COMMITTEE REPORT
OPERATIONS MANAGEMENT

New Care Model Promotes Early Intervention for Psychiatric Emergencies

Seth Thomas, MD and Gregg Miller, MD FAAEM

Are patients with substance abuse and mental health complaints waiting too long for care in your emergency department (ED)? If so, you're not alone. The average behavioral health patient now spends 11.5 hours in the ED.[1] The practice of holding patients waiting for consults and admissions creates congestion, drives up costs, and delays care for all patients.

To address this, we have developed an integrated model of acute psychiatric care that's improving throughput and patient outomes in multiple EDs. Here's how it works and how you can apply its principles to your own department.

Why Behavioral Health Patients Wait

One of the biggest challenges providers face when treating behavioral health patients in the ED is providing differentiated care. For example, a patient with chest pain is risk-assessed based on their history, physical, and selected testing and then they are treated accordingly. By contrast, every mental health and substance abuse patient tends to be placed into the same proverbial diagnostic bucket. Few standardized tools exist to help us assess and treat behavioral health patients in the same manner we do for medical patients. As a result, the majority of behavioral health patients wait for psychiatry consults or crisis worker evaluations regardless of their complaint.

The EPI Solution

Solutions like telepsychiatry, consult liaison services, and crisis stabilization units all benefit patients with mental health needs. But these require resources and take time to implement. We need additional solutions that can be rolled out *now* to manage mental health patients.

One solution that addresses these problems is what we call Emergency Psychiatry Intervention (EPI). EPI applies the same concepts we use for all other ED patients to patients with mental health needs: stratification by acuity, split flow streaming with an emphasis on early discharge for low-acuity patients, and early medical intervention for high acuity patients. EPI empowers ED care teams through clinical education, best-practice implementation, and leadership training. It provides teams with pathways to assess risk and provide early intervention. This includes identifying and stabilizing low- to moderate-risk patients, who, in many cases, can be safely discharged from the ED. Ultimately, EPI empowers the ED team to own more of the care of our behavioral health patients.

The EPI model has many benefits. Behavioral health patients receive early and appropriate treatment. Providers and staff feel more satisfied in their roles knowing they have the tools to help. The process reduces wait times and delays for all patients, improving outcomes and satisfaction. And finally, the process saves hospitals money and resources by improving throughput and freeing psychiatric consultants to focus where they are truly needed.

EPI in Action

Four EDs in the Chicago-based AMITA Health system, which were seeing high volumes of behavioral health patients, participated in the launch of EPI in late 2018. In particular, the ED team at AMITA Health Saint Joseph Hospital was facing a number of challenges, including turnover in the hospital's inpatient behavioral health unit. They needed resource-neutral solutions that could be fully implemented within the ED. To this end, they decided to focus on developing a risk-stratification process, creating discharge resources, and promoting earlier administration of oral second-generation antipsychotic medications to treat agitation, which are less sedating than older antipsychotics, and therefore, less likely to prolong patients' ED stays. After undergoing EPI training and implementing the toolkit, AMITA Saint Joseph reduced ED length of stay for low-risk patients by 38% and medium-risk patients by 20%. What's more, none of the discharged patients "bounced back" unexpectedly.[1] Three other hospitals saw similar results. The ED at AMITA Health Saint Francis Hospital cut their length of stay for discharged behavioral health patients in half, from 300 minutes to 150.[1] Together, the four participating hospitals reduced their average wait times for this population by an impressive 43 minutes.[1]

Pathway to Differentiated Care

In order to successfully differentiate behavioral care in the ED, departments need a few key elements in place.

First, it's crucial to get buy-in from everyone involved in patient care. Providing differentiated care requires emergency physicians and nurses to take true ownership of behavioral health patients rather than waiting for a psychiatrist or crisis worker to make decisions. This may require a significant cultural shift in your department.

Second, prioritize education. Physicians and staff are more likely to assist patients when they are confident in their ability to help. Essential topics to cover include risk assessment, de-escalation, and clinical management.

Third, create clinical pathways for behavioral health patients with different levels of need. Low-risk patients can often be stabilized in the ED and safely discharged for outpatient follow-up. However, some patients will need access to telepsychiatry, crisis stabilization, or inpatient care, so map out how and when you will transition them to these services.

We are happy to discuss our experiences if you're interested. Please email us at Seth.Thomas@vituity.com and Gregg.Miller@vituity.com.

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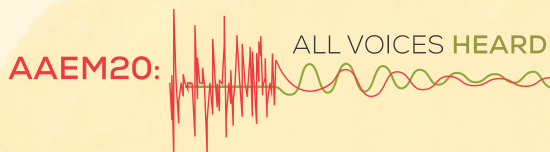
References:

1. 1 Thomas S. Closing the Gap on Psychiatric Care in the Emergency Department (webinar). Posted July 31, 2019. https://www.youtube.com/watch?v=GcOWbYIQbUs&feature=youtu.be

HIGHLIGHTS FOR SCIENTIFIC ASSEMBLY 2020



This year's theme is "All Voices Heard." This means that whether you are a physician, a patient, or the public, your voice is important and is heard. As physicians we need to be stronger advocates for our patients, the public, and each other. At AAEM, we hear you.

PHYSICIANS

We've heard what you have said about past conferences, and have made changes to AAEM20 programming to accommodate your requests. This year you will see:

More Breve Dulce talks – The afternoon of Tuesday, April 21st will be dedicated primarily to Breve Dulce talks located in a larger room with minimal other tracks running concurrently and will continue through Wednesday and Thursday. Thursday, April 23rd will be dedicated to one room only plenary and Breve Dulce talks.

Up-to-date literature discussions – New this year will be a literature review panel: "Meeting of the Minds" session where panels of experts will discuss recent controversial medical literature.

More Small Group Clinics – Small Group Clinics are back, and this year there are more than ever.

Fewer tracks – Past Scientific Assemblies have been chock full of education, and we heard that there were too many session choices and that physicians felt like they were missing out. This year we still have a ton of great education, and you won't have to worry about missing anything.

More advocacy-related talks – Not only did we add more advocacy talks to programming this year, we also moved the Health Policy in Emergency Medicine (HPEM) Symposium to a pre-conference course so you can kick-off AAEM20 by learning how to use your voice to advocate at the local and national levels.

New voices – You wanted to hear new voices from rising stars in emergency medicine so this year we invited new voices and faces to speak while maintaining the expert education of seasoned favorites you've come to expect from AAEM. View our full speaker list here.

We've also heard what you have said about the practice and business of EM and have specific talks that address your concerns:

- **The Influx of Advanced Practice Providers: What is the Role of the Emergency Physician?**
  Julie Vieth, MBChB FAAEM
  Monday, April 20, 2020 | 4:10pm-4:30pm (Phoenix A)
  This lecture will provide an overview of the scope of this issue, including training requirements for APP; discussion of several recent issues highlighted in the national press when APPs practice unsupervised and present options for utilizing a physician team-led approach in the treatment of our patients in the ED.
- **The Existential Threat to EM Right Now: If We Don't Take Control, Someone Else Will**
  Jason Adler, MD FAAEM
  Wednesday, April 22, 2020|11:45am-12:05pm (Camelback AB)
  This talk will explore three merging phenomenons, reduction in public reimbursement, reduction in private reimbursement, and an expanding labor force, that together could threaten the economic health of our community. Potential solutions will be discussed.
- **Emergency Medicine at the Precipice**
  Richard M. Pescatore II, DO FAAEM
  Wednesday, April 22, 2020 | 2:30pm-2:50pm (Phoenix DE)
  This lecture will discuss the evolution of EM from presence only for life- and limb-threatening disease toward our role as "availabilists" simultaneously the front line and the safety net for healthcare. The speaker will beat back on the over-consulting and under-treating culture driven by medicolegal fear and CMG influence.
- **How to Get Involved in Advocacy**
  Amish Mahendra Shah, MD FAAEM
  Wednesday, April 22, 2020 | 5:20pm-5:40pm (Camelback AB)
  Arizona State Congressman and emergency physician Dr. Amish Shah shares practical tips and advice on how to get involved in advocacy at the state and local level, and how to get other physicians to get involved.
- **The Joint Commission as Complicit in the Opioid Crisis**
  Talcott Franklin
  Thursday, April 23, 2020 | 11:40am-12:00pm (Phoenix DE)
  Attend the final AAEM Scientific Assembly 2020 presentation by plaintiffs' attorney Tal Franklin, who represents four West Virginia cities pursuing civil litigation against TJC for its culpability in causing and worsening the opiate epidemic in those cities.