Making the Case for the Psychiatric Emergency Hospitalist

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Our Challenge

To continue to provide high quality cost effective psychiatric care in a changing healthcare environment while fulfilling the mission of the Sisters of St. Joseph of Orange to, “Serve our dear neighbor.”

Where Did We Start? The Five Major Issues

1. Third busiest ER in the state
2. Surrounding community highly uninsured
3. No psychiatric services available in ER
4. Limited coverage by on-call psychiatrists
5. Inadequate county services
Emergency Room Gridlock

Extended wait times due to:

• No bed available on our inpatient unit
• Waiting for on-call psychiatrist to release patient from hold
• Waiting for patient to be transferred to another facility
• Waiting for physician-to-physician call
• Waiting for acceptance by other facility
• Medical acuity too high for transfer

The Bigger Picture

Trends in California

<table>
<thead>
<tr>
<th></th>
<th>1995</th>
<th>2012</th>
<th>% Change</th>
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<tbody>
<tr>
<td>Population in CA</td>
<td>32.0 M</td>
<td>38.0 M</td>
<td>20%</td>
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<tr>
<td>Psych Facilities in CA</td>
<td>+/-180</td>
<td>+/-140</td>
<td>-22.2%</td>
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• National = 1 bed per 2,550 in population
• California = 1 bed per 5,675 in population
• OC 354 beds = 1 bed per 8,875 residents
  • 277 Adult beds - (College 82, Mission LB 30, SJO 36, UCI 38, West Med 91)
  • 31 Adolescent beds - (UCI 14, College Costa Mesa 17)
  • 46 Gero-psyche beds - (Newport Bay 34 Chapman 12)

Sources: 2009 Federal State Data; 2011 Orange County Data
Need for Services is Trending Up
Between 2010 and 2020

- 11% increase demand for inpatient services
- 19% increase for outpatient services

**Psychiatry Services includes all mental health illnesses, chemical dependencies and dementias; Source: Sg2**

And then there are statistics like this …
ER Visits for Drug-Related Suicide Attempts

**Females by Age Group: 2005 and 2009**

*The change from 2005 to 2009 in women aged 50 or older was statistically significant at the .05 level.
Source: 2005 to 2009 estimates from the 2010 SAMHSA Drug Abuse Warning Network (DAWN).*
Impact of Alcohol Abuse in our ERs

- More than eight million Americans are dependent on alcohol, or twice the number dependent on illicit drugs

- Alcohol is associated with 85,000 deaths in the United States annually and additionally with accidents, suicides and abuse

- The combined cost of alcohol abuse in the United States is $200 billion

- 40% of all Emergency Room Patients have alcohol in their system

Hospital X in Orange County
Actual data from January 1 – October 31 2013 (34-bed ER)

- 410 PET Team requests (ER = 392 & Input. = 18)

Disposition:
- 105 (26%) sent to county Emergency Triage Service (ETS)
- 157 (38%) sent directly to a designated facility
- 148 (36%) discharged home after evaluation by PET team
Wait Times at Medical Center X

Time to first contact by PET team:
- Less than one hour = 19%
- One to two hours = 17%
- Two to three hours = 13%
- Three to 4 hours = 12%
- Over 4 hours = 40%

Total wait time before transfer:
- 129 (31%) waited 4.9 to 24 hours
- 139 (34%) waited 25 to 48 hours
- 142 (35%) waited 48 to 99 hours

Average LOS in ER = 39 hours

ER Volumes Are at Crisis Levels

What Can We Do?

- How do we discontinue holds on individuals who don’t require inpatient treatment?
- How do we start treatment with long wait times in our emergency department?
- How do we determine the primary need for psychiatric vs. substance use disorder treatment?
- How do we reduce repeat admissions?
- Who is appropriate for outpatient treatment?
Our First Step … a “Guesting Area”

- Four sleeper chairs
- Staffed with nursing staff from Behavioral Health
- Male and female patients housed together
- ER Physician is primary with on-call Psychiatrist providing consultation.

What “Guesting Area” Does Provide

- Removes patient from the ER environment
- Opens up an ER bed
- Psychiatric nurses provide the patient care
- Provides safe, secure and comfortable environment
- Provides improved access to patients for the on-call psychiatrists
What “Guesting Area” Does Not Provide

- Presence of psychiatry in ER for all patients
- Rapid triaging of patient with ER physician and RN
- Consultation with ER physician regarding treatment
- Screening of patients who don’t require treatment
- Access to families accompanying patients
- Psychiatrist-to-Psychiatrist consults for admission

Trends with 5150s in the Emergency Room

- Prior to Psychiatric Hospitalist
  - < 10% of the patients released from holds in ER
- Change by adding ER Hospitalist
  - 50% of holds were discontinued in the ER

“Discussion with Law Enforcement”

- Fewer holds coming in; 30% of those written are discontinued
Addition of Psychiatric Hospitalist to the Emergency Department

Gayani DeSilva, MD

“Dr. G.”

Objectives of Psychiatric Hospitalist

• Clinical direction
• Education
• Advocacy
• Cost effective care
## Clinical Direction

- Consult with ER physicians and staff
- Focused psychiatric evaluation
- Disposition
- Acute care

## Education

- For patients, families
- For ER physicians
- For staff
- About diagnoses and treatment
- About treatment options
Advocacy

- Underlies every activity
- Attention for medical needs
- Reduction of stigma
- Role modeling

Cost Effective Care

- Choice of acute medication
- Disposition options
- Removing 5150 holds
- Promoting outpatient services
- Managing inpatient resources
Patient Experience

• Less anxious ER physicians and staff
• Greater tolerance
• Faster response to needs
• Improved overall care

Questions?
Thank you

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