Hospital Strategies For Addressing Psychiatric Boarding

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The issue of how to address psychiatric emergencies in a prompt fashion – and without long waits that constitute "psychiatric boarding" – has been the recent subject of legislation (see Washington Ban On Psychiatric ER Boarding, and of my recent piece on the implications, Washington Ban On Psychiatric ER Boarding May Have Longer Legs). And that issue drew some great commentary from readers – Another Perspective On Psychiatric Boarding and You Have To Take Something Out, To Put Something In – published earlier this week.

But the issue is hitting the mainstream press. Just this week there have been updates on the situation in Washington – Washington DSHS Gives Progress Report On Psychiatric Boarding and Psychiatric boarding patients end up in jails on competency waitlists. The newspaper in Orange County, California also published a three-part series on the topic – Part 1: Psych patients pack emergency rooms, Part 2: No beds for youngest psych patients in Orange County, and Part 3: County, hospitals wrestle over a fix for mental health care.

With all of this focus on the problem, I want to turn to a discussion of the solutions. One view is from the hospital perspective – what can hospitals do to reduce emergency room wait times? A piece by Jacqueline Fellows in *HealthLeaders*, Strategies for ED Psych Patients, outlined four solutions that hospitals are using to limit waiting times:

1. Collaboration among competitors
2. Regional psychiatric emergency service
3. Telepsychiatry on demand
4. Behavioral emergency response team

Collaboration among competitors – These collaborations limit waiting times in emergency rooms by encouraging partnerships between local hospitals to find available psychiatric inpatient beds for patients using hospital EDs, regardless of where the patient originally sought care.

Example: Franklin County Mental Health Collaborative in Columbus Ohio, which takes the "patient who has been waiting the longest for a psychiatric inpatient bed" and gives them "the first one available, no matter where it is located." That location could be Mount Carmel Health, a four-hospital system that is part of CHE-Trinity; OhioHealth, a nine-hospital nonprofit health system; or The Ohio State University Wexner Medical System, an academic medical center. Ms. Fellows reports the preliminary results – a drop of wait times went from six days in 2009, to 30 hours in 2010, to 19 hours in 2013.

Regional psychiatric emergency service – In this model, psychiatric patients are transferred from general hospital EDs to a regional psychiatric emergency service facility to speed treatment. This facility can receive direct transfers, and then assess and treat psychiatric patients.

Example: Alameda Health System, an integrated public health system based in the city of Alameda, California, and serving an 800-square-mile area that includes large cities such as Berkeley, Oakland, and Fremont, has established this system. In their "Alameda Model", psychiatric patients are transferred from general hospital EDs to a regional psychiatric emergency service facility, which can receive direct transfers from other hospital EDs and assess and treat patients with mental health emergencies. In this case, the PES is the John George Psychiatric Hospital, an 80-bed AHS facility in San Leandro. The statistics on the system are impressive – average boarding time in the Alameda Model was less than two hours (107.6 minutes) and only 24.8% of patients actually needed an inpatient bed.

Telepsychiatry on demand – This technology-based solution is to speed time to service by having "on demand" telepsychiatry services for consumers with psychiatric emergencies.

Example: Seton Healthcare Family in Austin, Texas, an 11-hospital system that is part of Ascension Health, opened a new stand-alone psychiatric ED at its downtown Austin location, University Medical Center Brackenridge, that includes a 24/7 telemedicine suite.

Behavioral emergency response team – This model designates a specialist team that is on-call to respond to consumer needs in the emergency room.

Example: SSM Health Care–St. Louis, a seven-hospital system, established a three-person, behavioral emergency response team (BERT). The team includes a charge nurse, house supervisor, and security officer – "The charge nurse takes the lead, the house supervisor determines what resources are needed, and the security officer tries to build rapport." The approach has reduced escalation of consumer distress and use of physical interventions.

These four models are innovative approaches to this problem, from the hospital perspective. But, they don't answer the question of what is needed in financing of community-based services and in the design of community programming to decrease the need for ERs and speed the consumer transition home. We'll be looking for more innovative models in the months ahead.