Overuse of Emergency Departments by Uninsured Psychiatric Patients

The Problem

- **The Emergency Department (ED) is not a therapeutic setting for psychiatric patients.**
  - EDs hold psychiatric patients until therapeutic care can be arranged, i.e. a psychiatric consultation or admission.
- **Two changes in Florida law increased ED visits among uninsured psychiatric patients.**
  - ED use by uninsured psychiatric patients significantly increased after a) State funding for Crisis Stabilization Units (CSUs) was reduced in 2006, and b) a jail diversion program was enacted in 2007 to reduce the number of persons entering the criminal justice system who had a mental illness or substance abuse problem.
  - Uninsured patients now account for 43% of ED psychiatric visits.
  - From 2006 to 2011, ED patients with a primary psychiatric diagnosis increased by 22%, while patients with a secondary psychiatric diagnosis increased by 62%.
- **Crisis Stabilization Units (CSUs) can deny transfer requests from EDs if at 100% occupancy. However, it is unknown if CSUs are providing public patients with the utilization that is State-funded.**
  - The 2006 change in Florida law essentially encouraged CSUs to accept private patients to help meet financial needs, yet accountability for the State-funded volume is not required or reported.
- **Law enforcement officers can divert psychiatric or substance abuse patients to an ED using a Baker Act (72-hour) hold. However, the State does not collect statistics on the number of Baker Act holds in the ED.**
  - The State collects statistics on Baker Act holds in CSUs, but not in EDs, despite the Baker Act requiring an involuntary examination of the patient. ED Baker Act patients are often discharged from the ED (never transferred to a CSU), such that the State's annual Baker Act statistics are incomplete.
- **Among the 50 states, Florida ranked 48th in funding for per capita mental health expenditures ($39.55 in Florida compared to the U.S. average of $120.56).**
  Available at: http://kff.org/other/state-indicator/smha-expenditures-per-capita/

Recommendations

Accountability:

- **The State is encouraged to collect and report annual statistics on involuntary psychiatric exams (Baker Act) that occur in the ED, similar to statistics provided for CSUs.**
- **The State is encouraged to assure CSUs provide annual statistics on their public patient volume to ensure correct utilization of state-funded-beds, as well as report statistics on ED transfer requests of Baker Act patients that were denied.**
  - Oversight and transparency are absent regarding CSU State-funded psychiatric bed utilization, as well as diversion practices.
- **The State is encouraged to assure that CSUs adhere to the requirement to accept transfers of Baker Act holds from EDs in a timely fashion to ensure appropriate psychiatric treatment.**
  - The law requires CSUs to accept ED Baker Act patients within 12 hours of medical clearance. However, this law is not enforced, as evidenced by the high percent of patients that have an ED length of stay of 24 hours or more.

Funding and Resources:

- **The State is encouraged to provide funding for Assisted Outpatient Treatment (AOT), and Florida Assertive Community Treatment (FACT) teams at the local level, as both create cost savings.**
  - Florida's AOT law (F.S 394.4655) was enacted in 2004, but has not been funded. AOT is court-ordered

treatment (including medication), as a condition of remaining in the community, for individuals who have a history of medication noncompliance. AOTs save money by reducing the number of arrests, incarcerations, and unfunded ED visits.
    - Local governments cannot bear the entire costs of FACT teams and need State support. FACT uses a multidisciplinary team approach, providing community-based treatment and support to persons with severe or chronic psychiatric disabilities who are at high risk for repeated psychiatric admissions or CSU use.
    - Public support for AOT and FACT teams has grown due to acts of violence, e.g., mass shootings.
- **The State is encouraged to pass a version of "A Healthy Florida Works," thereby accepting federal funds to provide health care coverage, including mental health services, to Florida's working poor.**
    - Local communities do not have the resources to adequately fund public mental health systems, and funding in Florida has already declined due to public policy changes. The cost of care is higher in the ED and may ultimately increase costs for other payers via cost-shifting. "A Healthy Florida Works" is a relevant funding source since the majority of uninsured psychiatric ED patients are non-elderly adults, which is the target population of this initiative. It would also assure access to primary care, which has the potential to assist psychiatric patients with preventing crises and coordinating care.
- **The State is encouraged to maintain the current number of State-funded inpatient psychiatric beds in Florida.**
    - While some CSUs may have expanded their capacity, the extent to which the beds are used for private versus public psychiatric patients is unknown. While all states are reported to have a shortage of public psychiatric beds, Florida is ranked as the 15th worst state. Available at: http://mentalillnesspolicyorg.blogspot.com/2012/07/us-loses-psychiatric-beds-for-mentally.html
- **The State is encouraged to support telepsychiatry programs to expedite the provision of psychiatric care to ED patients in crisis and to reduce the incidence of boarding psychiatric patients.**
    - In South Carolina, a regional telepsychiatry program lowered average waiting times for a psychiatric examination from four days to less than 10 hours. A regional program in North Carolina reduced ED length of stay from 48 hours to 22.5 hours. However, implementing telepsychiatry requires addressing issues of licensing, liability and reimbursement.

ACEP Focus Groups - Psychiatric Boarding

- 15 of 18 agreed: 91 percent of responding emergency physicians reported that psychiatric boarding led to distracted staff, bed shortages or violent behavior by distressed psychiatric patients, all of which may harm patients.
- 10 of 18 agreed: Until more funding and services are made available, emergency departments will continue to serve as a safety net for patients having psychiatric emergencies.
- 12 of 18 agreed: When psychiatric patients are being held in an emergency department, fewer beds and less staff are available to accommodate additional patients.
- 12 of 18 agreed: Psychiatric patients are cared for in an emergency department, but emergency care is not psychiatric care.

Solutions

- 7 of 18 agreed: Need to increase hospital inpatient staffing and capacity. Additional psychiatric inpatient beds would help to alleviate boarding for those patients who require hospital-level care.
- 8 of 18 agreed: Better case management of patients to decrease psychiatric emergencies.
- 9 of 18 agreed: 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.
- 15 of 18 agreed: 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.