EMERGENCY DEPARTMENT CROWDING: ALTERNATIVE PROGRAMS FOR SPECIFIC POPULATIONS

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TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

INTRODUCTION 6
  Crowding in Emergency Departments 6
  State Initiatives 8
  Focus of Paper 10

PREVENTATIVE CARE 11
  Overview of Problem 11
  Current Challenges Facing Maryland 12
  Recommendation: Increase Participation Benefits for Community
    Preventive Care Program 14

MENTAL HEALTH PATIENTS 18
  Overview of Problem 18
  Current Challenges Facing Maryland 20
  Recommendation: Create a Diversion Center in Maryland 22

NON EMERGENCY CARE 26
  Overview of Problem 26
  Current Challenges Facing Maryland 26
  Recommendation: Allow Private Emergency Clinics to Accept Medicaid 28

CONCLUSION 31

WORKS CITED 32
EXECUTIVE SUMMARY

Emergency Departments (ED’s) in Maryland are extremely crowded. The national demand for ED care has increased\(^1\) while the capacity to handle emergency care has decreased.\(^2\) The need for highly efficient emergency departments will only increase if nothing is done to reduce the number of people coming to ED’s for care. Crowded ED’s put a strain on both hospitals and their supportive services such as ambulance services.\(^3\) ED care is considered the most expensive care in the entire health care system and approximately one third of all visits to Maryland ED’s are classified as not requiring care in an ED.\(^4\)

ED crowding is an extremely large and multifaceted issue. There are three general areas of ED care. They are categorized as inpatient inflow, hospital operation and outpatient flow. This paper will focus on inpatient inflow: patients who are entering the ED for care. More specifically, we are concerned with populations that can be treated more efficiently in other venues. The recommendations target specific populations who visit the ED: the population who lacks access to preventative care, mental health patients and non-emergency care patients. These recommendations will reduce overall costs for the state and allow for all patients to receive the correct and most efficient type of care.

PREVENTATIVE CARE OVERVIEW

The management of a diagnosed medical condition varies amongst populations for various reasons including access to healthcare and the quality of care received. While it is known that primary care and medical regimens lessen the chance of severe illness, many persons are not taking these necessary steps.\(^5\) The uninsured tend to have more problems getting care and tend to receive less therapeutic care.\(^6\) Racial and ethnic minorities make up more than half of the uninsured population.\(^7\) As result of not properly managing chronic illnesses, individuals may require emergency level care for preventable conditions that might have been prevented if proper chronic illness management had occurred. Having a regular source of care for these individuals will not entirely eliminate hospital ED use. However, available research suggests that it is associated with more appropriate use of the emergency department.\(^8\) If this population cannot get treated through primary care, another source of care besides the ED needs to be utilized.

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\(^3\)“Trends in Maryland Hospital Emergency Department Utilization.” iii.


\(^8\)“Trends in Maryland Hospital Emergency Department Utilization.”
PREVENTIVE CARE RECOMMENDATION:
INCREASE PARTICIPATION BENEFITS FOR COMMUNITY PREVENTATIVE CARE PROGRAMS

To assist with this clearly urgent problem we recommend offering incentives for persons who enroll and actively participate in preventive care programs. Strong evidence suggests that having a regular source of care produces better health outcomes, reduces disparities, and reduces costs. Incentives should be offered to ensure that a healthcare program experiences a high participation rate. An example of an incentive driven preventive care program exists in Mercy hospital, Miami, Florida. In this healthcare program participants are given medication discounts for enrolling and meeting program benchmarks such as, clinical visits and exercise.

The task of managing heath conditions is laborious and technically complicated for the state. However, the benefits gained by doing so are well worth it. Preventative care programs with incentives are a practical and cost effective way to ensure that persons properly manage pre-existing health conditions. By eliminating the use of ED’s by this category of users, those with emergency conditions that could have been prevented, the overall number of persons who visit ED’s can be expected to decrease.

MENTAL HEALTH CARE OVERVIEW

Nationally, psychosis is the second leading cause of hospitalization for ED patients. The long wait time mental health patients experience in the ED are related to lack of available state mental health beds and a lack of outpatient community resources for uninsured psychiatric patients. Many of the problems and challenges surrounding treating mentally ill patients include funding, effectiveness, having the patient receive the correct diagnosis and providing resources for the uninsured.

There are care centers for the mentally ill already in existence in Maryland. There are Residential Crisis Services and Community Mental Health Centers. These places provide an array of services, both for the insured and uninsured, and are significantly less costly than the ED. However, these resources currently in place need to be used more efficiently in order to alleviate the strain on ED’s and to serve more people more effectively.

MENTAL HEALTH CARE RECOMMENDATION:
CREATE A DIVERSION CENTER

Our recommendation is to create a diversion center based on a combination of two different cities’ already successful programs. It would give police officers and other officials the authority to take mental health patients to the center where the patient would be evaluated, stabilized, and then referred to treatment centers. This has already been proven to be an effective program in both Orlando, Florida and Denver, Colorado. It is recommended that this program be started in a place with similar demographics and high

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10 “Trends in Maryland Hospital Emergency Department Utilization.”
emergency room crowding, such as Baltimore City. This program has potential to expand statewide based after one such center’s success. It is recommended that a coalition of different departments be formed to initiate the project.

The diversion center will allow emergency department patients, both mental health patients and medical patients to be seen faster. Mental health patients in ED’s will eventually need to be treated in a place specialized for their illness. By sending mental health patients to a diversion center the costly step of an ED visit is eliminated while the patient receives the correct type of care immediately. Having a diversion center will increase awareness to staff of emergency departments, paramedics, and others who come in contact with the mental health population, that there are other more effective options to treat the mentally ill.

NON-EMERGENCY CARE OVERVIEW
A non-emergency ailment is classified as any symptom in which the patient’s initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours.\textsuperscript{13} Approximately one-third of visits to ED’s are classified as not requiring care in an emergency department.\textsuperscript{14} Non-emergency patients come to the ED for a myriad of reasons such as not being able to visit a clinic service during normal business hours or not being available to leave work for an appointment.\textsuperscript{15} The government health program Medicaid offers health insurance to many whom would otherwise not be able to afford care. To reduce the number of non-emergency visits to the ED programs that accept Medicaid must be expanded to include non-emergency facilities that are easily accessible.

NON-URGENT CARE RECOMMENDATION: 
ALLOW PRIVATE EMERGENCY CLINICS TO ACCEPT MEDICAID
An example of a privately owned emergency clinic is MinuteClinics. The MinuteClinic brand was founded in May 2000 and was recently purchased by the CVS Corporation. MinuteClinics have produced substantial savings of health care expenditures while also reduce wait time of patients seeking treatment for non-emergency ailments.\textsuperscript{16} If Maryland offers to subsidize allow private emergency clinics to accept Medicaid we hypothesize that the ED would see a significant decrease in the number of people entering the ED for non-emergency ailments. We recommend that a commission be formed to study the effect that private emergency clinics have, if any, on the percent of non-emergency visits to emergency departments in their vicinity.

\textsuperscript{15} “Trends in Maryland Hospital Emergency Department Utilization.” iv.
INTRODUCTION

Emergency Departments (EDs) in Maryland are being utilized more than ever before. The Baltimore Sun reports that at least once a week three quarters of emergency rooms in Baltimore and the surrounding counties are too full to accept any more patients. A task force on ED crowding for Baltimore City found that the number of hours hospitals are not accepting additional patients increased by 165 percent since 2002. However, crowding of ED’s extends beyond Baltimore City. This is a statewide issue. The largest increase in ED utilization during the last decade was in Region IV that includes Anne Arundel, Carroll, Harford and Howard Counties. In Maryland there are acute care hospitals, hospitals that provide short-term medical care for serious illnesses. Over the last decade ED utilization in acute care hospitals has increased 30.6 percent. However, Maryland is not the only state facing increased use of ED’s. Nationally, ED visits increased by 19 percent while Maryland hospitals reported a 23 percent increase in the same time period.

CROWDING IN EMERGENCY DEPARTMENTS

There are multiple reasons for the increased use of ED’s. Within Trends in Maryland Hospital Emergency Department Utilization, a report by the Joint Work Group on Emergency Room Utilization, one of the major factors identified as influencing ED

20 Ibid, 7.
21 Ibid, 17.
over-utilization was the increased demand for ED services.\textsuperscript{22} From 1990-2001 Maryland’s population has increased by 11.6 percent.\textsuperscript{23} With this population expansion, utilization of ED’s will naturally increase if nothing is done to address the problem.

Another reason people are turning to ED’s for care is a lack of access to primary care. Approximately one third of all visits to Maryland ED’s are classified as not requiring care in a ED.\textsuperscript{24} There are a myriad of reasons for choosing to visit the ED for care: lack of health insurance, no service available at night, not being able to get time off from work to come in for an appointment, and not getting an appointment soon enough.\textsuperscript{25} All of these factors contribute to crowding in EDs. Within the ED there is often a lack of beds for patients,\textsuperscript{26} a long wait time for admission,\textsuperscript{27} and a shortage of nurses,\textsuperscript{28} lab technicians and doctors.\textsuperscript{29}

Wait time within the ED’s has a ripple effect on state run emergency services. Hospitals go on alert when crowded requesting ambulances to divert patients to other institutions. According to data analyzed by the Maryland Institute for Emergency Services Systems for the Baltimore region, yellow alert, when a hospital experiences a temporary overwhelming overload of patients, and red alert, when a hospital has no inpatient ECG monitored bed available, have steadily increased over the last decade.\textsuperscript{30} The length of time required to transfer a patient from an ambulance to the care of the

\textsuperscript{22} “Trends in Maryland Hospital Emergency Department Utilization.” iv-vi.
\textsuperscript{23} Ibid, iii.
\textsuperscript{24} Cunningham, Peter J. “What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities?” Health Affairs. 25 (2006): W324.
\textsuperscript{25} “Trends in Maryland Hospital Emergency Department Utilization.” 26.
\textsuperscript{26} Ibid, 37.
\textsuperscript{27} “The Emergency Room Crunch.” Health Matters Feb. 2006.
\textsuperscript{28} “Trends in Maryland Hospital Emergency Department Utilization.” 37.
\textsuperscript{29} “The Emergency Room Crunch.” Health Matters Feb. 2006.
\textsuperscript{30} “Trends in Maryland Hospital Emergency Department Utilization.” 10.
hospital and return to service, increased from 2002 to 2005 by 45 percent. This was from a mean of 30.20 minutes in 2002 to 43.86 minutes in 2005.\textsuperscript{31}

In recent years, Baltimore City hospitals especially have experienced worsening ED crowding. Improving this situation is important to protect patient safety and improve emergency preparedness. If city hospitals and EMS systems can reduce emergency crowding, the region will be better prepared in the event of a disaster such as an influenza epidemic.\textsuperscript{32} If crowding in Baltimore City ED’s is stabilized other counties will see a decrease in diverted ambulances and in turn a decrease in visits to ED’s.

\textbf{STATE INITIATIVES}

Maryland has a tremendous responsibility in tackling the problem of crowded emergency departments. This relates to previous enacted laws and the effect crowded ED’s have on complimentary state services. Despite the overwhelming nature of this issue, Maryland has initiatives in place to combat this issue.

\textit{EMTALA}

The Emergency Medical Treatment and Active Labor Act (EMTALA), was originally enacted in 1986. Congress added Section 1867 to the Social Security Act due to wide-spread concerns that hospitals were turning away or transferring patients who were in need of emergency medical care, but who were unable to pay for the needed services. Initially, the law was enacted to stop patient "dumping." However, over time, EMTALA has become what it is today: a federally mandated standard of practice for hospitals that have a Medicare provider agreement.\textsuperscript{33} While this provides fairness to

\textsuperscript{31} Baltimore City Task Force, 1.
\textsuperscript{32} Ibid.
patients, this allows for many people to use the ED for non-emergency needs. The Joint Work Group on Emergency Department Utilization also identified the recent enforcement of EMTALA as contributing to longer wait times in ED’s.\textsuperscript{34}

In April 2002 the Maryland Health Care Commission released an analysis on trends in Maryland hospital ED utilization. This provided insight into the current problem facing Maryland EDs. This year a Baltimore City Task Force on Emergency Department Crowding was formed. It was comprised of 11 city hospitals, the health commissioner, and members of the fire department. In the study the task force recommended a series of steps to reduce ED overcrowding. However, this is only a framework for progress. The state now must take proactive steps in fixing the problems that were identified by the commission and task force.

There are additional steps the state has taken to alleviate ED crowding. Maryland, unlike many other states, has a command center for emergency services. The command center employs five people who act as dispatchers for the Maryland Institute for Emergency Medical Services Systems. It is a state agency that oversees ambulance traffic for most of Maryland.\textsuperscript{35} This helps to manage the flow of ambulances to ED’s. Last month the Governor also announced a $68 million Primary Adult Care Program that will aid low-income residents in receiving physician visits, prescription drugs and outpatient mental health care.\textsuperscript{36} This may help to reduce the number of people visiting the ED for primary care needs.

\textsuperscript{34}“Trends in Maryland Hospital Emergency Department Utilization.” v.
FOCUS OF PAPER

Emergency Department crowding is an extremely large and multifaceted issue. There are three general areas of ED care. They are categorized as inpatient inflow, hospital operation and outpatient flow. This paper will focus on inpatient inflow: patients who are entering the ED for care. More specifically, we are concerned with populations that can be treated more efficiently in other venues. The following recommendations target specific populations who visit the ED: the population who lacks access to preventative care, mental health patients and non-emergency care patients. These recommendations will reduce overall costs for the state and allow for all patients to receive the correct and most efficient type of care.
PREVENTIVE CARE

OVERVIEW OF PROBLEM

Preventive care is a set of measures taken in advance of symptoms to prevent illness or injury such as routine physical examinations and vaccinations.\(^{37}\) Research has demonstrated that providing high quality preventive care to people plays an integral role in helping people live healthier lives.\(^{38}\) Without preventive care services, persons tend to get diagnosed at later disease stages and therefore receive less therapeutic care. They are also sicker during hospital stays and are more likely to die during their stay.\(^{39}\) To some degree many of the leading causes of death in Maryland are preventable. For example, deaths related to heart disease and diabetes can be reduced if quality preventive care strategies are followed such as a healthy diet, regular exercise, and visits with a primary care physician. There are also a large number of ED visits that are preventable. Nine percent of all visits that require ED care could have been avoided with early treatment for underlying conditions.\(^{40}\) For example, a severe asthma attack may result in a visit to the ED. However, this visit may be avoided if the illness is properly managed. There are proven methods to manage specific medical conditions before they worsen to the degree that merits an ED visit.

ACCESS TO PRIMARY CARE

A major aspect of preventative care is primary care. As defined by the American Medical Association, primary care is the provision of a broad range of personal medical care in a manner that is accessible, comprehensive and coordinated by a licensed

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\(^{38}\) “Trends in Maryland Hospital Emergency Department Utilization.”


\(^{40}\) “Emergency Department Use in Maryland.”
physician over time.\textsuperscript{41} Research suggests that having a regular source of care produces better health outcomes for patients and reduces total health care costs for all involved parties.\textsuperscript{42} Ongoing visits with one health care practitioner may contribute to an increase of familiarity of the healthcare system for the patient and an elevated level of trust and communication between patients and physician.\textsuperscript{43}

However, having a primary care physician does not guarantee a preventative care focus within a visit. There are barriers to providing preventive care. Multiple publicly traded Health Maintenance Organizations (HMOs) have begun restricting doctors to an average seven-minute “encounter” with each “customer.”\textsuperscript{44} Clinician office visits must address other issues besides a preventative care focus such as chronic conditions and acute illnesses. This rushed environment has led to healthcare services being prioritized by focusing on the most immediate problem. This can lead to potentially preventable illnesses worsening because preventive care measures did not get addressed in the short visit.\textsuperscript{45} As former Surgeon General Dr. David Satcher states, “preventive services are worth the up front costs to save lives, increase national productivity, and to start to get a handle on downstream healthcare costs.”\textsuperscript{46}

**CURRENT CHALLENGES FACING MARYLAND**

For various reasons the management of a diagnosed medical condition varies amongst populations. While it is known that primary care visits and following medical

\textsuperscript{43} Ibid.
\textsuperscript{45} Ibid.
regimes lessen the chance of severe illness, many persons do not take these necessary steps.\textsuperscript{47} As a result, many individuals become ill enough, from these already known medical conditions, to warrant an ED visit. There are several factors that determine the degree of primary care a person is likely to receive. Some of these factors are explained by availability of services and social conditions.\textsuperscript{48}

The uninsured and minorities tend to use the ED more frequently than other patients.\textsuperscript{49} Research suggests that having a regular source of care is associated with more appropriate use of the ED.\textsuperscript{50} Without insurance coverage many Maryland citizens are unable to obtain adequate healthcare related services such as preventive care, diagnostic and screening of diseases, and management of chronic health conditions. The uninsured have more problems getting initial care, tend to be diagnosed at later disease stages, and receive less therapeutic care.\textsuperscript{51} Racial and ethnic minorities constitute one third of the total United States population yet they compromise more than one half of the uninsured population. The 2004 Maryland population was 39.6 percent minorities. This represents a 1.7 percent increase from the previous year. If current trends continue, minorities could constitute more than 50 percent of the population by 2010.\textsuperscript{52} Because minorities tend to be poorer and uninsured they often postponed seeking medical care and instead rely on emergency care to manage their day to day health.\textsuperscript{53} If these people cannot get treated through primary care, another source of care besides the ED needs to be utilized.

\textsuperscript{49} “Maryland Plan for Eliminating Minority Health Disparities.”
\textsuperscript{50} “Trends in Maryland Hospital Emergency Department Utilization”
\textsuperscript{52} “Maryland Plan for Eliminating Minority Health Disparities.”
\textsuperscript{53} Ibid.
**RECOMMENDATION:**
**INCREASE PARTICIPATION BENEFITS FOR COMMUNITY PREVENTIVE CARE PROGRAM**

More frequent quality preventive care measures must be made available to the uninsured and minorities with diagnosed medical conditions. Strong evidence suggests that having a regular source of care produces better health outcomes, reduces disparities, and reduces costs.\(^5\) To ensure that the preventative care program experiences a high success rate additional benefits need to be offered to participants such as medication discounts. An example of an incentive driven preventive care program exists at Mercy Hospital in Miami, Florida.

**THE MERCY HOSPITAL FREEDOM PROGRAM**

The Mercy Hospital Freedom Program provides a technology-based, community centered preventive care program. The program empowers patients to manage their chronic illnesses through a hospital-run preventive care program. Participating patients receive access to more affordable prescription medications. However, patients must meet a number of criteria to participate in the Mercy Hospital Freedom Program, including living in the Mercy Hospital service area and receiving preventive care by a participating physician as an outpatient from Mercy Hospital. Since its inception, approximately 4,000 patients have participated in the Mercy Hospital Freedom Program and 10,000 prescriptions have been dispensed to those patients. Patients who follow the program can save up to 60 percent off their medication. Patient compliance is monitored through a database maintained by Freedom HealthCare and prescriptions are delivered safely to patients via mail. Physicians are provided quarterly reports detailing patient compliance, participation and cost savings. Through mail service, enrolled patients are prompted to
comply with their individualized preventive care “road maps” and are notified when prescriptions need to be refilled.\textsuperscript{55}

Prescription cost is the primary incentive for participation in this program. The program requires that participants meet certain benchmarks each quarter to receive the medication discounts. Some of these benchmarks can include visits to a primary care physician, attending educational seminars, and visits with a nutrition counselor or exercise counselor.\textsuperscript{56} The medication discounts are a result of the 340B Drug Pricing Program. The 340B Pricing Program requires that drug manufacturers provide outpatient drugs to certain covered entities specified in the statute 42 U.S.C. 340B(a)(4) at a reduced price. The U.S. Preventive Services Tasks Force, an agency within the U.S. Department of Health and Human Services, dictates the benchmarks given to program participants.\textsuperscript{57} Persons who are engaged in preventive care measures have been shown to use emergency departments more appropriately.\textsuperscript{58}

\textit{Feasibility}

A trial program should be tested before enacting this on a large scale. A panel of experts composed of state, local, and hospital officials should review related information to decide what location would be best to conduct such a trial. This process could be headed by the Community Health Administration. To ensure that the quality preventive care is uniformly offered to program participants there also should be involvement from the Maryland Health Care Commission, the Maryland Services Cost Review Commission, and the Maryland Hospital Association.

\textsuperscript{55} “Freedom Healthcare Program.” \textit{Mercy Medical Center.} <www.mercymiami.org>.
\textsuperscript{56} Ibid.
COST

The technical work and a majority of the administrative duties of the Mercy Preventive care program were outsourced to Freedom Healthcare. As a result of outsourcing backroom operations, Mercy Hospital did not need to make any changes in their infrastructure. For the Maryland hospital that participates in a trial program there are technological upgrades and administrative duties that must be undertaken to ensure that proper tracking and progress monitoring can take place. Freedom Health Systems is one company that offers this sort of assistance. There was a $15,000 fee charged to Mercy Hospital for the setup of accounts and processing. After this one time fee, Mercy hospital charges $2.50 for each quarterly report given to its program participants. As 4,000 persons are enrolled into Mercy’s Preventive Care Program their total annual cost for quarterly reports is $40,000.59

As the uninsured and Medicaid enrollees disproportionately visit the ED’s for non-emergency or primary care treatable conditions,60 the state can expect to save money in the long run by offering incentive driven preventive care programs to these populations. The savings come from not having to pay for expensive ED visits. Similar programs are also being developed in New York, New Jersey, Michigan and Pennsylvania. New York and New Jersey best resemble Maryland in both the rate of uninsured and the size of the minority group.61 Monitoring these two states may help to alleviate concerns about program operations and possibly help create new methods in providing preventive care.

61 U.S. Census Bureau.
**Practicality**

While the task of managing health conditions is laborious and technically complicated for the state, the benefits gained by doing so are well worth it. Preventive care programs with incentives are a practical and cost-effective way to ensure that people can manage pre-existing conditions properly. By doing so there will be less demand on the ED reducing the overall number of persons who visit ED’s in the state of Maryland.
MENTAL HEALTH PATIENTS

OVERVIEW OF PROBLEM

Maryland hospitals recently stated that the number of psychiatric patients is increasing. Hospitals report a 63 percent increase in wait times for psychiatric patients, which is nearly double the wait time for other patients. There are a lack of available state mental health beds and a lack of outpatient and community resources for uninsured psychiatric patients. Dr. Gabor Kelen, Director of Emergency Medicine at Johns Hopkins School of Medicine, recently stated, “When there are no treatment places for drug users, or people with mental health problems they sit on those floors as inpatients forever and ever because there’s nowhere to send them. You can’t just send them out in the streets.” Many times when a mental health patient visits the ED there are other medical issues that need to be addressed.

Paramedics and other emergency service workers bring mental health patients to the ED first because EDs are in a position to evaluate them medically and conduct lab tests quickly. In Maryland there are resources available for both insured and uninsured mental health patients. There are Residential Crisis Centers (RCCs) that serve as voluntary inpatient community centers. RCC’s provide an array of services to ensure the long term care for mental health patients. There are also Community Mental Health Centers (CMHCs) that provide outpatient care and services to patients. The state provides money for these centers to operate through Medicaid. However, these centers must be used more efficiently in order to receive the maximum benefit of cost to the state and care of the patient.

63 Ibid.
64 Kelen, Gabor. Interview with Mark Steiner. The Mark Steiner Show. WYPR. 22 June 2006
RESIDENTIAL CRISIS CENTERS (RCCs)

A Residential Crisis Center (RCC) provides intensive mental health care and support services. They are designed to prevent psychiatric inpatient admissions, providing an alternative to psychiatric inpatient admission, or to shorten the length of inpatient stay. In addition, RCC’s are a significant resource that help to provide services, particularly when the individual has been stabilized on medication in the ED but is not yet ready to be discharged.65 RCC’s provide services on a short-term basis in a community-based residential setting.66 Typical care lasts about 10 days on a voluntary inpatient basis. These services are provided to mentally ill children or adults who are experiencing, or who are at risk of, a psychiatric crisis that would impair the individual’s ability to function in the community.67 These individuals often have co-occurring drug and alcohol problems and medical illnesses.68

Residential Crisis Centers provide an array of serves ensuring complete care. When a patient first arrives, a comprehensive exam is conducted. This includes a description of the individual's current behavior, symptoms, and current level of functioning. Then, the individual's strengths, needs, and treatment are then assessed.69 In addition, RCC’s assist patients with long term goals such as housing assistance and further medical treatments on an outpatient basis.70 This program costs $145 - $225

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67 Ibid.
68 “Strategies for Reducing Emergency Department Utilization for Psychiatric Emergencies.”
70 Doyle, Lori. Personal Interview. 10 July 2006.
dollars per day depending upon the treatment intensity level. This is less than half the
cost per day at a state psychiatric facility.\textsuperscript{71}

\textit{COMMUNITY MENTAL HEALTH CENTERS}

Community Mental Health Centers (CMHCs) are outpatient clinics. These
centers focus on the medical aspect of care and provide medications.\textsuperscript{72} CMHC’s serve
many patients with dual diagnoses. Providers do their best to address alcohol and
substance abuse problems however, reimbursement rates do not allow for hiring of
certified drug and alcohol counselors. It is not enough to refer the individual to substance
abuse programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), or
to notify the individual’s Managed Care Organization (MCO) that a problem exists.
Substance abuse services must be embedded in the mental services in order to provide
complete care.\textsuperscript{73} CMHCs provide interactive individual, family and group therapy. They
offer psychological evaluation and testing by staff psychologists. They also refer people
for medical evaluations. Treatment coordinators will collaborate with patients to assist in
the following areas: housing, school, employment, entitlements, social needs,
rehabilitation, and treatment. In addition, they provide crisis services and screen for
therapeutic group homes.\textsuperscript{74}

\textbf{CURRENT CHALLENGES FACING MARYLAND}

In a recent interview Dr. Brent Eastman, co-chair of the emergency medical
service portion of the Institute of Medicine’s study on ED overcrowding claims, “The
reason [the ED] is on the verge of collapse is a definite lack of funding from the federal

\textsuperscript{71} “Residential Crisis Services.” \textit{MHP Provider Manual. Maryland Health Partners for Maryland’s Public
Mental Health System}. 2001.
\textsuperscript{72} Doyle, Lori. Personal Interview. 10 July 2006.
\textsuperscript{73} Ibid.
government. We, as Americans value ER care very highly but don’t provide the funding." Reduced government support for CMHC’s may lead to an increase of psychiatric patients seeking care in ED’s consuming already limited resources. In order to receive the maximum benefits for both the patients and the state, CMHC’s must be properly funded by the government. Recently Maryland added a cost of living adjustment of four percent to CMHCs. However, these centers are at their full capacity and require more funds to continue running efficiently and allow for expansion.

In order for psychiatric patients to avoid the ED, they must receive effective out patient care to treat their illness. Typically, patients will be referred from an ED to an inpatient psychiatric unit. The average length of stay in an acute general psychiatric unit is five days. In many cases, that timeframe is not sufficient enough to stabilize the individual. Consequently, the patient is back in the ED within a matter of days, or even hours, only to have the process repeated again. This presents a challenge to the psychiatric inpatient unit which must administer care long enough to stabilize the patient and to facilitate community re-integration. Policy makers have been urged to work with hospitals to change financial incentives in order to allow adequate in-patient stays.

Nearly half of psychiatric patients reported a dual diagnosis of substance and psychiatric illness. However, there is not adequate funding for dual diagnosis programs. If either diagnosis goes untreated the patient will need future care since they have not been adequately treated. Eighty percent of uncompensated care patients coming through

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75 Eastman, Brent. Interview with Mark Steiner. The Mark Steiner Show. WYPR. 22 June 2006.
77 “Strategies for Reducing Emergency Department Utilization for Psychiatric Emergencies.”
78 Ibid.
ED’s have a drug abuse problem though it is not always included in the direct diagnosis given by the doctor.\textsuperscript{80}

Hospitals pay for care for the uninsured psychiatric patients to be treated in the most expensive venue: the ED.\textsuperscript{81} Dr. Peter Bielenson, former Health Commissioner of Baltimore expressed his concern, “Psych and substance abusers get stuck in psych beds because there are not enough substance abuse and mental health facilities outside of hospitals… there must be some type of healthcare for these people.”\textsuperscript{82} If patients do not have health insurance, the ED may be the only place they can receive medical attention. People who are uninsured often have the same level of need for mental health services as their Medicaid counterparts, however, they cannot receive Medicaid benefits since they are not eligible.\textsuperscript{83} Affordable mental health treatment is scarce, therefore psychiatric patients end up in the ED.\textsuperscript{84}

**RECOMMENDATION: CREATE A DIVERSION CENTER**

While this is a national dilemma, other states and cities have found successful approaches to managing mental health patients in ED’s. These examples provide insight into options that Maryland could adopt. The City of Orlando along with Orange County in Florida established a Central Receiving Center (CRC) so that police bringing in a patient on emergency petition can, for mental health or substance abuse, go directly to the center. These centers triage people to various inpatient treatment centers.\textsuperscript{85} This

\textsuperscript{80} Morhaim, Dan. Interview with Mark Steiner. *The Mark Steiner Show*. WYPR. 22 June 2006.
\textsuperscript{82} Bielenson, Peter. Interview with Mark Steiner. *The Mark Steiner Show*. WYPR. 22 June 2006.
\textsuperscript{83} “Strategies for Reducing Emergency Department Utilization for Psychiatric Emergencies.”
\textsuperscript{85} Baltimore City Task Force, 9.
provides a first contact point for patients who then can be directed to the appropriate
treatment facility rather going to an ED.

The Denver CARES program in Colorado operates 24-hours a day seven days a
week with a staff of registered nurses, licensed practical nurses, psychiatric technicians
and addiction counselors. Their mission is to provide a safe place for detoxification and
to provide assessment, education and motivational counseling. They mainly serve
patients with substance abuse problems. They handle over 2,000 admissions each month.
CARES offers appropriate care as oppose incarceration or emergency department visits
which are ultimately more costly to the community.\textsuperscript{86}

We recommend that a center be created based on a combination of these two
cities’ successful programs. The center would give officers and other individuals the
ability to take mental health patients including those with a dual diagnosis with substance
abuse, to a diversion center. This is similar to Florida’s CRC where the patient would
then be evaluated, stabilized, and referred to the appropriate treatment center.\textsuperscript{87} In
Maryland’s case “treatment centers” would qualify as utilizing pre-existing RCC’s and
CMHC’s. These places have been proven very cost effective. It takes approximately 11
minutes or less for law officers to process people through the CRC in Florida.\textsuperscript{88} This is
remarkable when compared to hours upon hours an individual can wait at an ED.

A trial program of such a center should begin in an area with extremely crowded
EDs such as those in Baltimore City or Howard County. We suggest Baltimore City
because it has a smaller population than Orlando by approximately 300,000, and has
about 100,000 more people than Denver. This center would be structured to evaluate

\textsuperscript{86} Ibid. 10.
\textsuperscript{88} Ibid.
people thoroughly and could significantly aid people suffering from dual diagnoses by identifying their problems and providing care. This would divert patients away from the ED.

Other states have proven that this would be a very effective program. In Orlando, over 5,800 [people] were diverted from ED’s in the two and a half years since the center opened. 89 In addition, this center could provide long term care and alternative options for mental health patients. According to the FY 2007 Budget Highlights, there are a projected 100,000 clients with mental health concerns in Maryland, nearly an 8,000 client increase in two years. 90 With this expected increase in mental health patients, a structure in Maryland must be created to provide appropriate services.

Cost

If the state implements a diversion center for mental health patients there will be savings from the reduced number of ED visits. These savings could fund training about the diversion center for emergency workers such as police, fire fighters and paramedics. The diversion center would receive funding from the county in which it was placed, the state, and the hospitals within the county. In Orlando the estimated start up cost for the center was $5.1 million. Since then, they have served nearly 6,000 people with the average cost per person being approximately $850. There would be a significant initial investment, but it would ultimately save money.

Feasibility

There is already some support for this program. Baltimore Mental Health Systems, Baltimore Substance Abuse Systems, and others are considering the formation

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90 “Strategies for Reducing Emergency Department Utilization for Psychiatric Emergencies.”
of a diversion center. The Department of Health and Mental Hygiene (DHMH) could head the diversion center project. This would be an excellent project for a coalition between the state agencies and hospitals. Some departments within DHMH that could assist with the program are the Mental Hygiene Association, the State Psychiatric Hospitals and Regional Institutes, and the Alcohol and Drug Abuse Administration. These participants could also decide if the diversion center would be integrated into a preexisting infrastructure of a hospital or if the center would be housed in a completely independent facility. There is no legislation currently in place that addresses this matter. This would be a new concept that would require new laws and regulations in order to be implemented.

Practicality

Implementing a diversion center could potentially reduce the number of ED patients. The diversion center requires a significant investment that would drastically change the way EDs and other venues treat mental health patients. However, this ultimately could be more effective than the treatment mental health patients receive within EDs today. The diversion center will ultimately allow both mental health patients and other patients waiting for care in EDs to get treated for their problem faster. Also, it would increase awareness for emergency workers of other available options besides the ED such as RCCs and CMHCs, available for mental health and dual diagnosis patients.92

91 “Strategies for Reducing Emergency Department Utilization for Psychiatric Emergencies.”
92 Ibid.
NON-EMERGENCY CARE

OVERVIEW OF PROBLEM

Another attribute to ED crowding is the large number of people coming to the emergency department for non-emergency ailments. Non-emergency ailment are classified as any symptoms in which the patient’s initial complaint (presenting symptoms, vital signs, medical history, and age indicated) that immediate medical care was not required within 12 hours. Overall, approximately one-third of visits to the ED are classified as not requiring care in an ED. Measures must be taken so that these patients can receive services outside of the ED. In return this will reduce crowding in the ED. There is a wide range of reasons for ED crowding including not having a regular source of care and convenience. Lack of convenience arises because many primary care providers do not offer evening hours or walk-in appointments. Many patients having expectations concerning their needs and desires to receive prompt care visit the ED.

CURRENT PROBLEM FACING MARYLAND

The uninsured and Medicaid patients typically use the ED as a primary care service. Consequently, these patients will enter the ED with minor ailments that could be cared for in a clinical setting. Approximately 8.8 percent of people living in Maryland are uninsured. The primary reason for lack of health insurance is the cost of care. Billing delays and long waiting periods to enroll in insurance programs have a negative impact on people seeking health care. Many people who are uninsured stop taking necessary

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95 “Emergency Department Use is Maryland” 39.
medications and stop visiting their physician and subsequently end up in ED’s.97 One of the solutions proposed by the Baltimore City Task Force is to increase access to primary care: “There is inadequate access to primary care in Baltimore City. When people do not have health insurance, or are not able to get timely appointments with their primary care providers even when they do have health insurance, they go to the emergency department, regardless of the level of acuity of the complaint.”98 If people were able to provide primary care for minor ailments in an accessible clinic it would reduce the amount of people entering the ED and minimize crowding.

Medicaid, or Medical Assistance, is a program that assists with the cost of medical bills for people who qualify and cannot afford medical care. Medicaid provides three types of critical health protection: health insurance for low-income families, children, the elderly, and people with disabilities; long-term care for older Americans and individuals; and supplemental coverage for low-income Medicare beneficiaries (e.g., payment of Medicare premiums, deductibles, and cost sharing).99 Medicaid is a joint federal and state program. Each state establishes its own eligibility standards, benefits package, provider requirements, payment rates, and program administration under broad federal guidelines. The Department of Health and Mental Hygiene (DHMH) runs Maryland’s Medicaid program.

Of the 296,000 visits to Maryland EDs by patients using Medicaid in 2001, 20.4 percent of them were categorized as non-emergency ailments and 20.5 percent of them were emergency but could have been prevented with primary care. Out of the ED visits from the uninsured, 21.2 percent were categorized as non-emergency ailments and 18.4

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96 “Emergency Department Use is Maryland.”
97 Ibid.
98 Baltimore Task Force.
99 “Medicaid/Medical Assistance Overview.” Maryland Medical Programs.
percent of them were emergency, but could have been prevented with primary care. In the
Baltimore Metro area 22.2 percent of ED users are uninsured and 16.2 percent are on
Medicaid. Approximately 8.8 percent of the people in Maryland are uninsured but
account for 21.7 percent of ED patients. For visits to Maryland EDs 17 percent were
categorized as non-emergency; another 17 percent were considered to be urgent, but
treatable in a primary care setting. 100

**RECOMMENDATION:**
**ALLOW PRIVATE EMERGENCY CARE CLINICS TO ACCEPT MEDICARE**

An example of an emergency care clinic is MinuteClinic. Originating in
Minneapolis Minnesota, the MinuteClinic brand was founded in May 2000.
MinuteClinics “provide a consultation with a health care professional, a prescription
when clinically appropriate and the choice of having it filled onsite.” 101 Since inception,
MinuteClinic has provided nearly 300,000 patient. They have produced substantial
savings of health care expenditures and have also reduced time spent by patients seeking
treatment for the preventable conditions. Some of the common ailments that are treated in
MinuteClinics are allergies, flu diagnosis, strep throat and pneumonia. Costs range from
$50 to $100. 102 There are currently 11 MinuteClinic locations in the Greater Baltimore
Area and suburban areas in Maryland. These clinics, however, are at least a 20-minute
drive and Baltimore City has the highest percentage of people on Medicaid and who are
uninsured. People who are on Medicaid and who are uninsured may not have access to a
car or may not be able to afford the additional cost of public transportation to these
facilities.

100 “Emergency Department Use is Maryland” 21.
102 Ibid.
COST

A visit to a MinuteClinic is affordable, even without insurance. However, the price for services may still be too high for people who are uninsured and on Medicaid. If MinuteClinics accepted Medicaid as a provider more patients would be able to receive care at such venues instead of visiting the ED. We recommend that Maryland offer incentives to private emergency clinics to support Medicaid as a provider.

In a four-state sample, an estimated savings of $39.5 million was predicted if non-urgent ED visits were reduced by 40 percent in the Medicaid population. We recommend that further research be conducted to assess the possibility of using such funds to allow Medicaid participants to use private emergency clinics.

FEASIBILITY

It is becoming very expensive for EDs to accept people on Medicaid. Some states are even beginning to consider restricting people on Medicaid or charging them some amount for services in which they do not believe is an actual emergency. These clinic services are less expensive ED services. Often patient’s wind up in the ED when they need medical care outside business hours.

This would be a very effective program, given the success MinuteClinics have already endured in such as Ohio, Tennessee, and North Carolina. The locations in Maryland that were recently added in Annapolis and Bowie, have also had a great amount of success. Because MinuteClinics are new and recently purchased by the CVS corporation, there is little actual data on their effectiveness in relation to ED visits to date. We recommend that private emergency clinics already located in Maryland be researched.

103 An Innovation in Health Care to Open in CVS/Pharmacy in Annapolis.” MinuteClinic.
104 “Primary Care In the Urban ER.” American Medical Student Association. 4 Aug. 2006.
to see if such locations have seen a reduction in ED visits before the state invests funds. Currently, there is no clinic in the United States similar to MinuteClinic accepting Medicaid as an insurance provider. In Florida there has been discussion about a similar corporation called ProntoClinic to begin considering accepting Medicaid as an insurance provider.  

**PRACTICALITY**

Research on the matter could be conducted could be headed by the Department of Health and Mental Hygiene. They could provide information dealing with the lack of health care and how the usage of these clinics as an alternative to ED’s. Some problems in relation to this recommendation may include certain people abusing these private emergency clinics much as they might abuse the ED. Certain abuses include feigning illness to receive prescriptions for drugs that they intend to sell or using these clinics for problems that could have been avoided through primary care visits. Private emergency clinics are staffed by only one nurse practitioner. Conditions that require a physician’s attention may not be treated in this environment. Another major concern in using these clinics is that the patients medical history is not readily available for the consultation and the importance of finding the root cause for conditions may not be considered. Private emergency clinics should not be seen as an alternative to primary care but as an additional venue to be used in addition to seeking a primary care physician. This would be a very practical option would lessen the cost that the state and hospitals spend on non-emergency ED visits. However, more research needs to be conducted before Medicaid can be accepted within private emergency clinics.

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CONCLUSION

Emergency Department crowding is a large problem facing the state of Maryland. The above recommendations are focused on decreasing the number of patients who visit the ED by providing different venues, where better care can be delivered at a lower cost. This would in return help reduce ED crowding overall. Patients with diagnosed chronic conditions are better treated in programs that will monitor their conditions in order to decrease the possibility of visits to the ED. Medication discounts are one incentive that will promote compliance. Mental health patients will be more efficiently managed if a diversion center is created. This will result in patient’s being triaged to appropriate facilities. Medicaid participants with minor non-emergency conditions could get treated in private emergency care clinics more efficiently if these clinics accepted Medicaid payments. This will in turn decrease the number of people entering the ED for care. With these recommendations in place the number of patients entering the ED for non-urgent care will decrease dramatically thus reducing ED crowding overall.
WORKS CITED


Bielenson, Peter. Interview with Mark Steiner. The Mark Steiner Show. WYPR. 22 June 2006.


Cunningham, Peter J. “What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities?” Health Affairs. 25 (2006): W324.


Doyle, Lori. Personal Interview. 10 July 2006.

Eastman, Brent. Interview with Mark Steiner. The Mark Steiner Show. WYPR. 22 June 2006.


Kelen, Gabor. Interview with Mark Steiner. *The Mark Steiner Show*. WYPR. 22 June 2006

Kirsh, William D. DO, MPH. Personal interview. 27 July 2006.


“Primary Care in the Urban ER.” *American Medical Student Association*. 4 Aug. 2006.


