Improving Crisis and Emergency Psychiatric Services

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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. Treatment Advocacy Center, 2012
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
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

- CMS “Emergency Psychiatry Demonstration Project” – not about Emergency Psychiatry, but about opening selected private psychiatric hospital beds to Medicaid

- Collaboratives to Identify Open Psychiatric Beds in a Region

- **More beds, someone? Anyone? Bueller?** But not a likely option – building de novo psych beds a very expensive and long-term project that counters current political and philosophical treatment approaches
Boarding Solutions Suggested (cont.)

• Most suggestions – even ideas that include community-based drop-in care and mobile crisis units – still follow concept that virtually all emergency psychiatric patients need hospitalization as the only possible 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?
Psychiatric Emergencies are Medical Emergencies!!

• Federal EMTALA Laws already designate psychiatric emergencies as equivalent to heart attacks and car accidents – time to start intervening with the same urgency and importance as medical emergencies.

• Psychiatric Emergencies are not going to “go away” – better to start preparing for these, and designing emergency programs with the recognition that ability to treat crises are as necessary to ERs as EKG machines, oxygen and IV equipment.
Real Solutions

Within General ED
- Commencement of Care
- Telepsychiatry

Output Alternatives
- PEETH Units
- Crisis Stabilization Units
- Diversion Units/Crisis Residential
“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
Beginning Treatment in the ED

- Many psychiatric crises can resolve in hours rather than days with no need for inpatient admission.

- Prompt medications can reduce symptoms of psychosis, paranoia, agitation, aggression, anxiety to subacute levels while in the ED.

- Suicidality can resolve with time, sobriety, end of withdrawal symptoms.

- Many treatments can start with ED physicians using standard protocols; patients can improve significantly by time of consultation or disposition decisions – greatly increases diversions compared to “wait for psych”.
Improving Throughput

- Calming techniques and de-escalation can avoid need for restraints and oversedation, lead to more prompt disposition, well worth the short amount of time to attempt

- Beginning appropriate medications in ED – not “chemical restraints” – can facilitate discharge in appropriate patients, shorten hospital stay, make time in ED part of treatment rather than “caretaking”, increasing possibility of resolution of emergency and safe discharge
Restraint use leads to a length of stay of psychiatric patients in EDs averaging 4.2 hours longer than that of patients not requiring restraints\(^1\)

Telepsychiatry
On-Demand ER Telepsychiatry

24/7 access to a board-certified psychiatrist via high definition, two-way video conferencing.
Telepsychiatry in the ED

• Overcomes need to have face-to-face psychiatrist available 24/7/365

• Cost savings substantial versus keeping ED manned with a psychiatric consultation at all times

• Telemedicine makes it possible to handle emergencies in a distributed area without the psychiatrist travelling

• Rapid therapeutic alliance decreases LOS

• Targeted pharmacologic management that works quickly without sedation / side effects delaying disposition
• Decreased liability makes it easier for ED physicians to discharge formerly suicidal or homicidal patients

• Reduced costs generated by inappropriate inpatient admissions, more rapid ICU discharges, less boarding, fewer one-to-one sitters, less overall staff time

• Decreased transportation costs to psychiatric facilities

• Telemedicine can be more tolerable than face to face encounters, especially for paranoid or personality disordered patients
Patient Benefits

• 24/7 access to board certified psychiatrists
• Improved Patient Satisfaction
• Focused on high quality, timely assessments
• Full evaluation, risk assessment, diagnosis, treatment and disposition recommendations
• Care plan collaboration with in-person providers
Hospital Benefits

- Address current physician shortage challenges
- Diverse care settings ED, ICU, inpatient, SNFs, and more
- Pay-per-consult model, cost-effective
- Improve ED capacity and throughput with more timely care
- Integration with providers across care settings
- Improve appropriate transfers and admissions with psychiatric eval. documentation
Improving Care with Telepsych

**DECREASE Up to 80% in mental health patients’ ED boarding time**

**DECREASED** admissions to Inpatient Units and LOS

**IMPROVED** Coordination between psychiatrists and consulting providers
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.

PEETH Units

- **Psychiatric Emergency Evaluation, Treatment and Healing**
  - Hospital-campus-based, combines best of community-based mental health care with ER approach of treating all comers promptly
  - Open design with room for patients to move about freely, choose activities, obtain food or drink or linens without having to ask staff
  - Focus on calming atmosphere conducive to reducing stress, therapeutic effects, but always in safe, supervised environment
  - No walls or glass ‘fishbowl’ separating patients from staff – staff are always interspersed with patients
  - Use of Peer Support Specialists
• **PEETH Units** provide a calming, healing, comfortable setting *completely distinct from the medical ED* where *prompt access to a psychiatrist* can help lead to timely and dramatic improvement for patients experiencing a psychiatric emergency.
Patient Benefits

- Immediate care setting change from chaotic ED to a “trauma-informed” unit
- Calming environment that best meets patient needs
- Restraints/Locked Seclusion practically eliminated
- Multi-disciplinary team treatment and resources available
- Rapid evaluation once medically stable with comprehensive care plan development
Hospital Benefits

- 24/7 Psychiatrist Coverage, in person and telepsych
- Alleviate volume pressure in the ED and holds
- ALOS less than 24 hours, while improving care
- EMTALA-compliant for mental health crises, both voluntary and involuntary
- Reimbursement options (typically a bundled hourly rate)
- Significant reduction in admission rates, up to 80% or more
Clinical Protocols

- Designated destination for medically cleared patients in crisis
- Immediate patient evaluation and treatment by a psychiatrist
- Medication administration and on-going monitoring to determine if hospitalization is warranted or discharge
- Able to do oral detox, treat basic medical needs
Physical Space Design

**Key Take-Away:**
Calming, healing environment that prioritizes safety and freedom

- Large, open milieu space where patients can be together in the same room – high ceilings and ambient light

- Space to move about and engage in socialization, discussion, and therapy

- Rather than beds, comfortable recliniers in which patients can participate in treatment, discussions and groups, or fold flat for a nap

- Open nursing station w/instant access to staff - No bullet proof Plexiglas separating the patients

- 1-2 Calming Rooms for patients (unlocked spaces), avoid locked rooms or restraints
Alameda Model Study: Benefits of Psych ER to a County 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
What’s in a Name?

• Virtually all names mean different things depending on where you are

• **Crisis Stabilization Unit (CSU):** tend to be thought of as community-based, voluntary patients only, focused on crisis counseling and linkage to services

• **PES/ETS/CPEP:** tend to be County-run or County-contracted, in hospitals or free-standing, some restricted to Medi-Cal and indigent patients only. Usually able to accept involuntary (5150) patients. May serve as gatekeeper role for county inpatient beds and programs

• **PEETH unit:** On hospital campus but separate from ER proper, combine healing atmosphere of community CSU with ability to work with high-acuity and involuntary patients as in a PES
Applicability

• “But can this work in our system?”

• A model of PEETH Unit/Psych ER/Crisis Stabilization Unit 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”
Questions