



**CALIFORNIA
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TO: Whom it May Concern

FROM: Sheree Kruckenberg, Vice President Behavioral Health

SUBJECT: Access to Timely Psychiatric Emergency Services

California, like the nation, is struggling to ensure individuals with a suspected/potential mental illness are able to receive a timely psychiatric evaluation and access to an appropriate level of treatment, if needed.

The California Hospital Association (CHA) represents over 400 hospitals. In 2011, these hospitals received over 1.1 million individuals in their emergency departments (EDs) in need of some level of behavioral health intervention. An analysis of emergency department utilization data between 2006 and 2011 verified that the overall use of EDs for behavioral health visits increased 47% during this 5-year time period and the trend data indicate this continues to increase each year.

The vast majority of individuals arriving at a community medical/surgical hospital ED with a behavioral health need do not have a physical health condition that requires an emergency level of care intervention. This holds true for psychiatric emergency medical conditions as well. Unfortunately, however, there are often no alternative behavioral treatment settings available on a 24/7 basis. This forces hospital emergency departments, including those without behavioral health clinicians, to become the only available resource in many communities.

The increasing dependence on medical/surgical hospital EDs to provide behavioral evaluation and treatment is not appropriate, not safe, and not an efficient use of dwindling community emergency resources. This includes not only hospitals, but emergency transportation providers and law enforcement. More importantly, it impacts the patient, the patient's family, other patients and their families, and of course the hospital staff.

In a few California counties, an innovative, effective, and efficient treatment model has evolved that provides dedicated emergency behavioral health evaluation and treatment service. The model, known as Psychiatric Emergency Services (PES), is explained in more detail in the attached document. A recent study of this model showed that a PES in a system decreased time in an emergency department by 80% and led to behavioral health stabilization and discharge without needing inpatient admission more than 75% of the time.

We believe this model or a hybrid of emergency psychiatric care, if replicated across the state, would immediately improve outcomes for patients, alleviate patient backlogs in emergency departments, free up ambulances and other emergency transportation providers, and reduce the time law enforcement personnel are spending in medical/surgical hospital emergency departments. The model could be regionalized by identifying a location to act as the primary "hub" to provide support into surrounding counties and act as a telemedicine "spoke" site (see attachment) linking the PES to hospital EDs and/or psychiatric specialists, where geographic barriers prohibit transportation between sites.

For additional information or to arrange a tour of a PES, please contact skruckenberg@calhospital.org or 916/552-7576.

The PES – Crisis Stabilization and Evaluation for All
Regional Dedicated Psychiatric Emergency Services (PES)
Dedicated Psychiatric/Substance Use Disorder Emergency Department

Too often, individuals with urgent mental health needs have no alternative but to go to medical emergency rooms (ER) at hospitals, where there can be few staff trained in mental health, the environment is not conducive to healing, and there may be little alternatives for disposition but psychiatric hospitalization.

The vast majority of individuals in mental health crisis who arrive at a hospital emergency department are placed on an involuntary LPS 5150 police detainment order and brought to a hospital by law enforcement or emergency transportation vehicles. The method by which an individual is placed on an LPS 5150 detainment and subsequently transported varies by county. There is also wide variation on whether a law enforcement officer physically stays with the individual detained on an LPS 5150 once they arrive at a hospital emergency department.

Unfortunately, there are no local or statewide mechanisms to track the number of LPS 5150 detainment orders written, nor is there a way to determine how many of the LPS 5150s are evaluated under LPS 5151 and upheld for detainment. This also holds true for determining the number of individuals who ultimately are involuntarily committed on an LPS 5152, 72-hour hold. It is estimated that a minimum of 300,000 individuals are on 5150 detainment in hospital emergency departments annually. It is also estimated that at least 210,000 (70%) of these 300,000 individuals did not meet the criteria for inpatient admission under the LPS 5152, 72-hour involuntary hold criteria.

A Psychiatric Emergency Services (PES) unit is a far better alternative for people in crisis. A PES can be located on a hospital campus or in the community, but even when on the hospital grounds, the PES interior is far more calming and welcoming than a medical ER. PES layouts typically have décor, lighting, sound/music, and open spaces designed with the goal of encouraging healing and recovery, which make them quite different from a hectic, antiseptic medical ER with its noisy machinery and frightening equipment.

PES programs are designed to provide accessible, professional, cost-effective services to individuals in psychiatric and/or substance abuse crisis, and strive to stabilize consumers on site and avoid psychiatric hospitalization whenever possible. A PES provides emergency/urgent walk-in and police-initiated evaluation and crisis phone service 24 hours a day, 7 days a week.

A PES provides complete evaluation and treatment for all who present, regardless of level of acuity or insurance status. PES programs do not have “exclusion” or “no-admit” lists which prevent certain patients from entering their facility. Rather, a PES will work with everyone in need, following “Zeller's Six Goals of Emergency Psychiatric Care”:

- Exclude medical etiologies of symptoms
- Rapidly stabilize the acute crisis
- Avoid coercion

- Treat in the least restrictive setting
- Form a therapeutic alliance
- Formulate an appropriate disposition and aftercare plan

As studies have estimated as many as 20-30% of psychiatric emergencies may be due to, or are combined with, serious medical concerns, it is important that all crisis patients receive an appropriate medical screening. Next, all efforts are made to stabilize or reduce the symptoms that are causing a person distress – be they suicidal thoughts, auditory hallucinations, severe paranoia, mania, or other difficult conditions. Whenever possible, all evaluation and treatment is done free of coercion, with staff forming a therapeutic, collaborative partnership with each consumer. Treatment is done in the least restrictive setting, so restraints and/or seclusion are to be avoided, and consumers should be returned to their home or freedom in the community as soon as possible. All who leave the PES should have a solid aftercare plan including follow-up appointments, medication information, and strategies to help the person avoid crises in the future.

A typical dedicated PES department meets all these goals, and is staffed with psychiatric physicians and mental health professionals around the clock who can provide:

- Screening for all emergency medical conditions and provide basic primary medical care (e.g., oral alcohol withdrawal, asthma, diabetes management, pain, continuation of outpatient medications)
- medication management
- laboratory testing services
- psychiatric evaluation/assessment for voluntary and involuntary treatment
- treatment with observation and stabilization capability on site
- crisis intervention and crisis stabilization
- screening for inpatient psychiatric hospitalization
- linkage with resources and mental health and substance abuse treatment referral information

A PES can dramatically improve access to care and quality of care while decreasing costs to the health care delivery system. Today, in communities without a PES, patients are taken to traditional hospital emergency rooms and often languish with no psychiatric assistance or intervention for hours, sometimes days, awaiting the arrival of an individual trained to provide a psychiatric assessment or an available inpatient psychiatric bed. This, in and of itself, undermines the formation of a positive therapeutic alliance for the patient, delays treatment for the patient, ties up staff time and an ER bed in an already overburdened medical emergency department. Unfortunately, for safety reasons, too often patients are placed in restraints, with a sitter, or both, if considered a danger to themselves or others.

A 2009 survey of Medical Directors of medical emergency departments in hospitals across the U.S. called for Regional Dedicated Psychiatric Emergency Programs as a potential solution to the major national problems of psychiatric patients boarding for long hours in emergency departments. Indeed, a recent study showed that a PES in a system decreased boarding times

over 80% compared to overall California boarding times, and led to stabilization and discharge without needing inpatient admission over 75% of the time.

The ability of a PES to avoid hospitalization for the vast majority of patients is due to being able to treat patients for up to 23 hours and 59 minutes (thus sometimes referred to as “23-hour treatment facilities”). This permits time for treatment, observation and “healing time,” which is often sufficient to stabilize patients’ symptoms so they can return home or to another less-restrictive level of care. This follows a simple truth, that most patients in psychiatric crisis do not need hospitalization, though they do need urgent intervention and care.

The goals of healthcare reform include improved access to care, improved quality of care, improved timeliness of care, along with less hospital admissions and reduced costs. Adding a PES to appropriate systems helps to meet all these goals.

To standardize definitions, the key concept that differentiates a true PES from what are more often called crisis stabilization units, crisis clinics, etc., is that a true PES is a program separately housed from a medical hospital ED (i.e., not considered to be just a wing of a larger ED) that can take ambulance/police deliveries independently from the field. This makes it different from the typical Crisis Stabilization Unit, which usually evaluates and treats patients who have already been initially received and medically screened in a medical ED, then transfers over when considered medically stable. However, both programs do what is basically called “Crisis Stabilization,” and there are so many variations in design that difference in these programs can be minimal.

The concept of a PES being a "dedicated emergency department" comes from EMTALA law:

“A dedicated emergency department is defined as meeting one of the following criteria regardless of whether it is located on or off the main hospital campus: The entity: (1) is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or (2) is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions (EMC) on an urgent basis without requiring a previously scheduled appointment; or (3) during the preceding calendar year, (i.e., the year immediately preceding the calendar year in which a determination under this section is being made), based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment. This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric units of hospitals) where patients are routinely evaluated and treated for emergency medical conditions.”

A PES is not a “medical emergency department,” nor a “community clubhouse model,” but a blend of both, which is community-based and uses the Recovery Model concept.

In California, there are at least 10 PES departments operating in seven counties. There may be other comparable facilities or programs as well. The current PES departments are:

1. Alameda Health System, Oakland
2. Contra Costa County Regional Medical Center
3. Los Angeles County (Harbor-UCLA Medical Center, LAC+USC Medical Center and Olive View Medical Center)
4. Marin County
5. San Francisco General Hospital
6. San Mateo County
7. Valley Hospital (Santa Clara County)
8. One under construction in Ventura County

There is a need for at least an additional ten PES units; see attached map.

Psychiatric Emergency Services (PES) vs. Crisis Stabilization Unit (CSU)

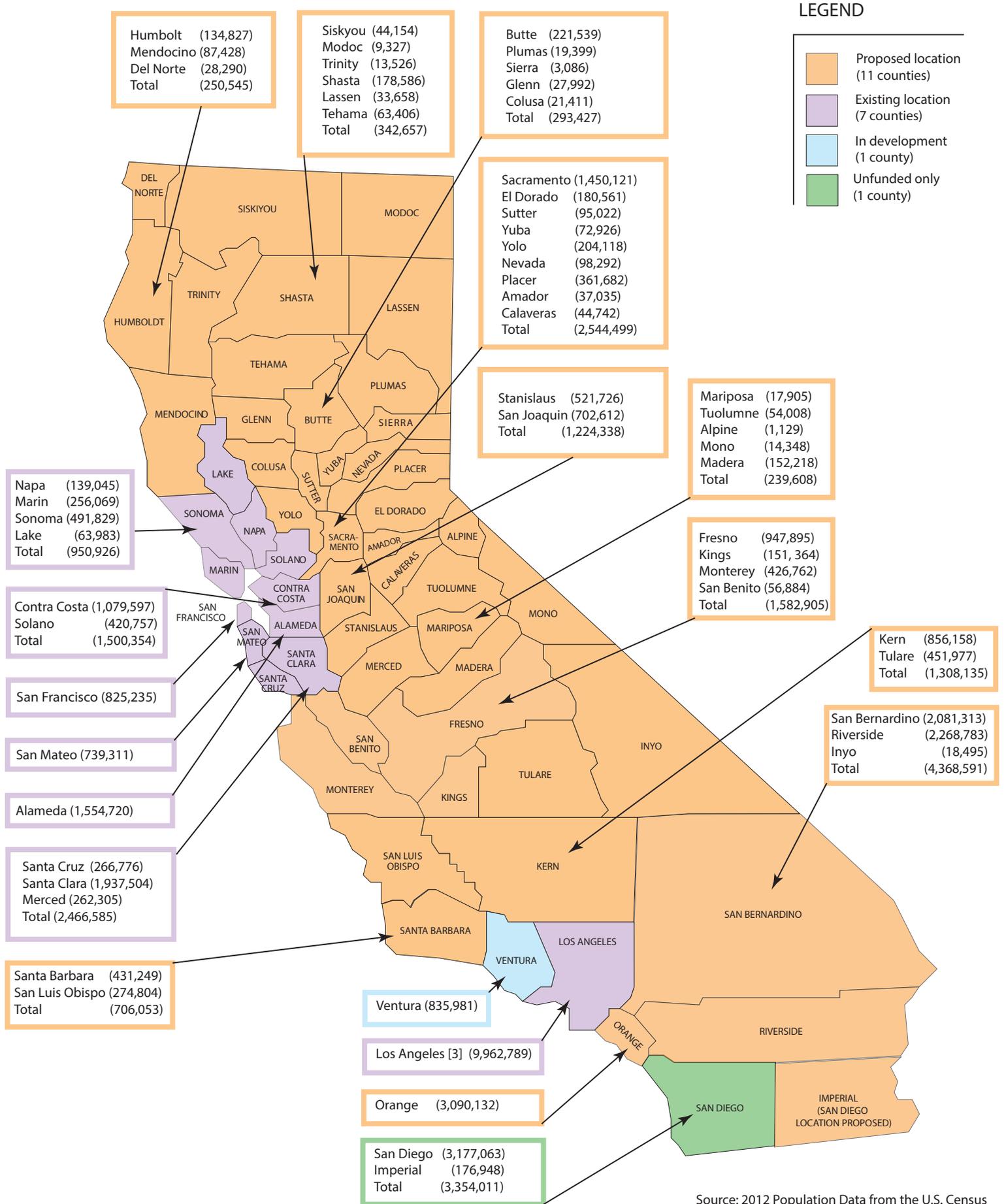
Psychiatric Emergency Department	Proposed Blended Model Emergency Treatment Services	Crisis Stabilization Unit
Operates as an active Treatment Model and services are available 24/7 and no one is restricted from using the service as it falls under EMTALA rules as patients are seen as having an “Emergency Medical Condition”	Open 24/7	Provides Triage and limited treatment, assessment for starting or discontinuing a hold and referral services. A psychiatrist is the lead clinician either in person or via telepsychiatry – may not be available 24/7
Open with physician available 24/7	Medical staff available 24/7 including telepsychiatry services	Not open 24/7 or have physician present
Capacity to screen for all “Emergency Medical Conditions”	Capacity to screen for all “Emergency Medical Conditions”	Does not have capacity to screen for all “Emergency Medical Conditions”
Has contracts for payment with plans	Contracts for payment with plans	Does not typically contract with plans
Qualifies under EMTALA	EMTALA qualification to be determined	Does not qualify as EMTALA provider
Required to assess all who present	Required to treat all individuals, regardless of payment or legal status (voluntary and involuntary)	Can be selective about patients served
Can bill Medicare		Cannot bill Medicare
Can bill under Medi-Cal Waiver		Can bill under Medi-Cal Waiver
Do not maintain “Do not admit lists”		May maintain a “Do not drop off list”
Law enforcement drop-offs allowed	Drop-off by EMS, law enforcement, family, friend, or self	No 5150 law enforcement drop offs
Typically located on hospital grounds	May be located on hospital grounds or in the community	May be located on hospital grounds or in the community

Regulations:

Residential Treatment: Welfare & Institutions Code §5671

Crisis Stabilization: Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, §1810.210

Proposed and Existing Psychiatric Emergency Services (PES) and Service Areas in California (with population)



Source: 2012 Population Data from the U.S. Census November 20, 2013