



1

Psychiatric Emergencies

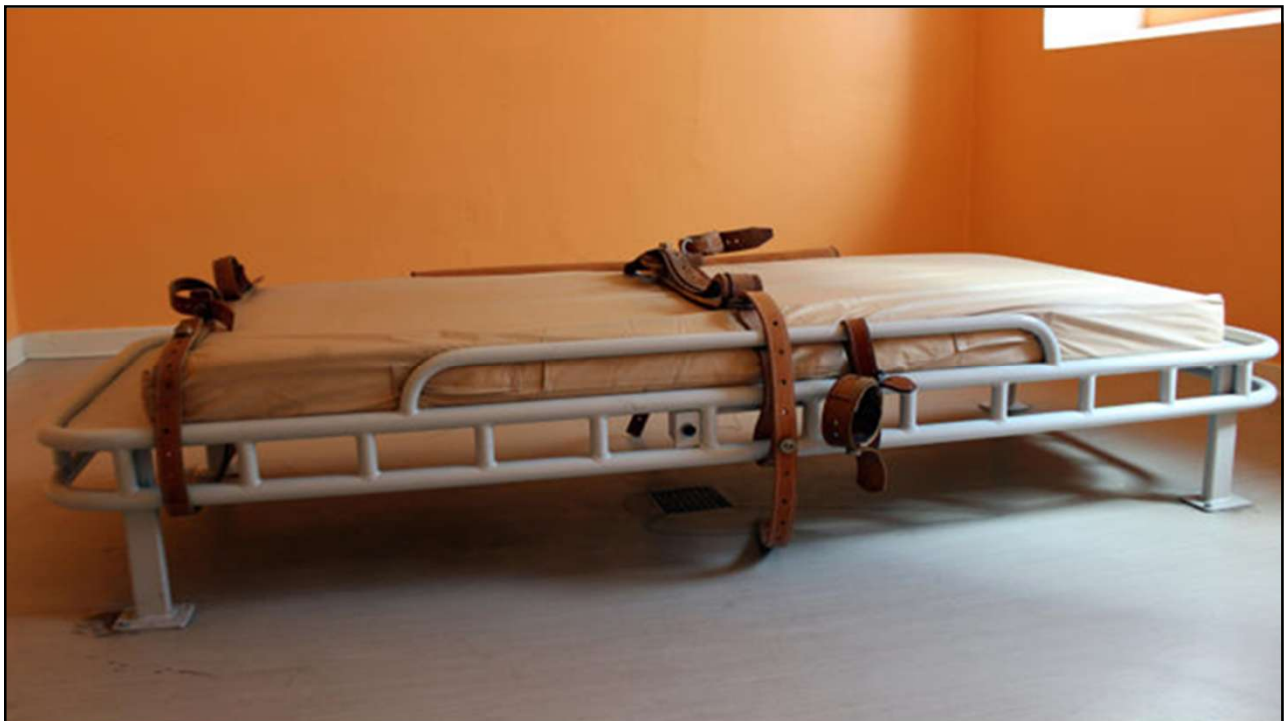
Are when a patient, due to a Behavioral Health Condition:

- Is a Danger to Himself or Herself
- Is a Danger to Others
- Is so psychiatrically impaired he or she cannot provide for own food, clothing or shelter
- Or when a patient appears at risk to evolve into one of the above conditions

2



3



4

Agitation is an Acute Behavioral Emergency

- Agitation is an acute behavioral emergency requiring immediate intervention.
- The preferred intervention for calming the agitated patient is verbal de-escalation.
- Medication can help, and offering medication is part of verbal de-escalation.
- Unless signs and symptoms dictate emergent medical intervention, de-escalation must take precedence in an effort to calm the patient.



5

Cost of Agitation and Aggression



- Eight **patient-to-staff assaults** per facility annually, with some centers reporting more than 25 assaults per year¹
- Most of these assaults resulted in staff injury severe enough to miss work¹
- one-third of assaults random, but **two-thirds** occur during containment procedures²

1. Allen, Currier, Hughes et al. *Postgraduate Medicine* 2001
 2. Carmel, Hunter. *Hospital and Community Psychiatry* 1989

6

Organizational Costs of Restraints

- Single episode of restraints costs an institution hundreds of dollars.
- One study reports a 1-hour restraint involves 25 different activities and claims nearly 12 hours of staff time to manage and process the event from beginning to end.¹
- High staff turnover (expensive to re-staff), high liability costs and high legal costs associated with restraints use.²
- Insurance companies look at an organization's restraint and seclusion numbers when underwriting.²

1. Lebel & Goldstein 2005

2. SAMHSA, 2011

7

'Zeller's Six Goals' of Emergency Psychiatric Care

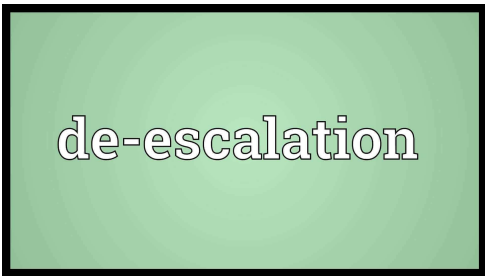
- **Exclude medical etiologies of symptoms/ensure medical stability**
- **Rapidly stabilize the acute mental health crisis**
- **Avoid coercion**
- **Treat in the least restrictive setting**
- **Form a therapeutic alliance**
- **Formulate an appropriate disposition and aftercare plan**



from Zeller, *Primary Psychiatry*, 2010

8

Verbal De-Escalation



de-escalation

- The goal is to help the patient regain control so that they can participate in the evaluation and treatment.
- Allows for listening to the patient and avoiding implicit bias.
- Successful de-escalation of the patient is the key to avoiding seclusion and restraint.

9

Benefits of Mastering Skills

- Verbal de-escalation usually takes less time than the process of restraint and involuntary medication.
- Avoiding “containment” procedures will result in fewer injuries to both staff members and patients.
- Patients are more trustful when not restrained or forcibly medicated.

10

One Patient's Experience

“Being restrained costs a lot!

*I was abused before I was in psychiatric care.
Being restrained made me feel the same way –
except staff are supposed to help you, right?*

*It made me worse and took away my self-esteem.
How is that supposed to make me feel better?*

I don't get it.

Wouldn't it be cheaper if staff just listened?”

11

Think this only applies to low-acuity patients?

2022 Study of British Forensic Inpatient units¹

Our findings indicate that de-escalation training in forensic settings should be implemented alongside adjunct interventions targeting: collaborative antipsychotic prescribing; debriefing and de-escalation planning; modifications to the physical environment; and ward manager role modelling and therapeutic intimacy in nurse-patient relationships.



1. Johnson et al BMC Psych 2022

12



13

Despite many innovative alternatives and new programs over the past decade with a goal of reducing the numbers of behavioral health patients going to hospital Emergency Departments (EDs)

- **The number of behavioral health patients coming to USA hospital EDs has only INCREASED during the past 10 years¹**
- Behavioral emergencies are now **1 in every 8 patients in hospital EDs nationwide!**^{2,3}
- Nationally, ED Behavioral Health stays can average over 30 hours.²

1. Beckerleg W, Hudgins J. Substance Use-related Emergency Department Visits and Resource Utilization. *West J Emerg Med.* 2022 Feb 28;23(2):166-173.
 2. Nordstrom K.D., Berlin J.S., Nash S.S., Shah S.B., Schmelzer N.A., & Worley L.L. (2019). Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document. *Western Journal of Emergency Medicine.* 20, 690 - 695.
 3. Peters, Z. J., Santo, L., Davis, D., & DeFrances, C. J. (2023). Emergency department visits related to mental health disorders among adults, by race and Hispanic ethnicity: United States, 2018–2020 (NCHS Data Brief N°464). National Center for Health Statistics.

14

Individuals too acute for alternative sites who still commonly end up presenting to Emergency Departments

- ✓ Patients who are currently agitated/aggressive or history of violence
- ✓ Patients with profound symptoms of psychosis/disorganization
- ✓ Patients with severe suicidal ideation or a serious suicide attempt
- ✓ Patients with active substance/alcohol intoxication or withdrawal
- ✓ Patients on involuntary status or with active criminal charges
- ✓ Patients pronounced comorbid medical issues, including overdose, self-injury
- ✓ Patients with vital signs abnormalities
- ✓ Patients with serious developmental disabilities/neurologic issues
- ✓ Patients who have utilized existing programs too frequently/recidivists
- ✓ Patients who refuse indicated medications

From Zeller, *Psychiatric Times*, 2019

15

Boarding

- Definition: Patients in hospital medical Emergency Departments who are medically stable and just waiting for a psychiatric evaluation or disposition.
- Often these patients are kept with a sitter, or in “holding rooms” or hallways on a gurney – some languishing for hours in physical restraints, often with no concurrent active treatment
- ED environment itself can often make crisis patient symptoms worse



16

Wrong solutions for ED boarding issues

- Too many ED clinicians still follow the concept that virtually all **emergency** psychiatric patients need hospitalization as the only possible disposition, which results in far too many patients being unnecessarily hospitalized
- Roughly equivalent to hospitalizing every patient in an ED with Chest Pain (typically only 10%-20% of such patients get hospitalized)
- Change in approach needed –
beginning with recognition that **the great majority of psychiatric emergencies can be stabilized in less than 24 hours**

17

Transforming Emergency Psychiatry

THE EMPATH UNIT MODEL

The Proven Solution to Emergency Department Psychiatric Boarding

EmPATH is a generic academic acronym well established in the literature for a specific model of hospital-based Behavioral Emergency Care Unit, not a trademark, not copyrighted

18



US Health and Human Services (HHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
2025 Federal Crisis Definitions and Standards

Officially defines EmPATH units as the highest acuity level capable with the lowest barrier to care - of the entire crisis care spectrum!

Hospital-Based Behavioral Health Emergency Stabilization Units (also known as **Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH)**) or are sometimes referred to as Psychiatric Emergency Services (PES) units) are co-located on hospital grounds and linked to the ED for triage and referral of individuals in need of behavioral health emergent crisis care. These facilities accept individuals of all level of acuity outside of an inpatient setting and can accept both voluntary and involuntary admissions from the hospital ED.

19

Emergency Psychiatric Assessment, Treatment & Healing

The solution to Psychiatric ED Boarding and increasing ED throughput

What makes the EmPATH Approach Different?

- **Designated destination for all medically-cleared patients in crisis** prior to determination of disposition or IP admission; not viewed as an alternative destination but THE destination
- **“No Exclusion” Philosophy**—designed and staffed to treat all emergency psychiatric patients, “pull to full”
- **Immediate patient evaluation and treatment** by a psych provider, constant observation and re-evaluation while under active treatment
- **Provides a calming, healing, comfortable setting** completely distinct from the Medical ED
- **Wellness and Recovery-oriented approach** minimizes causes of anxiety, frustration

20

Physical Space Design

Calming, healing environment that prioritizes safety and freedom compared to medical ERs

Large, open 'milieu' space

where patients can be together in the same room – high ceilings and ambient light, soothing décor

Designed to facilitate

socialization, discussion, interaction and therapy, between patients and staff and each other

Per chair model

outfitted with comfortable fold-flat sleeper recliners for short-term stays

Space recommendation

80 sq. ft. total per patient, which includes 40 sq. ft. patient area around each recliner

Open nursing station w/instant access to staff

No 'bulletproof glass fishbowl' separate from the patients, staff are intermingled with patients

Voluntary Calming Rooms

Avoids locked seclusion rooms or restraints

21

A Calming, Comfortable Environment



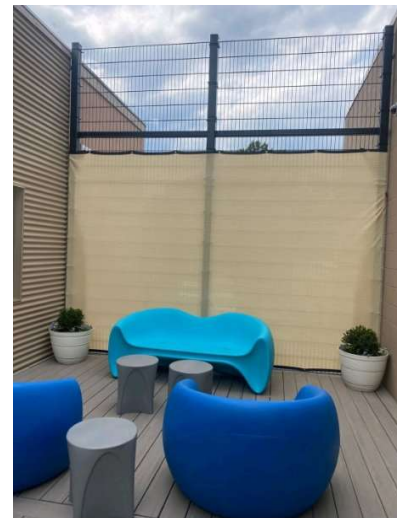
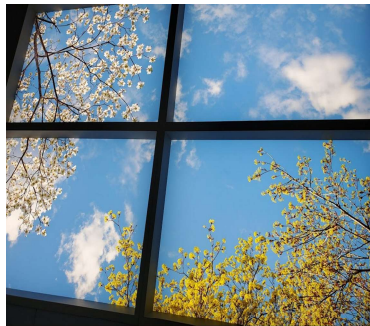
22

A Feeling of Spaciousness



23

Bringing In the Beauty of Nature



24

Making the environment part of the treatment

“The EmPATH unit’s real innovation is a structural shift in how we think about space and time. We usually consider drugs, devices, and procedures the kinds of medical care that make a difference, but **physical spaces can be therapeutic, too.**”

-Dhruv Khullar, *The New Yorker* magazine, July 2023



25

Patient Benefits

Trauma-Informed Unit

a home-like care setting different from a chaotic ED. Relaxation, movement, and recreation are encouraged.

Multi-disciplinary Treatment Team

involved from arrival to disposition.

Rapid Evaluation by Psych Providers

ensuring care integration with comprehensive care plan development.

Calming Environment

that best meets patients' needs, so they can serve themselves snacks, beverages, linens.

Constant Observation + Re-evaluation

leads to much higher diversion from hospitalization.

Restraint Elimination

Typically, used in far less than 1% of cases.

26

Hospital Benefits

EMTALA Compliant

for both voluntary and involuntary mental health crises.

ED Capacity Creation

alleviating volume pressure in the ED and reduce psychiatric holds and boarding.

Reimbursement Options

among CMS and private payers.

Eliminate Unnecessary Admissions

while reducing payer denials for inpatient psychiatric units.

Cost-Effective Implementation

by remodeling available, unused hospital spaces.

Up to 80% Reduction in Admission Rates

27

Pediatric EmPATH units

- Side-by-Side with Adult
- Peds only, typically in Pediatric Hospitals



28

EmPATH key facts and figures

- Currently over 70 EmPATH units operating in North America, over 100 expected by the end of 2027, multiple foreign countries.
- Model works in any setting – urban, rural, academic, community, and presently exist from as small as 4 to as many as 70 chairs! 8-20 chairs most common sizes.
- **“Go where the patients are”** There are already substantial behavioral health patient numbers in central GACH EDs and will continue to be; EmPATH meets patients where they already go rather than creating completely new sites, thus has the benefit of far lower startup costs, shared staff and other scale benefits
- Self-sufficient, fully reimbursable by Medicaid, Medicare, Private Insurance, no need for separate new annual funding.
- Complements existing systems and reduces cycling, improves outpatient follow-up.

29

Financial Benefits of EmPATH Units for Mental Health Payor Reimbursement

Approximately 75% stabilization

of involuntary patients in EmPATH units. EmPATH units avoid expensive inpatient hospitalization in 3 out of every 4 patients!

EmPATH Units are reimbursed by all payors

Including Medicaid, Medicare, and Private Insurance. Sacramento EmPATH estimates it **saved Medicaid \$34 million** while providing better and more timely care in just their first 2.5 years of operation.

30

Documentable Savings

Typical inpatient stay cost to Medicaid: **\$12,000**.

Typical EmPATH unit Medicaid reimbursement: **\$2,000**.

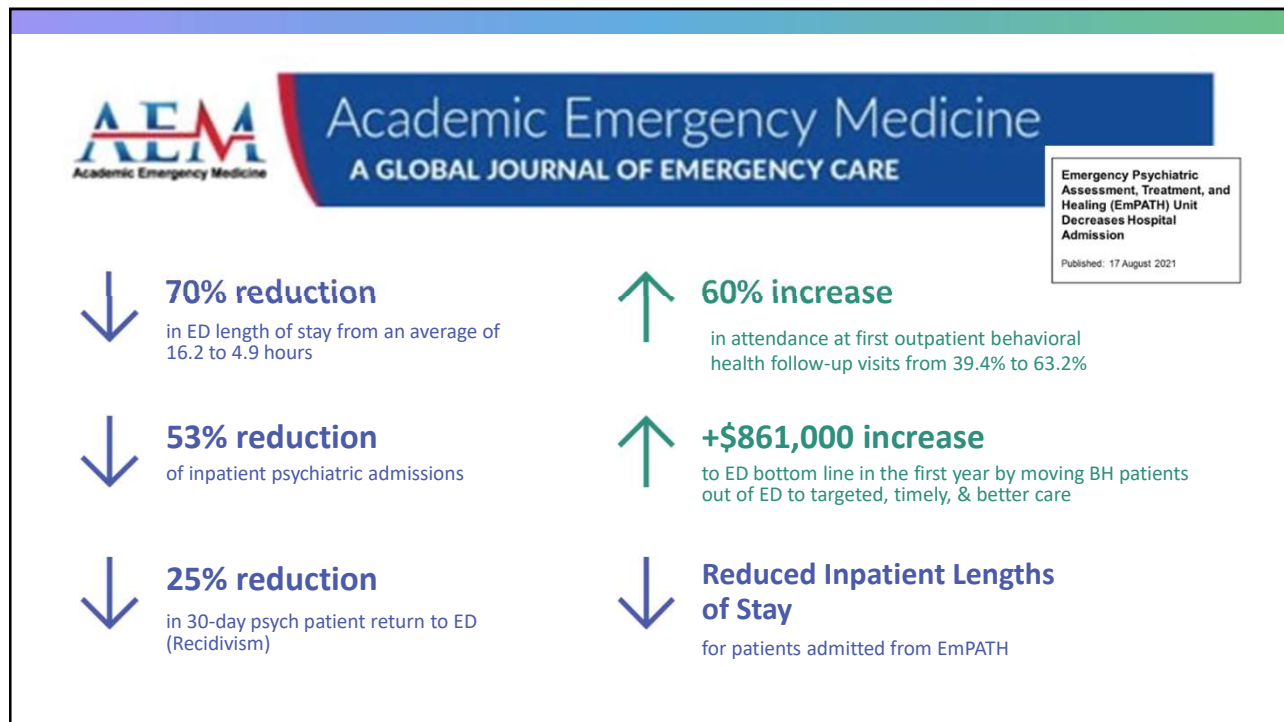
Thus, for every 4 patients (**$4 \times \$2,000 = \$8,000$**),
EmPATH units save Medicaid the cost of 3 inpatient stays (**$3 \times \$12,000 = \$36,000$**).

For every \$8,000 Medicaid pays for EmPATH care, they avoid \$36,000 in inpatient payments

31

Proven Impact: EmPATH Unit Case Studies

32



33

Dignity Mercy San Juan – Opened Sept 2019

Carmichael, CA

- **BH ED Boarding:** Baseline boarding time for psych patients in the ED FY '19 was 32.9 hours – in the first month this fell to 19 hours, by December the average was 7.6 hours (**77% reduction in just three months!**)
- **Restraint Use:** During first 5 months of opening, restraints had only been used **one time** (January 2020)
- **BH ED LOS:**
 - (Before) Avg ED Length Of Stay before transfer = 3.4 hours
 - (Now) From Medical Clearance in the ED to EmPATH Acceptance = less than 1 hour
- **Diversion Rate:** 70% of patients discharged home
- **Patient Satisfaction:** 90-94%
- **ED Recidivism:** declined 30%

34

University of Kentucky Healthcare – Opened July 2024

Lexington, KY

- **BH ED Boarding:** Reduced by 92%
- **Total Patients Served:** over 10,000
- **Average Length of Stay (LOS):** 14.8 hours
- **Diversion Rate:** 76.1%
- **Kept Appointment Rate Post-Discharge:** 60% (up from 29% baseline!)
- **Sitters Used in EmPATH:** 0 (leading to major cost savings!)

*Data from first two years of operation

35

Technical Report

AHRQ Summit to Address Emergency Department Boarding



2025 federal US Health and Human Services expert ER Boarding report!

Centers for Medicare and Medicaid/Agency for Healthcare Research and Quality

AHRQ Summit to Address Emergency Department Boarding Technical Report

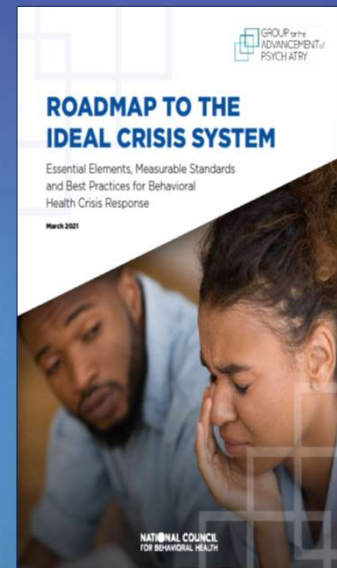
The report specifically lists *EmPATH units* as their top recommendation to solve Emergency Department Behavioral Health patient boarding, and calls for more funding and facilitation of EmPATH units in the states!

36

**EmPATH Units complement
community crisis programs, for
the highest-acuity patients**

*National Council for Mental Wellness,
“**Roadmap to the Ideal Crisis
System**”: specifically cites EmPATH
units in their recommendations, saying
that there*

**“should be at least one
in every mental health system”**



37

Thank you!

38