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ANALYSIS & COMMENTARY

A Plan To Reduce Emergency Room 'Boarding' Of Psychiatric Patients

ABSTRACT **Overcrowded U.S. emergency rooms have become a place of last resort for psychiatric patients. Psychiatric boarding, defined as psychiatric patients' waiting in hallways or other emergency room areas for inpatient beds, is a serious problem nationwide. Boarding consumes scarce emergency room resources and prolongs the amount of time that all patients must spend waiting for services. It is often the result of an inability to gain timely access to community-based care. As policy makers implement the new health reform law, improving access and continuity of community mental health care through health homes must be a priority. We present a seven-point plan to address psychiatric boarding.**

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In a 2008 survey of 328 emergency room (ER) medical directors, the American College of Emergency Physicians found that roughly 80 percent believed that their hospitals "boarded" psychiatric patients.[1] The term *boarding* is generally understood to mean the time spent waiting in an emergency room for a hospital bed or for transfer to another inpatient facility. Boarding times in Georgia, for example, average thirty-four hours, and many patients wait several days for an inpatient bed in one of the state's seven psychiatric hospitals.[2] In Maryland, many emergency rooms treat more than a dozen psychiatric patients a day and can board up to a dozen for days at a time.[3]

Because emergency rooms are poorly equipped to deal with mental health needs, boarded patients do not receive high-quality care there. Their presence affects the care received by other patients because boarded patients reduce ER capacity and increase pressure on staff. In addition, boarding has a negative financial impact on hospitals because reimbursement rates do not account for boarding.

This paper presents a seven-point action plan to reduce the boarding of, and ER use by, psychiatric patients. The plan aims to develop greater collaboration among hospital emergency rooms, community mental health providers, and law enforcement agencies, and and it proposes investments in the development of community infrastructure. The paper highlights opportunities in the new health reform law that support the implementation of this action plan.

Background

Psychiatric patients' overuse of and boarding in emergency rooms are symptoms of a lack of appropriate care stemming from a severe crisis in the mental health system. Beginning in the 1960s, the deinstitutionalization movement resulted in a decrease in the number of inpatient and residential psychiatric beds in state and county mental hospitals. The number of beds nationwide dropped from approximately 400,000 in 1970 to 50,000 in 2006.[2]

The Community Mental Health Centers Act of 1963 was intended to create a mental health center in every community to serve those who had been moved out of institutions. But this vision was never adequately funded or fully realized.[4]

This initial failure to create a robust community mental health system has been compounded

by several factors, leading to severe constraints on the capacity of community-based mental health care. Total state spending on mental health services was 30 percent less in 1997 than in 1955, when adjusted for population growth and inflation. The growth of managed behavioral health care and its use of strict medical management techniques has resulted in poorer access to care in the community, increasing the likelihood of mental health crises and the use of emergency room care.[5] A number of states that have enrolled people with disabilities in Medicaid managed care have cut back or denied coverage for high-cost antipsychotic drugs. Low reimbursement rates for behavioral health services under Medicaid and Medicare have further discouraged the provision of such services in the community. Some experts and commentators have even warned of a "wholesale collapse" of today's mental health system.[6–8]

The Patient Protection and Affordable Care Act of 2010 addresses the problem of boarding through the creation of a $75 million demonstration project known as the Medicaid Emergency Psychiatric Demonstration. This project will allow all hospitals to receive Medicaid reimbursement for emergency psychiatric care provided to working-age adults.

Outside the demonstration project, hospitals are not reimbursed for this care because Medicaid does not cover inpatient psychiatric services for working-age adults in institutions with more than sixteen beds. By expanding the number of hospitals willing to take psychiatric patients in an emergency, the project could reduce the pressure on all hospitals. However, it does not divert individuals away from emergency rooms and, therefore, is only a short-term fix. A longer-term solution will require increasing the capacity of community mental health services. This increase will be a challenge, given that the new health reform law expands Medicaid eligibility and thus adds more demand for community mental health services, whose primary clients in most states are Medicaid recipients.

The most important opportunity in the new law comes from the introduction of a Medicaid health home state plan option. This targets people with serious mental illnesses, as well as those with other chronic conditions, and is designed to facilitate continuity of care in the community. Under the law, states may file a state plan amendment to put the health home option in place for eligible chronically ill people in Medicaid. It is not clear how many states will ultimately take up the option, but because the share of the federal contribution toward this option will be 90 percent, many are expected to do so.

A Seven-Point Action Plan

The seven-point action plan described below builds a framework compatible with the Medicaid health home concept to reduce the boarding of, and ER use by, psychiatric patients.

The plan is based on an extensive literature review,[9] consultations with experts in the field, and interviews at nine hospitals. All of the hospitals are nonprofit. Eight are urban or suburban, and seven have a psychiatric ward. Three have psychiatric emergency services in addition to a traditional emergency room.

We interviewed seven physicians who practice in or direct emergency rooms, eight nurse case managers or social workers, and seven psychiatrists who are chairs of psychiatry departments or on call at a hospital. We also interviewed six community stakeholders, including representatives from community mental health centers and state facilities such as outpatient psychiatric facilities and mental health departments.[10]

Step 1: Quantify And Monitor The Problem

Psychiatric boarding was described by one respondent as the "number one problem of my Emergency Department."[10] Quantifying the extent of psychiatric boarding is the first step toward tackling the problem. No comprehensive, nationwide, scholarly evaluation of the extent of the problem exists. Policy makers so far have relied on newspaper reports and surveys of medical associations. As a result, it is difficult to make the case for any substantial investment in solutions. Addressing this information gap is critical.

One key barrier to data collection is the lack of a standard definition of what constitutes boarding, in terms of the length of time spent waiting in the emergency room for an inpatient bed. To address this issue, information about boarding of psychiatric and medical patients in emergency rooms could be added to the National Ambulatory Medical Care Survey conducted by the National Center for Health Statistics.

Step 2: Improve ER Care Of Psychiatric Patients

Another respondent stated that what psychiatric patients need, "they don't get."[10] Improving the care that patients receive in emergency rooms is an important step toward reducing boarding. Because high-quality care in a time of crisis can reduce the need for inpatient admission, patients who get better care are more likely to go home than to stay in the emergency room as boarders. Ensuring high-quality emergency care will be an important part of implementing

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the Medicaid Emergency Psychiatric Demonstration.

Poor care is the result of several factors. First, emergency rooms are generally loud, hectic environments that are poorly suited to deescalating a mental health crisis.

Second, ER psychiatric assessments are often inadequate,[11] and when treatment is provided, it is generally no more than medication.[9] This is because psychiatrists are not available in all emergency rooms,[1] and ER staff members are often not trained in psychiatry.

In fact, this lack of training contributes greatly to boarding. Evidence indicates that less experienced clinicians are more likely than psychiatrists to admit patients, fearing that they will be held liable if a patient who is not admitted harms him- or herself or someone else.[10]

Small, inexpensive changes in practice can lead to improvements in ER care for psychiatric patients. For example, hospitals that participated in the Institute for Behavioral Healthcare Improvement's 2008 learning collaborative found that they were able to reduce the length-of-stay of psychiatric patients in emergency rooms and the use of seclusion and restraint in caring for these patients. The hospitals used low-cost interventions such as training clinical and security staff in deescalation techniques and changing policies that required all psychiatric patients to remove their clothing in the emergency room. Being forced to undress can cause significant distress to individuals with mental health conditions who have experienced trauma. This can lead to their mental health worsening in the emergency room, prolonging boarding.[12]

An immediate barrier to improving ER care for people with mental illnesses is the lack of national standards for such care. In February 2009 the major professional bodies for emergency medicine jointly published an Emergency Care Psychiatric Clinical Framework.[13] Once it is approved by the boards of those organizations, it could be integrated into the Medicaid Emergency Psychiatric Demonstration to ensure the provision of high-quality emergency care.

Step 3: Make More Efficient Use Of Existing Capacity

In the absence of adequate investment to expand capacity (see Step 6 below), communities can make more efficient use of existing capacity in inpatient settings and community services to reduce boarding.

On the inpatient side, use-review teams have helped some hospitals improve inpatient capacity planning and implement more-timely discharges of patients. These teams are often given the authority to transfer or discharge patients and cancel or delay elective procedures.[14] Additionally, computerized bed management systems can improve the flow of patients into and out of the hospital.[15] At the community level, improved customer service and better management of no-shows and cancellations of appointments have been shown to create more timely access to mental health services for patients who do keep their appointments.

Carlsbad Mental Health Center, in New Mexico, used these techniques successfully to reduce wait times for a nonemergency first appointment with a clinician holding a master's degree. Wait times fell from six weeks to 11.2 days over a six-month period.[16] The center used a range of management initiatives, including phone calls to remind clients of appointments and letters sent to clients after two missed appointments to encourage clients either to discontinue services or to resume them.

Step 4: Implement Low-Cost Collaboration

Implementing low-cost collaboration between emergency rooms and community outpatient alternatives can also reduce psychiatric boarding. Collaboration provides alternative placement options for patients who do not require hospital-level care—and by the same token, in the absence of collaboration, alternative placement options usually don't materialize.

For example, hospitals participating in the Institute for Behavioral Healthcare Improvement's learning collaborative that lacked strong community collaboration found it harder to reduce patients' length-of-stay. This was because length-of-stay was frequently determined not by the stability of the patient's condition, but rather by the availability of an appropriate placement outside the emergency room.[11]

One example of a low-cost collaborative effort

is using community mental health clinicians to train ER staff in the management and care of patients with serious mental illnesses. Another is having a social worker in the emergency room who can connect individuals with community services when they are discharged, improving continuity of care.[9]

One of the major obstacles to collaboration is the lack of shared responsibility and accountability between the community mental health system and the hospital emergency room. This is exacerbated by the fact that the two systems do not share funding, governance, or licensing. State mental health agencies have little or no formal relationship with emergency rooms.

Thus, the first step in establishing collaborations is to bring the relevant stakeholders together to develop joint ownership of the problem of boarding, and to get everyone's commitment to remedying the problem.

For example, Bexar County, Texas, has developed an award-winning collaborative program to keep psychiatric patients out of both the emergency room and jail. The collaboration, which began in 2002, brings together representatives from public and private hospital systems in the area, as well as from community mental health services, law enforcement, the court system, and public officials.[17] The participants acknowledge that keeping psychiatric patients out of emergency rooms and jails is a "systems" issue and take collective responsibility for managing the movement of psychiatric patients among their institutions.

Step 5: Work With Law Enforcement

As first responders in many crises involving people with mental illnesses, law enforcement officers can play an important role in preventing the escalation of a situation involving a psychiatric patient and can thus make inpatient care unnecessary. Training these officers to manage mental health crises and giving them information about the appropriate use of local mental health services can keep some psychiatric patients out of the emergency room.

One model of specialized training is the crisis intervention team approach. Developed by the police department in Memphis, Tennessee, this approach educates law enforcement officers on how to recognize and deescalate mental health crises. Another approach is the co-responder model, developed in Los Angeles County, California, which involves a partnership between a trained crisis intervention officer and a mental health clinician. Several communities—including Bexar and Harris Counties, in Texas; Maryland's Montgomery County; and Miami-Dade County, in Florida—have invested in specialty training for law enforcement.

Lack of support from local police leadership and inadequate funding militate against such collaborations in other communities. However, federal support is available through the Justice and Mental Health Collaboration Program in the U.S. Department of Justice. The program provides grants of up to $250,000 for two years to plan, implement, or expand collaborative programs between criminal justice and mental health partners, including specialized training of law enforcement officers.

Step 6: Invest In Comprehensive Community Crisis Services

A comprehensive approach to mental health services must create appropriate alternatives to emergency rooms for crises and routine care. This type of approach is essential to achieving a reduction in psychiatric boarding.

Harris County, Texas, has developed the Comprehensive Emergency Psychiatric Program, which the American Psychiatric Association has recognized as a model for comprehensive emergency services in an urban setting. The program has six core features: a round-the-clock public help line; round-the-clock psychiatric emergency services; a mobile crisis outreach team; a crisis stabilization unit with beds for sixteen adult psychiatric patients; a voluntary emergency residential unit with beds for eighteen adult psychiatric patients; and a crisis counseling unit.[18] The most important of these six features for reducing emergency room boarding are the twenty-four-hour community-based psychiatric emergency services and the mobile crisis outreach team.

Developed more than forty years ago, psychiatric emergency services focus on providing high-quality psychiatric assessments and interventions outside an emergency room. The psychiatric emergency service in Harris County sees approximately 11,000 patients a year, including more than 1,000 children and adolescents. It is staffed by psychiatrists, licensed social workers, nurses, and psychiatric technicians. Seventy-eight percent of adults and 71 percent of children assessed at the service in 2006–7 could be adequately treated there and did not require hospitalization.[19]

The service's staff is trained to distinguish between a psychiatric crisis and the effects of drugs or alcohol. Because the service is funded by the county's mental health agency, the staff is likely to be aware of community-based options that can reduce the demand on the emergency room, such as detox beds for inebriated patients.

Ongoing, coordinated care would reduce mental health crises in many cases.

The Harris County mobile crisis outreach team is able to assess and resolve crises and provide brief therapeutic interventions in community-based settings, including individuals' homes. Of the 2,352 people seen by this team in 2006–7, only 4 percent required hospitalization.[19]

In 2008 the Texas legislature committed $82 million over two years to the development of core crisis services across the state.[20] The high price tag for such services, the need for legislative buy-in, competing priorities, and severely constrained state budgets all make it difficult to develop similar services in other parts of the country. The provision in the new health reform law to permit home and community-based services to be offered as part of a Medicaid state plan rather than through a waiver could provide a funding mechanism for the development of more community-based crisis services.

To support the use of this mechanism, it will be vital to have detailed data about the return on investment from existing systems such as the one in Harris County. Documenting the cost-effectiveness of community-based crisis systems compared to an ongoing reliance on ER services is critical in making the case for greater investment in these systems across the country.

Step 7: Invest In Continuity Of Care

Community-based crisis services can be a more appropriate form of crisis care than ER services for people with mental illnesses. But they are not a replacement for ongoing care in the community. Providing continuity of care through effective, accessible community mental health services, such as Assertive Community Treatment,[21] can prevent people from cycling into and out of mental health crises. In fact, one of the recommendations from the first-year evaluation of Texas's statewide investment in crisis services is to dedicate a portion of the funding earmarked for crisis services to improving outpatient mental health services. This would create better continuity of care for patients.[20]

As noted above, the option for states to offer Medicaid health homes for the chronically ill provides an important opportunity to improve continuity of care for individuals with serious mental illnesses. The option permits Medicaid reimbursement for coordinated care through an assigned health home, with the federal government contributing 90 percent of the costs in the first two years and an additional $25 million in planning grants. Ongoing, coordinated care would reduce mental health crises in many cases and, where crises do occur, would provide an alternative, trusted point of care that could divert patients from emergency rooms.

Conclusion

Psychiatric boarding is much more than a behavioral health problem. It is a health care delivery problem. To ensure that people with mental illnesses receive appropriate care, states need to couple efforts to expand Medicaid coverage with efforts to redesign the delivery system for mental health services. It is crucial to develop connections between community-based outpatient services, community-based crisis services, inpatient services, and emergency room services.

The health reform law's new Medicaid health home state plan option supports the development of community-based, coordinated services. It provides an important opportunity to reduce psychiatric boarding and improve the quality of community mental health services. If we fail to take advantage of that opportunity, we will not only compromise the quality of care and the health of those with mental illnesses, but we will also reduce the quality of care for all patients needing emergency room services. ■

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NOTES

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