ABMS COCERT Application for Focused Practice

Response ID:30 Data

1. General Questions

1. Board (s):

American Board of Emergency Medicine (ABEM)

2. Contact Name:

Melissa A. Barton, M.D

3. Email:

mbarton@abem.org

4. Phone:

517-332-4800

5.
1 - Please provide the name of the proposed area of focused practice:

Emergency Behavioral Health

6. 2 - Is this application a modification of an existing designation?

No

2a - If your Board is applying to offer an existing designation, you may choose to accept the responses supplied in the previously approved application. If you accept those responses, you should submit an addendum to a previous application.

Does your Board wish to use the already supplied information for this focused practice designation and submit only an addendum?

7.
3 - Are multiple Boards requesting this certification?

Yes

8. 3b. Have the cooperating Member Boards agreed on a single definition and clear set of criteria for the area of focused practice based on clinical experience?

Yes

9. 3c. Have the partner boards agreed to a Memorandum of Understanding (MOU) defining the roles that each board will play in the management of the focused practice designation if approved? This MOU should address the following elements:
The role of each Board in determining eligibility, registering candidates, reporting scores to candidates, and updating ABMS records
Resolution of conflicts between partner boards
Administration of continuing certification
Issuance of certificates
Reporting of scores
Development and administration of exam (e.g. plans for blueprint development, item development and review of test forms, standard setting, cut-score determination, psychometric analysis)

No

3ci. Please upload a copy of the MOU

10. 3cii. Please describe the roles for each board and provide a timeline for when an MOU will be finalized.

ABEM will be the administrative Board, and the ABPN will be a co-sponsoring Board. ABEM and ABPN will issue the FPD to their respective diplomates. ABEM will offer the EBH FPD to diplomates of other ABMS Boards upon approval of the ABMS. ABEM and ABPN will review the MOU after ABMS final approval of the FPD. It is expected that the MOU will be completed by the end of 2025

2. Purpose, Status, and Need

11. 4 - Briefly define and state the purpose of the proposed area of focused practice:

The purpose of a focused practice designation (FPD) in Emergency Behavioral Health (EBH) is to recognize the expertise held by physicians in the provision of emergency behavioral care. An FPD would also help this area of medical care more quickly evolve as an emphasis within emergency medicine and improve access to care for patients in need of unscheduled behavioral health and mental health expertise. Physicians with an FPD in EBH could provide a detailed mental health evaluation; initiate pharmacologic treatment quickly; arrange for safe discharge from the emergency department with coordinated, patient-family centered outpatient treatment based; and, confidently apply involuntary care and mandated treatment. Appropriate and timely care can be provided to patients who are boarding in the emergency department for days, weeks, or, on occasion, months, while awaiting an open inpatient psychiatric bed.[1] The mental health crisis in the US and lack of access to EBH care has created the need for more physicians to have greater expertise. A focused practice in EBH takes one step forward to address this public health emergency.

This FPD is different from a subspecialty in several ways. There is no single specialty that addresses this narrow range of EBH. Although residency-trained emergency physicians have foundational knowledge in providing mental health care for patients in the emergency department, physicians with expertise in EBH have acquired a greater breadth and depth of knowledge in this area of care. Similarly, psychiatrists and those who sub-specialize in consultation-liaison psychiatry have expertise in mental health care that could be 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. The 12-month fellowship training for ABEM-certified physicians would not be ACGME-accredited training—a marked departure from an ABMS subspecialty. More specifically, this FPD differs from a traditional subspecialty in that it would recognize emergency physicians who have acquired additional training dedicated in the care of EBH patients above the knowledge and skills obtained during a general Emergency Medicine residency program. Moreover, interested psychiatrists, even those who are subspecialty certified or who choose to tailor their practice to the provision of care to acute emergency behavioral health patients, will be recognized for this type of specialization of practice.

12. 5 - Areas of focused practice typically fall under one of these areas. Please describe which of the following this application addresses:
Evolving area of practice
Area of practice limited in scope or size
Specialized procedure
If the area of focused practice is procedurally defined, describe how the procedure is of sufficient breadth and depth to significantly benefit patient care
Describe how mastery of the procedure takes time, aptitude, and dedication beyond the training received for the underlying certificate

Evolving area of practice

The care of the unscheduled patient seeking acute emergency behavioral care is an evolving area of practice. Accordingly, EBH is growing into a unique body practice by melding a portion of the knowledge, skills, and abilities found in the specialties of emergency medicine and psychiatry with additional aspects of addiction medicine. Blending of these specialties has fostered the

development of a unique and well-defined clinical practice whose physicians are able to deliver valuable care in novel acute care settings, including the recently established "#988" suicide and crisis hotline, mobile crisis centers, telepsychiatry, regional psychiatric emergency centers, and emergency department psychiatric units.

Although all ABEM diplomates are expected to have acquired a fundamental knowledge of how to provide care for emergency patients with mental health concerns, EBH physicians have developed a more nuanced and defined skillset of expertise that includes EBH research portfolios, educational materials, medicolegal expertise, EBH care model design, and administrative leadership skills related to the care of patients with acute mental health concerns in an emergency department setting. EBH physicians have greater proficiency in the care of the psychiatric patient in the emergency department with regard to potential high-risk medicolegal areas including capacity determination, decision-making competency, risk stratification for discharge, guardianship, involuntary commitment, and knowledge regarding both civil and criminal liability in the care of the psychiatric patient in the emergency department. Physicians with EBH expertise are better equipped to reduce emergency department boarding of patients with mental health disorders thereby reducing associated adverse events from prolonged lengths of stay.[2]

EBH expertise has evolved as a one type of solution to better address the mental health crisis in the US. EBH physicians have helped to reduce the moral injury felt by emergency department staff and emergency physicians when caring for mental health patients, particularly children.[3] While each emergency department may not have its own EBH expert, recognition of this already established area of expertise is expected to expand the ease and accessibility to such experts to enhance knowledge translation of EBH throughout a wider number of acute care settings.

13. 6a - Describe how the existence of a body of scientific medical knowledge underlying the proposed area of focused practice is, in large part, distinct from, or more detailed than that of other areas in which certification or focused practice are offered:

The FPD in EBH would address several aspects of care that, when taken together, represent a new type of practice with a new type of focus. The elements contributing to this unique practice include: 1) unscheduled crisis care, 2) mental health and behavioral health beyond that taught in an Emergency Medicine residency, 3) expertise in treating severe agitation, 4) address a population at high risk for violence to others and self-harm, 5) sophisticated skills in assessing suicidality, and 6) treatment of various substance use disorders (SUDs).

A focused practice in EBH relies on more detailed knowledge that is broader in scope than that used by general emergency physicians, as evidenced in the Core Content of Emergency Behavioral Health (See Attachment 2: EBH Core Content). For EBH, greater emphasis is placed on psychopharmacology treatment initiation for psychiatric disorders, definitive disposition for patients with suicidal ideation, medicolegal administrative duties, system-based leadership, and quality improvement in the care of patients with mental health disorders.

In general, the patient who seeks emergency behavioral health treatment is seeking unscheduled care, which is markedly different than receiving care as an outpatient through routine, scheduled mental health care appointments. Science in the care of patients with severe agitation is almost uniquely applicable to the emergency department or an acute crisis center; research in the care of outpatient or intensive care unit patients with agitation is less generalizable to the challenges experienced in caring for this patient population in an emergency setting.

Prevention of suicide after discharge from the emergency department necessitates EBH physicians to work with high-risk patients with whom there is not an already established doctor-patient relationship. Therefore, outpatient studies with regard to suicide prevention do not always apply. Finally, there is great overlap in patients with substance use disorder also having a concomitant psychiatric disorder, such as depression.[4]

Patients who are experiencing either severe intoxication or withdrawal symptoms are referred to the emergency department. Physicians with recognized expertise in EBH will have the skills to treat such patients more effectively by managing their acute symptoms, evaluating any associated behavioral health component, and making a timely determination about the most effective, patient- and family-centered care plan. If inpatient psychiatric admission is warranted, these patients will be able to have symptoms related to SUD treated and appropriate behavioral health treatment initiated while pending available bed placement.

Body of Literature

There are three textbooks dedicated to the care of emergency behavioral health patients (Behavioral Emergencies for Healthcare Providers (2nd ed.) by Zun LS, Nordstrom K, Wilson MP (eds), Springer 2021, Emergency Psychiatry (2nd ed.) by Glick RL, Zeller SL, and Berlin JS, Wolters Kluwer 2020, and Primer on Emergency Psychiatry by Thrasher T, Oxford University Press 2023). 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 emergencies, 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:

- Academic Emergency Medicine
- American Journal of 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
- Journal of Crisis Intervention and Suicide Prevention
- Journal of Emergency Medicine
- Psychiatric Services
- Western Journal of Emergency Medicine

14. 6b - Explain how this proposed area of focused practice addresses a distinct and well-defined patient population and care need:

Focused practice in EBH 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. This need is further amplified in communities that have a paucity of available mental health care treatment options resulting in patients staying in emergency departments for prolonged periods of time, days and weeks, and even months, pending inpatient psychiatric care.

Today the number of patients with mental health disorders[5-7] and intentional ingestions[8] are rapidly increasing.[9-11] ED-based opioid use disorder treatment strategies have been identified as an urgent priority by patients, patient advocates, and researchers.[12] As many as 8% of ED patients now present to the ED after suicidal ideation or suicide attempt.[13] The number of patients and the acuity of symptoms therefore far outstrips the ability of outpatient community-based providers to provide sufficient care to patients with acute mental health treatment needs.

Notably, deaths from overdose[14] and suicide[15] are increasing faster in rural areas than more urban areas. In a recent survey, only 15% of EDs offered all safety planning elements to patients presenting after self-harm.[16] As many as 80% of patients are not offered buprenorphine despite the evidence supporting medication for opioid use disorder (MOUD) treatment.[17] An EBH focused practice could help provide better care for patients with emergency behavioral health disorders, especially in resource-poor communities.

The lack of access to care for pediatric patients needing acute care for mental health disorders is 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.[18] Most of these visits occur at non-children's EDs in both metropolitan and nonurban settings, which are less prepared to provide higher-level pediatric emergency care.[18]

15.
6ci - The current number of such physicians (along with the source(s) of the data):

As of March 2024, the American Association of Emergency Psychiatry (AAEP) reported 450 members, of whom, 225 are physicians who would likely 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.

The projected number of future diplomates is difficult to estimate. We anticipate there will be a moderately-sized initial group seeking an FPD that might then decline to 15-30 physicians each year. However, given the number of member organizations within the Coalition on Psychiatric Emergencies https://coalitiononpsychiatricemergencies.org representing thousands of physicians in the United States, there could be several hundred physicians who would likely apply for a focused practice designation if approved. To be clear, this FPD is a recognition based on a low-volume, high-need area of expertise that will have a substantial impact on emergency care in the United States.

16.

6cii - The annual rate of increase of such physicians in the past decade (along with the source(s) of the data):

The number of EBH fellowship graduates has been variable over the past five years. There are five recognized emergency behavioral health fellowships, each of which has had one fellow graduate in the last three to five years. The rate of change anticipated for diplomates who seek a focused practice designation in EBH can be expected to remain steady or likely increase once there is an opportunity for recognition of this expertise within the ABMS community. Over the past 15 years, the number of ABEM-certified physicians has steadily increased by 4 percent per year (there will be 50,000 ABEM-certified physicians by the end of 2025); the number of diplomates with EBH expertise, although unknown, has likely increased by a higher rate as well.

The American Association for Emergency Psychiatry has doubled its membership over the past 5 years, suggesting that the interest in behavioral emergencies is increasing rapidly. To date, it is estimated that approximately 225 physicians would seek recognition in EBH through this FPD if approved.

17.

6ciii - The current geographic distribution of this group of diplomates, its projected spread in the next five (5) years, and an explanation of how you arrived at this projection:

The geographic distribution of this group of diplomates is represented in all 50 states within the US. This estimate is provided by the Coalition of Psychiatric Emergencies, a collaboration of nine stakeholder organizations in the field of emergency behavioral health. The geographic distribution of diplomates is unknown. Moreover, given the projected small number of physicians who will receive this FPD, geographic saturation or meaningful distribution is not anticipated.

18. 6d - Identify the existing national societies that have a significant interest in the area of focused practice. Additionally, indicate the size and scope of the societies, 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.

The American Academy of Emergency Medicine (AAEM) is supportive of an FPD in EBH. AAEM represents 8,000 board-certified emergency physicians (ABEM and American Osteopathic Board of Emergency Medicine) 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.

The American College of Emergency Physicians (ACEP) has over 40,000 members and is incredibly supportive of recognition of EBH through a FPD. 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 is an 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.

The Coalition on Psychiatric Emergencies (CPE) is a coalition of leaders in emergency medicine, psychiatry, and patient advocacy who are focused on improving the treatment of psychiatric emergencies for patients and emergency providers. CPE is a coalition with nine 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. The member organizations of CPE represent thousands of physicians across the United States.

19. 6dii - Indicate the distribution of academic degrees held by their members, along with the source(s) of the data:

The vast majority of degrees held by emergency behavioral health physicians are doctor of medicine (M.D.). Additionally, the stakeholder professional societies as noted in Question 6d above have stated that degrees held by their members additionally include the following:

- Doctor of Osteopathy
- Doctor of Philosophy
- Master Business Administration
- Master of Public Health
- Master of Health Administration
- Master of Health Services Administration

20. 6diii - Indicate the relationship of the national societies' membership with the proposed focused practice designation:

ABEM has a collaborative relationship with the leadership of the national Emergency Behavioral Health societies. ABEM routinely holds discussions with the societies' leadership and will draw from nationally recognized physician leaders in EBH to develop an expert advisory panel as well as a non–Accreditation Council for Graduate Medical Education (ACGME)-approval body for the purpose of determining Board Eligibility for the Practice and Training requirements for this focused practice designation. ABEM has ongoing collaborative discussions about opportunities to recognize EBH expertise with the American Association for Emergency Psychiatry. There is significant interest in EBH from the Emergency Medicine resident community as career opportunity and a genuine desire to work to address the care of patients with mental health disorders in emergency departments.

21. 6div - Describe whether and how your Board has interacted with the key societies and stakeholders in developing this proposed designation:

ABEM formed a Task Force comprised of representatives from the American Board of Family Medicine, the American Board of Psychiatry and Neurology (ABPN), and ABEM to develop the Core Content and the eligibility criteria for a Focused Practice designation in EBH. The work of this Task Force was both generative and collaborative in nature. Moreover, the ABEM and the ABPN reached out to their respective professional societies to seek input on the development of the Core Content. ABEM has received 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.

22. 7a - Clinical Competence:

Emergency physicians with a focused practice in EBH will have additional expertise in caring for patients seeking acute, emergency treatment for their mental and behavioral health disorders that exceeds the level of competency expected for a residency-trained and ABEM-certified emergency physician. Moreover, these physicians will have more extensive knowledge in pharmacotherapy for behavioral health patients as well as expertise in navigating the complex administrative challenges experienced when caring for acutely ill patients seeking mental health treatment. Finally, they will have additional expertise for addressing the need for involuntary treatment and the legal requirements needed to get patients the care they need.

23. 7b - Scope of practice:

It is likely that the predominance of EBH practice would remain based in emergency departments across the country. The scope of practice for an emergency physician with a focused practice in EBH would be limited to her or his typical practice, including preferred practice setting(s), such as a mobile crisis unit, hospital-based emergency psychiatry unit, or community mental health crisis center. Those with the EBH designation might also 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.

EBH physicians will be experts at the timely delivery of care for emergency behavioral health patients pending inpatient psychiatric admission but without bed availability; these patients can wait weeks anticipating an appropriate psychiatric bed. During this time, it is critical to the well-being of the patients and their families to have sophisticated acute treatment beyond that of custodial care initiated and delivered throughout their boarding stay.[19] 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.

24. 7c - Body of knowledge and skills:

ABEM will require 12 months minimum of non-ACGME-accredited, ABEM-approved fellowship training for physicians seeking this focused practice designation after closure of the Practice Pathway and Practice-Plus-Training Pathway. If this FPD is approved, ABEM will develop EBH program requirements in collaboration with the ABPN and key stakeholders (e.g., EBH program directors, professional societies, and patient advocacy groups) that will serve as the basis for ABEM approval of EBH fellowships once the Practice-Only and Practice-plus-Training pathways have closed. This process is similar to that used by ABEM as the basis for FPD eligibility for graduates from Advanced Emergency Medicine Ultrasonography fellowships. Skills obtained upon successful completion of the fellowship will include those described in The Core Content of Emergency Behavioral Health (See Attachment 2: Core Content).

25. 8 - Is there any additional information you would like to provide to help the committee understand why this area is worthy of a Focused Practice designation?

Approval of an FPD in EBH would demonstrate to the house of medicine and to the public that the ABMS is addressing critical problems in the United States health care system. As demonstrated in the prior information, the challenge in proving better EBH care is an overt action that partially mitigates health care inequity. This FPD would help to improve timely access to EBH experts and thereby advance the highest standards of care in Emergency Medicine. Moreover, the FPD indirectly decreases the moral injury suffered by general emergency physicians who recognize that they are not able to provide the highest quality of emergency behavioral health care due to an overstressed and under resourced health care system.

26.

9a - Indicate whether there is any overlap between this area of focused practice and existing subspecialty certifications or other areas of focused practice.

The EBH knowledge acquired during a residency in Emergency Medicine, Psychiatry, or a fellowship in Consultation Liaison Psychiatry reflects only part of the knowledge and skills required for this focused practice since the ability to lead the care of a patient seeking emergency behavioral health care integrates elements from both fields (i.e., Emergency Medicine and Psychiatry) into one area of expertise. Moreover, many physicians who subspecialize in Consultation-Liaison Psychiatry choose to tailor their practice to the inpatient or outpatient setting due to the need for additional experiential knowledge in caring for patients in an emergency department setting. In summary, although there is a degree of overlap, it is not substantial.

27. 9b - Outline plans for evaluation of the impact of the proposed area of focused practice on your own programs of specialty and subspecialty certification and any other areas of focused practice:

ABEM will track the growth of diplomates seeking this designation on an annual basis, as it does for its primary and subspecialty certificates. ABEM maintains detailed records and publicly reports FPD and subspecialty numbers every year.

28. 9c - 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 (ABPN) supports this application and has actively participated in the Task Force that developed this application. The ABPN will also 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 the capacity of existing access to outpatient psychiatric care. Similarly, there will be no discernable impact on emergency physicians. Emergency physicians would welcome greater expertise in the time-constrained emergency department to address the needs of patients with behavioral health needs.

29.

9di - Access to care (please include your rationale):

A focused practice in EBH will increase access to care for emergency department patients seeking mental health treatment who routinely experience disparities of care based on insurance status, race, and age.[20-22] It would also decrease the number of boarded patients in the emergency department. The American College of Emergency Physicians (ACEP) defines a boarded patient as a patient who remains in the emergency department 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 under the age of 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 seven days in the emergency department) compared to Caucasian patients or those with private insurance (1 day).[20] It is anticipated that this health inequity would be attenuated by greater expertise in EBH and access to EBH care. Physicians with an FPD in EBH could make more efficient decisions about care as well as provide care with a greater therapeutic benefit.

30. 9dii - Quality and coordination of care (include your rationale):

EBH physicians will have greater experience with and knowledge about local community-based services. They will be in-house experts in system-based care. 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 accept at an inpatient (private or state-administered) psychiatric facility, crisis center, group home, or assisted living.[21] A focused practice in EBH will offer this group of patients high-quality care while boarding in the emergency department, including expertise in patient-centered cognitive therapy and pharmacotherapy as well as medicolegal and administrative acumen in navigating complex biopsychosocial systems-based challenges. In particular, the ethical and legal expertise for EBH is far more extensive that than expected for a general emergency physician and includes the ability to determine capacity, decision-making competency, risk stratification for discharge, guardianship, involuntary commitment, and knowledge regarding both civil and criminal liability in the care of the psychiatric patient in the emergency department. Moreover, EBH will help expedite discharge from the emergency department, when indicated.

31. 9diii - Benefits to the public (include your rationale):

An EBH focused practice is expected to 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. It is anticipated that by establishing more hospital-based (or emergency department–based) behavioral health units, patients will receive timelier, patient-centered care. These units will help to reduce the burden of overcrowding in emergency departments by patients pending definitive psychiatric care when there is no bed available. Decreasing boarding of behavioral health patients will free up emergency department beds to accept new, non-EBH patients and improve the timeliness of care for emergency department patients as a whole. Moreover, it is conceivable that expanding the availability of EBH expertise can help offset ED boarding by facilitating greater availability to EBH care mobile crisis units, walk-in centers, and crisis stabilization units.[23] The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies boarding of psychiatric patients in the emergency department as an indicator of insufficient capacity for the provision of mental health treatment.[24] 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 provide trauma-informed care more effectively to patients with mental health crises by establishing the knowledge, skills, and abilities that align this area of practice

between Emergency Medicine and Psychiatry.

32. 9ei - Immediate costs and their relationship to the probable benefits (indicate your methodology):

The cost of the required training is and would likely continue to be similar to the cost of a one-year subspecialty fellowship. It is not anticipated that the EBH fellowship costs would be greater than any other procedure-based subspecialty or focused practice training program. However, shorter lengths of stay in the emergency department for EBH patients will reduce the healthcare costs to society that would otherwise occur from prolonged stays in the emergency department, estimated at approximately $2200 per patient in 2012.[25] ED boarding impacts length of stay for all patients admitted through the ED and not just those admitted patients who are boarded.[26]

33. 9eii - Long-term costs and their relationship to the probable benefits (indicate your methodology):

It is likely that recognition of EBH expertise through a focused practice 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 decrease their ED boarding time and length of stay.[27]

34. 9f - Explain the effects if this area of focused practice is<u>not</u> approved:

The ABMS has an opportunity to make a material difference in the care of emergency behavioral health patients, albeit for a small group of patients. For those patients and their families who are living through a crisis in mental health care, this material difference cannot be overstated in its importance. Should this designation not be approved, EBH thought leaders would not have the deserved recognition for helping to advance the care of emergency behavioral health. In turn, this 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 choose to rely solely upon government-led or institution-led solutions to address the inhumane prolonged boarding of behavioral health patients in emergency departments. ABEM, the ABPN, and the ABMS community can take visible action to help move the house of medicine forward and improve emergency behavioral health treatment for those in their greatest hour of need.

3. Eligibility and Assessment

35.

10a - Describe how the eligibility criteria for the designation are consistent with the ABMS criteria for Focused Practice Criteria:

ABMS FPD Purpose

The ABMS requires that the FPD "…recognizes areas of practice within existing specialties and subspecialties that either evolve as diplomates progress throughout their professional careers or emergency as medicine changes due to advances in medical knowledge….are more limited in scope than those covered by subspecialty designation." (ABMS Focused Practice Designation) The EBH FPD recognizes an area of Emergency Medicine that has evolved as the number and acuity of patients seeking acute care for mental health needs has risen. The complexity of their care has similarly evolved that has resulted in the need for more nuanced expertise within Emergency Medicine to help ensure high quality of emergency behavioral health care.

ABMS FPD Eligibility

The ABMS requires that physicians must "hold an active specialty/subspecialty certification; meet continuing certification requirements; and, [demonstrate] expertise gained through clinical experience, which may include formal training." The eligibility criteria were developed by a Task Force comprised of subject matter expert representatives from Emergency Medicine and Psychiatry. The EBH FPD will be awarded to physicians who are either ABEM-certified or certified in Psychiatry by the American Board of Psychiatry and Neurology (ABPN); primary certification will be required to be maintained. Moreover, physicians will be required to meet continuing certification requirements in EBH to maintain an active FPD.

The ABMS requires "expertise gained through clinical experience which may include formal training." A minimum of twelve months of ABEM-approved EBH fellowship training will be required for eligibility once the Practice Pathway has closed. Prior to

closure of the Practice pathway, however, dedicated EBH clinical experience will be required for purposes of board eligibility. Requiring fellowship training is an approach to the FPD clinical experience for which ABEM has already embraced its FPD in Advanced Emergency Medicine Ultrasonography.
Also consonant with FPD criteria, that training is not ACGME-accredited.

ABMS Member Board Assessment
The ABMS requires a "Member Board-based assessment." ABEM will require a Board-based assessment in the form of a portfolio review. Subject matter experts from both the ABEM and the ABPN will comprise an advisory panel that will review applicants' portfolios to ensure that the physician is qualified to receive the FPD.

36.
10b - What specialty and/or subspecialty certificate(s) will a diplomate be required to hold and maintain in order to be eligible for this area of focused practice? (Note – appears only if multiple Boards are requesting, fill in information common to all applicant Member Boards, for information specific to your specialty, please use the addendum form)

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

37. 10c - Clinical practice experience (both in terms of time and patient volume) in the area of focused practice, beyond initial training: (Note – appears only if multiple Boards are requesting, fill in information common to all applicant Member Boards, for information specific to your specialty, please use the addendum form)

Please refer to the following eligibility criteria, which were approved by the ABEM Board of Directors for an FPD in EBH (See Attachment 3: EBH Eligibility Criteria). There are three eligibility pathways by which an interested emergency physician or psychiatrist could seek the FPD. Also note that in the following criteria, the time devoted to EBH practice can be as low as 0.25. This level is because ABEM-certified physicians who have a subspecialty certificate of FPD tend to continue to work substantially in the ED. Moreover, the active exposure of patients with behavioral health issues is robust in the routine practice of Emergency Medicine.

Training Pathway
The Training Pathway requires that physicians successfully complete an ABEM-approved EBH fellowship program, once established, that is a minimum of one year. For physicians who apply through the Training Pathway, 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
The Training-Plus-Practice Pathway will end on December 31 of the calendar year, seven years after the first ABEM-approved program is established. To apply for the FPD through the Training-Plus-Practice Pathway, a physician must meet all of the following criteria:

• 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 seven 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 emergency behavioral health patients. Additionally, of those designated 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

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 emergency behavioral health 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 emergency behavioral health patients

through one or more of the following areas:
• Direct Emergency Behavioral Health Patient Care
o Provision of direct emergency behavioral health care in the physician's practice of sufficient rigor (e.g., emergency department, psychiatry, community mental health, etc.). An additional narrative explanation of such care may be required.
• Education
o Responsible for leading educational initiatives on emergency behavioral health to emergency physicians, psychiatrists, residents/fellows, and health systems (e.g., faculty, department or system liaison, or representative).
• Talent management
o 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.
• Fiscal management
o Oversight and management of billing and coding, reimbursement, and financing for behavioral health treatment.
o 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 the Joint Commission, SAMHSA, etc.
• Care coordination
o 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.)
o 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

*ABEM will require verification of EBH experience, including time spent providing direct emergency behavioral health care, by an individual who served as a direct supervisor to the position/role during the same time as the experience occurred (e.g., Department Chair/Chief, Chief Medical Officer, Vice-President Medical Affairs). ABEM reserves the right to request a copy of a job description, organizational chart, and/or CV/resume to provide clarifying information for any application.

Practice-Only Pathway
The Practice-Only Pathway will end on December 31 of the calendar year, seven 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 seven 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. Additionally, of that designated 36 months, a minimum of 0.25 FTE of the physician's time is/was devoted to the care of emergency behavioral health patients.** The 36 months do not need to be contiguous.

Acceptable EBH Practice Experience and Responsibilities for the Practice-Only Pathway

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. 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 behavioral health patients through one or more of the following areas:

- Direct emergency behavioral health patient care
  - Provision of direct emergency behavioral health care in the physician's practice of sufficient rigor (e.g., emergency department, psychiatry, community mental health, etc.). An additional narrative explanation of such care may be required.
- Education
  - Responsible for leading educational initiatives on emergency behavioral health to emergency physicians, psychiatrists, 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.
- 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 the 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

**ABEM will require verification of EBH experience, including time spent providing direct emergency behavioral health care, by an individual who served as a direct supervisor to the position/role during the same time as the experience occurred (e.g.,

Department Chair/Chief, Chief Medical Officer, Vice-President Medical Affairs). ABEM reserves the right to request a copy of a job description, organizational chart, and/or CV/resume to provide clarifying information for any application.

38. 10ci - How will your board establish that candidates are meeting the experience requirement?

ABEM will require verification of EBH experience, including time spent providing direct emergency behavioral health care, by an individual who serves or served as a direct supervisor to the position or role during the same time as the experience occurred (e.g., Department Chair or Chief, Chief Medical Officer, Vice President Medical Affairs, etc.).

39.
10d - Additional Qualifications (if any):

Diplomates must fulfill the ABEM Policy on Medical Licensure and Code of Professionalism. Diplomates must be current in ABEM continuing certification requirements. To be eligible to apply, ABEM diplomates must also be current in their continuing certification requirements.

40. 11 - With regard to Board-based assessment for candidates prior to awarding this focused practice designation, which assessment methods will be required? (Check all that apply) (Note – appears only if multiple Boards are requesting, fill in information common to all applicant Member Boards, for information specific to your specialty, please use the addendum form)

Other (please specify): Portfolio, Expert Review, Verification

41. 11a - Describe the rationale behind the method(s) required in the assessment process:

The stringent eligibility criteria allow only those diplomates who have demonstrated expertise in EBH to submit their portfolios for consideration by subject matter experts. Without already having obtained this broad-based, multi-specialty knowledge in EBH, it is unlikely that the physician would be able to meet the eligibility requirements with regard to a number of emergency behavioral health patients and the complexity of diagnoses needed to have their portfolio approved that could lead to a FPD in EBH.

1) Portfolio: Given the anticipated small number of candidates for this focused practice designation, ABEM will use a portfolio review, not a traditional multiple-choice question examination. The validity construct in [28] is used to describe the validity evidence supporting this approach. There would be so few test takers each administration (maybe 20 physicians/year at a steady state) that a traditional multiple-choice item exam would be unreliable and have restricted validity evidence; specifically, validity evidence for: 1) internal structure (including reliability); and 2) relations to other variables (the ability to determine associations to other measures). ABEM proposes a critical review of a clinical portfolio that would emphasize two areas: 1) density of clinical experience as reflected in the number of patients (and particular types of patients/conditions) seen in clinical practice; and 2) span of clinical experience as reflected in the types of patients seen. Numeric criteria are being developed at this time, such as: "making 50 or more consequential determinations as a patient's suicide risk." Another example would be completing the process (including forms/paperwork) to have a patient involuntarily committed to inpatient psychiatric or behavioral care. Data for pediatric patients will also be included. The validity evidence for this evaluation approach satisfies content and construct validity approaches as well as Kane's validity model of assessment results would be used both in determining how to make a summative decision as well as how the resulting credential will be used.

2) Expert Review: Once a portfolio is submitted, it will be screened to ensure that quantitative criteria are met. if this screening is satisfied, then the portfolio will undergo a subject matter expert (SME) review. The SMEs will include representation by ABEM- and ABPN-certified physicians appointed by each Member Board. If the threshold for density of care, span of experience, and quality of care (met prevailing medical standards of treatment), the physician will be awarded a focused practice designation in EBH.

3) Verification: ABEM will verify submitted data for at least 1 of every 10 submissions (or more as needed) in the first year of application review. If verifications demonstrate no (or nearly no) irregularities in reporting submitted data, then verifications will drop to 1 of every 20 submissions. In addition, ABEM reserves the right to request and review de-identified EBH case logs, either as part of a random audit or as needed. Of note, ABEM currently has a strict data verification process that reviews at least 5% of thousands of attestations for Improvement in Medical Practice for Emergency Medicine continuing certification. A parallel process will be used for EBH.

4. Implementation and Approval Process

42. 12 - Outline the Continuing Certification (CC) program planned for this focused practice designation. Include how the CC program will relate to CC requirements for your diplomates' underlying certificate(s). Will the diplomate be required to pass multiple assessments in order to maintain both the underlying certificate and the designation?

The "MyEBHCert" program (name to be determined) will be a continuing certification process for the focused practice designation in EBH. Physicians who hold the FPD will be required to maintain their primary ABEM certification in Emergency Medicine. Also, physicians must maintain medical licensure in compliance with the ABEM Policy on Medical Licensure. The physician must also attest to ABEM's Code of Professionalism. The requirements for continuing certification for the EBH-focused practice designation will mirror those of ABEM's other focused practice designation in Advanced Emergency Medicine Ultrasonography as well as its subspecialties in Emergency Medical Services, Medical Toxicology, and the recently approved Health Care Administration, Leadership, and Management.

MyEBHCert will have a formative emphasis that optimizes learning opportunities to be consistent with the approach for all ABEM continuing certification processes. The FPD will have a five-year cycle length. ABEM will require three EBH activities or modules every five years. All activities or modules will need to be completed in the five-year period. Where there is the opportunity for reciprocity with some component of continuing certification for primary certification in Emergency Medicine, this will be provided.

Activities could include five to eight "resources" that could include review articles, web-based lectures, podcasts, presentations, etc., on which a multiple-choice question summative assessment will be based with likely 20-25 items. The activity or module will be open-book; however, the physician must complete it alone and will be provided three opportunities to pass.

Physicians who hold the FPD will also be required to attest that they are continuing in the practice of emergency behavioral health.

43. 12a - If your Board is planning to accept multiple options for assessment of knowledge, judgment, and skills for the designation, describe each:

N/A

44. 12b - How will your board monitor that diplomates continue to practice in the area of practice?

The cycle length for the FPD in EBH will be five years. At the end of the five-year cycle, ABEM will require re-verification of ongoing EBH practice experience to meet continuing certification requirements. This verification will be sought from the physician's direct supervisor to their EBH position or role (e.g., Department Chair or Chief, Chief Medical Officer, Vice President Medical Affairs, etc.). This process mirrors a process for continuing certification requirements for ABEM's other FPD in Advanced Emergency Medicine Ultrasonography.

45. 13 - Indicate how the proposed area of focused practice will be evaluated periodically (e.g., every five years) to assure that the area of focused practice remains viable:

ABEM monitors its certification statistics closely on an annual basis. ABEM would include a designation of Focused Practice in EBH in this data analysis to ensure that a need for such recognition continues to exist and to track further dissemination of EBH expertise into EM.

46. 14 - Provide an anticipated timeline for when your Board will assess candidates and when your Board will begin issuing this designation.

If COCERT were to approve this application and it were to be ratified at the February 2025 ABMS Board of Directors meeting, ABEM estimates that it would begin issuing this designation in EBH in the fall of 2026.

47. 15 - 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
Academy of Consult Liaison Psychiatry
American Academy of Emergency Medicine
American Academy of Emergency Medicine-Resident Student Association
American Association for Community Psychiatry
American Association of Directors of Psychiatric Resident Training
American Association for Emergency Psychiatry
American College of Emergency Physicians
Coalition on Psychiatric Emergencies
Council of Residency Directors in Emergency Medicine
Emergency Medicine Residents' Association
National Alliance on Mental Illness
Society for Academic Emergency Medicine

48.

16a - 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/

There are five trainee positions available currently (data provided by each of the above EBH fellowship directors). This number is expected to increase if this focused practice designation is approved. The establishment of fellowship training will be facilitated with the availability of a defined Core Content to use as the basis for an educational curriculum. As the practice track is time-limited, it is expected that the number of programs will increase in anticipation of that closure. As with the Emergency Ultrasound FPD fellowship programs, ABEM will establish a process to formally accredit these fellowship training programs, and as a result, will increase their visibility.

49.

16b - Indicate the total number of trainee positions available currently (along with the source(s) of the data):

There are five trainee positions available currently (data provided by each of the above EBH fellowship directors). This number is expected to increase (modestly at best) if this focused practice is approved. The establishment of fellowship training will be facilitated with the availability of a defined Core Content to use as the basis for an educational curriculum as well as formal recognition for such expertise within the ABMS community following successful completion of training.

50. 16c - Provide the number of trainees completing the training annually (along with the source(s) of the data):

There have been 6 trainees who completed the fellowship training since 2019 (data provided by each EBH fellowship director).

51. 16d - Organization(s) providing accreditation or oversight for training programs (Please submit evidence that they have the willingness, capability, and resources to conduct the review of these programs):

ABEM will work with thought leaders and experts in EBH to establish a process for accrediting EBH fellowships (referred to as "ABEM approved" throughout this document, including the eligibility criteria). This process will likely mirror, albeit on a smaller scale, the accreditation process used for Advanced Emergency Medicine Ultrasonography Fellowships or EUFAC, an independent accrediting body to whom ABEM delegated authority to make accreditation decisions for purposes of eligibility for a focused practice designation in Advanced Emergency Medicine Ultrasonography.

52. 17 - How much additional clinical experience is required beyond training?

Required clinical experience is similar to that for some ABEM subspecialties and is noted in the attached Eligibility Criteria. In summary, the physician must demonstrate that she or he holds or previously held a position for a minimum of 24 months (Practice-Plus-Training Pathway) or 36 months (Practice-only Pathway) that provides or provided direct care or supervision of the care of emergency behavioral health 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 emergency behavioral health patients through one or more of the following areas: direct emergency behavioral health patient care; education; talent management; fiscal management; regulatory oversight, or care coordination.

53. 18 - Additional Materials: If your boards has additional documentation that you wish to include with your application you may upload it here.

EBH_Application_Attachments_(1._Core_Content 2._Eligibility_Criteria_3._References).pdf

54. Copy of proposed application form for the candidates for this focused practice designation

EBH__Physician_Application_Example.pdf

55.
A written statement indicating concurrence or specific grounds for objection from each Primary and Conjoint Board having expressed related interests in the same field

American_Board_of_Psychiatry_and_Neurology_ABPN_Letter_of_Support_EBH.pdf

56.
Written comments on the proposed area of focused practice from at least one (1) public stakeholder group

Stakeholder_Letters_of_Support_(12).pdf

57. An example of how diplomates will be recognized for this focused practice designation (both for the diplomate's own record, and for credentialers and the public).
The acknowledgment that a diplomate has received a focused practice designation may be in the form of a letter or an email, or a notation on a diplomate's online public record.

EBH_Certificate_Example.pdf

5. Review

58. My Board's senior leadership has reviewed and approved these responses

Yes

Emergency Behavioral Health
Core Content

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

*Excerpts from Zun et al., Behavioral Emergencies for Healthcare Providers 2nd edition, Glick et al., Emergency Psychiatry Principles and Practice 2nd edition, and The Model of Clinical Emergency Medicine Practice

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)

*Excerpts from Zun et al., Behavioral Emergencies for Healthcare Providers 2nd edition, Glick et al., Emergency Psychiatry Principles and Practice 2nd edition, and The Model of Clinical Emergency Medicine Practice

        - 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

*Excerpts from Zun et al., Behavioral Emergencies for Healthcare Providers 2nd edition, Glick et al., Emergency Psychiatry Principles and Practice 2nd edition, and The Model of Clinical Emergency Medicine Practice

Screening, Brief Intervention, and Referral to Treatment (SBIRT)
Peer support/peer recovery (Cross Reference Domain # 1 and 10)

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

*Excerpts from Zun et al., Behavioral Emergencies for Healthcare Providers 2nd edition, Glick et al., Emergency Psychiatry Principles and Practice 2nd edition, and The Model of Clinical Emergency Medicine Practice

- 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

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

*Excerpts from Zun et al., Behavioral Emergencies for Healthcare Providers 2nd edition, Glick et al., Emergency Psychiatry Principles and Practice 2nd edition, and The Model of Clinical Emergency Medicine Practice

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

*Excerpts from Zun et al., Behavioral Emergencies for Healthcare Providers 2nd edition, Glick et al., Emergency Psychiatry Principles and Practice 2nd edition, and The Model of Clinical Emergency Medicine Practice

- 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

*Excerpts from Zun et al., Behavioral Emergencies for Healthcare Providers 2nd edition, Glick et al., Emergency Psychiatry Principles and Practice 2nd edition, and The Model of Clinical Emergency Medicine Practice

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 certified in Psychiatry by the American Board of Psychiatry and Neurology (ABPN) and considered to be in good standing by each Board
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, <YEAR>. Specifically, all eligibility requirements must be completed, and all applications received no later than December 31, <YEAR>.

ELIGIBILITY CRITERIA

Training Pathway

The Training Pathway requires that physicians successfully complete an <ABEM-approved> EBH fellowship program, once established, that is a minimum of one year. For physicians who apply through the Training Pathway, 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

The Training-Plus-Practice Pathway will end on December 31, <YEAR>, seven years after the first ABEM-approved program is established. To apply for the FPD through the Training-Plus-Practice Pathway, a physician must meet all of the following criteria:

- 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 seven 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 emergency behavioral health patients. Additionally, of those designated 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

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 emergency behavioral health 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 emergency behavioral health patients through one or more of the following areas:

- **Direct Emergency Behavioral Health Patient Care**
  - Provision of direct emergency behavioral health care in the physician's practice of sufficient rigor (e.g., emergency department, psychiatry, community mental health, etc.). An additional narrative explanation of such care may be required.
- **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.
- **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

***ABEM will require verification of EBH experience, including time spent providing direct emergency behavioral health care, by an individual who served as a direct supervisor to the position/role during the same time as the experience occurred (e.g., Department Chair/Chief, Chief Medical Officer, Vice-President Medical Affairs). ABEM reserves the right to request a copy of a job description, organizational chart, and/or CV/resume to provide clarifying information for any application.*

Practice-Only Pathway

The Practice-Only Pathway will end December 31, <YEAR>, seven 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 seven 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. Additionally, of that designated 36 months, a minimum of 0.25 FTE of the physician's time is/was devoted to the care of emergency behavioral health patients.* The 36 months do not need to be contiguous.

**Acceptable EBH Practice Experience and Responsibilities for the Practice-Only Pathway*

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. 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 behavioral health

patients through one or more of the following areas:

- **Direct emergency behavioral health patient care**
  - Provision of direct emergency behavioral health care in the physician's practice of sufficient rigor (e.g., emergency department, psychiatry, community mental health, etc.). An additional narrative explanation of such care may be required.
- **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.
- **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

***ABEM will require verification of EBH experience, including time spent providing direct emergency behavioral health care, by an individual who served as a direct supervisor to the position/role during the same time as the experience occurred (e.g., Department Chair/Chief, Chief Medical Officer, Vice-President Medical Affairs). ABEM reserves the right to request a copy of a job description, organizational chart, and/or CV/resume to provide clarifying information for any application.*

REFERENCES

1. Kim I, Bukhman AK, Chen PC, et al. Psychiatric care in the emergency department: Converting boarding time to treatment time. Academic Emergency Medicine. 2022;29(12):1512-1514. doi:10.1111/acem.14586

2. Costumbrado J, Nikroo N, Ge S, Guldner G. Emergency department psychiatric holds are linked to increased emergency department violence. Ethics, Medicine and Public Health. 2022;20:100731. doi:10.1016/j.jemep.2021.100731

3. Major D, Rittenbach K, MacMaster F, Walia H, VandenBerg SD. Exploring the experience of boarded psychiatric patients in adult emergency departments. BMC Psychiatry. 2021;21(1). doi:10.1186/s12888-021-03446-1

4. Saha S, Lim CC, Degenhardt L, et al. Comorbidity between mood and substance-related disorders: A systematic review and meta-analysis. Aust N Z J Psychiatry. 2021;56(7):757-7. 70. doi:10.1177/00048674211054740

5. Pandya A, Larkin GL, Randles R, Beautrais AL, Smith RP. Epidemiological trends in psychosis-related Emergency Department visits in the United States, 1992–2001. Schizophrenia Research. 2009;110(1-3):28-32. doi:10.1016/j.schres.2008.12.015

6. Larkin GL, Claassen CA, Emond JA, Pelletier AJ, Camargo CA. Trends in U.S. Emergency Department Visits for Mental Health Conditions, 1992 to 2001. PS. 2005;56(6):671-677. doi:10.1176/appi.ps.56.6.671

7. Wilson M, Shenvi C, Rives L, Nordstrom K, Schneider S, Gerardi M. Opportunities for Research in Mental Health Emergencies: Executive Summary and Methodology. WestJEM. 2019;20(2):380-385. doi:10.5811/westjem.2019.1.39260

8. Rudd RA, Aleshire N, Zibbell JE, Gladden RM. Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014. MMWR Morb Mortal Wkly Rep. 2016;64(50-51):1378-1382. doi:10.15585/mmwr.mm6450a3

9. Alexander GC, Stoller KB, Haffajee RL, Saloner B. An Epidemic in the Midst of a Pandemic: Opioid Use Disorder and COVID-19. Annals of Internal Medicine. 2020;173(1):57-58. doi:10.7326/m20-1141

10. Czeisler MÉ, Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep. 2020;69(32):1049-1057. doi:10.15585/mmwr.mm6932a1

11. Friedman J, Beletsky L, Schriger DL. Overdose-Related Cardiac Arrests Observed by Emergency Medical Services During the US COVID-19 Epidemic. JAMA Psychiatry. 2021;78(5):562. doi:10.1001/jamapsychiatry.2020.4218

12. 1Hawk K, Glick R, Jey A, et al. Emergency Medicine Research Priorities for Early Intervention for Substance Use Disorders. WestJEM. 2019;20(2):386-392. doi:10.5811/westjem.2019.1.39261

13. Gentil L, Huỳnh C, Grenier G, Fleury MJ. Predictors of emergency department visits for suicidal ideation and suicide attempt. Psychiatry Research. 2020;285:112805. doi:10.1016/j.psychres.2020.112805

14. Centers for Disease Control and Prevention. Updated April 21, 2023. Accessed February 3, 2023. https://www.cdc.gov/ruralhealth/drug-overdose/index.html

15. Centers for Disease Control and Prevention. Updated April 21, 2023. Accessed February 3, 2023. https://www.cdc.gov/ruralhealth/Suicide.html

16. Bridge JA, Olfson M, Caterino JM, et al. Emergency Department Management of Deliberate Self-harm. JAMA Psychiatry. 2019;76(6):652. doi:10.1001/jamapsychiatry.2019.0063

17. Hawk KF, D'Onofrio G, Chawarski MC, et al. Barriers and Facilitators to Clinician Readiness to Provide Emergency Department–Initiated Buprenorphine. JAMA Netw Open. 2020;3(5):e204561. doi:10.1001/jamanetworkopen.2020.4561

18. Lo CB, Bridge JA, Shi J, Ludwig L, Stanley RM. Children's Mental Health Emergency Department Visits: 2007–2016. Pediatrics. 2020;145(6). doi:10.1542/peds.2019-1536

19. Kim I, Bukhman AK, Chen PC, et al. Psychiatric care in the emergency department: Converting boarding time to treatment time. Academic Emergency Medicine. 2022;29(12):1512-1514. doi:10.1111/acem.14586

20. Pearlmutter MD, Dwyer KH, Burke LG, Rathlev N, Maranda L, Volturo G. Analysis of Emergency Department Length of Stay for Mental Health Patients at Ten Massachusetts Emergency Departments. Annals of Emergency Medicine. 2017;70(2):193-202.e16. doi:10.1016/j.annemergmed

21. Kraft CM, Morea P, Teresi B, et al. Characteristics, clinical care, and disposition barriers for mental health patients boarding in the emergency department. The American Journal of Emergency Medicine. 2021;46:550-555. doi:10.1016/j.ajem

22. Yoon J, Bui LN, Govier DJ, et al. Determinants of Boarding of Patients with Severe Mental Illness in Hospital Emergency Departments. The Journal of Mental Health Policy and Economics. 2020;23(2): 61–75.

23. Nordstrom K, Berlin J, Nash S, Shah S, Schmelzer N, Worley L. Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document. WestJEM. 2019;20(5):690-695. doi:10.5811/westjem.2019.6.42422

24. Substance Abuse and Mental Health Services Administration. National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. Accessed May 10, 2024. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

25. Nicks BA, Manthey DM. The Impact of Psychiatric Patient Boarding in Emergency Departments. Emergency Medicine International. 2012;2012:1-5. doi:10.1155/2012/360308

26. Laam LA, Wary AA, Strony RS, Fitzpatrick MH, Kraus CK. Quantifying the impact of patient boarding on emergency department length of stay: All admitted patients are negatively affected by boarding. JACEP Open. 2021;2(2). doi:10.1002/emp2.12401

27. Foster AA, Sundberg M, Williams DN, Li J. Emergency department staff perceptions about the care of children with mental health conditions. General Hospital Psychiatry. 2021;73:78-83. doi:10.1016/j.genhosppsych.2021.10.002

28. Bandalos DL. *Measurement Theory and Applications for the Social Sciences*. New York, The Guilford Press; 2018: 268.

Emergency Behavioral Health

ABEM Application for FPD in Emergency Behavioral Health

Please fill out all the required fields.

At any time throughout the application you may save your work and come back to it later.

HOWEVER, the form only saves the last completed page. Please complete the entire page and click 'next' before clicking 'Save and Resume Later'.

Name*

First Name | Middle Name (optional) | Last Name | Suffix (optional)

Medical Degree*

M.D.

Address*

Address Line 1

Address Line 2

City | State | ZIP Code

United States

Country

Preferred Phone*

Preferred Email*

Date of Birth*

MMMM DD, YYYY

NPI Number*

Last 4 digits of SSN or Government ID Number*

Medical School Graduation Year*

Medical Licensure Attestation

View the ABEM Policy on Medical Licensure .

Clarification of Licenses That Are Not "Current, Active, Valid, Full, Unrestricted and Unqualified"

A medical license is not considered "current, active, valid, full, unrestricted, and unqualified" if, in any manner or to any extent whatsoever, the license is encumbered. Examples of a medical license that does not fulfill the requirements of this Policy include, but are not limited to, one that is:

- Under probation
- Conditioned, e.g., the physician is required to practice under supervision or with modification, or to obtain continuing education
- Suspended for any duration
- Limited, e.g., to specific practice settings
- Inactive as a result of an action taken by or a request made by a medical licensing board
- Institutional, educational, or temporary

ABEM may consider additional factors beyond licensure when determining a physician's compliance with the ABEM Policy on Medical Licensure including, but not limited to:

- Felony convictions
- DEA restrictions
- Medicaid / Medicare exclusions

No License

A physician who has no current, active, valid, full, unrestricted, and unqualified license to practice medicine does not meet the requirements for medical licensure and may not appeal this policy.

Reporting Medical Licensure Information to the Board

If the physician does not report the required information to ABEM, upon investigation, the Board may impose sanctions it determines appropriate, including but not limited to, barring the physician from taking ABEM examinations, invalidating examinations the physician took, and revoking the physician's certification.

Each and every medical license issued to me is valid, unrestricted, unqualified, and without any limitations.*

○ Yes ○ No

I have continuously held at least one current, active, valid, full, unrestricted, and unqualified license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada, and in each jurisdiction where I practice.*

○ Yes ○ No

I will report to the American Board of Emergency Medicine any of my licenses that have the following conditions:

- **The license is inactive, whether voluntarily or involuntarily.The license is invalid, restricted, or qualified.**
- **The license was encumbered when it expired and it expired on or after January 1, 2004.**
- **The license was revoked or suspended on or after January 1, 2004.**
- **The physician surrendered or did not renew the license on or after January 1, 2004 as a result of or in order to terminate or settle disciplinary proceedings.**

I agree to report to the American Board of Emergency Medicine if any of my licenses have any of the conditions outlined above.*

○ Yes ○ No

ABEM's Code of Professionalism

Code of Professionalism

BACKGROUND

The American Board of Emergency Medicine (ABEM) believes that patients are entitled to quality emergency care delivered in a professional manner. Therefore, ABEM has adopted the following Code of Professionalism.

POLICY

ABEM certification requirements for professionalism includes an ethical requirement to:

- Treat patients in a safe and fair manner.
- Mitigate both implicit or explicit biases based on race, gender, age, sexual orientation, disability, national origin, or religion when providing patient care.
- Demonstrate compassion, integrity, and respect for patients, families, and other members of the health care team in all types of interactions.
- Respect patient privacy and autonomy.
- Be accountable to patients and peers.
- Refrain from conduct that the Board determines, in its sole judgment, to be sufficiently egregious that it is inconsistent with ethical behavior by a physician.

The ABEM Code of Professionalism requires ABEM board eligible– and -certified physicians to adhere to this construct.

ABEM -certified physicians and candidates for certification are required to report:

- Any potential breach of this Code as well as any alteration in the status of a state or federal medical or drug license or encumbrance on a license.
- Surrendering any state medical license to avoid action by a state medical licensing board.
- A felony conviction or federal indictment.
- Any restriction on a DEA license.
- Any exclusion from participating in Medicaid or Medicare.
- Any sanction or disciplinary action by a medical board.
- Any involuntary revocation of staff privileges.

ABEM board eligible– and -certified physicians who do not report will be subject to review under ABEM's disciplinary action process.

ABEM board eligible– and -certified physicians may not:

- Have any state medical license with an encumbrance. Each and every license held by the physician must be unencumbered irrespective of the state in which the physician practices.
- Provide false, misleading, or untruthful information on an application for certification or any other ABEM-requested information.
- Inaccurately represent one's certification status.
- Use ABEM eligibility or certification to advertise board certification credentials for clinical practice areas that are outside the scope of practice for Emergency Medicine as defined by The Model of the Clinical Practice of Emergency Medicine.
- Share the content of any ABEM written or Oral Examination. Verbal or written reproduction of test material is strictly prohibited. The material is copywritten and sharing the information may be a federal offense.
- Cheat on any ABEM examination.
- Obstruct an ABEM investigation into conduct.

ABEM board eligible– and -certified physicians who engage in these actions will be subject to review under ABEM's disciplinary action process.

Conduct that is prohibited by this Code shall be reviewed by the ABEM Board of Directors and may result in decertification or loss of eligibility for certification.

EXCEPTION

ABEM maintains an appeal process for physicians who are found to not fulfill the requirements described in the Code of Professionalism.

Do you agree to abide by ABEM's Code of Professionalism policy?*

Enter your American Board of Medical Specialties (ABMS) certification below.

ABMS Board*

Certification expiration date/reverification date*

MMMM DD, YYYY

I am up to date on the continuing certification requirements of my certifying Board.*

○ Yes ○ No

Save and Resume Later

Previous

Next

Application Pathway

Review the EBH Eligibility Criteria and select your appropriate application type:*

- ○ Training Pathway
- ○ Training-Plus-Practice Pathway
- ○ Practice Pathway

EBH Eligibility Criteria

Save and Resume Later

Previous

Next

Training Pathway

Name and Institution of Emergency Behavioral Health Fellowship Training Program*

If your program is not listed, please choose the Training-Plus- Practice applications type.

Name of Program Director*

First Name

Last Name

Program Director Phone Number

Program Director Email*

Training Start Date*

MMMM DD, YYYY

Training End Date*

MMMM DD, YYYY

ABEM policy states that training used to fulfill the eligibility criteria of one specialty or subspecialty may not also be used to fulfill the criteria of another specialty or subspecialty. Has the fellowship training listed in this application been used to fulfill the criteria of another specialty or subspecialty?*

○ Yes ○ No

AAEP-Approved Fellowship

Name and Institution of Emergency Behavioral Health Fellowship Training Program*

Name of Program Director*

First Name

Last Name

Program Director Phone Number

Program Director Email*

Training Start Date*

MMMM DD, YYYY

Training End Date*

MMMM DD, YYYY

ABEM policy states that training used to fulfill the eligibility criteria of one specialty or subspecialty may not also be used to fulfill the criteria of another specialty or subspecialty. Has the fellowship training listed in this application been used to fulfill the criteria of another specialty or subspecialty?*

○ Yes ○ No

Practice 1 Information

Practice 1 Institution Name*

Practice 1 Institution Address*

City

State

Practice 1 Start Date*

MMMM DD, YYYY

Practice 1 End Date*

MMMM DD, YYYY

Practice 1 Title Held*

Practice Description*

Describe duties related to the direct care or supervision of the care of emergency behavioral health patients.

ABEM requires independent verification of the information provided in this application. The verifier provided should be an individual who served as a direct supervisor to the position/role during the same time as the experience occurred.

Practice 1: Verifier Name*

First Name

Last Name

Practice 1: Verifier Title*

Practice 1: Verifier Email*

Practice 1: Verifier Phone

For Practice 1: I attest that 25% of my time is/was devoted to the care of behavioral health patients.*

○ Yes ○ No

Need to add a second practice location?*

○ Yes ○ No

Application Agreement

I attest that the information I have provided on this form is correct, to the best of my knowledge. I authorize any licensing boards, other persons, and organizations to furnish any information requested by ABEM on the status of my medical license(s).*

- (●) Yes
- ( ) No

Payment

I attest I have read the EBH Eligibility criteria, and I understand my application fee is not refundable.*

- ( ) Yes
- ( ) No

Please submit payment for your EBH application via the ABEM Payment Portal

The DM application fee of $470.00 is due when you submit your application. Your application will not be reviewed until payment is received.

Application fees are not refundable. Please review the EBH Eligibility Criteria before submitting your payment and application.

American Board of Psychiatry and Neurology, Inc.

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

Executive Committee 2024

Board Chair
Steven L. Lewis, M.D. *(January–June)*
Nina F. Schor, M.D., Ph.D. *(July–December)*

Board Vice Chair
Christopher R. Thomas, M.D.

Board Secretary
Josepha A. Cheong, M.D.

Board Treasurer
Jaffar Khan, M.D.

Board Member-at-Large
Imran I. Ali, M.D.

Board Member-at-Large
Robert J. Boland, M.D.

Directors for Psychiatry

Christopher R. Thomas, M.D
Chair, Psychiatry Council
Galveston, TX

Iqbal "Ike" Ahmed, MD
Kailua, HI

Sheldon Benjamin, M.D.
Worcester, MA

Robert J. Boland, M.D.
Houston, TX

Josepha A. Cheong, M.D.
Gainesville, FL

Sandra M. DeJong, M.D.
Cambridge, MA

David C. Henderson, M.D.
Boston, MA

Andrea G. Stolar, M.D.
Houston, TX

Directors for Neurology

Steven L. Lewis, M.D.
Chair, Neurology Council *(January–June)*
Allentown, PA

Nina F. Schor, M.D., Ph.D.
Chair, Neurology Council *(July–December)*
Bethesda, MD

Imran I. Ali, M.D.
Toledo, OH

Erika Fullwood Augustine, M.D., M.S.
Washington, DC

Amy Brooks-Kayal, M.D.
Sacramento, CA

Ericka P. Greene, M.D.
Houston, TX

Jaffar Khan, M.D.
Atlanta, GA

Benn E. Smith, M.D.
Scottsdale, AZ

Please address all communications to:

Jeffrey M. Lyness, M.D.
President and CEO
7 Parkway North
Deerfield, IL 60015

Phone: 847.229.6500
Fax: 847.229.6600
Website: abpn.org

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, and EBH Core Content. If approved by the ABMS, the ABPN plans to offer its physicians certified in Psychiatry the opportunity to obtain this focused practice designation.

The ABPN recognizes the mental health crisis facing the United States and its impact on emergency medicine services. The need to provide timely access to care for patients seeking acute emergency behavioral health treatment far exceeds the existing number of psychiatrists available to provide such care. This focused practice designation will enhance the abilities of emergency physicians to provide emergency behavioral health treatment and further recognize the tailored practice of physicians already certified Psychiatry who work in emergency medicine settings.

The ABPN looks forward to continued collaboration with ABEM in this unique area of expertise. We wish ABEM all the best in this pursuit to help ensure the highest standards of emergency behavioral health care for patients in need. Thank you for your consideration.

Sincerely yours,

Jeffrey M. Lyness, MD
President and CEO, American Board of Psychiatry & Neurology

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,

Madeleine Becker, MD, FACLP
President

AAEM
AMERICAN ACADEMY OF EMERGENCY MEDICINE
CHAMPION OF THE EMERGENCY PHYSICIAN

OFFICERS
JONATHAN S. JONES, MD FAAEM
President
Jackson, MS

ROBERT FROLICHSTEIN, MD FAAEM
President-Elect
San Antonio, TX

L.E. GOMEZ, MD MBA FAAEM
Secretary-Treasurer
Annapolis, MD

LISA A. MORENO, MD MS MSCR FAAEM FIFEM
Immediate Past President
New Orleans, LA

TOM SCALETTA, MD MAAEM FAAEM
Past Presidents Council
Bur Ridge, IL

BOARD OF DIRECTORS
HEIDI BEST, MD FAAEM
Virginia Beach, VA

LAURA J. BONTEMPO, MD MED FAAEM
Baltimore, MD

KIMBERLY M. BROWN, MD MPH FAAEM
Memphis, TN

PHILLIP DIXON, MD MPH FAAEM
Delaware, OH

ROBERT P. LAM, MD FAAEM
Colorado Springs, CO

BRUCE LO, MD MBA RDMS FAAEM
Virginia Beach, VA

VICKI NORTON, MD FAAEM
Boca Raton, FL

KRAFTIN SCHREYER, MD MBA FAAEM
Mickleton, NJ

YPS DIRECTOR
FRED E. KENCY, JR., MD FAAEM
Madison, MS

AAEM/RSA PRESIDENT
LEAH COLUUCI, MD MS
Woodbridge, CT

EDITOR, *JEM*
EX-OFFICIO BOARD MEMBER
STEPHEN R. HAYDEN, MD FAAEM
San Diego, CA

EDITOR, *COMMON SENSE*
EX-OFFICIO BOARD MEMBER
EDWIN LEAP II, MD
Tamassee, SC

EXECUTIVE DIRECTOR
MISSY ZAGROBA, CAE

EXECUTIVE DIRECTOR EMERITUS
KAY WHALEN, MBA CAE

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

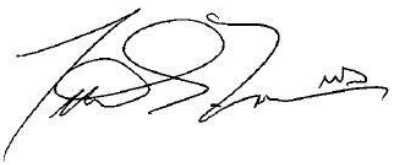
Dear Dr. Hawkins:

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.

Sincerely,



Jonathan S. Jones, M.D., FAAEM
President

AMERICAN ACADEMY OF EMERGENCY MEDICINE
555 East Wells Street, Suite 1100, Milwaukee, WI 53202-3823
(800) 884-2236 | info@aaem.org | www.aaem.org

AAEM RESIDENT & STUDENT ASSOCIATION

AAEM/RSA BOARD OF DIRECTORS
MAY 2023-APRIL 2024

PRESIDENT
LEAH B. COLUCCI, MD MS
Woodbridge, CT

VICE PRESIDENT
ANANTHA SINGARAJAH, DO
Palm Springs, CA

SECRETARY-TREASURER
MATTHEW CARVEY, MD FP-C
Cleveland, OH

IMMEDIATE PAST PRESIDENT
LAUREN E. LAMPARTER, MD
Chicago, IL

AT-LARGE DIRECTORS
ROBERT G. CANNING JR., MD
Washington, DC

REBA P. GILLIS, MD
New Haven, CT

KATHERINE A. MARCINIEC, DO
Iowa City, IA

TAYLOR SMITH, MD
Murfreesboro, TN

HEATH SPENCER, DO
Tulsa, OK

MARY UNANYAN, MD
Chicago, IL

STUDENT REPRESENTATIVE
KATY WYSZYNSKI
Fort Worth, TX

EXECUTIVE DIRECTOR
MISSY ZAGROBA, CAE

ADMINISTRATIVE MANAGER
DANIELLE NEEL

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 Emergency Behavioral Health and hopes to partner with them in engaging interested future physicians.

Sincerely,

Leah Colucci

Leah Colucci M.D., M.S.
President

555 East Wells Street
Suite 1100
Milwaukee, WI 53202-3823
phone 1-800-884-AAEM
fax 414-276-3349
email info@aaemrsa.org
website www.aaemrsa.org

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 Behavioral Health to interested physicians in the future.

Sincerely,

Altha J. Stewart, MD

Altha J. Stewart, M.D.
President, American Association for Community Psychiatry

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

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.

Respectfully.....

Junji Takeshita, MD
President – American Association for Emergency Psychiatry
TakeshitaJ@dop.hawaii.edu

American Association for Emergency Psychiatry (AAEP)
2851 S. Parker Road, Suite 1210, Aurora, CO 80014
P.O. Box 3406, Englewood, CO 80155
Office: 877-749-0737 | Fax: 303-200-7099 | Email: info@aaepsych.org

AAEP | AMERICAN ASSOCIATION FOR EMERGENCY PSYCHIATRY

THE VOICE OF EMERGENCY MENTAL HEALTH PROFESSIONALS

American Association for Emergency Psychiatry (AAEP)
2851 S. Parker Road, Suite 1210, Aurora, CO 80014
P.O. Box 3406, Englewood, CO 80155
Office: 877-749-0737 | Fax: 303-200-7099 | Email: info@aaepsych.org

American Association of Directors of Psychiatric Residency Training

PO Box 30413
Indianapolis, IN 46230

John Q. Young, MD, MPP, PhD
President

Tracey Guthrie, MD
President-elect

Rashi Aggarwal, MD
Secretary

Ulrick Vieux, DO
Treasurer

Consuelo "Chi-chi" Cagande, MD
Program Chair

Erick Hung, MD
Program Chair-elect

COMMITTEE/CAUCUS CHAIRS

John Q. Young, MD, MPP, PhD
ABPN/ACGME Liaison

Dustin DeMoss, MD
Addictions

Julie Sadhu, MD
Assessment

Laurel Williams, DO
Child & Adolescent Psychiatry

Anuja Mehta, MD
Curriculum

Ann Schwartz, MD
Development

Theadia Carey, MD, MS
J.E.D.I. (Justice, Equity, Diversity, Inclusion)

Madhu Rajanna, MD
IMG (International Medical Graduate)

Eitan Kimchi, MD
Information Management

Lindsey Pershern, MD
Membership

Isheeta Zalpuri, MD
Mentorship and Professional Growth

Mayada Akil, MD
Neuroscience Education

Ana Ozdoba, MD
Organizational Equity

Roopali Bhargava, BA
Program Administrator (non-voting)

Anne Ruble, MD
Psychotherapy

Lia Thomas, MD
Recruitment

Sandra Batsel-Thomas, MD
Regional Representatives

Carrie Ernst, MD
Subspecialty

Tanya Keeble, MD
Workforce

Lillian "Joy" Houston, MD
Wellbeing/Burnout

APPOINTED MEMBERS
Ronke Babalola, MD, MPH
Enrico Castillo, MD, MS
Jacqueline Hobbs, MD, PhD

PAST PRESIDENTS
Randon Welton, MD
Sallie De Golia, MD, MPH

LIAISONS
Donna Sudak, MD
Academic Psychiatry

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.

From our review of the literature and our own experiences, we agree that there is a significant gap between best practice and actual practice with respect to behavioral health care in emergency medicine contexts. This is multi-determined. One contributor is, in our view, the inadequate behavioral health training that emergency medicine residents receive during training, which in turn leads to a gap between the need and actual competencies.

We strongly support the development of the focused practice designation. We believe this is one important part of the solution. We recommend starting with the focused practice designation mechanism and leaving open whether or not a new subspecialty is necessary.

We also feel strongly that the ABEM and relevant stakeholders, including the ACGME Review Committee, should modify the requirements for Emergency Medicine residency such that graduates are more likely to possess the basic behavioral health related competencies necessary to provide effective care.

Please feel free to contact me with any questions. Thank you again for the opportunity to provide our feedback.

Sincerely,

John Q. Young, MD, MPP, PhD
President, AADPRT

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 access to outpatient mental health resources with an increase in need for these services, it is not surprising that the ED has become a major site of care for a large proportion of these patients.[7] Emergency physicians are best suited to meet patients where their needs are highest and provide early intervention in the ED. Given the breadth of training of EM physicians and the increasing exposure to patients with mental health concerns, emergency physicians are best suited to make decisions regarding efficiently screening for, distinguishing, and stabilizing both psychiatric and non-psychiatric conditions. As the increase in mental health care-related disorders is currently occurring in the ED, there is a recognized need for even further training and expertise to optimize care in this discipline.

EM physicians are frontline witnesses to the mental health crisis in the USA and want to take a more active role in combating this issue by providing both timely and quality care for our patients. Recognition of EM practicing physicians with expertise in behavioral health emergencies would allow for better engagement with our psychiatry colleagues at the local, regional, and national levels. Formal recognition via a Focused Practice

HEADQUARTERS
Post Office Box 619911
Dallas, Texas 75261-9911

4950 W Royal Ln
Irving, TX 75063-2524

972-550-0911
800-798-1822
www.acep.org

BOARD OF DIRECTORS
Aisha T. Terry, MD, MPH, FACEP
President
Alison J. Haddock, MD, FACEP
President-Elect
Jeffrey M. Goodloe, MD, FACEP
Chair of the Board
Ryan A. Stanton, MD, FACEP
Vice President – Communications
James L. Shoemaker, Jr., MD, FACEP
Vice President – Membership
Kristin B. McCabe-Kline, MD, FACEP
Secretary-Treasurer
Christopher S. Kang, MD, FACEP
Immediate Past President
L. Anthony Cirillo, MD, FACEP
John T. Finnell, MD, MSc, FACEP
Gabor D. Kelen, MD, FACEP
Rami R. Khoury, MD, FACEP
Heidi C. Knowles, MD, FACEP
Chadd K. Kraus, DO, DrPH, CPE, FACEP
Abhi Mehrotra, MD, MBA, FACEP
Henry Z. Pitzele, MD, FACEP

COUNCIL OFFICERS
Melissa W. Costello, MD, FACEP
Speaker
Michael J. McCrea, MD, FACEP
Vice Speaker

EXECUTIVE DIRECTOR
Susan E. Sedory, MA, CAE

Designation will allow EM experts in behavioral health to serve as research and clinical leaders in the field of acute behavioral health emergencies, and better advocate for increased resources and funding for patients with mental health needs.

Obviously, improving access to care and psychosocial resources for patients in the long term is ideal. EM physicians with specialized training could provide a unique care model and access to acute needs for patients in mental health crises while being able to also address their emergent medical and/or surgical problems. As an example, the average behavioral health patient spends 3.2 times longer in the ED than patients without a primary mental health diagnosis.[8] Nonetheless, the average stay in an inpatient psychiatric unit is just over 3 days, and 75% of patients can be discharged within 24 hours.[9] Thus, aggressive early intervention for psychiatric patients in the ED may result in decreased ED length of stay, increase in discharges from the ED, and improved safety and care for these patients. Furthermore, these EM behavioral health specialists could serve as a bridge to outpatient care and potentially help as a referral base or in a transitional role for ongoing outpatient mental health follow-up until more permanent psychiatric care can be arranged for patients. While the mental health crisis may be in part, due to a system issue, it will take these emergency physicians with expertise in emergency behavioral health to lead the solutions, develop the systems, and provide care for these patients.

ACEP strongly supports ABEM's efforts to establish a focused practice designation in emergency behavioral health. It recognizes it as a pivotal advancement in our shared mission to provide comprehensive and compassionate care to all patients facing mental health crises.

Sincerely,

Aisha Terry, MD, MPH, FACEP
President, American College of Emergency Physicians

References

[1] Bommersbach TJ, McKean AJ, Olfson M, Rhee TG. National Trends in Mental Health-Related Emergency Department Visits Among Youth, 2011-2020. JAMA. 2023 May 2;329(17):1469-1477. doi: 10.1001/jama.2023.4809. PMID: 37129655; PMCID: PMC10155071.

[2] Theriault KM, Rosenheck RA, Rhee TG. Increasing emergency department visits for mental health conditions in the United States. J Clin Psychiatry. 2020;81(5). doi:10.4088/JCP.20m13241

[3] Moore B, Stocks C, Owens PL. Trends in emergency department visits, 2006-2014. HCUP Statistical Brief #227. Healthcare Cost and Utilization Project; 2017.

[4] Emergency Department Visits by Patients with Mental Health Disorders — North Carolina, 2008–2010 (cdc.gov)

[5] Holland KM, Jones C, Vivolo-Kantor AM, et al. Trends in US Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the

COVID-19 Pandemic. JAMA Psychiatry. 2021;78(4):372–379. doi:10.1001/jamapsychiatry.2020.4402

[6] Kohn R, Ali AA, Puac-Polanco V, Figueroa C, López-Soto V, Morgan K, Saldivia S, Vicente B. Mental health in the Americas: an overview of the treatment gap. Rev Panam Salud Publica. 2018 Oct 10;42:e165. doi: 10.26633/RPSP.2018.165. PMID: 31093193; PMCID: PMC6386160.

[7] Krass P, Dalton E, Doupnik SK, Esposito J. US pediatric emergency department visits for mental health conditions during the COVID-19 pandemic. JAMA Netw Open. 2021;4(4):e218533-e218533. doi:10.1001/jamanetworkopen.2021.8533

[8] Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. Emerg Med Int. 2012;2012:360308. doi:10.1155/2012/360308

[9] alameda-model.pdf (virginia.gov) AND Scott Zeller, Vituity Health.pdf (ca.gov)

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.

A focused practice designation would therefore recognize a unique expertise that is held by physicians who choose to focus part of their practice on behavioral emergencies. The knowledge base of behavioral emergencies is both sophisticated and comprehensive, and exceeds that provided by successful completion of an Emergency Medicine or Psychiatry residency.

CPE is proud to support efforts by ABEM in this area, and give these efforts are highest endorsement.

Sincerely,

Michael Wilson, MD PhD
Chair, Coalition on Psychiatric Emergencies

hello@coalitiononpsychiatricemergencies.org
@Coalition on Psychiatric Emergencies
www.linkedin.com/company/coalition-on-psychiatric-emergencies/

COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE

Innovation • Collaboration • Scholarship

Board of Directors

Boyd Burns, DO
President

Laura Hopson, MD
President-Elect

Jaime Jordan, MD
Secretary-Treasurer

Jessica Smith, MD
Past President

Alexis Pelletier-Bui, MD
Member-at-Large

Kerry McCabe, MD
Member-at-Large

Dan Egan, MD
Member-at-Large

Rebecca Bavolek, MD
Member-at-Large

Cynthia Price, MD
Diversity, Equity, & Inclusion Member

Arlene Chung, MD
Member-at-Large

Jason Wagner, MD
Member-at-Large

Julia Ruggieri, MD
Resident -Member-at-Large

Natasha Brocks
EMARC Liaison

Anniekay Erby, MBA CAE
Executive Director

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

4950 West Royal Lane | Irving, Texas 75063 | Ph: 888-444-2090 | Fax: 972-692-5347

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 workforce and the access to care that patients with mental health problems have available to them. 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.

EMRA 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,

Blake R. Denley, M.D.
EMRA President

Board of Directors
Blake R. Denley, MD
President
Jessica Adkins Murphy, MD
Immediate Past-President
David Wilson, MD
President-Elect
Michaela Banks, MD, MBA
Speaker of the Council
Jacob Altholz, MD
Vice Speaker of the Council
Morgan Sweere, MD, MPH
Secretary/EM Resident Editor
Aaron R. Kuzel, DO, MBA
EMRA Representative to ACEP
Joe-Ann Moser, MD, MS
Director of Education
Kenneth Kim, MD
Director of Health Policy
Derek Martinez, DO
Director of Leadership Development
Angela Wu, MD, MPH
EMRA Representative to AMA
Jinger Sanders
Medical Student Council Chair

Executive Director
Kris Williams, CAE

4950 W. Royal Lane Irving, TX 75063 Phone: 866.566.2492 Fax: 972.692.5995 *www.emra.org*

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.

NAMI 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,

Ken Duckworth, MD
Chief Medical Officer

Society for Academic Emergency Medicine

Board of Directors
Wendy C. Coates, MD
President

Ali S. Raja, MD, DBA, MPH
President-Elect

Michelle D. Lall, MD, MHS
Secretary-Treasurer

Angela M. Mills, MD
Immediate Past President

Pooja Agrawal, MD, MPH
Member-at-Large

Jeff Druck, MD
Member-at-Large

Julianna J. Jung, MD
Member-at-Large

Nicholas M. Mohr, MD, MS
Member-at-Large

Ava E. Pierce, MD
Member-at-Large

Jody A. Vogel, MD, MSc, MSW
Member-at-Large

Michael DeFilippo, DO, MICP
Resident Member

Megan N. Schagrin, MBA, CAE, CFRE
Chief Executive Officer

February 22, 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 Society for Academic Emergency Medicine (SAEM) supports the application by the American Board of Emergency Medicine (ABEM) for focused practice designation (FPD) in Emergency Behavioral Health (EBH).

SAEM 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.

SAEM 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,

Wendy C. Coates, MD
President

SAEM | 1111 East Touhy Avenue, Suite 540 | Des Plaines, IL 60018
Tel: (847) 813-9823 | Fax: (847) 813-5450
www.saem.org | info@saem.org

AMERICAN BOARD OF EMERGENCY MEDICINE

Johnathon M. Doe, M.D.

has met the requirements for the Focused Practice Designation in

Emergency Behavioral Health

Effective April 1, 2022
Diplomate Number 12345

This designation is valid as long as primary certification is maintained and Emergency Behavioral Health FPD continuing requirements are met.

(signature)
President

(signature)
Secretary-Treasurer

A Member Board of the American Board of Medical Specialties