HELP: People Seeking Mental Health Care

in

New Hampshire

FOUNDATION FOR
HEALTHY COMMUNITIES

February 2013

Foundation for Healthy Communities

Our mission is to improve health and health care delivery through innovative partnerships.

Our objectives are:

- To collect, analyze, and evaluate data about health and the delivery, quality, management and organization of health services.
- To promote, sponsor and conduct applied research and scientific investigation relative to quality, health delivery process improvement and health policy.
- To communicate information, sponsor education and training, and facilitate innovation and access for the improvement of health and the creation of healthy communities.

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Key Findings

- Nearly 1 out of 3 people waited more than 24 hours in a hospital emergency department (ED) for mental health treatment. The average waiting time was 2.5 days among this group of patients.

- More than half of all patients recommended for an Involuntary Emergency Admission for psychiatric care waited more than 24 hours in a hospital ED.

- The primary diagnosis for more than 1 out of 5 patients was reported as suicidal and about one third reported major depression.

- More than 3 out of 4 patients required constant observation while waiting in the ED and almost half of the patients required special security.

- New Hampshire Hospital in Concord was the single most frequently identified destination following a visit to an ED among patients in this study.

- The total number of in-patient psychiatric beds in New Hampshire has decreased 27% from 526 beds in 2005 to 384 beds in 2013.

Introduction

The purpose of this report is to identify and document access issues related to people who go to a hospital emergency department (ED) in communities throughout New Hampshire seeking help for an acute mental health condition. In early 2012, there were an increasing number of anecdotal stories of people waiting in hospital EDs because there was no place to refer them for treatment of their acute mental health illnesses. This report describes a sample of people who needed mental health care and sought help.

"A middle-age man diagnosed with schizophrenia and bi-polar disease came to our ED. He required an involuntary emergency admission to the state hospital. With no room available for three days, he was required to stay in the Emergency Department. Known to be violent—and becoming so more than once, punching the walls in his room— the patient was sequestered in a room with no window, a stretcher for a bed, and access to only books and magazines for recreation. A 24-hour police detail (costing $5,184) was required for his security, as well as for the safety of staff and other patients. Additionally, to use the bathroom or shower, he had to be escorted. The very nature of a busy Emergency Department was unsettling to the patient, leading to his violent outbursts which caused further turmoil for staff and other patients. His occupation did cause delays in treating other patients."

Methodology

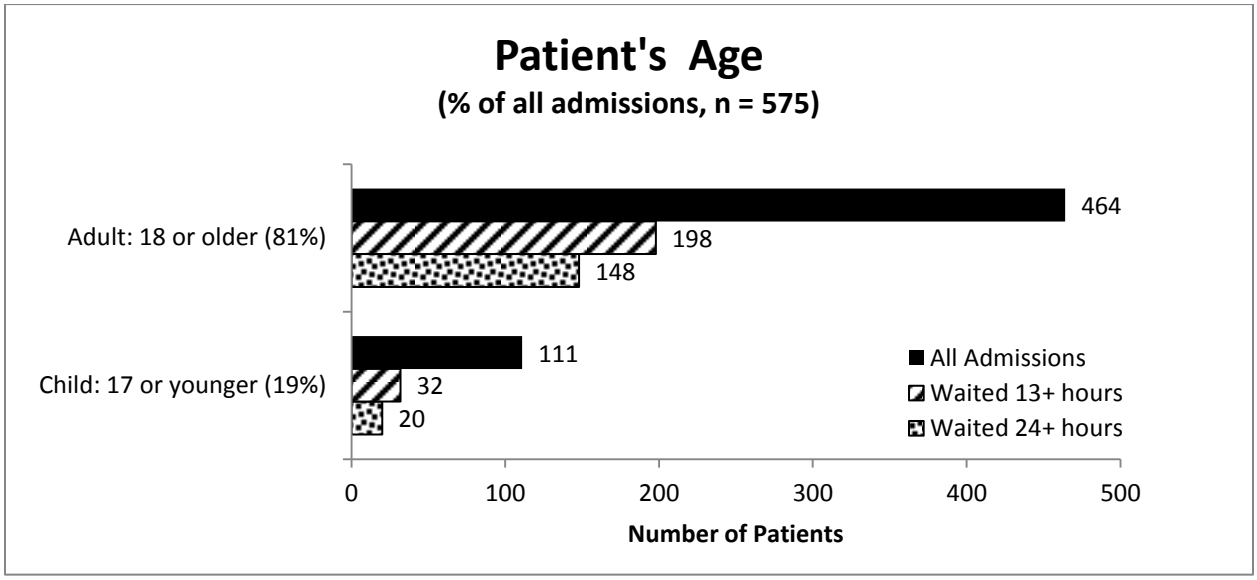
The 26 acute care hospitals in New Hampshire with emergency departments were invited to collect several data elements regarding people who were medically cleared in the ED but in need of an in-patient psychiatric admission. Fifteen hospitals (Appendix A.) agreed to submit data, for a minimum of 8 weeks, during the last quarter of 2012. There were four other hospitals that submitted 1-2 cases each, but they are not included in the sample because they were not able to submit over an 8 week period. Some of the participating hospitals have in-patient behavioral health services but a majority of hospitals do not. There is only one acute care hospital in the state that is a Designated Receiving Facility (DRF) or able to accept an involuntary emergency admission to a limited number of its psychiatric in-patient beds. The data collection instrument for this report is in Appendix D.

Results

Patient Age

There are 575 people in the sample. **Figure 1** identifies the two key age groups. Most people were adults (81%) although almost 1 out of 5 or 19% were 17 years old or younger. Based on discussion with the Foundation's Behavioral Health Unit (BHU) Workgroup it was decided to analyze the survey results among three categories: total sample; people who waited 13 hours or more in the ED; and people who waited 24 hours or more in the ED. There were 198 adults who waited in the ED for 13 hours or more and there were 148 adults who waited 24 hours or longer. Among the adults, 43% waited 13 hours or longer in the ED and almost a third (32%) waited more than 24 hours in the ED. Among the 111 children, 29% waited 13 hours or longer in the ED and 18% waited 24 hours or longer.

Figure 1. Patient's Age

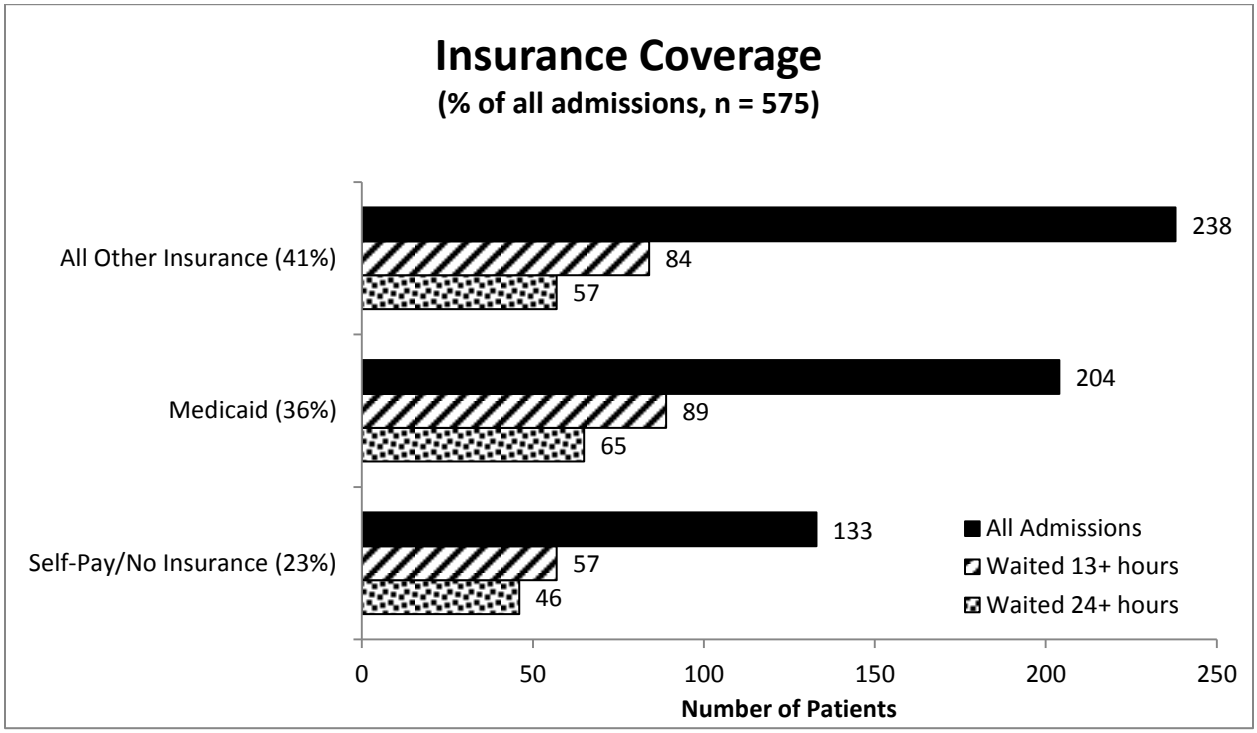


"One of our biggest concerns is that of extended stays for the children and adolescent population. Currently in our ED we have 2 teenagers awaiting beds who have been here for 6 days. Two days ago, after 6 days in seclusion in the ED, we transferred a 17 year old with a diagnosis of mood disorder and a rule out of poly-substance abuse. Resources for this one patient included local police, DCYF, hospital security, Emergency Department and Mental Health emergency services staff. Lockdown was needed several times to prevent injury to the patient and staff after a number of violent outbursts."

Insurance Coverage

Figure 2 identifies the insurance status of the people in the study. More than three fourths (77%) of the people had insurance with 41% having private insurance or Medicare. Medicaid provided coverage for 36% of the people. Self-pay, often a proxy or indicator for a person without health insurance, represented 23% of the people in this sample. There was no significant variation between insurance status and the time people waited in an ED.

Figure 2. Insurance Coverage



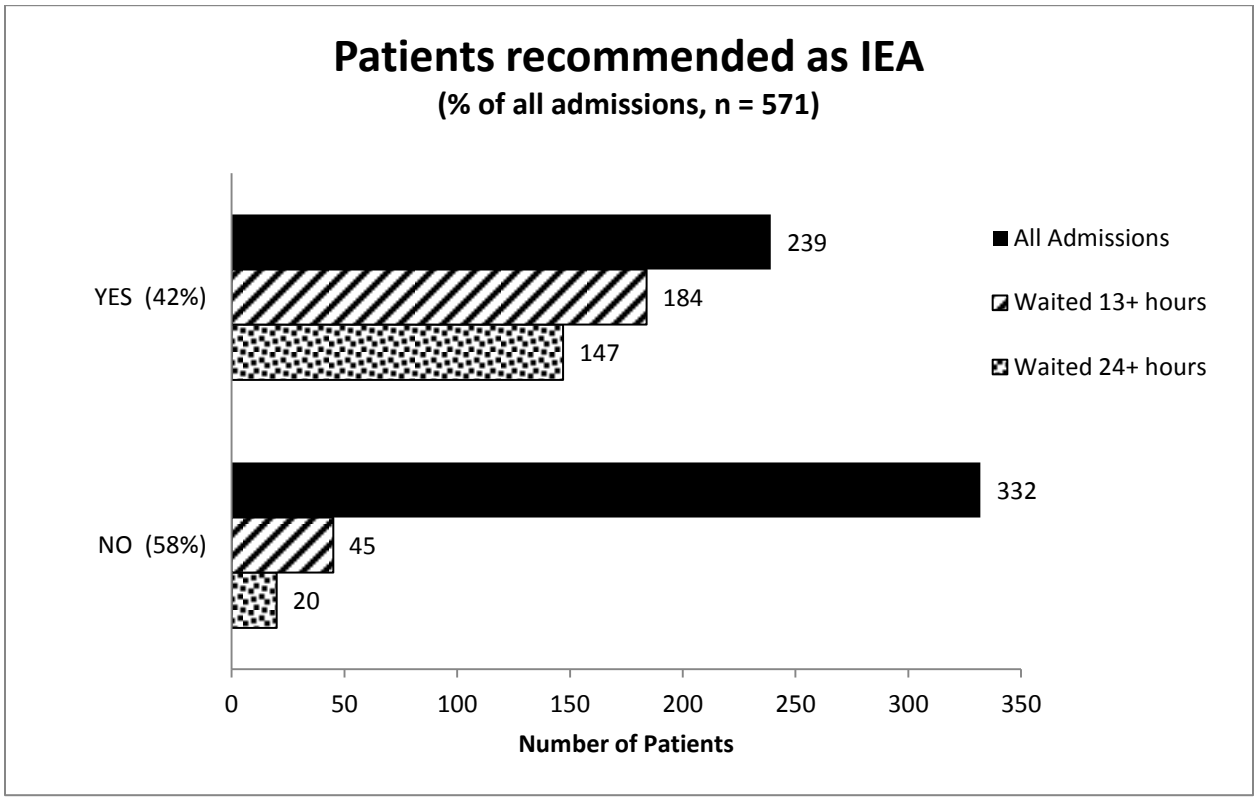
A mental health assessment, usually provided by trained staff from a community mental health center's Emergency Services assessment staff, was requested for most people (87%) in the sample.

*"These patient scenarios are a daily challenge to our state's Emergency Departments and certainly a disservice to our patients. As with our NH colleagues, our ED has experienced an increase in the length of stay for Involuntary Emergency Admissions to NHH. By comparison, in January 2012 we had **75** behavioral health patients = **760** total man hours for 1:1 observation. In January 2013, we had **73** patients = **1,477** man hours, acutely representative of the delays involved. This obviously strains resources and budgets."*

Involuntary Emergency Admission

Figure 3 identifies those people who were determined to need an Involuntary Emergency Admission (IEA) for psychiatric care to either New Hampshire Hospital (the State psychiatric hospital in Concord), Cypress Center (an in-patient facility in Manchester with DRF beds) or Elliot Hospital in Manchester (8 DRF beds in their psychiatric unit). There were 239 people or 42% of the total study population in need of an IEA. Among people in need of an IEA, 77% waited in the ED for 13 hours or longer and 62% waited 24 hours or longer. We examined the ED waiting time among the people who waited 24 hours or more and found that the average wait was 2.5 days. The longest waiting time in this group of patients was 7 days.

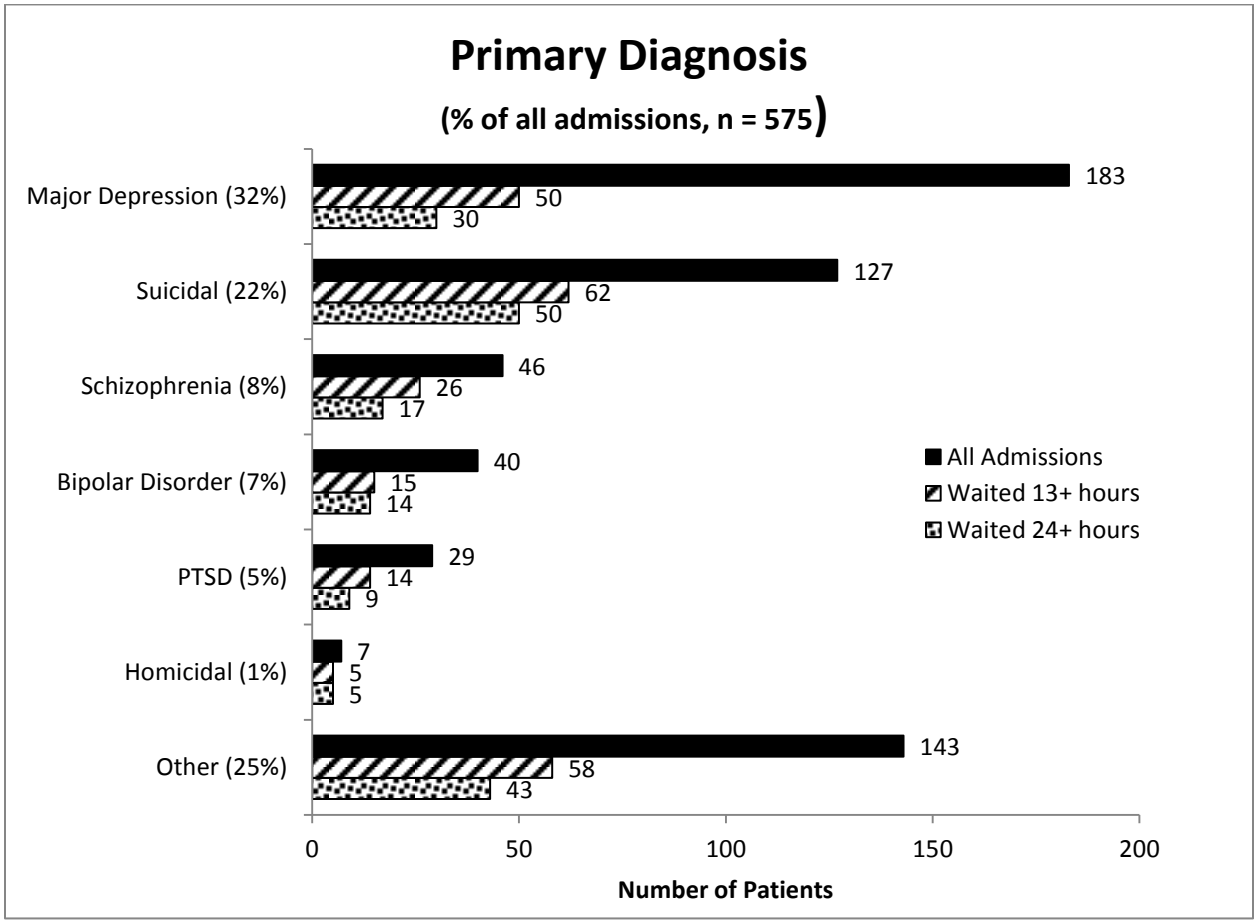
Figure 3. Patients recommended as IEA (4 surveys did not provide an answer to this question.)



Primary Diagnosis

The primary mental health diagnosis is identified in **Figure 4**. Major depression was reported as the primary diagnosis for nearly a third (32%) of the 575 people in this study. The other key mental health diagnoses were: suicidal (22%); schizophrenia (8%); bipolar disorder (7%); PTSD (5%); and homicidal (1%). Another 25% were other mental health diagnoses or unspecified.

Figure 4. Primary Diagnosis

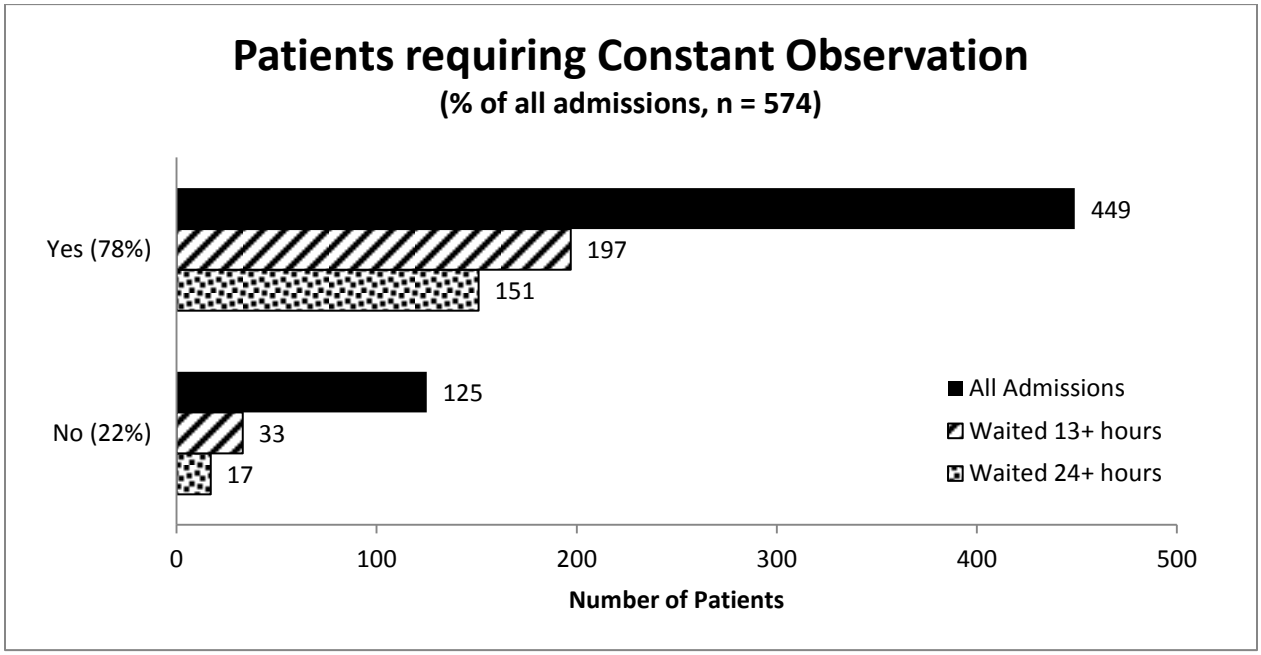


"A patient presented to the Emergency Department (ED) accompanied by the police for an evaluation of mania and suicidal ideation. The patient was triaged in the emergency department at 7:40 PM hours and was medically cleared to be evaluated by Mental Health staff at approximately 11:30 PM hours that same night. The patient was observed in the ED for approximately 130 hours (5.4 days) until she was transferred to New Hampshire Hospital for psychiatric care evaluation. It cost $26,310 in personnel hours to have the patient observed in the ED for 130 hours with one physician, one registered nurse, and one ED tech assigned to her. This figure includes time for the paramedics and security team who were called 14 times to the ED to assist the nursing staff when the patient became agitated and escalated. The above figure does not include unit secretary time that was spent coordinating physicians and mental health counselors to help meet the needs of the patient."

Observation

Figure 5 indicates that a significant proportion (78%) or 449 people required constant observation by a health care professional while waiting in the ED. More than a third of people who waited 13 hours or longer in the ED required constant observation.

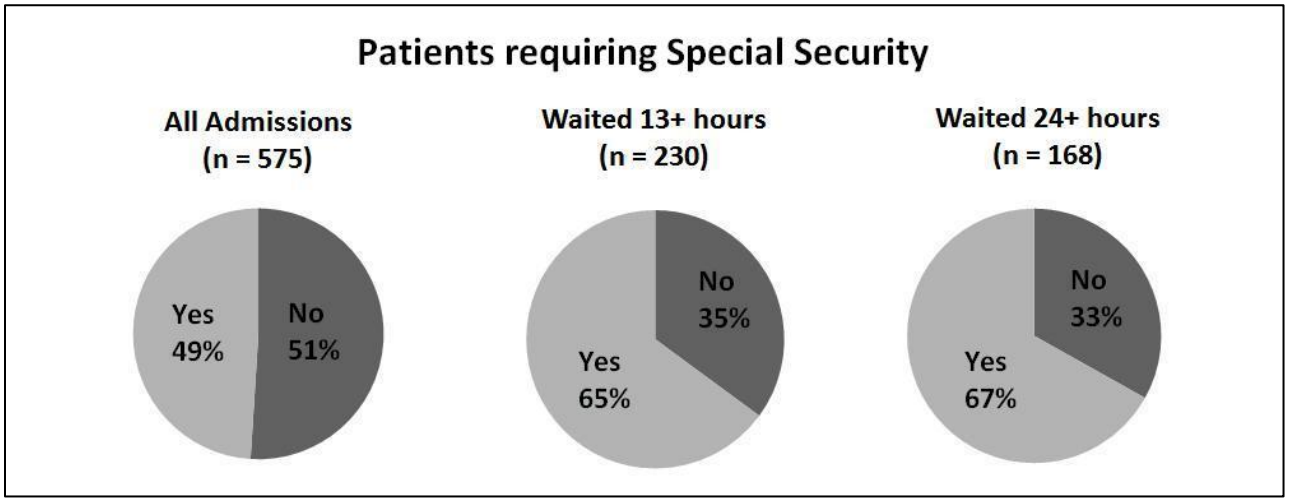
Figure 5. Patients requiring Constant Observation



Special Security

Figure 6 identifies safety concerns for the patients, staff and others in the ED. In addition to constant observation by a health care professional, nearly half (49%) of people waiting in the ED presented a risk of violence or engaged in violence and required special security. This proportion increased to two-thirds among those who waited for 13 hours or longer in the ED.

Figure 6. Patients requiring Special Security

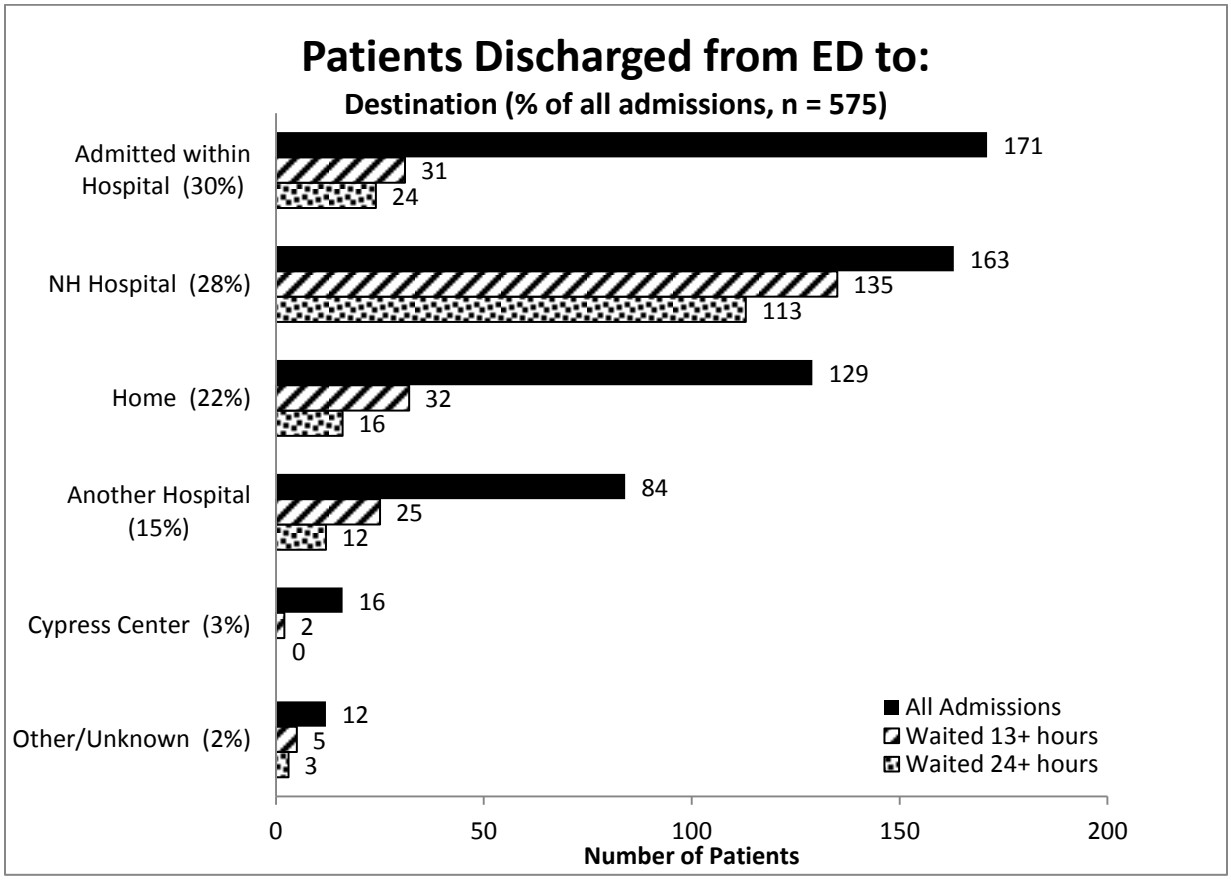


"A 47 year old man with psychotic disorder became very violent during his stay, threatening staff and security and destroyed hospital property by punching holes in the wall. This patient made the ED environment feel very unsettled for staff and patients. A family member upset with this patient's length of stay and overall process actually went to the Emergency Services office and threatened to blow it up. Our hospital went into high security alert until the family member was in the custody of our local police department. During these 8 hours the security staff had to call in additional officers and post them at hospital entrances."

Discharge Destination

Figure 7 identifies where patients went after discharge from the ED. Thirty percent were admitted to the hospital where they sought help at the ED. There were 4 hospitals, among the 15 hospitals reporting this ED data, that have some in-patient psychiatric services. These in-patient services are variable in terms of the number of psychiatric beds and the age group(s) (child, teen, adult, geriatric) who might be served. More than 1 out of 4 people (28%) waited for an admission to NH Hospital. Among the 163 people who went from a hospital ED to NH Hospital, 83% waited 13 or more hours and 69% waited 24 hours or longer. About 1 out of 5 people (22%) went home after their visit to the ED. Among these 129 people who went home, 25% waited 13 hours or longer and 12% waited 24 hours or longer in the ED before going home. Some people (15%) were transferred to another hospital. Thirty percent of these 84 transfer patients waited 13 hours or longer and 14% waited 24 hours or longer in the ED. There were 16 patients who went to Cypress Center in Manchester.

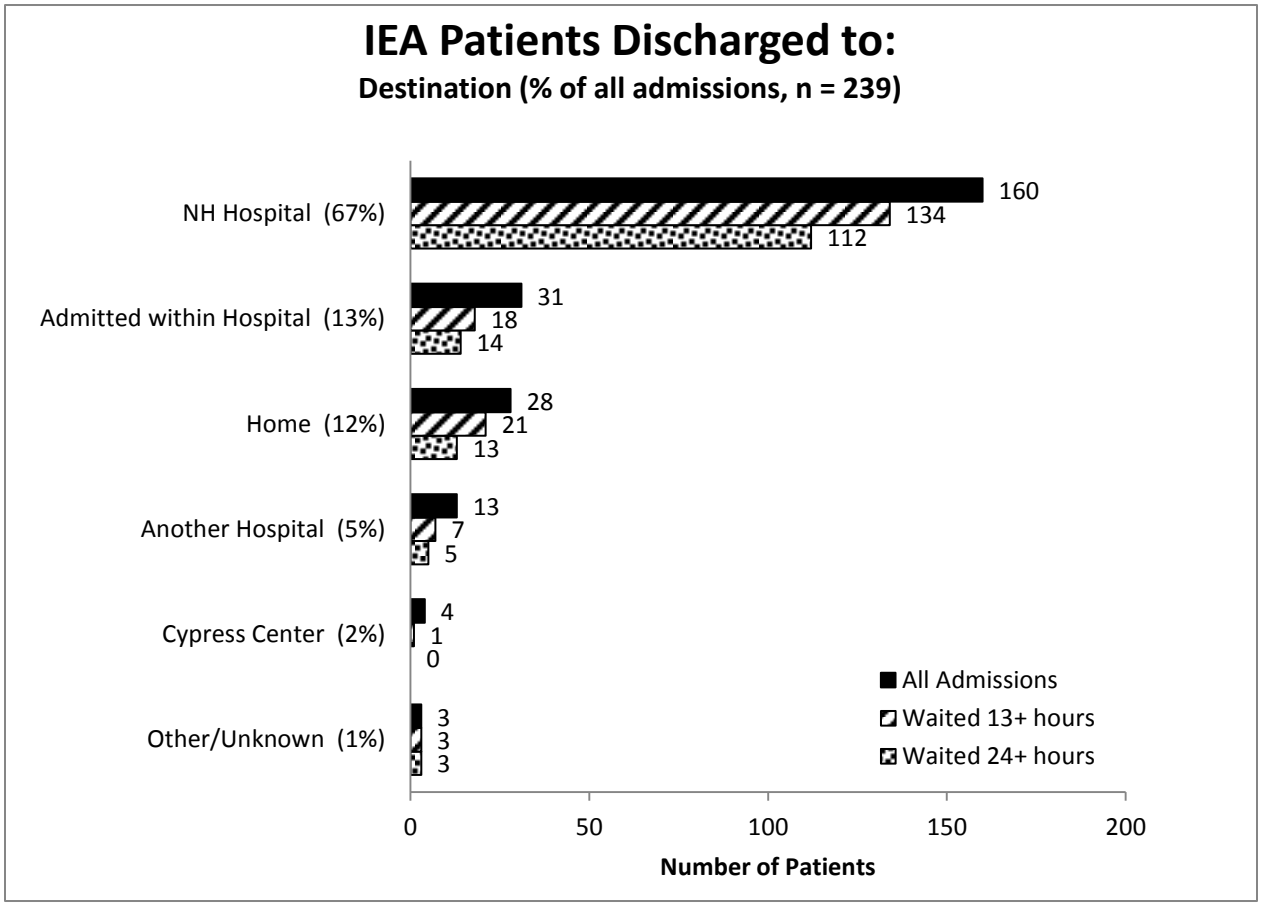
Figure 7. All Admissions Discharge Destination



IEA Patient Discharge Destination

Figure 8 provides further analysis on where the people who were identified as an IEA were discharged. Two-thirds of the people who were an IEA went to NH Hospital. Another 2% were discharged to Cypress Center, a facility in Manchester that is a DRF. Other hospitals accounted for 18% of the IEA patients. Some of these may include people who were discharged to the DRF at Elliot Hospital in Manchester. Also, it could include people admitted to a hospital because there was no ability for them to safely stay for an extended period in the ED and unsafe for them to be sent home. There were 61 people (12%) who were discharged home. These may include people unwilling to wait any longer in the ED for psychiatric treatment or their acute condition may have resolved.

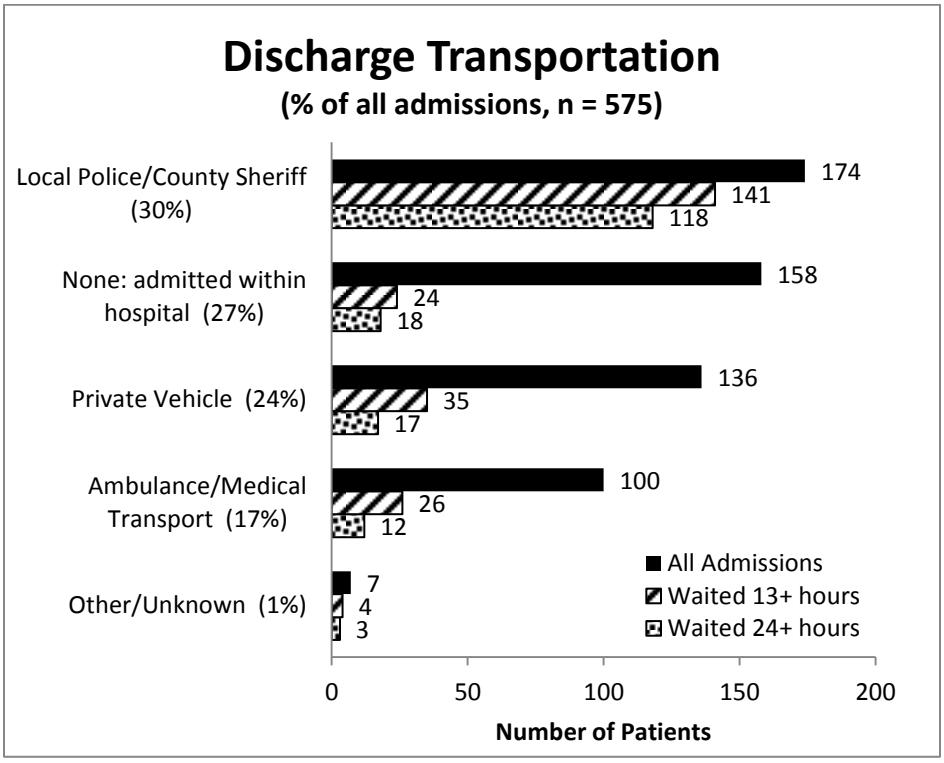
Figure 8. IEA Patient Discharge Destination



Discharge Transportation

Figure 9 identifies the transportation method used for people not admitted into the hospital where they presented in the ED. Local police or the county sheriff transported 30% of the people and they were the key transportation resource for people who waited 13 hours or longer in the ED. About 1 out of 4 people left in a private vehicle after their time in the ED and an ambulance or medical transport service was used for 17% or 100 people in this sample.

Figure 9. All Admissions Discharge Transportation



A closer examination of the people transported by local police/county sheriff (174 people) identified 90% of them went to NH Hospital (153 people) or Cypress Center (3 people) from the ED. Another 18 people in this category went to another hospital or this was unknown.

Patients Discharged to New Hampshire Hospital

The following figures provide a more focused look at four variables (e.g., age, diagnoses, constant observation, special security) of patients who were discharged from a community hospital ED to New Hampshire Hospital.

Figure 10. Age of Patients Discharged to NH Hospital

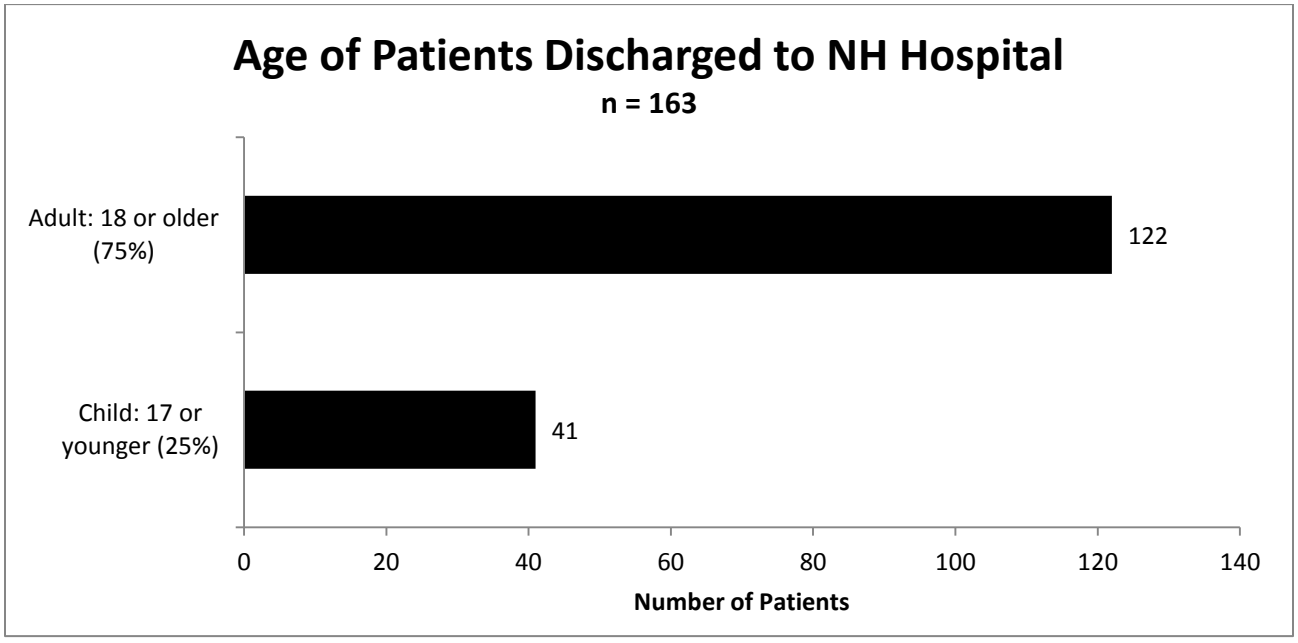


Figure 11. Primary Diagnoses of Patients Discharged to NH Hospital

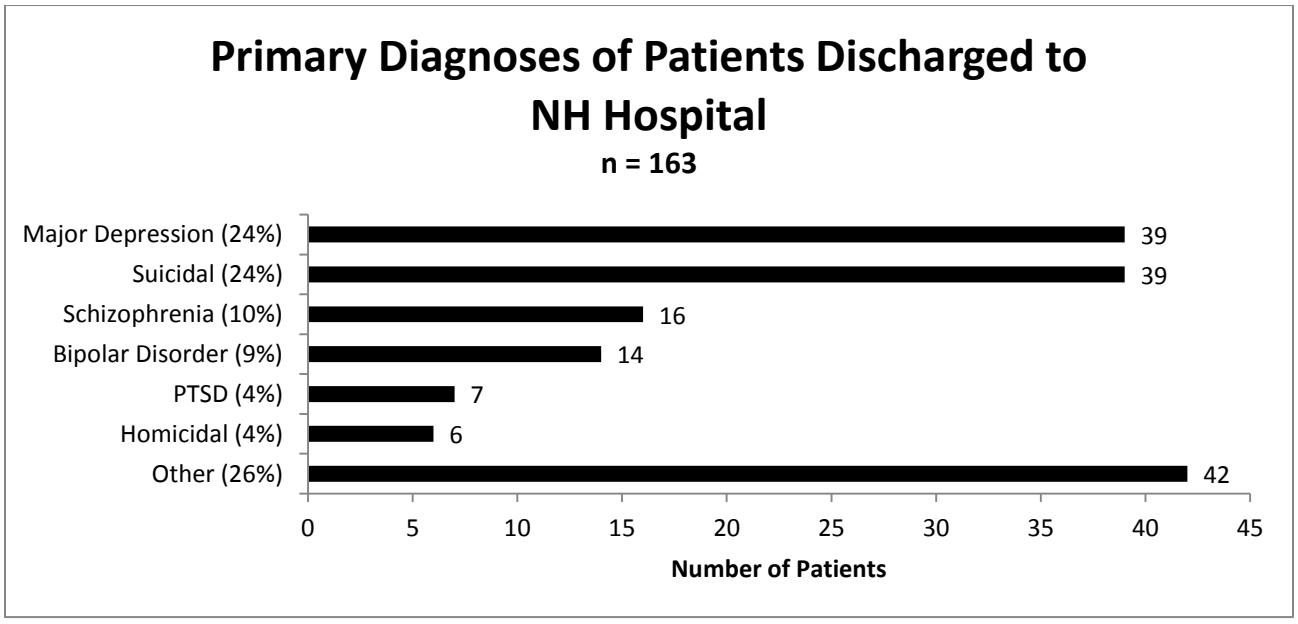


Figure 12. Patients requiring Constant Observation prior to discharge to NH Hospital

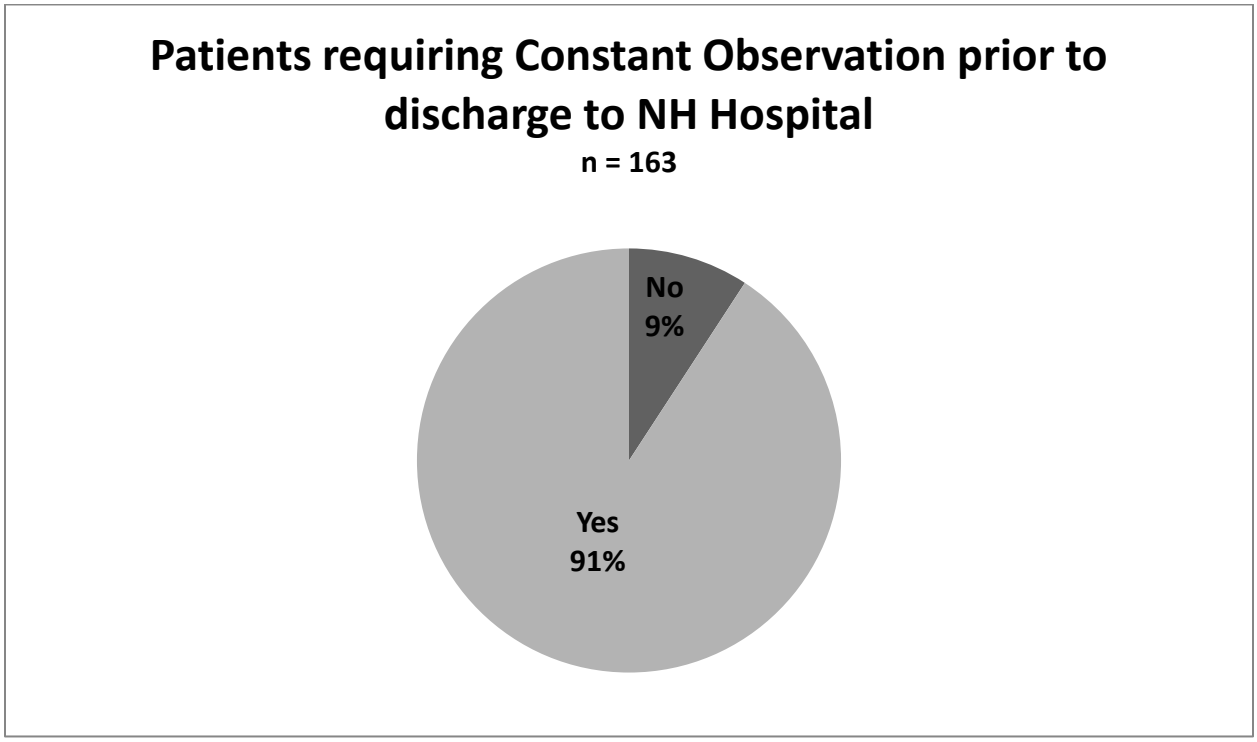
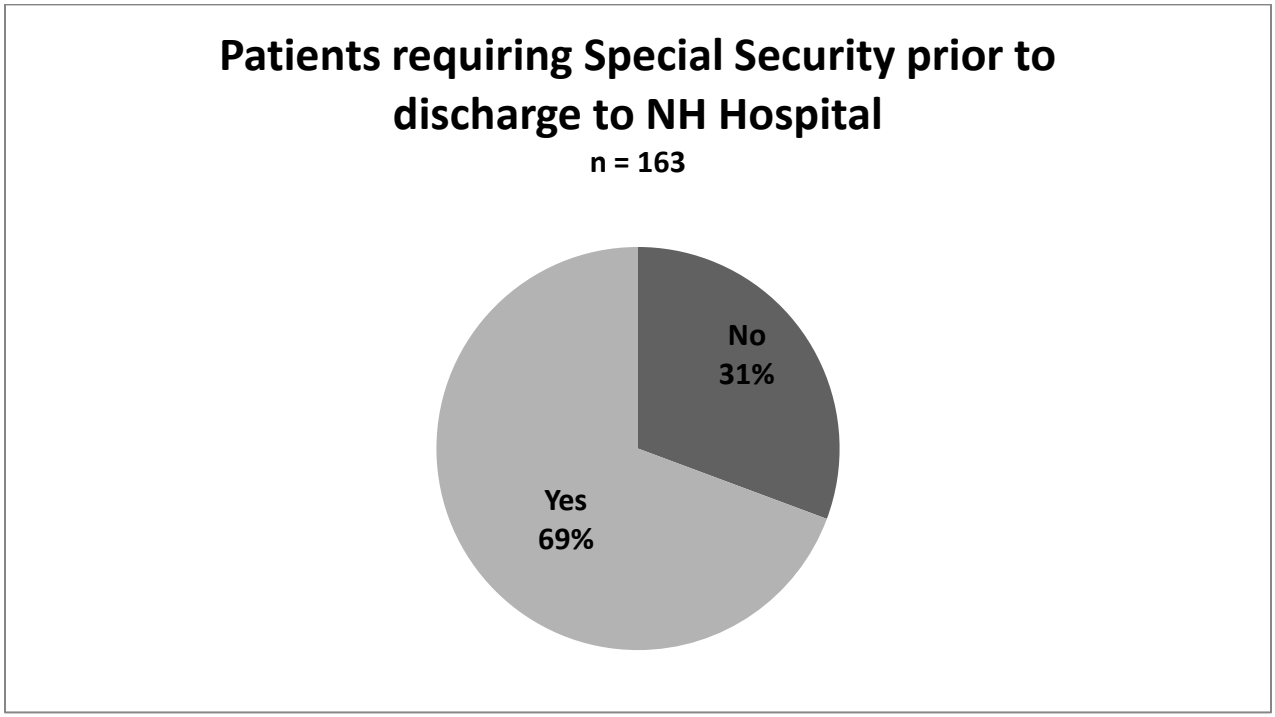


Figure 13. Patients requiring Special Security prior to discharge to NH Hospital



Discussion

This sample of 575 people seeking help for an acute psychiatric illness at a community hospital ED is only a small fraction of the total number of people who sought help statewide during the study period. The data indicate that there are significant access problems for some people with acute psychiatric illness in New Hampshire. The problems of access to treatment affect people of all ages and include people with health insurance and those who are uninsured.

Emergency Departments are open 24/7 and the key entry point for many people with a health crisis or emergency. EDs can assess people and treat some illnesses or injuries but they do not have-staff, facilities nor expertise for more difficult health crises such as a stroke, heart attack, broken bones, etc. These acutely ill patients are often transferred from the ED to a medical/surgical bed to be treated by a cardiologist, neurologist, orthopedic surgeon, etc. While all community hospitals have medical/surgical beds, most community hospitals do not have any in-patient psychiatric service. The 384 psychiatric beds in New Hampshire today are 27% fewer than in 2005. Less than half the psychiatric beds in the state are available for patients determined to need an Involuntary Emergency Admission. The overall bed capacity may be further limited because of the age group it is designed for or the gender of a patient occupying a bed in a two-bed room and the length of stay. A strong, accessible community-based mental health service is critical to addressing the problem of people with an acute psychiatric illness seeking help in hospital EDs. In 2012, it was found that close to one half of new consumers waited one month or more to have an appointment with a psychiatrist or nurse practitioner according to the NH Public Mental Health Consumer Survey Project.

The gap in available psychiatric beds and community mental health services may in part be related to our attitudes about mental illness. While 95% of adults in New Hampshire agreed that treatment for mental illness is effective, this understanding of the value of treatment varied significantly from the lower proportion of adults (63%) of adults who agreed that people are caring and sympathetic to people with mental illness.

The human or emotional costs and the social costs (e.g., unemployment or reduced productivity, court fees and jail expenses, school failure, etc.) associated with no mental health treatment or delayed treatments are important and the brief stories within this report provide a glimpse of the stress and risks for patients and others. Extended holding in the ED may exacerbate symptoms and/or the illness. Quality care and timely treatment requires adequate funding.

Not supporting a strong mental health system can result in wasted expenditures that have no bearing on treating the problem (e.g, observation staff and security costs). For example, the median charge for a hospital ED visit (moderate severity) among the 15 hospitals in this data was $524 (2012, NH Hospital Association) and median charge for one day in a community hospital was $4,503 (2009, NH Uniform Hospital Discharge Data Set). In contrast, the mental health center cost per patient was $4,269 (SFY 2011, NH Medicaid Annual Report) for the 21,958 Medicaid patients who were served. The same NH Medicaid Annual Report identified in-patient psychiatric facility services were provided for 353 children/ young people under age 22 at $4 million in expenditures or an average of $11,331 per child. Examining this range of

expenditures to maximize the value of each dollar spent is important to effectively meeting the needs of people who need mental health services.

In summary, our report indicates a failure to fulfill the promise for many people seeking help for mental health problems in New Hampshire. The 2008 report, Fulfilling the Promise: Transforming New Hampshire's Mental Health System, was commissioned by the NH Legislature and it provides important recommendations for how a system of mental health services can work to promote recovery and resiliency in the state. Leadership and action are urgently needed to achieve the promise.

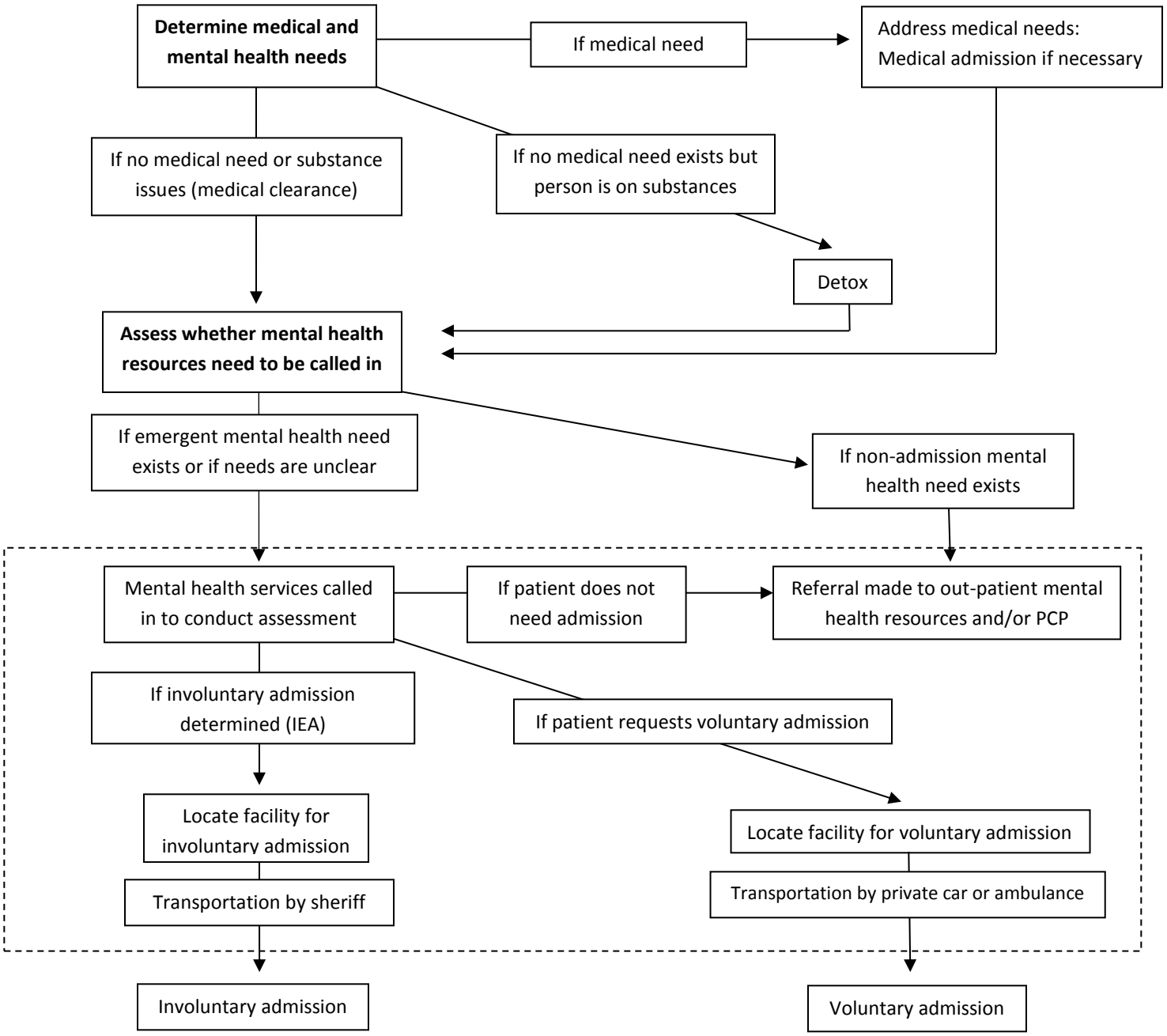
Appendix A: List of participating hospitals:

Catholic Medical Center (Manchester)
Cheshire Medical Center (Keene)
Concord Hospital
Elliot Hospital (Manchester)
Franklin Regional Hospital
Huggins Hospital (Wolfeboro)
Lakes Regional General Hospital (Laconia)
Littleton Regional Hospital
Memorial Hospital (North Conway)
Monadnock Community Hospital (Peterborough)
Parkland Medical Center (Derry)
Speare Memorial Hospital (Plymouth)
Upper Connecticut Valley Hospital (Colebrook)
Valley Regional Hospital (Claremont)
Wentworth-Douglass Hospital (Dover)

Appendix B: Emergency Department and Mental Health Care

Staff in hospital EDs are committed to getting patients the mental health care they need as effectively and efficiently as possible. This flowchart presents the key steps in meeting the needs of patients who present with mental health issues.

Emergency Department Patient Flow for Person with Mental Illness



Appendix C: New Hampshire In-Patient Psychiatric Bed Data

Figure C1.

In-Patient Psychiatric Beds

	Year			% Δ
	2005	2008	2013	'05-'13
Acute Care Hospitals	238	186	149	-37%
Specialty Hospitals	288	310*	235*	-18%
Total	526	496	384	-27%

* Includes 16 beds at Cypress Center

Figure C2.

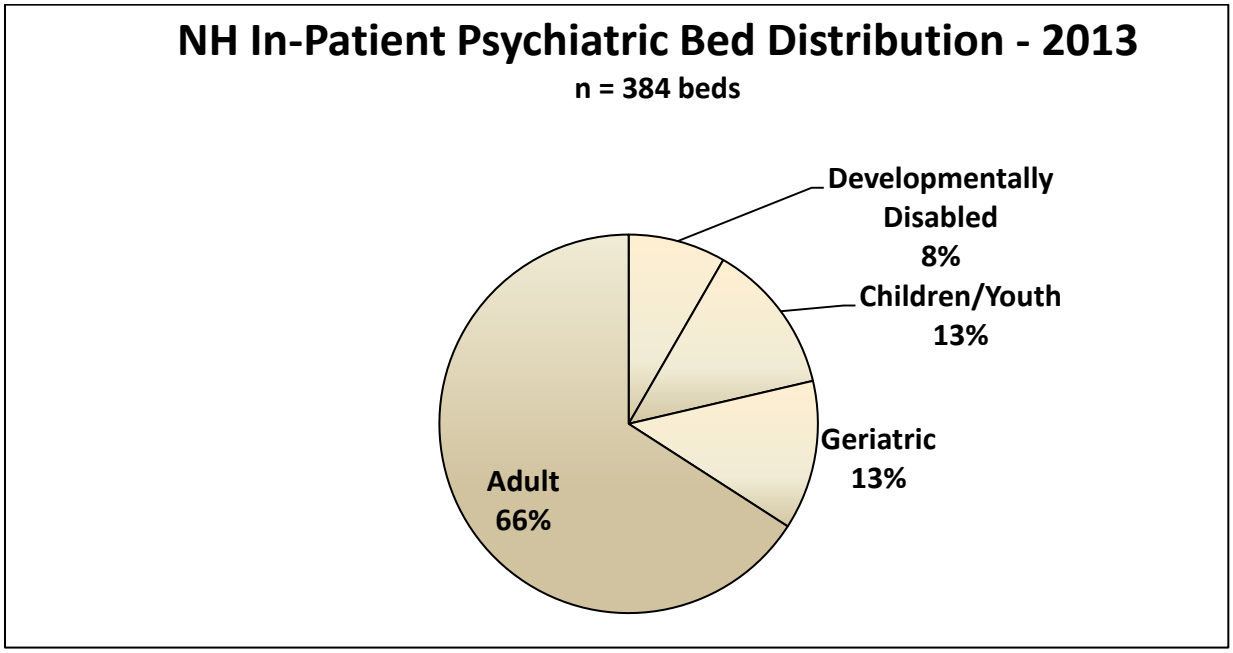


Figure C3. In-Patient Psychiatric Beds for IEA's - 2013

Elliot Hospital (Adult)	8
Cypress Center (Adult)	16
NH Hospital (Adult)	128
NH Hospital (Child/Youth)	24
Total	**176***

*46% of total bed capacity (384 total beds)

Appendix D: Data Collection Instrument

Emergency Department Mental Health* Needs Survey

Purpose: To improve quality of care for patients with acute with mental health illness by documenting access issues related to patients who come to an ED with a primary diagnosis of mental health illness and who require an in-patient admission (voluntary or involuntary) to treat their mental illness.

Directions: This survey tool is only for people who come to the ED with a **Primary Diagnosis of Mental Health AND require an In-patient Admission (voluntary or involuntary**) for their mental health problem. Complete a form for each patient who meets the definition above. Please do not include any other patient identifying information on this form.

Please submit data online via SurveyMonkey or by fax (FAX: 225-4346). Contact Shawn LaFrance at slafrance@healthynh.com or 603-415-4270 for the Survey Monkey link and if you have any questions).

Send data sheets for each week (Sunday-Saturday) by the close of business on Tuesday of the following week.

Data for WEEK of: Sunday _____ - Saturday_____ **Form #_____**

Hospital Name:_____
Person Completing Form: _____ Phone:_____

1. Patient Age (check one box): ☐ Child ☐ Adult
2. Insurance (check one box): ☐ Self-Pay/No Insurance ☐ Medicaid ☐ All Other Insurances
3. Day when Patient Arrived in ED (Check one box): ☐ Weekday ☐ Weekend (Sat. 12:00 am – Sun 11:59pm)
4. Mental Health ES Assessment by Community Mental Health Center Requested: ☐ Yes ☐ No
5. *Primary Diagnosis:_____
6. Patient required constant observation*: ☐ Yes ☐ No
   *Constant observation – This is defined as on-going direct observation of the patient by health care staff.
7. Patient presented a risk of or engaged in violence to self and/or others in ED and required special security:

   ☐ Yes ☐ No

8. Time in ED:

	1-4 Hrs	5-8 Hrs	9-12 Hrs	13-24 Hrs	24+ * Hrs
Medical Clearance					
Time elapsed from arrival in ED until completed E.S. patient assessment					
Discharged					

*If greater than 24 hours, please indicate total # of days/hours

9. Patient assessed by E.S. and recommended as IEA: ☐ Yes ☐ No

10. Discharged from ED to:

☐ N.H. Hospital ☐ Another hospital ☐ Admitted to Your hospital ☐ Home after ED Tx ☐ Other

11. Discharge Transportation (Please check one box):

☐ Ambulance/Medical Transport ☐ Local Police/County Sheriff ☐ Other (Priv. Vehicle, Taxi, etc)

*"Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning, resulting in a diminished capacity for coping with the ordinary demands of life, which may make a person a danger to themselves or others. Serious mental illnesses may include diagnosis such as major depression, schizophrenia, bipolar disorder, and post-traumatic stress disorder (PTSD)."

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