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
Appelbaum PS. "Boarding" Psychiatric Patients in Emergency Rooms: One Court Says "No More." Psychiatric Services 2015; 66:668–670

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 http://www.cbsnews.com/news/mentally-ill-youth-in-crisis/

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

Asplin BR, Knopp RK. A room with a view: on-call specialist panels and other health policy challenges in the emergency department. Ann Emerg Med. May 2001;37:500-503.

Kellermann AL, MartinezR., The ER, 50 Years On. N Engl J Med June 16, 2011;364;24

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
Shahani AK (1981). Reasonable averages that give wrong answers.Teaching Statistics 3: 50-54.
http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9639.1981.tb00425.x/abstract

For a review of queuing theory applied in health care see
Fomundam S, Herrmann J. A Survey of Queuing Theory Applications in Healthcare.
Inst for Systems Res Tech Report 2007-24, Univ of Maryland, College Park
http://drum.lib.umd.edu/bitstream/handle/1903/7222/tr_2007-24.pdf;jsessionid=4162562CF9A117FA8DC26F721866077E?sequence=1

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.
Am J Emerg Med. 1996 May; 14(3):329-33.

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:
ED Manag. 2015 Jan;27(1):1-5.
http://www.ncbi.nlm.nih.gov/pubmed/25564695
Zeller S, Calma N, Stone A.
Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments.
West J Emerg Med 2014;15:1-6. Feb 2014
http://escholarship.org/uc/uciem_westjem?volume=15;issue=1
Alameda Health Systems (about us & fact sheet)
http://www.alamedahealthsystem.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 re:solve 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

mytelepsychiatry.org - Advanced Telepsychiary, www.mytelepsychiatry.org
Telepsychiatry Video SW - securetelehealth.com
and more [accessed 2015.08.29 21.01 UTC]

Unresolved Issues

Legal & Regulatory - State Statues, 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*
http://www.usccr.gov/pubs/2014PATDUMPOSD_9282014-1.pdf [accessed 2015.08.29 22:10 UTC]
EMTALA could be used to force hospitals with psychiatric inpatient services to take emergency department patients independent of their financial status:
https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/
[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
Falvo T, Grove L, Stachura R, Vega D, Stike R, Schlenker M, Zirkin W.
The opportunity loss of boarding admitted patients in the emergency department.
Acad Emerg Med. 2007 Apr;14(4):332-7. Epub 2007 Mar 1.
http://www.ncbi.nlm.nih.gov/pubmed/17331916

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 worrying 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.)

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