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Alameda Model an Answer to Psychiatric Patient ED "Boarding"

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Psychiatric patients awaiting treatment in hospital emergency rooms for many hours, even days – a process known as "boarding" – has become a major dilemma across the USA. A hospital in South Carolina recently made national news after holding a patient needing transfer for a stunning 38 days. With little options for care in most sites other than transfer for psychiatric hospitalization, emergency departments (EDs) are often stuck with patients acutely dangerous to themselves or others until an available inpatient bed can be obtained.

Until now, most authorities have become frustrated over a lack of options. Most proffered ideas have focused on opening up access to more inpatient psychiatric beds. The Centers for Medicare and Medicaid have recently begun a Demonstration Project to allow more private psychiatric hospitals to accept Medicaid patients. Yet such approaches still rely on the concept that most acute psychiatric care requires inpatient hospitalization – a practice roughly equivalent to hospitalizing everyone who came to the ED with chest pain. Little attention has been paid to confronting the problem head on, by treating patients at the emergency level of care.

But now a new study conducted at the John George Hospital of the Alameda Health System in Oakland, California, has shown a way to decrease ED boarding times by over 80%, and reduce the need for psychiatric hospitalizations by up to 75%. The results dramatically increase access to care while substantially saving money overall. The system, described as the "Alameda Model," features a dedicated, regional psychiatric emergency service which immediately accepts, evaluates and treats all medically-stable mental health patients from area EDs and the community, is the key to these impressive numbers.

"The fundamental concept is that most psychiatric emergencies can be treated to the point of stability and discharge in less than 24 hours," said Scott Zeller, MD, lead author of the study and Chief of Psychiatric Emergency Services at the John George Hospital. "Considering inpatient hospitalization as the only option is a tremendous waste of resources. What people in crisis need is immediate help, not sitting for hours untreated in an ED while already-overwhelmed staff call around to arrange a three-day

hospital stay."

A dedicated Psychiatric Emergency Service, often called a "PES" or a "CPEP" at locations around the country, is an ED for psychiatric conditions only. A PES typically has the capacity to provide intensive treatment onsite for up to 24 hours. Able to both promptly evaluate and treat patients on an outpatient, emergency level, PES programs commonly can avoid the need for inpatient hospitalization in 70% or more of acute psychiatric patients. This can keep local psychiatric inpatient beds available for those who truly have no alternative.

Dr. Zeller's team postulated that if a PES is set up to accept transfers of all emergency mental health patients from a region's EDs, that region should have much lower boarding times, along with reduced percentages of inpatient psychiatric admissions. They then studied the PES at the John George Hospital, which accepts direct transfers from 11 EDs in the county of Alameda. The results of their 30-day study of all transfers from five of those EDs amazed even the researchers, who published their findings in the Western Journal of Emergency Medicine.

In summary, findings show that where comparable California state averages showed psychiatric patients boarding in EDs for 10.05 hours, in the Alameda Model patients waited a mean of only one hour and 48 minutes – a time reduction of over 82%. Further, only 24.8% of those patients needed hospitalization after evaluation and treatment in the PES. Even better, the study showed that the costs of all the care in the PES was less per patient than the cost of the typical boarding time in a general ED alone – not to mention the additional thousands of dollars saved by avoiding a psychiatric hospitalization. Plus, the Alameda Model's design has two-thirds of psychiatric emergency cases coming directly to the PES from the community, thereby sparing area EDs completely from increased census and costs.

While the benefits of a PES seem clear, the price tag to create such a program might be considered a stumbling block. Yet the authors posit that a simple coding change to USA Medicare and Medicaid may permit such programs to be self-sufficient or even profitable, which could attract hospitals and private providers to develop a PES. Dr. Zeller reports that his team has been working with government agencies to consider the code change, which could result in overall cost savings for Medicare, Medicaid and privately insured patients – while leading to improved quality and access to care, and decreased hospital admissions. As Dr. Zeller says, such outcomes "seem perfectly aligned with the goals of healthcare reform."

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