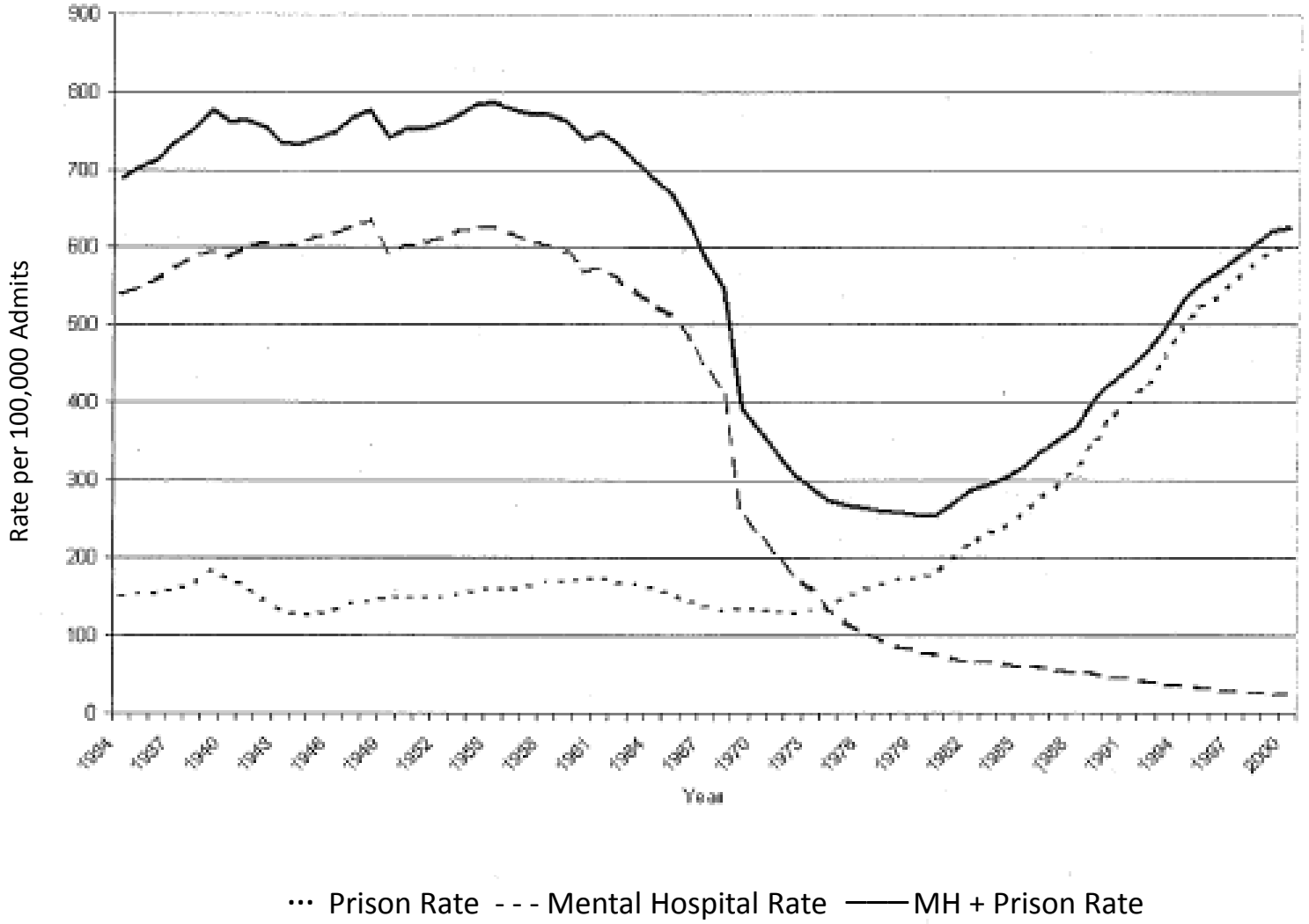
What Is ED Boarding?

- Definitions
- Context
- Emerged as an issue in the 21st century
- Weekly in 80% of hospitals, more often in 55%
- More patients seeking a bed than there are beds
- EDs act as buffers for ebbs/flows of demand vs. fixed supply
- Not just a hospital problem

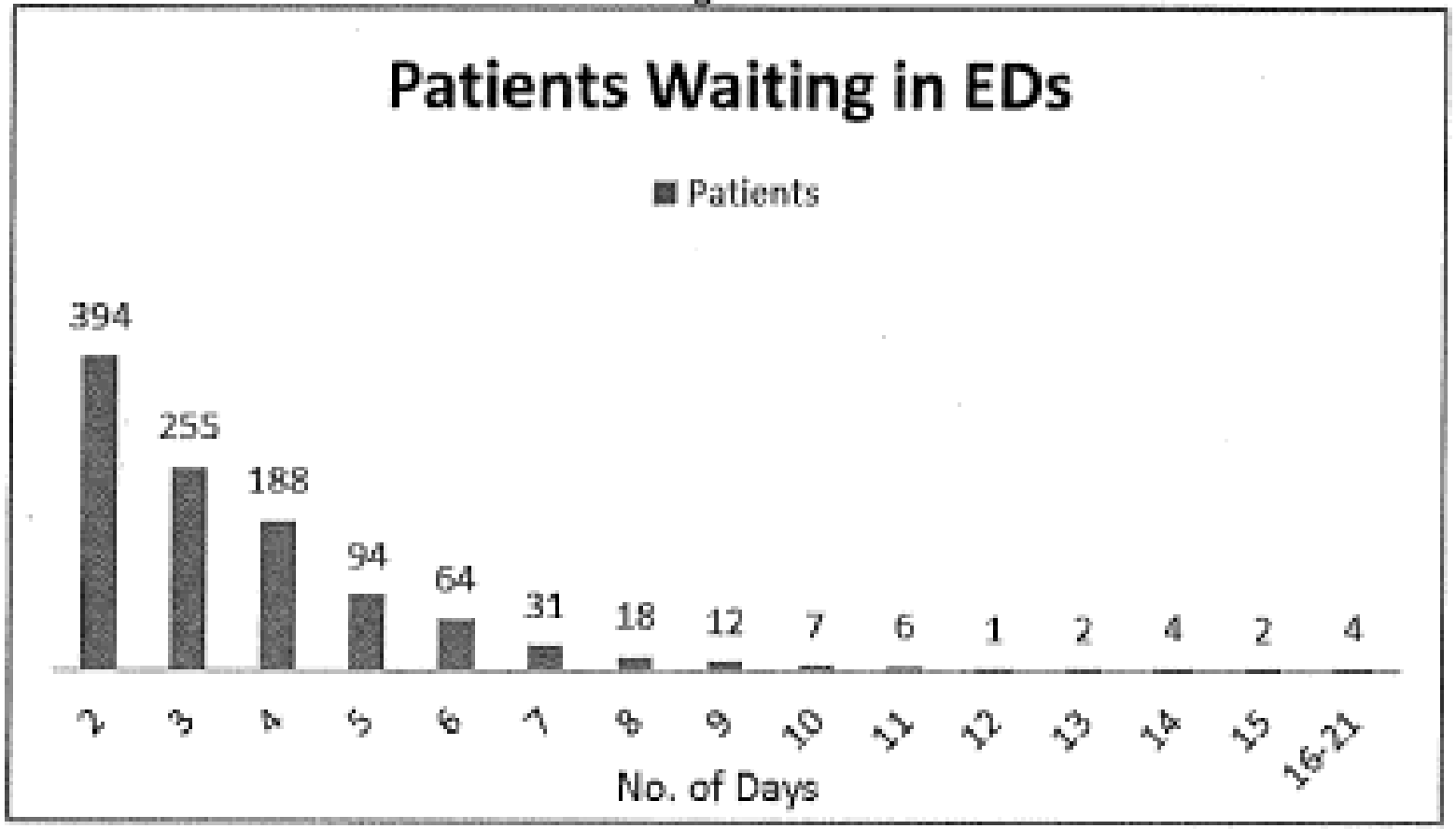


··· Prison Rate - - - Mental Hospital Rate —— MH + Prison Rate

Why Is It A Problem?

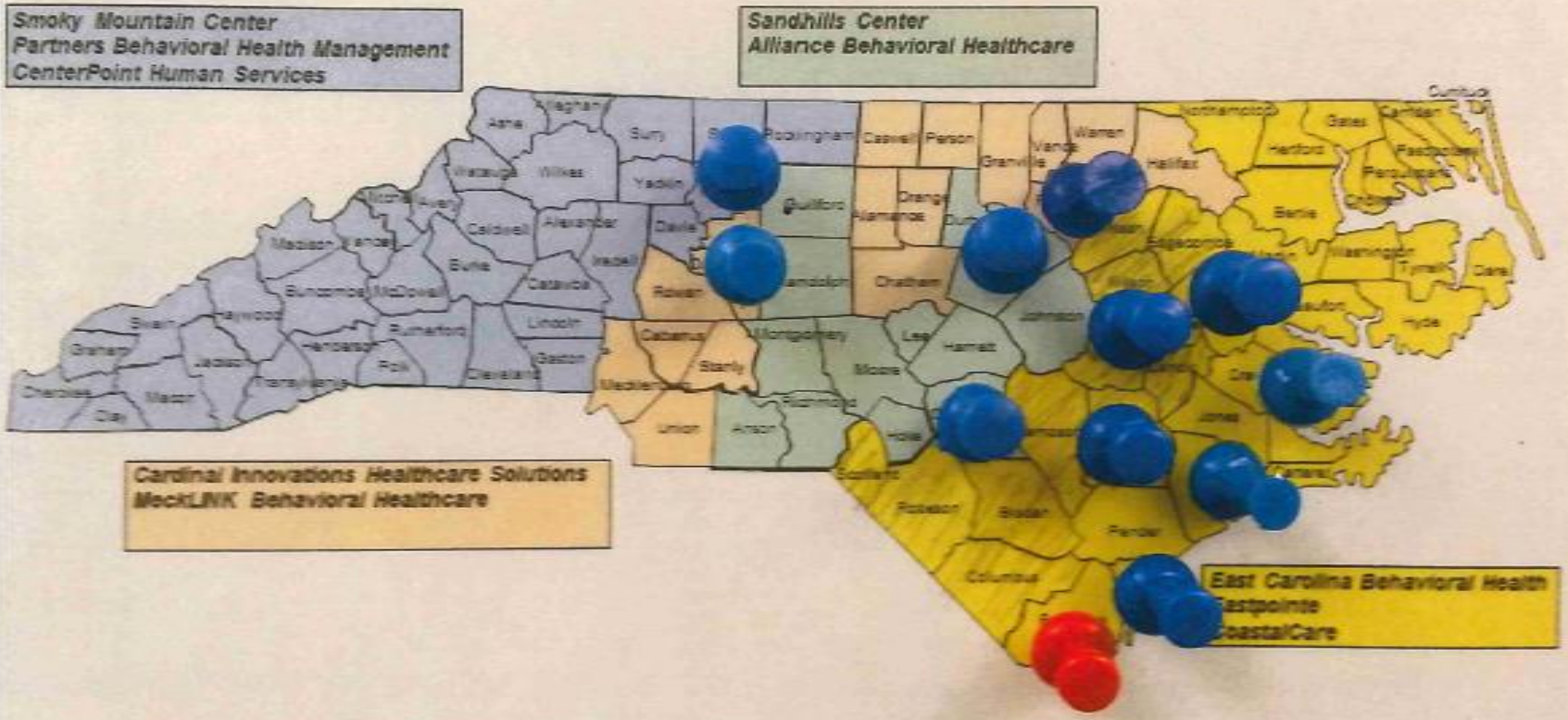
- “Contrary to established medical principles of respect and dignity”
- Compromised care for all patients
- Examples: Mission Hospital and Wake Med
- Costs:
  - Wake Forest Study: $2,000/day
  - Wake Med: $2M/year on “sitters,” transportation services
- Distribution of waiting times in EDs
- Finding a bed – take first available
- Separation from community of origin

Figure 2


Patients Waiting in EDs
Patients
394
255
188
94
64
31
18
12
7
6
1
2
4
2
4
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16-21
No. of Days

LmE_MCOs.PNG (1099×607)

Proposed Local Management Entity - Managed Care Organizations (LME-MCOs)
As of 12/13/13



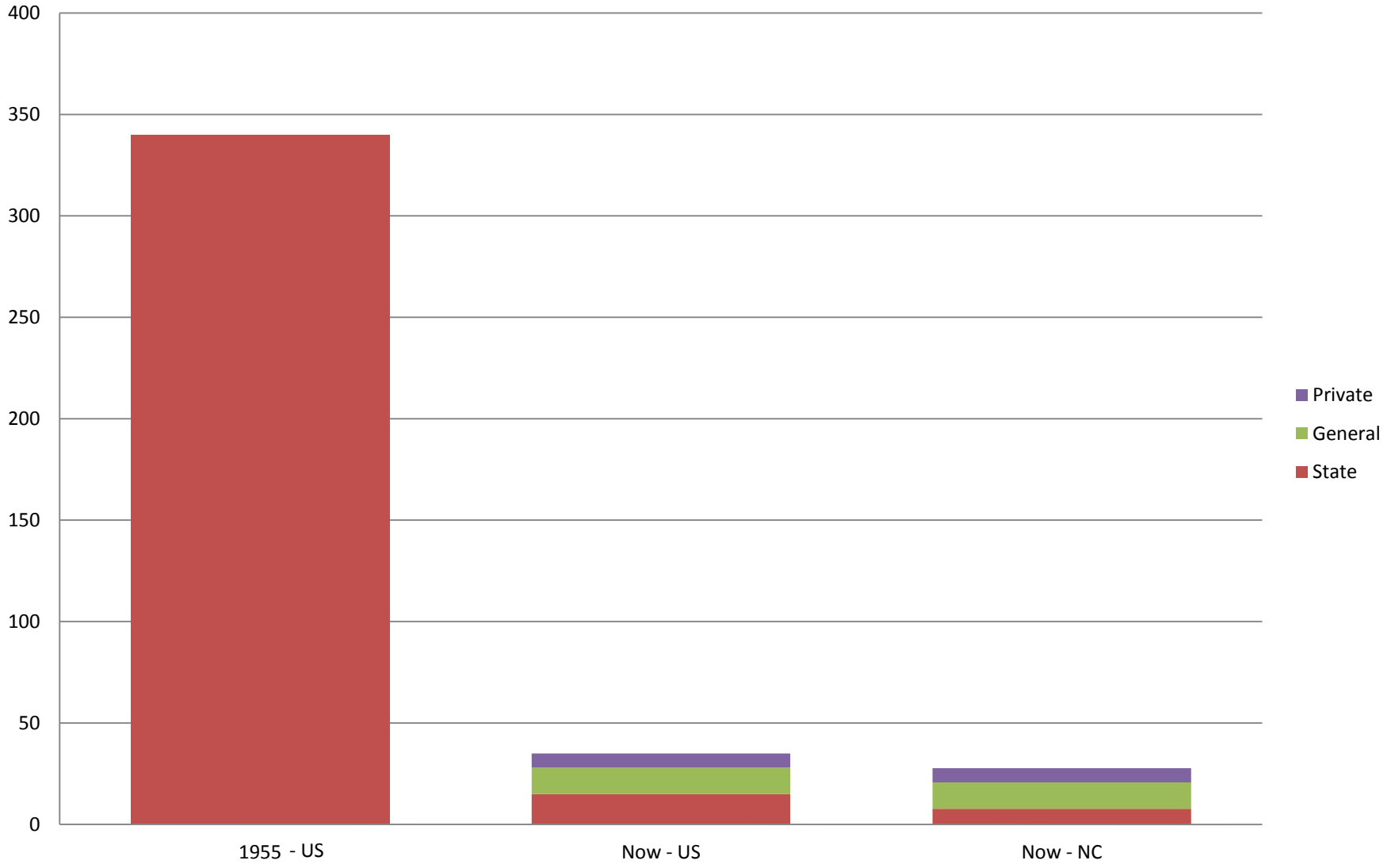
Whom Does ED Boarding Affect?

- Potentially anyone with primary psychiatric diagnosis in an ED
- 30-40% of psychiatric ED patients are admitted
- 2.5 times the rate of other ED patients
- Both voluntary and involuntary
- All insurance plans, Medicare, Medicaid, Uninsured
- In hospitals with and without psych inpatient units
- Particularly the violent and aggressive, and I/DD patients

What Are The Causes?

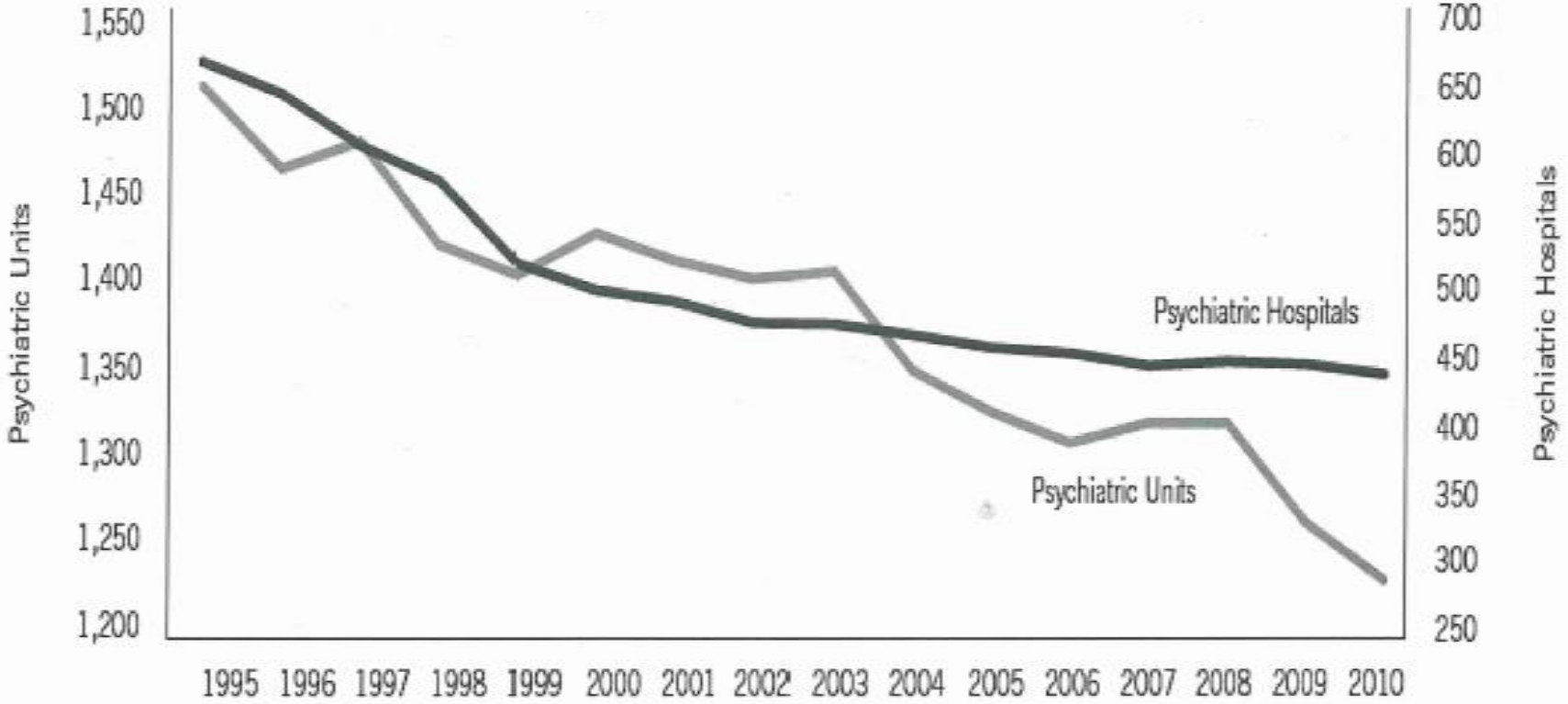
- A relative lack of beds – not the whole story
- “Mental Health Reform” in NC/Olmstead Decision (1999)
- Central Hospital example, changes since 2000
  - % of admissions with SPMI: 40% to 70%
  - Average LOS: 10 days to 75 days
  - Loss of long-term care beds
- Impact of forensic referrals on acute access

Psychiatric Inpatient Beds/1,000



The health care system's capacity to deliver mental health services has been shrinking.

Chart 5: Total Number of Psychiatric Units[1] in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals[2] in U.S., 1995-2010



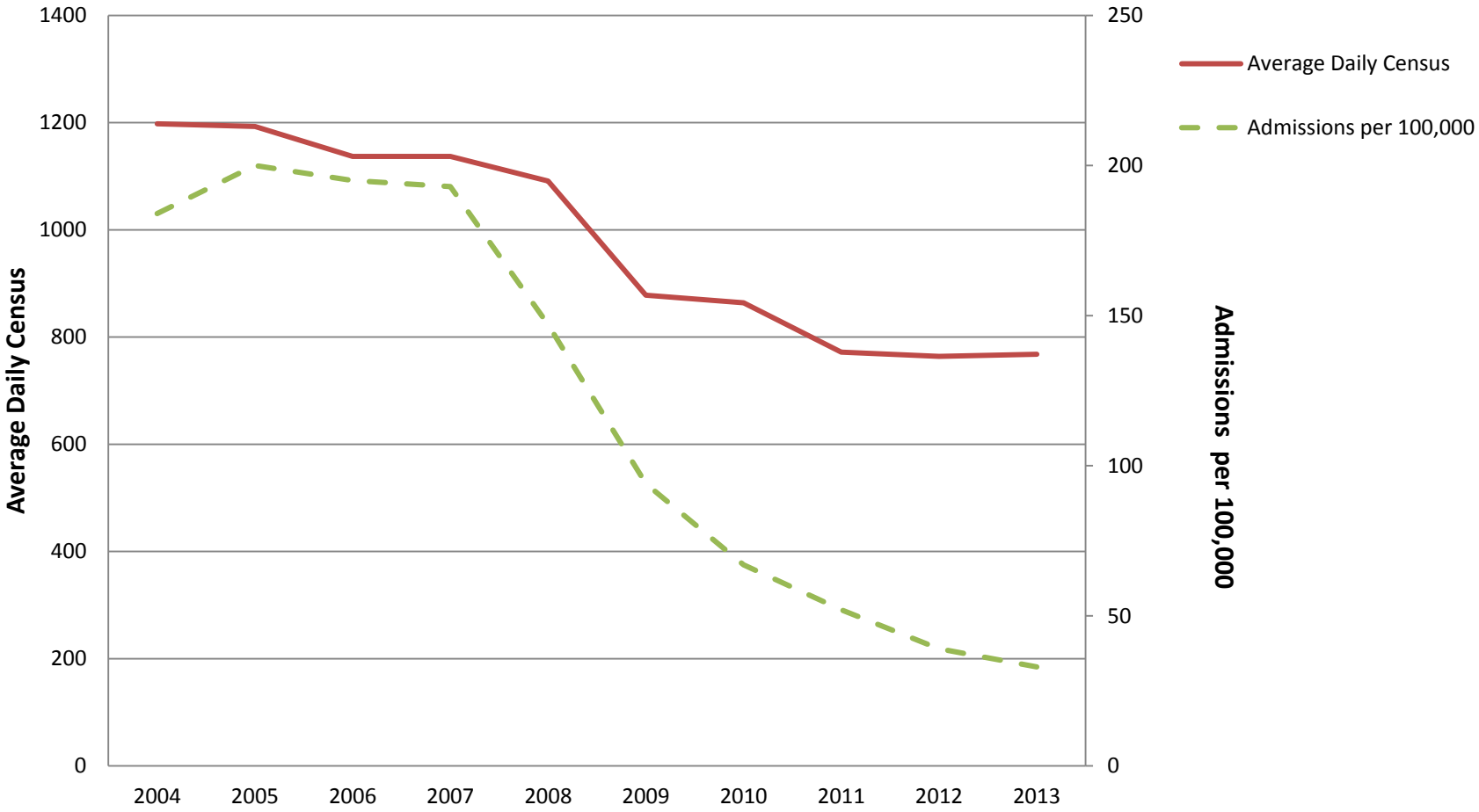
Note: Includes all registered and non-registered hospitals in the U.S.

(1) Hospitals with a psychiatric unit are registered community hospitals that reported having a hospital-based inpatient psychiatric care unit for that year.

(2) Freestanding psychiatric hospitals also include children's psychiatric hospitals and alcoholism/chemical dependency hospitals.

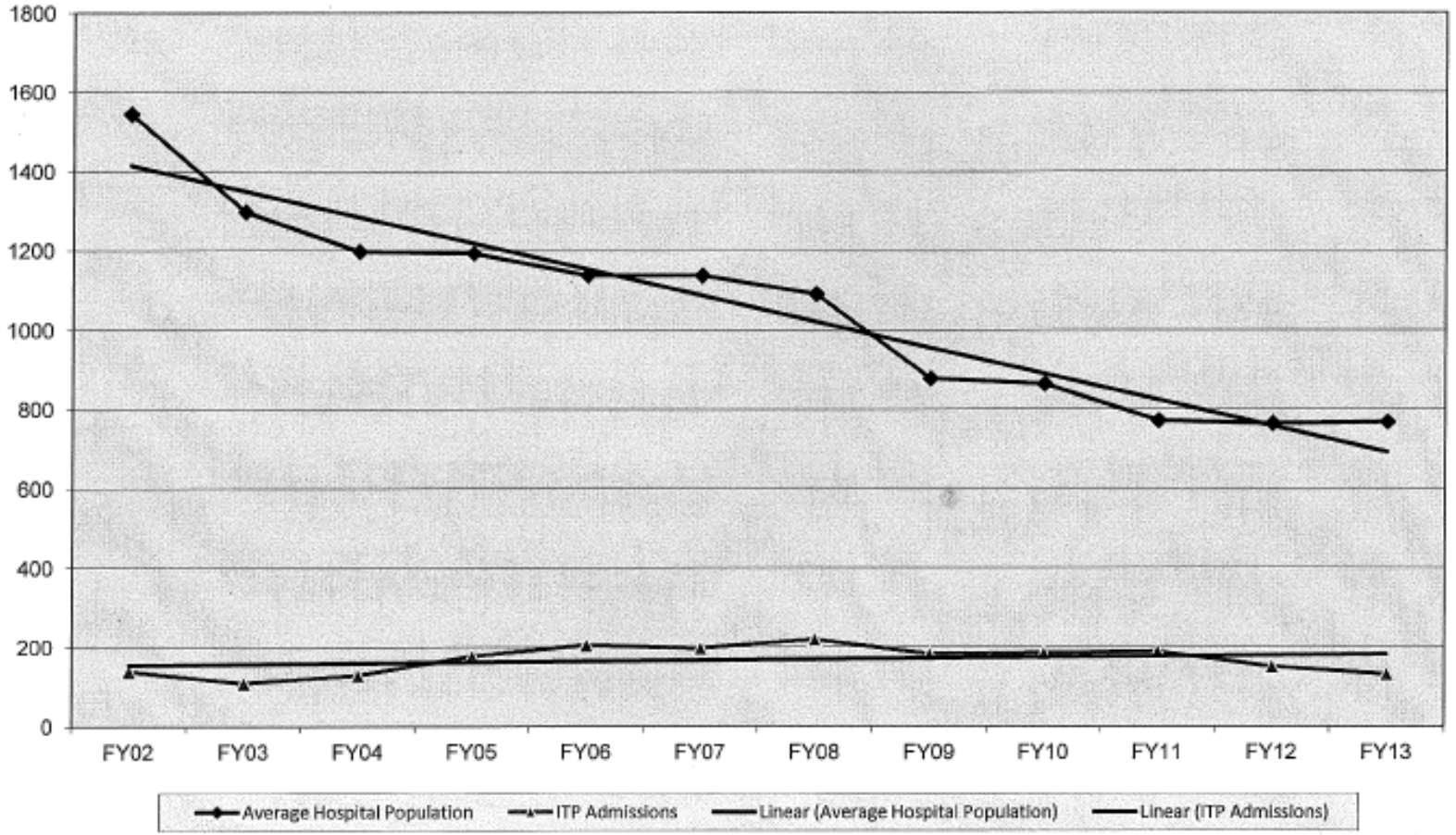
Source: Health Forum, AHA Annual Survey of Hospitals, 1995-2010.

Utilization of NC State Hospital Beds



North Carolina State Hospital Average Inpatient Population and ITP Admissions, FY02 to FY13

(source: State Hospital Annual Reports)



Fragmentation and Diminution of Community MH Resources with Reform

- Redirected inpatient funding diverted
- 20% decrease of funding for community behavioral health since 2003
- Closing of general hospital psychiatric units (only 42 of 116 have them)
- Privatization and demedicalization
- Decline of psychiatrists in public mental health and in EDs
- Diminished coordination

Changing Role of the ED

- Has become the default provider
- Medication bridging
- 9% rise in NC behavioral health ED visits from 2010 – 2012
- Role of the magistrates
- 30 – 40% get admitted

What Is To Be Done?

- Increase available staffed beds
  - State and community hospitals, 3-way and long-term beds
- Minimize use of EDs:
  - Mobile Crisis/CIT/FBC/EMS
- More assertive use of telepsychiatry
- More psychiatrists in EDs to reverse IVCs
- More effective and better coordinated community care
- Behavioral health crisis centers – “Alameda Model”