

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2 - A-08

Subject: Access to Psychiatric Beds and Impact on Emergency  
Medicine

Presented by: Georgia A. Tuttle, MD, Chair

Referred to: Reference Committee G  
(H. Christopher Alexander, III, MD, Chair)

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At the 2007 Annual Meeting, the House of Delegates adopted Resolution 714 as amended. The resolution asks “that our American Medical Association (AMA) work with relevant stakeholders (American College of Emergency Physicians, American Psychiatric Association (APA), the National Association of EMS Physicians, and the American Ambulance Association) to study and develop recommendations regarding the national scope of the problem of psychiatric bed availability and its impact on the nation’s emergency and general medicine resources, including emergency department overcrowding.” The Board of Trustees assigned this item to the Council on Medical Service for study and report back at the 2008 Annual Meeting.

This report summarizes mental health care in the US; reviews emergency department overcrowding and boarding; presents information on the financing of mental health care services; provides examples of national and state mental health reform efforts; identifies psychiatric workforce issues; highlights AMA policy and activity; discusses the need for mental health policy reform; and presents policy several recommendations.

### MENTAL HEALTH CARE IN THE US

About 26% of Americans aged 18 and older meet the criteria to be diagnosed with a mental health disorder every year. It is estimated that only about 15% of Americans diagnosed with a mental health disorder receive treatment. The prevalence of mental illnesses combined with the lack of treatment results in serious consequences. The World Health Organization measures disability based on the number of years of “healthy” life lost due to having less than full health and has identified depression as the leading cause of nonfatal medical disability in the US for individuals aged 15 to 44. The Institute of Medicine reports that suicide claims approximately 30,000 lives each year in the US, with the vast majority of all people who die by suicide having an undiagnosed or untreated mental illness.

In the US, the treatment locale of the chronically mentally ill has shifted in the past five decades from inpatient psychiatric settings in the 1950s toward outpatient and community-based treatment starting in the 1960s. The trend toward outpatient and community-based treatment settings continues today. Factors contributing to this shift include questions about the conditions of inpatient mental health facilities, increased patient advocacy efforts, evolving treatment techniques, advancements in psychotropic medications, financing of mental health services, hospital budgetary pressures and managed care.

1 This historic trend to “deinstitutionalize” the chronically mentally ill has resulted in decreasing the  
2 number of inpatient and residential psychiatric beds for state and county mental hospitals from  
3 approximately 400,000 nationwide in 1970 to 50,000 in 2006. The loss of public inpatient  
4 psychiatric beds was only partially offset by the combined increase during the same time of an  
5 additional 50,000 private and general hospital psychiatric beds.

6  
7 Mass deinstitutionalization did not result in successful community integration of individuals  
8 needing psychiatric services because the necessary services and funding were not put in place for  
9 adequate community support. As a result, increasing numbers of chronically mentally ill  
10 individuals have no place to go for comprehensive treatment. Rather than being integrated into the  
11 community, this population has been supplanted into other facilities such as nursing homes, jails  
12 and prisons, while a growing number routinely visit emergency departments (EDs).

#### 13 14 EMERGENCY DEPARTMENT OVERCROWDING AND BOARDING

15  
16 The influx of patients with psychiatric illnesses seeking care in EDs has been identified as a trigger  
17 exacerbating medical personnel resources and causing emergency department overcrowding. A  
18 2004 survey of emergency physicians conducted by the American College of Emergency  
19 Physicians (ACEP) revealed a severe shortage of inpatient psychiatric beds nationwide. Seventy  
20 percent of emergency physicians reported an increase of psychiatric patients “boarding” in the ED,  
21 or waiting for an inpatient bed to become available. The ACEP survey found that psychiatric  
22 patients board in EDs more than twice as long as other patients. Even when an inpatient bed  
23 becomes available, there is a high probability that it will not be located in close proximity to the  
24 patient’s community, resulting in ambulance diversion for potentially many hours in some areas.

25  
26 The extended boarding of psychiatric patients in EDs not only results in delayed and inadequate  
27 care for the mentally ill, but also increases the backlog of patients in the emergency department.  
28 Sixty percent of emergency physicians in the ACEP survey reported that the increase in psychiatric  
29 patients negatively affected access to emergency medical care for all patients. Additionally, these  
30 physicians reported that ED staff spend more than twice as long looking for beds for psychiatric  
31 patients than for non-psychiatric patients. Such inefficiencies deplete emergency medical  
32 resources and lead to poorer emergency care in affected communities.

33  
34 The increase of patients seeking psychiatric care in EDs is a symptom of a larger systemic  
35 problem – the lack of comprehensive mental health care services across the continuum of care,  
36 which could include housing with supportive services, employment support, outpatient and  
37 community resources, dual substance use and mental health services, dual mental health and  
38 medical services, and inpatient psychiatric care. The crumbling infrastructure of the mental health  
39 system is an example of what could happen in other areas of medicine if not properly financed  
40 according to the needs of the population.

#### 41 42 FINANCING OF MENTAL HEALTH CARE SERVICES

43  
44 In 2003, national health expenditures for mental health services were approximately \$100 billion.  
45 Almost a quarter of these expenditures were for retail prescription drugs (\$23 billion). Medicaid  
46 has historically excluded payment for mental health services received in an institution for mental  
47 diseases (IMD), defined by the US Department of Health and Human Services as “a hospital,  
48 nursing facility, or other institution of more than 16 beds that is primarily engaged in providing  
49 diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing

care, and related services.” An institution is considered an IMD if established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. Medicaid still pays for about 26% of all mental health services. State and county psychiatric hospitals can obtain Medicaid funding through several sources including disproportionate share hospital (DSH) payments and payment for administrative services for Medicaid beneficiaries in IMDs. Private health insurance is the second largest payer of mental health services at approximately 24%, followed by other state and local governments, out-of-pocket payments and Medicare.

There is a widespread perception that the Medicaid exclusion for payment of mental health services in IMDs has had a significant impact on the mental health delivery system and contributed to the decline in psychiatric inpatient beds. The decline of psychiatric beds, however, is a complex issue involving numerous previously mentioned trends in the mental health services system, one of which is financing. While the IMD exclusion most likely had an impact, it is difficult to determine exactly how large a contribution it had on the decline of public inpatient psychiatric beds. In general, the financing of mental health services appears to have historically driven the availability of services.

After weighing the advantages and disadvantages of supporting a repeal of the IMD exclusion, the American Psychiatric Association (APA) recently adopted policy to allow states the opportunity to apply for federal exemption from the exclusion for state hospitals and all nonprofits with more than 16 beds (e.g., private hospitals, community residential programs, dual diagnosis residential treatment). A major argument for repealing the IMD exclusion is that it is discriminatory against individuals needing mental health services and is based on an outdated understanding of mental illness and its treatment. In addition, repealing the exclusion could help states to maintain or expand their current state hospital capacity. However, supporting a repeal remains controversial since no studies have been done predicting the effect it could have on the delivery of mental health services.

### NATIONAL MENTAL HEALTH DELIVERY SYSTEM REFORM

Efforts to revamp our nation’s mental health delivery system are gaining momentum. In 2002, the president announced the creation of the New Freedom Commission on Mental Health, which was charged with studying and recommending improvements for the mental health service delivery system. The final report of the Commission, *Achieving the Promise: Transforming Mental Health Care in America*, was issued in 2003. The American Hospital Association’s Task Force on Behavioral Health released *Behavioral Health Challenges in the General Hospital* in 2007, which provides recommendations to hospital leaders on behavioral health service strategies and examples of successful practices. The Joint Commission has selected the mental health crisis as the topic to be addressed through its 2009 public policy initiative. The Joint Commission will be appointing an expert roundtable panel as part of its process to address the issue.

### STATE ACTIVITY

States are implementing a variety of solutions to address the lack of psychiatric bed availability. Due to extended emergency room boarding of psychiatric patients in southern Nevada, sometimes for more than 96 hours, the state has instituted “Legal 2000.” This system expedites the transfer of psychiatric patients who appear to be in danger of harming themselves or someone else to psychiatric facilities rather than boarding them in EDs. Boarding times for psychiatric patients in

Georgia's emergency rooms average 34 hours, with many waiting several days for an inpatient bed in one of seven state-run psychiatric hospitals. Once admitted to a state-run psychiatric hospital, the conditions are reportedly so unacceptable that the US Department of Justice is investigating whether the hospital conditions violate patients' civil rights. This federal investigation has prompted Governor Sonny Perdue (R) to form a Mental Health Commission to examine "conditions, needs, and issues associated with the services to those with mental illness and substance abuse."

A survey by the Maryland Hospital Association found that 4.3 percent of emergency room visits were associated with psychiatric complaints. Maryland hospitals report these numbers are increasing as are the wait times for psychiatric patients, which are already nearly double that for other patients. Maryland hospitals are working to manage the wait time for psychiatric patients as well as a general increase of individuals seeking care in EDs. Some of the solutions include building new emergency rooms and expanding existing ones, revising procedures to better use limited hospital personnel, and devising an "Emergency Department Collaborative" to implement changes that would increase patient safety.

The Minnesota Medical Association, the sponsor of Resolution 714 (A-07), has developed a task force comprised of physician members from psychiatry, emergency medicine, family medicine, and internal medicine. Primary goals of the task force are to reduce the state's psychiatric bed shortage and to devise strategies and solutions to address the ED diversion problem in Minnesota. Along with developing recommendations on how to increase the number of beds, the task force has formulated measures to gauge the success of a reformed system. The task force acknowledges the complexity of this issue, including the need for comprehensive mental health services and adequate physician payment.

### WORKFORCE

According to the National Graduate Medical Education (GME) Census, there were 4,613 psychiatry residents on duty for the 2006-2007 year, which is comparable to the number of psychiatry residents ten years ago. In addition, according to the AMA Physician Masterfile, there were 41,385 practicing psychiatrists in 2006, compared to 38,417 in 1996. While the numbers of psychiatry residents and practicing psychiatrists has not changed dramatically in the past decade, there are some concerning trends regarding psychiatry's ability to meet the mental health needs of the population.

There are substantial differences in the number and proportion of practicing psychiatrists across geographical regions of the US, and among practice settings. These discrepancies greatly impact access to psychiatric services in some areas. In 2004, as a percentage of vacancies, the greatest recruitment difficulty in community health centers was for psychiatrists, with an estimated 22.6% of funded psychiatrist positions being vacant. Recruiting for rural areas posed the greatest difficulty. Some states, such as Minnesota, have experienced a shortage of psychiatrists in all settings. Minnesota reports ten psychiatrists per 100,000 individuals, which is 61% of the national average of 16 per 100,000. In addition, there has been a decline in the number of psychiatrists working in inpatient settings due to seclusion/restraint regulations, case management requirements, difficulty securing discharge placements, malpractice liability and commitment laws. Historically low payment rates for psychiatric services has an impact on psychiatrists' availability, acceptance of new patients, and future workforce trends.

RELATED AMA POLICY AND ACTIVITY

The Council has previously considered the issue of ED overcrowding and emergency medical services (EMS) diversion in Council on Medical Service Report 1-A-02, “Overcrowding and Hospital EMS Diversion,” which recommended increased federal funding for ED expansion, staffing, availability of beds, and an increased overall system capacity. In addition, the report recommended better integration of ambulatory care and urgent care centers into the emergency health care system, and that greater efforts be made to educate both patients and physicians on the appropriate use of the ED. The report, which did not focus on the psychiatric issue, concluded that local, multi-organizational task forces would be best suited to devise local solutions to the problems of ED overcrowding and diversion (Policy H-130.945, AMA Policy Database).

The Board of Trustees recently issued two reports on emergency medicine: Board Report 14-I-06, “The Future of Emergency and Trauma Care,” and Board Report 3-I-07, “The Looming Crisis in Emergency Care in the US – Managing the Causes and Consequences.” The most recent report outlines the AMA’s response to the recommendations in Board Report 14-I-06, which are reflected in Policy D-130.971. The AMA has met with relevant specialty societies to increase dialogue about emergency care workforce issues. In addition, the AMA supports the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties. Furthermore, the AMA advocates for physician payment and financial support for providing Emergency Medical Treatment and Active Labor Act (EMTALA) mandated emergency care.

AMA policy supports access to mental health services, including an adequate supply of psychiatrists and appropriate payment for all services provided (Policies H-345.981, D-345.997 and D-345.998). In addition, the AMA encourages appropriate funding levels for public sector mental health services (Policy H-345.980). The AMA supports mental health insurance parity for mental illness, alcoholism, and related disorders under all governmental and private insurance programs and has developed model state legislation for state medical associations and specialty societies to promote legislative changes assuring parity for mental health coverage (Policies H-185.974, H-345.992[1], D-180.998 and D-185.994). Furthermore, the AMA supports medical, surgical and psychiatric service integration and payment to ensure medically appropriate treatment is provided when an individual has multiple health care needs (Policy H-345.983). The AMA encourages treatment and integration of chronic mentally ill patients into the community in order to prevent unnecessary hospitalization or jail confinement (Policy H-345.995).

The AMA is a member of the Coalition for Fairness in Mental Illness Coverage, which has been active in supporting the US Senate and House mental health parity bills. The Senate has unanimously passed the Mental Health Parity Act of 2007, a bill that eliminates financial and treatment limitations currently applied toward patients with mental and substance use disorders (S. 558). The House has passed the Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424), which seeks similar goals. Congress is now challenged with reconciling the two bills. The AMA will continue to work with Congress to enact mental health and addiction parity legislation that is consistent with AMA policy and does not include inappropriate or harmful provisions.

1 DISCUSSION

2  
3 At its meeting in November 2007, the Council met with representatives from ACEP and APA to  
4 discuss the requests in Resolution 714 (A-07) and potential directions of the report. ACEP is  
5 disseminating an updated survey on psychiatric bed availability to ED directors. In addition, an  
6 educational session on psychiatric bed availability, emergency overcrowding and patient safety will  
7 be held at the 2008 Interim Meeting as suggested by ACEP. The APA assisted with providing  
8 background content and information on the IMD exclusion for this report. The National  
9 Association of EMS Physicians acknowledged psychiatric bed availability as problematic,  
10 however, identified a lack of data limiting their ability to make a formal statement on this issue.  
11 The American Ambulance Association was also contacted but did not provide input.

12  
13 The lack of comprehensive mental health services directly results in the “revolving door” syndrome  
14 whereby the same patients repeatedly return to the emergency room for care – never obtaining the  
15 extent of the care that is needed. Without systemic solutions, this problem will further escalate  
16 because mental health needs are increasing in the population as a whole. Furthermore, there are  
17 increasing numbers of veterans returning from combat needing psychiatric care. Combat duty in  
18 Iraq has been associated with high use of mental health services, with 19% of service members  
19 reporting a mental health problem upon returning home. Adequate mental health resources,  
20 including psychiatrists in the workforce, are necessary to meet the mental health needs of the  
21 general population and returning veterans. In addition, appropriate payment for psychiatric  
22 services is essential to ensure services are available.

23  
24 The Council believes that financing for mental health services should be adequately provided  
25 according to the needs of the population. As states, particularly Minnesota, are demonstrating, a  
26 thorough review of the needs of a specific geographical area are key to devising local solutions to  
27 the lack of mental health care services and the resulting ED overcrowding. As such, the Council  
28 believes it is important to support local area task forces to devise local solutions.

29  
30 The AMA continues to work with Congress to enact mental health and addiction parity legislation.  
31 As such, the Council suggests modifying Policy H-185.974 to reflect current terminology, which  
32 focuses on substance use rather than substance abuse. Depending on whether legislation is  
33 ultimately enacted, there could still be hurdles to obtaining mental health services. Some mental  
34 health diagnoses and out-of-network services may not be covered under parity. In addition, parity  
35 only helps those who have health insurance, and individuals with mental illnesses are  
36 disproportionately uninsured. With the goal of expanding coverage to the uninsured, the AMA’s  
37 Voice for the Uninsured Campaign addresses this issue.

38  
39 RECOMMENDATIONS

40  
41 The Council recommends that the following be adopted and the remainder of this report be filed:

- 42  
43 1. That our American Medical Association reaffirm Policy H-130.945[3], which supports the  
44 establishment of local, multi-organizational task forces with representation from hospital  
45 medical staffs, to devise local solutions to the problem of emergency department  
46 overcrowding, ambulance diversion, and physician on-call coverage and encourage the  
47 exchange of information among these groups. (Reaffirm HOD Policy)

- 1 2. That our AMA modify Policy H-185.974, which supports parity of coverage for mental illness,  
2 alcoholism and substance ~~abuse~~ use. (Modify HOD Policy)  
3
- 4 3. That our AMA support efforts to facilitate access to both inpatient and outpatient psychiatric  
5 services, and the continuum of care for mental illness and substance use disorders, ameliorate  
6 the psychiatric workforce shortage, and provide adequate reimbursement for the care of  
7 patients with mental illness. (New HOD Policy)  
8
- 9 4. That as a follow-up to the 2008 American College of Emergency Physicians Task Force Report  
10 on Boarding, our AMA report back to the HOD at A-09 with a progress report on the  
11 effectiveness of measures implemented to mitigate boarding and crowding in the emergency  
12 department. (Directive to Take Action)

Fiscal Note: Staff cost estimated to be less than \$500 to implement.

References for this report are available from the AMA Division of Socioeconomic Policy Development.