Understanding New Developments in Funding and Payment Models, and Cost Data Needed to Support Crisis Services
An Introduction to Our Challenge:

- 2 million people seek treatment annually in the US for Behavioral Health Care problems in hospital emergency departments at a cost of about $4 billion.
- There is much variation in ED expertise and training in mental health problems, which can lead to inadequate care and negative patient and staff experiences.
More than 62 million Americans (22.2%) have some form of mental disorder.

Of this group, 8.7% have what is categorized as severe mental illness.

6 to 12% of all US ED visits are related to psychiatric complaints.

The average ED length of stay for psych patients is double that of non-psych patients (median 5.5 hours) exacerbating ED overcrowding.
Boarding

• Definition: Patients in hospital medical Emergency Departments who are medically stable and just waiting for a psychiatric evaluation or disposition.

• Often these patients are kept with a sitter, or in “holding rooms” or hallways on a gurney – some languishing for hours in physical restraints, often with no concurrent active treatment

• Studies showing average psychiatric patient in medical emergency departments boards for an average of between 8 and 34 (!) hours
Impact of Boarding

• Boarding is a costly practice, both financially and medically

• Average cost to an ED to board a psychiatric patient estimated at $2,264

• Psychiatric symptoms of these patients often escalate during boarding in the ED

Boarding Solutions Suggested

• Most suggestions still follow concept that virtually all emergency department acute psychiatric patients need hospitalization as the only disposition

• Results in far too many patients being unnecessarily hospitalized at a very restrictive and expensive level of care

• Roughly equivalent to hospitalizing every patient in an ED with Chest Pain (typically only 10% of such patients get hospitalized)
Wrong Solution: Treating at the Destination instead of the Source!

- All these solutions call for more availability for hospitalizations, nothing innovative at the crisis level.

- Change in approach needed – beginning with recognition that the great majority of psychiatric emergencies can be stabilized in less than 24 hours.

- *To reduce boarding in the ED, shouldn’t the approach be at the emergency level of care?*
Local Level Approach - How to start

- Set a vision: mental health patients need the same level of care as our patients with medical illnesses
- Look at the financials: these are boarded patients
  - Nursing hours
  - Security hours
  - Patients in the waiting room
  - LWOT rate
- Have a committed leader for the work - this is not easy!
- Determine staffing models based on arriving volumes
- Consider alternative models of care (telepsychiatry, community)
- Recognize that a single community option may be insufficient
- Get away from idea of ‘who we CAN’T take’ to “take everyone’
REGIONAL DEDICATED EMERGENCY PSYCHIATRIC FACILITIES

- Can accept self-presentations and ambulance/police directly, only medically-unstable psychiatric patients go to general EDs

- Accepts medically-stable transfers from area medical EDs that do not have psychiatric care onsite

- “Higher Level of Care” outpatient service so no need to wait for “a bed” to transfer from general ED – comparable to transferring patient to a trauma service from general ED
REGIONAL DEDICATED EMERGENCY PSYCHIATRIC FACILITIES

• Are considered an outpatient service, avoid many of the regulatory demands of inpatient psychiatric care

• Thus no need for actual “number of beds” which would limit capacity – many programs use recliner chairs or other furniture that flattens out for rest/sleep

• Focus is on relieving the acute crisis, not comprehensive psychiatric evaluation – much like medical emergency departments, treat the presenting problem
REGIONAL DEDICATED EMERGENCY PSYCHIATRIC FACILITIES

• Will treat onsite up to 24 hours (or longer in some areas), avoiding many inpatient stays

• Discharge rates within first 23 hours of 70% or higher very common, meaning less that 30% admitted to inpatient beds – better for patients and preserves inpatient bed availability

• Of great interest to insurance companies, which are often willing to pay more than daily hospital rate for single day of crisis stabilization to avoid multiple-day inpatient stay
PES Facilities operate using “Zeller’s Six Goals of Emergency Psychiatric Care”

1. Exclude Medical Etiologies/Ensure Medical Stability
2. Rapidly Stabilize the Acute Crisis
3. Avoid Coercion
4. Treat in the Least Restrictive Setting
5. Create a Therapeutic Alliance
6. Form an Appropriate Disposition/Aftercare Plan

Zeller SL. Primary Psychiatry, 2010
Complement to other resources

- Inpatient
- Community Resources
- Nursing Home/SNF
- Peer Support
- Home
- Group Home
- Crisis Residential
- Board and Care
- Acute Hospital
- Police
- Fire
- Crisis Drop-In Center
- Psych Facility
- Acute Hospital
- 911/EMS
- MD office
- Home
- SubSTANCE ABUSE PROGRAM
- Outpatient Therapy
- Nursing Home/SNF
### Return on Investment Scenarios

<table>
<thead>
<tr>
<th>PES Patients Per Day</th>
<th>32</th>
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<tbody>
<tr>
<td><strong>20% Diversion Rate 80% Admission Rate</strong></td>
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<tr>
<td>Avoided Admissions</td>
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<td>Cost of inpatient stay</td>
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<td>Cost of PES stay 20 hrs x $90 hr</td>
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<td><strong>System ROI</strong></td>
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<td><strong>35% Diversion Rate 65% Admission Rate</strong></td>
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<td>Savings per patient x avoided admissions (6200x4088)</td>
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<td><strong>System ROI</strong></td>
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<td><strong>System ROI</strong></td>
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Success Example

- Reduction of inappropriate psychiatric inpatient admissions

- 50 beds usage before PES decreased to < 10 beds by Feb 2015 after PES
- Estimated decrease in daily cost from $20K to $3.2K = $16.8K cost savings per day
- Conservative estimate taking $15K cost savings per day = $5.5M cost savings per year
- Removing the $1.8M PES budget expense:

  *Total Savings = Approx. $3.5M*
Alameda Model

• Almost no police transport of patients for psychiatric evaluations, which can “criminalize a psychiatric crisis”

• Instead, peace officers placing a 5150 hold summon an ambulance, then paramedics do a field screening with criteria approved by PES and EMS

• Transport decision based on medical stability
  – Medically stable go directly to PES (2/3 of all patients)
  – Medically unstable go to nearest of 11 area Emergency Departments for medical clearance (1/3 of all patients)
• Currently averaging 1500-1800 very high acuity emergency psychiatric patients/month, approximately 85% on a 5150 involuntary detention

• Focus is on collaborative, non-coercive care involving a therapeutic alliance when possible, with voluntary treatment in the least-restrictive setting as the goal

• Presently averaging only 0.1% of patients placed in seclusion/restraint – comparable USA PES programs average 8%-24% of patients in seclusion/restraint

• John George Psychiatric Hospital in Top 10% of patient satisfaction scores in USA though competing with voluntary, luxury facilities
Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments

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Introduction: Mental health patients boarding for long hours, even days, in United States emergency departments (EDs) awaiting transfer for psychiatric services has become a considerable and widespread problem. Past studies have shown average boarding times ranging from 6.8 hours to 34 hours. Most proposed solutions to this issue have focused solely on increasing available inpatient psychiatric hospital beds, rather than considering alternative emergency care designs that could provide prompt access to treatment and might reduce the need for many hospitalizations. One suggested option has been the “regional dedicated emergency psychiatric facility,” which serves to evaluate and treat all mental health patients for a given area, and can accept direct transfers from other EDs. This study sought to assess the effects of a regional dedicated emergency psychiatric facility design known at the “Alameda Model” on boarding times and hospitalization rates for psychiatric patients in area EDs.
Alameda Model Study: Benefits of PES to a Medical System

- Mental health patient boarding times in area EDs were only One Hour, 48 minutes – compared to California average of Ten Hours, 03 minutes:

  an improvement of over 80%

- Approximately 76% of these patients were able to be discharged from the PES, avoiding unnecessary hospitalization and sparing inpatient beds for those with no alternative
Study: Benefits of PES to System

• 2/3 of patients deemed medically stable in field, brought directly to PES, avoiding area medical EDs altogether

• PES programs can reduce overall costs by average of thousands of dollars per patient, while leading to improved quality and access to care, and decreased hospital admissions

• Adding a PES in appropriate systems perfectly aligns with these goals of healthcare reform
Crisis Stabilization Bundled Code

• California Medicaid (Medi-Cal) pays hourly bundled “Crisis Stabilization” rate (also available in several other states), as do many private insurers via contract, but difficult to get adequate Medicare reimbursement

• Crisis Stabilization pays hourly in California for up to 20 hours maximum, enough to make programs self-sufficient

• Yet total cost for top Crisis Stabilization reimbursement is still LESS than typical cost just to board a psychiatric patient in a medical Emergency Department
Crisis Stabilization Bundled Code

• Medicaid S9484 “Crisis Stabilization” rate (available in CA, several other states), is all-inclusive; no professional fees, no line items for meds, labs, etc.

• Crisis Stabilization pays hourly in California for up to 20 hours maximum, typically $80 to $110 per hour per patient, depending on county

• Cost Savings/Avoidance from reduced inpatient utilization more than covers costs of crisis programs – in fact, can allow for more funding for other community programs
Crisis Stabilization Units (CSUs) and others

- Similar to outpatient-level program of Psychiatric Emergency Facilities, but do not directly accept ambulances
- Typically affiliated with medical ED, which will receive patients, do physician evaluation, transfer medically appropriate patients to CSU (which can be in community)
- Can fill same role as a “PES” in systems with lower census numbers, for less staffing and less costs
- Many variations on PES/CSU model, with many names – but all with idea that patients can improve in < 24 hours, and patients do better in appropriate setting/treatment
Applicability

“But can this work in our system?”

- A unique model of CSU/Psych ER can be developed for just about any size hospital or community mental health program

- **Burke Center, Texas**
  - Remote PES served by telepsychiatry *50 miles from nearest delivery point for FedEx*
  - Winner of American Psychiatric Association’s **Gold Award** for Innovation