Statement of

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American College of Emergency Physicians (ACEP)

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I. Introduction

In the emergency department, doctors expect the unexpected. Even so, there's one thing they're starting to anticipate more and more: patients in need of psychiatric care.

Mr. Chairman and members of the subcommittee, my name is Jon Mark Hirshon, MD, MPH, FACEP, FAAEM, FACPM, and I would like to thank you for allowing me to testify today on behalf of the American College of Emergency Physicians (ACEP) to discuss the impact of providing psychiatric care in emergency departments across the nation. ACEP is the largest specialty organization in emergency medicine, with more than 32,000 members committed to improving the quality of emergency care through continuing education, research, and public education. ACEP has 53 chapters representing each state, as well as Puerto Rico and the District of Columbia and a Government Services Chapter representing emergency physicians employed by military branches and other government agencies.

In addition to my recent role as Task Force Chair for the development of ACEP's 2014 National Report Card on Emergency Care, I currently serve as an Associate Professor in the Department of Emergency Medicine; Department of Epidemiology and Public Health; and the National Study Center for Trauma and EMS at the University Of Maryland School Of Medicine.

In every community across the nation, America's emergency departments are experiencing increased demand and decreased funding. With the consolidation of hospitals, reductions in reimbursements and the shuttering of doors to many mental health facilities, there are fewer

places for patients to get help for mental health issues. More often than not, when mental health patients have emotional/psychological set-backs or medication issues, they may seek care at a psychiatric facility within the community only to find inadequate resources available. At that point, they often turn to the one part of the health care system that never closes and never turns anyone away – the emergency department (ED).

Emergency physicians are trained to treat the emergent medical and psychiatric conditions of anyone and everyone who arrives at their door, but more and more they find themselves busy caring for people with psychiatric issues like psychotic break-downs and suicidal tendencies. Where once they might have been stabilized and transferred to a psychiatric facility, they now end-up staying in the ED much longer than necessary, risking further harm to themselves and to others.

Emergency physicians are seeing more and more psychiatric patients because our "health care system" has failed to address the needs of patients with chronic psychiatric conditions, especially individuals with acute flairs of their chronic conditions. Until more services and funding are made available to address this crisis, EDs will be the safety net for those patients.

II. Reduction of Resources/Increased Utilization of Emergency Department Services

The 1960s movement to deinstitutionalize mental health patients and transition them to outpatient and community-based treatment centers saw a nationwide drop in inpatient and residential psychiatric beds for state and county mental health hospitals from approximately

400,000 in 1970 to 50,000 in 2006.[i, ii, iii] While this was partially off-set by an increase of 50,000 private and general hospital psychiatric beds during the same timeframe, a large gap remains in the supply of psychiatric beds and facilities because of financial decisions and aggressive managed care utilization review. As noted in a 2009 Health Affairs study: "The decline in inpatient psychiatric services has been driven primarily by economics, not by advances in medical science or by changes in clinical need . . . the overriding motivation for deinstitutionalization was states' ability to shift the financial burden of care for the seriously mentally ill to federal sources."[iv]

Community-based treatment centers for the mentally ill continue to see sharp declines in state funding. In fact, states cut more than $1.6 billion (almost 10 percent) from their mental health spending from fiscal year 2009 to 2012. This decrease in funding has downsized or eliminated many mental health community services for children and adults. According to the National Alliance on Mental Illness (NAMI), approximately 60 percent of adults, and almost one-half of youth ages 8 to 15, with a mental illness received no mental health services in the previous year. Furthermore, NAMI states more than 61 million Americans experience mental illness in a given year with more than 13 million of them living with a serious mental illness, such as schizophrenia, major depression or bipolar disorder.

The shortage of inpatient psychiatric beds is a nationwide occurrence and this problem exists in all sites and settings – urban, suburban and rural geographic locations, as well as teaching and non-teaching hospitals alike. In January, ACEP released its 2014 National Report Card on Emergency Care. One of the data points we used to evaluate access to emergency care in each

state was how many psychiatric care beds there were per 100,000 people. The average of all the states was 26.1, with the fewest being 5.5 and the most being 52.7. This represents a decline in all categories compared to the same data collected five years ago in the 2009 iteration of that report (29.9 average, 8.2 fewest, and 54.8 most).

As the capacity of the mental health system continues to decline, patients turn to the ED for their unmet health needs. The ED has seen sharp growth in psychiatric visits, accounting for 12.5% of all ED visits in 2007, compared to 5.4% of all visits in 2000.[v, vi] This growth in psychiatric visits to the ED can be seen as an indirect measure of the failures of the outpatient mental health system.

The ED is often the last resort for patients with mental illness and is therefore used to attain basic, as well as acute, psychiatric care that includes medications, case management and therapy. The ED is regularly the primary resource for patients with a dual need for mental health and medical services. This is largely a factor of the federal Emergency Medical Treatment and Labor Act (EMTALA) mandate that requires emergency physicians to evaluate and stabilize anyone seeking care in a hospital ED.[vii]

However, the focus of the ED is to provide treatment for medical, not psychiatric, conditions. Though emergency providers are trained, and EDs are prepared, to address patients with acute psychiatric needs, mental health care services are often inefficiently delivered in the ED, which leads to an overall decrease in ED capacity, shifting time, attention and resources away from other critical patients. In short, the destabilization of outpatient and inpatient psychiatric

resources has further exacerbated already overburdened emergency departments, which threatens the overall health care delivery system in this country.

III. Psychiatric Boarding in the Emergency Department

When the appropriate resources are unavailable to admit patients who require psychiatric services, these patients wait, or are "boarded," in the ED until an inpatient psychiatric bed becomes available or a facility that is willing to accept the patient transfer can be found. ED staffs spend more than three times as long looking for beds for psychiatric patients than for non-psychiatric patients.

According to a 2008 ACEP study on psychiatric and substance abuse, almost 80 percent of emergency physicians said psychiatric patients are boarded in their emergency department. Respondents to the study indicated that psychiatric boarding is a symptom of a greater mental health system crisis. Furthermore, 99 percent of emergency physicians reported admitting psychiatric patients daily. These psychiatric patients require more physician, nurse and hospital resources than other patients and thus diminish a doctor’s ability to evaluate and treat other medical patients who are awaiting emergency care services.

There are several other factors that contribute to extended ED boarding times for psychiatric patients:

- Defensive medicine or the threat of legal action. A discharged patient who subsequently harms him/herself may take legal action against the ED and its personnel citing improper care or failure to admit.
- Required prior authorization from a health plan before a patient may be admitted as an inpatient.
- Psychiatric patients must first be cleared medically (per EMTALA requirements) before they can be screened for a psychiatric evaluation.
- Substance abuse can further complicate the admission process because patients cannot be sent to their inpatient bed until they are no longer intoxicated.
- Inadequate outpatient services, community resources and housing alternatives often leads to patients remaining in their inpatient beds for longer periods of time.

IV. Practice Improvements

There is still a great deal that we do not know about patients with mental illness. Addressing this information gap and making the case for tangible solutions is critical as our nation continues to grapple with implementation of new health reform laws. It is imperative that access and continuity of community mental health care be a priority as we move forward in the development of new policy.

Hosting a dialogue such as this one today is an important step in the right direction. As I previously discussed, ***quantifying*** the extent of psychiatric boarding is the first step in surmounting this critical problem. The U.S. Department of Health and Human Services (HHS)

has developed some valuable suggestions of practice improvements in that could prove useful in ameliorating the use of EDs as a primary source of psychiatric care.

Some of these solutions include:

- **Increased Staffing**. Given that boarding is, at times, caused by lack of inpatient hospital staff to care for the psychiatric patient rather than lack of inpatient psychiatric hospital beds, having additional staff would help alleviate this problem. This may include psychiatrists, psychologists, social workers, nurses, etc.
- **Better Case Management**. Ensuring that psychiatric patients receive care coordination regarding medication adherence and outpatient appointments may help prevent these patients from experiencing a relapse and potentially seeking care in the ED again.
- **Full-Capacity Protocol**. Some hospitals have instituted a policy that moves some boarded patients to other areas of the hospital, such as inpatient floors, when the ED is already operating at full capacity. These areas tend to be less chaotic and noisy and, therefore, are less likely to exacerbate a mental health crisis.
- **Improved Discharge Practices**. Improved throughput can include discharging patients before noon to improve the patient flow in the hospital and preparing for the busiest times of the day/week.
- **Improved Community Collaboration**. Better knowledge of outpatient alternatives among ED staff and strong collaboration between community crisis services and the ED are likely to lead to more appropriate discharge of patients to outpatient facilities, and a reduction in boarding.

- **Increased Outpatient Capacity/Community Alternatives**. Two specific community services that have shown promise as part of system-wide improvements of mental health services were crisis residential services and mobile crisis teams. Crisis residential settings could care for patients who do not need to be in a hospital setting, allowing the ED to see more acute medical patients. Mobile crisis, often referred to as diversion teams, provide crisis intervention and stabilization services to psychiatric patients in the community, preventing many patients from seeking care in the ED.
- **Separate Psychiatric ED/Behavioral Health Annex**. A separate psychiatric ED or behavioral health annex is a component of the psychiatric emergency services (PES) model in which psychiatric patients are placed in a separate ED/annex after medical clearance. This removes patients from the general ED, as well as increases the likelihood that they receive care from trained mental health professionals while boarding.
- **Increased Hospital Inpatient Capacity**. Additional psychiatric, inpatient beds would help to alleviate boarding for those patients who require hospital-level care.
- **Regionalization of Care**. The care of boarded patients could be improved by implementing standard processes across hospitals within the same region such as standard boarding procedures, as well as coordination across hospitals and at the state level regarding capacity issues.
- **Innovative Psychiatry (Tele-Psychiatry & Psychiatrists as Hospitalists)**. Use of tele-medicine would allow psychiatrists to perform evaluations and screenings of psychiatric patients when they cannot be physically present in the ED. This may alleviate inappropriate inpatient admission, and thus, lead to reduced boarding.

- **Eliminate Out-of-Network Insurance Issues**. Hospitals that have available psychiatric beds are not always authorized to accept patients if these hospitals are not in the patients' insurance network. Eliminating the in-network requirement would increase available options for inpatient care.
- **Community/State Mental Health Buy-In**. State health departments and legislatures must be involved in reforming the existing system in order to properly implement community-wide solutions. Such involvement to improve mental health access and quality and reduce boarding would entail a fiscal commitment among partners at the community or state level. Federal resources could significantly help states and local communities meet these additional financial obligations.

VI. Conclusion

The prevalence of mental illnesses in this country, combined with a lack of resources to care for these individuals in the most appropriate setting, is a national crisis. Mass deinstitutionalization of mental health patients over the past few decades did not result in successful community integration of individuals needing psychiatric services because the necessary services and funding were not put in place for adequate community support. As a result, increasing numbers of chronically mentally ill individuals have no place to go for comprehensive treatment. Rather than being integrated into the community, this population has been supplanted into other facilities, such as nursing homes, jails and prisons, while a growing number routinely seek psychiatric care in the nation's emergency departments.

Emergency physicians do their best to provide care to patients with psychiatric conditions, but the ED is not the ideal location for these services. Poor clinical outcomes, evidenced as delays in care and increases in morbidity and mortality, have been directly associated with ED overcrowding. For patients with mental health and/or substance abuse issues, prolonged ED stays are associated with increased risk of symptom exacerbation or simply leaving the ED without being seen or treated. Furthermore, as the normal capacity of the ED is overwhelmed with boarded patients, it leaves absolutely no room for surge capacity, which would be critical in the event of a man-made or natural disaster.

Systemic changes are needed in the way individuals with mental illness are cared for in this country. Additional resources must be made available to conduct vitally needed research on this issue and to fund additional inpatient and outpatient treatment beds with the corresponding professional staff. Otherwise, mental health and emergency care services will continue to deteriorate.

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