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E.R. Costs for Mentally Ill Soar, and Hospitals Seek Better Way

By JULIE CRESWELL

RALEIGH, N.C. — As darkness fell on a Friday evening over downtown Raleigh, N.C., Michael Lyons, a paramedic supervisor for Wake County Emergency Medical Services, slowly approached the tall, lanky man who was swaying back and forth in a gentle rhythm.

In answer to Mr. Lyons's questions, the man, wearing a red shirt that dwarfed his thin frame, said he was bipolar, schizophrenic and homeless. He was looking for help because he did not think his prescribed medication was working.

In the past, paramedics would have taken the man to the closest hospital emergency room — most likely the nearby WakeMed Health and Hospitals, one of the largest centers in the region. But instead, under a pilot program, paramedics ushered him through the doors of Holly Hill Hospital, a commercial psychiatric facility.

"He doesn't have a medical complaint, he's just a mental health patient living on the street who is looking for some help," said Mr. Lyons, pulling his van back into traffic. "The good news is that he's not going to an E.R. That's saving the hospital money and getting the patient to the most appropriate place for him," he added.

The experiment in Raleigh is being closely watched by other cities desperate to find a way to help mentally ill patients without admitting them to emergency rooms, where the cost of treatment is high — and unnecessary.

While there is evidence that other types of health care costs might be declining slightly, the cost of emergency room care for the mentally ill shows no sign of ebbing.

Nationally, more than 6.4 million visits to emergency rooms in 2010, or about 5 percent of total visits, involved patients whose primary diagnosis was a mental health condition or substance abuse. That is up 28 percent from just four years earlier, according to the latest figures available from the Agency for Healthcare Research and Quality in Rockville, Md.

By one federal estimate, spending by general hospitals to care for these patients is expected to nearly double to $38.5 billion in 2014, from $20.3 billion in 2003.

The problem has been building for decades as mental health systems have been largely decentralized, pushing oversight and responsibility for psychiatric care into overwhelmed communities and, often, to hospitals, like WakeMed.

In North Carolina, the problem is becoming particularly acute. A recent study said that the number of mental patients entering emergency rooms in the state was double the nation's average in 2010.

More than 10 years after overhauling its own state mental health system, North Carolina is grappling with the consequences of a lost number of beds and a reduction in funding amid a growing outcry that the state's mentally ill need more help.

In Raleigh, where the Dorothea Dix Hospital — a state psychiatric institution that served the area for more than 150 years — was closed in 2012, mentally ill patients began trickling into hospital emergency rooms.

Hospitals, which cannot legally turn away any patient seeking care, say the influx of psychiatric patients is straining already busy E.R.'s and creating dangerous conditions.

This spring, University Medical Center of Southern Nevada in Las Vegas declared an "internal disaster," shutting its doors to arriving ambulances for 12 hours, after mental patients filled up more than half of its emergency room beds. A suicidal patient took out a gun and shot herself in the head while in a hospital emergency room in New Mexico in January.

With a crisis facing states, communities and hospitals across the country, experts say no clear solution has emerged. St. Joseph's Hospital Health Center in Syracuse created a separate psychiatric emergency department. Interim LSU Hospital in New Orleans opened a 10-bed mental health emergency room extension six years ago that is typically full.

But in Raleigh, the goal is slightly different: keep the psychiatric patients out of the hospital emergency room altogether.

The problem facing North Carolina and other states is a legacy of the 1960s, when warehousing of the mentally ill in large psychiatric hospitals was seen as inhumane.

The first wave of so-called deinstitutionalization was driven by new psychiatric drugs and by a 1963 law championed by President John F. Kennedy that provided federal funding for community-based mental health centers.

States began reducing the number of psychiatric beds. From a peak of more than 300 beds per 100,000 people in 1955, states had cut the number of beds to an average of 14 by 2010, according to research from the Treatment Advocacy Center, a nonprofit organization that promotes improved psychiatric care through better laws, policies and practices.

For decades, North Carolina resisted the broad mental health reforms. But in 2000, state lawmakers moved to overhaul the state's mental health system, closing state facilities and pushing counseling and outpatient programs to local communities.

When the economy plummeted in 2008, North Carolina, like other states, reduced funding to community programs. In all, the state spends 20 percent less on community mental health services than it did a decade ago.

Today, North Carolina has only eight beds in state psychiatric hospitals per 100,000 people, the lowest ratio in the country.(North Carolina, like other states, has added beds in local community facilities but, even then, its total beds are down a quarter since 2001.)

Uninsured patients rarely receive individual therapy, only group sessions. And it can take up to three months to see a psychiatrist.

"Now, we are seeing some of the most acute, the most aggressive and the most chronic mental health patients, and we're holding them longer," said Janice Frohman, the director of WakeMed's emergency department.

The effects of the upheaval in care of the mentally ill are playing out vividly at WakeMed. A private, nonprofit organization with 884 beds, WakeMed is struggling to find a way to meet the needs of increasing numbers of mentally ill patients while also controlling costs.

Hospital officials, along with their counterparts at the county and state level, support the pilot program but say it is one small step toward meeting a much bigger challenge.

WakeMed has treated an average of 314 patients a month whose primary diagnosis is some form of psychosis. That is up a third from two years ago.

On any given day, 25 to 50 mentally ill patients can be found throughout its halls.

Some linger in the busy emergency room bays, surrounded by the bright lights and the soft beeps of machines. Others are mixed into the hospital's inpatient rooms.

The nurses on the ward wear small panic buttons on the lapels of their hospital coats. When asked when she last pressed her panic button, which immediately floods the ward with help to subdue a violent patient, Francine Moseley, a petite nurse smiles ruefully: It was just last night.

The panic calls happen about 25 times a month.

WakeMed, like Holly Hill, receives some money from a variety of sources to care for the patients, but it must pay for many other costs.

Last year, the hospital spent $2 million on so called sitters, who monitor the most aggressive patients 24 hours a day. When the county sheriff's office became overwhelmed transporting patients to facilities up to three hours away, WakeMed hired a private transportation company.

The hospital now employs 14 behavioral health specialists and four patient service assistants who spend hours contacting care facilities in the hopes of finding an empty bed.

As the state's mental health system became more fragmented, community leaders in Wake County have been trying to better coordinate care for patients who use the bulk of resources.

They are focusing on the "high users" — individuals who repeatedly call 911 or show up at emergency rooms.

There is the elderly man suffering from chronic pain who has been transported by ambulance to Raleigh emergency rooms 120 times in the last two years. A female patient with a history of mental illness called 911 nine times in June alone.

A little more than three years ago, Brent Myers, an emergency room physician, noticed that increasingly at the start of his shift more than half the beds were already full of patients needing mental health care, rather than physical care.

The head of Wake County Emergency Medical Services, Dr. Myers was also among a handful of paramedics in the county who are trying to expand the role of first responders. Seeing an opportunity to both accomplish that goal and help reduce the number of patients flowing into the hospital emergency room, he persuaded county and state officials to agree to an experiment.

Shortly thereafter, a group of Wake County paramedics began to be trained to perform mental health exams on patients in the field who are judged not to be in need of emergency medical care. By asking a series of questions, the paramedics are then able to evaluate a patient's mental condition. While giving a patient the option of going to a local emergency room if they prefer, they also offer the choice of being taken to another facility that might be better suited to provide the kind of care they need.

Last year, more than half of the 450 patients identified with mental illness asked to go somewhere other than the emergency room.

Dr. Myers sees it as the start for connecting other types of patients with alternatives to hospital emergency rooms.

Emergency officials in many other areas are looking to replicate aspects of the Wake County program. But many states have laws and protocols that essentially dictate that patients may be transported by ambulance to only hospital emergency rooms. Moreover, Medicare and state Medicaid programs are largely unable to reimburse for transports to nonhospital facilities.

Still, Dr. Myers says there are bigger costs that can be squeezed out of the health care system by changing how emergency responders deal with high users, whether they be mentally ill patients or simply those suffering from chronic conditions like diabetes who could be better served by connecting with a home-health provider.

"Our next big step is to get into the community in a big way," Dr. Myers said. "That's where we're headed."