Psychiatric Boarding: Averting Long Waits in Emergency Rooms

September 16, 2013 | Psychiatric Emergencies [1], Cultural Psychiatry [2]
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Emergency departments are often forced to hold patients who are acutely dangerous to themselves or others for long periods until an inpatient bed can be obtained.
Source:

Psychiatric patients awaiting treatment in hospital emergency departments (EDs) for hours and even days—a process known as "boarding"—has become a major issue across the US, with exposés appearing in publications such as *The Washington Post* and the *Los Angeles Times*.[1,2] A facility in South Carolina recently made national news after keeping such a patient for a stunning 38 days.[3] With few options for care at most sites other than transfer out for psychiatric hospitalization, EDs are often forced to hold patients who are acutely dangerous to themselves or others for long periods until an inpatient bed can be obtained.

Until now, many authorities have reported frustration over lack of effective solutions to this dilemma. Most proffered ideas have focused on opening up access to more inpatient psychiatric beds; in this regard, the Centers for Medicare and Medicaid Services has recently begun a demonstration project to allow more private psychiatric hospitals to accept Medicaid patients.[4] Yet such approaches still rely on the outdated concept that most acute psychiatric care requires inpatient hospitalization—a practice roughly equivalent to hospitalizing everyone who comes to an ED with chest pain. Relatively little attention has been paid to confronting the problem head on, by treating patients at the emergency level of care.

Addressing the problem at the front end, by providing emergency psychiatric services, is not a new concept. Dedicated psychiatric emergency service (PES) programs, often alternatively called a "CPEP" or "ETU" at locations around the country, are specialized EDs solely for psychiatric patients. In a 2008 American College of Emergency Physicians survey about psychiatric boarding, 81% of respondents endorsed "dedicated regional psychiatric emergency centers" as a potential solution to the boarding problem.[5] And later the same year, the US Department of Health and Human Services produced a study on boarding that called for expansion of PES programs as its top recommendation.[6] However, although one might presume a PES could lead to reduced boarding in a system, there have been few studies showing just how much of an effect there might be—and whether any such effect would be significant enough to justify creation of a PES. And then, if a PES is indicated, just how could such a program be funded?

Recently we tackled these questions, and reported our findings in a study published in the *Western Journal of Emergency Medicine*[7] We assumed there would be a noticeable difference between emergency medical systems with a PES and those without. But the profound disparity seen in the study data was truly amazing. Compared with state averages, the PES in the study decreased ED boarding times by over 80% and reduced the need for psychiatric hospitalizations by up to 75%. The PES was shown to dramatically increase access to care while substantially saving money overall.

The study compiled boarding and admission results in an emergency mental health system described as the "Alameda Model." This model, which features a dedicated, regional PES that immediately accepts, evaluates, and treats all medically stable mental health patients from area EDs and the community, is the key to these impressive numbers.

Whereas comparable California averages showed psychiatric patients boarding in EDs for 10.05 hours, in the Alameda Model patients waited a mean of only 1 hour and 48 minutes—a time reduction of over 82%. Further, only 24.8% of those patients needed hospitalization after evaluation and treatment in the PES. Even better, the study showed that the costs of all the care in the PES was less per patient than the cost of the typical boarding time in a general ED alone—not to mention the thousands of dollars more saved from avoiding a psychiatric hospitalization. And the design of the Alameda Model has two-thirds of psychiatric emergency patients coming directly to the PES from the community, thereby sparing area EDs completely from these cases and their related costs.

The fundamental concept is that most psychiatric emergencies can be treated to the point of stability and discharge in less than 24 hours. Thus, considering inpatient hospitalization as the only option is a tremendous waste of resources. What people in crisis need is immediate help, not sitting

for hours untreated in an ED while already overwhelmed staff members call around to arrange a multiple-day hospital stay.

A PES typically has the capacity to provide intensive treatment onsite for up to 24 hours. With this ability to both promptly evaluate and treat patients on an outpatient, emergency level, PES programs nationwide commonly can avoid the need for inpatient hospitalization in 70% or more of acute psychiatric patients. This can keep local psychiatric inpatient beds available for those patients who truly have no alternative.

While the benefits of a PES might seem clear, the price tag to create such a program might be considered a stumbling block. However, it may be that a simple coding change to US Medicare and Medicaid might permit such programs to be self-sufficient or even profitable, which could attract hospitals and private providers to develop a PES. Recently, our study team has been working with government agencies about considering this code change, which could result in overall cost savings for Medicare, Medicaid, and privately insured patients—while leading to improved quality and access to care and decreased hospital admissions. Such outcomes seem perfectly aligned with the goals of health care reform.

Note: This article was first posted online on September 16, 2013, ahead of the print publication date of November 2013.

Disclosures:

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