PARALLEL SESSION 1 – THURSDAY JUNE 20TH 2019, 15h15 – 16h45

Psychiatric Emergency Services-1:
The American Response to Mental Health Integration in the Emergency Department

- V. Stiebel, H. DuBois: The Use of Telepsychiatry in Acute Crisis Centers
- S. Zeller: The Alameda Model: Evolving the Concept of Psychiatric Emergency Services in the USA
- S. Shah: Psychiatric Emergency Services: The American Response to Mental Health Integration in the Emergency Department
- E. Himadi: Crisis Stabilization Unit Decreases Inpatient Psychiatric Admissions. Lessons Learned and Ongoing Challenges

**Theme**
As the number of public mental health beds declined in the USA over the last 30 years, the number of mental health patients presenting to the Emergency Department (ED) has grown. Between 2007 and 2011, those visits increased by 15%. “Boarding” is the term that describes these patients spending days waiting for a disposition. The Psychiatric Emergency Service (PES) model began in the USA in the 1990’s as an attempt to provide crisis treatment and interventions and act as a diversion from inpatient admission. It is based on a robust model including the Emergency Psychiatrist. A review of this subspecialty will lead to a discussion of data showing the effectiveness of this model. We will discuss how to create the PES; Its role in the general ED for patients in crisis; and The role of tele-psychiatry.

**Takeaways**
1. Understand the history of the PES in American ED’s (Zeller) 2. Be aware of how process improvement can facilitate disposition of psychiatric boarders. (Shah) 3. Become familiar with how to establish a PES and its effect on costs and admission rates (Himadi) 4. How the use of Tele-psychiatry impacts on mental health in the medical ED (stiebel)

**Chair:** Victor Stiebel, Assistant Professor, University of Pittsburgh, US
The Use of Telepsychiatry in Acute Crisis Centers

Aim
The use of telemedicine has increased over 50% in the last ten years. It has become and increasingly utilized resource in the American emergency department (ED) and has more recently been extended to mental health. It is hypothesized that using telepsychiatry will decrease ED boarding times, expedite treatment and improve disposition options. We will discuss recent data confirming that this is a safe and viable option for treating acute psychiatric conditions.

Methods
We performed a retrospective review of all telepsychiatry encounters seen in five crisis centers in Texas in 2017. Admission and discharge dispositions were evaluated.

Results
Following implementation of a telepsychiatry program admissions decreased by almost 40%, with increased referrals to outpatient clinics and substance abuse treatment centers.

Conclusion
Telepsychiatry is a viable option for emergency medicine, providing safe patient care, improving ED throughput and enhancing disposition options.

Reference

Author(s)
Victor Stiebel, MD 1 / Holly DuBois 2

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The Alameda Model: Evolving the Concept of Psychiatric Emergency Services in the USA

Aim
Mental health patients boarding for long hours, even days, in United States emergency departments (EDs) awaiting transfer for psychiatric services is a widespread problem. Most proposed solutions have focused on increasing inpatient beds, rather than alternative emergency care designs that provide prompt access to treatment and might reduce the need for many hospitalizations. We test the solution of "regional dedicated emergency psychiatric facilities," which serve to evaluate and treat all area mental health patients, and can accept direct transfers from other EDs.

Methods
Over a 30-day period 5 community hospitals in California, tracked all ED patients on involuntary mental health holds to determine boarding time, and the percentage later admitted to inpatient beds.

Results
In a total sample of 144 patients, the average boarding time was approximately 1 hour and 48 minutes. Only 24.8% were admitted for inpatient psychiatric hospitalization from the psychiatric emergency service.

Conclusion
The study found transferring patients from general hospital EDs to a regional PES reduced boarding times by over 80% versus comparable state ED averages. Additionally, the PES can provide assessment and treatment that stabilize over 75% of the crisis population at this level of care, thus dramatically alleviating the demand for inpatient psychiatric beds. The improved, timely access to care, along with savings from reduced boarding times and hospitalization costs, may justify the costs of regional psychiatric emergency services in appropriate systems.

Reference

Author(s)
Scott Zeller r

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Psychiatric Emergency Services: The American Response to Mental Health Integration in the Emergency Department

Aim
The overall aim was to address boarding of patients with psychiatric illness at a tertiary care center without a psychiatric unit on-site. Significant barriers existed in transferring patients to an affiliated community hospital inpatient psychiatry unit including delay in triage review times, numerous reviewers with duplicate processes all leading to increased wait times in sub-optimal treatment settings.

Methods
A process improvement approach addressed the inefficiencies and redundancies in the triage process with outcome measures including, in part, increasing the average daily census of the psychiatric unit and decreasing average length of stay with assessment goals including role definition for staff including consultation-liaison (C-L) physicians. Data from June 2015 to March 2017 was included.

Results
With the advent of a standardized triage review process and patient tracking tool, the time for triage review decreased from 107.5 minutes to 81.9 minutes. The average daily census increased from 18 to 19 and discharges per month increased from 20 to 21. Review process redundancies were eliminated with clear role definition; the C-L physician became responsible for determining appropriateness for inpatient psychiatric admission without second review by an inpatient psychiatry physician.

Conclusion
The described project illustrates the importance of process review within a healthcare system to develop a standardized method of triage review for patients requiring psychiatric hospitalization. This approach can decrease the burden of psychiatric boarding in emergency departments.

Reference

Author(s)
Sejal Shah

P: Presenting author
Crisis Stabilization Unit Decreases Inpatient Psychiatric Admissions. Lessons Learned and Ongoing Challenges

Aim
To determine whether the opening of our CSU (Crisis Stabilization Unit) has decreased inpatient psychiatric admissions and/or decreased Emergency Room costs. I will discuss lessons learned so far and challenges we are still facing.

Methods
Comparing data from 5 months prior to and after opening of our CSU (Crisis Stabilization Unit) regarding admission rates to inpatient psychiatric beds and costs per patient in the ED proper versus costs per CSU pt. I will discuss number of homeless and ID (intellectual disability) patients who have repeated admissions and the challenges this brings.

Results
We have noted a significant reduction in psychiatric inpatient admissions since opening the CSU. Cost savings noted per patient seen in the CSU versus boarded in the ED proper. Data to follow.

Conclusion
Our CSU which opened in October 2018 has resulted in a significant decrease in inpatient admissions and saved costs per patient due to decreased boarding times in the ED and care in a more cost effective location--the CSU. We have seen an uptick in re-admission of patients with ID (intellectual disability) and those who are homeless and we are still struggling to best serve them.

Reference
References: PMC3935777 Scott Zeller et al.

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