Improving Psychiatric Care in the Emergency Room Setting

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Abstract

The COVID-19 pandemic has left a mental health crisis in the United States in its wake. With a shortage of mental health professionals, it is vital that the U.S. addresses this crisis. Before the pandemic, one in ten adults reported symptoms of anxiety or a depressive disorder, but now four in ten adults report those same symptoms. Emergency rooms (ER) are taking the brunt of this increase in mental health concerns, and they simply do not have the resources to continue to support this patient load. This paper was written to determine what can be done to address this concern by aiming to answer this question: How can improving psychiatric care and workflow in the emergency room setting benefit MHPs, ER staff, hospital administration, and the community as a whole? The Outcomes Approach Logic Model and the Eclipse Model were utilized to explore the various implications of this concern and what outcomes can and should be expected. Resources used in this review were chosen with strict guidelines as to ensure that the evidence presented here is accurate, reliable, and relevant. Three interventions are explored which include creating EmPATH units in the ER, investing in outpatient mental health resources, and Telehealth services. Each of these interventions was reviewed through the five lenses of best practice to analyze each one in depth. Ultimately, an intervention is recommended that involves integrating psychiatric telehealth resources with ER resources to form a type of EmPATH unit.

Introduction

The health care community in the United States (U.S.) should give utmost attention to the worsening mental health crisis following the COVID-19 pandemic (Panchal et al., 2023; *Unable to find information for 14276560*, n.d.)(Panchal et al., 2023; *Unable to find information for 14276560*, n.d.). Through a survey about mental health issues related to the pandemic, 40% of U.S. adults reported symptoms of at least one mental health condition that developed due to effects of the pandemic (Czeisler et al., 2020). These included symptoms such as anxiety, depression, trauma and stress related disorders, and substance abuse. The National Center for Health Statistics reported that, before the pandemic, 11% of adults reported symptoms of anxiety or depression. During the pandemic, 44% of adults reported experiencing those same symptoms (Terlizzi & Schiller, 2021).

Even with this increase in mental health concerns, outpatient behavioral health visits fell at the height of the pandemic by 75%, 56%, and 25% for commercial insurance, Medicare, and Medicaid holders respectively. With fewer outpatient mental health options, emergency rooms (ERs) saw an increased volume of patients seeking mental health services which placed a burden on the emergency health system (Davenport et al., 2017). One study analyzed ER mental health visits versus ER non-mental health visits. They found that, after the pandemic started in 2020, the number of non-mental health related ER visits decreased by 39% while mental health related visits decreased by 23% compared to 2019. These results ultimately mean that ER mental health visits actually increased from 8% in 2019 to 9% in 2020 (Villas‐Boas, PhD1 et al., 2023). That tells us that there are fewer alternative options for those facing mental health issues than other medical issues. Clearly the COVID-19 pandemic exacerbated and even created mental health

issues for the U.S. population due to social and cultural unrest, employment instability, and health and wellness uncertainty (World Health Organization, 2022).

Another contributing factor is that ERs are seeing an increased rate of boarding mental health patients (MHPs) due to lack of sufficient mental health resources (Griffin et al., 2023). With insurance companies often not covering outpatient psychiatric services (Davenport et al., 2017), and the U.S. shortage of mental health providers (A. Satiani et al., 2018), it is all the more important to focus on the mental health care structure in U.S. ERs in order to improve care for MHPs, keep ER staff safer, and assist ER administrative efforts.

The U.S. is also facing a major shortage of mental healthcare professionals. In 2022, the HRSA categorized more than 6,000 regions as having a mental health provider shortage which affected approximately one third of U.S. citizens (Bureau of Health Workforce, 2023). In those areas, on average only 28% of mental healthcare needs were being met (Bureau of Health Workforce, 2023). Therefore, patients aren't easily able to establish themselves as new patients with mental health offices (Kalter, 2019). In a 2021 study conducted by the American Psychological Association, 65% of psychologists stated that they don't have enough time to accommodate all appointment requests (APA, 2021). Another report showed that the average wait time is approximately six weeks for general mental health appointments (CCBHC, 2021).

There is also a shortage of inpatient beds for mental health services. Nationwide inpatient psychiatric demand has increased from 4% to 13% from 2018 to 2020 (McGinty et al., 2020). A 2022 study found that there should be at minimum 30 and ideally 60 inpatient psychiatric beds per 100,000 population. Shortages were defined as mild, 25 to 30 beds; moderate, 15 to 25 beds;

and severe, fewer than 15 beds (Mundt et al., 2022). In 2023, the U.S. averaged 10.8 available inpatient psychiatric beds per 100,000 population (Silver & Hancq, 2024). These numbers place the U.S. in a severe shortage. This shortage can be traced back to the Community Mental Health Act of 1963. This act ultimately led to people being deinstitutionalized, and the funds that were once directed to the well-funded state hospital system were not funneled into community mental health resources (Kalter, 2019). This left MHPs with very few options.

Exploring better avenues for delivering mental health care in the ER setting is deeply important to bettering our healthcare system and improving the lives of MHPs throughout the country. On the ER side, there are huge financial incentives to developing better care structures for MHPs. There is an estimated $8.3 billion per year in preventable costs in the ER setting, and, by making mental health services more accessible outside of the ER, hospitals could effectively work towards reducing those preventable visits (Mulrooney, 2022). By seeking alternative care structures, that money could be funneled into other initiatives that would lead to better care for patients. Additionally, alternatives have been shown to improve certain measurables such as decreased boarding time for MHPs, decreased wait times, and decreased psychiatric hospitalizations (Lockwood, 2020).

Literature Review

After reviewing the current literature, there are three distinct areas that experts and clinicians continue to propose as the best avenues for change. These areas include building EmPATH units, investing in outpatient health resources, and building robust training programs for ER staff.

EmPATH Units

When an MHP seeks help at an ER, they are often met with a busy, loud, and rushed atmosphere which can be stressful and exacerbate symptoms for many people (Nordstrom et al., 2019). In response, some hospitals have created dedicated mental health units, specifically called EmPATH Units. This stands for Emergency Psychiatric Assessment, Treatment, and Healing units (Tozzi, 2022). EmPATH units were first known as the Alameda model which was created in 2018 by Dr. Scott Zeller, assistant professor at University of California-Riverside, for the Alameda County Hospital (Moulin, MD & Jones, DO, 2014).

Short term studies have shown that EmPATH units have led to a 70-80% decrease in acute psychiatric hospitalizations, 90% decrease in MHP boarding in the ER, average length of ER visit reduced to 16 hours, and varied increase in ER income (Husereau, Drummond, Petrou, Carswell, Moher, Greenburg, et al., 2013; Lockwood, 2020). Another study performed an analysis of an ER before and after implementing an EmPATH unit. They found that after the EmPATH unit, they brought in an additional $861,065 annually, they decreased MHP boarding time in the ER from 212 minutes to 152 minutes, and they decreased the length of stay in the ER from 351 minutes to 334 minutes (Stamy et al., 2021). A study performed in Alameda County, California found that an EmPATH unit led to an average boarding time of 1 hour and 48 minutes, and only 24.8% admittance of psychiatric patients

(Zeller et al., 2015). A CHEERS statement found that these units reduced MHP inpatient admissions from 42% to 25% thereby decreasing the workload on ER staff to complete those admissions and freeing up those inpatient beds
(Husereau, Drummond, Petrou, Carswell, Moher, Greenberg, et al., 2013). In Dr. Zeller's initial research, he found that 75% of the patients who went to an EmPATH unit, instead of the traditional ER, were able to be stabilized, connected with outpatient care, and sent home instead of being admitted (Lockwood, 2020).

EmPATH units can be found in more than 30 states across the U.S. (Behm, 2023). Hospitals could look to the successful EmPATH units at M Health Fairview, Vituity, and Centra Care's Billings Clinic (CentraCare, 2021; Staff Writer, 2022; Vituity, n.d.).

One limiting aspect of building a new EmPATH unit is the startup cost. The cost of building an EmPATH unit varies widely between different regions, hospital systems, and existing facilities. Hospitals such as Centra Health in Virginia, the California Hospital Association, Sheridan Memorial Hospital in Wyoming, Trident Medical Center in South Carolina, and many others rely on grants and donations to initially fund their EmPATH unit
(Centra Health, 2022; CHA News, 2023; Philanthropy New York, 2023; SCHA, 2024). Additionally, EmPATH units have been shown to bring in a source of income for hospitals. In a study conducted at a Midwest hospital, the ER brought in $861,065 more in the first year after establishing their EmPATH unit (Stamy et al., 2021).

Telepsychiatry

Hospitals could also pursue integrating telepsychiatry into their EmPATH units. Multiple studies regarding the use of telepsychiatry services have found large benefits to incorporating these services into MHP care. One such study found an 84% reduction in the time it took to see a

telehealth psychiatrist accompanied by a 97% patient satisfaction rate (Brenner et al., 2020). Another study conducted in Veterans Health Administration ERs, found that telepsychiatry visits benefitted the ER and did not present with any adverse effects (McNaughton, MD, PhD et al., 2022). They collected feedback cards from staff and patients regarding their experience with telepsychiatry visits, and 97% of the responders stated that this service improved their visit. This is highly attributed to decreased wait and visit times.

There are pros and cons associated with telepsychiatry. Among 172,708 ER telepsychiatry visits studied, researchers found a 4.3% increase in psychiatric bed admissions, a 2% decrease in medical/surgical bed admissions, a 3% increase in length of stay in the ER, and a differential increase of $292 in spending (Patel et al., 2022). A separate study found the opposite, stating that telepsychiatry actually decreases inpatient admission for MHPs (Lin et al., 2023). They analyzed data from 2018-2022. 2018-2019 was categorized as pre-COVID and pre-telepsychiatry while 2020-2022 was categorized as post-COVID and post-telepsychiatry implementation. There was no difference in inpatient admissions between 2018-2019 or 2020-2021. However, admission rates decreased from 5.47% in 2019 to 4.58% in 2020 after telepsychiatry services were implemented (Lin et al., 2023).

Outpatient Mental Health Resources

The sheer amount of MHPs in the ER stems from uneven access to general information about outpatient mental health resources. Many people view the ER as a means to get connected with programs in their community (Vandyk et al., 2018). Many experts agree that by investing in outpatient mental health treatment and prevention options, the healthcare system could improve MHP experience and care (Navas et al., 2022). This would secondarily improve the mental

health care in the ER because it would eventually lead to people going to the ER when they had a true mental health emergency that could not be managed by outpatient resources.

More psychiatrists and outpatient mental health staff will lead to better safety plans (Cullen et al., 2021). Additionally, more formal contractual agreements between ERs and outpatient resources will lead to more positive, long-term outcomes (Cullen et al., 2021). In 2018, there was a projected shortage of between 14,280 and 31,091, depending on the ratio used for calculations, that would reach a low in 2024. They anticipated a growth from 2025-2050 that would ideally result in a range from a shortage of 17,705 to a surplus of 3,428 psychiatrists (B. Satiani et al., 2018).

In a study that sought to determine how well an integrated outpatient mental health and ER model worked, a 67% decrease was found in average time to triage: 91.90 ± 29.08 minutes before implementation and 30.34 ± 3.54 minutes after implementation (Okafor et al., 2016). This same study found an 8% decrease in time from arrival to departure from the ER although it was not statistically significant: 131.80 ± 6.83 minutes compared to 121.60 ± 3.97 minutes (Okafor et al., 2016). Furthermore, a study followed a behavioral intervention team (BIT) that was comprised of hospital staff and a social worker, who could be drawn from outpatient resources (Sledge et al., 2015). They found that this BIT worked through interdisciplinary collaboration, and there was a statistically significant decrease in length of inpatient stay for patients who had a mental health concern (Sledge et al., 2015).

Discussion

Based on the current literature and existing models for change, it is recommended that hospitals adopt an integrated approach which utilizes EmPATH units in addition to telepsychiatry services. Success and sustainability might vary among institutions depending on level of access to community resources, financing available, and attitudes of staff regarding such a change, but this could be widely applicable.

With finances being a large barrier to implementing an EmPATH unit, hospitals ought to integrate psychiatric telehealth services into their EmPATH units. This could help the hospital get traction with the new approach to mental health care, and it could give them time to find the support and funding needed to support a fully in-person EmPATH unit. Programs like the NC-STeP
(Kothadia et al., 2020; N.C. Department of Health and Human Services: Office of Rural Health, 2021) are examples of highly successful psychiatric telehealth programs in the ER and should be used for an initial framework.

A successful integrated model's success can be measured by certain observables such as length of stay, waiting room times, MHP boarding times, patient satisfaction surveys, and ER spending. Reducing cost per capita, improving the population's health, and improving the patient experience are all areas to observe as well when measuring the success of the intervention (IHI, 2023). Outpatient mental health professionals and ER staff all see the need for change so bringing them together to tackle the problem will merge resources, ideas, and manpower, and it will be likely to succeed (Fleury et al., 2019; Navas et al., 2022).

Conclusion

Attention must be given to the mental health crisis in the United States. Hospitals across the country have begun implementing EmPATH units, and they have already demonstrated their benefits. Patients and healthcare systems across the U.S. would greatly benefit from further EmPATH unit implementation. Future research ought to explore integrating various interventions that have been tried in the field. While there is research to suggest that integrating outpatient mental health resources into the ER is beneficial, there is very minimal if any research about integrating those resources with EmPATH units. Additionally, future research should target how outpatient health resources benefit the community. It was difficult to find statistics about this topic, and it could be very beneficial to the field when trying to argue for better equipped outpatient mental health centers.

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