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FEATURED ON THE BARTON BLOG:

NEW TRENDS IN EMERGENCY PSYCHIATRY

Strategies to treat psychiatric crises and improve ED throughput

Reports continue to surface indicating that psychiatric patients are overwhelming emergency departments (ED) nationwide. The surge is extending wait times for both psychiatric and non-psychiatric patients, impacting the timeliness of care provided, and affecting hospitals' ability to generate revenue.

At Emanuel Medical Center in Turlock, CA the number of patients with psychotic diagnoses presenting to the ED has doubled since 2007, according to an article in The Modesto Bee.

Similarly, a recent study published by the American College of Emergency Physicians (ACEP) found that psychiatric patients spend an average of 11.5 hours boarded in the ED.

"We know that general EDs are getting overwhelmed because of the contraction of inpatient and outpatient psychiatric services, and we know that it is affecting the length of stay patients have in the ED," says Dr. Leslie Zun, Chairman of the Department of Emergency Medicine at Mount Sinai Hospital in Chicago.

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In fact, a recent HealthLeaders Media Intelligence Report survey found that 46% of respondents said their ED is overcrowded, and 43% said improving patient flow was their greatest strategic challenge.

To deal with the influx of patients with psychiatric needs, some facilities are implementing Psychiatric Emergency Service (PES) programs. According to the HealthLeaders Media report, 42% of EDs surveyed have programs that focus specifically on psychiatric health issues.

Comprehensive Psychiatric Emergency Programs

Some facilities have established dedicated emergency psychiatric programs called Comprehensive Psychiatric Emergency Programs (CPEP) to deal with the influx of patients with psychiatric needs. CPEPs are dedicated to treating individuals experiencing a psychiatric crisis. Individuals that typically present to the CPEP are either a danger to themselves or others. Some may have attempted suicide, attacked a person, or been found unfit to care for themselves.

The typical CPEP is staffed 24/7 with psychiatrists, psychiatric nurse practitioners, and other mental health professionals. Psychiatrists are generally either onsite or readily available; however many different models exist. In some cases, CPEPs are an extension of a healthcare facility's medical emergency department. St. Joseph's Hospital in Syracuse, NY operates a CPEP program within the hospital's Emergency Services Building. Other healthcare organizations operate the CPEP as a free-standing facility, such as the UHS facility in Binghamton, NY.

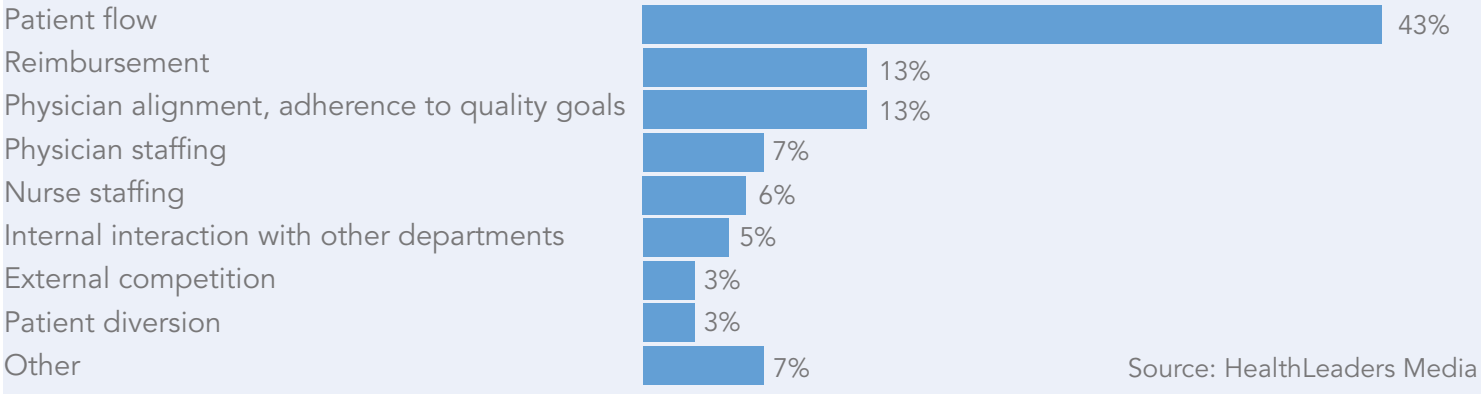
> "We know that general EDs are getting overwhelmed because of the contraction of inpatient and outpatient psychiatric services."
>
> ***– Scott Zeller, MD***

Individuals who present to the CPEP receive a complete psychiatric evaluation, and if necessary can be held in certified emergency observation beds for up to 72 hours for additional evaluation. From there, individuals are either discharged home or to another mental health facility.

A cost effective solution

CPEP programs are a cost-effective way to treat individuals undergoing a mental crisis, says Dr. Scott Zeller, Chief of Psychiatric Emergency Services at Alameda County Medical Center and president of the American Association for Emergency Psychiatry.

What is the greatest strategic challenge for your ED?



Source: HealthLeaders Media

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"A good emergency psychiatric program can treat people in crisis and avoid hospitalization 70% of the time," Zeller says. "Many of these patients would be automatically admitted if they presented to the medical ED," Zeller adds.

Quickly treating psychiatric patients and preventing inpatient admission is not only good for the hospital's bottom line—psychiatric patients are typically underfunded or unfunded—it is what is best for the patient. In some medical EDs, psychiatric patients can spend days in the ED waiting for a psychiatric consultation. "That is not the best place for them," Dr. Zun says.

In many areas, CPEPs serve as regional psychiatric evaluation sites. EDs transfer medically stable patients to the CPEP where the staff then treats patients and determines whether inpatient admission is necessary. The facility in which Dr. Zeller practices receives transfers from nine area medical EDs.

"Having one regional CPEP decompresses area EDs and is a very cost-effective solution," Dr. Zeller says, "One day in the CPEP is much cheaper than a psychiatric admission, which would rarely be shorter than three days."

In a 2008 survey conducted by the ACEP, 81% of respondents agreed that regional CPEPs nationwide would be better than the current system of boarding psychiatric patients in the ED.

Regional CPEPs improve the emergency experience for both psychiatric and non-psychiatric patients. The programs ensure psychiatric patients quickly receive the care they need in the appropriate setting while also freeing up valuable emergency beds for non-psychiatric patients in the area's medical EDs. They also help medical EDs move patients through the system more effectively and maximize patient volume.

A growing trend

Dr. Zeller estimates there are 200 dedicated CPEPs in the country. There are even more EDs that offer emergency psychiatric services in other ways, either with a dedicated wing or an emergency psychiatrist on staff. Those numbers are continuing to grow as more facilities learn about the benefits emergency psychiatric programs provide. B

CPEP by the numbers:

200 CPEPs operating in the United States

81% of doctors believe regional CPEPs would be better than the current system of boarding patients

71% of patients treated in emergency psychiatric programs avoid hospitalization

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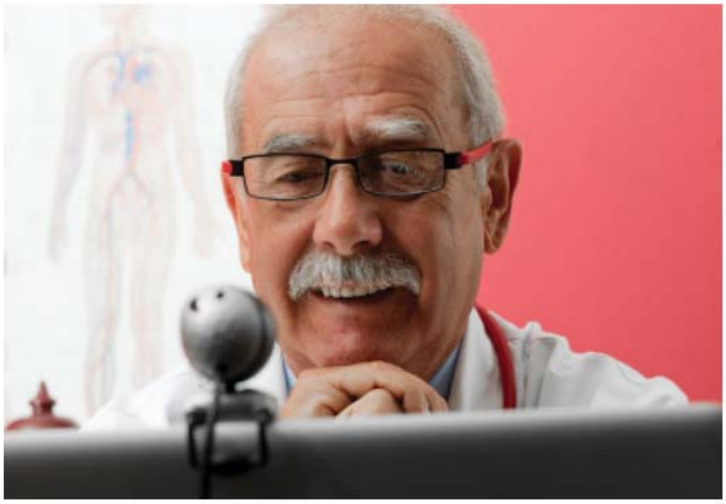
MOBILE CRISIS UNITS AND TELEPSYCHIATRY

Comprehensive Psychiatric Emergency Programs (CPEP) provide care to individuals undergoing a psychiatric crisis, but what about people who cannot get to a CPEP?

That's where mobile crisis units come in. Mobile crisis units provide emergency psychiatric services to individuals who are not willing or able to travel to receive proper treatment. They deploy into the community to perform assessments and in some cases administer medications to individuals undergoing a psychiatric crisis.



In many cases, mobile emergency psychiatric teams get a majority of referrals from law enforcement, says Dr. Scott Zeller, Chief of Psychiatric Emergency Services at Alameda County Medical Center and president of the American Association for Emergency Psychiatry (AAEP).

For example, police respond to a 911 call about a disturbance. After assessing the situation, officers determine that the individual stopped taking prescribed medication and became paranoid. Police then call the mobile crisis team to come to the scene and handle the situation. Upon their arrival, the police are often free to leave and attend to other calls.

According to Dr. Zeller, mobile teams can be extremely helpful in reducing the number of patients that come to the emergency department (ED) or CPEP. Mobile teams are also used to check up on patients who were recently discharged from the hospital, making sure individuals are sticking to their medication regimen and going to appointments.

Many rural mental health providers who lack the resources to support an onsite emergency psychiatrist are turning to telepsychiatry. This option allows a psychiatrist to communicate with individuals via a secure webcam link, rather than in person.

Burke Center, a mental health center in rural Texas, uses telepyschiatry. Within 30 minutes of arrival at Burke Center, the patient is scheduled to see a psychiatrist via videoconferencing regardless of the hour or day of the week.

Some facilities have created a separate unit that houses multiple patients that use telepsychiatry for treatment. Other organizations that cannot afford to create a new unit simply use telepsychiatry technology within the medical ED.

The method works well, according to Dr. Zeller. Initially there was concern that patients would not respond well to speaking with a psychiatrist that appears on a monitor. However, many facilities have actually found patients to be more forthcoming than they would in a face-to-face setting, Dr. Zeller says.

Mobile crisis units and telepsychiatry technology are just two examples of the innovative strategies providers are using to treat psychiatric patients more effectively and efficiently while freeing up valuable resources in the medical ED. B

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EDUCATIONAL OPTIONS FOR ED STAFF

In a time of decreasing reimbursement, it is not easy for facilities to implement psychiatric emergency programs such as Comprehensive Psychiatric Emergency Programs (CPEP), mobile units, or dedicated telephyschiatry units. The problem is compounded by the fact that psychiatric patients are notoriously under- or un-funded, says Dr. Leslie Zun, Chairman of the Department of Emergency Medicine at Mount Sinai Hospital in Chicago.

"What hospital in this country wants to add a service that doesn't pay?" Dr. Zun asks.

Converting an existing space into an appropriate emergency psychiatric space for a CPEP or dedicated telephyschiatry unit that houses multiple patients can cost millions, Zun says. And purchasing the equipment for a mobile emergency psychiatric unit can be equally expensive.

The hard truth is that many facilities see boarding psychiatric patients in the emergency department (ED) as standard operating procedure. In that case, it is essential that ED staff understand the needs of psychiatric patients in order to ensure the services they receive while boarded in the ED are the same as they would receive on the floor, Zun says.

National Update on Behavioral Emergencies

Dr. Zun developed a national two-day conference to help ED staff understand and treat psychiatric patients. The National Update on Behavioral Emergencies looks at cutting edge techniques for emergency psychiatry and discusses issues such as psychiatric boarding, discharge decisions, and ED treatments.

"We all agree that emergency physicians, psychiatrists, nurse practitioners, and social workers need help when dealing with psychiatric patients in the ED," Dr. Zun says.

The following are a few of the topics that will be discussed at this year's conference, which will be held in Las Vegas December 5-7, 2012:

- New drugs of abuse
- Pediatric behavioral emergencies
- Difficult patient presentations
- Providing psychiatric care with limited resources
- Who can go home with suicidal thoughts

Emergency psychiatry certification

Those who attend the National Update on Behavioral Emergencies earn continuing medical education credits that may be applied towards American College of Emergency Physicians (ACEP) and American Medical Association (AMA) credentials.

At this time there is no specific certification for emergency psychiatry services, but the American Association of Emergency Psychiatrists (AAEP) is looking into developing one, says Dr. Scott Zeller, Chief of Psychiatric Emergency Services at Alameda County Medical Center and president of the AAEP. Doing so would be a step towards standardizing emergency psychiatry and improving patient care. B

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