

Psychiatric Patient Boarding Problems in the Emergency Department

*IMPROVING TIMELINESS, ACCESS, AND QUALITY
LOWERING COSTS AND RE-HOSPITALIZATIONS*

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Psychiatric Patients Adding to ED Overcrowding

- Patients waiting for a psychiatric bed wait three times longer than patients waiting for a medical bed in hospital EDs.
- ED staff spend twice as long locating inpatient beds for psychiatric patients than other patients
- Psych patients boarding in an ED can cost that hospital more than \$100 per hour in **lost income alone**¹

Increased Mental Health Demand

- The number of people coming for care in ambulatory mental health settings increased more than 300 percent, from 1,202,098 in 1969 to 3,967,019 in 1998
- Presently 1 in 8 patients seen in EDs have a mental health or substance-abuse condition¹



1. Agency for Healthcare Research and Quality, 2007

Boarding

- Definition: Patients in hospital medical Emergency Departments who are medically stable and just waiting for a psychiatric evaluation or disposition.
- Often these patients are kept with a sitter, or in “holding rooms” or hallways on a gurney – some languishing for hours in physical restraints, often with no concurrent active treatment
- Some psychiatric boarders even kept in the very expensive option of the Intensive Care Unit because of need for close supervision

Psychiatric Patients Boarding in Medical Emergency Departments is a National Problem Getting National Attention



StarTribune

Los Angeles Times

Bloomberg

The Seattle Times

Boarding Across the USA

- Studies showing average psychiatric patient in medical emergency departments boards for an average of between 8 and 34 (!) hours
 - 2012 Harvard study: Psych patients spend an average of 11.5 hours per visit in ED; those waiting for inpatient beds average 15-hour stay
 - 2012 CHA Study: After decision made for psychiatric admission, average adult waits over ten hours in California EDs until transferred

Impact of Boarding

- Boarding is a costly practice, both financially and medically
- Average cost to an ED to board a psychiatric patient estimated at **\$2,264**
- Psychiatric symptoms of these patients often escalate during boarding in the ED

Boarding Solutions Suggested

- Most suggestions still follow concept that virtually all emergency psychiatric patients need hospitalization as the only disposition
- Results in far too many patients being unnecessarily hospitalized at a very restrictive and expensive level of care
- Roughly equivalent to hospitalizing every patient in an ED with Chest Pain (typically only 10% of such patients get hospitalized)

Wrong Solution: Treating at the Destination instead of the Source!

- All these solutions call for more availability for hospitalizations, nothing innovative at the actual ED level
- Change in approach needed – beginning with recognition that the great majority of psychiatric emergencies can be stabilized in less than 24 hours
- ***To reduce boarding in the ED, shouldn't the approach be at the ED level of care?***

“Zeller’s Six Goals of Emergency Psychiatric Care”¹

- **Exclude medical etiologies and ensure medical stability**
- **Rapidly stabilize the acute crisis**
- **Avoid coercion**
- **Treat in the least restrictive setting**
- **Form a therapeutic alliance**
- **Formulate an appropriate disposition and aftercare plan**

1. Zeller, *Primary Psychiatry*, 2010

ACEP Study Results 2008

- 81% of surveyed emergency medicine leaders agreed that regional dedicated emergency psychiatric facilities nationwide would be better than the current system

Regional Dedicated Emergency Psychiatric Facilities

A 2003 survey of psychiatric consumers reported that a majority had unpleasant experiences in medical emergency facilities and would prefer treatment in a specialized Psychiatric Emergency Service location.

Regional Dedicated Emergency Psychiatric Facilities

- EMTALA-compliant “dedicated emergency departments” for mental health crises, both voluntary and involuntary
- Can serve to screen/evaluate and treat all acute psychiatric patients for a region, eliminating need for urgent psychiatric consults in a general ED

Regional Dedicated Emergency Psychiatric Facilities

- Can accept self-presentations and ambulance/police directly, only medically-unstable psychiatric patients go to general EDs
- Accepts medically-stable transfers from area medical EDs that do not have psychiatric care onsite
- “Higher Level of Care” outpatient service so no need to wait for “a bed” to transfer from general ED – comparable to transferring patient to a trauma service from general ED

Regional Dedicated Emergency Psychiatric Facilities

- Are considered an outpatient service, avoid many of the regulatory demands of inpatient psychiatric care
- Thus no need for actual “number of beds” which would limit capacity – many programs use recliner chairs or other furniture that flattens out for rest/sleep
- Focus is on relieving the acute crisis, not comprehensive psychiatric evaluation – much like medical emergency departments, *treat the presenting problem*

Regional Dedicated Emergency Psychiatric Facilities

- Will treat onsite up to 24 hours (or longer in some areas), avoiding many inpatient stays
- Discharge rates within first 23 hours of 70% or higher very common, meaning less than 30% admitted to inpatient beds – better for patients and preserves inpatient bed availability
- Of great interest to insurance companies, which are often willing to pay more than daily hospital rate for single day of crisis stabilization to avoid multiple-day inpatient stay

Alameda Model

- Serves as a Regional Dedicated Psychiatric Emergency Service (PES) for all of Alameda County, large county with population > 1.5 Million (Oakland, Berkeley, Fremont etc.)
- Accepts patients from all eleven (11) adult medical Emergency Departments in the region as soon as medically stable, regardless of insurance coverage

Alameda Model

- Almost no police transport of patients for psychiatric evaluations, which can “criminalize a psychiatric crisis”
- Instead, peace officers placing a 5150 hold summon an ambulance, then paramedics do a field screening with criteria approved by PES and EMS
- Transport decision based on medical stability
 - Medically stable go directly to PES (2/3 of all patients)
 - Medically unstable go to nearest of 11 area Emergency Departments for medical clearance (1/3 of all patients)

Alameda Model – John George PES

- John George Psychiatric Hospital is a stand-alone psychiatric-only campus, part of eight-campus medical center
 - Main affiliated medical ED is 12 miles away
 - John George campus has 69 inpatient psychiatric beds and EMTALA-compliant PES
 - PES has attending-level psychiatrists on duty 24/7/365
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Alameda Model – John George PES

- Currently averaging 1500-1800 very high acuity emergency psychiatric patients/month, approximately 85% on a 5150 involuntary detention
- Focus is on collaborative, non-coercive care involving a therapeutic alliance when possible, with voluntary treatment in the least-restrictive setting as the goal
- Presently averaging **only 0.1% of patients placed in seclusion/restraint** – comparable USA PES programs average 8%-24% of patients in seclusion/restraint
- John George Psychiatric Hospital in Top 10% of patient satisfaction scores in USA though competing with voluntary, luxury facilities

2014 Alameda Model PES Study

- Compared medical ED psychiatric patient boarding times and hospitalization rates in a system with a Dedicated Regional Psychiatric Emergency Service to statewide averages in California
- Published in
Western Journal of Emergency Medicine
<http://escholarship.org/uc/item/01s9h6wp>

Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments

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Introduction: Mental health patients boarding for long hours, even days, in United States emergency departments (EDs) awaiting transfer for psychiatric services has become a considerable and widespread problem. Past studies have shown average boarding times ranging from 6.8 hours to 34 hours. Most proposed solutions to this issue have focused solely on increasing available inpatient psychiatric hospital beds, rather than considering alternative emergency care designs that could provide prompt access to treatment and might reduce the need for many hospitalizations. One suggested option has been the “regional dedicated emergency psychiatric facility,” which serves to evaluate and treat all mental health patients for a given area, and can accept direct transfers from other EDs. This study sought to assess the effects of a regional dedicated emergency psychiatric facility design known at the “Alameda Model” on boarding times and hospitalization rates for psychiatric patients in area EDs.

Alameda Model Study: Benefits of PES to a Medical System

- Psych patient boarding times in area EDs were only One Hour, 48 minutes – compared to California average of Ten Hours, 03 minutes:

an **improvement of over 80%**

- Approximately **76% of these patients were able to be discharged** from the PES, avoiding unnecessary hospitalization and sparing inpatient beds for those with no alternative

Study: Benefits of PES to System

- 2/3 of patients deemed medically stable in field, brought directly to PES, avoiding area medical EDs altogether
- PES programs **can reduce overall costs by average of thousands of dollars per patient**, while leading to improved quality and access to care, and decreased hospital admissions
- Adding a PES in appropriate systems perfectly aligns with these goals of healthcare reform

Regional Dedicated Emergency Psychiatric Facilities

- California Medicaid (Medi-Cal) pays hourly bundled “Crisis Stabilization” rate (also available in several other states), as do many private insurers via contract, but difficult to get adequate Medicare reimbursement
- Crisis Stabilization pays hourly in California for up to 20 hours maximum, enough to make programs self-sufficient
- Yet total cost for top Crisis Stabilization reimbursement is still **LESS** than typical cost just to board a psychiatric patient in a medical Emergency Department

Applicability

- **“But can this work in our system?”**
- A model of 23-hour Crisis Stabilization can be developed for just about any size hospital or community mental health program
- Many different versions/models -- key is recognizing that most psychiatric emergencies *can resolve in less than 24 hours* with prompt, appropriate treatment – and applying that to your area
- **Burke Center, Texas**
 - Remote PES served by telepsychiatry: 50 miles from nearest delivery point for FedEx!
 - Winner of American Psychiatric Association

Gold Award for Innovation

Increasing Emergency Psychiatry/ Crisis Stabilization Programs Nationally

Perfectly aligned with health care reform:

improves access to care, quality of care, and
timeliness of care, while being

patient-centric, avoids unnecessary inpatient

hospitalizations and rehospitalizations, and

dramatically lowers overall costs.

Questions

