white paper

TEAMHealth

Beyond Boarding: A New Paradigm for Behavioral Health in the Emergency Department

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Individuals with mental health or substance-use related issues are one of the fastest growing patient populations in U.S. hospital emergency departments. Between 2006 and 2014, this population experienced a 44% increase in emergency department (ED) visits.[i]

This surge is creating a crisis for some hospitals. Without adequate access to behavioral health specialists to perform mental health evaluations or readily available psychiatric beds for admission, these patients often hold or "board" for hours, days and even longer, often without receiving the specialized psychiatric care they need. While these patients wait, their conditions may be exacerbated by the isolation of a private room or the loud and chaotic environment of an ED hallway. In addition, by occupying beds that might otherwise be taken by patients with physical medical conditions, these patients can inhibit patient flow, extend wait times and contribute to ED diversions.[ii]

There are a multitude of factors that have led to this situation, and hospitals cannot solve the problem alone. They can, however, make some fundamental changes to the way they approach and treat patients with behavioral health conditions while boarding in the ED to improve their care and, concurrently, expedite patient flow. This

white paper discusses a new approach to treating behavioral health patients in the ED.

THE CHALLENGE

The rise in behavioral health ED visits can be attributed to several converging trends, making it a complex problem with no quick fix. The country is amid a well-documented mental health[iii], drug abuse and addiction[iv] crisis. According to the National Institute of Mental Health, nearly one in five U.S. adults lives with a mental illness,[v] and individuals with mental health diagnoses make 25% more visits to the ED than those without mental illness.[vi] In addition, the Center for Disease Control (CDC) reports 48.5 million Americans used illicit drugs or misused

prescription drugs in 2016, with the number of opioid overdose visits to EDs increasing 30% in the 14-month period ending September 2017.[vii]

Meanwhile, the systematic closure of state mental health facilities in prior decades has dramatically reduced the number of psychiatric beds available for those who require inpatient treatment.[viii,ix] Additionally, a national shortage of mental health professionals often makes it difficult for hospitals to obtain timely patient evaluations to determine whether they require inpatient care or can be discharged to an outpatient setting.[x] A 2016 survey of 1,700 emergency medicine clinicians by the American College of Emergency Physicians found only 16.9% had a psychiatrist on call to respond to psychiatric emergencies in the ED, and more than 11% reported having no one to call in those situations.[xi]

While these patients wait, some emergency clinicians may feel unprepared to initiate treatment that looks beyond a medical screening examination and medication to sedate patients if their condition escalates. Previously, these patients would undergo a short-term stay for evaluation and transfer, but that's no longer the case. When patients wait hours, days or longer without getting the care they both need and deserve, their condition often worsens—and the entire ED feels the negative impact of slower patient flow, reduced quality and worsened patient experience.

FACING A NEW PARADIGM

Hospitals can't change the trends driving behavioral health patients to the ED. What they can do is change the way they think about this patient population and take a more active approach to providing mental health treatment. With the right perspective, tools and training, ED teams can deliver better, more meaningful care to behavioral health patients to shorten boarding or hold times, expedite discharges and improve flow throughout the department.

CHANGING THE PERCEPTION

A large share of behavioral health patients who board in the ED to wait for a mental health evaluation ultimately do not need inpatient treatment and can go home with a referral to outpatient or other community-based resources. Others will continue to wait for an inpatient bed.

It's time to approach those patients who are unlikely to require an inpatient bed as an opportunity for a quicker discharge. And, particularly for those they suspect will need inpatient care, it may be advantageous to begin offering medication beyond sedatives to de-escalate agitated patients.

Consider how ED clinicians treat behavioral health patients compared to those with physical conditions, such as pneumonia. A patient with pneumonia would not be made to wait for an inpatient bed before receiving antibiotics, breathing treatments or other necessary care. ED clinicians would administer treatment right away, knowing fast treatment increases the patient's chances of a swift recovery. If hospitals approach behavioral health patients in the same way — moving with urgency to secure an evaluation and/or begin active care — with the goal of discharging patients home, if possible, they can potentially:

- Help patients get well, faster
- Expedite discharges, improving patient flow throughout the ED and to inpatient units
- Reduce wait times, length of stay and left without treatment rates
- Improve all patients' experience of care in the ED
- Reduce demand for patient sitters, security, etc.

A ROLE FOR TELEPSYCHIATRY

For hospitals struggling with timely mental health evaluations for ED patients, telepsychiatry is an increasingly attractive option for access to high-demand specialists. Telepsychiatry programs are designed to use telecommunications technology, such as videoconferencing, to make psychiatrists available "on-demand" to provide evaluations to psychiatric ED patients. Through this model, hospitals without a mental health professional on staff can receive quick access to specialists for patient evaluations, risk factor assessments, disposition and treatment plan discussions and psychotropic medication recommendations.

Telepsychiatry, when available, can alleviate patient boarding by quickly determining which patients are safe to discharge. When inpatient care is required, it can provide support to the emergency clinician in determining appropriate medications for treatment while the patient awaits placement. Effective programs will also encourage reassessment of patients in the ED for prolonged periods, allowing for care adjustments when necessary.

START MEDICATION

Regardless of telepsychiatry is availability, ED clinicians can take steps to provide better quality care to behavioral health patients. Starting medication is often the best strategy to manage the patient's illness and keep him

stable while waiting for a consultation or bed placement.

The vast majority of behavioral health patients can benefit from medication. Patients with psychosis can rapidly improve with antipsychotic medication. At times, patients with depression can improve with a single dose of an anxiolytic to allow them to sleep and can be discharged in the morning. The sooner the patient begins treatment, the better. For example, if you have a patient with severe depression in the hospital for more than a week, starting antidepressants on day one might allow them to return home.

When starting antidepressants or medications for bipolar affective disorder, a psychiatrist should be consulted. A simple and safe guideline for emergency clinicians is to start patients on their prior medications in case they have not been recently compliant with prescribed doses.

OFFER TRAINING

In the past, emergency clinicians may have thought prescribing behavioral health medications was outside their scope of practice, primarily because of the delayed clinical effect of these medications extending beyond the duration of the traditional ED visit. Providing additional education on behavioral health conditions—beyond usual emergency care—and appropriate medications to start in the ED for longer-term management may help overcome such hurdles so clinicians feel confident in how to approach treatment for patients who present with depression, suicidal thoughts, agitation, psychosis, etc.

Will a patient's outpatient or inpatient psychiatrist ultimately change or adjust a medication after discharge? Possibly. However, if clinicians receive training and feel confident in initiating longer-term care, it can go a long way to helping patients get better faster and potentially be discharged more quickly. Ideally, medications could even be adjusted in the ED as patients are evaluated for clinical responsiveness.

CONSIDER THE ENVIRONMENT

If possible, EDs should also offer an environment that does not exacerbate symptoms. That means avoiding isolation and restraint when possible, providing human interaction, ensuring bathroom privileges, etc. Like all patients, behavioral health patients should be cared for and treated with dignity and respect. For individuals who may be a threat to themselves or others, ED leaders should ensure patient rooms are safe and provide a 1:1 sitter relationship, when necessary.

For one TeamHealth client hospital in Pennsylvania, the creation of a five-bed behavioral health suite within the ED helped reduce restraint use among the approximately 135 behavioral health patients it treats each month. It's a calmer environment, free from the loud sounds of monitors and staffed with a dedicated, specially-

trained nursing team. Clinicians start medications when appropriate and round on patients each shift. A psychiatrist from the hospital's affiliated psychiatric facility is available when necessary. The improved environment and enhanced focus on these patients have been well-received by patients and staff.

ONGOING MANAGEMENT IS CRITICAL

After providing treatment, clinicians should re-evaluate behavioral health patients who remain in the ED. As in the example above, regular rounding on these patients allows clinicians to better monitor symptoms, evaluate the effects of medications and assess improvement. Following treatment, many patients can be discharged with a referral for outpatient services.

The outpatient referral should particularly be emphasized when prescribing medications prior to discharge. Side effects that most often appear days after starting a medication are a leading reason for suicide attempts. Connecting patients to outpatient follow-up in a very short time is critical.

CONCLUSION

Industry trends indicate hospital EDs will continue to see a high volume of behavioral health patients. Instead of providing expectant care while patients board in the ED, it's time for hospitals to take a more active approach to caring for these patients – moving with urgency to secure an evaluation, providing meaningful treatment and re-evaluation with the goal of helping patients get better faster. This shift in thinking can help EDs deliver better care, improve the patient experience, and improve patient flow while also creating a safer work environment for ED staff.

If you would like more information concerning Clinical Integration, please contact our Business Development team today at **800.818.1498** or ***business_development@teamhealth.com***.

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