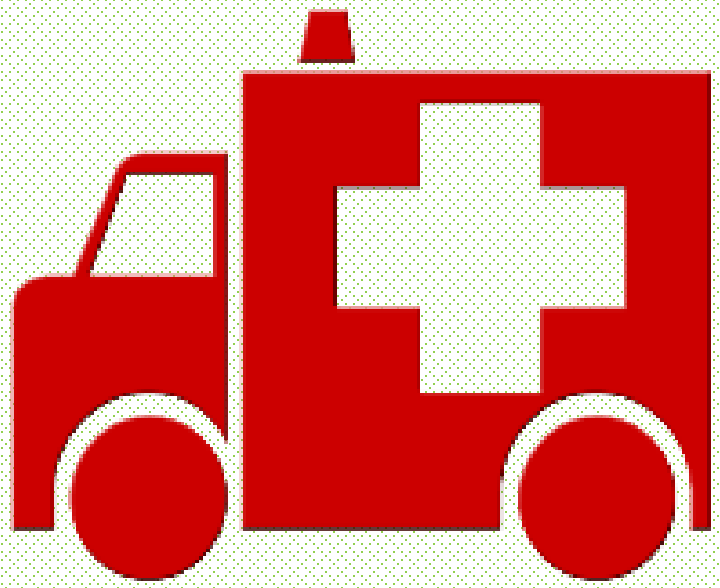
Improving care for Behavioral Emergency Patients for any size or shape Emergency Department

Scott Zeller, M.D.

Vice-President, Acute Psychiatry, Vituity
Assistant Clinical Professor| University of California, Riverside
Past President, American Association for Emergency Psychiatry
Immediate Past Chair, National Coalition on Psychiatric Emergencies

Psychiatric Emergencies are Medical Emergencies!!

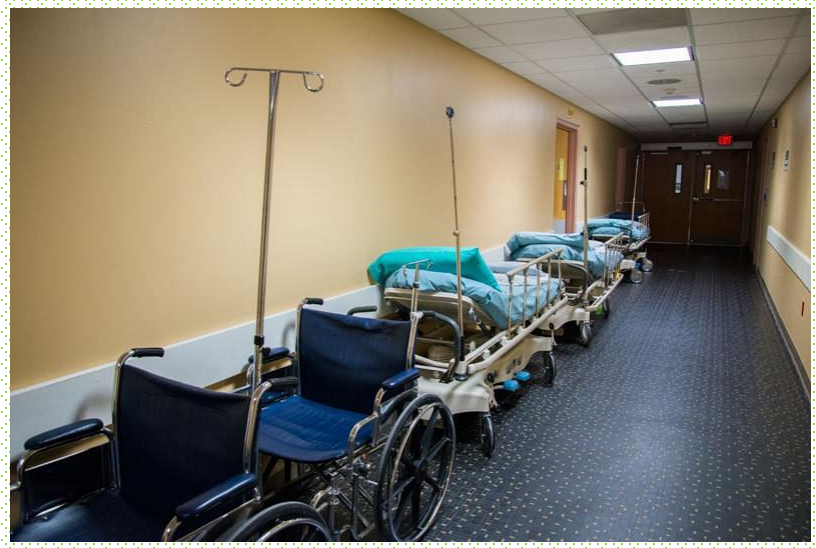


- Federal EMTALA Laws already designate psychiatric emergencies as equivalent to heart attacks and car accidents – time to start intervening with the same urgency and importance as medical emergencies

- Psychiatric Emergencies are not going to “go away” – better to start preparing for these, and designing emergency programs with the recognition that ability to treat crises are as necessary to ERs as EKG machines, oxygen and IV equipment

Boarding

- Definition: Patients in hospital medical Emergency Departments who are medically stable and just waiting for a psychiatric evaluation or disposition.
- Often these patients are kept with a sitter, or in “holding rooms” or hallways on a gurney – some languishing for hours in physical restraints, often with no concurrent active treatment
- ED environment itself can often make crisis patient symptoms worse



Bottlenecks and Inefficiencies

Psychiatric patients spend **3x longer** than other patients in the ED.

Longer LOS of psychiatric patients

Boarding of psychiatric patients

Operational
and
Financial Impacts

Prevents
2.2 bed turnovers

Financial Loss
$2,264 per patient

SOURCE: The Impact of Psychiatric Patients Boarding in Emergency Departments, B Hicks, DM Manthey, Department of Emergency Medicine, Wake Forest University Health Sciences, Winston-Salem, NC 27157, USA, June 2012

Focus for the past decade has been on community-based crisis solutions, with a goal of reducing the numbers of patients going to hospital ERs

- But the number of behavioral health patients coming to hospital emergency departments has only INCREASED during the past 10 years

- Behavioral emergencies are now 1 in every 7 patients in hospital ERs nationwide! ED Psychiatric Patient boarding averages across the nation ***often exceed 24 hours***.

- **HOSPITALS NO LONGER LOOKING TO EXCLUDE, NOW REALIZE "THESE ARE OUR PATIENTS TOO" AND ARE WILLING TO ENGAGE WITH QUALITY, TIMELY CARE. BUT TOO OFTEN, HOSPITAL CRISIS CARE IS OVERLOOKED IN STATE/COUNTY IN MENTAL HEALTH PLANNING AND FUNDING.**

- ***CRISIS CARE SHOULD NOT END AT THE EMERGENCY DEPARTMENT DOOR!***

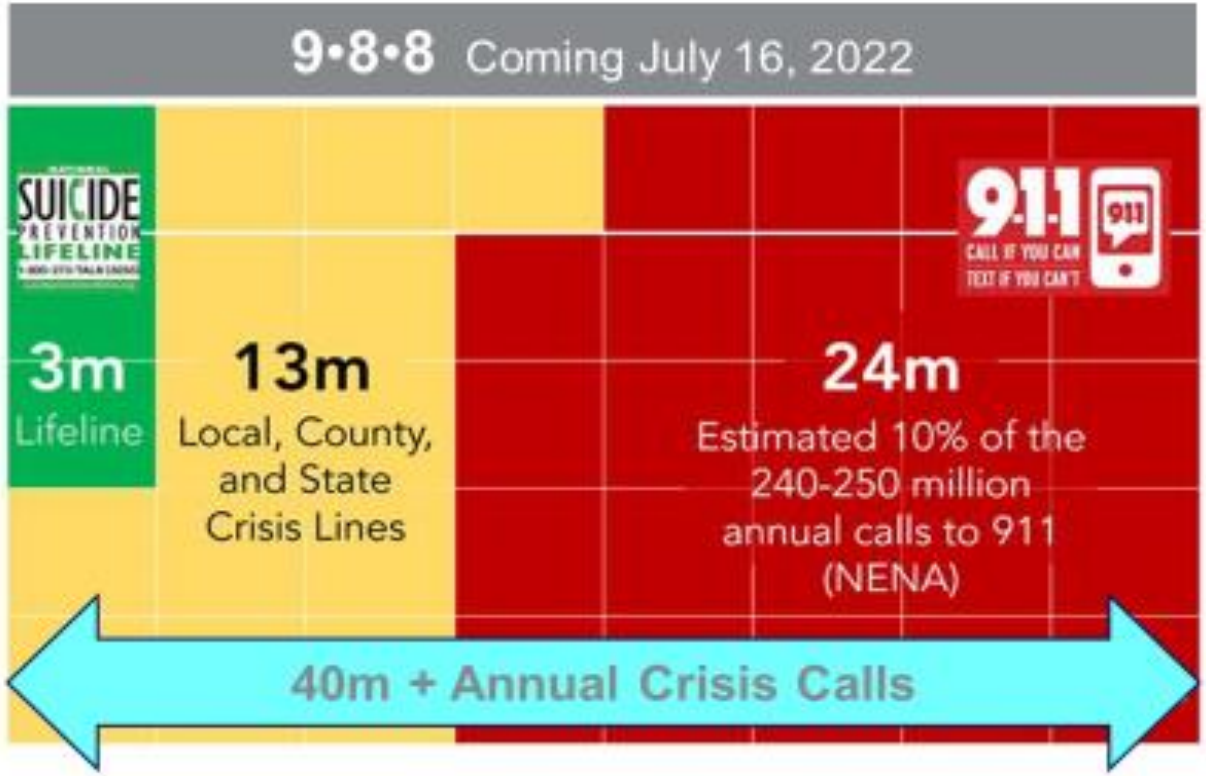
Many wonderful community crisis programs have been created with the hopes of reducing ED use for psychiatric patients – but here's why these often don't solve everything, and many emergency psychiatry patients still come to the ED:

1) **These programs tend to be set up for mild-to-moderate severity patients**
2) **They have exclusion algorithms for the more acute patients, which resort to 'send to the ED' or 'call 911"**

Common Exclusion Criteria for Community Crisis Centers

- ✓ **Patients who are currently agitated/aggressive or history of violence**
- ✓ **Patients with profound symptoms of psychosis/disorganization**
- ✓ **Patients with severe suicidal ideation or a serious suicide attempt**
- ✓ **Patients with active substance/alcohol intoxication or withdrawal**
- ✓ **Patients on involuntary status or with active criminal charges**
- ✓ **Patients pronounced comorbid medical issues**
- ✓ **Patients with vital signs abnormalities**
- ✓ **Patients with serious developmental disabilities/neurologic issues**
- ✓ **Patients who have utilized the crisis program too frequently/recidivists**
- ✓ **Patients who refuse indicated medications**

988: The new Nationwide 3-digit number for behavioral health emergencies



- Replaces the current National Suicide Prevention Lifeline 1-800-273-TALK
- Phone, Text, and chat functions
- Geolocation
- National standards
  - SAMHSA oversight
  - single national administrator
    Vibrant Emotional Health: www.vibrant.org
- People with BH emergencies now have an alternative to calling 911
- More info: https://www.samhsa.gov/988

Credit: Margie Balfour, MD PhD, Connections Health Solutions

‘Zeller’s Six Goals’ of Emergency Psychiatric Care

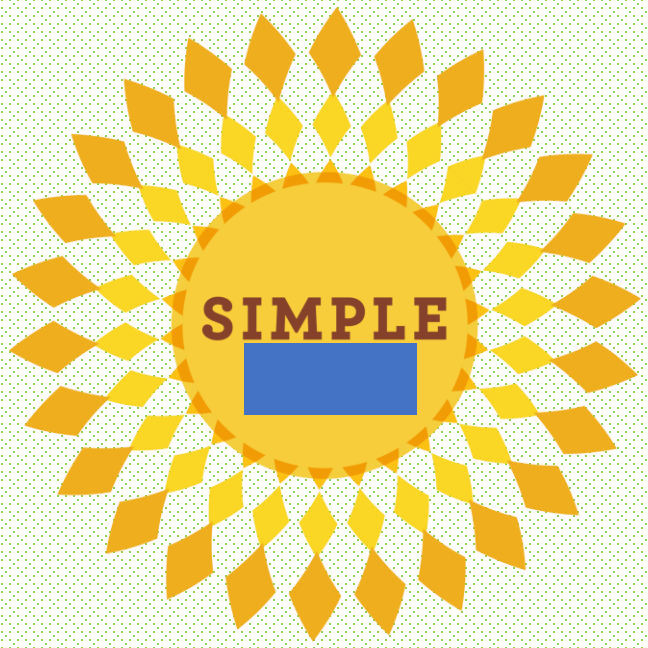
- Exclude medical etiologies of symptoms
- Rapidly stabilize the acute crisis
- Avoid coercion
- Treat in the least restrictive setting
- Form a therapeutic alliance
- Formulate an appropriate disposition and aftercare plan

from Zeller, Primary Psychiatry, 2010

Simple Changes all EDs can make

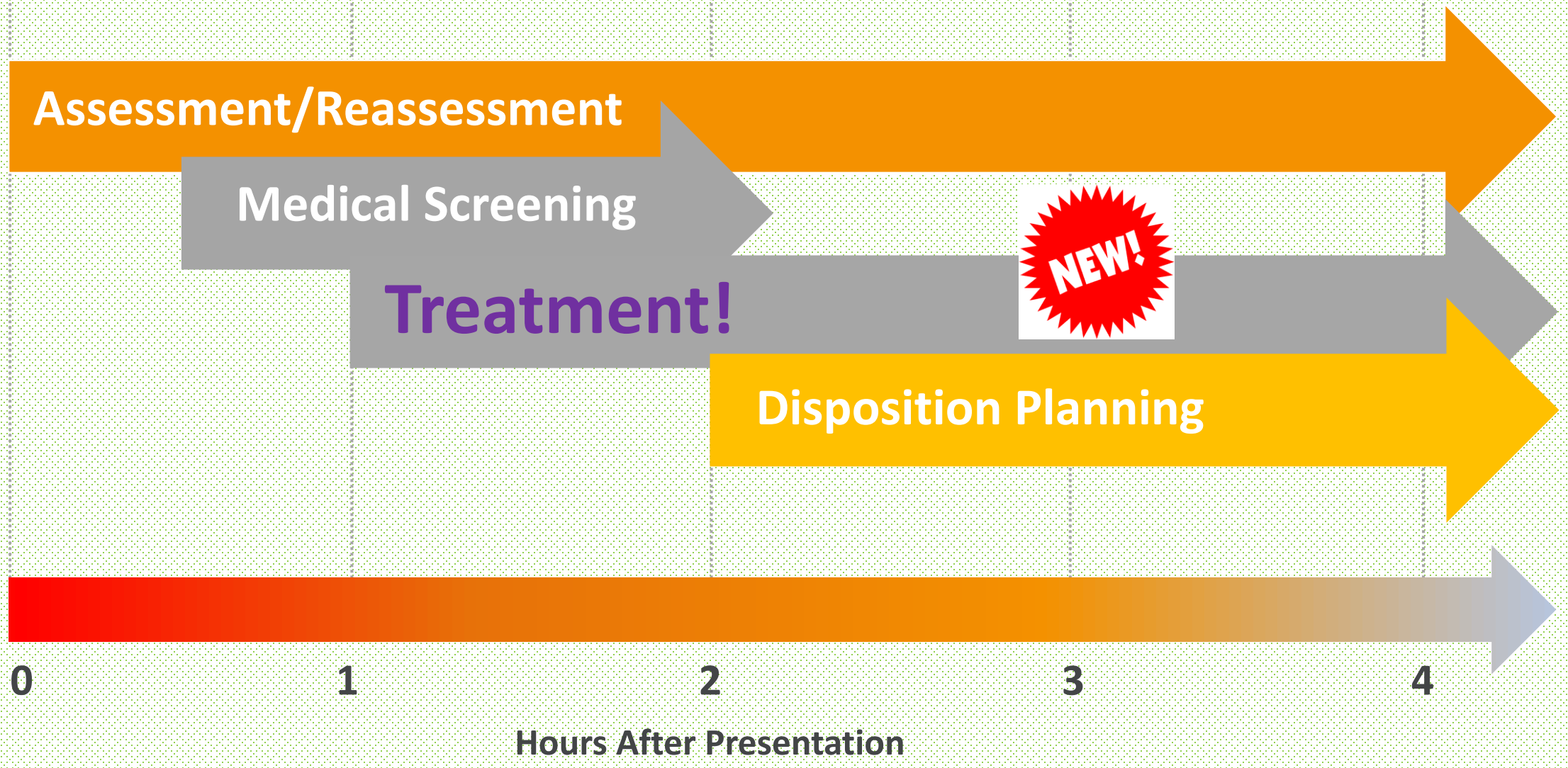
- Adopt a Trauma-Informed Approach
- Consider psychiatric emergencies the same as other medical emergencies in terms of obligations
- Start Mental Health Assessment and Medical Assessment simultaneously

Simple Changes all EDs can make



- No need for routine phlebotomy
- Don’t make disposition decisions based on a single snapshot in time
- Recognize psychiatric emergency conditions can improve with treatment while in the ER, and thus change disposition options

Goal-directed Interventions



Keys to Emergency Psychiatry Success

- 1. Speedy Evaluation by provider
- 2. Prompt initiation of treatment plan
- 3. Do not prejudge disposition, wait to see response to treatment plan
- 4. Regular reassessment and adjustment of treatment plan
- 5. Disposition decision after ample care time to least restrictive setting

Starting psychiatric meds in emergency settings– most useful for acute psychosis, agitation, anxiety

- **Oral meds preferred**
  - Less coercive, therapeutic alliance, reduced risk from needle use, easy to administer with cooperative patient

- **Calming is initial goal rather than heavy sedation**

- Traditional "B-52" cocktail can lead to oversedation, serious side effects, which can also seriously delay throughput

General Principles

- Restart existing meds when known
- Consider patient wishes when possible (more likely to continue a med they are OK with and is not forced on them)
- Better to start on regular schedule than waiting to be asked for prn's – by then it's often too late!

Agitation is an Acute Behavioral Emergency

- Agitation is an acute behavioral emergency requiring immediate intervention.
- The preferred intervention for calming the agitated patient is verbal de-escalation.
- Medication can help, and offering medication is part of verbal de-escalation.
- Unless signs and symptoms dictate emergent medical intervention, de-escalation must take precedence in an effort to calm the patient.

Goals of Agitation Medications

- Reduce dangerous behaviors, distress, anguish
- Minimize side effects
- Agitation meds are NOT chemical restraints!
- **Calm to tranquility, not unconsciousness**
- Minimize need for physical restraints
- Treat while creating therapeutic alliance
- Help decrease future episodes of acute agitation

Complications of Oversedation

- Prevents ability to do full medical/psychiatric evaluation, and can mask medical comorbidities
- Patients unable to answer questions
- Patients unable to keep self hydrated, other self care
- Psychiatric consultant will typically not come to evaluate until patient is awake
- Receiving hospitals/programs unwilling to consider patient transfers until alert, leading to boarding, dispositional delays
- Unconscious patient not receiving treatment but taking up vital space in ED – thus not helping patient while preventing other ED patients from treatment

Treating without medications

The Ten De-Escalation Commandments

I You shall be non-provocative

II You shall respect personal space

III You shall establish verbal contact

IV You shall use short phrases; repeat yourself

V You shall identify the patient's wants and feelings

VI You shall listen

VII You shall law down the law and offer choices for what is next

VIII You shall agree or agree to disagree

IX You shall have a moderate show of force and be prepared to use it

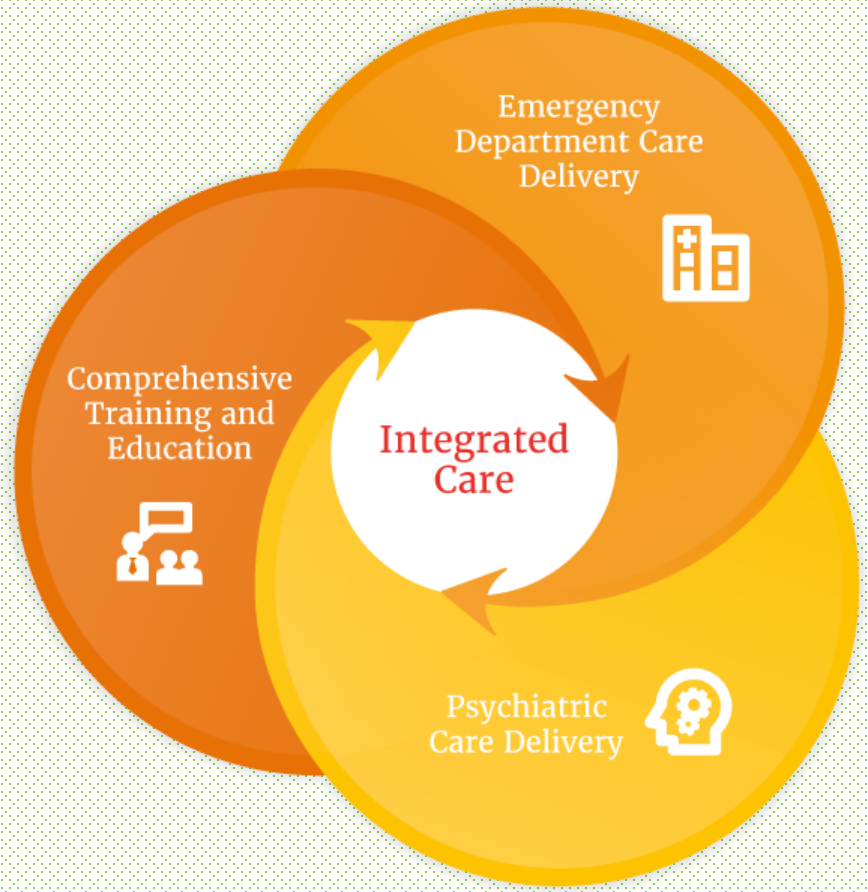
X You shall debrief with patient and staff

from Fishkind, *Current Psychiatry*, 2002

Respite

Improving Healthcare for ALL Emergency Patients

- Encourages integrated, simultaneous emergency and psychiatric care.
- Empowers ED providers to treat all patients — behavioral and physical.
- Trains providers to properly evaluate and treat behavioral health patients.



Psychiatric Observation

- Observation should be done for specific purpose:
  - Longer period of treatment and/or evaluation to determine if inpatient admission is warranted….. **OR for**
  - Diagnostic clarity

- Once you've documented your disposition decision, you can't then initiate Observation – this is BOARDING

- For best reimbursement for Observation, transfer from initial ED provider to a dedicated Observation provider

Basic Treatment Principles of Emergency Psychiatry Observation Unit

1. Goal is for the patient to end up in the least restrictive disposition alternative after the stabilizing interventions

2. Prompt evaluation and initiation of treatment plan, including starting medications immediately when indicated

3. Avoid judging disposition decision on initial evaluation, especially if there are targeted symptoms, which if improved, will lead to alternative disposition options

Basic Treatment Principles in an Emergency Psychiatry/Observation Unit

4. Constant re-evaluation of a patient's condition to determine response to the treatment plan, and to drive considerations of medication change, direction of condition and disposition options

5. Allow for several hours of treatment and observation time before a decisive decision on next steps, but no more than 12 hours into a patient's 23-hour stay. This will allow ample time for referrals and arranging aftercare, transportation

6. Never be reluctant to change the initial evaluation and treatment plan, even if done by a different provider

General Principles of extended observation

- Allow time for recuperative sleep and detox
- Have targeted goals in mind for meds
- Psychosis symptoms can be reduced to subacute levels during 23-hour stay

Regional Approaches

Proven Success for multiple smaller Emergency Departments collaborating

Transforming Emergency Psychiatry

The EmPATH Model

- EmPATH is a generic academic acronym for a specific model of hospital-based Crisis Stabilization Unit (CSU) or Psychiatric Observation Unit, not a trademark nor copyrighted!
- Is a defined new section of the Facility Guidelines Institute's *2022 FGI Guidelines on Design and Construction of General Hospitals*

EmPATH unit

From Wikipedia, the free encyclopedia

EmPATH unit (Emergency Psychiatric Assessment, Treatment, and Healing) is an acronym for a specialized hospital-based emergency department or outpatient medical observation unit dedicated to mental health emergencies. Unlike standard emergency departments, EmPATH units gather their patients in chairs in a central room called a milieu.[1][2][3]

EmPATH units were developed in response to US emergency department overcrowding as large numbers of mental health patients were waiting for hours or days until they could be transferred to an inpatient psychiatric facility.[4][5]

Moving psychiatric patients to a separate area for specialized emergency care opens emergency department beds for medical emergency patients and avoids the more confined structure of a standard emergency department which has been cited as a potential cause of worsening psychiatric patient symptoms.[6] The open design of the EmPATH unit allows patients to move about freely, helping reduce stress.[7][8] A study of the EmPATH unit at the University of Iowa Hospitals and Clinics has shown that patients need shorter stays, less inpatient care, and return to hospital less frequently.[9] Other hospitals' EmPATH units have reported fewer than 25% of psychiatric emergency patients still require inpatient care after an EmPATH stay.[10][11][12][13]

In their "Roadmap to the Ideal Crisis System," the National Council on Mental Wellness stated that there should be at least one EmPATH unit in every mental health system.[14]

History [edit]

The concept of EmPATH units was developed by Scott Zeller. For his work on EmPATH units, Healthcare Design magazine named him one of the "Top 10 People in Healthcare Design" in 2020[15] and the California Hospital Association awarded him the Ritz E. Heerman Memorial Award in 2019.[16]

References [edit]

1. ^ Gorman, Anna (March 25, 2019). "She Was Dancing On The Roof And Talking Gibberish. A Special Kind Of ER Helped Her". *Health News Florida*. WUSF. Kaiser Health News. Retrieved 1 January 2022.
2. ^ Ojeda, Hillary (April 12, 2019). "University of Iowa Crisis Stabilization Unit challenges convention". *Iowa City Press-Citizen*. Gannett Co. Retrieved 1 January 2022.
6. ^ Nicks, B. A.; Manthey, D. M. (March 8, 2012). "The impact of psychiatric patient boarding in emergency departments". *Emergency Medicine International*. **2012**: 360308. doi:10.1155/2012/360308. PMC 3408670. PMID 22888437.
7. ^ Picone, Linda. "Empath: A new approach to mental health crisis" (pdf). *Minnesota Medicine*. No. September/October 2021.
8. ^ "One mental health solution: a kinder, gentler emergency
11. ^ "Beth Heinz: What M Health Fairview is learning from its new emergency mental-health unit". January 28, 2022.
12. ^ Marian Huber (2021-07-23) [2021-07-22]. "Virginia's mental health hospitals must be restored". *The Washington Post*. Washington, D.C. ISSN 0190-8286. OCLC 1330888409. [*please check these dates*]
13. ^ Gray, Callan (October 13, 2021). "M Health Fairview's new

Wikipedia
The Free Encyclopedia

Main page
Contents
Current events
Random article
About Wikipedia
Contact us
Donate

Contribute
Help
Learn to edit
Community portal
Recent changes
Upload file

Tools
What links here
Related changes
Special pages
Permanent link
Page information
Cite this page
Wikidata item

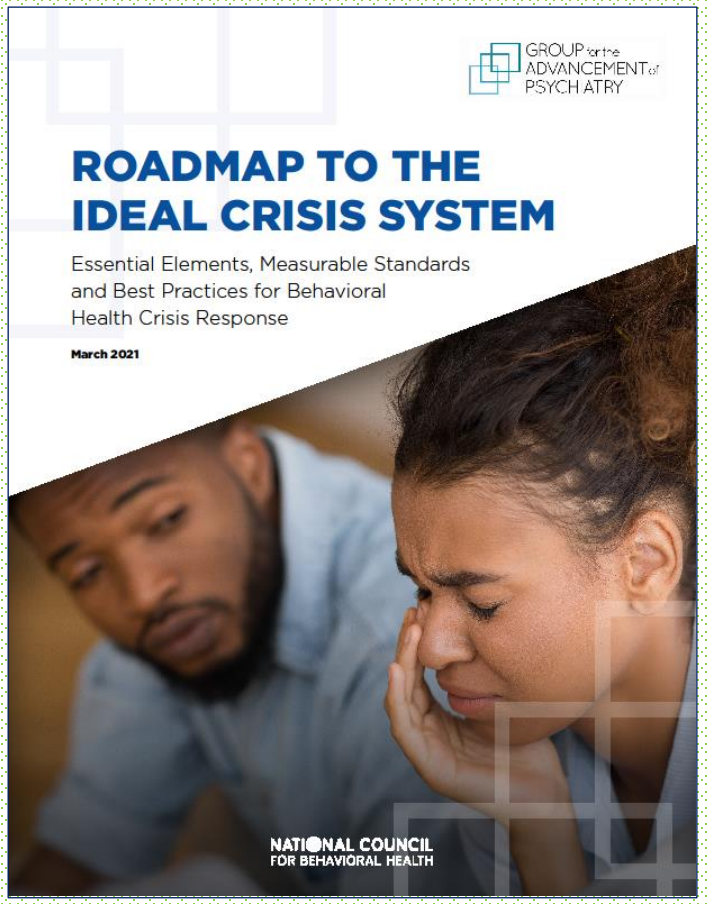
Print/export
Download as PDF
Printable version

EmPATH Units complement community crisis programs, for the highest-acuity patients in EDs

- *National Council for Mental Wellness*, ***"Roadmap to the Ideal Crisis System"***: specifically cites EmPATH units in their recommendations, saying that there

"should be *at least* one

in every *REGIONAL* mental health system"



EmPATH

Emergency **P**sychiatric **A**ssessment **T**reatment **H**ealing

Research shows that 75% or more of severe psychiatric emergencies can be **stabilized within 24 hours**

What makes the EmPATH Approach Different?

- Designated destination for all medically-cleared patients in crisis prior to determination of disposition or IP admission; not viewed as an alternative destination but *THE* destination
- Designed and staffed to treat all emergency psychiatric patients – philosophy of “no exclusion”
- Immediate patient evaluation and treatment by a psychiatrist, constant observation and re-evaluation
- Provides a calming, healing, comfortable setting completely distinct from the Medical ED
- Wellness and Recovery-oriented approach

Physical Space Design

Calming, healing environment that prioritizes safety and freedom

Large, open ‘milieu’ space
where patients can be together in the same room – high ceilings and ambient light, soothing decor

Designed to facilitate
socialization, discussion, interaction and therapy

Per chair model
outfitted with fold-flat recliners

Space recommendation
80 sq. ft. total per patient, which includes 40 sq. ft. patient area around each recliner

Open nursing station w/instant access to staff
No ‘bulletproof glass fishbowl’ separate from the patients

Voluntary Calming Rooms
Avoids locked seclusion rooms or restraints

A Calming, Comfortable Environment

Diverse Professionals Staffing the Unit

EmPATH is an academic term, not copyrighted or licensed, and each unit differs

Multidisciplinary Team Approach

- Psychiatrists/Psychiatric Providers
- RNs
- Social Workers
- Psychiatric Assistants
- LVNs/ LPTs
- Peer Support Specialists

Patient Benefits

Trauma-informed Unit, a home-like care setting different from a chaotic ED; relaxation, movement, recreation encouraged

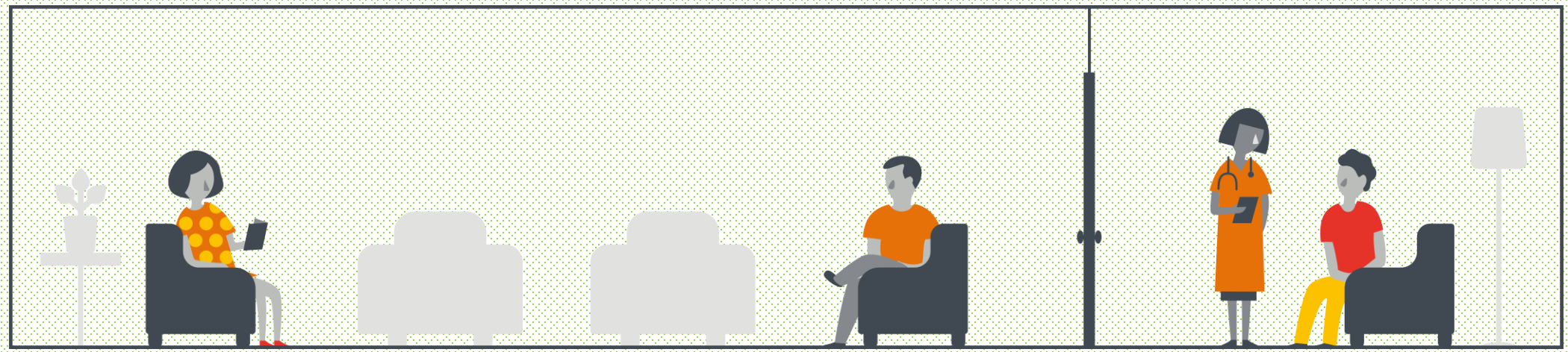
Calming Environment that best meets patients' needs, can serve themselves snacks, beverages, linens

Multi-disciplinary Treatment Team involved from arrival to disposition

Constant Observation & Re-evaluation leads to much higher diversion from hospitalization

Rapid Evaluation by Psychiatrists, ensuring care integration with comprehensive care plan development

Restraint Elimination Typically far less than 1%



Hospital Benefits

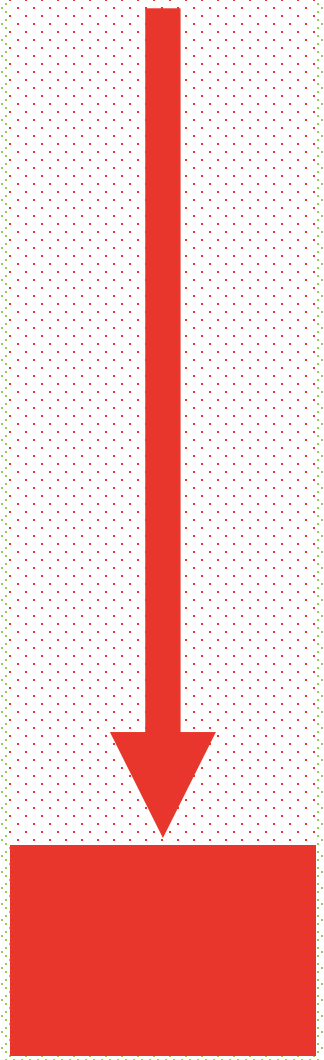
EMTALA-Compliant
for both voluntary and involuntary mental health crises

ED Capacity Creation
Alleviate volume pressure in the ED and reduce psychiatric holds and boarding

Reimbursement Options
Among CMS and private payers

Eliminate Unnecessary Admissions
While reducing payer denials for inpatient psychiatric units

Cost-Effective Implementation
by remodeling available, unused hospital spaces



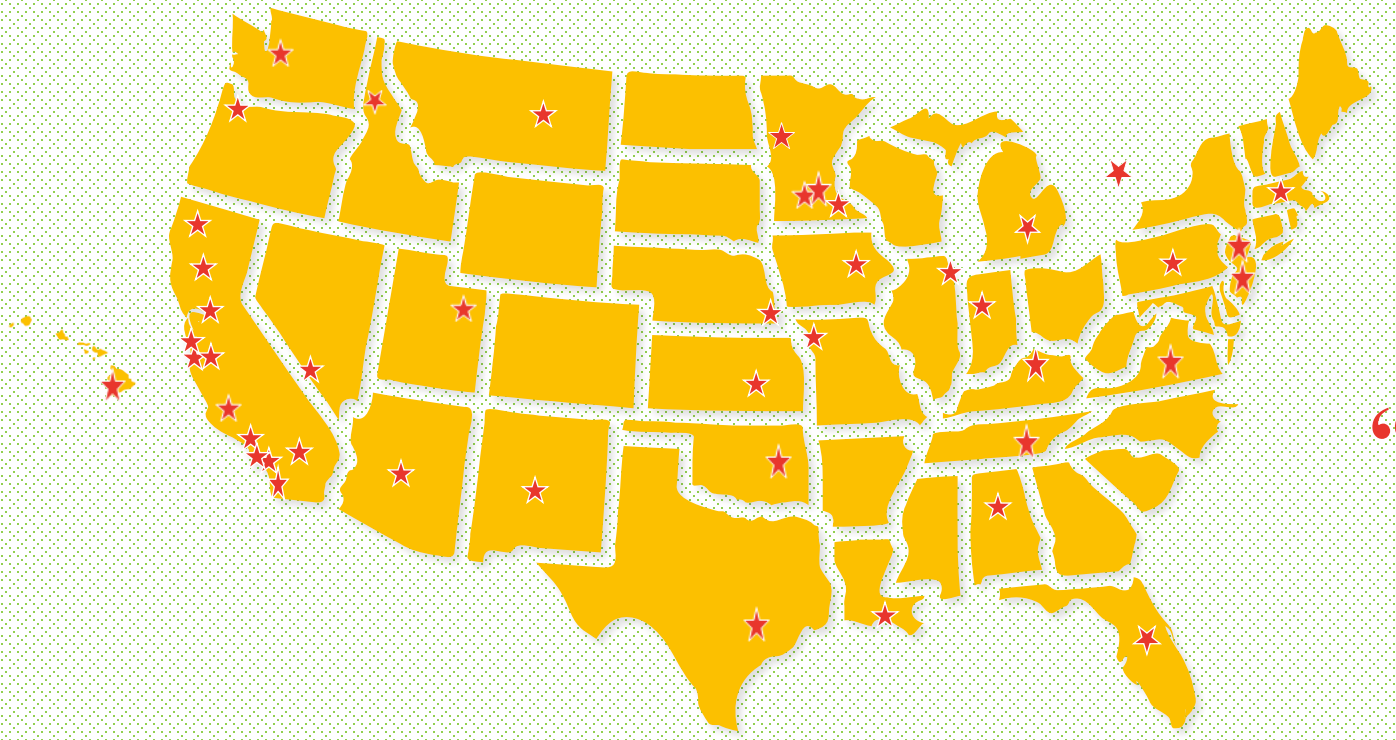
Up to

80%

Reduction in Admission Rates

Success Stories Across Geographies and Hospital Sizes

The Model is Expanding Across North America



"EmPATH units should be considered a National Best Practice, and we will take the EmPATH unit knowledge back as a *best practice to Joint Commission Central…*"

- Joint Commission Surveyor

Academic Emergency Medicine
A GLOBAL JOURNAL OF EMERGENCY CARE

Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) Unit Decreases Hospital Admission

Published: 17 August 2021

- **Reduced ED length of stay from an average of 16.2 hours to just 4.9 hours (70% reduction!)**
- **Reduced inpatient psychiatric admissions by 53%! (*from 57% of patients to just 27% of patients*)**
- **Improved the outpatient follow-up of patients from 39.4% to 63.2% (60% improvement!)**
- **Reduced 30-day psych patient return to ED (recidivism) by 25%**
- **Added $861,000 to ED bottom line in first year by moving BH patients out of the ED to more targeted, timely, better care!**
- **Reduced inpatient lengths of stay for patients admitted from EmPATH**

M Health Fairview's new EmPATH approach to mental health crises shows 58% reduction in hospital admissions to just 17% overall !

KSTP.COM EYEWITNESS NEWS

Billings Clinic, MT – Psychiatric Stabilization Unit

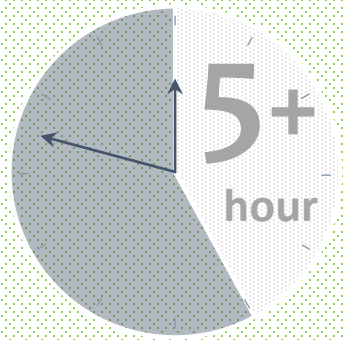
12-chair adult EmPATH unit and 5-chair youth EmPATH unit, opened Spring 2018

Serves an entire huge REGION of the state of Montana – takes referrals from **critical access hospitals** from many miles away

Readmissions Reductions

37%
decrease in psych 30-day readmission
from 19% to 12%

51%
decrease in overall readmission
from 57% to 28%



Reduction in ED ALOS
for psychiatric patients

0.2%
seclusion or restraint
(4100+ patients seen to date)

50%

Reduced recidivism
rates for ED psychiatric patients by nearly 50%

$1.7M
Annual Cost Savings
for public and private insurers

Providence Little Company of Mary EmPATH, Los Angeles

12-Chair EmPATH Unit (opened November 2017)

Featured on CNN

✓ Accepts transfers of involuntary psychiatric patients from over 12 area hospitals/emergency departments of every size/shape/demographics!

Results

Patients Discharged
To home or community programs

16 hours

Average LOS

>3,500

Annual Visits

0.2% Restraints
0.1% Patient injury

Safety

Dignity Mercy San Juan EmPATH, Carmichael, CA

Collaboration between Hospital and Sacramento County - Opened September 2019

Now accepting patients from 8 different REGIONAL emergency departments, both urban and rural!

Celebrating the Early Wins

- ✓ Baseline boarding time for psych patients in the ED FY '19 was 32.9 hours – in the first month this fell to 19 hours, by December the average was 7.6 hours (**77% reduction**)
- ✓ Since opening, restraints have only been used **one time** (January 2020)

FY 2021 Impact (July – Oct)

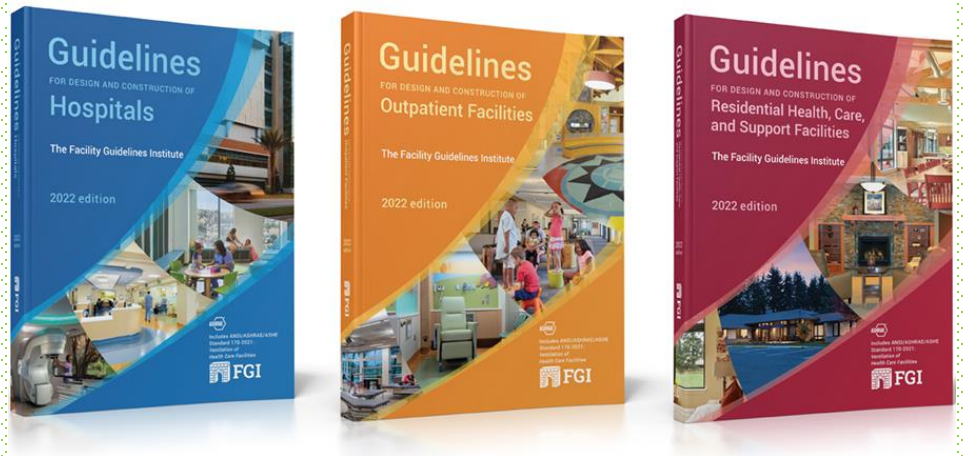
- ✓ Avg ED Length Of Stay before transfer = 6.3 hours (median = 4.3 hours)
- ✓ From Medical Clearance in the ED to CSU Acceptance = less than one hour
- ✓ 80% of patients discharged home
- ✓ Patient Satisfaction = 85%
- ✓ ED Recidivism = declined 30%

FGI 2022

A2.2-3.2 Behavioral health crisis unit. This unit is a dedicated emergency services unit to serve behavioral and mental health patients presenting in a state of crisis. Advantages of this unit are that services and staffing can be tailored to the needs of this population, and the physical environment can be controlled to help alleviate stressors for patients and staff.

2.2-3.2.2.3 Multiple-patient observation area (aka EmPATH Unit)

*80 square feet total space per patient
*One restroom for every 8 patients
*Can be inside ED, accessible to ED, or elsewhere on hospital campus
*Can share requirements with ED spaces



Compare to traditional individual observation rooms, which must be 100 sq ft each, and need constant monitoring

Financial Benefits of EmPATH units for Mental Health Medicaid reimbursement

- On average, **EmPATH units stabilize 75% of the involuntary patients they see** – in a typical ER, 100% of these patients by definition would be sent to inpatient hospital beds. Therefore, EmPATH units avoid an expensive inpatient hospitalization in three out of every four patients!
-
- Typical inpatient stay cost to Medicaid: $12,000
-
- Typical EmPATH unit Medicaid reimbursement: $2,000
-
- Thus: for every four patients at $2,000 = $8,000, EmPATH units save Medicaid the cost of three inpatient stays at $12,000 = $36,000.
-
- **So for every $8,000 Medicaid pays for EmPATH care, they avoid $36,000 in inpatient payments – documentable savings!**


Thank
You