & Levkovich, 2020). Telehealth Medicaid reimbursements and parity for behavioral health telemedicine have been

implemented as part of a COVID response. Forty-nine state Medicaid programs now reimburse for some form of live video.

Behavioral health parity, or equal payments, has been implemented in Texas, California, Arkansas, and New York due to COVID. In Georgia, telehealth parity laws were in place prior to the COVID epidemic and in Oregon. Telehealth was expanded via COVID emergency response, but parity was not required (Arkansas Department of Human Services, 2021; Whaibeh et al., 2020).

Non-Conforming Data

Responses from participants were in many cases centered on what the individual being interviewed did to support behavioral health care and how the institution allowed for that intervention, or what outside of organizational interventions helped the participants to support BH. This is somewhat of a diversion from the original expectation that responses would reveal only what the institutions did to support behavioral health care and how it was possible for them. This led to additional categories such as flexibility in staff roles that allowed the individuals to better provide care rather than what institutions did to help in the provision of better care.

Summary

By answering the overarching research question through the three sub-questions, this study has provided a general understanding of the phenomenon of how policy supports staff in provision of BH care in EDs in the United States. Interpretations have been based on eight participants,, supporting documents from online searches, and expert accounts. In answer to the first sub-question, we see the positive attitudes and beliefs of

ED staff. In answer to the second sub-question, we are shown how processes support the provision of behavioral health care for staff in the ED. By answering the third sub-question through online data searches and expert accounts, we can understand how policies support those processes. With this information collected and analyzed, the data has shown how policies enable the processes that support behavioral health care in an ED. Multiple data collection and analysis methods are adopted to develop and understand the case, shaped by context and emergent data (Stake, 1994). This qualitative approach "explores a real-life, contemporary bounded system (a *case*) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving *multiple sources of information* … and reports a *case description* and *case themes*" (Creswell, 2013b, p. 97).

Theoretical generalizations may be made for how ED staff are supported in this phenomenon. Similarities may be identified in other EDs in the United States where this phenomenon is occurring and may be considered part of or related to the case that has been studied (Morrow, 2005). Data collected achieved the purpose of this study. Positive attitudes of participants were identified, responses confirmed that they were engaged in processes that supported BHCFUP, information about how they feel supported to provide BH care in the ED was revealed. An understanding was developed for what policies support those effective processes. The meaning and potential application of these findings are discussed in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Findings

The purpose of this critical instance case study was to discover and explore positive attitudes and beliefs of ED staff toward components that support BHCFUP to reduce return ED visits for those with a BH condition and how they are aligned with policy. By understanding through this study how processes and components are influencing ED staff engagement and how they align with policy, policymakers can incorporate those factors into funding policy to improve outcomes of reduced return ED visits for those with a behavioral health condition.

Data collected achieved this study's purpose. Participants' positive attitudes were identified, and understanding was developed for how those who work in an ED feel supported by processes to provide BH care. The resources needed for those processes to occur were captured, and an understanding was developed for how/what policies support those effective processes and needed resources. This study found that the resources enabling those supported processes included: (a) hospital culture, (b) crises facilities, (c) community mental health centers, (d) community connections, (e) residential psychiatric facilities, (f) outpatient therapy, (g) shared data systems, (h) mandates for treatment, (i) peer support, and (j) government and privately funded insurance. Data analysis in this study concluded that the provision of these resources requires funding in some form. Funding may be in the form of government or private insurance reimbursements, grants, allocation from hospital budgets, or savings realized for avoided future costs. Three critical areas of funding needed to support processes identified by those who work in an

ED are related to: (a) the provision of social workers in the ED, (b) staffing capacity to engage in screening and assessment, provision of telehealth, availability of acute care, and (c) availability of behavioral health professionals and outpatient and residential treatment.

Provision of Staffing and Urgent Care Capacity in the ED

Dedicated social workers and other staff in the ED were identified as significant toward improving care for individuals with a behavioral health condition by providing improved screening, assessments, and connections with urgent care and follow-up care. Their efficacy has been documented, but limited reimbursements inhibit the ability of the hospitals to expand social workers and other staff to perform related functions as an integral part of the ED. Policymakers may consider long-term savings that have been shown in studies through the engagement of social workers and other types of support staff in an ED by redirecting reimbursements and financial supports in this area.

The value of the availability of robust urgent care was also highlighted in the study findings. Facilities in EDs that provide urgent care, including detoxification facilities for substance use disorders, were cited by ED staff as helpful in improved care and have been shown to have a potential of reduced return ED visits. Federal grants have at times supported hospitals in developing facilities to provide this care. State regulations and federal and private insurance have also had a role in making this type of urgent care possible. However, gaps remain in reimbursements for hospitals to engage in substance use or mental health urgent care. With several studies demonstrating a likely benefit of

reduced long-term costs in providing this care in hospitals, policymakers may consider how this care can be supported in hospitals.

Availability of BH professionals and Outpatient and Residential Treatment

A key finding in this study was the significance of the availability of behavioral health support. Behavioral health professionals and outpatient and residential treatment availability were indicated by those who work in the ED to be a significant factor in their ability to connect individuals with a behavioral health condition to needed follow-on care. However, reimbursements and federal and state policies limit the availability of these resources. Policymakers can consider these limited resources' impact and balance the costs associated when these follow-up care options are not available.

The findings of this study also highlight the value placed by those who have worked in an ED and is supported by other studies that show increased access to BH professionals and outpatient treatment through telehealth improves access to care for individuals with a behavioral health condition. Access to telehealth is made possible through increased availability of mental health and substance treatment professionals, technology to support telehealth, and reimbursements provided. Changes made under COVID pressures expanded payment options and loosened regulatory policy; however, there are indications from CMS and some states that there will be a decrease in availability due to future tightening of restrictions or reduced reimbursements. Policymakers could use findings of this and other studies to consider the potential negative impact of reduced reimbursements and tightened legislation concerning telehealth.

Interpretation of the Findings

This study has confirmed processes that can support care for individuals who visit an ED with a behavioral health condition and also confirmed organizational interventions that enable those processes. This study has extended the knowledge beyond knowing what can work to understanding what is working given the current funding and policy environment. By exploring specific in-depth information from the point of view of those working in EDs, an understanding was gained of how effective processes are occurring and how current policies support those processes through document searches and expert accounts.

Through the theoretical framework of TRA/TRB that accounts for individual engagement in action, and by applying the contextual framework of the provision of care for individuals with a behavioral health condition who visit an ED, significant processes and associated policies were identified. Processes identified as supportive of those who work in an ED to provide care involved developing an understanding where ED staff believed they had control of outcomes associated with the attainment of BHCFUP and the attainment of reduced return ED use. Understanding this perceived volitional control involved learning if staff believed their participation in those components contributed to BHCFUP and reduced return ED visits. The perceived volitional control was based on the judgments about different components that support BHCFUP. The perceived value ED staff attach to the outcome of BHCFUP and reduced return ED visits as identified by the contextual framework. The theoretical and contextual frameworks provided an avenue to understand how policies support engagement in behavioral health care in an ED.

Limitations of the Study

Procedures were in place to establish trustworthiness as described in chapter 1 that included credibility, transferability, dependability, and confirmability. No limitations have been realized beyond dependability limitations. Creditability was established through validity and reliability checks and processes. Reliability was established through a document trail and analysis development. Internal and external validity was maintained through pretesting interview questions with nurses who had extensive ED experience and have been engaged in some components of BHCFUP and external validity by identifying mechanisms and influential contingencies for staff engagement in BHCFUP. The depth and detail necessary for capturing how staff engagement is influenced have been accomplished by investigating the phenomena and context of support for behavioral health care in an ED. Reliability has been established through adherence to procedures to maintain the document trail and analysis development. In addition to extensive notes, intracoder and intercoder reliability were enhanced by establishing a chain of evidence.

Transferability was developed through thick descriptions that gathered information about a wide range of features around the case through interviews, online searches, and expert accounts. In addition to accounts about the experience of conducting the interview, online searches provided a span of knowledge about state and federal funding, related regulations, and reimbursement structures, including information about payment and regulation structures, funding, regulatory hierarchy, public funding policies and reimbursement structures. The attitudes of the ED staff and the environment of the case, which is EDs in support of BH care, lay a foundation for transferability of these

theoretical perspectives across other EDs in the United States. By applying appropriate theoretical constructs, this study can address the limitation of the potential transferability of findings. By putting what participants express into the context of the surrounding social and cultural environment of the participant experiences, which is EDs in the US, better enable readers to make transferability judgments.

Because this study utilized a document review and a qualitative interview approach, not a survey approach which is a more common application of TRA/TPB theory, it raises a potential dependability limitation of this study application of an interview-only approach. However, based on the study constructs for this study, interviews were able to elucidate relevant themes in attitudes, normative beliefs, and control beliefs to help mitigate dependability limitations. Dependability was also established through triangulation and audit trails to strengthen measures; however, since hospitals were not engaged in recruitment, expert consultation did not include hospital administration for any of the hospitals where participants worked in the ED.

Triangulation has been described as one of the strengths of case studies in that the evidence is collected from multiple sources (Rowley, 2002). Triangulation was supported by including participants who have had experience in various hospital settings and document searches that included a variety of platforms. Through the quality of the contextual description, which are the processes, by identifying links back to the literature, and through triangulation of participants from varied EDs and information from various platforms have all enhanced the validity of this research (Patton & Applebaum, 2003). By looking at the issue from a variety of perspectives increased the triangulation of the

experiences and created a description of the issue from a more general perspective. This resulted in findings where specific policies could be applied to the practices in several states or environments. Findings rather are more of a macro statement about the policies that drive general behavior and the result related to behavioral health care in EDs. In addition to gathering input from various settings, data was gathered from multiple online sources to align interview findings with related policy and funding. By gathering information from literature review and documents, content experts in government, and association, and partner organizations in addition to ED staff, multiple sources of information were triangulated to support study finding dependability. Dependability was further supported through audit trails that used a case study protocol and the creation of a database to document this case study process as described by Yin (2014).

Confirmability concerned with an aspect of neutrality and subjectivity was supported by using detailed notes and documents collected to maintain audit trails. Confirmability was also accomplished in this study through audits conducted by others. Audits helped to ensure that the interpretation of the data was not based on my preferences and viewpoints to minimize the bias effect as much as possible. Also, utilizing detailed notes in terms of interview transcriptions and documents collected that were maintained in an extensive, compiled database provided an audit trail where unbiased interpretation could be validated. Confirmability was supported in this study through detailed notes and documents collected, with no confirmability limitations to be noted.

Linkage of Research Findings with Reality

This study found that processes and organizational interventions can effectively support care for individuals who visit an ED with a behavioral health condition, as is known through experience documented in the literature review. This study goes beyond that reality is the understanding for which policies are supportive in the case where there are no special grants or projects to support those processes. Social norms or processes that supported BHCFUP that were identified through interviews mirrored effective processes that were identified through a literature review that framed the conceptual framework. Those processes found through literature to be effective were also identified in the interviews as those processes taking place in effective scenarios and environments. This study has construct validity in that operational measure (how ED staff are motivated to support BHCFUP) for the concepts being studied aligns with the support processes for BHCFUP (Rowley, 2002).

Findings in Relation to the Context of the Theoretical and Conceptual Framework

The context of this study was focused on support for behavioral health care in EDs. The context provided rich information, which helped to develop a theoretical explanation of the phenomenon for this study. This study approach captured the interaction between the various aspects of BHCFUP in EDs and the essential parts of that system that support staff engagement in BHCFUP. Through the theoretical lens of TBP/TBA an explanation was developed for the relationship between how staff are motivated and their engagement in BHCFUP. This theoretical explanation applied to the

population on which the study was based (staff involved in BH support in EDs in the US).

The initial theory of what was successful in supporting BHCFUP in an ED was built through the literature review. The existing literature on the study objective of understanding what is supportive of BHCFUP in EDs helped frame the case study, establish validity for the research, and support confidence in the findings. The theories in the existing literature to establish what processes were supportive of BHFUP in EDs coincided with the findings of the case study where participants identified the same processes to provide care. The theory developed from the findings of this case for how staff is supported to provide BHCFUP in an ED aligns with the existing literature enhancing the generalizability foundation for theory building (Patton & Appelbaum, 2003).

Recommendations for Further Research

Based on the findings of this study, and what is known about how policies support effective care for individuals who enter an ED with a behavioral health condition, further research can explore how policies may be adjusted or expanded to reduce overall costs through strategic reimbursements ED staff find supportive. This study identified that well-placed policies could support ED staff to provide care for individuals who enter an ED with a behavioral health condition but did not address overcoming the barriers to improved policy implementation or adoption. Methodically identifying how and why barriers related to policy exist can assist government, administration, and legislators to use that information to restructure payment systems and incentives. This study has

provided some insight into what is currently helpful and can provide a foundation for exploring.

Positive Social Change

Improved care for individuals who visit an ED with a behavioral health condition impact individuals, families, communities, and societies. Not providing effective care for individuals with a behavioral health condition results in increased long-term costs for society, detracts from the quality of care in hospitals, and has economic and emotional hardship on families and individuals. The barriers to providing this care have been extensively documented. However, by identifying where policies support connections with behavioral health care and reduced ED visits, policies can be reinforced to improve effective care for these individuals. With behavioral health accounting for a large portion of ED visits and government insurance payments, improvements in outcomes have a significant effect on health care systems and economic impact in the United States.

Methodological, Theoretical, and Empirical Implications

This study has demonstrated the value in the application of TRA/TPB theory through interviews to understand a phenomenon, which is support for behavioral health care in and ED. Additionally, this study has reinforced the value in data collection that includes interviews, online data searches, and consultation with experts.

Recommendations for Practice

Though demonstrations have shown how support for individuals who enter an ED with a behavioral health condition can occur through policy, this study has also shown

what is working given the current general state and federal funding policies. BHFUP that provides continuity of care can be achieved with funding flexibility that allows for shifting staff roles, institutional incentives, and capitation payments. Funding flexibility has been shown in this study to support nontraditional services, training, pay for clinician time and services, expedited triage, and development of a team-based approach that allows for continuity of care to meet the needs of individuals with behavioral health. Planned approaches through organizational interventions supported by funding policy to bring services together have been shown in this study to lay a foundation for providing needed care for vulnerable patients such as those with a behavioral health condition. The organizational interventions that include formal integration, the establishment of multidisciplinary teams, professional role revisions, and the establishment of continuity of care are avenues that can support successful follow-up care planning. Integration of services involves team-based approaches that can simultaneously provide physical and behavioral health needed care. Integration results where care is provided by a practice team of primary care and behavioral health providers in a systematic approach. Telepsychiatry services, as an example of integration of services, have been shown to provide an avenue to connect individuals for needed screening and assessment but are at risk of tightening policies or legislation that would reduce the effectiveness.

Examination of first-hand staff accounts for funding policies supporting ED staff attitudes, social norm beliefs, and perceived control beliefs can improve policymakers' understanding of how policies can encourage staff engagement and help overcome barriers to reduce return ED visits. By understanding how components influence ED staff

engagement and how they align with policy, policymakers can incorporate those factors into funding policy to improve outcomes of reduced return ED visits for those with a behavioral health condition.

Conclusion

This study has been a systematic way of looking at what is happening, collecting data, analyzing information, and reporting the results. The product is a sharpened understanding of how ED staff are supported to provide care for individuals who enter an ED with a BH condition and what might be valuable to look at more extensively in future research. This study found similar key processes that those working in an ED found to support their care for individuals who visit the ED with a behavioral health condition.

Policies that make these processes possible include funding policies that are predominately government insurance such as Medicaid and Medicare and include private insurance, federal and state mandates, and hospital culture. Hospitals have been highlighted in this study as pivotal in supporting behavioral health care by promoting a philosophy of care for individuals with a behavioral health condition and a commitment to provide screening, assessment, urgent care, and follow-up connections. Hospital leadership was cited by ED staff as seeking solutions or adaptations for the care of individuals with a behavioral health condition and developing policy to improve screening and assessment, reduce potential harm from inadequate or care that may be lacking to the point of aggravating the conditions. Further, ED staff accounts highlighted the significance of hospital administration involvement in a hands-on approach and providing needed support to improve the skills of ED staff through training and staff

connections. However, supporting documentation found in this study has shown that hospitals' ability to provide this care is subject to reimbursements and grants. Where there is no direct reimbursement to improve care, hospitals may provide those services or modify delivery systems "out of pocket," intending to reduce repeat ED visits or boarding. Alternatively, the hospitals may be providing improved care with the hope of ultimately reaping the benefit of some return on that investment through reduced repeat ED visits or boarding of BH patients. Some reimbursement and related assistance have been received by hospitals through adaptations in Medicaid and Medicare payments, through federal grants, and through a Medicaid/Medicare DSH payment to reimburse uninsured or underinsured high-need individuals. These payments, however, are in continual flux and are frequently at risk of being reduced or changed, resulting in increased challenges for hospitals to support care for individuals who visit an ED with a behavioral health condition.

In conclusion, it was found in this study that more robust and effectively developed funding policies are needed to provide for staffing in EDs to engage in screening and assessment, and support provision of acute care that includes access to BH support, as well as policies that provide for needed resources. These needed resources include crises facilities, community mental health centers, community connections, residential psychiatric facilities, outpatient therapy, shared data systems, mandates for treatment, peer support, and government and privately funded insurance.

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