TEAMHealth

WHITE PAPER

Addressing Psychiatric Boarding in the Emergency Department

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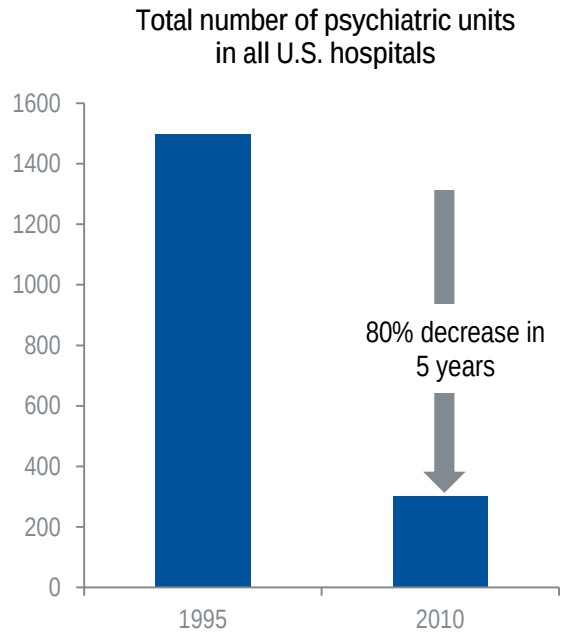
Across the United States, hospital emergency departments (EDs) are experiencing an increase in the number of patients seeking care for mental health emergencies. Most EDs lack both the hospital and community mental health resources and staff training to treat psychiatric conditions and are forced to "board" these patients until they can find available psychiatric inpatient beds, the numbers of which have greatly reduced over the last decade. This predicament – which can leave psychiatric patients isolated, bound to beds and/or parked in hallways for hours or days – is detrimental to both patients and hospitals. This white paper discusses the issues of psychiatric boarding and strategies that EDs can consider and employ to better manage patients experiencing mental health emergencies. It also makes suggestions for helping ensure that they receive the appropriate care as promptly as possible.

BACKGROUND

Psychiatric boarding in an ED occurs when patients present to the ED seeking psychiatric evaluation and treatment for which the ED lacks the appropriate resources to provide. Every patient presenting to an ED receives the required 'medical' screening exam by an ED provider, and once medically stabilized, is often required to then wait for an appropriate mental health resource to complete the psychiatric evaluation that is necessary to determine the safest and most appropriate disposition. This may include admission to an inpatient psychiatric facility or an outpatient community mental health clinic where the patient can receive follow-up care. The patient waiting time for a mental health resource, be it provider (psychiatrist and/or mental health professional) and/or psychiatric bed, can take upwards of many hours and days, and in some cases weeks, during which time patients are held and forced to wait in the unsuitable environment of an ED.

In 2014, 84 percent of emergency physicians responding to a survey by the American College of Emergency Physicians said psychiatric patients were being boarded in their ED.[i] The ED staff must then accommodate and hold these patients in an already overcrowded ED. This affects the emergency patients at large who are forced to compete for an insufficient number of beds and resources. As a consequence, patient care is delayed, as they must wait to be seen. This poses a complex challenge that requires a multi-disciplinary and multi-agency solution. In the meantime, the EDs assume the burden, with no immediate reprieve but to hold and to do their best under these difficult circumstances as they assume care for these patients and continue to advocate for their safety.

Unfortunately, the steady decline in the number of inpatient psychiatric beds in recent decades has made it increasingly difficult for ED staff members to find available beds when patients need them most.[ii] According to the nonprofit Treatment Advocacy Center, the number of state-owned psychiatric beds across the country declined by 14 percent between 2005 and 2010. This puts the number of beds available in the U.S. at just 28 percent of the number considered necessary for minimally adequate inpatient psychiatric services.[iii] The American Hospital Association reports the total number of psychiatric units in all U.S. hospitals declined from about 1,500 in 1995 to fewer than 300 in 2010.[iv]



CHALLENGE

For patients experiencing a mental health emergency, being forced to wait in an ED may only compound their distress. Some patients may receive private rooms but experience isolation. And those who are boarded in hallways are subjected to the 24-hour noise, lights, and chaos of an ED that may necessitate their restraint for the safety of themselves and others. A 2012 study published in *Emergency Medicine International* reports that prolonged ED stays are associated with "increased risk of symptom exacerbation or elopement" for mental health patients, and the external stimuli can "increase patient anxiety and agitation, which is potentially harmful for both

patients and staff," given that these patients may become physically violent.[v] In a study by *Accident and Emergency Nursing*, 38 percent of violence to ED nurses were from patients that displayed behaviors associated with mental illness.[vi]

The *Emergency Medicine International* study looked at data from a large academic medical center and also noted the possible negative impacts of psychiatric boarding on hospital operations and finances. For example, holding psychiatric patients in the ED generally results in patients with other medical emergencies settling for back-ups, increasing the risk of poor outcomes. Plus, because the length of stay for psychiatric patients awaiting inpatient placement was about 3.2 times greater than for non-psychiatric patients, each boarded psychiatric patient prevented the ED from treating 2.2 additional patients and resulted in $2,400 per psychiatric patient in missed revenue.

In a 2015 report, the Arizona Hospital and Healthcare Association estimates that psychiatric boarding costs the state's hospitals approximately $20 million annually. In that state, the number of mental health visits to ED doubled between 2004 and 2010, and psychiatric boarding increased 33 percent between 2012 and 2013.[vii] Many, if not all, other states face very similar issues.

STRATEGIES AND BENEFITS

Facing these challenges, EDs across the country are exploring and implementing new strategies designed to reduce psychiatric boarding and help all patients get the care they need when they need it most.

Telepsychiatry

Among the most common strategies hospitals can employ to address psychiatric boarding is the introduction of a telemedicine program in psychiatry, or a telepsychiatry program. These programs have been shown to help hospitals:

- Reduce psychiatric boarding
- Improve patient throughput
- Reduce patient wait times
- Lower the risk of elopement and injury

Telepsychiatry may not be an available or appropriate option for all facilities. In those cases, hospitals may find success implementing other practical innovations, such as specialized units within the ED that are dedicated to psychiatric patients.

Telepsychiatry programs are designed to expedite the provision of psychiatric care to patients in crisis and reduce both boarding and length of stay. These programs use telecommunications technology, such as videoconferencing, to make psychiatrists available on an "on-demand" basis to provide evaluations to psychiatric patients in the ED.

Through this model, hospitals that do not have a psychiatrist on staff can get quick access to a specialist to help evaluate a patient, assess risk factors, discuss disposition and treatment plans or dispense psychotropic medications. In many cases, this kind of access to a psychiatric specialist can help alleviate boarding by quickly determining which patients are safe to discharge.[viii] And in situations where inpatient care is required and the patient must wait in the ED prior to being transferred, telepsychiatrists can help emergency physicians determine the appropriate medications to begin treatment

immediately – hopefully providing some short-term symptom relief and shortening the patient's psychiatric hospital stay.[ix]

Hospitals that have implemented telepsychiatry programs for ED patients have seen positive results, including reduced wait times, decreased staff burden and monitoring responsibilities, and lowered risk of patient elopement and staff injury.[x] In addition, these programs can result in reduced expenses related to boarding, involuntary commitments, patient sitters, length of stay, non-reimbursable admissions, and delayed discharges.[xi] One health system in North Carolina saw a reduction in length of stay from 48 hours to 22.5 hours for psychiatric patients discharged from the ED to an inpatient psychiatric setting.[xii]

Specialized Units

Some hospitals may find success in reducing psychiatric boarding by segmenting and designating an area of the ED specifically for mental health patients, providing an environment that is more conducive to psychiatric well-being while better managing internal resources.

St. Joseph Medical Center in Bellingham, Washington, found success by creating a Special Emergency Care Unit, or SECU.[xiii] The SECU is a five-bed carve-out from the 39-bed ED that is housed in a separate area, away from the main ED. It offers enhanced security features for the safety of both patients and staff, including secured access to the unit, storage of in-room gases and equipment within locked cabinets and acrylic glass windows that allow for visualization by staff into the unit and individual rooms.

The SECU is staffed 24/7 by a psychiatric nurse and behavioral health counselor, and observation attendants are used when needed to augment the staff. In addition, social workers provide mental health evaluations and coordination of outpatient services. Psychiatrists round on the patients who are waiting for an inpatient psychiatric bed – which may be in the campus' inpatient psychiatric unit – and begin patients' treatment.

Since implementing the SECU, the hospital has seen a reduction in the use of restraints and seclusion from approximately 25 episodes per 1,000 patients to around 7 episodes per 1,000. It has also had a 50 percent reduction in violent encounters against staff and a 50 percent reduction in patient elopements.

Management Strategies

For hospitals where telepsychiatry or specialized units are not possible options, there are a few general tactics that can positively impact the management of psychiatric patients. These strategies can also help improve patient and staff safety as EDs mitigate challenges related to caring for psychiatric patients who are frequently boarded for extended periods.[xiv] These management tactics are multi-pronged and include efforts involving administration, training, technology, and enhanced staff awareness. It also

includes collaborating and building an alliance and partnership with key stakeholders in the community who are also involved in the management of the psychiatric patients.

Some strategies to consider include:

- *Initiate a dialogue*. Include hospital leaders, risk management, HR, and multi-disciplinary front-line staff (i.e., security and physicians/providers). Also, include outside law enforcement, mental health, and community members to incorporate their perspective in discussing patient and staff safety issues related to the psychiatric patients. The purpose of these discussions is to align goals, share different perspectives, create a partnership with the patient at the center, and apply collective brain trust to solutions.
- *Conduct a security assessment.* Include physical assessment of the ED (parking lots, corridors, patient rooms, waiting room, work stations); review policies and procedures (which are frequently not aligned among the different disciplines); review of incidences/injuries to trend and identify risk areas; review of training (de-escalation, take-down procedure, restraint); and interview of staff and patients/families and technology (that includes access controls, video cameras, and alarms).
- *Review policies and procedures*. Many hospitals have separate security and clinical policies that should be reviewed and integrated to help staff better coordinate care for psychiatric patients.
- *Enhance data reviews/reporting*. Better understanding the cause and numbers of incidents of violence and staff injury is critical to developing solutions. As data and reports are generated and tracked through different departments, as well as processes and systems (security, HR, RM), information should be drawn from the various systems to review. Hospitals should consider the impact of under-reporting by staff as a problem that is common among ED staff. Incidences should be assessed and tracked in a way that allows for a global view to identify areas requiring staff training or other action.
- *Create controlled access* to reduce opportunities for elopement and violence. Considering ingress and egress doors for patient rooms to prevent entrapment can also help reduce injuries.
- *Evaluate use of metal wands and detectors,* which is controversial for many EDs with concerns related to potential adverse perceptions of patients.
- *Conduct staff training*. Recommend conducting staff training that is standardized and combines different multi-disciplinary team members to include physicians, nursing staff, security and other support staff. Staff training programs should be designed to include any specific problems or needs, as well as de-escalation, basic self-defense/team take-down, and other safety techniques and strategies.

The Franciscan Health System (Catholic Health Initiatives) Emergency Departments, comprised of five hospital EDs in the Pacific Northwest (St. Joseph Medical Center, St. Francis Hospital, St. Clare Hospital, St. Anthony Hospital, and St. Elizabeth Hospital) conducted a comprehensive security assessment for their EDs in 2011/2012 as a tactic to address the growing psychiatric patient volumes and holds in the EDs. This resulted in system-wide countermeasures that included implementation of standardized training for the different disciplines as well as policy and procedure alignment.

CONCLUSION

Boarding psychiatric patients in the ED creates challenges for patients, ED staff and hospitals. When possible, hospitals should consider strategies that allow for a reduction in boarding and enhancement in timely care for psychiatric patients. Implementing a telepsychiatry program or creating a carve-out unit within the ED are two strategies that have proven successful for hospitals with a high volume of psychiatric patients in the ED. In cases where those strategies are not an appropriate fit, hospitals may want to consider smaller-scale steps to improve patient management and ED safety.

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