

## Alleviating ED boarding of psychiatric patients

### Issue:

In April 2014, the first issue of *Quick Safety* addressed the care of psychiatric patients boarded in emergency departments (EDs),\* particularly those patients at risk for suicide and other acts of harm, including self-harm.<sup>1</sup> This issue of *Quick Safety* covers the challenge of providing appropriate and timely care to all psychiatric patients in both metropolitan and rural hospitals, with the goal to help alleviate boarding.

The dramatic rise in emergency patients with chronic psychiatric conditions is a national crisis, with millions of people across the U.S. seeking care in our nation's overcrowded and often overwhelmed EDs.<sup>2,3</sup> A 2008 survey conducted by the American College of Emergency Physicians (ACEP) found that 99 percent of emergency physicians reported admitting psychiatric patients daily.<sup>2</sup>

In a series of interviews conducted in 2014 with ED directors in a convenience sample of 15 safety-net hospitals around the U.S., ED directors reported that EDs are acting as a safety net for psychiatric treatment, since there are severe gaps in access to both inpatient and outpatient psychiatric care. In addition, they reported:<sup>4</sup>

- Difficulty securing inpatient psychiatric treatment for patients. Their hospitals have limited capacity for inpatient psychiatric care and must often transfer these patients to another hospital.
- The ability to obtain inpatient care for psychiatric patients varied dramatically based on the patient's insurance status.
- Estimated boarding times of six hours or more, with longer times for Medicaid patients, the uninsured, and children with psychiatric emergencies.

Other factors contributing to the boarding of psychiatric patients in the ED include a lack of screening tools or evaluations by qualified psychiatric clinicians, requirements for pre-authorization of insurance prior to admission, and a lack of appropriate levels of outpatient care.<sup>5</sup>

For rural hospitals, the lack of available mental health services and the scarcity of qualified professionals to treat psychiatric patients are even worse. In November 2014, the Oregon Office of Rural Health organized a listening tour of 27 rural hospitals to learn about their challenges during the period of health reform. All of the rural hospitals reported significant difficulty in finding inpatient beds for mental health patients, with stays in EDs reportedly lasting up to 18 days.<sup>6</sup>

The practice of boarding psychiatric patients:<sup>7</sup>

- Increases psychological stress on patients who may already be in depressed or psychotic states
- Delays mental health treatment that could mitigate the need for a mental health inpatient stay
- Consumes scarce ED resources
- Worsens ED crowding
- Delays treatment for other ED patients – some of whom may have life-threatening conditions
- Has a significant financial impact on ED reimbursement

A persistent problem, boarding of psychiatric patients has become so widespread that one state in the U.S. has taken action through legislation. In 2014, the Washington State Supreme Court ruled that psychiatric boarding is unconstitutional; that involuntarily committed persons had a right to timely and appropriate treatment.<sup>8</sup>

(Cont.)

Boarding can be exacerbated or the boarding time lengthened by the following:

- The pre-certification process that is required by many insurance carriers<sup>7</sup>
- Additional diagnostic testing or routine screening laboratory tests (which have been shown in some situations to have limited utility) prior to inpatient admission<sup>7</sup>
- Lack of resources to conduct psychiatric evaluations<sup>5</sup>
- Patients presenting for care on the overnight shift or during the weekend<sup>7</sup>
- Patients with out-of-network insurance, which prevents the hospitals from accepting the patient, even if it has available inpatient beds<sup>2,3</sup>
- Uninsured or underinsured patients; it's difficult to find facilities that will accept these patients<sup>7</sup>
- Patients with any of the following characteristics:
  - Intoxication<sup>7</sup>
  - Pediatric<sup>7</sup>
  - Having a diagnoses of autism, mental retardation or development delay<sup>7</sup>
  - Having suicidal ideation<sup>7</sup>
  - Having a comorbid medical illness<sup>4,7</sup>
  - Having a substance abuse issue<sup>4</sup>
  - Requires restraints or sitters<sup>5,7</sup>
  - Is a threat to ED staff or to themselves<sup>7</sup>
  - Homeless<sup>5</sup>

Safety Actions to Consider:

For many years, hospitals in the U.S. have been struggling to meet the needs of psychiatric patients seeking help. Boarding these fragile patients in the ED is a Band-Aid solution to a complex problem that is only worsening. This section of *Quick Safety* includes actions that hospitals can take to alleviate boarding of psychiatric patients, including several community-based approaches through which hospitals can leverage their influence with local and regional partners (see the “Community-based approaches to ease ED boarding” section below).

This first section includes actions that hospitals can take within their facility to help alleviate boarding of psychiatric patients:

- Improve case management of patients to decrease psychiatric emergencies.<sup>3</sup>
- Incorporate a validated screening tool into the process for determining the necessity for psychiatric hospitalization for suicide, such as Emergency Medicine Network’s [ED-SAFE Patient Safety Screener](#) and the [Columbia Suicide Severity Rating Scale \(C-SSRS\)](#).
- Engage existing outpatient mental health and substance use disorder treatment providers into the ED improvement process to fully identify existing community resources and to facilitate assessment, referral, and discharge processes that reduce wait times.
- Expand outpatient psychiatric care.<sup>4</sup>
- Implement programs to better manage existing bed capacity. For example, “bed czars” who manage inpatient capacity and computerized bed management systems.<sup>7</sup>
- Provide more resources to assist with ED disposition and facility transfer. Consider a crisis clinic staffed by a nurse or social worker to assist during peak times of mental health patient ED occupancy.<sup>7</sup>
- Improve access to psychiatrists in the ED. Promote improved collaboration between ED providers and psychiatric consultation services to treat and discharge patients, or to reduce ED boarding times.<sup>7</sup>
- Use psychiatric telehealth services to mitigate the lack of access to psychiatrists during nights and weekends, or in EDs without psychiatrists.<sup>6,7</sup>
- Increase hospital inpatient staffing and capacity. Additional psychiatric beds would help alleviate boarding patients who require hospital-level care.<sup>3</sup>
- Create a dedicated psychiatric emergency services (PES) unit (a stand-alone ED specifically for psychiatric patients). PES units provide outpatient services, which include patient evaluation, intensive treatment, and observation. A common goal of the PES units is to stabilize acute symptoms and avoid



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psychiatric hospitalization (when possible).<sup>5</sup> One hospital that implemented a PES unit was able to reduce boarding time to 1 hour and 48 minutes – an improvement of more than 80 percent.<sup>5,7</sup>

- Eliminate out-of-network insurance issues in order to increase available options for inpatient care.<sup>3</sup>

### Community-based approaches to ease ED boarding

Below are some successful community-based approaches to minimize or eliminate boarding of psychiatric patients. Hospitals may want to work with others within the community, region or state to help develop, implement and fund these strategies, which include:

- Increase outpatient mental health services in the community. Basic and intermediate needs, including medication management, can be delivered at a much lower cost.<sup>7</sup>
- Expand community crisis services. Examples include: 24/7 crisis hotline and/or psychiatric emergency services; mobile crises teams (also called diversion teams); crisis residential services; crisis stabilization unit; voluntary emergency residential unit; crisis counseling unit.<sup>3,7</sup>
- Implement a primary prevention and jail diversion program that teaches first responders, such as law enforcement and emergency medical services personnel, best practices to help people undergoing a mental health crisis. This can prevent an unnecessary trip to jail or to the hospital.<sup>6,9</sup>
- Work with law enforcement, group home staff and other “secondary utilizers” and train them to manage mental health crises prior to the hospital.<sup>7</sup>
- Improve the accessibility of mental health and substance abuse care.<sup>6</sup>
- Address mental health provider shortages through loan repayment funding in order to relieve the financial burden of student debt and offset the reduced salaries that newly trained, unlicensed providers receive. This may encourage them to continue to serve underserved populations following licensure.<sup>6</sup>
- Create Health Homes, where providers integrate and coordinate all primary, acute, behavioral health, and long-term services for persons with chronic conditions This is an optional benefit for states because of the Affordable Care Act.<sup>7</sup>

### Resources:

1. The Joint Commission. 2014. [Care of psychiatric patients boarded in EDs](#), *Quick Safety*, Issue 1, April 2014 (accessed Nov. 4, 2015)
  2. American College of Emergency Physicians. 2014. ACEP Member Testifies Before Congress About “National Crisis” in Regard to America’s Mental Health Patients
  3. American College of Emergency Physicians. 2014. [Psychiatric Emergencies](#) Web page (accessed Nov. 4, 2015)
  4. Burke, G., and Paradise, J. 2014. Safety-Net Emergency Departments: A Look at Current Experiences and Challenges. The Kaiser Commission on Medicaid and the Uninsured
  5. Zeller, S., Calma, N., Stone, A. 2013. Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments. *Western Journal of Emergency Medicine*, XV(I). doi: 10.5811/westjem.2013.6.17848
  6. The Oregon Office of Rural Health. 2015. Oregon Rural Hospital Listening Tour: 2014
  7. Abid, Z., et al. 2014. Psychiatric boarding in U.S. EDs: A multifactorial problem that requires multidisciplinary solutions. *Policy Brief*, 1(2)
  8. Burley, M., and Scott, A. 2015. Inpatient psychiatric capacity and utilization in Washington State (Document Number 15-01-4102). Olympia: Washington State Institute for Public Policy
  9. National Council for Behavioral Health. [Mental Health First Aid](#) Web site
- Note: This is not an all-inclusive list.*

\*Boarded patients are defined in the glossary of The Joint Commission’s hospital accreditation manual as: *Patients being held in the emergency department or another temporary location after the decision to admit or transfer has been made.*



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