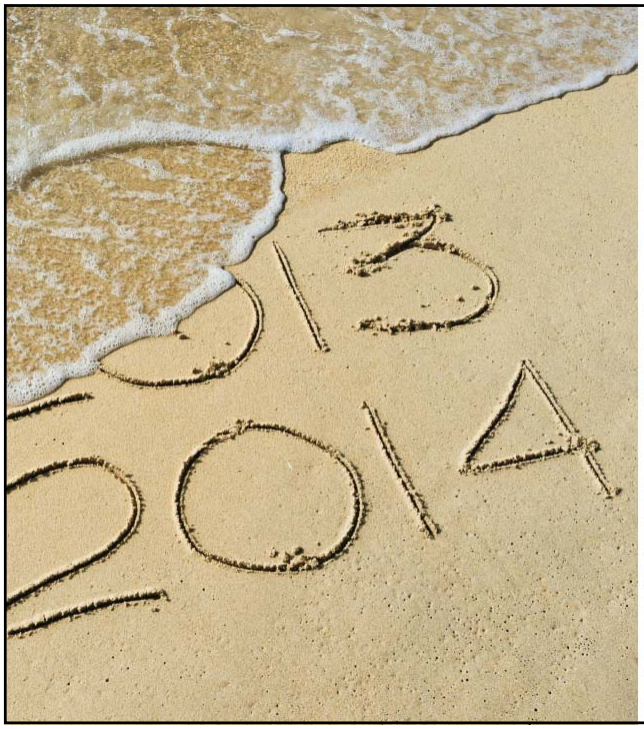

the future is now
are we ready?

The 8th Annual Behavioral Health Care Symposium

CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health

the future is now
are we ready?

The 8th Annual Behavioral Health Care Symposium

A Model for Psychiatric Emergency Services

Improving *Access and Quality*
Reducing *Boarding, Re-Hospitalizations and Costs*

Scott Zeller, MD
Chief, Psychiatric Emergency Services
Alameda Health System, Oakland, CA
Immediate Past President
American Association for Emergency Psychiatry

CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health

Stress on the Emergency Departments (ED) & Community Health – Increasing Numbers of Behavioral Health Care Patients

- Reduced psychiatric inpatient beds
- Decreased inpatient lengths of stay
- Lack of community resources to prevent crises
- Lack of or limited health insurance
- Lack of access to care

3

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]

1. Treatment Advocacy Center, 2012

4

Decreased Public Facilities

- At the end of 1955 there were 558,922 patients in state psychiatric hospitals; in 1970 there were 413,066 beds in state and county psychiatric hospitals; and in 1998 there were 63,525 beds in state and county psychiatric hospitals
- The number of state psychiatric beds decreased by 14% from 2005 to 2010; in 2005, there were 50,509 state psychiatric beds available nationwide; by 2010, the number had shrunk to 43,318

5

Decreasing Psychiatric Inpatient Capacity

- And many additional beds have been eliminated since 2010, bringing the estimated current number to **38,847**; and more hospital beds are slated for closure
- Inpatient capacity unlikely to increase in the future, but actually may not be necessary with innovative approaches

6

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 condition[1]

1. Agency for Healthcare Research and Quality, 2007

7

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

8

Overcrowding

- Overcrowded ED facilities and those with "boarders" correlated directly with increased walkouts, increased medical errors and increased negligence claims
- ED patient crowding cited as a potential cause of compromised patient care[1]

1. Annals of Emergency Medicine, October 2007

9

Overcrowding and Diversions

- America's emergency departments handle more than 115 million patient visits annually and wait times increased by 36 percent between 1997 and 2004
- 500,000 ambulance diversions occur each year (on average, one every minute) due to overcrowded emergency departments

10

ACEP Study Results 2008

- More than 90 percent indicated that they board psychiatric patients every week with more than 55 percent daily or multiple times per week
- 62 percent indicated there are no psychiatric services involved with patient care while patients are being boarded in the emergency department prior to admission or transfer

CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health

11

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

StarTribune

Los Angeles Times

Bloomberg

12

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 a decision is made for psychiatric admission, average adult waits over ten hours in California EDs until transferred

13

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

Nicks B, Manthey D. *Emerg Med Int.* 2012.

14

Boarding Solutions Suggested (cont.)

- CMS "Emergency Psychiatry Demonstration Project" – not about Emergency Psychiatry, but about opening private psychiatric hospitals to Medicare
- Collaboratives to Identify Open Psychiatric Beds in a Region
- More beds, someone? Anyone? Bueller?

15

Boarding Solutions Suggested (cont.)

- 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)

16

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 approach be at the ED level of care?*

17

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

18

Regional Dedicated Emergency Psychiatric Facilities (cont.)

- 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

Allen MH et al. Journal of Psychiatric Practice, 2003

19

Regional Dedicated Emergency Psychiatric Facilities (cont.)

- 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

20

PES Facilities Function Using "Zeller's Six Goals of Emergency Psychiatric Care"

- Exclude Medical Etiologies for Symptoms
- Rapid Stabilization of Acute Crisis
- Avoid Coercion
- Least Restrictive Setting
- Therapeutic Alliance
- Appropriate Disposition and Aftercare Plan

Zeller SL. Primary Psychiatry, 2010

21

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

22

Regional Dedicated Emergency Psychiatric Facilities (cont.)

- Is considered an outpatient service, avoids 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*

23

Regional Dedicated Emergency Psychiatric Facilities (cont.)

- 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

24

Alameda Model

- Serves as a Regional Dedicated Psychiatric Emergency Service (PES) for all of Alameda County
- Accepts patients from all 11 adult medical Emergency Departments in the region as soon as medically stable, regardless of insurance coverage

25

Alameda Model (cont.)

- 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
  - Medically unstable go to nearest of 11 area Emergency Departments for medical clearance

26

Alameda Model – John George PES (cont.)

- 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

27

Alameda Model – John George PES

- Currently averaging over 1200 very high acuity emergency psychiatric patients/month, approximately 90% on a 5150 hold
- 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 **0.6% of patients placed in seclusion/restraint** – comparable USA PES programs average 8%-24% of patients in seclusion/restraint

28

2013 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

29

ORIGINAL RESEARCH

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

Scott Zeller, MD[*]
Nicole Calma, MA[†]
Ashley Stone, MPH[‡]

[*] Alameda Health System, Department of Psychiatric Emergency Services, Oakland, California
[†] The Wright Institute, Berkeley, California
[‡] California Hospital Association, Sacramento, California

Supervising Section Editor: Michael P. Wilson, MD, PhD
Submission history: Submitted March 31, 2013; Revision received June 9, 2013; Accepted June 11, 2013
Full text available through open access at http://escholarship.org/uc/uciem_westjem
DOI: 10.5811/westjem.2013.6.17848

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.

30

Alameda Model Study: Benefits of PES to System

- Psych patient boarding times in area EDs were only 1 hour, 48 minutes – compared to California average of 10 hours, 3 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

31

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

32

Regional Dedicated Emergency Psychiatric Facilities

- Can be expensive to staff and maintain 24/7
- Typically only makes sense for systems >3000 psychiatric emergencies/year
- Medicaid pays hourly "Crisis Stabilization" rate in several states, as do many private insurers via contract, but difficult to get adequate Medicare reimbursement
- Currently our team in contact with CMS and SAMHSA urging Crisis Stabilization-style reimbursement nationally

CALIFORNIA HOSPITAL ASSOCIATION Center for Behavioral Health

33

Crisis Stabilization Units

- Similar to outpatient-level program of Psychiatric Emergency Facilities, but do not directly accept ambulances
- Thus will not need physicians/psychiatrists onsite 24/7 (though required on-call at all times)
- Typically affiliated with medical ED, which will receive patients, do physician evaluation, transfer medically appropriate patients to CSU
- Can fill same role as a "PES" in systems with lower census numbers, for less staffing and less costs

CALIFORNIA HOSPITAL ASSOCIATION Center for Behavioral Health

34

Increasing Emergency Psychiatry/ Crisis StabilizationPrograms Nationally

- All Medicare, Medicaid, private insurers should have available Crisis Stabilization hourly rate
- This will make programs self-sufficient or even profitable, which will lead more provider organizations to consider implementing
- Creative staffing mixes including use of "peer" counselors can provide high quality while being cost-effective

35

Applicability

- "But can this work in our system?"
- A version of Crisis Stabilization/PES can be developed for just about any size hospital or community mental health program
- **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"

36

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

CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health

37

QUESTIONS?

CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health

Thank you

Scott Zeller
510-346-1363
szeller@acmedctr.org

CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health