Stronger Together: ER Care with Behavioral Health by Your Side

Bryan Health Rural Division HHA Council of Network Affairs

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Introductions

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Brief History and Overview

Since starting in March of 2011, Fillmore County Hospital has been committed to providing mental health services for our patients as we believe that treating the whole person is essential for overall wellness.

We operate a total of 9 distinct programs with Solution Based Recovery programming and PCIT being added most recently, the busiest program being Traditional Outpatient Therapy (TOPS), School contracts, and Medication Management Services.

We employ 20 individuals in the BH department, with 11 therapists and 1 psychiatric provider, with 1 in training, and 7 support staff.

Our service area includes 9 counties, although with telehealth, we can serve all 93 counties in Nebraska.

We contract with six school districts as well as serving both Fillmore and Thayer county Head Start programs.

Why We're Here

- Share real examples of mental health crises in the ER
- Highlight what we learned and what we'd do differently
- Showcase our integrated BH-ED model
- Emphasize trauma-informed care (TIC) as a universal precaution
- Discuss our partnership with area schools

The Need for Integration

HIGH ER DEMAND FOR MENTAL HEALTH CARE.

EDS OFTEN ILL-EQUIPPED FOR BEHAVIORAL NEEDS.

INTEGRATED BH REDUCES LOS, BOARDING, AND IMPROVES CARE.

Case Study #1 – 'The Patient in Briefs'

Male patient with complex trauma history

Came in during COVID with panic + bowel incontinence

Stripped of soiled clothes, given only briefs

Staff unaware of sexual assault history; response lacked compassion

Patient left feeling ashamed, dismissed; therapy gains undone

What Could Have Helped (Case #1)

- Assume everyone who walks in our doors, have some trauma history
- Offer choices
- Use gentle voice, dim lights
- Involve BH staff early
- Clarify: “We do have clothing, but staff didn’t know” = training gap
- Lesson: “We don’t have to fix everything—sometimes we just need to not make it worse.”

Case Study #2 – ‘Adolescent SI with No Resources'

Teen presents with suicidal ideation after trauma at home
Seen late Friday; no local services open until Monday
No youth inpatient beds available in-state
ED staff overwhelmed by length of stay, unclear next steps
Therapist works with teen to stabilize, develops safety plan with family
Outcome: Avoided unnecessary hospitalization; connected to school-based therapist Monday

What Could Have Helped (Case #2)

- Clearer after-hours BH support protocols
- More education for ED on crisis stabilization options
- Earlier coordination with school partners
- Lesson: Crisis can be a bridge to continuity, not a stopgap
- Key takeaway: “Integrated care prevents people from falling through the cracks.”

Benefits to Patients

- Rapid assessment and support Connection to follow-up care
- Safety and stabilization
- Reduced stigma
- Decrease chance of Re-traumatization
- Improved coping & outcomes

Benefits to ED Staff

- Reduced burden
- Enhanced safety
- Increased confidence
- Lower burnout
- Collaborative decision making

Why It Works – Whole Person Care

- BH notes in medical records
- Warm handoffs and shared care plans
- Nurses work to full scope; BH manages education + de-escalation
- Better follow-through, faster access, reduced burnout

Therapist Role in ER

- Crisis de-escalation
- Rapid assessment
- Safety planning
- Brief CBT, MI
- Linking to services
- Family involvement

Final Thoughts

- If 70% of patients have trauma, treat it like infection control and use as a Universal Precaution.
- TIC isn’t extra work—it *is* the work.
- You can't have good health without good mental health.
- We are much more effective when we work together at the top of our scope.
- Together, we provide compassionate, efficient, trauma-informed care—right when it’s needed most.

Closing and Q & A

TOGETHER, WE PROVIDE COMPASSIONATE, EFFICIENT, TRAUMA-INFORMED CARE—RIGHT WHEN IT'S NEEDED MOST.

QUESTIONS & DISCUSSION