

The “Crisis” Crisis: Emergency Department Use and Community Resources in North Carolina’s Behavioral Health Crisis System

Mike Vicario

An unprecedented number of North Carolinians are coming to hospital emergency departments with behavioral health needs. There are significant delays after emergency treatment as the patient awaits placement in an inpatient facility often requiring the patient to be “boarded” in the hospital. Any viable solution to this “crisis” crisis will require significant community collaboration.

A recent report from the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services “From Crisis to Recovery: Strategic Planning for Response, Resilience and Recovery,” contains recommendations to address the unnecessary use of emergency departments (EDs) in acute care hospitals to house behavioral health patients for whom treatment in a community setting cannot be found [1]. It is a problem that North Carolina’s hospitals are all too familiar with.

North Carolina’s Mental Health Reform Bill of 2001 [2] was based on the US Supreme Court’s *Olmstead* decision of 1999 [3], which held that behavioral health patients are best served in their communities, close to their families, friends and support system. The reform bill proposed increased provider choice for at least some of these patients, through a privatized system of care overseen by Local Management Entities (LMEs). The reform effort touted caring for behavioral health patients in their communities as a cost-saving proposition. Savings would be attained by reducing the number of state hospital beds. However, the reform failed.

Between 1992 and 2011, 1,879 beds closed at the four state-operated psychiatric facilities [4, 5]. The reform bill established a statewide Mental Health Trust Fund to finance the transition of mental health services from institutions to community providers. However, as the result of the shortfall in the 2001-2002 state budget, most of the money in the fund was diverted to other purposes and was unavailable to develop the community system of care [6]; thus insufficient resources were available to develop the community system of care. The provision of unproven, and sometimes fraudulently billed, community support services followed, at a cost to North Carolina taxpayers of more than \$400 million [6].

LMEs were directed to submit detailed reports outlin-

ing plans to develop and bolster crisis-specific services [7]. Unfortunately, in many areas, a key element of the plan adopted was that the person in crisis should call 911 or go the ED. Consistently available services for those in mental health or substance abuse crisis and recovery never evolved. Instead, multiple providers offer limited bundles of outpatient services. It remains unclear who is accountable to ensure access to a continuum of behavioral health services to residents that present to the ED in a mental health crisis situation.

Prior to passage of the 2001 reform bill, area mental health programs provided clinical care and other community services to most communities from a few familiar locations. Although the bill’s call for a privatized system may have expanded the overall number of private providers, because the services made available were fragmented in nature, access did not improve for those in greatest need or for uninsured populations. Services such as community support were not shown to be effective in treating those with severe mental illnesses. For many high-need consumers, the safety net disintegrated. North Carolina’s sustained population increases, along with job losses, state budget cuts, changes in leadership, and program cuts further stressed the behavioral health system. When in crisis, more patients turned to the hospital ED, a site without the staff and resources to provide the care they need. From 2008 to 2011, the number of patient visits to EDs with a primary diagnosis of a mental health or substance abuse problem increased by more than 38% [8, 9], compared with a 6% increase in the total number of ED visits (M.V., unpublished data).

State hospitals are full, community inpatient beds are scarce, and federal “antidumping” laws ban the transfer of patients from EDs to nonhospital settings, even if those settings are designated by the state for behavioral health care. Of the 116 medical-surgical hospitals serving North Carolina, 42 operate inpatient behavioral health units that provide

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acute care for psychiatric or substance abuse patients. One also operates an ED that is open 24 hours a day and that is designated for behavioral health patients [10]. Most hospitals with behavioral health units lack the staff to provide psychiatric coverage for the ED 24 hours a day. A few of the 72 hospitals that lack inpatient behavioral health units have psychiatrists or clinical specialists to treat psychiatric illnesses, but the rest can only treat any immediate medical conditions and provide a safe boarding area until a bed in a behavioral health facility opens. Last year, patients with behavioral health needs waited, on average, for nearly 10 hours in the ED [11]. It is not uncommon for any hospital, large or small, to have been forced to board a patient for a week or more. Through personal communication with hospital administrators, some hospitals that have high numbers of boarded patients noted that additional behavioral health patients are also being cared for in medical-surgical units, intensive care units, and observation areas. One hospital with a full inpatient psychiatric unit recently estimated that at least as many behavioral health patients were housed in emergency and acute care areas of their facility as were admitted to their psychiatric unit.

Behavioral patients boarded in EDs suffer from treatment delays that can result in dangerous conditions for both patients and staff members, as well as for any other patients who might have to be diverted from the ED because of overcrowded conditions. Assaults by patients on other patients and on hospital staff are becoming more common. In response to this increased danger, hospitals have spent millions of dollars on measures to increase security and have brought sworn police officers into their facilities.

Some hospitals have addressed this crisis by creating behavioral units within the ED. Forsyth Memorial Hospital in Winston-Salem has a locked unit within its ED that has private rooms and a dedicated behavioral staff; it offers pharmacy services, evaluation, and therapy. The unit in the ED works in conjunction with the inpatient unit to reduce the average census in the ED and the number of hours that patients needing behavioral health care spend in the ED. Another smaller hospital without a psychiatric service depends on a psychiatrist from an LME-contracted provider to conduct regular assessments in its ED. The psychiatric consultation includes assessment and treatment of ED patients with behavioral problems, and it can help the hospital physician reach a decision to discharge the patient when appropriate outpatient and support services are available. ED length of stay continues to be a problem at both of these hospitals. Part of their strategy to improve conditions is to collaborate with the LME and contractors. A promising telepsychiatry pilot program in the EDs of Vidant Health hospitals in several communities—a program created by the Albemarle Hospital Foundation and funded by a grant from The Duke Endowment—is enabling psychiatrists to remotely assess patients in the ED and to work with emergency physicians to treat and discharge those

patients whose needs can be appropriately met by available and suitable outpatient alternatives. This is discussed more fully by Davies in the Philanthropy Profile in this issue of the *NCMJ* [12]. Mobile crisis management teams may be accomplishing similar results for a limited number of patients in some areas.

If the vision of successful treatment in less restrictive, community-based settings is to be realized, agencies, organizations, and facilities that provide behavioral health care must have adequate resources for, and accountability for, the provision of all services needed to prevent inappropriate ED utilization and, ultimately, hospitalization. Access to services ranging from basic transportation and housing to care coordination and timely physician visits must be improved. All components of the behavioral health care system must both communicate and collaborate. The array of crisis services available should be based on the recognition that a behavioral health visit to the ED is a sign of that system's failure.

Providing patients with community services that can help them avoid the ED must be a primary focus of North Carolina's 11 LMEs as they convert to LME managed care organizations (LME/MCOs) during 2012. They will be taking on the new role of at-risk payer for the behavioral care of Medicaid enrollees, while retaining the responsibility of managing community programming for all patients with behavioral health needs in their catchment areas. The LME/MCOs need to develop arrangements for service alternatives that are accessible to all consumers, such as walk-in and facility-based crisis centers; they then need to work closely with hospitals, community providers, law enforcement and other entities to strengthen and promote these alternatives to inappropriate ED visits. Several LME/MCOs have begun to track ED wait times and other data required to measure progress as they undertake this process.

For patients with severe and/or persistent behavioral health needs, inpatient care may be the only reasonable option. A combination of short-term beds in community hospitals and longer-term beds in the state hospital system provides the best opportunity for effective, local treatment. In 2008, funding was appropriated for additional capacity in community hospital psychiatric units; the funding was increased a year later, and there are now a total of 121 funded beds [13]. Referred to as "3-way contract beds" because of the agreements the hospital has with its LME and with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, these beds are located in communities across the state, and funding for the services can be "relocated" to meet the changing needs of communities. Not all units can provide services for those patients whose need for behavioral care is most acute, however. A workgroup sponsored by the North Carolina Department of Health and Human Services is evaluating how existing beds may be better utilized to meet the needs of patients boarded in EDs. Hospitals, in conjunction with the Division of Mental Health,

Developmental Disabilities, and Substance Abuse Services and the Division of State-Operated Healthcare Facilities, will need to continue to look closely at patient needs as they try to achieve the right mix of long-term and acute inpatient care in North Carolina.

Ultimately, however, the problem of ED overutilization will not be successfully solved by randomly adding services or beds. Any viable solution will require thoughtful and strategic planning of service provision in a community-based system to supplant or supplement inpatient hospitalization for crisis and emergency care. Carefully evaluating the LME/MCOs' progress in addressing this issue and holding them accountable for their performance are critical aspects of any resolution of this crisis. The North Carolina Hospital Association and its member hospitals are committed to reducing the unnecessary use of EDs by patients needing behavioral health care and will continue to collaborate with community stakeholders to improve access to crisis and recovery services in community settings, empowering patients to quickly receive the specialized care they need in the least restrictive setting. **NCMJ**

Mike Vicario, MHA vice president, Regulatory Affairs, North Carolina Hospital Association, Cary, North Carolina.

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