OREGON HEALTH & SCIENCE UNIVERSITY

School of Medicine
Department of Psychiatry

Division of Child and Adolescent Psychiatry

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Senate Committee on Human Services
May 16, 2017

RE: HB 3090 and 3091

Good Afternoon Chair Gelser, Vice Chair Olsen and Members of the Senate Committee on Human Services,

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 have co-led the introduction of acute care support services for Emergency Departments (EDs) funded by OHA in 7 counties in my role as consultant to Oregon Health Authority's Health Services Division. **I am not representing OHSU or OHA with this testimony in support of both bills.**

I have served on Representative Keny-Guyer's mental health task force from the beginning and greatly appreciate the effective convening of a broad and effective group of stakeholders by the Representative and Jerry Gabay and Julie Mager.

As you know, 3090 and its companion 3091 arose in the context of Oregon's unacceptable rates of suicide…any suicide is unacceptable…and long waits for acute care services that continue escalating in our state at an alarming pace.

These bills seek to improve the quality of care and safety for people presenting with mental health emergencies to the ED by addressing two broad issues:

A. They ensure that hospitals have shared basic standards of care for mental health evaluation, family or care giver engagement, safety planning and appropriate outpatient supports.
B. Historically, commercial payers have lagged behind Medicaid programs in developing intensive community based services, including peer delivered services. This legislation requires that all payers must cover necessary services for people in mental health crises which should lead to improved care across Oregon.

Please support both bills and if you wish read my written testimony you will see an example of the type of care this legislation seeks to support.

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Here is a case example of what appropriately funded and delivered care could look like:

A few weeks ago, I worked with a family in our ED where the parent and adolescent were locked in significant interpersonal battles that led to a youth's suicide attempt and ongoing suicidal ideation.

Step One:
The ED pediatrician 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 (higher level of care vs outpatient).

Step Two:

The Child Psychiatry Team (could have been a skilled social worker or other clinician type in this case where the ED Pediatrician determined that there was not concern for psychosis or medically induced mental illness) interviewed the patient and family and utilized brief intensive family intervention. The child and parent were able to shift out of a stuck place and expressed a desire to participate in an outpatient treatment.

The family did not have an outpatient provider in place. On Saturday morning at 10 am their 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. The 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.

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