Joint Legislative Oversight Committee

Mental Health Challenges for Emergency Rooms

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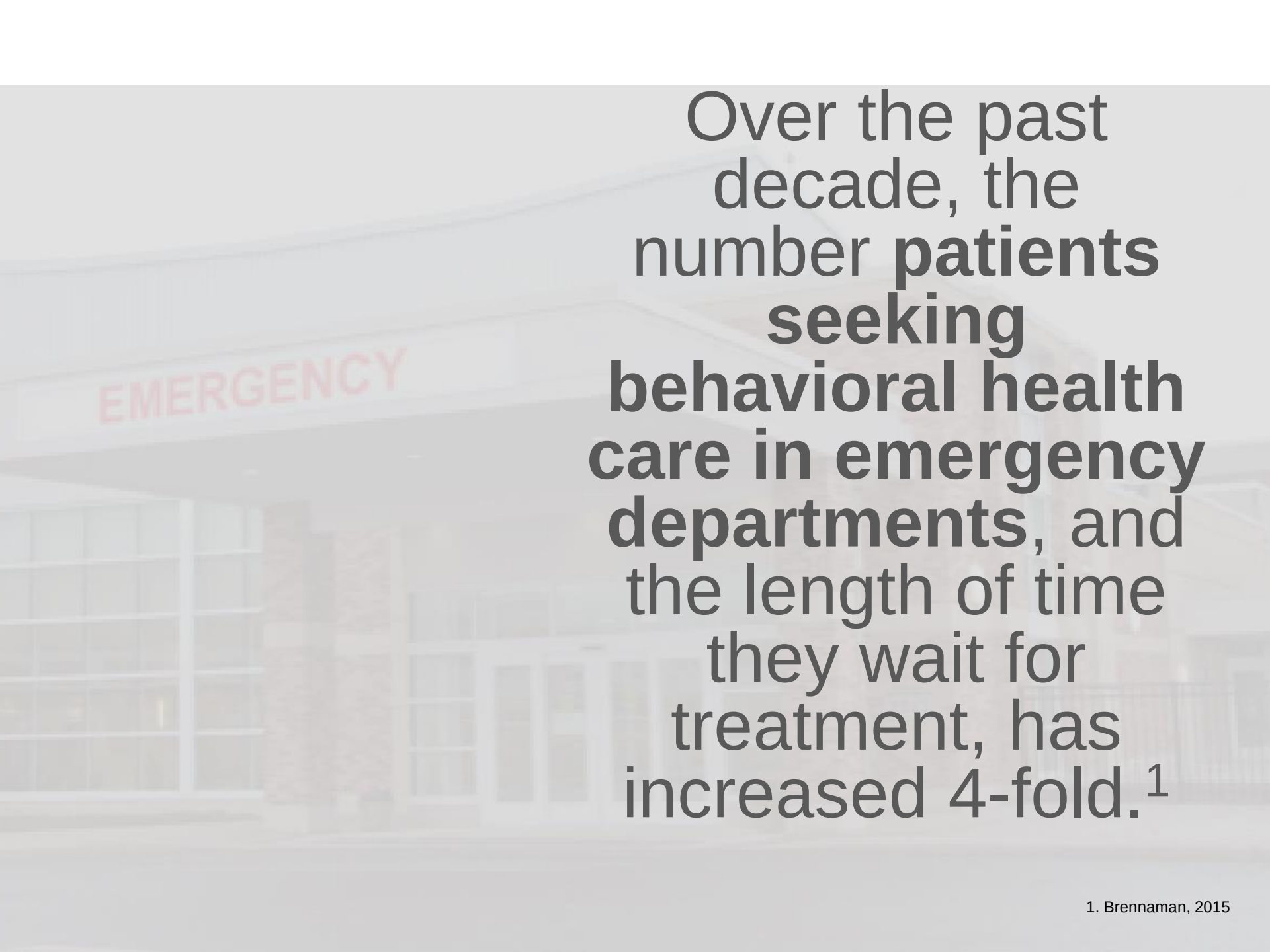


Over the past decade, the number **patients seeking behavioral health care in emergency departments**, and the length of time they wait for treatment, has increased 4-fold.[1]

1. Brennaman, 2015

Crisis in NC emergency departments

- Between 30-80% of ED beds occupied by patients waiting for mental health care
- Patients wait ~4 days for a state bed[2] and ~2.5 days for community hospital bed[3]
- Urban hospitals averaging ~40 patients under involuntary commitment per day

2. DHHS Facility Data Reports, 2015 3. NCHA, 2016

National perspective

- In 2015, behavioral health needs accounted for 1 out of 8 visits to EDs[4]
- Behavioral health patients wait for care over 3 times as long as medical patients[5]
- Direct correlation between ED wait time and inpatient length of stay[6]

4. Nolan, 2015 5. Nicks, 2012 6. Singer, 2011

How did this happen?

- Attempts to deinstitutionalize and reinvest in communities
  - Since 1955, number of psychiatric beds in the US has fallen 95%, while community mental health spending *reduced* 30%[7]
- Currently, psychiatric bed space per capita = levels in 1850[8]

7. Alakeson, 2010 8. Treatment Advocacy Center, 2012

NC falling even further behind

- NC has half the number of beds per resident than the national average[9]
  - Ranked 44th in US
- Only 35% of NC hospitals have a psychiatric unit
- From 2012-2015, NC was one of only three states to *decrease* behavioral health spending each year[10]

9. Treatment Advocacy Center, 2012 10. Copeland, 2016

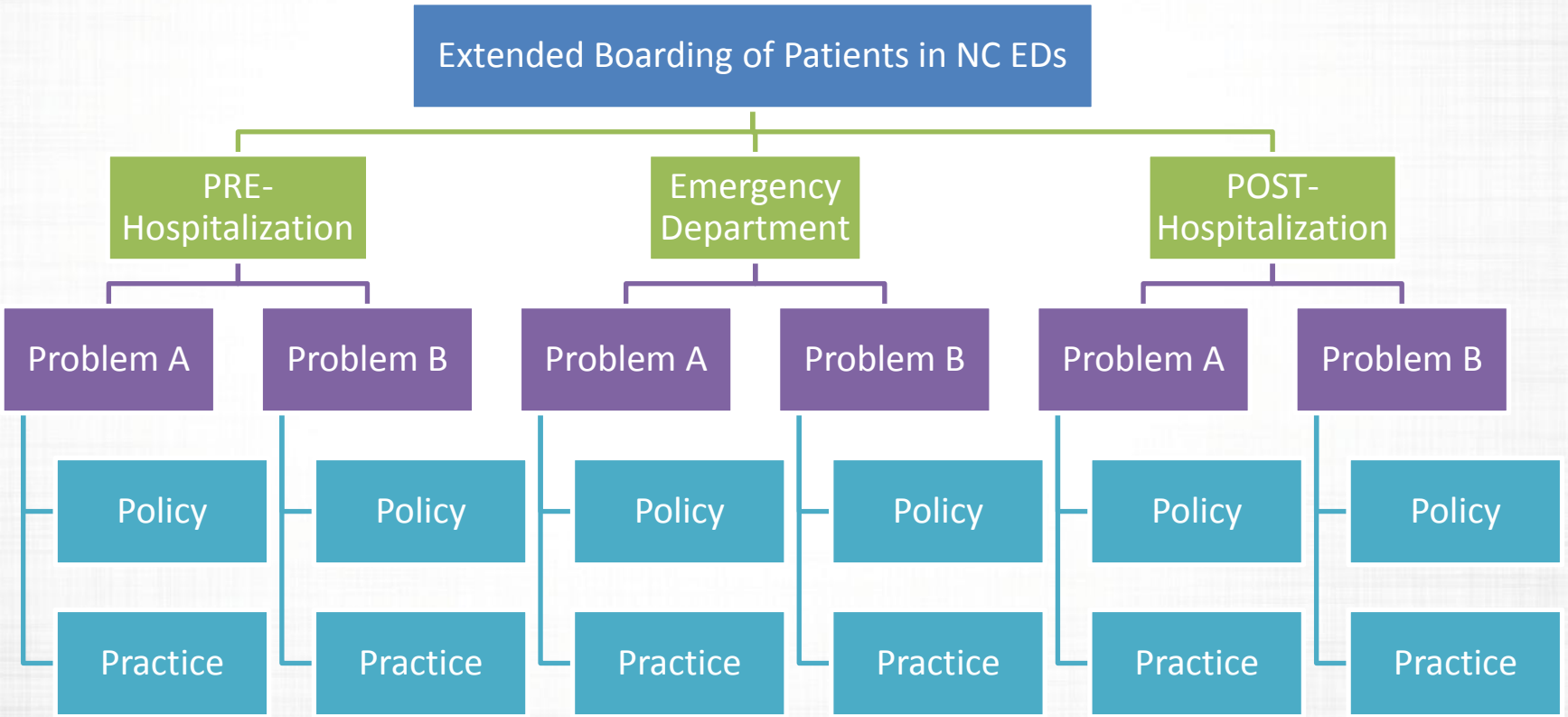
NCHA Behavioral Health Workgroups

- Statewide multi-sector representation:

  Hospitals, patient advocates, LME/MCOs, DHHS, NAMI NC, EMS, Department of Justice, NC Psychiatric Association, Benchmarks, Disability Rights NC, Coalition of Emergency Physicians, philanthropic foundations

- 2016 quarterly meetings assessing policy and practice gaps, solutions

NCHA Behavioral Health Workgroups



Root causes

- Poor system for assessing patient's actual treatment needs
  - Recommendations too often based on availability of services, not the illness
- Inadequate transition to community care for the most acute
  - Hospitals pressured to discharge patients before they are actually well

Programmatic fixes underway

- Mobile Crisis/EMS co-location pilot
- Physician, magistrate education on IVC
- Increased communication with LME/MCOs via real-time ED data sharing
- Improvements to the statewide Bed Board
- Dissemination of ED care best practices
- Evaluation of workforce needs and fixes
- Promotion of integrated care
- Improved utilization data

Needed legislative changes

- Strengthen crisis response
  - Reform the *involuntary commitment* statute
    - Convene a study commission on the *incapacity to proceed* statute
  - Expand EMS hospital diversion programs
    - In coordination with mobile crisis/EMS pilots
- Increase funds for case management
  - Integrate with crisis response systems

But to really fix things…

- Fund a robust crisis response system
  - Proper evaluation via mobile crisis/EMS integration & mental health boards
- Provide adequate inpatient treatment for the most acute patients
  - Including transitional, recovery-oriented care
- Significantly expand case management
  - Guaranteed service, fully integrated in care continuum