Information Sharing Across Institutions to Enhance Operations of Psychiatric Emergency Rooms in New York City

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Introduction by the column editors: This column demonstrates the use of an electronic mailing list (e-list) to generate a collaborative problem-solving process. The process is modeled on key features of the academic curriculum of the Columbia University Public Psychiatry Fellowship (PPF) (ppf.hs.columbia.edu). PPF alumni who encounter management problems at their worksite may present these concerns to current PPF fellows and faculty and lead a discussion aimed at identifying potential solutions. This column describes one such solution that involves information sharing among psychiatrists working in busy psychiatric emergency rooms in New York City. It describes variations in management approaches and the sharing of promising practices as informed by the e-list discussion. Ravi N. Shah, M.D., M.B.A., a Columbia psychiatry resident, and Kendra Campbell, M.D., a PPF fellow and emergency psychiatry fellow, established the e-list and communicated with psychiatric emergency room directors and attending physicians in New York City to facilitate discussion of management approaches. Readers are invited to submit suggestions for e-list discussions of management problems to column editor Jules Ranz, M.D. (e-mail: jmr1@columbia.edu).

For multiple, complex reasons, the number of people seeking mental health services in hospital emergency rooms has continued to increase over the past three decades. Between 1992 and 2003, the number of mental health–related emergency room visits increased by 75%, and in 2007, such visits accounted for 12.5% of all adult emergency room visits (1,2). These increases have exacerbated overcrowding in emergency departments and have led to concerns about the quality of care and increased likelihood of medical errors for both psychiatric and emergency medicine communities (3).

The lack of inpatient psychiatric beds has left patients awaiting psychiatric consultation or admission in hallways or other emergency room areas (4). A 2008 American College of Emergency Physicians survey found that 79% of psychiatric patients awaiting psychiatric consults or inpatient beds had been boarded in an emergency room—60% for more than four hours, 33% for more than eight hours, and 6% for more than 24 hours (5). This problem has garnered widespread attention

in the broader medical establishment and the media. In 1989, because of the growing concern about the timeliness and quality of psychiatric care in general medical emergency departments, the New York State Office of Mental Health (OMH) developed Comprehensive Psychiatric Emergency Programs (CPEPs) to address the needs of individuals with psychiatric emergencies (6).

OMH regulations specify that a CPEP must include four components: hospital-based crisis intervention services in the emergency room, including triage, referral, and psychiatric and general medical evaluation; extended observation beds in the hospital to provide extended evaluation, assessment, or stabilization of acute psychiatric symptoms for up to 72 hours; crisis outreach services in the community, including clinical assessment and crisis intervention treatment; and crisis residence services in the community for temporary residential and other necessary support services for up to five consecutive days (7). OMH designates and reviews CPEPs' adherence to regulatory requirements. Individual sites have substantial flexibility for determining operating procedures within these requirements. Currently, there are 12 CPEPs and 16 additional dedicated psychiatric emergency rooms in New York City.

In 2010, *Health Affairs* published a seven-point action plan to reduce boarding, which included improving the psychiatric care provided in emergency rooms, increasing collaboration with outpatient resources, and expanding the use of crisis centers (8). In fact, many states have developed dedicated psychiatric emergency services (PESs) similar to CPEPs, although they do not necessarily include all the additional enhanced services. The development of the PES model has led to new and evolving relationships with general medical emergency departments, creating both improvements and challenges. Healthy patients with primary psychiatric complaints can be treated in a safe, specialized environment, which decreases the risk of self-harm or harm to others.

The physical separation of psychiatric and general medical emergency rooms creates new challenges for managing patients with comorbid psychiatric and medical illnesses.

Policies must be created to determine which patients belong in which location and who, if anyone, may go directly to the psychiatric emergency room. In addition, if acute medical emergencies arise with a patient being treated in the psychiatric emergency room or CPEP, the patient may require transfer to the general medical emergency department for further stabilization. Given these potential challenges, the two departments benefit from collaborative communication and the development of policies and procedures to establish protocols of care.

PROJECT DESCRIPTION

In the fall of 2013, the New York Presbyterian Comprehensive Psychiatric Emergency Program (Columbia CPEP) was renovated. Creating a larger space doubled the patient capacity from 12 to 24 and physically removed the CPEP from the general medical emergency room. Within a year, patient volume had significantly increased, which led to an evaluation of staffing models and processes to increase efficiency. This project began as a quality improvement project to learn more about processes used by other CPEPs and psychiatric emergency rooms. We surveyed other New York City hospitals with psychiatric emergency rooms to identify promising practices that might be implemented in the Columbia CPEP. Psychiatrists from the following psychiatric emergency rooms were interviewed: Columbia CPEP, Mount Sinai Beth Israel Medical Center CPEP, Mount Sinai St. Luke's and Roosevelt Hospital CPEP, Kings County Hospital Center CPEP, Bellevue Hospital Center CPEP, and Maimonides Medical Center psychiatric emergency room.

PRACTICE VARIATION

All participants agreed to share information, with the understanding that it would be distributed to all group members. As such, each institution stood to gain from participation by learning about other institutions' practices. Even though these institutions have similar missions and regulatory guidelines, substantial variability was noted in policies and procedures. Some CPEPs have explicit policies defining which patients can safely be sent directly to the psychiatric emergency service and which patients first require medical clearance in the general medical emergency room. Some institutions require all patients to change into hospital gowns and undergo a physical exam as well as basic labs tests. Other institutions have either a de facto or proceduralized "fast track" for patients who they believe are likely to be treated and released. These patients are examined in their street clothes without physical exams or lab tests. One institution reported hospitalizing about 75% of all patients, while the others hospitalized approximately 25%–45% of patients. Shift length also was found to vary across institutions—some requiring attending physicians to work eight-hour shifts and others requiring 12-hour shifts to minimize handoffs. One institution offered shifts ranging from four to eight hours. Despite the desire to have consistent

full-time staff, the institutions were found to vary widely among full-time, part-time, and moonlighter attending physicians. One institution reported having no full-time emergency room attending physicians, and two reported that all emergency room attending physicians are full-time.

These initial interviews led to two immediate results. First, the observation that other PESs identified a primary physician provider for each patient at morning rounds prompted leadership at the Columbia CPEP to adopt this practice to enhance patient care. Second, perhaps the most robust finding of the survey was that interviewees were interested in joining a CPEP/psychiatric emergency room e-list to share ideas, ask questions, and address common challenges.

E-LIST

The e-list includes psychiatrists at each emergency room in the initial survey. In addition to being used for the initial quality improvement project at the Columbia CPEP, the e-list contributes a sense of cohesion and community and has quickly developed into an ongoing resource for obtaining information about specific practices at the participating institutions. One of the first questions posed to the e-list after the initial survey involved the role of social workers. A CPEP director reached out to the other institutions to determine the various clinical responsibilities filled by social workers in their emergency rooms. The responses indicated that social workers do not serve as primary clinicians but commonly perform psychosocial evaluations, plan for disposition, locate hospital beds, obtain insurance authorizations, arrange transportation, and obtain collateral information. One CPEP for children reported utilizing social workers as primary clinicians, who present their cases to attending physicians.

Another e-list topic, which was prompted by the following posting, involved the use of telemetry monitoring of patients in CPEPs or psychiatric emergency rooms. "I have a quick question for all: do any of your CPEPs or psych ERs use cardiac monitors on patients? We never heard of such a thing (for starters, if they need that they aren't medically stable enough for psych) since those machines/cords can be used as weapons or strangulation hazards, but our medical ED is asking us why not. Prompt replies appreciated."

Three CPEP attending physicians responded on the same day, all stating that their emergency rooms prohibit the use of telemetry for safety reasons. This finding helped the CPEP attending physician enhance the safety discussion with his general medical emergency department colleagues by adding the information that allowing telemetry in a CPEP would make their institution an outlier compared with peers.

An emergency and public psychiatry fellow utilized the e-list to distribute an official survey querying leadership about the training practices for their clinical and nonclinical staff in verbal de-escalation, manual restraint, and trauma-informed care. All hospitals participated in the survey, and the results were shared with the group. The results reflected a wide variability in training in these areas, which served as

a learning experience for leadership. Many members commented on how the survey questions and results sparked interest in augmenting their staff training and education in these areas.

One of the liveliest discussions involved a question posed to the group about what specific triage criteria various institutions require patients to meet in order to go directly to the CPEP or psychiatric emergency room without an evaluation in the medical emergency room. The specific criteria, such as vital sign parameters and comorbid general medical conditions, varied widely across institutions. One hospital used very specific criteria, which were embedded within its electronic medical record (EMR) in order to triage patients to either the general medical or psychiatric emergency room. Many group members shared their challenges with managing medically unstable patients, such as learning how to appropriately manage the flow of patients with the general medical emergency room. These discussions prompted one hospital to revise its triage criteria and incorporate a checklist system in its EMR.

CONCLUSIONS

In April 2015, the e-list was formalized into an actual List-serv and expanded to include leadership from all CPEPs and psychiatric emergency rooms in New York City. Even across institutions with a similar mandate and regulatory requirements in the same city, there is a wide variation in practices. Instead of risking reinventing the wheel when designing a quality improvement project at a specific site, an institution can gather data across various sites and obtain valuable information to help inform operational changes. People are interested in sharing information about their own sites to learn more about opportunities for improvement and to identify areas where their site may be an outlier. Via information gathering and sharing, a simple e-list has facilitated information integration across peer institutions, expanded the administrative team, and enhanced quality improvement.

The experience with the survey conducted by the emergency and public psychiatry fellow raises the possibility of using such e-lists both for informal data gathering and for research purposes. As health care reform, integrated care, and other environmental changes alter the health care landscape, collaboration is critical to facilitate sharing of promising practices to maximize quality improvement across institutions.

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