at the hospital and where he was earlier in the day. After initial evaluation it became clear he had no recollection of the past 3 months. On chart review, the patient previously presented to a separate hospital two weeks prior with admission for sepsis, rhabdomyolysis, acute renal failure requiring HD, and brachial plexus injury. Prior to that admission, he was found down at home after ingesting cocaine and MDMA. Notably, staff at that facility reported he was in clear mentation and had no signs of memory loss or confusion prior to discharge. Further discussion at the current ED visit resulted in a staff member stating the patient recognized the term schizophrenia and the patient agreed that he had been previously diagnosed. He was admitted to the inpatient psychiatric unit for further evaluation of an acute schizophrenia exacerbation. He was unable to provide collateral nor did he have any recollection of prior hospitalizations, including the recent admission two weeks prior. His MoCA on admission was 8/30. Upon discussion over the next few days, the patient expressed frustration at his memory loss but was able to say his last well-formed memory was finding some cocaine in a house I was cleaning and using it. Initial CT without contrast showed no evidence of acute territorial infarct, intracranial hemorrhage, or mass lesion. MRI showed diffuse and heterogenous hyperintensities throughout the white matter in both cerebral hemispheres. This finding raised suspicion for a toxic component to the patient's memory loss. He received an extensive medical workup evaluating metabolic and clinical manifestations of toxic leukoencephalopathy. Over the course of one week, he showed slight improvement in memory and cognition. His MoCA improved to and peaked at 14/30. As mentation improved, he denied any previous psychiatric illness and did not recall stating he has schizophrenia. At this time, he is continuing to be evaluated for mild clinical improvement and counseled on a new baseline for memory retention and cognition in the setting of delayed toxic leukoencephalopathy due to substance use. This case illustrates the benefit in an expanded differential diagnosis in the setting of confusion and bizarre behavior. Although toxic leukoencephalopathy is rare and the understanding of pathophysiology is incomplete, its prominence is expanding in a society with increasing access to severely leukotoxic agents.

## 10 Risk Assessment Clinical Pathway

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A comprehensive risk assessment should encompass suicide and violence risk factors, protective factors, and mitigating factors to help determine the level of risk and subsequently drive clinical care to arrive at a safe treatment plan. The psychiatric emergency setting requires a thoughtful suicide and violence risk assessment by the clinical team. Using a variety of published resources coupled with input from the clinical team (psychiatrists, nurses, social services), a suicide and violence risk assessment tool was created in the Electronic Health Record (EHR) for implementation across all treatment settings to be used by any clinically trained staff (psychiatrists, nurses, social services). Depending on the risk assessment findings, clinical staff is then able to determine the next steps in the clinical pathway to best support the patient, treatment plan with specific focus on least restrictive interventions. There are several benefits to establishing a risk assessment clinical care pathway. First and foremost, the patient is not subjected to unnecessary hospitalization(s) that can be traumatic and overall damaging to his/her treatment. The risk assessment accounts for all contributing factors along with protective and mitigating factors to provide the best care for that patient at that moment in time. Next steps involve assessing the level of acute and chronic risk (ie. Low, moderate, high) to determine the clinical care formulation. High risk levels and/or Red flags require an enhanced response that may involve considering emergency evaluation for psychiatric hospitalization. However, the risk formulation for low and moderate results may involve performing safety plans, psychoeducation, outpatient therapy, and/or more intensive monitoring with Intensive Outpatient Programs (IOP) or Partial Hospitalization options. The risk assessment yielding chronic risk levels focuses on long term treatment options to work on suicide focused strategies, engage the patient in treatment, and providing a variety of resources to support that patient. Moreover, a standardized risk assessment tool and clinical care pathway can trigger a therapeutic and individualized response to patients presenting in crisis focusing on the recovery model. By making this tool and clinical pathway available to all clinical team members (ie. Psychiatrists, nurses, social services), more patients can be served with appropriate determinations on the next level of care. In addition, standardizing the risk assessment and clinical care pathway provides consistent reliable care that aligns with Safe, Timely, Effective, Efficient, Equitable, Patient-centered (STEEEP) principles. While the psychiatric emergency setting is one touchpoint along the continuum of care, the risk assessment and clinical pathway is applicable to any clinical setting (ie. Primary care, OB/Gyn, etc.) when indicated. Lastly, evaluation of the systems of care available at the community level opens up a vast array of resources available for patients that can have a positive impact on patient outcomes, population health, and reduction in healthcare costs.

## 11 Comparison of Emergency Department 14-Day Recidivism Rates in Emergency Behavioral Health Patients: EmPath Versus Standard ED Care

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**Introduction**: Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) units are an emerging and