METROPOLITAN ST. LOUIS PSYCHIATRIC CENTER (MPC)
EMERGENCY DEPARTMENT (ED) AND 25-BED ACUTE CARE CLOSURE

EMERGENCY RESPONSE, CAPACITY AND COMMUNICATIONS PLAN

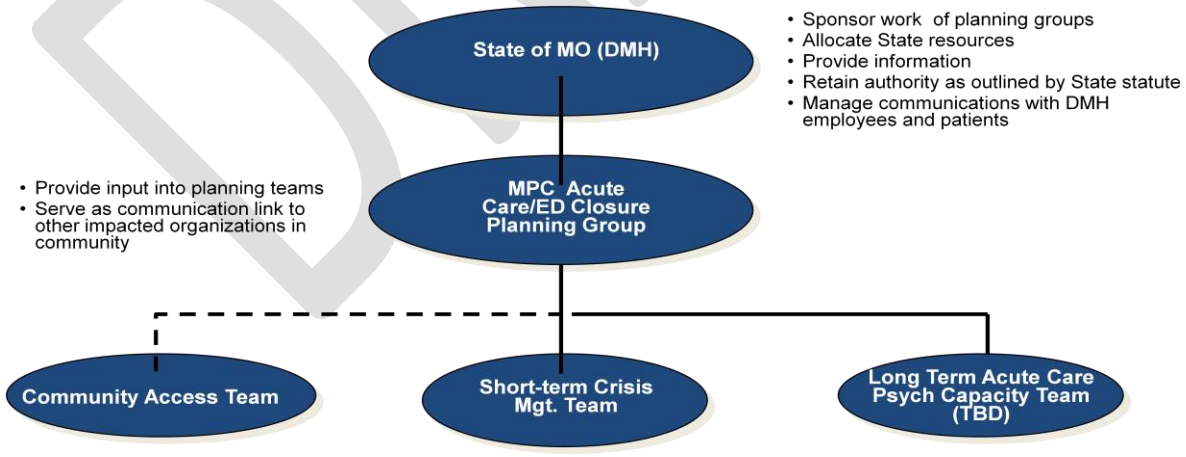
Final Draft Prepared by MPC Short-Term Crisis Team and Approved by MPC Planning Group

JULY 30, 2010

Background

In April 2010, the State of Missouri Department of Mental Health (DMH) announced its intent to close the Emergency Department (ED) and acute care beds at Metropolitan St. Louis Psychiatric Center (MPC). On May 19, 2010, the state made a formal request to the St. Louis Regional Health Commission (RHC) to create a local plan to address issues created by the closure. In response to the state's request, the RHC convened a regional Planning Group on May 27, 2010, and a Short-Term Crisis Management Team on June 3, 2010. These groups have been meeting regularly since to understand the scope and scale of the closure and its impact on the community and to identify and address the key issues the closure creates. During that time, DMH announced the ED and 25 acute care beds will close at MPC on July 15, 2010, leaving 25 acute care beds open until May 2011. After this time, MPC will provide competency restoration services for individuals who are court-ordered.

Planning Team Structure



The short-term crisis planning has been conducted in two phases: (1) emergency response; (2) capacity related issues.

The following document details the Short-Term Crisis Team and Planning Groups' recommendations. Members of the Short-Term Crisis Team include representatives from community hospitals, community mental health centers, city and county jails, and first responders (police and EMS). (See Appendix I for complete team roster.) This work has been conducted in coordination with the Community Access Transformation Team (CATT). Hospital representatives have attended CATT meetings and members of CATT have participated in Short-Term Crisis Team and Planning Group meetings, which prompted recommendations from the Short-Term Crisis Team to the CATT team. These recommendations are detailed in the following document.

This plan addresses the immediate issues presented by the closure of emergency department (ED) and acute care beds at Metropolitan St. Louis Psychiatric Center (MPC), recognizing that MPC will continue to provide psychiatric services to forensic patients after the closure of the ED and acute care beds. The Planning Group further recognizes the need to address the significant care shortfalls in the aftermath of the ED closure.

The individuals and organizations participating in the planning process have worked together to develop the best possible solutions to the challenges created by this closure. As representatives of DMH have publicly stated, the closure of MPC's ED and acute care beds deteriorates the behavioral health system in the St. Louis region, and has been precipitated solely by significant revenue shortfalls in the State of Missouri in 2011 and 2012. Combined with the reduction in psychiatric services by Eastern Region community hospitals over the past five years, the changes at MPC will continue to strain existing health care providers, and especially EDs, which will create challenges for patients and families. The recommendations and solutions presented in this document are designed to mitigate negative impacts as much as possible; however, the team members believe it is important to note that these solutions are sub-optimal vis-à-vis maintaining or enhancing acute care and emergency services for psychiatric patients in the Eastern Region.

The Short-Term Crisis Team and Planning Group's anticipate the greatest impact to be on those patients who are uninsured. In 2008, 61 percent of MPC patients were uninsured. While hospitals expect to be able to enroll many of those patients in Medicaid, there is an expectation that the number of uninsured psychiatric patients that community hospitals will treat will increase with the closure of MPC. The RHC's previous recommendation to DMH for expedited Medicaid determination in the Eastern Region for psychiatric diagnosis will be important to implement in the near future given MPC's recent reduction in services.

Issues Identified to Address

The Short-Term Crisis Team worked to identify the immediate issues created by the closure of MPC services by first understanding the scope and impact of the situation on the following stakeholders: patients and families, police, EMS, courts, jails, community hospitals, community mental health centers, other behavioral health providers and homeless shelters. Through conversations with representatives of each stakeholder and analysis of critical data, the Short-Term Crisis Team identified the following issues to address in the Emergency Response and Capacity plan:

- Protocols for police and EMS to bring patients to community hospitals instead of MPC.
- Best practices for community hospitals to manage an increasing number of involuntary admissions, both civil and court ordered.
- Best practices for conducting an increasing number of "fit for confinement" evaluations in community hospital EDs.
- Identification of providers for patients coming from jails who traditionally would go to MPC.
- Protocols for securing admission of patients in need of maximum security at Fulton State Hospital or in need of long-term care, either in an inpatient setting at St. Louis Psychiatric Rehabilitation Center, or in an Intensive Residential Treatment Service maintained by a Community Mental Health Center. (Individuals detained in jail settings awaiting transfer to Fulton State Hospital for hospitalization need not be screened for admission by any provider in the St. Louis Region and can be admitted directly to Fulton State Hospital.)
- Identification of a service provider to assign attorneys to patients from St. Louis City or St. Louis County admitted involuntarily to a local community hospital
- Identification of a service provider to assign a drug and alcohol substance abuse provider to patients committed to involuntary treatment.
- Identification of tools that could help facilitate transfers between hospitals.
- Identification of community-based resources that would help community hospitals transition patients from acute hospital beds to more appropriate care settings.
- Services MPC provides for its patients that may need to be replicated by other organizations.

The following recommendations represent the collective input of the Short-Term Crisis Team and should be reviewed and considered by each individual entity's staff and legal counsel before implementing. These recommendations are not intended to serve as legal advice.

The Short-Term Crisis Team also recommends a task force be assembled by DMH and the Missouri Hospital Association to oversee the implementation of the following recommendations and to ensure collaboration among all the psychiatric providers in the region continues. It is the Short-Term Crisis Team's intent that this task force would help ensure the equitable distribution of psychiatric patients and resources in the region.

Key Data

Since 2006, MPC has operated at 100 staffed beds or fewer. Over the last several years, this number has steadily declined, reducing access to vitally needed inpatient mental healthcare in the community. Since December 2009, MPC has been staffing only 50 inpatient beds. This decline has reduced the annualized discharges from about 1,500 discharges in fiscal year 2009 to about 1,200 discharges in fiscal year 2010.

The MPC ED also has experienced declining volumes due to reductions in service. The ED treated about 4,000 patients in fiscal year 2009, down to an annualized 2,800 patients for fiscal year 2010.

Recent statistics represent an average of about seven to eight patient visits per day at MPC's emergency department, resulting in two to three inpatient admissions per day.

Other key statistics and facts include:

- From December 2009 to May 2010, MPC admitted 389 involuntary patients, or about 65 involuntary patients per month, which represents 78 percent of all admissions.
- Of these 65 involuntary patients per month served by MPC since December 2009, about 31 per month are court-ordered patients. In addition, about nine involuntary patients per month are brought in by law enforcement.
- St. Louis City EMS reports transporting about one patient per day to MPC. If EMS psychiatric patients are presenting any other medical conditions, they are taken to a community hospital that can handle both the behavioral and physical health needs of the patient.
- In the past year (6/15/2009 to 6/15/2010), MPC treated 38 patients from jails, an average of about three to four patients per month.
- Psychiatric patients on average spend 6-8 hours in busy community hospital emergency departments, and sometimes as long as 20 hours waiting for an inpatient bed placement. Community hospitals do not have the physical plant or the specialized skill and expertise to safely manage the increase in volume and acuity of psychiatric patients.

For additional analysis and data regarding MPC , please refer to the Impact Statement created by the Short-Term Crisis Planning Team and available at www.stlrhc.org.

EMERGENCY RESPONSE RECOMMENDATIONS

A dedicated Stabilization Unit for psychiatric patients with procedures for increased linkages from acute care to outpatient services is in the best interest of patients, staff, and community stakeholders. While that plan is being formulated, the following protocols are recommended. .

Police and EMS Protocol

Police report they would be able to better serve the community if area hospitals followed the same standard protocol for managing patients brought by police. As a result, the Short-Term Crisis Team developed a flow chart of recommended protocol for community hospitals and standard forms that community hospitals may review and consider using with the input of their staff and legal counsel. These forms will be available on the website of Behavioral Health Response (www.bhrstl.org) for hospitals to easily access and customize.

Police report that standard protocols and forms throughout the community will help officers return to the streets sooner and enable police and ED staff to easily manage patient flow and information under HIPAA guidelines. (See Appendix II for flow chart and forms.)

The standard protocol and forms also will help facilitate patient transfers among hospitals. With an increasing number of patients expected to receive care at community hospitals due to MPC's closure, transfers will be more common than they are today.

The Short-Term Crisis Team consulted with Commissioners Patrick Connaghan and Kimberly Coon in St. Louis City and St. Louis Country respectively to determine if certain forms required notarized signatures or two signatures by witness nurses. Both judges advised hospitals to obtain notarized signatures for these forms. The community hospitals may take this information into consideration as their staff and legal counsel determine their own course of action.

Some community hospitals report requiring all ED charge nurses receive notary certification to ensure a notary is always present in the ED.

Involuntary Admissions

From December 2009 to May 2010, MPC admitted 389 involuntary patients, representing 78 percent of all admissions. This volume equates to about 2 additional involuntary admissions per day that the community hospitals across the region will collectively need to manage in the future. Generally speaking, about 50 percent of MPC's involuntary patients go before a judge who considers MPC's request for a 21-day commitment.

To help community hospitals manage these additional involuntary admissions, it is recommended that community hospitals consider the following:

- Integrate auto-complete worksheets (currently used at MPC and Barnes-Jewish Hospital) into electronic health record systems to facilitate the court application for an involuntary admission. A psychiatrist, psychiatric social work with one year of experience, or psychiatric nurse with three years of experience may complete the forms, which then are sent to the community hospital's review team before submitted to the courts. These forms are accepted in both St. Louis City and St. Louis County. (See Appendix III for sample forms.)

- Provide remote courtrooms with teleconferencing capabilities in community hospitals. MPC and Barnes-Jewish Hospital currently have these facilities, which were developed under the guidance of Commissioner Connaghan in St. Louis City. The Short-Term Crisis Team recommends that St. Louis County courts begin facilitating hearings via remote courtrooms. Members of the Short-Term Crisis Team will conduct a meeting with Commissioner Coon in St. Louis County to discuss this recommendation. MPC and Barnes-Jewish Hospital both report that the patients prefer to remain in the hospital for these proceedings. (When MPC and Barnes-Jewish Hospital built these courtrooms about two years ago, they did so at a cost of about $25,000 per courtroom. It is anticipated that the cost would be lower today due to the decreasing cost of the technology employed.)

Of the about 65 involuntary admissions per month at MPC, about 31 are court-ordered. DMH is developing a complete list of hospitals with psychiatric units for judges in the Eastern Region to consult as they determine where to send court-ordered patients. The Short-Term Crisis Team recommends that judges send court-ordered patients to the hospital nearest the patient's residence for evaluation.

Fit for Confinement Evaluations

When police arrest someone who exhibits mental or physical illness, they take them to a hospital for assessment to determine if they are fit for confinement. The hospital assesses the patient to determine if he or she meets the criteria for inpatient admission. MPC currently conducts a number of psychiatric fit for confinement evaluations for both police and jails.

With the closure of MPC's ED, it is anticipated that community hospitals will perform an increasing number of these evaluations. The Short-Term Crisis Team has developed a recommended form for these evaluations that community hospitals may review and consider using with the input of their staff and legal counsel.

Members of the Short-Term Crisis Team recommend a standard form and approach throughout the community to help better facilitate these evaluations for police and jails. (See Appendix IV for a sample form.)

St. Louis City and St. Louis County jails currently reimburse hospitals $150 for a medical fit for confinement evaluation. There is no budget set aside in these departments to provide psychiatric fit for confinement evaluations, which historically have been conducted by MPC at no cost to the jails.

Providers for Jail Patients

Community hospitals currently treat very similar patients to those seen at MPC with one exception. Patients who are in jail and need acute inpatient psychiatric care rarely are treated in community hospital psychiatric units. Historically, in the St. Louis region, county and city jails have sent individuals who they are unable to treat in their own facilities to MPC at no cost to the county or city. The Department of Mental Health (DMH) has covered the cost of these services.

In a recent call with providers from Springfield and Columbia, the Short-Term Crisis Management Team ascertained that other community hospitals throughout the State do provide services for jail patients. While they are compensated for medical care, they are not compensated for mental health services.

During fiscal year 2010, MPC treated 49 hold prisoners. Analysis of a subset of that data reveals a median length of stay of seven days at a total cost of $291,834. At least 14 of these patients were from St. Louis City Jails and at least four were from St. Louis County. The remaining patients were sent from a number of municipalities. It is important to note that patients from jails are comingled with other psychiatric inpatients; the number of these patients is not sufficient to require a separate treatment unit.

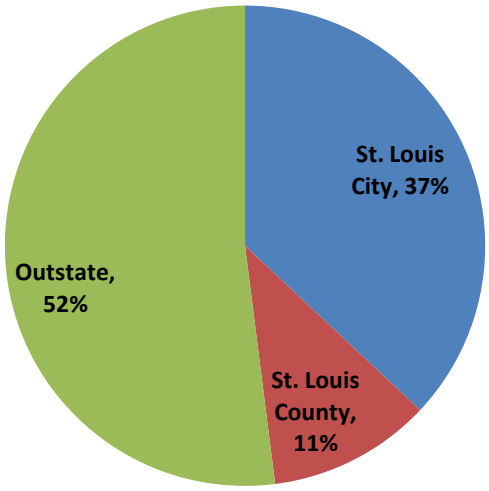
Subset of Hold Prisoners Court Committed to MPC

6/15/09 – 6/15/10

	Frequency	
City	**Count**	**%**
ST LOUIS	**14**	**37%**
CLAYTON*	**4**	**11%**
KAHOKA	**2**	**5%**
WARRENTON	**2**	**5%**
WAYNESVILLE	**2**	**5%**
DESOTO	**1**	**3%**
DIXON	**1**	**3%**
GRANITE CITY	**1**	**3%**
HANNIBAL	**1**	**3%**
LAKE ST LOUIS	**1**	**3%**
LOUISIANA	**1**	**3%**
PARK HILLS	**1**	**3%**
PILOT KNOB	**1**	**3%**
POTOSI	**1**	**3%**
RICHLAND	**1**	**3%**
SALEM	**1**	**3%**
ST JAMES	**1**	**3%**
TROY	**1**	**3%**
WASHINGTON	**1**	**3%**
	38	

(Total does not equal 49 due to data discrepancies)

*St. Louis County Jail



MPC medical staff report that the patients who come from jail settings are similar to the other patients they treat in terms of diagnosis and length of stay. Outlined below is a summary provided by MPC that describes the most typical clinical profiles of patients who admit from jails.

Group 1: *Patients with personality disorder diagnoses and behavioral disturbances*

This group is usually comprised of young males with a lifelong history of impulsivity, behavioral disturbance, and anger problems. Extremely primitive personality functioning with mixed borderline and antisocial traits. Many of these patients will carry a plethora of old diagnoses, typically ADHD and bipolar, but in most cases these traits are secondary to personality issues. They usually present from jail with behavioral outbursts that the jail has problems managing. The outbursts are multi-factorial in nature and represent a combination of manipulation and frustration with their incarceration. Most often present from rural jails. Length of stay is very short, usually 96-hour observation then out.

Group 2: *Patients with antisocial personality disorder, who are malingering to avoid jail*

This group typically consists of patients with a long history of criminality, deviancy, and antisocial behaviors. Has typically had sparse treatment for mood complaints and/or impulsivity and aggression. These individuals often present after having self-injurious behavior or verbalizing suicide. Length of stay is very short, usually 96-hour observation then out.

Group 3: *Patients in acute psychotic or manic episode*

These patients usually have a history of schizophrenia or bipolar disorder. They often times present in the context of psychosis or mania in the context of medication refusal. Often times index crimes are relatively minor and likely represent psychotic behaviors that happened to be illegal in nature. A significant amount of these will represent the migratory psychotic patient, who has no ties to the immediate geographic area, and was detained by police while wandering across the country. Length of stay is bimodal and depends upon the level of dangerousness. If the patient is dangerous, length of stay can be long – on the order of several weeks. If the patient is not dangerous the course of treatment is 96-hour observation, then out. This is the typical scenario from St. Louis County Jail that has in-house treatment services.

Psychiatric patients who have committed major felonies (rape, murder, arson, etc.) are eligible for admission to Fulton State Hospital (See Appendix V, Major Crime Exclusion List.)

The Short-Term Crisis Team discussed potential solutions for treating jail patients not eligible for care at Fulton State Hospital, including:

- DMH uses a portion of the $2 million allocated to the region to fund services for individuals from the Eastern Region's jails.
- Community hospitals with appropriately secure facilities provide inpatient psychiatric care for a contracted per diem fee.
- Jails build capacity to provide services in-house. One jail could perhaps build this capacity and offer services to other regional jails for efficiency.

MPC may still be able to serve some of this patient population through May 2011 depending on availability in the remaining 25-bed unit.

To further evaluate potential solutions and determine a recommended course of action, the Short-Term Crisis Team recommends the following:

- St. Louis City and St. Louis County jails consult legal counsel to determine how custody of these patients can be managed. Current understanding is that these patients need to be supervised by an armed officer of the jail for the jail to maintain legal custody. Community hospitals report that armed or uniformed officers are not allowed on psychiatric units. Weapons of any kind are not allowed on these units and uniformed officers create difficulty in providing appropriate care to the other mental health patients.
- St. Louis City and St. Louis County jails consult legal counsel to determine their ability to administer involuntary medications – one of the primary reasons these jails seek hospital care for their inmates. Currently, the jails do not administer involuntary medications. The jails may study this issue further to understand the legal, ethical and licensure considerations.
- Community hospitals identify psychiatric units that offer patient environments that may be secure enough to serve this patient population.

No regional solution to provide inpatient psychiatric care for inmates has yet been identified, and individual hospitals are assessing their skills, security, and experience to care for this population. Some community hospitals have stated they will not admit jail patients for psychiatric care. It should be noted that while community hospitals often contract for reimbursement for providing medical services to jail patients, no plan has been identified to provide reimbursement for providing psychiatric services.

Protocols for DMH Admissions

Historically, St. Louis area patients who need to be admitted either to Fulton State Hospital or to a DMH long-term care facility have gone to MPC first. DMH reports that patients can be admitted directly to either Fulton or a DMH long-term care facility. (See Appendix V for protocols for transfers to Fulton State Hospital.)

In the near term, MPC will be providing admissions only for scheduled patients from community hospitals, consumers who need revocation and for clients committed pursuant to Chapter 552 RSMo for restoration of competency. St Louis Psychiatric Rehabilitation Center (SLPRC) will only admit clients transferred from other DMH facilities and some consumers who need revocation. At a later date, DMH with the community will develop an admission protocol for those in need of long-term care, either in an inpatient setting at SLPRC, or in an Intensive Residential Treatment Service maintained by a Community Mental Health Provider.

Other MPC Services

MPC currently assigns attorneys to involuntary psychiatric patients in St. Louis City and St. Louis County. The ED at MPC manages this process because the assignment needs to happen as soon as possible after an admission decision. Behavioral Health Response (BHR) has indicated that through its 24/7 call center it could manage this service for hospitals in St. Louis City and St. Louis County. BHR will work with MPC immediately to understand the full scope of the service and its associated costs.

MPC also facilitates the assignment of substance abuse providers for those patients in the region committed to 30-day alcohol and drug involuntary treatment. At this time, very few community hospitals seek drug and alcohol involuntary commitments. In fiscal year 2010, MPC did 153 drug and alcohol commitments. At MPC, these patients experience very brief lengths of stay (less than 96 hours) before they are admitted into one of the alcohol and drug treatment programs, assigned on a rotating basis. MPC anticipates that families and patients will begin presenting in community hospital emergency departments seeking involuntary commitments for drug and alcohol abuse. Each hospital will have to determine how they will handle these patients. Bridgeway has established an alcohol and drug abuse residential treatment rotation accessible through (314) 226.9030 x253 for 30-day alcohol and drug commitments.

MPC provides free medications to patients committed to these treatment programs. This is at an average retail equivalent cost of $175 per client.

CAPACITY ISSUES RECOMMENDATIONS

Facilitating Patient Transfers Between Hospitals

As psychiatric inpatient capacity continues to tighten in the St. Louis region, hospitals will more frequently need to transfer patients to facilities that have available beds.

In 2005, the Missouri Hospital Association worked with community hospitals to develop a web-based tool that enabled hospitals to share information about bed availability. Every two hours, hospital staff would update the number of beds available. The system also provided up-to-date contact information for hospitals to use when trying to find an available bed for a patient. The hospitals report they quit using the system because not all hospitals were updating the information and hospitals did not trust that all participants were sharing accurate information.

The Short-Term Crisis Team discussed how frequently their bed availability changes and that information even an hour old may be inaccurate. They also noted that bed availability fluctuates depending on the medical acuity of patients in the unit at the time. If patients require isolation for medical reasons or because of psychiatric acuity, semi-private rooms become private, making some beds unavailable.

For illustration purposes, when the web-based system was operating, the following was a typical situation: Hospital A would show they had beds available in the system; Hospital B would call Hospital A to try to place a patient; Hospital A would report they had no beds available; Hospital B did not trust the information in the system nor the information provided when staff called Hospital A.

The Short-Term Crisis Team recommends investigating a redeployment of this tool. The team believes it could be effective in more easily facilitating transfers between hospitals if (1) hospital staff understood that the numbers reported in the system were merely for guidance and would not be 100 percent accurate and (2) all hospitals participated. It also may be helpful if the system only tracked adult acute care beds.

The Short-Term Crisis Team has asked the Missouri Hospital Association to provide information about activities and associated costs to redeploy the tool.

Managing Increased Volume in Emergency Departments

It is estimated that the region's community hospitals treat about 1,500 psychiatric patients in their emergency departments each month. With MPC's closure, the hospitals in the region can expect a total of about 80 additional psychiatric patients each month, most of whom are likely to be involuntary patients.

The Short-Term Crisis Team recommends the consideration of development of a Community-Wide Psychiatric/Substance Abuse Intake and Stability Unit at the former MPC ED. This new unit could:

- Ensure that appropriate mental health and behavioral services are provided to patients in a setting that has been developed and staffed to deliver the specialized care necessary for these patients
- Ensure that EMS providers, police and community members are aware of where to take patients who are suffering only from psychiatric issues and/or substance abuse.
- Establish and follow protocols that provide clarity on when and under what conditions psychiatric/substance abuse patients are to be transferred to community hospital emergency departments
- Establish a potential 23-hour observation unit to manage patients (typically intoxicated or suicidal) that don't require inpatient psychiatric hospitalization
- Allow judges to court order patients for evaluation to this site

The Short-Term Crisis Team has evaluated ways to manage increased volumes in emergency departments using non-hospital treatment options. The group believes that the ability to secure next day, urgent care appointments at Community Mental Health Centers may enable emergency departments to discharge more patients rather than admitting them.

The Short-Term Crisis Team recommends that the Community Access Transformation Team (CATT) consider how CMHCs may be able to provide these next day appointments specifically to hospitals with psychiatric units treating involuntary patients.

The Short-Term Crisis Team recognizes that DMH has provided the following guidelines for patient populations eligible for funding available from the $2 million allocated to the Eastern Region by DMH:

Target Population

- *Individuals discharged from a community hospital acute psychiatric unit or emergency room, who are Medicaid eligible and have a CPRC qualifying diagnosis.*
- *Existing DMH consumers, Mental Health 4 consumers (individuals with Serious Mental Illness) discharged from correctional settings, consumers discharged from long-term care state-operated facilities.*
- *Other individual exceptions can be made based on the acuity of the crisis and the limits of each CMHC's allocation.*

Desired Plan Elements:

The following elements are intended more as guidance than as strict requirements:

- *The Front End: The FIRST priority is attending to the replacement of the ED function, meaning services intended to engage people in existing community based services, managing crises and minimizing use of community ED services, and serving as an alternative to inpatient admission. All such services enhance access and connectivity, focus on high utilizers (frequent users) of ED and inpatient services. This include such services as:*
  - *Mobile Outreach (scrambling BHR or agency staff to the scene of a crisis including a community ED, with or without existing psychiatric beds and expertise), or staffing community ED units (with BHR or CMHC staff).*
  - *Urgent Care (i.e., at least "next day" if not "same day" appointments).*
  - *Crisis/Respite Beds in Sub-Acute settings (which can be a part of an Intensive Residential Treatment Service [See */IRTS below] with shorter lengths of stay.)*
- *The Back End: A SECONDARY priority is attending to the needs of consumers who have been admitted into community hospital acute inpatient beds.*
  - *It is NOT the department's intention for the regional plans to spend all, or even the majority of their dollars, on operating EDs, purchasing inpatient days, capital improvement efforts to build beds, etc. However, should a region submit a plan in which such features predominate, and it is has broad support across the regional planning group, such a plan will receive serious consideration.*
  - *The department DOES encourage the use of service/residential support options that facilitate release from inpatient care and continuity of care with our community providers. Such services/supports mitigate excessive Lengths of Stay in high dollar inpatient beds, enhance opportunities for coordination of care with community providers, and facilitate effective community reintegration, The following are examples that the department:*
    1. *Processes for staffing acute care consumers in the community hospitals to facilitate discharge planning.*
    2. **Intensive Residential Treatment Service options (IRTs) in sub-acute residential settings with intermediate to long-term lengths of stay.*
  - *Other Desirable Features*
    1. *Coordination with Law Enforcement (including CIT officers) and the Courts.*
    2. *Strategies for involving Peer Specialists in the provision of care.*

It is acknowledged in the short planning window of the Short-Term Crisis Team that the full details of the stabilization unit have not been developed to date. If the details are reasonable and agreeable to all parties, the Short-Term Crisis Team and MPC Planning Group would like DMH to consider directing the funds to stabilize emergent psych patients and support outpatient care for uninsured psychiatric patients. Outpatient care would be directed to patients coming from (1) an inpatient stay at a community hospital or (2) an ED visit that does not require immediate hospitalization. If possible, priority could be given to "high utilizers" of inpatient or ED services. Patients who have been incarcerated may be considered part of the "high utilizer" priority group. In addition, patients with a first

psychosis or who are delusional and possibly homicidal or suicidal could also be considered as part of the priority group.

The Teams believe that funds should be first available to fund coordinated stabilization and outpatient care from those hospitals with adult, locked acute psychiatric units, and those hospitals that accept involuntary patients. The intent is to maximize the $2 million from DMH with local, state and/or federal dollars.

Increasing Inpatient Capacity by Facilitating Timely Discharge

It has been noted by members of the MPC Planning Group that MPC's lengths of stay are longer than those of community hospitals, enabling patients and families to better plan for care after a hospital stay. MPC reports a median length of stay of seven days in fiscal year 2009. When outliers are accounted for, the average length of stay is 17.56 days. For comparison, hospitals in the region report a range of about five to eight days as an average length of stay on an adult psychiatric acute unit.

Hospitals are scrutinized by Medicare and other payers to ensure all patient days are medically necessary, making it impossible to keep patients longer than medically necessary.

With the closure of MPC and the continued tightening of psychiatric inpatient beds in the St. Louis region, the Short-Term Crisis Team has worked to identify ways to improve discharge planning, possibly enabling more patients to discharge earlier with better care plans. These earlier discharges will make more psychiatric beds available to the community.

The team evaluated several potential solutions, including:

- Priority CMHC appointments (within one week of discharge).
- Coordination with community case managers.
- Discharge to crisis beds.
- Short-term housing support.
- Substance abuse treatment.
- Intensive residential treatment.
- Access to medication at discharge.
- Resources for discharging developmentally disabled patients.

After evaluating each of these options within the context of the $2 million available to the Eastern Region from the State of Missouri, the Short-Term Crisis Team recommends community hospitals and CMHCs work more closely to facilitate effective and timely discharges. This could involve mobile care coordination, enabling CMHC staff to visit patients in hospitals, work with hospital social workers and help facilitate discharge. Some CMHCs already provide this service for their current patients. To help with the MPC closure, this service would need to be extended to new patients.

It is the recommendation of the Short-Term Crisis Team that the CATT evaluate the viability and scope and scale that this service could be offered in order to determine if it would help alleviate some of the pressures on the system created by the closure of MPC.

One of the challenges identified is the ability of community hospitals and CMHCs to share patient information under HIPAA guidelines. As an option, DMH has provided a template for a Business Associate Agreement (Appendix IV) the department uses with providers to enable the sharing of information. Hospitals and CMHCs can use this as a basis to draft their own agreements between each other.

It was also noted that access to affordable medication is an issue for some patients at discharge. The Short-Term Crisis Team will provide hospitals with a list of places to receive affordable medications that MPC currently provides its patients.

Key MPC Relationships

MPC provides services to its patients that community hospitals may want to consider offering. Examples include family education provided in cooperation with the National Alliance on Mental Illness (NAMI) and promotion of patient rights via the Missouri Protection and Advocacy Services. MPC is conducting an inventory of these types of relationships for community hospitals to review.

CONCLUSION

Summary of Recommendations

As a result of the Short-Term planning process, several recommendations have been made for area hospitals and other providers to consider with their staff and legal counsel. These include:

- A standard process and protocol in community hospitals for handling involuntary patients.
- Standard fit for confinement and police hold forms.
- Notarized signatures on affidavits instead of two witness signatures.
- Auto-complete forms (currently used by MPC and Barnes-Jewish Hospital) for court applications for involuntary admissions).
- Additional tele-courtrooms in community hospitals.

These changes in process are designed to help hospitals handle more involuntary patients than they currently treat , to help facilitate transfers of patients between hospitals; and to help police officers leave hospitals and return to the streets sooner.

In addition, the group identified services MPC provides the community that other organizations will need to absorb or that different protocol will need to address. The resolution to these issues follows:

- Behavioral Health Response will manage the rotational assignment of attorneys for involuntary psychiatric patients.
- Bridgeway will manage the rotational assignment of alcohol and drug abuse treatment programs for drug and alcohol involuntary commitments.
- Jails and law enforcement will follow DMH procedures for direct transfers to Biggs Forensic Center at Fulton State Hospital. (Traditionally, patients would come to MPC before going to Biggs.)

The group also recommended solutions for the Community Access Transformation Team to consider in their recommendations to DMH:

- Next day, urgent care appointments at Community Mental Health Centers (CMHCs) for emergency department patients, enabling some patients to discharge rather than admit.
- Facilitated inpatient discharge coordinated between community hospitals and CMHCs, enabling more patients to access outpatient care.

It is acknowledged in the short planning window of the Short-Term Crisis Team that the full details of the stabilization unit have not been developed to date. If the details are reasonable and agreeable to all parties, the Short-Term Crisis Team and MPC Planning Group would like DMH to consider directing the funds to stabilize emergent psych patients and support outpatient care for uninsured psychiatric patients. Outpatient care would be directed to patients coming from (1) an inpatient stay at a community hospital or (2) an ED visit that does not require immediate hospitalization. If possible,

priority could be given to "high utilizers" of inpatient or ED services. Patients who have been incarcerated may be considered part of the "high utilizer" priority group. In addition, patients with a first psychosis or who are delusional and possibly homicidal or suicidal could also be considered as part of the priority group.

The Teams believe that funds should be first available to fund coordinated stabilization and outpatient care from those hospitals with adult, locked acute psychiatric units, and those hospitals that accept involuntary patients. The intent is to maximize the $2 million from DMH with local, state and/or federal dollars.

The Teams further recommend consideration of a Stabilization Unit at the former MPC ED.

Unresolved Issues

The Short-Term Crisis Team has spent considerable time understanding the issue of treating patients from jails. At this time, no regional solution to provide inpatient psychiatric care for inmates has yet been identified, and individual hospitals are assessing their skills, security, and experience to care for this population. Some community hospitals have stated they will not admit jail patients for psychiatric care. It should be noted that while community hospitals often contract for reimbursement for providing medical services to jail patients, no plan has been identified to provide reimbursement for providing psychiatric services.

Issues for Long-Term Team's Consideration

The following long-term issues have been identified by the Short-Term Crisis Team for the Long-Term Team's consideration:

<u>System of Care Coordination</u>

- Limited availability of slots in Community Mental Health Centers, especially for the uninsured
- Shrinking inpatient psychiatric capacity in the region with longer waits in EDs as patients wait for beds
- Lack of available long-term care beds for psychiatric patients; regulations preventing placement of psych patients in long-term beds
- Lack of housing for patients after treatment
- Lack of capacity of substance abuse providers especially for those without insurance

<u>Unique Patient Populations</u>

- With DMH's closure of MPC ED and acute care beds, lack of provider for patients from jails

<u>Reimbursement</u>

- Typically, 90-days from application for patients to become enrolled in Medicaid

<u>Workforce</u>

- Lack of psychiatrists and other licensed staff

Communications Recommendations

Executive Summary of Metropolitan St. Louis Psychiatric Center (MPC) Emergency Response Plan for Community Distribution

The Missouri Department of Mental Health (DMH) has announced it is closing the emergency department and 25 acute care beds at MPC July 15, 2010, leaving 25 beds in operation until May 2011. Next spring, MPC will convert its operations to a 50-bed forensic pre-trial program.

The Planning Group assembled by the St. Louis Regional Health Commission, at DMH's request, has developed a short-term crisis planning process that has developed cross-organizational recommendations to address: (1) emergency response issues and (2) capacity issues of inpatient psychiatric units.

In developing the Emergency Response and Capacity Plan, the MPC Planning Group has determined that community hospitals already treat many of the same kinds of patients as MPC. While the community hospitals' behavioral health units already are taxed, they believe they will be able to continue to absorb most of MPC's remaining patients, which account for seven to eight emergency department visits per day and two to three inpatient admissions per day. Patients can expect to experience longer waits in emergency departments as hospitals treat more patients and psychiatric inpatient beds become scarcer.

To help manage the increased volume, the MPC Planning Group has developed a series of recommended protocols, procedures and forms to help all area hospitals with behavioral health services more easily serve former MPC patients and clients. Each hospital may review these recommendations with their staff and legal counsel to determine if they are appropriate for their own organization. With greater patient demand, it is expected that hospitals will frequently transfer patients to other hospitals where beds are available. These standard protocols, procedures and forms are intended to better manage patient flow and information.

Hospitals in the St. Louis area that provide emergency and adult acute psychiatric services include:

- Barnes-Jewish Hospital
- CenterPointe Hospital
- Christian Hospital Northeast/Northwest
- Forest Park Community Hospital
- Jefferson Memorial Hospital
- MPC (25 beds after July 15, 2010)
- St. Alexius Hospital – Broadway Campus
- St. Anthony's Medical Center
- St. John's Mercy Medical Center
- St. Louis University Hospital*
- SSM DePaul Health Center
- SSM St. Joseph Health Center (Wentzville & St. Charles)
- SSM St. Mary's Hospital

*Note: St. Louis University Hospital will not accept involuntary psychiatric patients, which account for 78 percent of MPC's current admissions.

Community hospitals currently do not typically serve one type of MPC patient: those who come from jails. In the last year (June 15, 2009 – June 15, 2010), MPC admitted 38 patients from jails. The Planning Group has evaluated several options and is conducting additional research to determine the best approach. MPC may be able to serve some of this patient population through May 2011, depending on availability in the remaining 25-bed unit.

In order to address capacity-related issues, the Short-Term Crisis Team will investigate the viability of restoring a web-based solution that enables hospitals to share information about bed availability. This will help facilitate transfers between hospitals, which will be necessary as inpatient beds become scarcer.

The Short-Term Crisis Team also has requested that the Community Access Transformation Team consider developing a proposal for DMH that may include next day, urgent care appointments for patients seen and discharged from EDs and greater coordination of discharge planning between hospitals and CMHCs. Hospitals report significantly better outcomes when patients meet a representative from a CMHC prior to discharge.

Audiences for Emergency Response Communications

First Responders

- St. Louis City Police
- St. Louis Fire Department (EMS)
- St. Louis County Police/Municipal and University Police Departments
- St. Louis area EMS
- 911 Dispatchers

Courts

Jails

- St. Louis City Jails
- St. Louis County Jails
- Municipal Jails

Community Hospitals

Primary Care Physicians

Patients and Families

Other Referral Sources

- Community Mental Health Centers and Affiliates
- Homeless Shelters
- Social or Community Agencies

Communications Strategies

I. Hospital representatives of Short-Term Crisis Team and Planning Group to share recommended protocols, procedures and forms with hospital staff
II. EMS, Police and Crisis Intervention Team (CIT) representatives of Short-Term Crisis Team and Planning Group to distribute protocols, procedures and forms to officers, 911 dispatchers and EMS
III. DMH to distribute a letter to courts, communicating their options for services
IV. DMH to distribute a letter to jails (those who have used MPC services in last two years) communicating their options for services
V. DMH to distribute a letter to MPC patients/guardians (of last two years) communicating their options for services
VI. DMH to distribute a letter to MPC referral sources (of last two years) communication options for services
VII. DMH to distribute a letter to associations representing primary care physicians to communicate options for care (examples: Missouri State Medical Association; Missouri Academy of Family Physicians)

Appendices

Appendix I: Short-Term Crisis Team Roster

Appendix II: Mental Health Admission Process: ED Patients Brought by Police Flow Chart and ED Patient Brought in by Family, Friends, or Self

Appendix III: Involuntary Admission Forms

Appendix IV: Fit for Confinement Evaluation Form

Appendix V: Major Crime Exclusion List

Appendix VI: Protocols for Transfers to Fulton State Hospital

Appendix VII: Business Associate Agreement