U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

PSYCHIATRIC BOARDING INTERVIEW SUMMARY

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This report was prepared under contract #HHS-100-03-0027 between HHS's ASPE/DALTCP and the Lewin Group. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, John Drabek, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. His e-mail address is: John.Drabek@hhs.gov.

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I. INTRODUCTION

The U.S Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation contracted with The Lewin Group to interview physicians and other clinical staff on the issue of psychiatric boarding. The interviews were designed to gain the perspective of Emergency Department (ED) Directors/ED Physicians, Department of Psychiatry Chairs/on-call Psychiatrists, and Nurse Case Managers/Social Workers in nine hospitals. Where possible, community stakeholders of these hospitals were also interviewed. These stakeholders were from community mental health centers (CMHCs), state facilities, and state mental health departments. These interviews were intended to provide additional information on the issue of boarding to supplement the literature review conducted by The Lewin Group, "A Literature Review: Psychiatric Boarding,"[1] in light of the limited amount of published research on the topic.

Key areas of interest discussed during the interview included:

1. The extent to which psychiatric boarding is perceived as a problem;
2. Reasons why psychiatric patients are boarded;
3. The impact of psychiatric boarding on patient care and the capacity of hospitals to provide effective emergency services; and
4. The views of those interviewed concerning potential short-term practice improvements and long-term solutions to reducing the frequency with which psychiatric patients are boarded in EDs.

The following paper is a summary of the interviews conducted by The Lewin Group.

A. Methodology

The Lewin Group identified a sample of nine hospitals based on geographic location across the United States, urban or rural status, bed size, public or private status, presence of a psychiatric ward, and state rank in a national study on mental illness to identify state leaders and laggards in mental health care.[2] Of the nine hospitals interviewed, eight are urban or suburban, all are non-profit and seven have a psychiatric ward. Three of the nine hospitals included in the interviews had implemented psychiatric emergency services (PES) in an attempt to provide better diagnosis and treatment of the mentally ill in the ED.

From September 19 to November 6, 2008, The Lewin Group interviewed seven ED Directors/ED Physicians, eight Nurse Case Managers/Social Workers, and seven

[1] Available at http://aspe.hhs.gov/daltcp/reports/2008/PsyBdLR.htm.

[2] The National Alliance on Mental Illness (NAMI). Grading the States: A Report on America's Health Care System for Serious Mental Illness, 2006.

Department of Psychiatry Chairs/on-call Psychiatrists at these nine hospitals, and six community stakeholders. Community stakeholders included representatives from CMHCs , state facilities, outpatient psychiatric facilities and state mental health departments. Given the small number of individuals interviewed during this process, the findings presented here are indicative of the issues relating to the boarding of psychiatric patients in emergency rooms and should not be considered representative or definitive.

B. Summary

> *"Every month someone has died waiting. This is a problem of great dimensions."*
>
> *"This is a systems issue that manifests itself in the ER, which is a common pathway for the problem; but the real problem is about capacity in other parts of the system, adequate funding, and being able to move patients to the level of care they need."*

There was no standard definition of psychiatric boarding among respondents. Interestingly, respondents within the same hospital differed on their definitions, including the time period cited in their definitions. With regard to the frequency of boarding, length of time boarded, and repeat users, most respondents stressed that they did not have exact numbers and did not track this data. However, a few respondents did track this data and noted that the purpose of such tracking was often to draw attention to the problem.

The majority of respondents interviewed found psychiatric boarding to be a serious problem when it occurred. The reasons for psychiatric boarding reported during the interviews included the general lack of inpatient beds, insurance pre-authorization necessary for admission, difficulty in placement/transfer to a receiving facility, and lack of outpatient facilities/community resources. However, most respondents indicated that psychiatric boarding is a symptom of a greater mental health system crisis.

In the majority of hospitals, ED physicians were in charge of deciding whether a psychiatric patient should be admitted to the hospital. Yet, of these hospitals, only one provided ED physicians with special training beyond that received in medical residency. Not surprisingly, liability was an important concern among respondents as most ED physicians and psychiatrists would rather admit a patient to an inpatient unit than have them harm themselves or others after being dismissed from the hospital.

Once the decision to admit is made and the boarding process begins, respondents indicated that medication is usually administered but rarely much else. Further, most respondents stated that although attempts have been made to reduce the use of restraints, they are still used, typically with an extremely violent patient. Additionally, all hospitals interviewed mentioned the overwhelming amount of resources that psychiatric boarders use during their stay.

Those hospitals that had implemented a model of PES found collaboration with the community to be strong, while other respondents reported either poor or moderate collaboration between the ED and the community. PES models focus on providing better diagnosis and treatment of the mentally ill in the ED which can reduce psychiatric boarding. PES can take the following forms: a psychiatric consultant to the ED is called when needed; a separate psychiatric ED in a general hospital or the ED of a freestanding psychiatric hospital.[3]

Given the small sample size of the study, it is difficult to extrapolate findings. However, the views expressed by those interviewed do support the findings from the literature review and are an important supplement to existing research evidence.

[3] Evaluation of the Quality of Care and Process Improvement in Psychiatric Emergency Services: An Informatics Perspective, Fall 2003. http://www.emergencypsychiatry.org/PDF/AAEP_Fall2003.pdf.

II. EXISTENCE AND REASONS FOR PSYCHIATRIC BOARDING

This section discusses the definition of psychiatric boarding and perceptions of the extent of boarding. This section also discusses reasons for the boarding of psychiatric patients, including estimates of the frequency of boarding and length of time boarded.

A. Definition

"Patients that come into the ED … are triaged and evaluated and admitted to floors, but [if] there is no bed, [they] are boarded. We do not go by a time."

"A patient who has to stay in the ED occupying a space while waiting to be placed in a facility for inpatient treatment."

"A patient kept in the ER for lack of a psychiatric bed for more than 12 hours."

Respondents provided a range of definitions of psychiatric boarding, even when working within the same hospital. Generally, respondents defined psychiatric boarding as a patient waiting in the ED or hallway, awaiting placement, after a decision has been made to admit the patient. Respondents also included in their definitions the length of time a patient must wait before such waiting is deemed "boarding." Respondents varied with regard to this "pre-boarding time" estimate: The most common amount of time was two hours or four hours, with a range of two to 24 hours. However, almost half the respondents did not provide a pre-boarding time period in their definition of psychiatric boarding. The variation in definitions of boarding indicates a lack of national practice standards.

B. Extent of the Problem

"It is the number one problem of my Emergency Department."

The majority of respondents interviewed agreed boarding was a significant problem in their hospitals. ED Directors/ED Physicians tended to perceive boarding as a more serious problem than other types of clinical staff, for example psychiatrists. Further, hospitals that had implemented a PES model did not rate the problem significantly higher than those without a PES model. This suggests that the implementation of PES alone may not be adequate to address the problem of boarding.

C. Frequency of Boarding and Length of Time Boarded

All hospitals indicated that they boarded patients every week, although not necessarily every day. Estimates of the number of patients boarding per day or per week varied by hospital and by respondent within each hospital, indicating knowledge disparities between respondents within the same hospital. Three hospitals tracked data on psychiatric boarders generally to show legislators and other stakeholders that psychiatric boarding was a problem in their hospitals. In addition, one state hospital and two outpatient facilities tracked data on psychiatric boarders in an attempt to identify high utilizers and set up case management. It was a commonly held view among respondents that psychiatric boarding involves repeat users. However, no reliable data was provided regarding the percent of psychiatric patients who were repeat users.

Respondents were asked to provide the length of time that psychiatric patients boarded at their hospitals. Responses were typically given in ranges, with variance given by time of day, day of the week, insurance status, and voluntary/involuntary status. The range of boarding times was from two hours to two weeks, with one respondent recalling a patient who was boarded for 300 days. However, typical responses included a patient waiting after the decision to admit for "2-3 hours, up to 3-4 days."

D. Reasons for Boarding

> *"It is a resource issue primarily. The closing of state hospitals has backed up general hospitals for psychiatric patients with disorders who are frequent patients."*
>
> *"There is not necessarily a shortage of inpatient beds, but a failure at all other levels."*

Respondents were asked to explain the reasons for psychiatric boarding at their hospitals. A summary of the main reasons given for psychiatric boarding is provided below:

- **Lack of Inpatient Hospital Capacity**. Hospitals that do not have available inpatient psychiatric beds must board psychiatric patients until a bed becomes available.

- **Liability**. A majority of respondents indicated that liability was taken into consideration in the decision to admit as most ED physicians and psychiatrists would rather admit a patient to an inpatient unit than have them harm themselves or others after being dismissed from the hospital.

- **Insurance Status or Delays in Pre-authorization**. Boarding can be exacerbated if a patient's health plan requires authorization for an inpatient

admission. Further, several respondents noted that certain hospitals "screen" a patient's insurance status, and will admit patients dependent upon their ability to pay, leaving uninsured patients to board longer.

- **Placement or Transfer Issues**. Some patients can be hard to place for a variety of reasons. For example, they are uninsured or are viewed as "difficult patients." A significant amount of time can be spent calling other facilities to locate a bed for these patients and completing the necessary paperwork which prolongs boarding.

- **Insufficient or Lack of Outpatient/Community Resources**. The absence of community alternatives to EDs that are available 24 hours a day can lead to greater use of ED services and greater demand for inpatient care for psychiatric patients.

- **Insufficient Staffing**. Insufficient staffing can exacerbate boarding if beds are available but psychiatrists or other staff, such as psychiatric nurses, are not. For instance, one respondent mentioned that nurses in the psychiatric inpatient wing of her hospital had to maintain a nurse-patient ratio of 1:5.

- **Necessity of Medical Clearance**. In the ED, psychiatric patients must be cleared medically before they can be screened for a psychiatric evaluation. This medical clearance prolongs the time the psychiatric patient must wait in the ED although many respondents did not count this pre-boarding wait time in their length of boarding estimates. In the case of substance abuse, patients will not be cleared until they are sober, causing them to board longer.

- **EMTALA**. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to screen and stabilize patients with emergency conditions regardless of their ability to pay. Patients can board longer due to uncertainty over whether they meet EMTALA's definition of "stabilized" for transfer to a facility with a psychiatric bed.

- **Insufficient Housing Alternatives**. One respondent indicated that if there were sufficient housing alternatives, some homeless, psychiatric patients could be discharged more quickly from a hospital inpatient bed, allowing new psychiatric patients to access these beds.

III. CARE DELIVERY

"Patients are taken to the general ED by ambulance, triage, or the police. They are medically cleared and then transferred by security to the psychiatric ED."

"Upon arrival to the ED, the patient is evaluated by a triage nurse. They ask if the patient is suicidal. If yes, he/she is immediately placed on one-to-one supervision in the ED. If the patient is not suicidal, the nurse makes the decision on how rapidly the patient needs to be seen (urgent, emergent, non-emergent)."

This section describes the type of care received by psychiatric patients while boarded in the hospitals interviewed, including who treats the patient, whether previous patient assessments and collateral information are obtained, boarding placement, care administered during boarding and the use of restraints.

A. Mental Health Professionals

"For a patient who [I am] … not certain of whether to admit, a psychiatrist is called. On rare occasions, a psychiatrist sees the patient."

Respondents noted that several health care professionals were generally involved in the care of mental health patients during the screening and boarding process. Typically, a medical screen is performed by a triage nurse or ED Physician. Respondents indicated that the decision to admit is more often made by an ED physician rather than by a psychiatrist. In fact, the role of psychiatrists in emergency psychiatric services was found to vary considerably. In some hospitals they were significantly involved in the screening process for admission, while in others they were only available by phone and rarely entered the ED. ED physicians indicated that, in general, it was difficult to reach psychiatrists by phone after hours and on weekends. Social workers are often involved in the transfer process, seeking outpatient or alternative treatment for the psychiatric patient.

The extent of training ED physicians had received in the management and care of patients with mental health conditions varied greatly. In some hospitals, training in crisis prevention and suicide evaluation was a requirement. Further, security staff was trained in de-escalation techniques. However, some ED physicians had not received any training since their residency.

B. Assessments and Collateral Information

ED staff in nearly all hospitals sought to obtain previous patient assessments and collateral information in assessing psychiatric patients. However, respondents noted the difficulty that exists in obtaining this information. Respondents mentioned Health

Insurance Portability and Accountability Act constraints and the lack of availability of private psychiatrists and case managers after hours as factors leading to limited access to such information.

C. Boarding Placement

"There is no separate psychiatric room; that is our biggest problem."

"The ED is not the best place to deal with a psychiatric emergency."

Respondents described a variety of boarding locations depending on the hospital and on the services available. In the hospitals where psychiatric patients are boarded primarily in the ED, patients are generally placed in any available ED bed. Some hospitals reported using inpatient hallways, as these are less noisy and hectic than EDs. Some facilities have separate psychiatric EDs or separate areas for psychiatric patients, such as a behavioral health annex. Two hospitals mentioned the use of a locked unit for psychiatric boarders who become violent.

D. Medication and Care

"What they really need, they don't get."

Respondents were asked what type of psychiatric care patients received while boarding and whether necessary medication was given to patients during the boarding process. All hospitals indicated that patients are started on medication during the boarding process. However, few hospitals reported providing psychiatric therapy to boarded patients. Many respondents mentioned the lack of continuity of care that exists both within the hospital, (as patients are continually "signed over" with shift changes), and within community mental health facilities. A few respondents noted that psychiatric patients are given bright colored gowns or socks to distinguish them from the medical patients, and to prevent elopement. Several respondents noted that this only further stigmatizes the psychiatric patient.

Nearly all respondents indicated that chemical and/or physical restraints were used in their hospital. Most respondents stated that although attempts are made to reduce the use of restraints, they are still used, typically with an extremely violent patient. If restraints are used, hospital security and/or law enforcement are often involved.

IV. IMPACT

This section details the impact of boarding on psychiatric patients and hospital staff. This section also includes the financial impact of psychiatric boarding.

A. Impact on Patients and Staff

"I cannot overemphasize the negative impact this has on staff."

"Often there are mentally ill patients on one side of a curtain and medically ill patients on the other. One mother with a 5-year-old with diarrhea had a roommate who was a crack addict. She was absolutely petrified of her the entire time."

Many respondents reflected on the negative impact psychiatric boarding has on hospital staff. They noted that boarding increases the workload of nurses, nurse practitioners, and ED physicians, and decreases the time spent with medical emergencies. Several respondents noted staff turnover due to this particular issue.

In many cases, mental health patients are next to or very close to medical patients in the ED or waiting room. If psychiatric patients are agitated or disturbed, this can cause concern among some medical patients.

B. Financial and Overall Impact

"The hospital eats the cost. There is a mental health fund, but it is vastly inadequate."

"If the state is going to abandon its safety-net role, then it will bankrupt the community hospitals."

The hospitals interviewed shared the view that psychiatric boarding places a tremendous resource burden on hospitals. Respondents explained that boarders take up a considerable amount of time and space, often crowding hallways and EDs and tend to board longer than medical patients, consuming more hospital resources (i.e., meals, bedding, etc.) during their stay. One facility indicated that their mental health annex costs over a million dollars a year to maintain, and reimbursement is vastly insufficient to cover the cost of food, security, and staff.

Respondents were asked "who pays for the care of the psychiatric patient when he/she is boarding," and "what is the financial impact of boarding on the hospital." For uninsured patients, most hospitals reported absorbing the costs themselves. Some respondents indicated that the state pays for the care of uninsured patients. For

insured patients, hospitals typically bill Medicaid, Medicare, or private insurance for an ED visit or services rendered. However, total patient care is often rolled up into one charge, with the hospital receiving the same amount regardless of length of stay.

V. COMMUNITY COORDINATION AND COLLABORATION

This section describes the transfer process of psychiatric patients between hospitals as well as the level of community coordination and collaboration with the ED regarding the care of psychiatric patients. This section also explores the involvement of law enforcement in the psychiatric boarding process.

A. Transfer Process

> *"If [they are] committed [patients], a privately owned security company has an agreement with police to transfer the patient. If [they are] voluntary [patients], the family can transfer the patient, and the crisis stabilization unit often uses cabs to transfer the patient."*

> *"In our institution, it is not a problem with [not having] insurance, it is only a matter of beds … It is more of a problem for the insured because they need pre-authorization."*

Respondents indicated that patients are transferred to state hospitals, private acute care hospitals, crisis centers, and community alternatives with less acute settings. Most hospitals noted that they are aware of their transfer options. Some hospitals also give the patient a list of outpatient options at discharge, while others help the patient through the process, including appointment scheduling.

While some hospitals indicated that they transfer patients to nearby facilities, others indicated long transfer distances. In one instance, a stakeholder noted that a patient was transferred to a facility approximately 100 miles away. Some hospitals interviewed made arrangements with transportation services (e.g., taxi services, bus companies, security companies) and/or law enforcement to ensure appropriate transfers are made.

Respondents indicated that the transfer process can frequently be extremely slow for hospitals. Of those interviewed, typically, social workers are tasked with calling local hospitals and facilities in search of a bed for patient transfer. ED physicians, and occasionally resident psychiatrists and on-call psychiatrists, handle pre-authorization and other paperwork involved in the transfer. Several respondents noted that insurance issues can delay transfer. The need for pre-authorization can cause delay. Transfer can also be delayed if hospitals with available beds are out-of-network and alternatives have to be found. In some hospitals, respondents reported that uninsured patients boarded longer than privately insured patients because it was harder for them to find facilities willing to take uninsured patients.

B. Community Collaboration

"We have a whole repertoire of referral services."

"It's housing that's the issue … or families that bring them in and won't take them back; we have a good working relationship with outpatient options but patients must wait because they [these options] are not available 24/7."

EDs reported having varying degrees of collaboration with the community regarding community outpatient alternatives. Generally, hospitals that have implemented a PES model had greater collaboration with outpatient facilities than those without a PES model. Hospitals in which community mobile crisis teams and diversion evaluation teams are placed in the hospital ED demonstrated the greatest degree of collaboration. Often these teams would triage psychiatric patients in the ED, helping to alleviate some of the burden on ED Physicians, nurses, and social workers. A few hospitals also reported being involved in committee meetings with local stakeholders, including hospital employees, law enforcement, and outpatient facilities, to discuss emergency issues for mental health patients.

C. Law Enforcement

"[There is] a large security force, and there is law enforcement in the general ED. Law enforcement brings someone to the ED, and wants a quick turnaround, but sometimes police have to wait on the patient."

"The hospital is limited in security, as there are 107 treatment spaces with two security guards. One is at the traffic, influx ambulatory [side], the other at the ambulances, psych entrances. Both arrive if there is an issue and there are additional security guards in the medical center."

The majority of respondents indicated that law enforcement and security guards were involved in some capacity in the boarding process. Law enforcement typically is involved in bringing a psychiatric patient to the ED on an involuntary commitment. Once the patient is in the ED, hospitals differ in their dependence on law enforcement, with police leaving immediately at some hospitals and others requiring one to one police observation until admission. Most hospitals utilize staff security in psychiatric boarding, primarily during chemical and physical restraints. A few hospitals noted that their local law enforcement has undergone training in mental health issues, primarily the Crisis Intervention Team model.

VI. PRACTICE IMPROVEMENTS AND SOLUTIONS

Respondents were asked to provide suggestions for practice improvements and long-term solutions to address psychiatric boarding issues raised during the interviews. Practice improvements were characterized as practices that would not require a significant overhaul of the current mental health system. Long-term solutions were characterized as system-wide solutions that would aim to reduce or even eliminate boarding.

A. Practice Improvements

"Best practices are only 'Band-aids' on the problem."

"Notwithstanding capacity, we need to provide psychiatric evaluation by a mental health professional/psychiatrist within 90 minutes of contact of the ED Doctor. This is a better model, so the patient can be discharged instead of sitting for 18-36 hours."

The following provides a summary of the practice improvements suggested:

- **Increased Staffing/Number of Social Workers**. Given that boarding is, at times, caused by lack of inpatient hospital staff to care for the psychiatric patient rather than lack of inpatient psychiatric hospital beds, having additional staff would alleviate this problem.

- **Better Case Management/Identifying Frequent Users**. Ensuring that psychiatric patients receive care coordination regarding medication adherence and outpatient appointments may prevent these patients from presenting to the ED, and thus boarding.

- **Change Boarding/Placement Location within Hospital**. Some respondents recommended moving boarders to inpatient hallways or designated areas rather than the ED. These areas tend to be less chaotic and noisy and, therefore, are less likely to exacerbate a mental health crisis.

- **Improved ED Staff Training and Education**. Improved training and education of ED staff would result in better screening and psychiatric evaluations in the ED, which may reduce hospital admission rates of psychiatric patients and decrease boarding.

- **Better Screening/Psychiatric Evaluation**. Some respondents indicated that improved screening and psychiatric evaluations in the ED, including having a psychiatrist involved in the ED screening process, may reduce hospital admission rates of psychiatric patients and decrease boarding.

- **Improved Throughput/Scheduling**. Improved throughput can include discharging patients before noon to improve the patient flow in the hospital and preparing for the busiest times of the week.

- **Improved Community Collaboration/Relationship**. Better knowledge of outpatient alternatives among ED staff and strong collaboration between community crisis services and the ED are likely to lead to more appropriate discharge of patients to outpatient facilities, and a reduction in boarding.

B. Long-Term Solutions

"Longer term solutions include improving the infrastructure that is not available in most communities at this time, but may help to decrease the problem in 5-10 years."

"A number of areas in the country have 24 hour psychiatric crisis units. They are not inpatient facilities; they are evaluation facilities where a patient is evaluated, has medical clearance and is transferred to a crisis center."

Many respondents noted that while practice improvements can lessen the impact of psychiatric boarding, system-wide solutions would have to be implemented to significantly address the problem. The following provides a summary of the long-term solutions recommended by respondents:

- **Increased Outpatient Capacity/Community Alternatives**. Respondents indicated that because of the lack of outpatient and community alternatives, they believed patients must wait in the hospital inpatient unit for community outpatient placement. This, in turn, delays placement of a new psychiatric patient to the inpatient unit, creating greater boarding in the hospital. Two specific community services identified as part of system-wide improvement of mental health services were crisis residential services and mobile crisis teams. Crisis residential settings would care for patients who do not need to be in a hospital setting, allowing the ED to see more acute patients. Mobile crisis or diversion teams provide crisis intervention and stabilization services to psychiatric patients in the community, preventing many patients from ultimately presenting to the ED.

- **Separate Psychiatric ED/Behavioral Health Annex**. A separate psychiatric ED or behavioral health annex is a component of the PES model in which psychiatric patients are placed in a separate ED/annex after medical clearance. This removes patients from the general ED, as well as increases the likelihood that they receive care from trained mental health professionals while boarding.

- **Increased Hospital Inpatient Capacity**. Additional psychiatric, inpatient beds would help to alleviate boarding for those patients who require hospital level care.

- **Regionalization of Care**. The care of boarded patients could be improved by implementing standard processes across hospitals within the same region such as standard boarding procedures, as well as coordination across hospitals and at the state level regarding capacity issues.

- **Innovative Psychiatry (Tele-Psychiatry & Psychiatrists as Hospitalists)**. Use of tele-medicine would allow psychiatrists to perform evaluations and screenings of psychiatric patients when they cannot be physically present in the ED. This may alleviate inappropriate inpatient admission, and thus, lead to reduced boarding.

- **Eliminate Out-of-Network Insurance Issues**. Hospitals that have available psychiatric beds are not always authorized to accept patients if these hospitals are not in the patients' insurance network. Some respondents noted that eliminating the in-network requirement would increase available options for inpatient care.

- **Community/State Mental Health Buy-In**. Some respondents said that they believed that state health departments would have to be involved in reforming the existing system in order to properly implement community-wide solutions; such involvement to improve mental health access and quality and reduce boarding would entail a fiscal commitment among partners at the community or state level.

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