ED Boarding and Other Approaches to Psychiatric Care

Notes & references for an invited presentation to the North Carolina Psychiatric Association Annual Meeting 2015

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Objectives
1) Audience members will be able to describe how "emergency department boarding" fits into the spectrum of approaches to providing emergency psychiatric care.
2) Audience members will be able to describe "cost shifting," and how it is often a critical issue in decisions about emergency psychiatric care.
3) Audience members will be able to describe at least two approaches to reduce "emergency department boarding."

Disclosures
None: neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services related to the content of this CME activity. I do not intend to discuss any unapproved or investigative use of commercial products or devices.

ED Boarding - Introduction
More and more patients are stuck waiting for care in emergency departments
Psychiatric patients in particular are waiting, and wait longer
It's a local phenomenon that has received national attention
Public concern about senseless violence & mass murders
   More background discussion can be found in
   For a sense of national attention to this topic see
   Pelly S. Nowhere to Go: Mentally Ill Youth in Crisis. CBS 60 Minutes 2014.01.26

Personal Perspective
Even at Yale, there are times we must evaluate & treat patients in our ED hallways
Administration and staff ask "what are you going to do about all your patients?"
Was different back when I joined the faculty in 1986: very little boarding, but state asylums were filled & underfunded
1990s saw Connecticut hospital closures and clinic reductions
2013 YNHH (Yale-New Haven Hospital) added 24x7 full time psychiatric ED faculty
2014 YNHH had gone from 8 ED Psych beds to 12 + 14 Observation beds
Our ED has implicitly become part of psychiatric services for a large area
   It buffers periods of increased demand for beds
   It substitutes for urgent clinic appointments
   It offers short term treatment or medication monitoring
NAMI Grades 2009
<< p.69 Connecticut ... In 2006, the state received a grade of B. Three years later, its grade has stayed the same... Connecticut’s paradoxes do not inspire confidence among consumers and family members. The fact that the state receives a B reflects its sophisticated vision and willingness to address problems. However, for a person with schizophrenia stuck in a nursing home, or a family who loses a loved one to suicide inside a state facility, the system is failing.

p.123 [Back] In 2006, North Carolina’s mental health system received a grade of D. Three years later, the grade remains the same, but does not even begin to convey the chaos that now pervades the state’s mental health care system.

p.137 In 2006, South Carolina’s mental health system received a B grade, one of the few states to reach the B range. In 2009, its grade is a D. This precipitous drop reflects the devastation of community mental health care at a point when the state is struggling with a budget crisis. >>

For their full report see:
https://www2.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75459

Conceptual Views of ED Boarding

Conservation of patients
Fewer patients in asylum beds, more patients in ED beds

Just Part of a Large System / Spectrum of Treatment
Primary prevention of behavioral problems (reduce poverty, reduce child abuse, etc)
PMD & PCP & School programs for early detection of mental illness
Psych Clinics, Crisis Centers, Halfway Houses, ED, Psychiatric Hospital for formal treatment
Psychiatry itself is part of a much larger health care system. For a larger overview see

Cost Shifting vs Cost Reduction
Reducing clinic hours, especially walk-in hours, shifts burden of urgent care to crisis centers or EDs
Goal: reduce cost; Effect: shift cost from clinic budget to crisis center or ED budget
Cost reduced only if people with self-limited trouble never receive formal care
Small scale cost shifting example: inpatient service requires ED patients have screening lab work for admission (CBC, ’Lytes, etc); shifts cost of lab tests & phlebotomy to ED

Queuing theory (patient flow without the euphemisms)
ED visit is a series of events each preceded by a wait, a queue
Get to the emergency department, after waiting for a transport (eg ambulance)
Triage, after waiting in line
ED bed assignment, after waiting for a bed to become available
Initial nursing evaluation, after a nurse finishes his/her current task
Urine drug screening, after waiting for specimen container & specimen...
Medical clearance, after waiting for a physician (and lab results)
Psychiatric evaluation, after waiting for a mental health professional
Psychiatric admission, after waiting for a bed to become available or Discharge, after waiting for followup instructions & paper work
Outpatient psychiatric treatment, after waiting for a clinic opening
Easier to improve flow after delineating tasks & queues & decision points
Acknowledgements

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For an introduction to queues and their sometimes surprising behavior see

For a review of queuing theory applied in health care see
Fomundam S, Herrmann J. A Survey of Queuing Theory Applications in Healthcare.

Models of Care / Approaches to reducing ED Boarding

Traditional med-surg approach
ED staff decide to admit or not, all delays are to be eliminated
Hospital inpatient services accept patients as quickly as possible
If there's a backlog / boarding:
  Speed discharges, reduce length of stay
  Inpatient teams start treating patients in the hall
  or Add more beds

Tinley Park 1970s- Just Admit (south side of Chicago, Cook County)
  Take whatever other hospitals and police send
Patients routinely fill hallways
For background see
  http://patch.com/illinois/tinleypark/a-ec8223af
  http://www.tplibrary.org/tinleynet-history-tinley-park-illinois

Chicago 1990s- Private ED & State Hospital Cooperation
Agree ahead of time on requirements for admission from private ED
  Zun LS, Leikin JB, Stotland NL, Blade L, Marks RC.
  A tool for the emergency medicine evaluation of psychiatric patients.

New Haven 2000 - Do More During the ED Visit
Put more staff and expertise at the front door (of large training center)

Milwaukee 2004-13 - Community Cooperation
Assemble police, sheriff, local clinics, EDs, private hospitals
Agree about utilization of the one, major psychiatric crisis service
Step back from the tragedy of the commons (overgrazing, depriving all)
For a description of the county crisis service, see
  http://county.milwaukee.gov/BehavioralHealthDivi7762/CrisisServices/Psychiatric-Crisis-ServicesObservation.htm [accessed 2015.08.29 20:48 UTC]
Aim to treat & discharge

Alameda 2005 - Central Psychiatric Emergency Service + Observation Units
Centralized county hospital service embraced the challenge
Simplified & standardized transfer from general EDs (ala Chicago)
EDs reciprocated for medical problems
Increased staffing
Observation unit expanded their capacity for quick (under 24 hour) intervention
Did enjoy favorable observation reimbursement
For details see:
Zeller S, Calma N, Stone A.
Effects of a dedicated regional psychiatric emergency service on boarding of
psychiatric patients in area emergency departments.
http://escholarship.org/uc/uciem_westjem?volume=15;issue=1
Alameda Health Systems (about us & fact sheet)
http://www.alamedahalthsystem.org/about-us

Pittsburgh 2007 - Intervene Before the ED
Offer a mix of phone, mobile, and walk-in service
Expand psychiatric crisis an urban location
Emphasize recovery model, minimize physician & medical intervention
<<Contact resolve Crisis Network 24 hours a day, 365 days a year. Telephone: call any time and
speak with a trained counselor at 1-888-7-YOU CAN (1-888-796-8226). Mobile: our trained crisis
counselors will travel to where you are — anywhere in Allegheny County. Walk in: you don’t need
an appointment when you visit our North Braddock Avenue location, near Pittsburgh, Pa. Just walk
in and talk about your concerns or those of a family member or friend. Residential services:
Residential and/or overnight services are accessible only for individuals, ages 14 and older, whose
crisis extends over a period of time. We provide up to 72 hours of residential services at our North
Braddock Avenue location. An individual may not admit him or herself for residential services, but
rather would be assessed during walk-in and then referred to residential services by a staff member.
Individuals must have a diagnosis to be admitted to residential, (but that could happen during a
walk-in evaluation).>>
For details see
http://www.upmc.com/services/behavioral-health/pages/resolve-crisis-
network.aspx [accessed 2015.08.29 20:55 UTC]

Texas 2008 – Telepsychiatry for Rural Areas
Stand-up / expand centers for psychiatric crisis in rural locations
RN, MSW, and counseling staff are on-site
Supply psychiatric (MD) expertise through telepsychiatry
For example, Burke Mental Health Emergency Center, Lufkin Tx
<<Burke Center, a community mental health center located in rural eastern Texas, began offering an
inspired approach to its psychiatric services in the latter part of 2008. The number of services
offered became much more in line with urban facilities thanks to the implementation of
telepsychiatry. Servicing a population of 370,000 in over 11,000 square miles, Burke Center is the
first psychiatric emergency program in which all services are performed by telepsychiatrists.>>
For details see
http://www.advancedtelemedservices.com/telepsychiatry-provides-
comprehensive-and-innovative-care-in-rural-texas/ [accessed 2015.08.29
21:06 UTC]
Avrim Fishkind, MD JSA Health Telepsychiatry
http://jsahealthmd.com/staff/ [accessed 2015.08.29 21:05 UTC]
Searching with Google for "telepsychiatry" also yields
Telepsychiatry made Easy - Snap.MD, www.snap.md
Unresolved Issues

Legal & Regulatory - State Statutes, EMTALA, TJC aka JCAHO
Gus Deeds case (Virginia) highlighted the way some state laws limit ED time
For details and legislative changes, see:
Developments in Mental Health Law, UVA May 2014
http://cacsprd.web.virginia.edu/ILPPP/PublicationsAndPolicy/DownloadPDF/67
JCAHO has set standards for care of patients boarding in EDs:
Patient Flow Through the Emergency Department
R3 Report: Requirement, Rationale, Reference
The Joint Commission Issue 4, December 19, 2012
http://www.jointcommission.org/assets/1/18/R3_Report_Issue_4.pdf
[accessed 2015.08.29 22:00 UTC]
United States Commission on Civil Rights views psychiatric patient boarding as a possible violation a disabled population’s rights: Patient Dumping
EMTALA could be used to force hospitals with psychiatric inpatient services to take emergency department patients independent of their financial status:
[accessed 2015.08.29 22:10]

Old concepts, new realities
Policy makers view American emergency departments are as if they shared their British counterparts’ name, “A&E – Accidents & Emergencies”
Nowadays, the public is starting to view all services like Jiffy Lube® or even McDonald’s®, and expects 24x7 operation to fit their schedule
Clinics and solo practitioners leaving instructions to call 911 after hours are not doing their patients any favors. Everyone knows to call 911. They may not know when they might call back and talk with someone they know.

Money is tight
State asylums are seen as large, costly
Psychiatric illnesses are seen as chronic, recurring
There are new calls on the public purse, like Hepatitis C treatment
Hidden cost of ED boarding is not well recognized, see
Law & Order remains popular

Voters may be more likely to approve funding for prisons than mental health centers
Court decisions require medical & mental health care for prisoners
Voters may not realize that prison funding is starting to go to mental health care:

Judicial Cost Shifting

For details see:
Ford M. America's Largest Mental Hospital Is a Jail - The Atlantic Jun 8 2015
http://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/

Suicide is of greater concern

Public is paying more attention to suicide as a waste of human potential
Ever since Columbine, public is worryiing more about collateral damage
No one is quite sure what to do about suicidal comments while intoxicated

What Can We Advocate?

We can work together or suffer separately.
To our Emergency Department colleagues

You can run but you can't hide!
To Hospital & Emergency Department Administration
JCAHO and the Feds are coming

It's not a question of whether or not to pay to care for the mentally ill, it's a question of how to use the money already being paid.
To our voters and policy makers.
(And, we should carefully weight the options if we are given some say over the funds.)