Establishing Best Practice Benchmarks in Emergency Psychiatry: A National Survey

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Background

- Emergency Department (ED) visits for psychiatric concerns are increasingly common, comprising **>10% of more than 130 million ED visits annually**.[1]
- Despite the growth of ED-based psychiatric care, there are limited data available regarding ***staffing and service models***, ***productivity***, ***resource utilization***, and ***clinical quality*** of emergency psychiatric care.[2,3]
- This study aims to address this gap by **characterizing existing service models**, **quality-/value-based metrics**, and **best practices** across a spectrum of Emergency Psychiatry practice settings nationwide.

Methods

**The survey and project proposal were reviewed by the IRB, and a determination was reached that the project did not meet criteria for human subject research on 11/21/2023.*

Invitations to complete a voluntary, anonymous, 30-question Qualtrics survey were disseminated to the **email listservs of two national Emergency Psychiatry organizations between 12/5/2023-2/23/2024**.

Potential participants entered their **primary practice institution** into a Google-based worksheet.

Survey links were sent to the **first respondents from an identified institution** to mitigate duplicative responses.

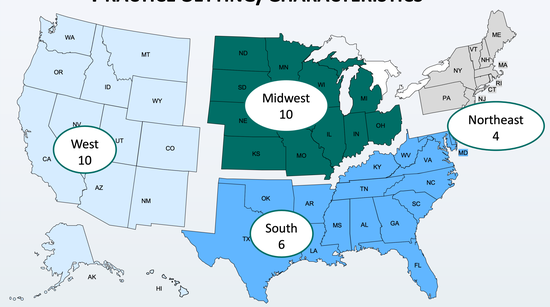
30 complete survey responses were received during the study period.

Survey

Scan the QR code to view the complete survey.

Results

Practice Setting/Characteristics



Responses by institution type	
12	***Dedicated psychiatric emergency service/unit,*** affiliated with/adjacent to/within a general hospital
10	***Traditional hospital-based consultation team*** providing service to a general emergency department (ED)
8	Psychiatric consult service ***embedded*** in a medical ED

Figure A. Geographic representation of responses. *Note*: the majority of respondents (24) practice emergency psychiatry in an **ACADEMIC** setting.

Staffing

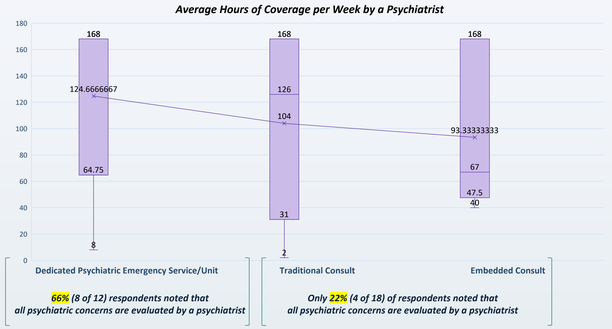
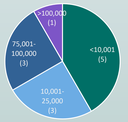
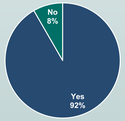
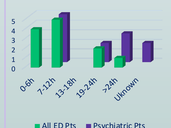
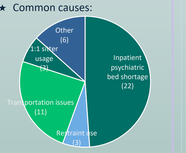
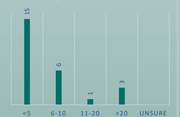
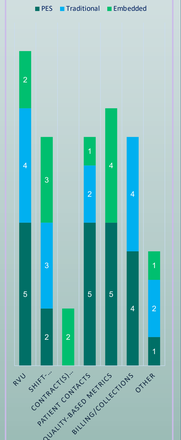
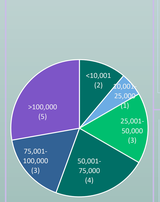
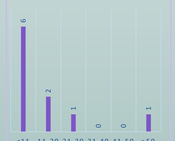
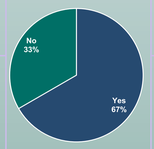
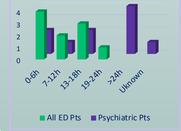
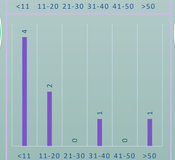
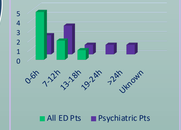


Figure B. Nearly all respondents (83%, 25/30) reported the use of multidisciplinary teams. Average FTE (Full Time Equivalent) for psychiatrists was highest in the dedicated psychiatric emergency services and embedded psychiatric consult services in medical EDs. Other frequently represented team members across practice settings include residents/fellows, non-physician providers (PAs, NPs), Social Workers, Counselors, and Peer Supporters.

★ Dedicated psychiatric emergency services have the ***most in-person availability*** of psychiatrists, with minimal overnight telepsychiatry coverage.
★ Embedded Psychiatry services in medical EDs have the ***least in-person availability outside of business hours***.

Table 1. Respondent data classified by service type *(dedicated psychiatric emergency service/unit, traditional hospital-based consultation team, psychiatric consult service embedded in a medical ED).*

	Patient Capacity (no. of rooms, beds, chairs)	*Annual Patient Visits*	*Daily Psychiatric Patient Volume*	*Direct Access to Inpatient Psychiatric Beds?*	*Average Length of Stay*	*Boarding*	*Productivity Measures*
(12)						★ 83% *(25/30)* of respondents reported ED boarding of psychiatric patients ★ 37% *(11/30)* of respondents reported medically significant harm to the patient/staff due to boarding in CY2022 ★ 70% *(21/30)* of respondents report daily rounding on boarding patients by psychiatrists ★ Common causes:  ★ Average number of pts boarding/day: 	
(10)							
(8)							

Discussion

- While the *"n"* of respondents is low, represented in our data set are:
  - *Services in every US region*
  - *Dedicated psychiatric emergency services/units/facilities, as well as consult teams that serve entire hospitals and teams that are embedded in medical EDs*
  - *Institutions that are academic and non-academic*
  - *Low, moderate, and high-volume practice settings*
- While nearly all respondents report having **direct access to inpatient psychiatric beds**, nearly all respondents report issues with **boarding**, with **inpatient psychiatric bed shortage** being the most universally experienced contributing factor.
- The use of **psychiatrists** to evaluate and treat patients in these acute settings is most common/available in dedicated psychiatric emergency services/units/facilities.

Clinical Best Practices	
Completion of suicide safety plans	80%
Provision of bridge doses of prescribed medications until next appointment	73%
Initiation of medication-assisted treatment for SUD	67%
Naloxone dispensing	60%
Post-discharge follow up contacts	47%
Provision of gun locks/lock boxes	10%

Conclusions

The practice of Emergency Psychiatry is widely variable across clinical settings in terms of **patient volume**, **availability/utilization of psychiatrists**, and **access to adequate community-based resources**.

Despite the variations that exist, there are common experiences and practices across the subspecialty that can/should inform the establishment of "benchmarks" for best practice.

References

1. Theriault KM, Rosenheck RA, Rhee TG: Increasing Emergency Department Visits for Mental Health Conditions in the United States. *J Clin Psychiatry* 2020; 81(5).
2. Bruffaerts R, Sabbe M, Demyttenaere K. Emergency psychiatry in the 21st century: critical issues for the future. *Eur J Emerg Med* 2008; 15(5), 276–278.
3. Lofchy J, Boyles P, Delwo J. Emergency Psychiatry: Clinical and Training Approaches. *Can J Psychiatry* 2015; 60(6), 1–7.