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Selected Topics: Psychiatric Emergencies

IMPLEMENTING AND EVALUATING A STANDARD OF CARE FOR CLINICAL EVALUATIONS IN EMERGENCY PSYCHIATRY

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□ **Abstract—Background: Psychiatric presentations are common in emergency departments (EDs), but the standard of care for treatment remains poorly defined. We introduced standards for emergency psychiatric evaluations that included obtaining collateral information, writing a safety plan for discharging patients, identifying the next best provider, and alerting that provider to the patient's visit. Objective: We sought to demonstrate the feasibility and clinical impact of implementing standards for emergency psychiatric evaluations. Methods: To evaluate feasibility, physicians attested to completion in the electronic health record. To evaluate the effect on clinical outcomes, we compared admission rates, 30-day return rates, and median length of stay from a 4-month pre-implementation period to a 4-month post-implementation period. Data were extracted from a quality-improvement database. Results: There were 1896 patient encounters in the pre-implementation period and 1937 encounters post-implementation. Pre-and post-cohorts were similar demographically. Collateral was obtained for 1035 (86%) encounters, a written safety plan was completed for 793 (77%) eligible patients, the next-best provider was identified for 1094 (91%), and that provider was contacted for 837 (70%). There was no difference from pre to post periods in admission rates (17% vs. 18%; $p = 0.36$), median length of stay (13.3 ± 0.6 vs. 12.5 ± 1.4; $p = 0.35$), or 30-day return rates (15% vs. 16%; $p = 0.66$). Conclusions: This standard work for emergency psychiatric evaluations was feasible even in a highly acute patient population. However, the benefits of this intervention are less clear. We question the utility of prevailing metrics in emergency psychiatry.** © 2018 Elsevier Inc. All rights reserved.

□ **Keywords—psychiatric emergency services; standard of care; total quality management; utilization**

INTRODUCTION

Behavioral emergencies comprise > 10% of emergency department (ED) visits nationally (1). Patients present to EDs with a wide variety of psychiatric, substance use, and medical comorbidities (2). Clinicians must be prepared to manage both straightforward concerns and severe psychopathology: almost 1% of ED visits are for suicidal ideation, and > 20% of those patients will attempt suicide in the following year (3,4). The annual risk of suicide for an ED patient seen after a suicide attempt exceeds 1% (5).

A standard of care for an emergency psychiatric evaluation remains difficult to define. General references agree on general goals for psychiatric evaluations in the ED, including discerning the etiology of symptoms, assessing suicide and violence risk, and determining the need for psychiatric hospitalization, but are less clear on specific techniques that can achieve those goals (6,7). The American College of Emergency Physicians has provided guidelines focused on ensuring an adequate medical evaluation of patients awaiting psychiatric disposition and reducing ED boarding times (8–10). The feasibility and benefit of implementing more detailed

guidelines for reducing suicide risk among suicidal patients in the ED have not been investigated (11).

EDs vary widely in their capacity to deliver psychiatric care, and it is unknown how easily standards and expectations can be implemented (1). Barriers to providing more intensive care include the availability of specialized psychiatric providers, inconsistency of reimbursement, and the lack of education among nonpsychiatric providers in managing acute behavioral emergencies like suicidal ideation. Where available, specialized psychiatric staff and care models lower hospitalization rates, reduce return ED visits, and improve length of stay (12).

In this article, we describe the introduction of common clinical work for psychiatric evaluations in the psychiatric emergency service (PES) of a public safety-net hospital and level I trauma center. Our service identified five expectations that we sought to complete for all patients. The expected elements for all psychiatric evaluations and their importance are summarized in Table 1.

Our aims are to describe a process and demonstrate the feasibility of implementing expectations for emergency psychiatric evaluations and to describe the impact of implementation on clinical outcomes for patients. We anticipated that successful introduction of this standard of care would reduce admission rates to inpatient psychiatry and reduce PES recidivism. We expected overall length of stay to improve, as these expectations encouraged completion of this work by a provider (eg, nurse or midlevel) other than the attending physician.

MATERIALS AND METHODS

This study was completed in the PES at Denver Health Medical Center in Colorado. Denver Health is an academically affiliated public safety net hospital with a level I trauma center. The emergency medicine department manages > 140,000 annual patient encounters across its adult and child units. The PES is a 17-bed unit designed to manage a full range of behavioral emergencies. The unit is staffed by a faculty psychiatrist 24/7; other clinicians include advanced practitioners, psychiatry residents, social workers, and specialized nursing staff. Approximately 50% of patients are under involuntary treatment orders. All patients are seen or staffed by an attending psychiatrist.

Implementation

Standard work elements were introduced along Kotter's Change Model (22). Through a series of preparatory meetings, PES leadership discussed the urgency of developing a standard work model in order to maintain care quality, despite increasing patient volumes. Leaders presented other faculty with proposed standards of care in a series of meeting and e-mail exchanges, and the group agreed upon elements of the expected evaluation in early 2017. Other PES staff including advanced practitioners and nurses were subsequently introduced to the expectation elements and invited to comment on how to feasibly implement these expectations. Feedback was integrated

Table 1. Elements of an Emergency Psychiatric Evaluation

Element	Process	Justification
Obtain an accurate admission medication reconciliation	Obtain a list from available medical records and review with the patient. Call outside pharmacies if necessary.	In studies, most patients on admission have errors in their medication reconciliation, and most of those errors pose a threat to patient safety (13,14).
Obtain collateral information for all patients	Speak with family, friends, or current provider; or, review records from prior or current providers.	The standard of care for a risk assessment requires incorporation of collateral information (15,16).
Complete a written safety plan with patients who discharge	Identify triggers, coping skills, and social supports using the standard form, an index card, or similar tool	Completing a written safety plan improves the intensity of suicidal ideation and reduces self-harm by > 50% after an emergency psychiatry visit (4,17,18).
Identify a follow-up provider and make appointment	Identify one single best provider from whom the patient can receive follow-up care and arrange for an appointment if possible.	Providing a follow-up appointment (instead of a phone number) improves follow-up adherence from 46% to 65%. Securing a follow-up appointment within 3 days doubles the mean time for a repeat PES visit (19–21).
Transmit information to next level provider	Fax or mail PES notes or instructions for accessing records to the outpatient provider; leave phone message.	Consulting with the following provider improves follow-up adherence and reduces return ED visits (16,21).

ED = emergency department; PES = psychiatric emergency service.