
THE
EMERALD COAST
CONFERENCE


Emergency Behavioral Crisis:
The Cavalry is Coming!
Michael Gerardi, MD, FAAP, FACEP
June 5, 2024

Emergency Behavioral Health Crisis: The Calvary is Coming!

Michael Gerardi, MD, FAAP, FACEP

President-elect , American Association for Emergency Psychiatry

June 5, 2024

Disclosures

- American Association of Emergency Psychiatry
  - Board of Directors 2021 - present
  - President-elect 2023 - 2024
- Past President of American College of Emergency Physicians
  - 2014-1015
- Coalition on Psychiatric Emergencies 2015 - Present
  - Founding Chair of the Inaugural Steering Committee

AND YOU!

- If not for your inquisitive minds there would be no need for a conference or me to share some knowledge and experience
- Comradery
- Rejuvenation
- New friends

Objectives

- Acknowledge the scope of the growing number of the adult and pediatric behavioral health emergency crisis and the impact on emergency departments (ED's) and acute psychiatric services
- Discuss ongoing need for collaboration and advocacy to address management and the boarding of patients with mental illness.
- Application has been submitted by ABEM to ABMS asking for **"Focused Practice Designation"** to promote a new subspecialty in Emergency Behavioral Health

Advocacy

- Public support for or recommendation of a particular cause or policy.
- Helping people find their voice.
  1. self-advocacy,
  2. individual advocacy,
  3. systems advocacy.

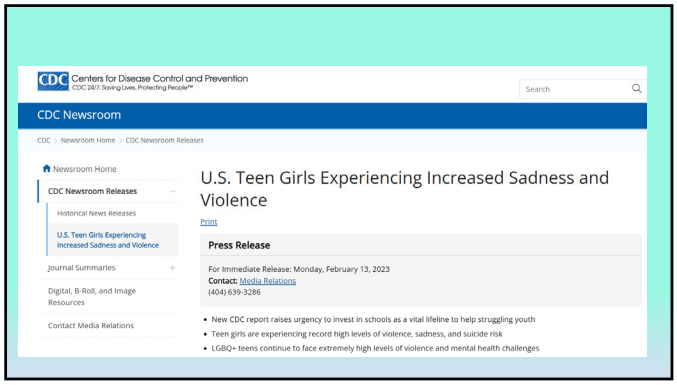
Advocacy

Advocacy refers in a broad sense to efforts to promote, in the domain of humanitarian aid, respect for humanitarian principles and law with a view to influencing the relevant political authorities.

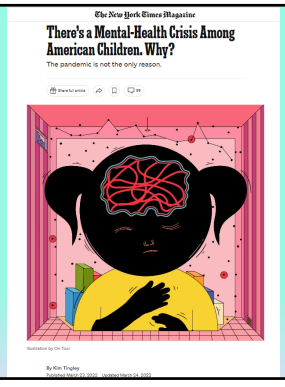
Prevention and/or Cure for Burnout

- Be part of something larger than oneself
  - Medical career
  - Military
  - Religion
  - Athletics
  - Professional organizations
    - AAEP, APA, AMA, etc.
  - **Advocacy groups!**

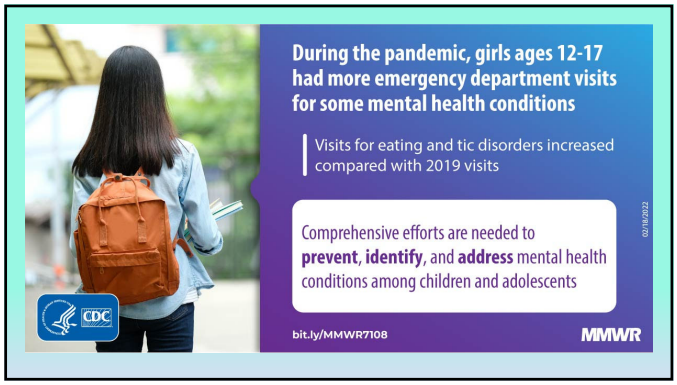


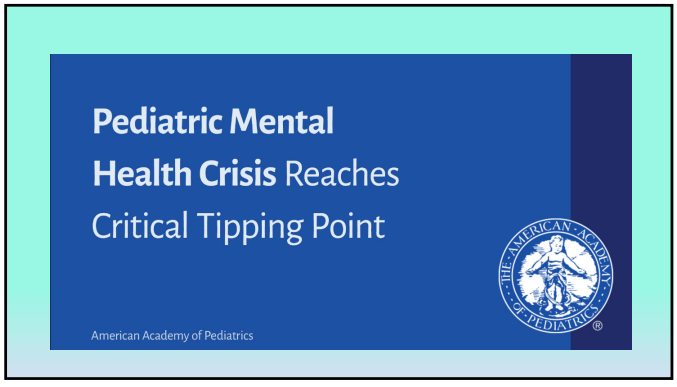



- The pediatric mental health crisis is ECRI's top concern for patient safety in 2023.
- Prior to the pandemic, the rates of depression and anxiety rose in children due to the increased use of social media, gun violence, alcohol, drugs and socioeconomic factors.
- Rates of anxiety and depression in children ages 3 to 17 rose 29% and 27% respectively in 2020 compared to 2016 according to a study published in JAMA Pediatrics.
- Teenage girls are experiencing a record high level of violence, sadness and suicide risk.




Colorado's pediatric mental health crisis continues, professionals say
By Debbie Kelley debbie.kelley@gazette.com · May 24, 2022 Updated Jan 13, 2023
CHILDREN'S EMERGENCY
AHIP
Transforming Consumer Experience in Health Care
David L. Holmberg
President & CEO, Highmark Health
Dawn Maroney
President, Markets, Alignment Health & CEO, Alignment Health Plan


During the pandemic, girls ages 12-17 had more emergency department visits for some mental health conditions
Visits for eating and tic disorders increased compared with 2019 visits
Comprehensive efforts are needed to prevent, identify, and address mental health conditions among children and adolescents
bit.ly/MMWR7108
MMWR
02/18/2022


Pediatric Mental Health Crisis Reaches Critical Tipping Point
American Academy of Pediatrics

Children's mental health: Huge rise in severe cases, BBC analysis reveals

Many teachers considering leaving due to toll of dealing with students' mental health issues

'The time for talking is over... we are in a mental health crisis', says Dr Alex George

We need to step up to fight the pandemic-driven mental health crisis for young people

We sit for hours with students who want to end their lives: The toll university mental health crisis takes on staff

Child referrals for mental health care in England up 39% in a year

Teachers 'buckling under strain' of pupils' mental health crisis

Quarter of 17-19-year-olds have probable mental disorder

Youth mental health referrals on the up as cost-of-living crisis hits Liverpool hard

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Hospitals are short of workers and crowded ERs are a symptom of the crisis

Shortages of health care personnel keep patients 'stuck' at every turn in the system.

Staff make formal complaint about plight of North Shore Hospital's ED and mental health patients

The Independent

Mental health patients held 'unlawfully' in A&Es across the country, experts warn

American College of Emergency Physicians

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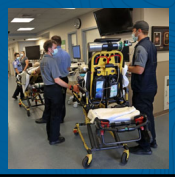

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Letter to President Biden on the ED Boarding Crisis

The letter details five negative effects of emergency department boarding:

1. Patient harm – morbidity & mortality
2. Providing care in waiting rooms
3. Effects on care of pediatric patients
4. Effects on care of psychiatric patients
5. Boarding drives burnout

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November 7, 2022

The President
The White House
1600 Pennsylvania Avenue NW
Washington, D.C. 20500

Mr. President:

There is no question that Americans have suffered great loss of life and endured financial hardships, across all sectors, over the past 32 months due to the COVID-19 pandemic. Frontline healthcare workers risked their lives, provided care during physically and emotionally demanding situations, and bore witness to their patients' goodbyes to loved ones from afar.

Yet, in recent months, hospital emergency departments (EDs) have been brought to a breaking point. Not from a novel problem – rather, from a decades-long,[1] unresolved problem known as patient "boarding," where admitted patients are held in the ED when there are no inpatient beds available. While the causes of ED boarding are multifactorial, unprecedented and rising staffing shortages throughout the health care system have recently brought this issue to a crisis point, further spiraling the stress and burnout driving the current exodus of excellent physicians, nurses and other health care professionals.

Boarding has become its own public health emergency. Our nation's safety net is on the verge of breaking beyond repair; EDs are gridlocked and overwhelmed with patients waiting – waiting to be seen; waiting for admission to an inpatient bed in the hospital; waiting to be transferred to psychiatric, skilled nursing, or other specialized facilities; or, waiting simply to return to their nursing home. And this breaking point is entirely outside the control of the highly skilled emergency physicians, nurses, and other ED staff doing their best to keep everyone attended to and alive.

Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Patients in need of intensive care may board for hours in ED beds not set up for the extra monitoring they need. Those in mental health crises, often children or adolescents, board for months in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. Boarding doesn't just impact those waiting to receive care elsewhere. When ED beds are already filled with boarded patients, other patients are decompensating and, in some cases, dying while in ED waiting rooms during their tenth, eleventh, or even twelfth hour of waiting to be seen by a physician. The story recently reported[2] about a nurse in Washington who called 911 as her ED became completely overwhelmed with waiting patients and boarders is not unique – it is happening right now in EDs across the country, every day.

> *"At peak times which occur up to 5 days per week we have more patients boarding than we have staffed beds. High numbers have included last week when our 22 bed emergency department had 35 boarders and an additional 20 patients in the waiting room…In addition, we have patients who unfortunately have died in our waiting room while awaiting treatment. These deaths were entirely due to boarding. Our boarding numbers have unfortunately skyrocketed in the wake of covid as a consequence of increasing surgical volumes and decreasing inpatient nurse staffing."* –anonymous emergency physician

To illustrate the stark reality of this crisis, the American College of Emergency Physicians (ACEP) recently asked its members to share examples of the life-threatening impact the recent uptick in boarding has brought to their emergency departments. Excerpts of the responses received, as well as key findings from a qualitative analysis of the submissions, are included in this letter to summarize aspects of the problem. The full compilation of anonymized stories, attached as an appendix, paint a picture of an emergency care system already near collapse. As we face this winter's "triple threat" of flu, COVID-19 surges, and pediatric respiratory illnesses that are on a sudden rise, **ACEP and the undersigned organizations hereby urge the Administration to convene a summit of stakeholders from across the health care system to identify immediate and long-term solutions to this urgent problem.** If the system is already this strained during our "new normal," how will emergency departments be able to cope with a sudden surge of patients from a natural disaster, school shooting, mass casualty traffic event, or disease outbreak?

American College of Emergency Physicians
Academy of General Dentistry
Allergy & Asthma Network
American Academy of Child and Adolescent Psychiatry
American Academy of Emergency Medicine (AAEM)
American Academy of Family Physicians
American Academy of Physical Medicine and Rehabilitation
American Academy of Physician Associates
American Association of Oral and Maxillofacial Surgeons
American College of Allergy, Asthma & Immunology (ACAAI)
American College of Osteopathic Emergency Physicians (ACOEP)
American College of Radiology
American Foundation for Suicide Prevention
American Medical Association
American Nurses Association
American Osteopathic Association
American Psychiatric Association
American Society of Anesthesiologists
Association of Academic Chairs of Emergency Medicine
Association of State and Territorial Health Officials (ASTHO)
Brain Injury Association of America
Council of Medical Specialty Societies
Council of Residency Directors in Emergency Medicine (CORD)
Emergency Medicine Residents' Association
Emergency Nurses Association
Family Voices
Infectious Diseases Society of America
International Association of Fire Chiefs
National Alliance on Mental Illness
National Association of EMS Physicians
National Health Care for the Homeless Council
National Partnership for Women & Families
Society for Academic Emergency Medicine
Society of Emergency Medicine Physician Assistants (SEMPA)
The National Alliance to Advance Adolescent Health

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Cries for Help from the Frontline…

"We are a very rural hospital with only family practice and emergency physicians - there are no specialists within 90 miles…Recently I had a woman with abdominal pain in the ER. When she arrived, she had normal vital signs and was not really very sick. Testing showed that she had an infected gallbladder - a simple problem for any surgeon to treat. ***We called <u>27 hospitals</u> before one in a different state called us back when a bed finally opened up.*** *She spent thirty-six hours in our ER and was in shock being treated with maximum doses of drugs to keep her alive when she was transferred.* ***She didn't survive."***

"We are a top nationally ranked hospital that, due to budget issues, has now prioritized transfers and surgery admissions over ED admissions. We typically board 120-200 hrs/day and **LBTC rates have climbed from 3- 4% to 15-20%."**

"I'm working in a 9-bed ED with an additional 3-beds dedicated to psychiatric patients. We now have a patient who has been ***<u>boarding with us for over 5 MONTHS</u>*** *with no end in sight. She is unfortunately a disruptive person as well, interrupting patient care elsewhere in the ED as she wanders the hallways (we do have to allow her out of her 10x10 room on occasion and tying up our security resources. She has injured herself on occasion and has refused medications until she is so psychotic that she can't refuse them any longer."*

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May 28, 1990

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NEJM Catalyst

COMMENTARY

Emergency Department Crowding: The Canary in the Health Care System

Gabor D. Kelen, MD, Richard Wolfe, MD, Gail D'Onofrio, MD, MS, Angela M. Mills, MD, Deborah Diercks, MD, Susan A. Stern, MD, Michael C. Wadman, MD, Peter E. Sokolove, MD

Annals of Emergency Medicine
An International Journal

HEALTH POLICY AND CLINICAL PRACTICEREVIEW ARTICLE | VOLUME 52, ISSUE 2, P126-136.E1, AUGUST 01, 2008

Systematic Review of Emergency Department Crowding: Causes, Effects, and Solutions

Nathan R. Hoot, PhD, A. ✉ • Dominik Aronsky, MD, PhD

Published: April 24, 2008 • DOI: https://doi.org/10.1016/j.annemergmed.2008.03.014

Google emergency department crowding

All Images News Videos Maps More

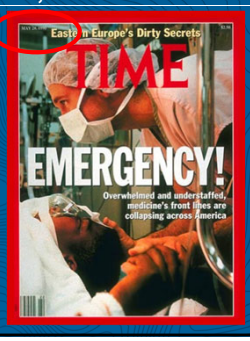
About 2,410,000 results (0.59 seconds)

Scholarly articles for **emergency department crowding**

Emergency department crowding - Higginson - Cited by 190

The effect of **emergency department crowding** on ... - Bernstein - Cited by 1170

... perspectives on **emergency department crowding** - Pines - Cited by 532



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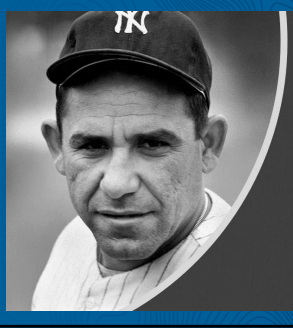


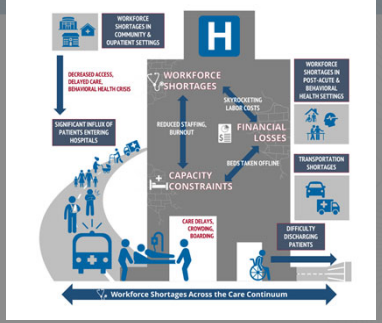
It's like déjà vu, all over again.

~Yogi Berra

AN ACUTE CRISIS:

How Workforce Shortages are Affecting Access & Costs

MHA MASSACHUSETTS Health & Hospital ASSOCIATION October 2022



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BEHAVIORAL HEALTH

Job Name	% Vacancy Rate
Mental Health Worker/Technician (MHW)	32%
MSW Social Worker (LCSW)	29%
Psychologist	27%
Licensed Independent Social Worker (LICSW)	24%
Mental Health Counselor	17%
Social Worker (BSW)	17%

TECH

Job Name	% Vacancy Rate
Pulmonary Function Technician	35%
Paramedic	28%
Surgical Technician/Technologist	26%
Anesthesia Technologist	24%
Registered Respiratory Therapist (RRT)	20%
Cardiac Catheter Tech	19%
Endoscopy Technician	19%
Medical Technologist (MT)	16%
Pharmacy Technician	15%
Radiologic Technologist	13%

OTHER

Job Name	% Vacancy Rate
Patient Safety Specialist	22%

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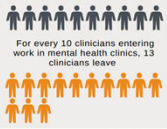
ABH Association for Behavioral Healthcare

OUTPATIENT MENTAL HEALTH ACCESS AND WORKFORCE CRISIS ISSUE BRIEF: SUMMARY

A workforce crisis is causing significant access delays to essential outpatient mental health treatment

COVID-19 has exacerbated longstanding workforce challenges in behavioral healthcare settings at a time when the need for mental health and substance use treatment is increasing. ABH surveyed our members in October and November 2021 to learn about the depth of these challenges. Full details can be found in the **ABH Outpatient Mental Health Access and Workforce Crisis Issue Brief**.

More clinicians are leaving mental health clinics than new clinicians entering



For every 10 clinicians entering work in mental health clinics, 13 clinicians leave

Improved reimbursement is the most important retention factor

Compensation was **the driving factor** for the departure of clinicians from outpatient clinics, and improved compensation was cited as the **top recommendation** of providers to recruit and retain staff.

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For every 10 clinicians entering work in mental health clinics, 13 clinicians leave

Compensation was **the driving factor** for the departure of clinicians from outpatient clinics, and improved compensation was cited as the **top recommendation** of providers to recruit and retain staff.

Key Recommendations:

- Rebalance healthcare expenditures towards behavioral healthcare
- Commercial and public payers should immediately increase outpatient clinic rates to improve access
- The Commonwealth should implement a behavioral health workforce data collection and planning strategy
- Commercial plans must reimburse for supervised Master's-prepared clinicians in clinic settings
- The Commonwealth should leverage its leadership and purchasing power as an employer and health plan purchaser
- Expand student loan repayment programs for the clinic-based workforce
- Health plans should take immediate steps to reduce redundant or outdated administrative and documentation requirements

15.3 weeks — average wait time for ongoing therapy for children and youth

9+ months — amount of time it takes 67% of members to fill a MD prescriber position

13,797 — individuals on waitlists for outpatient services

Association for Behavioral Healthcare - February 2022

For more information, contact Lydia Conley at lconley@abhmass.org or Abby Kim at akim@abhmass.org

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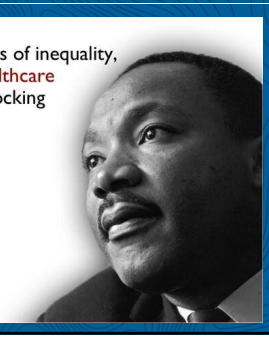
Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.

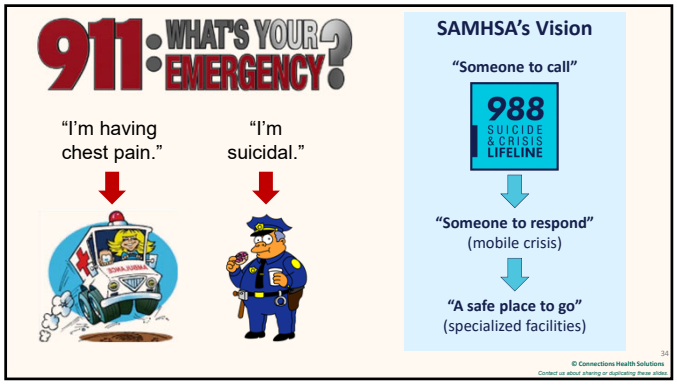
Dr. Martin Luther King, Jr.
March 25, 1966



Every day in America…

"I'm having chest pain."

"I'm suicidal."


911 WHAT'S YOUR EMERGENCY?
"I'm having chest pain."
"I'm suicidal."
SAMHSA's Vision
"Someone to call"
988 SUICIDE & CRISIS LIFELINE
"Someone to respond" (mobile crisis)
"A safe place to go" (specialized facilities)
34
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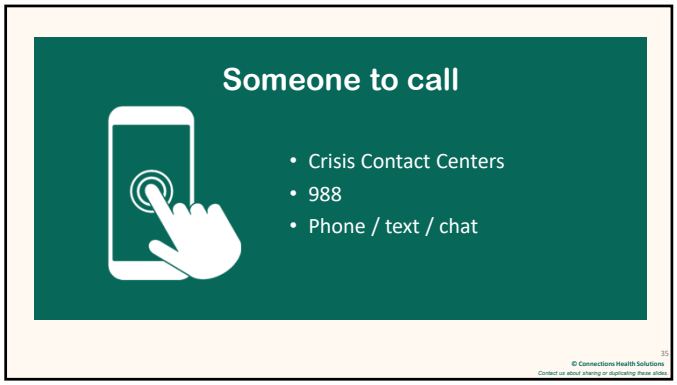
Someone to call
• Crisis Contact Centers
• 988
• Phone / text / chat
35
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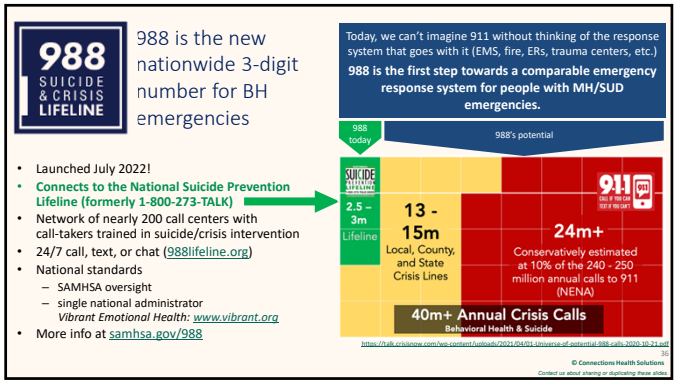
988 SUICIDE & CRISIS LIFELINE
988 is the new nationwide 3-digit number for BH emergencies
• Launched July 2022!
• Connects to the National Suicide Prevention Lifeline (formerly 1-800-273-TALK)
• Network of nearly 200 call centers with call-takers trained in suicide/crisis intervention
• 24/7 call, text, or chat (988lifeline.org)
• National standards
– SAMHSA oversight
– single national administrator
Vibrant Emotional Health: www.vibrant.org
• More info at samhsa.gov/988
Today, we can't imagine 911 without thinking of the response system that goes with it (EMS, fire, ERs, trauma centers, etc.)
988 is the first step towards a comparable emergency response system for people with MH/SUD emergencies.
988 today
988's potential
2.5 – 3m
Lifeline
13 - 15m
Local, County, and State Crisis Lines
24m+
Conservatively estimated at 10% of the 240 - 250 million annual calls to 911 (NENA)
40m+ Annual Crisis Calls
Behavioral Health & Suicide
https://talk.crisisnow.com/wp-content/uploads/2021/04/01-Universe-of-potential-988-calls-2020-10-21.pdf
36
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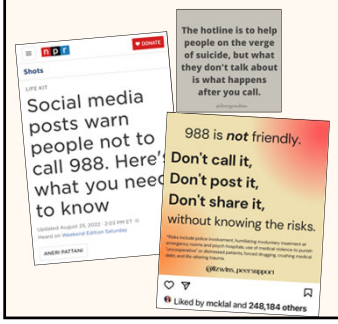
What happens after the 988 call?



- *988 activates 911 in a small number of calls (about 2%) when there is an immediate threat to life.*
- ***The more alternatives a community has (like mobile crisis), the less need to involve law enforcement.***

Source: 988lifeline.org

What happens after the 988 call? It depends on where you live.

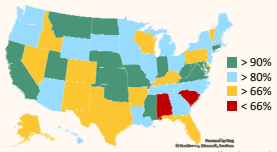
For the ideal outcome, 988 callers need to

- Be routed to a **local call center**
- Connect to **local crisis services** *(someone to respond, a safe place to go)*

Challenges:

- Calls are routed based on the area code of the caller's phone, not their geolocation
- Variable call center performance across states
- Inconsistent access to crisis services across communities

988 In-State Answer Rate

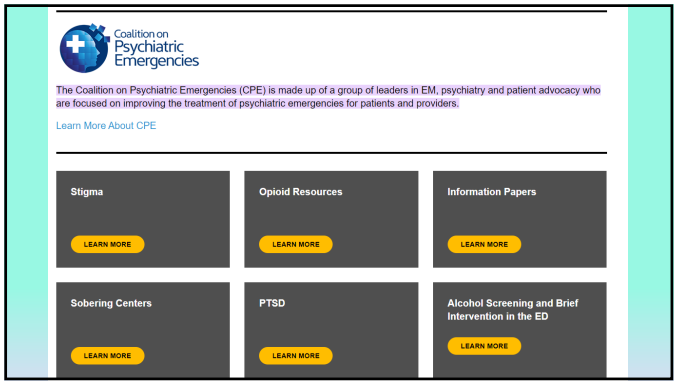


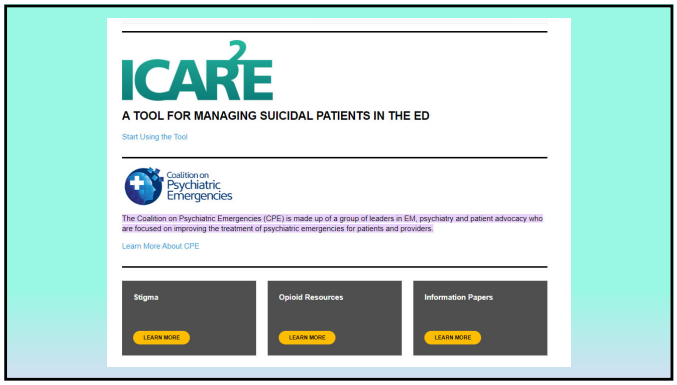
April 2023. Source: https://988lifeline.org/our-network/

Created December 2014
2 Months into Presidency of ACEP

- <<Coalitiononpsychiatricemergencies.org>>

Coalition on Psychiatric Emergencies





Coalition on Psychiatric Emergencies

- "Chemical Restraints"
  - Lead to 1:1 observation for hours
- National initiative: "**No Chemical Restraint**"
  - Severe agitation initiative
  - "Chemical Restraint" is common in State Legislatures' language
  - **"Emergency psychoactive medication"**
  - Focus on symptom treatment
- CMS.gov: Centers for Medicare & Medicaid Services: Agree!

Policy and Legislation "Psych" Boarding & ACEP

- Psych Boarding is a "carceral" event = suggesting prison!
- How do you/we address this practice?
- Can we agree that it is wrong and dehumanizing?

Policy and Legislation "Psych" Boarding & ACEP

Actions:

1. Individual: email / call your Congressman/woman & Senator
2. Institutional: What is our health system / hospital / Medical Executive Committee / Nursing Leadership / Bed Mgmt. doing?
3. Professional Associations: What is happening at your State and National organizations? Do they have a Political Action Committee?
4. Have you thought of engaging community stakeholders?

Behavioral Health Emergencies: Organizations That Are Involved

AAEP AMERICAN ASSOCIATION FOR EMERGENCY PSYCHIATRY
THE VOICE OF EMERGENCY MENTAL HEALTH PROFESSIONALS

American Board of Psychiatry and Neurology, Inc.

American College of Emergency Physicians
ADVANCING EMERGENCY CARE

AMERICAN PSYCHIATRIC ASSOCIATION
Medical leadership for mind, brain and body.

American Board of Emergency Medicine

American Board of Medical Specialties
Higher standards. Better care.®

Emergency Behavioral Health Focused Practice Designation vs. ABMS Subspecialty Fellowship

- October - Dec 2022: AAEP & ACEP start "socializing" the idea
- Spring 2023: Unofficial exploration with ABNP, ABEM, APA
- June 2023: We discussed last year here at Emerald Coast Conf! Idea started getting traction
- Fall 2023 @ ACEP: ABEM offers to take the lead
- January 2024: Emergency Behavioral Health Task Force created
- **May 24, 2024**: Application submitted by ABEM to COCERT (ABMS)
  - COCERT = Committee on Certification
- **Committee on Certification (COCERT) :** develops, proposes, revises, and enforces ABMS standards, policies, and programs of certification and subcertification by the Member Boards

Emergency Behavioral Health Task Force

Conference Call

MEETING AGENDA

LOGISTICS

Date: Wednesday, January 24, 2024
Time: 12:00 P.M. – 1:00 P.M. (EST)
Location: Zoom

PARTICIPANTS

Samuel M. Keim, M.D., M.S.
EBH Task Force Chair and ABEM Immediate-Past-President
Ernest E. Wang, M.D.
ABEM Director, Task Force Representative
Michael J. Gerardi, M.D.
President-Elect, American Association for Emergency Psychiatry, EBH Task Force Representative
Tony Thrasher, D.O.
Immediate-Past-President, American Association for Emergency Psychiatry, EBH Task Force Representative
David Price, M.D.
American Board of Family Medicine, EBH Task Force Representative
Sejal B. Shah, M.D.
American Board of Psychiatry and Neurology, EBH Task Force Representative
Melissa A. Barton, M.D.
ABEM Director of Medical Affairs
Colleen E. Livingston
ABEM Medical Affairs Administrator
Benson S. Munger, Ph.D.
ABEM Consultant

Describe whether and how your Board has interacted with the key societies and stakeholders in developing this proposed designation:

- ABEM Task Force Developed Core Content and the eligibility criteria for a Focused Practice designation in EBH.
  - generative and collaborative in nature.
- ABEM & ABPN reached out to their respective professional societies to seek input on the development of the Core Content.
- **Unanimous** support from **all** Emergency Medicine professional societies regarding this opportunity to ensure the highest standards of care for patients seeking acute mental health treatment.

Application for an Area of Focused Practice

Overview

The ABMS Focused Practice designation recognizes areas of practice that either evolve as specialists progress through their professional careers or emerge as medicine changes due to advances in medical practice. Focused Practice is not intended to be a form of certification, since it recognizes areas of focus within recognized specialties or subspecialties and is based upon clinical experience. Use of the designation will recognize an evolution of practice relevant to continuing certification.

Requests from a Member Board to designate an area of focused practice within a specialty or subspecialty will go through an approval process that is similar to the process outlined in Article VII, Section 7.2 of the Amended and Restated Corporate Bylaws of the American Board of Medical Specialties.

Focused Practice Criteria

1. The area of focused practice must have a sponsoring ABMS Member Board who will define the eligibility criteria and submit the application to COCERT.

Focused Practice Criteria

1. The area of focused practice must have a **sponsoring ABMS Member Board** who will define the eligibility criteria and submit the application to COCERT.
2. Eligible diplomates **must be certified** by the sponsoring Member Board and have an active primary or relevant subspecialty certificate with good standing in the community.
3. The sponsoring Member Board will develop the **clinical practice experience** (both in terms of time and volume) beyond initial training required for eligibility. Formal fellowship training may count toward the practice requirement.
4. The sponsoring Member Board will be required to develop requirements, including a **Board-based assessment** for eligible diplomates, prior to awarding a focused practice designation.
5. The area of focused practice must have an **MOC requirement** that is determined and described by the Member Board. The MOC requirement may be fully tailored toward the area of focused practice.

Application for an Area of Focused Practice (Read-only)

Contact Person Name: Melissa Barton, M.D.
Email: mbarton@abem.org
Phone: 517-332-4800

Name of Sponsoring Board: American Board of Emergency Medicine

1. **Provide the name of the proposed area of focused practice:** Emergency Behavioral Health

2. **If multiple Boards are interested in this Focused Practice Designation and wish to collaboratively submit an application, please view the addendum found at the end this application. Each Board should complete an addendum to describe specialty-specific modifications.**

   American Board of Psychiatry and Neurology

State the purpose of the proposed area of focused practice and include the rationale for how this area of focused practice is different than a subspecialty, in two paragraphs or less:

- **Purpose FPD in** Emergency Behavioral Health **(EBH)** is to recognize expertise held by physicians who choose to tailor a portion of their practice to the provision of acute emergency behavioral health care using a sophisticated and comprehensive knowledge base of EBH.
- **Residency-trained emergency physicians** have acquired a foundation of knowledge in providing mental health care for patients in the emergency department.
- However, those physicians who specialize in EBH have acquired a greater breadth and depth of knowledge that is distinct from most emergency physicians.
- Similarly, psychiatrists and those who sub-specialize in **consultation-liaison psychiatry** have expertise in mental health care that could be greatly enhanced with fostering additional knowledge, skills, and abilities that optimize patient care for those who are treated in an outpatient crisis center, boarded in an **emergency department, or seek care through crisis hotlines or telepsychiatry**.

State the purpose of the proposed area of focused practice and include the rationale for how this area of focused practice is different than a subspecialty, in two paragraphs or less:

- ABEM will require ABEM-approved EBH fellowship training that provides practitioners with a depth of knowledge and specialized expertise in education, medicolegal, and system-based practice and research that exceeds that of other practitioners with general emergency competencies in the care of acute psychiatric patients in the emergency department.
- Appropriately trained emergency physicians, who **have not completed fellowship programs in EBH** as well as general psychiatrists and consultation-liaison psychiatrists, **would not be precluded** from practicing EBH in the routine care of patients with mental health disorders.
- EBH expedites patient care as patients can be provided with detailed **mental health evaluation,** have appropriate **pharmacologic** treatment quickly initiated or modified to **reduce suffering**, or **safely discharged** for coordinated, patient-family centered outpatient treatment based on medical and legal standards of care for EBH.

Purpose (Continued)

- Appropriate and timely care can be provided to patients boarding in the emergency department for days, weeks, or on occasion, months, while pending availability of an inpatient psychiatric bed.[1] (Kim et al., 2022).
- Even when controlling for ED volume, an increase in the frequency of violent assaults that take place in the emergency department is associated with the number of boarded patients with a certified mental health hold.[2] (Costumbrado et al., 2022).
- The mental health crisis in the US and lack of access to emergency behavioral health care has created the need for focused expertise in EBH. A focused practice in EBH takes one step forward to address this public health emergency.

Please outline the eligibility criteria required of candidates in the proposed area of focused practice, as it pertains to the following:

1. **What specialty and/or subspecialty certificate(s) will a diplomate be required to hold in order to be eligible for this area of focused practice?**

All diplomates seeking a focused practice designation in EBH must hold current primary board certification issued by ABEM in Emergency Medicine or by ABPN in Psychiatry.

2. **Clinical practice experience (both in terms of time and patient volume) in the area of focused practice, beyond initial training:**

What Body of Literature Supports this New FPD?

Body of Literature : 3 textbooks

1. (*Behavioral Emergencies for Healthcare Providers* by Zun, Nordstrom, Wilson,
2. *Emergency Psychiatry* by Glick, Zeller, and Berlin
3. *Primer on Emergency Psychiatry* by Thrasher). All major Emergency Medicine and Psychiatry reference textbooks have sections on either emergency behavioral health or psychiatric emergencies.

- **There are over 19,000 peer-reviewed, emergency behavioral health articles archived in PubMed** dedicated to emergency behavioral health, psychiatric emergency, mental health emergencies, or psychiatric boarding–specific topics in the United States (accessed March 6, 2024).

The primary journals of interest for EBH are as follows (March 2024)

- Academic Emergency Medicine
- Annals of Emergency Medicine
- FOCUS The Journal of Lifelong Learning in Psychiatry
- General Hospital Psychiatry
- Health Affairs
- JAMA Network Open
- Journal of the Academy of Consultation-Liaison Psychiatry (JACLP)
- Psychiatric Services
- The Journal of Crisis Intervention and Suicide Prevention
- The Western Journal of Emergency Medicine

Explain how this proposed area of focused practice addresses a distinct and well-defined patient population and care need:

- Addresses the acute management and disposition of patients in crisis, which often necessitates different treatment goals and procedures than for patients who are stable enough to seek care as outpatients.
- Further amplified in communities that have a paucity of available mental health care treatment options resulting in patients staying in ED's for prolonged periods of time, days and weeks, and even months, pending inpatient psychiatric care.
- Footnote: Sudave Mendiratta, MD – Innovative research! (personal conversation June 4, 2024)

Some Background Supporting Data

- Today the number of patients with mental health disorders[7-9] and intentional ingestions[10] are rapidly increasing.[11-13]
- ED-based opioid use disorder treatment strategies have been identified as an urgent priority by patients, patient advocates, and researchers.[14]
- As many as 8% of ED patients now present to the ED after suicidal ideation or suicide attempt.[15]
- The number of patients and the acuity of symptoms therefore far outstrips the ability of outpatient providers to provide comprehensive care to patients with acute mental health treatment needs.

Some Background Supporting Data

- Notably, deaths from overdose[16] and suicide[17] are increasing faster in rural areas than more urban areas. However, the state of training is currently poor.
- In a recent survey, only 15% of EDs offered all safety planning elements to patients presenting after self-harm.[18]
- As many as 80% of patients are not offered buprenorphine **(MAT)** despite the evidence supporting medication for opioid use disorder (MOUD) treatment.[19]
- An EBH focused practice could help disseminate optimal care of patients with emergency behavioral health disorders to resource-poor communities.

Some Background Supporting Data

- The lack of access to care for pediatric patients needing acute care for mental health disorders is even greater and at a state of national crisis. Pediatric emergency department visits for deliberate self-harm increased 329% over nine years (2007-2016), and visits for all mental health disorders rose 60% among EDs of all pediatric volumes.[20] (Lo et al., 2020).
- Most of these visits occur at nonchildren's EDs in both metropolitan and nonurban settings, which have been shown to be less prepared to provide higher-level pediatric emergency care.[20] (Lo et al., 2020).

Please provide information about the group of diplomates concentrating their practice in the area of focused practice, if known

- Difficult to estimate. However, given the number of member organizations within **the Coalition on Psychiatric Emergencies** https://coalitiononpsychiatricemergencies.org **representing thousands of physicians** I
- USA : the long-standing behavioral emergencies section within the Journal of Emergency Medicine, there are likely several hundred physicians who would likely apply for a focused practice designation if approved.
- As of March 2024, the American Association of Emergency Psychiatry **(AAEP)** reports 450 members, of whom, **225 are physicians** anticipated to seek recognition through a focused practice.
- The American Board of Psychiatry and Neurology reports 1,284 active certifications in **Consultation-Liaison (CSLP) as of February 2023**. The CSLP certification exam is offered every other year. In 2021, there were 160 physicians who obtained CSLP subspecialty certification. There were 178 physicians who became subspecialty certified in CSLP in 2023. Although unknown, it is anticipated that those CSLP physicians **who routinely provide EBH** care will seek this recognition.

Let's Be Honest Here!

1. Many of EM and CLP physicians know there is an incredible need for well-trained physicians in EBH.
2. 1989 – just out of residency: Chair of EM: "Mike, **find a niche** in something that you care about. The rest will follow." General EM but niche was new subspecialty: Pediatric EM – the rest is history.
   a) Think Toxicology, EMS, US, Administrative Medicine, etc.
3. So, you want to have a great career and **YOU** pick YOUR location?
   1. Job offers will follow
   2. Remuneration follows the demand
   3. We are at the ground floor level of a new area of expertise

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   1. Job offers will follow
   2. Remuneration follows the demand
   3. We are at the ground level of a new area of expertise

Indicate the existing national societies' size and scope, along with the source(s) of the data:

- The **American Association of Emergency Psychiatry (AAEP)** is a multi-specialty organization with over 450 members that includes emergency physicians, psychiatrists, consultation-liaison psychiatrists, and psychologists.
- The AAEP sponsors educational programs and provides a **network of experts** to address clinical, educational, administrative, research and legal programs for the diverse disciplines involved in emergency psychiatry.
- The AAEP is a multidisciplinary organization that serves as the **voice of emergency mental health**. The membership includes directors of psychiatric emergency services and emergency departments, psychiatrists, emergency physicians as well as other care professionals engaged in emergency psychiatry.

American Academy of Emergency Medicine (AAEM)

- Supportive of recognition of emergency behavioral health expertise.
- AAEM represents 8,000 board-certified emergency physicians throughout the nation, many of whom are community physicians or employed by private physician groups in hospitals without the traditional resources that can be found in teaching institutions.

American College of Emergency Physicians (ACEP

- > 40,000 members and is incredibly supportive of recognition of EBH through a focused practice designation. This support is demonstrated by its numerous policy statements, work groups, and legislative testimony on emergency behavioral health care in emergency departments (https://www.acep.org/federal-advocacy/mental-health).

Consultation-Liaison (C-L) Psychiatry

- ABPN board-certified subspecialty of psychiatry.
- C-L psychiatrists are at the forefront of integrated medical and psychiatric practice and provide expert psychiatric care for patients with complex medical conditions to all inpatient and outpatient primary care and specialty services. The **Academy of Consultation-Liaison Psychiatry** (ACLP) represents 2000 members and aims to provide education, research, and advocacy to advance integrated psychiatric care for the medically ill.

Coalition on Psychiatric Emergencies (CPE)

- Leaders in EM , psychiatry and patient advocacy who are focused on improving the treatment of psychiatric emergencies for patients and emergency providers. 9 collaborating partners: American Association for Community Psychiatry; American Association for Emergency Psychiatry; American College of Emergency Physicians; American Academy of Emergency Medicine; American Psychiatric Association; Depression and Bipolar Support Alliance; Emergency Nurses Association; Emergency Medicine Residents Association; and, the National Alliance on Mental Illness.
- CPE is strongly supportive and believes that a focused practice will elevate the standards of care for patients seeking treatment for mental health disorders in times of crisis.

Please describe how the cognitive knowledge, clinical and interpersonal skills, professional attitudes, and practical experience of diplomates in this area of focused practice will be distinct from diplomates in other specialties, subspecialties, and areas of focused practice in terms of:

1. **Clinical competence:**

- Expertise in caring for patients seeking acute, emergency treatment for their mental health disorder that exceeds the level of competency expected for a residency trained and ABEM certified emergency
- Will have a more extensive knowledge base in pharmacotherapy for behavioral health patients as well as expertise in navigating the complex and variable medicolegal and administrative challenges experienced when caring for acutely ill patients seeking mental health treatment.
- Note: Substitute Toxicology, EMS, Pediatric EM, US

Scope of practice = "Job Description"

- ED's across the country.
- Limited to their typical practice, including preferred practice setting(s), such as a mobile crisis unit, hospital-based emergency psychiatry unit, or community mental health crisis center.
- Oversee the practice of EBH by other emergency physicians or nurse practitioner psychiatric nurses as well as the team of care providers, such as behavioral health staff, social workers, and case managers. EBH physicians will also likely serve as liaisons to collaborate on work to establish police and EMS protocols for the pre-hospital care and/or triage of patients with a mental health crisis.
- Experts at the timely delivery of care for EBH patients pending inpatient psychiatric admission but without bed availability; these patients uniformly spend hours to days, weeks, or more waiting for an appropriate psychiatric bed. During this time, it is critical to the well-being of the patients and their families to have acute treatment initiated and delivered throughout their boarding stay.[21] (Kim et al., 2022).
- Establishing this focused practice will aid in knowledge translation throughout Emergency Medicine by providing recognition to content experts on best practices in care delivery for this patient population.

Body of knowledge and skills:

- ABEM will require ABEM-approved fellowship training for physicians seeking this focused practice designation after closure of the Practice Pathway and Practice-Plus-Training Pathway.
- Skills obtained upon successful completion of the fellowship will include those described in **The Core Content of Emergency Behavioral Health)** Attachment).

Please outline plans for evaluation of the impact of the proposed area of focused practice on other Member Boards' programs of specialty and subspecialty certification and any other areas of focused practice:

- Recognition of focused practice in EBH is expected to have little or no impact on other Member Boards' programs of specialty and subspecialty certification. The American
- Board of Family Medicine and the American Board of Psychiatry and Neurology supports this application and has actively participated in the Task Force that developed this application. The ABPN will offer this focused practice designation to its physicians, who are certified in psychiatry, and interested in special recognition for expertise in EBH.
- This focused practice designation will not negatively affect other specialists, including Consultation-Liaison Psychiatrists, as the scope of the mental health care crisis represented by the increasing numbers of patients presenting to emergency departments for mental health treatment exceeds capacity of existing access to outpatient psychiatric care. Similarly, emergency physicians do not have time nor comfort level to safely treat mental health patients during most shifts in the emergency departments.

The impact of the proposed area of focused practice on practice, both existing and long-term, specifically:

1. Access to care (please include your rationale):

- Increase access to care for ED patients seeking mental health treatment that routinely experience disparities of care based on insurance status, race, and age.[22-24] (Perlmutter et al., 2017; Kraft et al, 2017; Yoon et al., 2020).
- ACEP defines a boarded patient as a "patient who remains in ED after the patient has been admitted or placed into observation status at the facility, but has not been transferred to an inpatient or observation unit" (ACEP 2018).
- Children <12, male, those with government funded insurance, and those with a neurocognitive disorder have a median of 18 days of ED prolonged boarding (i.e., greater than 7 days in the ED) compared to Caucasian patients or those with private insurance (1 day).[22] (Perlmutter, et al., 2017).

Quality and coordination of care (please include your rationale):

- EBH patients with severe and persistent mental illness, including **schizophrenia or a psychotic disorder or a cognitive disorder** are those patients who require psychiatric admission but will be the most difficult to be accepted at an inpatient (private or state-administered) psychiatric facility, crisis center, group home, or assisted living.[23] (Kraft et al., 2017).
- FPD EBH will offer this cohort of patients high-quality care while boarding in the emergency department expertise in patient-centered cognitive therapy, pharmacotherapy as well as medicolegal and administrative acumen in navigating complex biopsychosocial systems-based challenges.
- EBH will help **expedite discharge** from the emergency department, when indicated.

Benefits to the public (please include your rationale):

- Increase the available resources to the public who seek emergency mental health treatment through not only initiation of treatment in the ED, but also through leadership of a greater number of hospital-based psychiatric observation units.
- Help offset ED boarding by facilitating greater availability to EBH care mobile crisis units, walk-in centers, and crisis stabilization units.[25] (Nordstrom et al., 2019).
- The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies boarding of psychiatric patients in the ED as an indicator of insufficient capacity for the provision of mental health treatment.[26] (SAMHSA, 2020).
- Recognizing EBH **expertise within Emergency Medicine** will highlight efforts underway and increase the speed by which other **interested physicians** could focus their careers in EBH to more effectively provide trauma-informed care to patients with mental health crises by established the knowledge, skills, and abilities that align this area of practice between Emergency Medicine and Psychiatry.

Long-term costs and their relationship to the probable benefits (please indicate your methodology):

- FPD will increase the establishment of emergency psychiatric assessment, treatment, and healing (EmPATH) units led by EBH physicians.
- EmPATHs are outpatient, hospital-based programs that provide emergency care for mental health patients who present to the emergency department. EmPATHs have been shown to offer a positive revenue stream (over $400,000 in one year) and more importantly to the EBH patients and their families, decrease their ED boarding time and length of stay.[27] (Stamy et al., 2021).

Please explain the effects if this area of focused practice is not approved:

- Future unknown benefits to patient care would not be realized.
- EBH thought leaders would not have the deserved recognition for helping to advance the care of emergency behavioral health.
- May **limit younger physicians from seeking this expertise** and halt further progress in helping physician-led solutions to help address the mental health crisis facing the United States.
- Patients will continue to be harmed while waiting for timely access to definitive EBH care if the ABMS community would **rely solely upon government-led or institution-led solutions** to address the inhumane prolonged board of behavioral health patients in emergency departments.

- Let's not even entertain this possibility!

Please list key stakeholder groups from which ABMS may wish to solicit commentary on the proposed area of focused practice:

- American Board of Family Medicine
- American Board of Psychiatry and Neurology
- American Academy of Emergency Medicine
- American Academy of Emergency Medicine-Resident Student Association
- American Association for Emergency Psychiatry
- American College of Emergency Physicians
- Academy of Consult Liaison Psychiatry
- Coalition on Psychiatric Emergencies
- Emergency Medicine Residents' Association
- National Alliance on Mental Illness
- Society for Academic Emergency Medicine

Please list the names of training programs in the proposed area of focused practice:

- The University of Buffalo Jacobs School of Medicine & Biosciences Emergency Psychiatry Fellowship https://medicine.buffalo.edu/departments/psychiatry/education/emergency-fellowship.html
- The Columbia University Emergency Psychiatry Fellowship https://www.columbiapsychiatry.org/education-and-training/clinical-fellowships/emergency-psychiatry-fellowship
- The Denver Health Emergency Psychiatry Fellowship https://www.denverhealth.org/for-professionals/office-of-education/graduate-programs/emergency-psychiatry-fellowship
- The ECS-Western Michigan University Behavioral Health Emergency Medicine Fellowship https://www.ecs-wmi.com/education-fellowships/behavioral-health-emergency-medicine-fellowship/
- The Vituity Arrowhead Medical Center Emergency Psychiatry Fellowship https://www.vituity.com/careers/resident-physicians/physician-fellowships/emergency-psychiatry-fellowship/

How much additional clinical experience is required beyond training?

- Eligibility Criteria.
- Minimum of 24 or 36 months that provides or provided direct care or supervision of the care of emergency behavioral health patients.
- Minimum of 0.25 FTE of the physician's time is/was devoted to the care of EBH patients through one or more of the following areas:
  - direct emergency behavioral health patient care
  - education; talent management
  - fiscal management
  - regulatory oversight
  - care coordination.

AMERICAN BOARD OF EMERGENCY MEDICINE
Emergency Behavioral Health Eligibility Criteria

Physicians seeking to take the focused practice designation examination in Emergency Behavioral Health (EBH) must:

1. Be certified by the American Board of Emergency Medicine (ABEM) or the American Board of Psychiatry and Neurology (ABPN)
2. Complete and submit the application to ABEM
3. Actively participate in the ABEM continuing certification requirements (or those of the sponsoring Board) at the time of application and throughout the certification process
4. Fulfill the Policy on Medical Licensure

Additionally, the physician must fulfill the eligibility criteria for one of three application pathways:

1. Training Pathway
2. Training-Plus-Practice Pathway
3. Practice-Only Pathway

The EBH Training-Plus-Practice Pathway and Practice-only Pathway will close on December 31, <20XX) Specifically, all eligibility requirements must be completed, and all applications received no later than December 31, <20YY>.

ELIGIBILITY CRITERIA

Training Pathway

- Physicians successfully complete an ABEM-approved EBH fellowship program, once established, that is a **minimum of one year**.
- ABEM will seek independent verification of the physician's successful completion of the EBH fellowship program from the fellowship program director.
- The physician must successfully complete the fellowship training program by the date of the examination in the year in which the application is submitted.

Training-Plus-Practice Pathway

- End on December 31, <20XX>, seven years after the first ABEM-approved program is established.
- The physician must successfully complete an American Association of Emergency Psychiatry (AAEP)–approved fellowship of at least one year in EBH
- Demonstrate that within the 7 years (84 months) immediately preceding the date on which they submit their EBH application, the physician must demonstrate that she or he holds or previously held a position for a minimum of **24 months** that provides or provided direct care or supervision of the care of EBH patients.
- 24 months, a minimum of 0.25 FTE of the physician's time is/was devoted to the care of behavioral health patients.* The 24 months do not need to be contiguous.

Acceptable EBH Practice Experience and Responsibilities for the Training-Plus-Practice Pathway

- Holds or previously held a position for a minimum of 24 months that provides or provided direct care or supervision of the care of EBH patients.
- Additionally, of that total number of months, a minimum of 0.25 FTE of the physician's time is/was devoted to the care of EBH patients through one or more of the following areas:
- **Direct EBH Patient Care**
  - Provision of direct emergency behavioral health care in the physician's practice (e.g., ED, psychiatry, community mental health, etc.).
- **Education**
  - Responsible for leading educational initiatives on EBH to emergency physicians, psychiatrists, and residents/fellows and health systems (e.g., faculty, department or system liaison, or representative).

- **Talent management**
  - EBH health physicians and other care providers (e.g., emergency physicians, nursing, social worker, behavioral health therapist, counselor) to include staff evaluations and indirect or direct supervision of care provided by behavioral health clinicians.
- **Fiscal management**
  - Oversight and management of billing and coding, reimbursement, and financing for behavioral health treatment.
  - Participates in major negotiations with payers and state and federal legislative bodies to increase funding for care.
- **Regulatory oversight**
  - Leading organizations through regulatory, accreditation, or certification processes, such as Joint Commission, SAMHSA, etc.
- **Care coordination**
  - Oversight and management of the care continuum between the acute care intervention and transition to ongoing long-term behavioral health treatment (e.g., outpatient, community mental health, etc.)
  - Leads initiatives to optimize care of behavioral health patients to minimize length of stay pending definitive treatment plan.

By way of examples and not limitation, administrative positions or clinical care roles that may be considered eligible provided that the position meets the functional responsibility noted above, could include:

1. Emergency department director/liaison for behavioral health services
2. Medical director for behavioral health services
3. Director of Crisis Services
4. Director of Behavioral Health Clinical Decision Units (CDUs)
5. Director of Hospital-based (including emergency department) Behavioral Health Unit
6. Consultation-Liaison Psychiatrist
7. Director of Crisis Services
8. Director of Psychiatric Emergency Services (PESs)
9. Director of Comprehensive Psychiatric Emergency Programs (CPEPs)
10. Director of Emergency Psychiatry Assessment, Treatment, and Healing (EmPATH) Units
11. Director of ACCESS line (e.g., 24-hour mental health line, #988, etc.)
12. Director of Mobile Mental Health Crisis Unit
13. Director of Regional Dedicated Behavioral Health or Psychiatric Emergency Department
14. Medical Director Community Mental Health Center
15. City/County/State Director of Behavioral Health Services
16. Government or Correctional Agency Director of Behavioral Health Services

Practice-Only Pathway

- Will end December 31, <20XX>, 7 years after the first ABEM-approved fellowship is established. To apply for certification through the Practice-Only Pathway, a physician must meet all the following criteria:
- Demonstrate that within the 7 years (84 months) immediately preceding the date on which they submit their EBH application, the physician must demonstrate that she or he holds or previously held a position for a minimum of 36 months that provides or provided direct care or supervision of the care of emergency behavioral health patients.
- Of that designated 36 months, a minimum of 0.25 FTE of the physician's time is/was devoted to the care of behavioral health patients.* The 36 months do not need to be contiguous.

Practice-Only Pathway (cont'd)

- **Direct emergency behavioral health patient care**
  - Provision of direct emergency behavioral health care in the physician's practice (e.g., emergency department, psychiatry, community mental health, etc.).
- **Education**
  - Responsible for leading educational initiatives on emergency behavioral health to emergency physicians, psychiatrists, and residents/fellows and health systems (e.g., faculty, department or system liaison or representative).
- **Talent management**
  - Oversight and management of emergency behavioral health physicians and other care providers (e.g., emergency physicians, nursing, social worker, behavioral health therapist, counselor) to include staff evaluations and indirect or direct supervision of care provided by behavioral health clinicians.

Practice-Only Pathway (cont'd)

- **Fiscal management**
  - Oversight and management of billing and coding, reimbursement, and financing for behavioral health treatment.
  - Participates in major negotiations with payers and state and federal legislative bodies to increase funding for care.
- **Regulatory oversight**
  - Leading organizations through regulatory, accreditation, or certification processes, such as Joint Commission, SAMHSA, etc.
- **Care coordination**
  - Oversight and management of the care continuum between the acute care intervention and transition to ongoing long-term behavioral health treatment (e.g., outpatient, community mental health, etc.)
  - Leads initiatives to optimize care of behavioral health patients to minimize length of stay pending definitive treatment plan.

By way of examples and not limitation, administrative positions or clinical care roles that may be considered eligible provided that the position meets the functional responsibility noted above could include:

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12. Director of Mobile Mental Health Crisis Unit
13. Director of Regional Dedicated Behavioral Health or Psychiatric Emergency Department
14. Medical Director Community Mental Health Center
15. City/County/State Director of Behavioral Health Services
16. Government or Correctional Agency Director of Behavioral Health Services

Timeline

- The application will be submitted **May 24, 2024**
- The next step will be a presentation to the Committee on Certification within the American Board of Medical Specialties on November 4, 2024.
- This presentation will be given by **ABEM Past Chairman of the Board, Samuel M. Keim, M.D., M.S.**, Chair of the Task Force, and possibly along with a representative of the American Board of Psychiatry and Neurology **(ABPN).**
- November 2024: If approved by COCERT, then the application will be referred to the ABMS Board for approval, at which time there will be a period of public comment (late 2024).
- **The Task Force would then be asked to help promote the public comment period, which is open to any individual or organization, for solicitation of support**.
- A final decision would then be made at the February 2025 ABMS Board of Directors meeting.

Proposed Core Curriculum
COCERT Application May24, 2024

Approach to the Emergency Behavioral Health Patient (Domain #1)

- Behavioral Interview and mental status exam
- Behavioral Communication skills
  - Building a therapeutic alliance
  - Interpersonal skills
  - Dialectical Behavioral Therapy (DBT) basics
    - Validation
  - Patient and family engagement
  - Collateral information gathering
  - Empathetic and compassionate care management skills
  - Informed decision-making
  - Verbal de-escalation (Cross Reference Domain # 5)
  - Cultural humility
    - Cultural competence
    - Implicit bias
    - Systemic racism
    - Trust building
    - Ageism
    - Gender
    - Socioeconomic
    - Functional
- Emergency department boarding
  - Medication initiation/continuation
  - Observation status
  - Physical plant changes
  - System changes

- Monitoring
- Motivational interviewing
- Firearm screening/mitigation (Cross Reference Domains # 3, 6, and 8)
- Psychological first-aid
- Physician Self-Care and Wellness
- Therapeutic limit-setting
- Trauma-informed care
- Service recovery and grievance management
- Virtual behavioral health consultation (Telehealth)
  - Working in interdisciplinary teams
  - Discharge planning and care coordination
- Peer support (Cross Reference Domains # 4 and 10)
- Triage assessment
  - Suicide and homicidal ideation
- Transference/Countertransference

Medical Evaluation of the Behavioral Health Patient (Domain #2)

Differentiation of Medical Illness
- Catatonia
- Delirium
- Dementia and other neurocognitive disorders
- Neuroleptic malignant syndrome
- Serotonin syndrome
- Toxidromes
- Withdrawal syndromes
- Other etiologies

EKG indication and interpretation in behavioral health
History and physical exam for the psychiatric patient
Free-standing psychiatric units (e.g., Institutes of Mental Disease)
Hospital-based psychiatric units
Structured instruments (e.g., SMART form)
Medical Screening

Suicide Assessment, Management, and Mitigation (Domain #3)

Assessment
- Epidemiology
- Risk factors – Static
- Risk factors – Dynamic
- Protective factors
- Assessment Tools
- Universal screening requirements
- Weapon access screening (Cross Reference Domain # 3, 6, and 8)
  - Safe storage
  - Off-site storage
  - State laws
    - Extreme protection order
    - Do-not-sell laws

Management
- Stratification within the ED
- Differentiation of chronic risk vs. acute risk
- Role of medications/supportive brief therapy
- Placement/physical plan within the ER
- Safety Planning ACEP
- Consultation
- Disposition
- Medical decision-making documentation
- Placement of involuntary hold

Mitigation
- Inpatient treatment
- Outpatient treatment
  - Intensive outpatient program (IOP)
  - Partial hospital program
  - Case Management
  - Post-discharge caring contact
  - Sobriety encouragement for patients with substance use disorder (Cross Reference Domain #4)
  - NA/AA/Al-Anon /NAMI family organizations/meeting (Cross Reference Domain #4)
  - Medically managed detoxification (Cross Reference Domain # 4)
  - Linkage/Follow-Up for Discharge Planning
- Harm Reduction
  - Means Reduction
  - Safety Planning
- Weapon interventions
  - Safe storage
  - Patient education

Risk stratification
Non-Suicidal Self-Injury (Cross Reference Domain # 7)
- Assessment
- Management

Substance Use Disorders in the Emergency Setting (Domain #4)

- Alcohol use disorder
  - Intoxication
  - Withdrawal
  - Medications and treatment for AUD
- Cannabis use disorder
  - Intoxication
  - Withdrawal
- Opioid use disorder
  - Intoxication
  - Medication and treatment for opioid use disorder
  - Withdrawal
- Prescription Drug Misuse
  - Prescription diversion
  - Electronic prescription monitoring (state registries)
- Benzodiazepine use disorder
  - Intoxication
  - Withdrawal
- Stimulant use disorder
  - Intoxication
  - Withdrawal
  - Amphetamine/methamphetamine
  - Cocaine

- Ketamine
- Hallucinogens/Psychedelics
  - Psilocybin
  - MDMA-based compounds
- Tobacco use disorder
- Treatment settings
- Polysubstance Use
- Medically managed detoxification (Cross Reference Domain # 3)
  - Sobriety centers
- Harm reduction strategies
  - Naloxone
  - Safe use (patient education, supply kits)
- Motivational Interviewing

Treatment of the Patient with Agitation (Domain #5)

- Verbal De-escalation (Cross Reference Domain # 1)
  - Family or caregiver engagement
- Psychopharmacology to treat agitation and aggression due to psychiatric disorders
  - Monitoring
- Identifying medical etiologies of severe agitation
- Risk stratification
- Use and avoidance of restraints and seclusion (Cross Reference Domain # 8)
- Use of Sitters
- After actions
  - Debriefing
  - Service recovery

Mitigating Aggression in the Healthcare Workplace Environment (Domain #6)

- Affective (emotional) violence
- Homicidality
- Security
- Threat
  - Assessment
  - Management
  - Mitigation
    - Weapons (Cross Reference Domain # 3, 6, and 8)
- Use or avoidance of law enforcement
- Violence
  - Imminent risk factors
  - Planned systemic attacks
    - Mass casualty
- Workplace violence
  - Effects of workplace violence on providers

Psychiatric Diagnoses (Domain #7)

- Approach to Diagnosis and Treatment
- Psychotic disorders
  - Schizophrenia and schizoaffective disorders
    - Delusions
    - Hallucinations
    - Thought disorganization
    - Pharmacology
- Anxiety disorders
  - Agoraphobia
  - Generalized anxiety disorder
  - Panic attack
  - Panic disorder
  - Social anxiety disorder
  - Pharmacology
- Autism spectrum
  - Pharmacology
- Bipolar Disorder
  - Manic syndrome
  - Pharmacology
- Catatonia
- Disruptive behavioral disorders
  - Oppositional defiant
  - Conduct disorder
  - Intermittent explosive disorder
  - Attention-deficit/hyperactivity disorder
  - Pharmacology
- Eating Disorders
  - Anorexia nervosa
  - Avoidant/restrictive food intake disorder
  - Binge eating
  - Bulimia nervosa
  - Pharmacology
- Grief
- Illness anxiety disorder
- Intellectual disabilities
- Major Depression
  - Atypical
  - Catatonia
  - Post-partum
  - Seasonal
  - Pharmacology

- Grief
- Illness anxiety disorder
- Intellectual disabilities
- Major Depression
  - Atypical
  - Catatonia
  - Post-partum
  - Seasonal
  - Pharmacology
- Obsession-based disorders
  - Body dysmorphia
  - Hoarding
  - Obsessive-compulsive
  - Trichotillomania
  - Pharmacology
  - Non-suicidal self-injury (Cross Reference Domain # 4)
- Personality Disorders
  - Potential indications for short-term use of pharmacotherapy
  - Cluster A
    - Paranoid
    - Schizoid
    - Schizotypal
  - Cluster B
    - Antisocial
    - Borderline
    - Histrionic
    - Narcissistic
  - Cluster C
    - Avoidant
    - Dependent
    - Obsessive-Compulsive
- Post-Traumatic Stress/Acute Stress Disorders
  - Pharmacology
- Secondary to a medical condition (e.g., traumatic brain injury)
- Somatic Symptom Disorder
- Symptomatic Exaggeration

Ethical and Legal Considerations (Domain #8)

- Capacity
- Confidentiality
  - HIPAA
  - Exceptions to HIPAA in the emergency department
- Decision making
  - Capacity
  - Competency
- Discharging Behavioral Health Patients and Transitions of Care
  - Risk stratification
    - Medical record documentation
    - Discharge planning
    - Medication management
    - Coordination of outpatient care
    - Patient and family education
    - Behavioral/psychosocial interventions
- Duty-to-warn
  - Third-party (Tarasoff)
- Health Equity/Disparities
- Emergency Medical Treatment and Active Labor Act

- Surrogate decision-making and guardianship (Cross Reference Domain #9)
- Informed consent
- Law enforcement
  - Court-ordered mandatory lab (or blood) testing
  - Mandatory reporting
- Use and avoidance of restraints and seclusion (Cross Reference Domain # 5)
- Firearms (Cross Reference Domain # 1, 3, and 6)
- Contraband
- Liability
  - Civil
  - Criminal
- Involuntary commitment
  - Petition and Certification (could also do subsections here on med orders and/or forced placements)
  - State and federal laws
- Risk management

Special Populations (Domain #9)
Medical-legal decision-making (Cross Reference # 8)
Children and Adolescents
Developmental disorders and disabilities
Foreign
- Refugees, asylum seekers, migrants, recent immigrants

Forensic
Geriatric
Interpersonal violence or neglect
- Child
- Intimate partner
- Vulnerable adult
- Elder

LGBTQIA+
Military veterans
Post-concussive
Pregnancy-related
Rural
Sexual assault
Transiently Housed and Unhoused

Community-based Care, Law Enforcement Partnerships, and Special Crisis Service Units (Domain #10)
Co-responder models with Emergency Medical Services (EMS)
Co-responder models with Law Enforcement Officers (LEO)
Crisis stabilization units
- Mobile crisis teams
- 988 Suicide and Crisis Lifeline

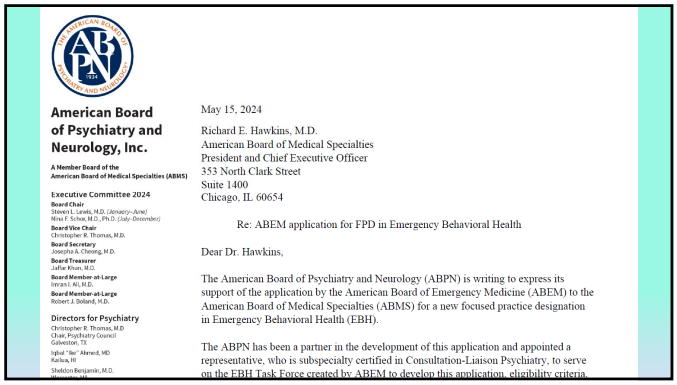
Disaster mental health training
Emergency department
- Co-located behavioral health units
- Embedding (behavioral health consultation)
- Free-standing behavioral health emergency departments

Emergency Psychiatric Assessment Treatment and Healing (EmPaTH) units
Regional emergency department behavioral health programs (Alameda model)
Voluntary crisis centers
Psychiatric emergency services
Community
- Community mental health centers
- Shelters
- Peer-run respite and support (Cross Reference Domain # 1 and 4)

Hospital
- Psychiatric observation
- Crisis stabilization
- Comprehensive Psychiatric Emergency Program

Outpatient clinics

Support Letters
COCERT Application



American Board of Psychiatry and Neurology, Inc.

A Member Board of the American Board of Medical Specialties (ABMS)

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May 15, 2024

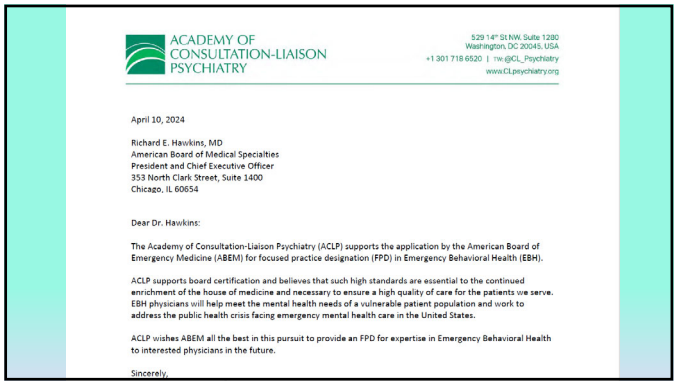
Richard E. Hawkins, M.D.
American Board of Medical Specialties
President and Chief Executive Officer
353 North Clark Street
Suite 1400
Chicago, IL 60654

Re: ABEM application for FPD in Emergency Behavioral Health

Dear Dr. Hawkins,

The American Board of Psychiatry and Neurology (ABPN) is writing to express its support of the application by the American Board of Emergency Medicine (ABEM) to the American Board of Medical Specialties (ABMS) for a new focused practice designation in Emergency Behavioral Health (EBH).

The ABPN has been a partner in the development of this application and appointed a representative, who is subspecialty certified in Consultation-Liaison Psychiatry, to serve on the EBH Task Force created by ABEM to develop this application, eligibility criteria,



ACADEMY OF CONSULTATION-LIAISON PSYCHIATRY

529 14th St NW, Suite 1280
Washington, DC 20045, USA
+1 301 718 6520 | tw.@CL_Psychiatry
www.CLpsychiatry.org

April 10, 2024

Richard E. Hawkins, MD
American Board of Medical Specialties
President and Chief Executive Officer
353 North Clark Street, Suite 1400
Chicago, IL 60654

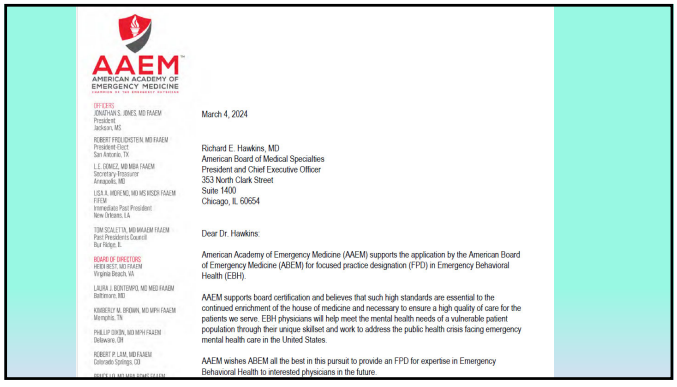
Dear Dr. Hawkins:

The Academy of Consultation-Liaison Psychiatry (ACLP) supports the application by the American Board of Emergency Medicine (ABEM) for focused practice designation (FPD) in Emergency Behavioral Health (EBH).

ACLP supports board certification and believes that such high standards are essential to the continued enrichment of the house of medicine and necessary to ensure a high quality of care for the patients we serve. EBH physicians will help meet the mental health needs of a vulnerable patient population and work to address the public health crisis facing emergency mental health care in the United States.

ACLP wishes ABEM all the best in this pursuit to provide an FPD for expertise in Emergency Behavioral Health to interested physicians in the future.

Sincerely,



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Colorado Springs, CO

March 4, 2024

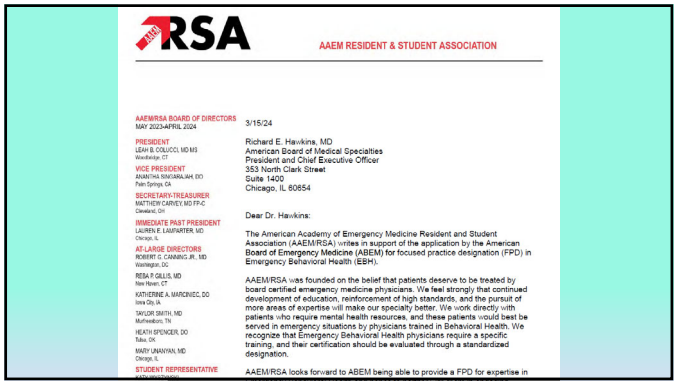
Richard E. Hawkins, MD
American Board of Medical Specialties
President and Chief Executive Officer
353 North Clark Street
Suite 1400
Chicago, IL 60654

Dear Dr. Hawkins:

American Academy of Emergency Medicine (AAEM) supports the application by the American Board of Emergency Medicine (ABEM) for focused practice designation (FPD) in Emergency Behavioral Health (EBH).

AAEM supports board certification and believes that such high standards are essential to the continued enrichment of the house of medicine and necessary to ensure a high quality of care for the patients we serve. EBH physicians will help meet the mental health needs of a vulnerable patient population through their unique skillset and work to address the public health crisis facing emergency mental health care in the United States.

AAEM wishes ABEM all the best in this pursuit to provide an FPD for expertise in Emergency Behavioral Health to interested physicians in the future.



RSA

AAEM RESIDENT & STUDENT ASSOCIATION

3/15/24

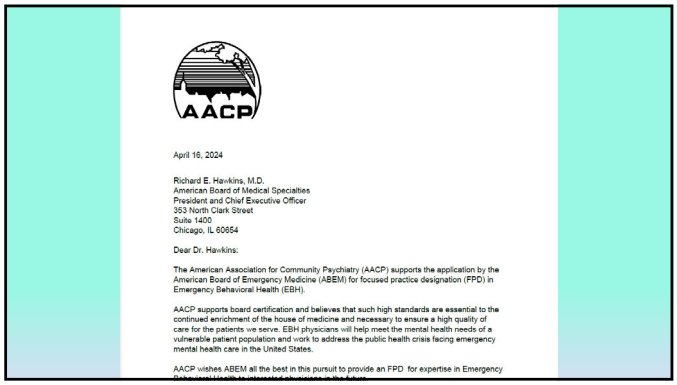
Richard E. Hawkins, MD
American Board of Medical Specialties
President and Chief Executive Officer
353 North Clark Street
Suite 1400
Chicago, IL 60654

Dear Dr. Hawkins:

The American Academy of Emergency Medicine Resident and Student Association (AAEM/RSA) writes in support of the application by the American Board of Emergency Medicine (ABEM) for focused practice designation (FPD) in Emergency Behavioral Health (EBH).

AAEM/RSA was founded on the belief that patients deserve to be treated by board certified emergency medicine physicians. We feel strongly that continued development of education, reinforcement of high standards, and the pursuit of more areas of expertise will make our specialty better. We work directly with patients who require mental health resources, and these patients would best be served in emergency situations by physicians trained in Behavioral Health. We recognize that Emergency Behavioral Health physicians require a specific training, and their certification should be evaluated through a standardized designation.

AAEM/RSA looks forward to ABEM being able to provide a FPD for expertise in



AACP

April 16, 2024

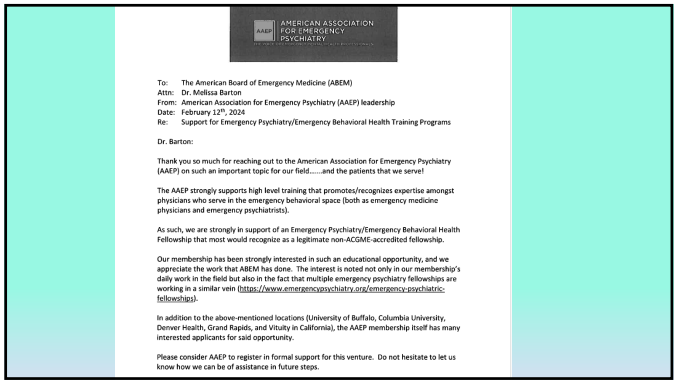
Richard E. Hawkins, M.D.
American Board of Medical Specialties
President and Chief Executive Officer
353 North Clark Street
Suite 1400
Chicago, IL 60654

Dear Dr. Hawkins:

The American Association for Community Psychiatry (AACP) supports the application by the American Board of Emergency Medicine (ABEM) for focused practice designation (FPD) in Emergency Behavioral Health (EBH).

AACP supports board certification and believes that such high standards are essential to the continued enrichment of the house of medicine and necessary to ensure a high quality of care for the patients we serve. EBH physicians will help meet the mental health needs of a vulnerable patient population and work to address the public health crisis facing emergency mental health care in the United States.

AACP wishes ABEM all the best in this pursuit to provide an FPD for expertise in Emergency



AMERICAN ASSOCIATION FOR EMERGENCY PSYCHIATRY

To: The American Board of Emergency Medicine (ABEM)
Attn: Dr. Melissa Barton
From: American Association for Emergency Psychiatry (AAEP) leadership
Date: February 12th, 2024
Re: Support for Emergency Psychiatry/Emergency Behavioral Health Training Programs

Dr. Barton:

Thank you so much for reaching out to the American Association for Emergency Psychiatry (AAEP) on such an important topic for our field……and the patients that we serve!

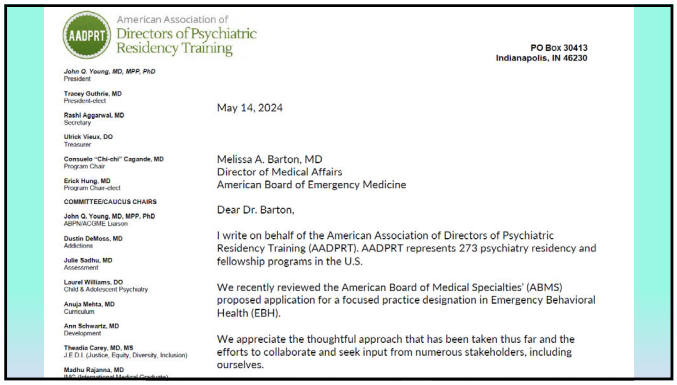
The AAEP strongly supports high level training that promotes/recognizes expertise amongst physicians who serve in the emergency behavioral space (both as emergency medicine physicians and emergency psychiatrists).

As such, we are strongly in support of an Emergency Psychiatry/Emergency Behavioral Health Fellowship that most would recognize as a legitimate non-ACGME-accredited fellowship.

Our membership has been strongly interested in such an educational opportunity, and we appreciate the work that ABEM has done. The interest is noted not only in our membership's daily work in the field but also in the fact that multiple emergency psychiatry fellowships are working in a similar vein (https://www.emergencypsychiatry.org/emergency-psychiatric-fellowships).

In addition to the above-mentioned locations (University of Buffalo, Columbia University, Denver Health, Grand Rapids, and Vituity in California), the AAEP membership itself has many interested applicants for said opportunity.

Please consider AAEP to register in formal support for this venture. Do not hesitate to let us know how we can be of assistance in future steps.



American Association of Directors of Psychiatric Residency Training

PO Box 30413
Indianapolis, IN 46230

May 14, 2024

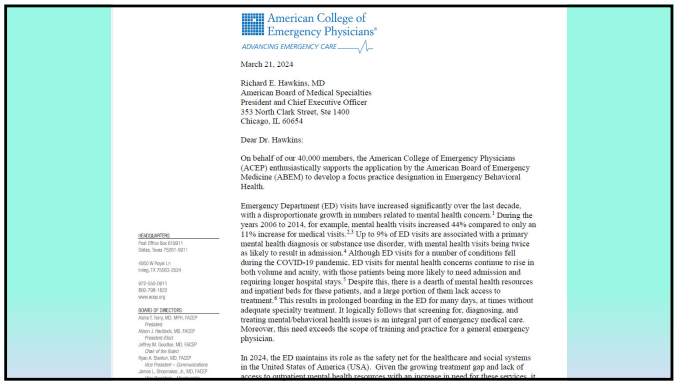
Melissa A. Barton, MD
Director of Medical Affairs
American Board of Emergency Medicine

Dear Dr. Barton,

I write on behalf of the American Association of Directors of Psychiatric Residency Training (AADPRT). AADPRT represents 273 psychiatry residency and fellowship programs in the U.S.

We recently reviewed the American Board of Medical Specialties' (ABMS) proposed application for a focused practice designation in Emergency Behavioral Health (EBH).

We appreciate the thoughtful approach that has been taken thus far and the efforts to collaborate and seek input from numerous stakeholders, including ourselves.



American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

March 21, 2024

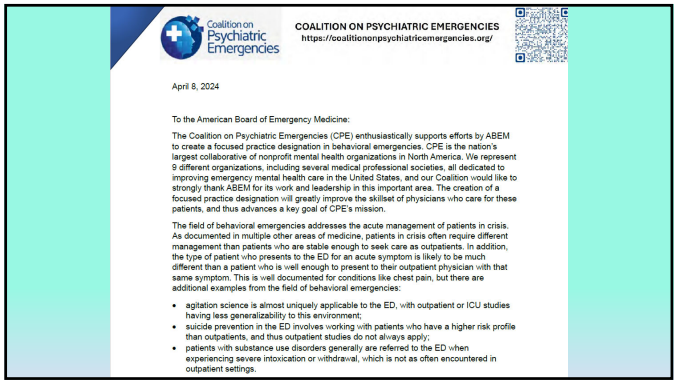
Richard E. Hawkins, MD
American Board of Medical Specialties
President and Chief Executive Officer
353 North Clark Street, Ste 1400
Chicago, IL 60654

Dear Dr. Hawkins:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) enthusiastically supports the application by the American Board of Emergency Medicine (ABEM) to develop a focus practice designation in Emergency Behavioral Health.

Emergency Department (ED) visits have increased significantly over the last decade, with a disproportionate growth in numbers related to mental health concern.[1] During the years 2006 to 2014, for example, mental health visits increased 44% compared to only an 11% increase for medical visits.[2,3] Up to 9% of ED visits are associated with a primary mental health diagnosis or substance use disorder, with mental health visits being twice as likely to result in admission.[4] Although ED visits for a number of conditions fell during the COVID-19 pandemic, ED visits for mental health concerns continue to rise in both volume and acuity, with those patients being more likely to need admission and requiring longer hospital stays.[5] Despite this, there is a dearth of mental health resources and inpatient beds for these patients, and a large portion of them lack access to treatment.[6] This results in prolonged boarding in the ED for many days, at times without adequate specialty treatment. It logically follows that screening for, diagnosing, and treating mental/behavioral health issues is an integral part of emergency medical care. Moreover, this need exceeds the scope of training and practice for a general emergency physician.

In 2024, the ED maintains its role as the safety net for the healthcare and social systems in the United States of America (USA). Given the growing treatment gap and lack of



Coalition on Psychiatric Emergencies

COALITION ON PSYCHIATRIC EMERGENCIES
https://coalitiononpsychiatricemergencies.org/

April 8, 2024

To the American Board of Emergency Medicine:

The Coalition on Psychiatric Emergencies (CPE) enthusiastically supports efforts by ABEM to create a focused practice designation in behavioral emergencies. CPE is the nation's largest collaborative of nonprofit mental health organizations in North America. We represent 9 different organizations, including several medical professional societies, all dedicated to improving emergency mental health care in the United States, and our Coalition would like to strongly thank ABEM for its work and leadership in this important area. The creation of a focused practice designation will greatly improve the skillset of physicians who care for these patients, and thus advances a key goal of CPE's mission.

The field of behavioral emergencies addresses the acute management of patients in crisis. As documented in multiple other areas of medicine, patients in crisis often require different management than patients who are stable enough to seek care as outpatients. In addition, the type of patient who presents to the ED for an acute symptom is likely to be much different than a patient who is well enough to present to their outpatient physician with that same symptom. This is well documented for conditions like chest pain, but there are additional examples from the field of behavioral emergencies:

- agitation science is almost uniquely applicable to the ED, with outpatient or ICU studies having less generalizability to this environment;
- suicide prevention in the ED involves working with patients who have a higher risk profile than outpatients, and thus outpatient studies do not always apply;
- patients with substance use disorders generally are referred to the ED when experiencing severe intoxication or withdrawal, which is not as often encountered in outpatient settings.

CORD
COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE
Innovation · Collaboration · Scholarship

April 15, 2024

Richard E. Hawkins, MD
American Board of Medical Specialties
President and Chief Executive Officer
353 North Clark Street
Suite 1400
Chicago, IL 60654

Dear Dr. Hawkins:

Council of Residency Directors in Emergency Medicine (CORD) supports the application by the American Board of Emergency Medicine (ABEM) for focused practice designation (FPD) in Emergency Behavioral Health (EBH).

CORD supports board certification and believes that such high standards are essential to the continued enrichment of the house of medicine and necessary to ensure a high quality of care for the patients we serve. EBH physicians will help meet the mental health needs of a vulnerable patient population through their unique skillset and work to address the public health crisis facing emergency mental health care in the United States.

CORD wishes ABEM all the best in this pursuit to provide an FPD for expertise in Emergency Behavioral Health to interested physicians in the future.

Sincerely,

Boyd (Bo) Burns, DO
President

Emergency Medicine Residents' Association

March 24, 2024

Richard E. Hawkins, MD
American Board of Medical Specialties
President and Chief Executive Officer
353 North Clark Street
Suite 1400
Chicago, IL 60654

Dear Dr. Hawkins:

The Emergency Medicine Residents' Association (EMRA) supports the application by the American Board of Emergency Medicine (ABEM) for focused practice designation (FPD) in Emergency Behavioral Health (EBH).

EMRA, the largest and oldest independent medical resident group in the world, represents over 90% of all Emergency Medicine (EM) physicians-in-training in the United States. EMRA supports board certification and believes that such standards are essential to ensuring the highest quality of care for the patients we serve. Furthermore, EMRA members, who are oftentimes the first physician point of contact for a patient undergoing a mental health crisis, have voiced their concerns regarding the current systemic gaps in the health system's ability to care for these patients. Therefore, EMRA wholeheartedly supports an FPD in EBH as a means of increasing the mental health

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NAMI
National Alliance on Mental Illness

April 24, 2024

Richard E. Hawkins, MD
American Board of Medical Specialties
President and Chief Executive Officer
353 North Clark Street
Suite 1400
Chicago, IL 60654

Dear Dr. Hawkins:

NAMI, the National Alliance on Mental Illness, supports the application by the American Board of Emergency Medicine (ABEM) for focused practice designation (FPD) in Emergency Behavioral Health (EBH).

NAMI supports board certification and believes that such high standards are essential to the continued enrichment of the house of medicine and necessary to ensure a high quality of care for the patients we serve.

EBH physicians will help meet the mental health needs of a vulnerable patient population and help to address the public health crisis facing emergency mental health care in the United States.

Exciting time!

AMERICAN ASSOCIATION FOR EMERGENCY PSYCHIATRY
THE VOICE OF EMERGENCY MENTAL HEALTH PROFESSIONALS

American Board of Psychiatry and Neurology, Inc.

American College of Emergency Physicians
ADVANCING EMERGENCY CARE

AMERICAN PSYCHIATRIC ASSOCIATION
Medical leadership for mind, brain and body.

American Board of Emergency Medicine

American Board of Medical Specialties
Higher standards. Better care.®

ABEM Vote (+) May 24, 2024!
On to COCERT / ABMS

AMERICAN ASSOCIATION FOR EMERGENCY PSYCHIATRY
THE VOICE OF EMERGENCY MENTAL HEALTH PROFESSIONALS

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Medical leadership for mind, brain and body.

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Higher standards. Better care.®

- We will need letters of support from YOU during Public Comment Period!

AAEP – NUBE
December 6-8, 2023

AMERICAN ASSOCIATION FOR EMERGENCY PSYCHIATRY
THE VOICE OF EMERGENCY MENTAL HEALTH PROFESSIONALS

15th Annual NUBE Conference
December 9-11, 2024 | Phoenix, AZ.

Join AAEP at the luxurious Sheraton Phoenix Downtown in Phoenix, Arizona from December 9-11 (Monday-Wednesday) for the 15th Annual National Updates on Behavioral Emergencies (NUBE) Conference.

AMERICAN ASSOCIATION FOR EMERGENCY PSYCHIATRY
THE VOICE OF EMERGENCY MENTAL HEALTH PROFESSIONALS

Who Should Attend

- Emergency physicians
- Emergency psychiatrists
- Psychologists
- Nurses
- Nurse practitioners
- Mental health workers
- Social workers
- Physician assistants

Moment of Personal Privilege

New Options in 2024!

Atlantic Health System

Where to Go for Care?

Before you're faced with a health crisis, make sure you plan ahead. Know the nearest urgent care and emergency care locations, hours, ages treated, and what insurance plans are accepted.

	APPOINTMENTS	HOURS	CARE	AGES
Primary Care	Appointments preferred, online appointments and virtual visits available	Business hours, some evenings/ weekends	Well and sick visits, moderate health concerns that need to be treated quickly	Internal Medicine: 18 and above; Family Medicine: All ages
Urgent Care	No appointments needed, walk-in care, virtual visits	Business hours, weekday evenings/ weekends	Convenient, same-day medical care for mild to urgent health concerns, including X-rays and	Call in advance; site and clinician dependent
AdventCD Urgent Care	No appointments needed, walk-in care, no virtual visits	7 days/week (8:00am - 8:00pm and Saturdays/ Sundays 8:00am - 5:00pm), 365 days a year	Immediate care for minor to complex illnesses or injuries. CT scans, X-rays, comprehensive on-site labs are available	All ages
Hospital Emergency Department (ED)/ Pediatric ED	No appointments needed, walk-in care, no virtual visits	Open around-the-clock, 365 days a year	Life-saving care Severe mental or physical health concerns that need to be treated immediately. The ED is supported by the full hospital and its medical staff	All ages

Atlantic Health System

Let's Take A Tour: Nurse's Station

133

Atlantic Health System

On Site Laboratory Testing & AHS Core Lab

134

Presentation 2

Atlantic Health System

CT Scanner!
64-slice

135

Atlantic Health System

Why Do You Come Here Almost Every Year?

- Tom Arnold
- Bryan Balentine
- Andrea Brault
- Melissa Costello
- Dave Garvey
- Kirk Hawley
- Sandy Herman
- Kenneth Holbert
- Hammad Husainy
- Bobby Lewis
- John McMahon
- Suvid Mendiratta
- John Proctor
- "Sully" Smith and Skyler, and Sullivan
- **THE BOSS LADY – Analise Sorrentino**
- Larry Stack
- Ryan Stanton
- Michael Steinberg

michael.gerardi@atlantichealth.org

michael.gerardimd@amm-mso.com

Questions?

My Phone #

973-464-3351

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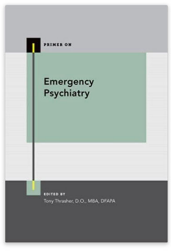

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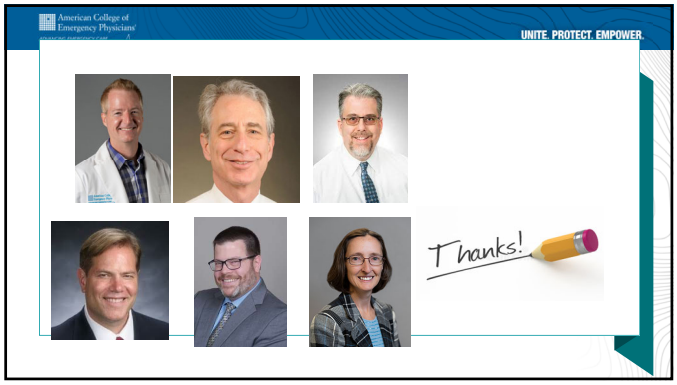
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