School of Medicine
Department of
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Division of Child and
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House Health Care Committee
April 3, 2017

RE: HB 3090 and 3091

Good Afternoon Chair Greenlick and members of the House Health Committee,

My name is Dr. Ajit Jetmalani and I am a Clinical Professor of Psychiatry and Head of OHSU's Division of Child and Adolescent Psychiatry. I also serve as a consultant to the Oregon Health Authority's Health Services Division. **I am not representing OHSU or OHA with this testimony**. I have served on Representative Keny-Guyer's mental health task force from the beginning and have co-led the introduction of acute care support services for Emergency Departments (EDs) funded by OHA in 7 counties in my role with Oregon Health Authority. I also work with my pediatric colleagues frequently in our ED and medical floors at Doernbecher hospital supporting youth families and our medical teams when people present with mental health emergencies. I wish to thank Representative Keny-Guyer, Julie Magers and Jerry Gabay for pushing many of us to collectively contemplate the reasons for the failure of our system to adequately address the needs of Oregonians of all ages struggling with life threatening mental and behavioral health crises. You have have created opportunities for a broad range of stakeholders to sit together in a way that simply would not have happened without your efforts and your passion. While grappling deeply with these issues, I think about our challenges as a reflection of a stressed ecosystem with many interrelated participants and forces at play. Any change in one aspect can have unexpected benefits or consequences for the whole system so any legislation must proceed with caution and clarity of purpose...but we need to act.

I believe that 3090 and 3091 seek to address two broad areas of concern:

A. Care provided during crises in EDs can be variable in quality and may not consistently follow evidence informed practices that reduce the risk of lethal outcomes.

B. Transitions of care are not adequately in place when people present to the ED with crises as made evident by:

1. Boarding or long lengths of stay in the ED.
2. Discharge occurs when the patient and or family are not feeling safe or connected to adequate services.
3. Timely follow up care is not available or assured.

I ~~have~~ do not fully understand 3091 as currently amended. I do not recommend proscriptive legislative language that defines specific medical practice or mandates one provider setting must develop or deliver all aspects

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of a continuum of care. However, if these bills were to accomplish to the following, they would have my support and I believe that legislative mandates are needed in this arena as our current system is not responding on its own:

A. To improve quality of services in emergency rooms across Oregon:

Formation of a committee led by the Oregon Hospital Association (or other highly regarded entity) to create an ED care guide or clinical pathway for at risk patients, dissemination plan and monitoring strategy to influence all EDs and crisis teams across the state (with a timeline for report back to the legislature). This care guide should include the following elements define adequate mental health and substance use assessment strategies that:

a. Evaluate biological, psychological and social factors leading to the emergency situation.
b. Evaluate risk of suicide including use of recommended standardized tools.
c. Inform patients and their supports of methodologies to reduce access to lethal means of suicide
d. Create meaningful safety planning strategies and elements
e. Defines methodologies to inform insurers and PCPs that their patients are in the ED in real time
f. Assures methodologies for post discharge welfare follow up calls within 48 hours
e. Assures methodologies for follow up in person within 7 days after discharge
f. Clarify provider types and their roles (including peer and family support specialists)

B. Transitions of Care Challenges are primarily impacted by:
a. how our insurers vary with regards to contracted services within continuums of care and
b. the limited array of services available in rural settings.

Here is a case example of a very common dilemma and an example of possible solutions:

Last weekend, I worked with a family in our ED (a relatively resource rich environment) where the parent and adolescent were locked in significant interpersonal battles that led to a youths suicide attempt and ongoing suicidal ideation.

Step One:

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The ED pediatrician and Social worker evaluated the child and determined that they were not physically harmed by the overdose, but found that the patient was still expressing suicidal thinking and wondered about treatment of depression as well as discharge planning.

Step Two:

The Child Psychiatry Team (could have been a skilled social worker or other clinician type in this case where there was not concern for psychosis or medically induced mental illness) interviewed the patient and family and found that intensive family intervention improved the acute conflicts and the child and parents were able to shift out of a stuck place and began to collaborate. The family did not have an outpatient provider in place. On Saturday morning at 10 am there commercial insurer was not available for care coordination. There were no outpatient providers on the commercial payer's provider list who were advertised to provide 24 hour crises services for new patients. In the past, this patient and parent would have stayed in our ED waiting for outpatient care arrangements as we would not have felt comfortable with discharge due to the volatile family relations and lack of clear follow-up. Psychiatric hospitalization is rarely available over the weekend as all of the 44 beds in our region or usually full during the winter months.

Step Three:

Thanks to OHAs Block Grant with Multnomah County, we were able to contact Catholic Community Services (other regions are using Youth Intercept through Youth Villages or other community teams). A QMHP arrived within 90 minutes of our call. We collaboratively completed our suicide risk assessment, lethal means counseling and safety planning. That parent and child would have 24 / 7 crises supports a family support specialist, therapist and psychiatrist for up to 30 days until connecting to their commercially funded network. The family went home feeling reassured and no longer alone with their struggles.

Step three is expensive to deliver. The need in each community waxes and wanes but you must fund these services to be ready 24 / 7. I believe that ***all payers in Oregon*** should be required to develop or contract for these services as part of the benefit for mental health care, not just CCOS as written in this bill. The description of these services might vary from region to region depending on the array of service providers available.

We must address the high rates of suicide in Oregon as well as the inappropriate boarding of patients waiting for care in our EDs and medical units and there are ways to improve things. These bills represent one important effort to address crises while we continue examine way to practice

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better health promotion, early identification and early intervention over the long haul. Thank you for the opportunity to submit this testimony and participate in this important effort.

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