Psychiatric Consult Liaison Program

Patient Safety

Patient Experience

Executive Statement of Support:

Dr. Michael Brant-Zawadzki -Executive Medical Director, Sr. Physician Executive

The substance abuse and mental health epidemic in our country has created a crisis for the emergency rooms in our community hospitals. Ours, like most, is designed for acute medical and surgical conditions. Our hospital does not even have a psychiatric ward, yet on any given day, up to 20% of our ED beds are occupied by mental patients awaiting disposition or placement to appropriate levels of care, detracting from the quality of patient care and limiting community access to our emergency room. The worst place for patients with a mental health crisis is an emergency room ill-equipped to deal with it, as it heightens patient and caregiver safety risks.

Deploying a trained Psychiatrist for optimizing care and disposition in our ED was initially daunting from a financial perspective, but the return on the investment in improved patient safety and care, as well as shortened length of stay- which translates into cost savings and increased revenue from patient compensation for increased medical and surgical visits: is validation of the strategy.

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1. Executive Summary

The environment in the Emergency Department (ED) is not ideal for a psychiatric patient to be treated because of the chaos, noise, and stress that is present for most parts of the day. Also, the requisite staff training may be limited. However, with the continuing decline of psychiatric inpatient beds and programs, the number of available options for psychiatric patients is severely constrained. These patients often end up in the ED for days due to the absence of a qualified psychiatrist to do a prompt evaluation or triage the patient to an appropriate level of care. Hoag addressed this short fall in care by hiring a psychiatrist to proactively address psychiatric patients in the ED leading to significantly reduced lengths of stay and improved quality of care for the patient.

2. Background and Relevance

Recent federal regulation allows for enhanced access to behavioral health coverage, but the ability for hospitals to meet the current needs of psychiatric patients can be considerably improved. The ED is a resource highly utilized by psychiatric patients. According to the California Hospital Association (CHA), only 27 of the 58 counties in California have psychiatric treatment facilities.

Since 1995, the state of California has lost 43 facilities that provided inpatient psychiatric beds. Facility closures or elimination of psychiatric inpatient programs account for this nearly 24% reduction. This drop in available facilities has resulted in close to 30% loss of beds available for psychiatric inpatient needs since 1995. Referring to a panel of 15 leading psychiatric experts, the CHA reports the minimum need for psychiatric beds is 1:200. California currently sits at a ratio of 1 bed for every 5572 people.

In order to overcome the resulting surge in demand for inpatient psychiatric needs in the ED, Hoag Hospital started a Psychiatric Consult Liaison program which includes staffing a psychiatrist in the department Monday through Friday for eight hours per day. Having a psychiatrist in the ED allows for incoming patients to be screened early in the boarding process and move them into the care process more quickly. Reducing the ED wait time for psychiatric patients is a major goal for Hoag Hospital. The period March through May 2016 saw a 40% reduction in average ED wait time for psych patients.

3. Project

In March of 2016 Hoag Hospital Newport Beach hired psychiatrist Dr. Patricia De Marco to perform assessments and provide crisis intervention and stabilization for persons presenting with an acute mental health crisis or acute intoxication. The initial goal is to provide stabilization for the patient in the Emergency Department (ED) and begin the process of placement into the proper care environment. The psychiatrist can clear involuntary holds when appropriate. She also works closely with attending physicians, hospital staff, local case managers, county departments, non-profits and public safety to ensure the best care available both during and after they come to the ED.

The day starts with morning rounds to assess & stabilize all those that have come into the ED the previous night and those that arrive during the day. Once diagnosis and treatment is recommended, the psychiatrist then can follow them up to the various floors including the detox unit where the doctor can enhance their care. While the psychiatrist is rounding on the floors, follow-up can be done on patients that arrived days prior and provide them the information and buy-in needed for the psychiatric patients to engage a long term care solution.

The primary goal in providing real-time coordination of care that begins at the crisis episode was to provide the proper diagnosis as quickly as possible and therefore lower the psychiatric patient's total length of stay in the ED while improving the quality of care.

From the beginning the biggest challenge for this new program was lack of capacity. With only one psychiatrist on duty there is not 24/7 coverage of the ED by a licensed psychiatrist. To address this gap in coverage, there are plans to add another shift starting the 2nd half of 2016.

4. Results

Through the hiring of a psychiatric consult/liaison, the ED has addressed an unmet need of treating a psychiatric patient with timely and appropriate care. As shown in the graphics below, there has been significant decrease in psychiatric patient holds since the onboarding of Dr. De Marco. Data collected includes both patient volumes and hours of psychiatric patients in the ED. Since Jan 1st, Hoag's ED has average 265 patients per month with behavioral and psychiatric crisis of which 120 patients per month were on a 5150 hold (Section 5150 is a section of the California Welfare and Institutions Code which authorizes a qualified officer or clinician to involuntarily confine a person suspected to have a mental disorder that makes them a danger to them self, a danger to others, and/or gravely disabled).

Given these patient volumes over the past months, the total hours psychiatric patients have spent in the ED has decreased from 4848 hours in March just before the program launched to 2841 hours in May, two months after Dr. De Marco arrived. This represents a 40% reduction in total hours these patients spent in ED. In looking at only the financial savings from the decrease number of hours, this represents an approximate 47% reduction in the additional costs due to psychiatric holds.

CY 2016 Month	# Pts on Hold	Hours of Holds	Additional Cost
Jan	244	4458	
Feb	269	4853	
March	**272**	**4848**	**$215K**
April	270	3934	
May	**272**	**2841**	**$113K**
		40% Reduction	**47% Reduction**

5. Significance

The decrease in total wait times for both categories of psychiatric patients is significant considering that the program has been in existence for only a couple of months. Wait times will continue to decrease as both the psychiatrist and ED staff become more comfortable in their new working arrangement as well as with the hire of an additional psychiatrist for increased coverage during the day and weekends.

6. Sustainability and Scaling

In the current state our psychiatrist is touching approximately 40% of the psychiatric patients coming through ED. Coverage will continue to increase once more psychiatrists are recruited which should take 3 to 6 months to accomplish. For the Psychiatric Consult Liaison Program to continue to grow it is imperative that we prove through data that the reduction in Length of Stay (LOS) for these patients will increase ED access for medical and surgical patients' thus driving revenue. We all are aware of the intrinsic value of the program; decreased LOS, better quality of care, and diagnosis and recommendation for the proper care pathway.

7. Lessons Learned

In developing a Psychiatric Consult Liaison Program to perform assessments and provide crisis intervention and stabilization for psychiatric patients in the ED, it has become apparent to everyone involved that we are only addressing the downstream effect of a much larger problem. The solution in addressing the mental health epidemic in our society is to create a mental health care delivery system upstream. In order to treat mental health across the whole continuum of care, analysis has to be done on the demographics of the population, demand for different types of facilities, and the resources we have as a community to address the need for increased quality mental health care.

As part of the recent merger between Providence Health & Services and St. Joseph's Health, in affiliation with Hoag, our newly formed healthcare system launched the Institute for Mental Health and Wellness, designed to drive collaboration and learning across the now seven-state system. The new system also is making what it calls an "initial" $100 million investment to establish a foundation to support initiatives identified in partnership with local leadership. The funding will support research and startup operations for mental health awareness, diagnosis and treatment.

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