JOINT STATE GOVERNMENT COMMISSION

General Assembly of the Commonwealth of Pennsylvania

BEHAVIORAL HEALTH CARE SYSTEM CAPACITY IN PENNSYLVANIA AND ITS IMPACT ON HOSPITAL EMERGENCY DEPARTMENTS AND PATIENT HEALTH

REPORT OF THE ADVISORY COMMITTEE ON EMERGENCY DEPARTMENT TREATMENT AND BEHAVIORAL HEALTH

JULY 2020

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<u>**REPORT**</u>

Behavioral Health Care System Capacity in Pennsylvania and Its Impact on Hospital Emergency Departments and Patient Health

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The report is also available on our website http://jsg.legis.state.pa.us/publications.cfm

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The Joint State Government Commission was created in 1937 as the primary and central non-partisan, bicameral research and policy development agency for the General Assembly of Pennsylvania.[1]

A fourteen-member Executive Committee comprised of the leadership of both the House of Representatives and the Senate oversees the Commission. The seven Executive Committee members from the House of Representatives are the Speaker, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. The seven Executive Committee members from the Senate are the President Pro Tempore, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. By statute, the Executive Committee selects a chairman of the Commission from among the members of the General Assembly. Historically, the Executive Committee has also selected a Vice-Chair or Treasurer, or both, for the Commission.

The studies conducted by the Commission are authorized by statute or by a simple or joint resolution. In general, the Commission has the power to conduct investigations, study issues, and gather information as directed by the General Assembly. The Commission provides in-depth research on a variety of topics, crafts recommendations to improve public policy and statutory law, and works closely with legislators and their staff.

A Commission study may involve the appointment of a legislative task force, composed of a specified number of legislators from the House of Representatives or the Senate, or both, as set forth in the enabling statute or resolution. In addition to following the progress of a particular study, the principal role of a task force is to determine whether to authorize the publication of any report resulting from the study and the introduction of any proposed legislation contained in the report. However, task force authorization does not necessarily reflect endorsement of all the findings and recommendations contained in a report.

Some studies involve an appointed advisory committee of professionals or interested parties from across the Commonwealth with expertise in a particular topic; others are managed exclusively by Commission staff with the informal involvement of representatives of those entities that can provide insight and information regarding the particular topic. When a study involves an advisory committee, the Commission seeks consensus among the members.[2] Although an advisory committee member may represent a particular department, agency, association, or group, such representation does not necessarily reflect the endorsement of the department, agency, association, or group of all the findings and recommendations contained in a study report.

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[1] Act of July 1, 1937 (P.L.2460, No.459); 46 P.S. §§ 65–69.
[2] Consensus does not necessarily reflect unanimity among the advisory committee members on each individual policy or legislative recommendation. At a minimum, it reflects the views of a substantial majority of the advisory committee, gained after lengthy review and discussion.

Over the years, nearly one thousand individuals from across the Commonwealth have served as members of the Commission's numerous advisory committees or have assisted the Commission with its studies. Members of advisory committees bring a wide range of knowledge and experience to deliberations involving a particular study. Individuals from countless backgrounds have contributed to the work of the Commission, such as attorneys, judges, professors and other educators, state and local officials, physicians and other health care professionals, business and community leaders, service providers, administrators and other professionals, law enforcement personnel, and concerned citizens. In addition, members of advisory committees donate their time to serve the public good; they are not compensated for their service as members. Consequently, the Commonwealth receives the financial benefit of such volunteerism, along with their shared expertise in developing statutory language and public policy recommendations to improve the law in Pennsylvania.

The Commission periodically reports its findings and recommendations, along with any proposed legislation, to the General Assembly. Certain studies have specific timelines for the publication of a report, as in the case of a discrete or timely topic; other studies, given their complex or considerable nature, are ongoing and involve the publication of periodic reports. Completion of a study, or a particular aspect of an ongoing study, generally results in the publication of a report setting forth background material, policy recommendations, and proposed legislation. However, the release of a report by the Commission does not necessarily reflect the endorsement by the members of the Executive Committee, or the Chair or Vice-Chair of the Commission, of all the findings, recommendations, or conclusions contained in the report. A report containing proposed legislation may also contain official comments, which may be used to construe or apply its provisions.[3]

Since its inception, the Commission has published almost 400 reports on a sweeping range of topics, including administrative law and procedure; agriculture; athletics and sports; banks and banking; commerce and trade; the commercial code; crimes and offenses; decedents, estates, and fiduciaries; detectives and private police; domestic relations; education; elections; eminent domain; environmental resources; escheats; fish; forests, waters, and state parks; game; health and safety; historical sites and museums; insolvency and assignments; insurance; the judiciary and judicial procedure; labor; law and justice; the legislature; liquor; mechanics' liens; mental health; military affairs; mines and mining; municipalities; prisons and parole; procurement; state-licensed professions and occupations; public utilities; public welfare; real and personal property; state government; taxation and fiscal affairs; transportation; vehicles; and workers' compensation.

Following the completion of a report, subsequent action on the part of the Commission may be required, and, as necessary, the Commission will draft legislation and statutory amendments, update research, track legislation through the legislative process, attend hearings, and answer questions from legislators, legislative staff, interest groups, and constituents.

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[3] 1 Pa.C.S. § 1939.

ADVISORY COMMITTEE ON EMERGENCY DEPARTMENT TREATMENT & BEHAVIORAL HEALTH

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July 2020

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To the Members of the General Assembly of Pennsylvania:

House Resolution 268 of 2019 directed the Joint State Government Commission to appoint an advisory committee to conduct an assessment of the Commonwealth's current behavioral health needs and the impact that the behavioral health care system's capacity has on hospital emergency departments and patient health. In other words, the advisory committee studied the practice known as psychiatric boarding—wherein people with behavioral health needs are maintained in hospital emergency departments while awaiting care in more appropriate settings. We are pleased to release *Behavioral Health Care System Capacity in Pennsylvania and Its Impact on Hospital Emergency Departments and Patient Health*.

The advisory committee consisted of experts across the spectrum of behavioral health care, and included physicians, public health authorities, behavioral health professionals, hospital administrators, and patient advocates. Accordingly, this report's comprehensive recommendations represent the breadth and depth of their expertise. Generally, the recommendations are to improve alignment of patient needs with resources, to improve how behavioral health patients are helped through emergency departments, and to support better outcomes for people with behavioral health needs.

The Commission wishes to thank the members of the advisory committee for their assistance with this report and their ongoing commitment to behavioral health care across the commonwealth.

Respectfully submitted,

Glenn J. Pasewicz
Executive Director

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House Resolution 268 of 2019 (Printer's No. 1817) called upon the Joint State Government Commission to conduct, in consultation with an advisory committee, a study of "the impact of this Commonwealth's current behavioral health needs and behavioral health care system capacity on hospital emergency rooms and patient health." The impetus of this study has been what appears to be insufficient capacity in the mental health and substance use disorder system that is affecting the level of care and appropriateness of treatment that persons with mental health and substance use disorder symptoms receive. This is manifested by a phenomenon referred to as "psychiatric boarding," defined in HR 268 as encompassing "the time period in a hospital emergency department after medical stabilization of a patient in need of psychiatric care and prior to the admission or transfer of that patient to an inpatient psychiatric bed" and can extend from a few hours to days. Superficially, this is often attributed to a lack of hospital or mental health or substance use disorder facility bed capacity, but more broadly is a symptom of the insufficiencies found in a constellation of systems affecting persons with mental health and substance use disorders.

People who are uninsured or under-insured face access barriers. They are often unable to connect to a full continuum of care, including a lack of ambulatory care options, limited crisis intervention services, and a limited number of community programs to help maintain stability and avert declines and relapses, and are thus driven to use the emergency department as a last resort. Primary prevention, in the form of supporting individuals in their daily lives in the community and treatment options beyond hospitalization, would help diminish the flow of patients to the emergency department. Insufficient resources in the emergency department, including timely availability of specialty trained or health evaluators, appropriate waiting space for mental health and substance use disorder patients, and an inability to coordinate with other facilities for placements can exacerbate the waiting time. Further, the milieu of an emergency department is not conducive to calming an already agitated person. Insufficient appropriate referral resources, including community programs and other placements that are the least restrictive treatment setting for a particular individual can make a safe discharge harder to arrange. This report will look at the various systems that contribute to these missed connections and make recommendations to attempt to ease some of the challenges that arise when a person with health concerns seeks treatment in an emergency department.

The Covid-19 pandemic has further raised alarms about mental health needs and capacity. A preliminary study out of San Diego University showed that the likelihood of screening positive for serious mental illness was eight times higher than a comparable survey found in 2018. Various groups were identified as having greater mental health issues than others, in particular younger adults (18-44), and parents with children under

age 18 in the home.[4] Farmers have been at higher risk for depression and suicide for many years, and the stress of the pandemic is adding to the toll, coupled with a shortage of mental health professionals in rural America.   The U.S. Health Resources and Services Administration identified more than 5,500 designated mental health professional shortage areas throughout rural America, which include approximately 120 million people.[5] Efforts designed to protect physical health can collaterally lead to social isolation and economic stress, exacerbating and sometimes triggering depression, substance use disorder, and suicidality.[6] It is now more important than ever to take a closer look at Pennsylvania's mental health and substance use disorder system to eliminate barriers and provide increased support for residents suffering from mental health and substance use disorders.

The advisory committee was composed of representatives of state agencies, mental health and substance use disorder provider organizations, county mental health and intellectual disability administrators, consumers of mental health and substance use disorder services, emergency medical service providers, nurses, emergency department physicians, psychiatrists and psychologists. The advisory committee met in-person or by conference call seven times, on September 6, 2019; December 5, 2019; January 9, 2020; February 6, 2020; May 1, 2020; June 12, 2020; and July 8, 2020.

It should be noted that the recommendations contained in this report represent the general consensus of the Advisory Committee. They are not unanimously endorsed and should not be considered the official position of some of the organizations represented on the committee.

NOTE: While it is a common practice to refer to hospital emergency services as an "emergency room" or "ER", this name is an archaic designation reflecting early practices of assigning a single room or small suite of rooms to triage accident victims and person suffering from the sudden onset of disease. The modern emergency department has a broader scope and ability to treat patients that is beyond the concept of a "room." Therefore, throughout this report, the reference to hospital emergency services will reflect the preferred appellation of "emergency department" or "ED."

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[4] Jean Twenge, "New Study Shows Staggering Effect of Coronavirus Pandemic on America's Mental Health," *The Conversation*, last modified May 7, 2020, https://theconversation.com/new-study-shows-staggering-effect-of-coronavirus-pandemic-on-americas-mental-health-137944.

[5] Sandy West, "Economic Blow Of The Coronavirus Hits America's Already Stressed Farmers," *Kaiser Health News*, last modified May 7, 2020, https://khn.org/news/pandemic-economic-blow-hits-americas-already-stressed-farmers/.

[6] MA Reger, IH Stanley, TE Joiner, "Suicide Mortality and Coronavirus Disease 2019—A Perfect Storm?" *JAMA Psychiatry* (April 10, 2020), DOI:10.1001/jamapsychiatry.2020.1060.

SUMMARY OF RECOMMENDATIONS

The fundamental concept underlying the recommendations offered in this report is that the current mental health and substance use disorder system in Pennsylvania is underfunded, and in many areas, fragmented, to the detriment of the mental and physical health of those individuals in need of its services. This lack of cohesion across systems is exacerbated by a relative dearth of non-hospitalization options, especially for those without persistent illness, and post-discharge continuity of care. Recommendations to address these systemic issues may take time to implement, while others may be implemented quickly. Many will require additional funding for expansion of health systems. The Advisory Committee supports the concept of "The Triple Aim" to improve the U.S. health care system, to wit: (1) improving the experience of care, (2) improving the health of populations, and (3) reducing per capita costs of health care. A fourth aim, improving the work life of health care providers, is also supported.[7] These aims underlie the specific recommendations in this report to address the individual problems that manifest themselves in the rising rate of emergency department boarding for individuals with mental health and substance use disorder needs by looking at three central issues:

- Align Input: In many regions, there are not sufficient community-based resources available that could help prevent deterioration of persons with mental health and substance use disorders into emergent situations, or redirect those in need of services to alternative sources of supports. Currently, this scarcity can force emergency medical services personnel to take these patients to emergency departments. The appropriate alternatives may include crisis intervention, specialized hospitals, specialized emergency departments, stabilization and recovery units, peer-run alternatives, and other similar services. Some regions have implemented a variety of these interventions and could serve as models.

- Improve Throughput: Most emergency departments (EDs) do not have specific resources for individuals with mental health and substance use disorders and have limited resources and capacity to care for patients with acute psychiatric needs. This absence of resources can result in exacerbation of acute illness and lead to long delays in engagement of appropriate care for these patients. This capacity is impacted by a variety of factors, including limitations in insurance

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[7] Berwick DM, Nolan TW, Whittington J. "The Triple Aim: Care, health, and cost." *Health Affairs,* 2008 May/June;27(3):759-769, accessed through the Institute for Health Care Improvement, http://www.ihi.org/resources/Pages/Publications/TripleAimCareHealthandCost.aspx and Thomas Bodenheimer and Christine Sinsky, "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider," *The Annals of Family Medicine*, November 2014, 12 (6) 573-576; DOI: https://doi.org/10.1370/afm.1713

coverage, EMTALA[8] obligations, shortages of mental health professionals, the inability to match patient medical and psychiatric needs with suitable inpatient mental health beds, and a lack of treatment and staff resources to care for patients experiencing acute psychiatric illness who are "boarded" in the ED. Additional factors include frequent misunderstandings of privacy and confidentiality requirements, especially around substance use disorders, and the potential for enhanced recognition of how mental health and substance use disorder symptoms are expressed in individuals, for all persons assisting persons with mental health and substance use disorder diagnoses.

- Increase Quality Output: In many regions, there are not enough non-hospital, intermediate treatment facilities for referral of individuals who may be discharged from the emergency department but are still in need of treatment, leading to an "all or nothing" choice for placement.

Recommendations to Align Input

RECOMMENDATION #1:

Pennsylvania's health system should increase the tempo of its movement to a person-centered, trauma-informed, integrated practice model focused on positive results for patients. The behavioral health system in Pennsylvania has, for over two decades, continually strengthened its focus on these themes, but they have not been addressed as robustly in other medical systems. Team-based approaches to health care should be expanded beyond their current settings (e.g. behavioral health providers and federally qualified health centers) to facilitate the coordination of care of all patients with mental health and substance use disorders. Insufficiency of mental health and substance use disorder health options in many primary care settings and resulting challenges in coordination of mental health and substance use disorder services contribute to expanded use of emergency departments for all types of mental health and substance use disorder conditions. Quality of care should be paramount regardless of the person's insured status or type of payer.

Because many of the patients who would benefit most from integrating physical and mental health and substance use disorder care are receiving Medical Assistance, the General Assembly should consider directing the Department of Humans Services (DHS)

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[8] In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented. https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA.

to further coordinate with the federal Centers for Medicare and Medicaid Services (CMS) to promote and expand models to deliver integrated care programming to Medical Assistance beneficiaries who have mental health and substance use disorder. Additionally, since models of both patient-centered physical health homes and behavioral health homes have had significant success with care integration, DHS should further investigate whether it would be feasible and cost-effective for the Commonwealth to participate in CMS's Health Home option, which is explained further at pp 69-70 of this report. In addition, DHS should evaluate strategies that would further expand development of programs that already exist in Pennsylvania, such as:

- The Collaborative Care model and other strategies that support behavioral health practitioners in medical settings, especially primary care practices, and

- Whole person primary health services consisting of fused physical/behavioral disorder health teams that serve individuals in the community.

In order to encourage the development and expansion of integrated care models, the General Assembly could provide tax incentives to any health system, provider, or insurance company that begins or expands provision of integrated medical and behavioral health services. For instance, an incentive could take the form of a tax deduction for the initial costs of integrating care or developing payment structures.

RECOMMENDATION #2:

All facilities offering ED services to adults presenting with psychiatric and behavior health signs and symptoms should adopt and apply the clinical policies of the American College of Emergency Physicians (ACEP) as they related to the care of persons with mental health and substance use disorder needs.[9]

RECOMMENDATION #3:

Crisis intervention services should be supported and expanded within each county. These services can be enhanced through the use of peer-run facilities, certified peer specialists, mental health crisis intervention providers, and other community-based services. To further expand the range of providers able to offer crisis services, the development of specialty psychiatric urgent care services should be encouraged.

Commercial insurers are required to cover crisis intervention services to the extent the crisis is an emergency under federal laws that mandate such coverage, including the Affordable Care Act, or the Mental Health Parity and Addiction Equity Act. Clarification

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[9] ACEP, Clinical Policies Subcommittee on the Adult Psychiatric Patient, "Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department," *Annals of Emergency Medicine*, Volume 69, no. 4 : April 2017, 480-498, https://www.acep.org/contentassets/04e7623d4991457bbcd9a53a40ba427d/cp-adultpsychiatricpatient-1.pdf

regarding crisis intervention services coverage requirements should be communicated to private insurers offering mental health and substance use disorder benefits to ensure appropriate coverage.

RECOMMENDATION #4:

There should be no barriers to mental health or substance use disorder services based on the system paying for the benefits, including for uninsured patients. Sustainable, permanent funding streams should be established and maintained for all levels of mental health and substance use disorder services to provide adequate financial support for these activities and projected future needs. Additionally, annual cost-of-living adjustments from the Commonwealth to community mental health services should be implemented to reverse the long-term effects of the 10 percent cuts made in the state budget in 2012.

RECOMMENDATION #5:

Given the insufficiency of community-based mental health services available to support individuals receiving assisted outpatient treatment in Pennsylvania and the fact that counties are not required to adopt assisted outpatient treatment (AOT) programs, the consensus of the Advisory Committee is that, as currently structured, the coercive aspects of AOT outweigh the lack of supplemental enhanced community services such as housing and vocational services that contribute to the successful use of AOT. At the time of the adoption of AOT, no funding was provided to assist counties in implementing it, which may have contributed to the failure of many counties to adopt it. If the other recommendations offered in this report are adopted, and the Commonwealth moves to a person-centered, recovery-oriented approach to mental health and substance use disorder services, any coercive treatment processes would be unnecessary. Further expansion of existing mental health and substance use disorder services would permit these providers to offer timely intervention for people in sub-crisis, and could prevent the need for coerced compliance. Further, court-ordered involuntary outpatient treatment was initially included as an option in the MHPA and remains a viable option. Accordingly, AOT[10] should be repealed. For further discussion, see page 35 of this report.

RECOMMENDATION #6:

Telemedicine has been vital in ensuring healthcare access to Pennsylvania residents during the Covid-19 pandemic. Efforts to further expand the use of telehealth, including telepsychiatry, are supported. This should include the provision of resources to assist providers in their ability to afford to provide access to care. The Pennsylvania Medical Society and American Medical Association principles for the provision of telemedicine should be taken into account. Paramount is the ability of providers to safely give patients a full range of choices to access healthcare. Consistent with this approach, the Advisory

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[10] As defined in the act of October 24, 2018 (P.L. 690, No. 106).

Committee supports efforts to expand broadband internet service to assist in the further development of telehealth for physical and mental health and substance use disorder systems, which could provide persons in need with the ability to access a broader complement of services.

Recommendations to Improve Throughput

RECOMMENDATION #7:

Private psychiatric hospitals and other inpatient mental health facilities are licensed by the Pennsylvania Department of Human Services (DHS). The Pennsylvania Department of Drug and Alcohol Programs (DDAP) licenses public and private drug and alcohol treatment facilities. The Pennsylvania Department of Health (DOH) licenses general and acute care hospitals, including those that maintain mental health and/or substance use disorder units within the hospital. Additionally, DOH maintains a database of all health care facilities in the Commonwealth. DOH, in coordination with DHS, should develop a statewide registry for mental health inpatient beds. These beds should be considered a state resource. The program could begin as a regional pilot. Further expansion could occur at specific time intervals. The database should meet the requirements recommended by the American College of Emergency Physicians (ACEP) set forth below:

- Reporting of available beds must be mandatory and not voluntary.

- Availability in both public and private institutions must be included.

- The database must report available beds in a "real-time" format.

- The database must list the type of bed and patient acceptable for transfer (e.g., adult, pediatric, or geriatric) as well as treatment services available.

- All personnel working within a health care facility that provides emergency stabilization and treatment must be able to access the database.[11]

The bed registry should begin as a pilot program with a set assessment period, after which the data collected can be used to revise and expand the program, as well as determine barriers that exist that potentially diminish its effectiveness.

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[11] ACEP, Emergency Medicine Practice Committee, "Practical Solutions to Boarding of Psychiatric Patients in the Emergency Department: Does Your Emergency Department Have a Psychiatric Boarding Problem?" October 2015, https://www.macep.org/Files/Behavioral%20Health%20Boarding/Practical%20Solutions%20to%20Boarding%20of%20Psych%20Patients%20in%20EDs.pdf.

The Advisory Committee further recommends that any legislation creating a bed registry should take into consideration the following preferences:

- Emphasis should be given to the match between the patient's needs and the type of bed available;

- The complexity and challenges of the patient's individual case should be taken into account; and

- Referrals should, whenever practicable, be made to facilities in the immediate geographic area the patient resides in, should be prioritized in order to provide the patient with family engagement and involvement and to make discharge planning more purposeful, and be realistically designed to allow the patient the ability to maximize resources in the person's home community, if at all possible.

While the Advisory Committee discussed a substance use disorder bed registry, the needs for placement and treatment, as well as the confidentiality concerns of persons with a substance use disorder, are different from those of persons with mental health issues. Substance use disorders have been excluded from most funding for electronic medical records and the ability of substance use inpatient treatment facilities to readily afford to participate in a registry is questionable. Further, another advisory committee of the Joint State Government Commission is meeting through the fall of 2020 to further research and develop continuity of care systems for persons with substance use disorders and will be issuing its own recommendations on many SUD issues in its final report. Accordingly, the current recommendation for use of a bed registry is limited to inpatient bed availability for mental health and co-occurring disorders.

RECOMMENDATION #8:

All facilities offering ED services should provide training to all staff on how to recognize persons with substance use disorder and psychiatric conditions and how to appropriately respond to those encounters. Although not an exhaustive list, priority should be given to training on the role of trauma in mental health and substance use disorder symptoms and diagnoses, sensitivity, de-escalation, and implicit bias training.

RECOMMENDATION #9:

Emergency medical services (EMS) personnel are increasingly called upon to provide crisis intervention as part of their response, a role not originally part of the concept of emergency services. For decades, EMS providers have encountered patients with mental illness, communicated with them, assessed them, done verbal de-escalation, and when needed provided restraint and/or medication to assure safety. Current education standards for emergency medical responders, emergency medical technicians, and advance

emergency medical technicians, who comprise 78 percent of Pennsylvania's certified emergency service system workforce, call for these first responders to only be able to recognize clearly visible signs of mental disturbances – e.g., dangerous behavior, acute psychosis, suicidal behavior or risk of suicide, and agitated delirium. Mental Health First Aid or other available resources could enhance EMS training. The Advisory Committee recommends that continuing education offered to these providers as part of their triennial re-certification process should include training on mental health and substance use disorders. These trainings could include mental health and substance use disorder literacy, Mental Health First Aid, crisis diversion, and de-escalation techniques. This is especially important for EMRs and EMTs, who can be certified as young as age 16 in Pennsylvania.

There should be expanded opportunities for EMS to get the right person to the right place at the right time. Steps to achieve this goal may include community paramedicine/ Mobile Integrated Health, telemedicine, and the presence of alternative destinations for mental health care. The Department of Health should develop protocols on alternative destinations to assist emergency services personnel in making non-emergency department diversions when appropriate. Foundational to this evolution are assured reimbursement for appropriate transport to alternative destinations and active oversight through medical direction and online medical oversight.

RECOMMENDATION #10:

Efforts to enforce and improve compliance with mental health and addiction parity laws are supported and encouraged. Further, parity of payment for telepsychiatry services as for in-person psychiatric visits should be required. Efforts by the Pennsylvania Insurance Department (PID) to improve monitoring of commercial insurers' compliance with parity rules are supported by the Advisory Committee. In particular, verifying compliance should be carried out through insurers' mandatory reporting to PID, rather than through PID's investigation of consumer complaints.

Recommendations to Increase Quality Output

RECOMMENDATION #11:

Regional/localized dedicated psychiatric emergency departments should be established in areas that are currently underserved. Areas designated as health professional shortage areas (HPSA) or medically underserved areas/populations (MUA/P) by the U.S. Department of Health and Human Services Health's Resources and Services Administration could be used to define where such emergency departments would be useful.

RECOMMENDATION #12:

Alternative programs within hospitals and emergency departments, as well as community based alternative programs designed to prevent emergency admissions, relapse and readmission, or provide non-inpatient discharge and referral options, should be implemented, as appropriate. DHS and DDAP could provide guidance on minimum requirements to be met by various models that could be adopted. Stabilization and recovery units, psychiatric emergency service centers, mental health emergency centers, crisis stabilization units, comprehensive psychiatric emergency programs, home-based psychiatric services, and supportive housing, as well as intermediate treatment centers, are potential models and are discussed more fully at pp 67-97.

RECOMMENDATION #13:

Mental health programs and facilities in rural areas are scarce. DHS could provide guidance on the development of programs specifically designed to address rural areas. Multiple organizations within Pennsylvania are working on this issue. Potential models are discussed more fully at pp 67-97.

RECOMMENDATION #14:

To further bolster the workforce for community mental health and substance use disorder health services in underserved and rural communities, a student loan forgiveness program could be implemented for qualified college graduates entering the mental health, intellectual disability, and substance used disorder treatment professions to commit to a fixed time of service with a community mental health or substance use disorder health provider.[12] Such a program should engage stakeholders to establish standards for the level of education and training to be commensurate with the services needed in the community. This is not intended to change scope-of-practice provisions in statute or regulation. Currently, Pennsylvania has two health care provider student loan programs, one for primary care practitioners (including medical doctors, dentists, nurse practitioners, nurse midwives, and physician assistants) who agree to work in underserved areas for three consecutive years[13] and one for professional nurses, who agree to work in areas of physician shortages and medically underserved areas for three consecutive years.[14]

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[12] House Bill 1307, P.N. 1527, would create the Mental Health and Intellectual Disability Staff Member and Alcohol Addiction Counselor Loan Forgiveness Program. The bill was introduced and referred to the House Human Services Committee on April 25, 2019.

[13] §1303 of the act of December 2, 1992 (P.L. 741, No. 113), known as the Children's Health Care Act.

[14] Article XXII-A, §§ 2201-A to 2234-A, of the act of March 10, 1949 (P.L.30, No. 14), known as the Public School Code of 1949, as added by the act of October 30, 2001 (P.L.828, No.83).

An insufficient supply of psychiatric beds is frequently cited as a cause of emergency department backlogs and boarding. But it is a simplistic explanation to a complex problem. Frequently, in the case of adult patients with mental health needs, it is not that there are no beds available, but a question of matching patient needs to suitable inpatient placements. This misalignment of needs and appropriate resources is further complicated by uneven geographic distribution of psychiatric inpatient facilities across the state. Inadequate supply compounds the problems for children in need of mental health services, persons in need of detoxification or rehabilitation beds, or those who have co-occurring mental health and substance use disorder diagnoses. Additional capacity issues arise when an individual does not need inpatient placement, but is nonetheless admitted to inpatient treatment because less restrictive, more diagnostically appropriate referrals are not available.

Pennsylvania reported that the commonwealth had 561 mental health treatment facilities that had a total of 225,921 clients in treatment as of April 30, 2018. Two percent of those clients, or 4,578 individuals, received 24-hour hospital inpatient mental health services; another 1.1 percent, or 2,517 individuals, received 24-hour residential treatment services. The vast majority of clients, 96.9 percent, received partial hospitalization, day treatment, or outpatient treatment.[15]

Number of Mental Health and Substance Use Disorder Inpatient Beds

There are 246 hospital organizations that report to the Pennsylvania DOH. They include 92 specialty and federal hospitals and 154 general acute care hospitals.[16] Hospitals that provide psychiatric services may do so either as a stand-alone facility or as an identified psychiatric unit or in beds dispersed throughout the hospital.[17] Pennsylvania is home to a variety of psychiatric inpatient facilities, including state hospitals, private psychiatric hospitals, general acute care hospital psychiatric units, Veterans Administration (VA) facilities, and other federal hospitals. There are 23 specialty psychiatric hospitals, six state psychiatric hospitals, 63 general acute care hospitals with psychiatric units, one

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[15] U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) National Mental Health Services Survey (N-MHSS), "2018 State Profile-Pennsylvania," https://www.samhsa.gov/data/sites/default/files/reports/rpt23233/2018_NMHSS_StPro_combined.pdf, pp. 157.

[16] "Hospital Reports," *Pennsylvania Department of Health*, accessed August 21, 2019,
 https://www.health.pa.gov/topics/HealthStatistics/HealthFacilities/HospitalReports/Pages/hospital-reports.aspx.

[17] Health Care Facilities Act

VA health system and seven VA medical centers with psychiatric units. Of the 23 specialty psychiatric hospitals, eight provide services to all age groups. Nine psychiatric hospitals serve only adults (although one also provides mental health services adolescents age 13-17). Five are dedicated to children and adolescents only, while one serves only clergy.[18]

State Hospitals

Pennsylvania's six state hospitals provide inpatient psychiatric beds for 1,036 adult patients statewide, which include patients with co-occurring substance use disorders. State hospitals are generally designed for longer term care for persons with severe mental illness. Persons are admitted via transfer from a community hospital. Forensic beds at Norristown and Torrance State Hospitals are not included in the total bed count, as these beds are reserved for persons who are admitted for services by court order through the criminal justice system.

Table 1 Pennsylvania State Psychiatric Hospitals		
Area Served (home county in bold)	**Name of Facility**	**Number of Psychiatric Beds[19]**
Bradford, Carbon, **Lackawanna**, Luzerne, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming Counties	Clark Summit	242
Columbia, Centre, Clinton, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lycoming, Mifflin, **Montour**, Northumberland, Perry, Schuylkill, Snyder, and Union Counties	Danville	180
Bucks, Chester, Delaware, **Montgomery**, and Philadelphia Counties	Norristown	255 forensic beds in the regional psychiatric center; 120 in the forensic stepdown program
Allegheny, Armstrong, Bedford, Blair, Butler, Cambria, Fayette, Indiana, Somerset and **Westmoreland** Counties	Torrance	361 – 196 civil; 165 combination of forensic and sexual responsibility and treatment program
Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, and **Warren** Counties	Warren	152
Adams, **Berks**, Lancaster, Lebanon, Lehigh, Northampton, and York Counties	Wernersville	266
Source: Pennsylvania Department of Human Services, State Hospitals, https://www.dhs.pa.gov/Services/Assistance/Pages/State-Hospitals.aspx; Number of Beds at Clark Summit, Danville, Norristown and Wernersville as reported on the Pennsylvania Department of Human Services facility locator found at https://www.dhs.pa.gov/Services/Assistance/Pages/default.aspx, accessed January 28, 2020. Numbers for Torrance and Warren were located in the American Hospital Directory, www.ahd.com.		

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[18] See Appendix A for more information on inpatient psychiatry facilities in Pennsylvania.

Veterans Administration Hospitals

Most of the VA hospitals have inpatient psychiatric units or beds, but it appears that Altoona and Erie do not. However, all of the VA hospitals offer outpatient behavioral health services.[20]

Psychiatric Hospitals and General Acute Care Hospitals with Psychiatric Units

General acute care hospitals with psychiatric beds for persons over age 17 are present in 43 of Pennsylvania's 67 counties, with a total of 2,258 beds available. Utilization rates range from 26.71 percent in Bucks County to 90.29 percent in Northampton County, averaging 73.14 percent statewide.   Only eight counties account for the 157 psychiatric general acute care hospital beds dedicated to children 17 and under, at an average utilization rate of 66.05 percent.

Beaver, Greene, Lawrence, and Washington Counties are not listed in the service areas of any of the six state hospitals. Beaver and Greene Counties each have one general acute care hospital, while Lawrence County has two and Washington County has three. Beaver and Washington Counties report 32 and 50 psychiatric beds respectively in those hospitals. Greene and Lawrence report no general hospital psychiatric beds in their counties. Beaver and Lawrence report one specialty or federal hospital per county, but no inpatient psychiatric beds in those counties. Persons needing inpatient services in Greene and Lawrence Counties presumably must find general hospital beds in adjoining counties.

The tables in Appendix A detail the number of mental health and substance use disorder inpatient beds and utilization rates by county.

The following maps show the distribution of the different types of inpatient/residential facilities around the Commonwealth. The information in these maps was compiled by JSGC staff from the DHS facility locator, the SAMHSA services locator and the individual websites of each facility. These are hospitals or other inpatient/residential facilities only. There are hundreds of drug and alcohol and mental health facilities statewide that provide non-hospital services. Appendix B contains tables listing these inpatient facilities. Types of services provided by facilities are included in Appendix C.

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[20] U.S. Veterans Administration Facility Locator – Pennsylvania, https://www.va.gov/directory/guide/state.asp?dnum=ALL&STATE=PA,; VA Pittsburgh Healthcare System https://www.va.gov/pittsburgh-health-care/; James E. Van Zandt VA Medical Center (Altoona) https://www.altoona.va.gov/; VA Butler Health Care Center www.butler.va.gov , Coatesville VA Medical Center www.coatesville.va.gov ; Erie VA Medical Center www.erie.va.gov ; Lebanon VA Medical Center www.lebanon.va.gov ; Corporal Michael J. Crescenz VA Medical Center www.philadephia.va.gov; Wilkes-Barre VA Medical Center www.wilkes-barre.va.gov; all accessed February 4, 2020.

Pennsylvania Facilities Providing
Inpatient Treatment For Primary Diagnosis
of Mental Health Disorders in 2020

Type of Behavioral Health Facility
▲ Stand Alone
● Located within Hospital

Pennsylvania Facilities Providing Inpatient Treatment
for Primary Diagnosis of Substance Use Disorder 2020
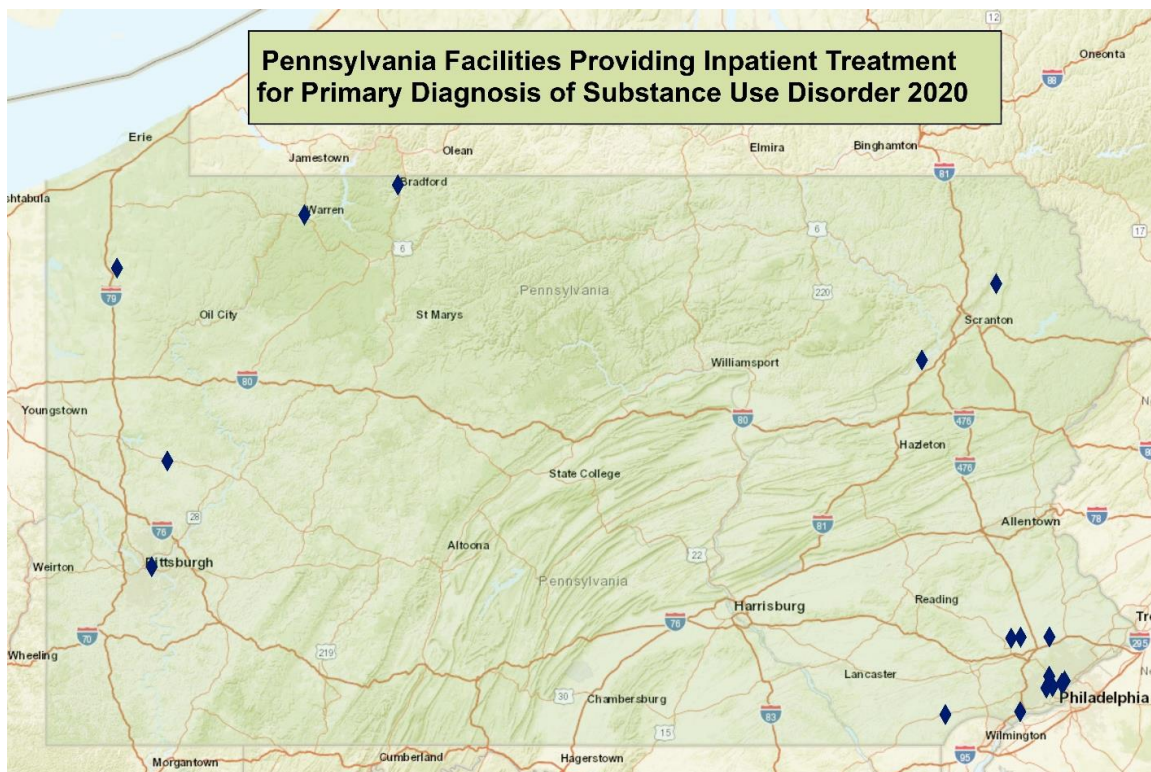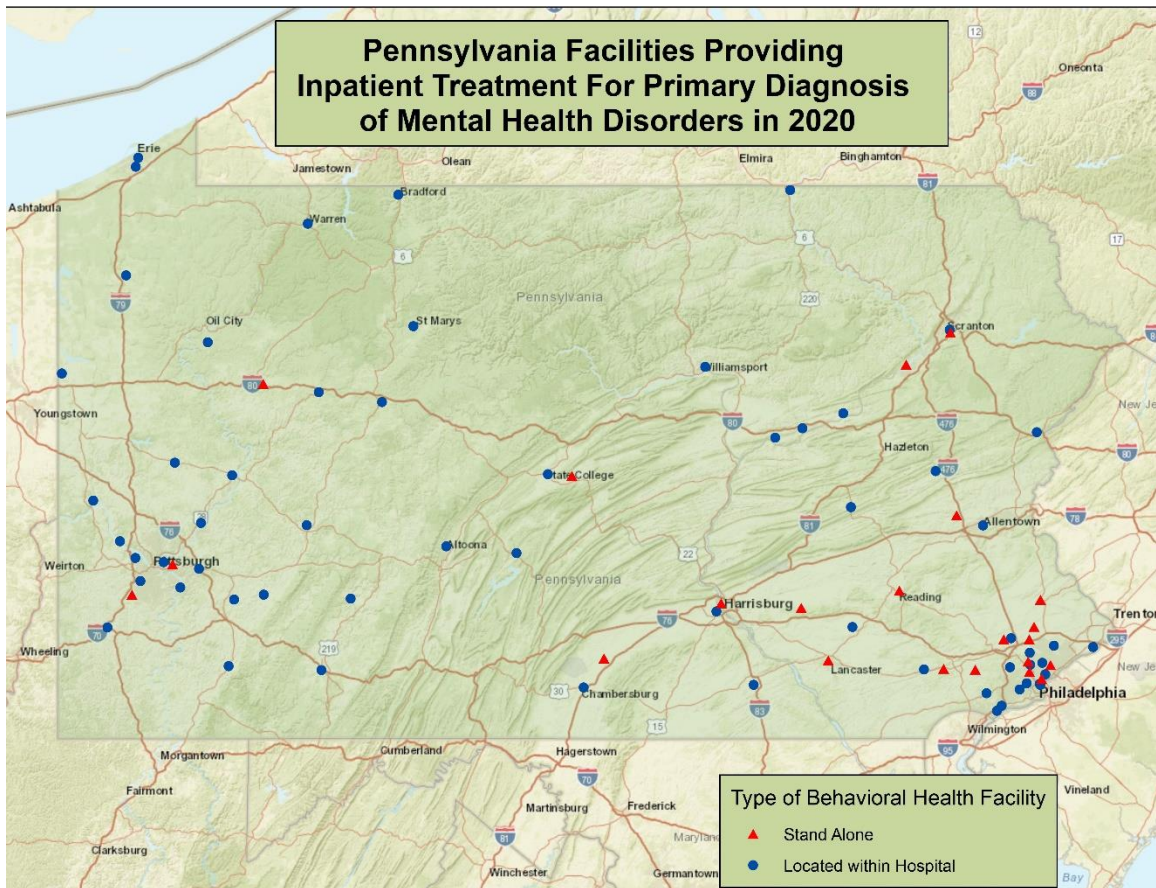
Wait Times

According to data from the 2017 National Hospital Ambulatory Medical Care Survey, the average wait time for a patient in an emergency department to see a physician, advanced practice registered nurse (APRN), or physician assistant (PA) was 37.5 minutes. Approximately 40 percent of patients in the United States saw a physician, APRN or PA in fewer than 15 minutes, while nearly 33 percent waited 15 to 59 minutes. Of the remaining cases, wait times for almost 13 percent were unknown, and 14 percent of the patients in an emergency department had to wait more than one hour to see a physician, APRN or PA.[21]

Studies have demonstrated the adverse effects of emergency department boarding on all patients, but an increasing subset within the overall population are those patients presenting with psychiatric emergencies. To provide further insight on that subset, a 2012 study retrospectively examined all psychiatric and non-psychiatric adult admissions in an academic medical center over a two-year period. Data were collected from an electronic health record system within the institution and utilized psychiatric consultation, admission or transfer information as the identifier for those patients with a primary psychiatric diagnosis. One limitation of this particular study was it only represented an experience from a single, large academic center. However, the results showed that psychiatric patients awaiting inpatient placement remain in the emergency department 3.2 times longer than non-psychiatric patients, preventing 2.2 bed turnovers in additional patients per psychiatric patient, and decreasing financial revenue.[22]

In a larger scale study from 2016, a retrospective length-of-stay analysis of psychiatric and nonpsychiatric emergency department visits was conducted using 2002-2011 data from the National Hospital Ambulatory Medical Care Survey (NHAMCS). Using a four-stage probability procedure, NHAMCS derives unbiased estimates based on sampling visits to approximately 40,000 patients annually across 350 to 400 hospital emergency and outpatient departments. The analysis showed that the average length-of-stay was significantly longer for a majority of the psychiatric patients than for non-psychiatric patients, 355 minutes (5.9 hours) versus 279 minutes (4.7 hours) for patients admitted for observation, 312 minutes (5.2 hours) versus 195 minutes (3.3 hours) for patients who were transferred to other facilities, and 189 minutes (3.2 hours) versus 144 minutes (2.4 hours) for patients who were discharged. The only area where the average length-of-stay for psychiatric patients was not significantly different from their non-psychiatric counterparts was for patients who were eventually admitted to the hospital. However, less than one-fifth (18 percent) of psychiatric patients fell into that category.

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[21] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, "National Hospital Ambulatory Medical Care Survey: 2017 Emergency Department Summary Tables," accessed on April 27, 2020, https://www.cdc.gov/nchs/ahcd/web_tables.htm.
[22] B.A. Nicks and D.M. Manthey, "The Impact of Psychiatric Patient Boarding in Emergency Departments," *Emergency Medicine International* 2012 (July 2012),
https://www.hindawi.com/journals/emi/2012/360308/.

The authors concluded that while it may be true that psychiatric conditions are fundamentally different from medical conditions, the differences in length-of-stay suggest deficiencies in emergency departments' capacity for psychiatric care. It was recommended that a number of structural and process-related improvements could increase the system's capacity to care for a growing population with mental health needs.[23]

Effect of Provider Shortages

A noticeable trend taking place across the country's health care systems is a demand for mental health care services that has grown faster than the supply of mental health care professionals. In some cases, the number of certain practitioners is projected to decline. It should be noted that psychiatrists are medical doctors within the specialty of psychiatry and are identified by the title MD (medical doctor) or DO (doctor of osteopathic medicine). Doctoral level psychologists are identified as PhD or, if the person's doctorate is in clinical psychology, PsyD. According to data from the Health Resources and Services Administration (HRSA), Pennsylvania had an inadequate number of psychiatrists to meet demand in 2016, with a shortfall of between 230 and 380 psychiatrists. By 2030, the HRSA projects that this shortfall will increase to between 580 and 730 psychiatrists.[24] A 2016 survey of the psychiatrist workforce revealed that the population of practicing psychiatrists across the country actually declined from 2003 to 2013. Although the net loss of practicing psychiatrists was less than 100, the decline represented a 10.2 percent decrease in the number of psychiatrists per 100,000 persons because the population of the country increased during that time period.[25]

The impact this has had on the practice of boarding psychiatric patients in emergency departments is difficult to conclusively quantify, as crowding is influenced by multiple variables.[26] One study analyzing the variables of emergency department efficiency found that higher physician and RN staffing ratios correlated with a shorter waiting time to see a provider as well as a lower rate of patients leaving the ED before their treatment is completed.[27] However, in this particular study the percentage of patients leaving before treatment is completed was the only measure of ED efficiency, as the

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[23] Jane M. Zhu, Astha Singhal, and Renee Y. Hsia, "Emergency Department Length-Of-Stay For Psychiatric Visits Was Significantly Longer Than For Nonpsychiatric Visits, 2002–11," *Health Affairs* 35, no. 9, (September 2016): 1698-1706, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0344.

[24] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, "State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030," (Sept. 2018), https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/state-level-estimates-report-2018.pdf, 7-8.

[25] Tara F. Bishop, Joanna K. Seirup, Harold Alan Pincus *et al.*, "Population of US Practicing Psychiatrists Declined, 2003-13, Which May Help Explain Poor Access to Mental Health Care," *Health Affairs* 35 no. 7 (2016): 1271-1277, doi: 10.1377/hlthaff.2015.1643.

[26] American College of Emergency Physicians, "Emergency Department Crowding: High Impact Solutions," (May 2016), 11.

[27] D. Anderson *et al.*, "Drivers of ED Efficiency: A Statistical and Cluster Analysis of Volume, Staffing, and Operations," *American Journal of Emergency Medicine* 34, no. 2 (Feb. 2016): 155-161, DOI: 10.1016/j.ajem.2015.09.034.

objective of the study was to identify characteristics of hospital operations that correlate with this metric.[28]

Another study examining the effect of staffing levels on ED crowding concluded that the addition of one attending physician or senior resident was associated with decreased length of stay by 3.88 and 1.64 minutes, respectively. Increasing nursing staff had no correlation to length of stay, while the addition of one junior resident was associated with a prolonged length of ED stay.[29] An article in *Nursing Economics* questioned the need for statutorily-mandated nurse-to-patient ratios, basing its opinion on a hospital's dynamic environment, since appropriate staffing levels are determined by variables such as number of patients, staff experience, observation and intervention requirements, and treatment requirements, among many others.[30]

These variables are similar in EDs across the Commonwealth and the U.S., and include others specific to the ED such as time of day, number of walk-in patients, number of patients arriving by ambulance, bed occupancy, admission percentage, and severity of cases presenting to the ED. An ED may have too few or the right amount of staff depending on all of these variables and how they interact with each other, making it difficult to clearly measure how a general shortage of a given professional impacts the operation of an ED.

Any effect that a shortage of mental health care providers has on ED boarding of psychiatric patients is likely to be symptomatic of an overall lack of available mental health care resources in the community. Evidence presented in the literature points to a lack of accessible mental health care in the community as the primary cause of an increased rate of non-emergency use of EDs by psychiatric patients. In turn, this lack of available mental health care in the community is partially driven by a lack of providers. A similar shortage of providers has been recognized in the substance use disorder field. According to the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) 2018 National Survey on Drug Use and Health, only about 11.1 percent of people aged 12 or older in 2018 who needed treatment received it at a specialty facility. This figure has been at a consistently similar level since 2015.[31] Additionally, a 2013 survey by SAMHSA conducted in Region III (Delaware, the District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia) found that addiction counselors in Pennsylvania had the second lowest salary level at $39,450, higher only than that of West Virginia. The survey also found that addiction counselors received salaries comparable to social workers, but on

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[28] *Ibid.*

[29] Takahisa Kawano, Kei Nishiyama, Hiroyuki Hayashi, "Adding More Junior Residents May Worsen Emergency Department Crowding," *PLoS One* 9, no. 11 (November 4, 2014), DOI: 10.1371/journal.pone.0110801.

[30] Kathy Douglas, "Ratios — If It Were Only That Easy," *Nursing Economics* 28, no. 2 (March-April 2010): 119-125.

[31] U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), *"Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health"* (HHS Publication No. PEP19 5068, NSDUH Series H 54), published August 20, 2019, Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

average $3,500 less a year than mental health counselors and $9,000 a year less than marriage and family therapists. [32]

The problem of boarding psychiatric patients in EDs across the Commonwealth is a multifactorial issue, resulting from the convergence of inefficient use of existing ED resources; fewer psychiatric resources available to the EDs (itself partially a result of reductions in reimbursement for psychiatric admissions); poor communication between the ED, law enforcement (who often transport psychiatric patients to the ED), and inpatient and outpatient psychiatric resources located off-site; and a lack of mental health resources available in the community.

Further, other factors can affect whether an ED can appropriately treat patients presenting with psychiatric symptoms or must board them while they wait for appropriate services. These factors include the psychiatric patient's diagnosis, insurance status (private, Medicare/Medicaid, or uninsured), the behavior of the psychiatric patient (e.g. whether they are combative or aggressive), if the psychiatric patient is under the influence of drugs or alcohol, if the psychiatric patient has comorbid medical conditions (e.g. infarction, diabetes, fractures), and if the attending emergency physician has decided to admit or transport the psychiatric patient to another facility (as opposed to discharge).

In the future, technology may help alleviate a shortage of psychiatrists by allowing an off-site psychiatrist to evaluate patients arriving at an ED with a psychiatric complaint. Telepsychiatry is a way to augment emergency physicians' evaluation and assessment of patients with mental health and psychiatric needs. The practice can be of particular help to smaller EDs with fewer resources or those in underserved or rural areas where hospitals may not have a psychiatrist on staff or available on-call. The ability to have a psychiatrist evaluate a patient from a remote location can be a practical, less resource-intense solution to determine a patient's clinical needs.[33]

Another means to augment the number of mental health and substance use disorder providers is through interstate licensing compacts, by which a provider licensed in one state may practice in another state. Such arrangements are particularly useful as telemedicine becomes more common. In fall 2016, Pennsylvania enacted the Interstate Medical Licensure Act, allowing licensed physicians (MD or DO) to more easily practice across state lines.[34] During the 2019-2020 legislative session, Senate Bill 655 was introduced to authorize Pennsylvania to join the Nurse Licensure Compact. The bill passed the Senate on June 24, 2020, by a vote of 50-0, and was referred to the House Professional Licensure Committee on June 29, 2020.

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[32] SAMHSA, "Behavioral Health Workforce Overview, National and Regional Data," Region 3, Behavioral Health Workforce, Slide 3. Document provided by advisory committee member Ken Martz via email dated July 16, 2020.

[33] Scott Zeller, "What Psychiatrists Need to Know: Patients in the Emergency Department," *Psychiatric Times* 35, no. 8 (August 16, 2018), https://www.psychiatrictimes.com/psychiatric-emergencies/what-psychiatrists-need-know-patients-emergency-department.

[34] Act of October 26, 2016 (P.L. 891, No. 112), known as the Interstate Medical Licensure Compact Act; 63 P.S. §395.1 et seq.

The Association of State and Provincial Psychology Boards approved the Psychology Interjurisdictional Compact (PSYPACT) in 2015 to facilitate telehealth and temporary in-person, face-to-face practice of psychology across jurisdictional boundaries. As of late June 2020, 14 states, including Pennsylvania, have joined the compact. Pennsylvania enacted the compact in May 2020 for licensed psychologists.[35] Another 13 states and the District of Columbia have pending legislation to approve the compact.[36]

Impact of Certified Registered Nurse Practitioners and Physician Assistants

Although the effect a shortage of providers has on psychiatric boarding in the ED may be hard to quantify, a better use of resources, including non-physician providers, can be part of the solution. As was discussed in greater depth in the Commission's 2019 report titled *Pennsylvania Health Care Workforce Needs* and the Commission's 2020 report titled *Pennsylvania Mental Health Care Workforce: Challenges and Solutions*, nurse practitioners (NP), known more formally within the Commonwealth as Certified Registered Nurse Practitioners, and PAs are not only the fastest-growing medical professions but among the fastest-growing professions in general across the country. Pennsylvania is particularly well-endowed with both NPs and PAs, as well as the educational programs needed to prepare them for work in the field.[38]

Physician assistants have 2-2.5 years of education and training and 2,000 patient care hours. Physician assistants can obtain post-graduate training in specific areas of specialty, including psychiatry, but a very small percentage of physician assistants complete such additional training; they are not limited to practicing in this specialty. One of the six population foci (specialized treatment groups) of NPs is psychiatric/mental health. NPs can take a certifying exam in this area. NPs, however, are not required to begin or continue practicing in the population foci in which they are trained and educated. In comparison, psychiatrists complete four years of graduate level education, plus 4-7 years of residency/fellowship training and 12,000-16,000 hours of clinical training.

A PA must earn a Certificate of Added Qualifications (CAQ) in order to practice in areas such as emergency medicine and psychiatry. Awarded by the National Commission on Certification of Physician Assistants (NCCPA), the certification requires experience working as a PA in the specialty, continuing medical education credits in the specialty, and a specialty exam.[39] According to NCCPA data, there are only approximately 1,470 PAs certified in psychiatry across the country, totaling about 1.5 percent of all PAs.

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[35] Act of May 8, 2020 (P.L. 124, No.19), known as the Psychology Interjurisdictional Compact Act; 35 P.S. § 7671 et seq.

[36] "Psychology Interjurisdictional Compact (PSYPACT*)," Association of State and Provincial Psychology Boards*, accessed June 27, 2020, https://www.asppb.net/page/PSYPACT.

[38] Joint State Government Commission, "Pennsylvania Healthcare Workforce Needs," (April 2019), 93, 103-104.

[39] "Psychiatry CAQ," *National Commission on Certification of Physician Assistants*, accessed July 15, 2020, https://www.nccpa.net/psychiatry; "Emergency Medicine CAQ," *National Commission on Certification of Physician Assistants*, accessed July 15, 2020, https://www.nccpa.net/emergencymedicine.

Although a specific figure was not given in the data, Pennsylvania is listed as a state with an above average rate of psychiatric PAs.[40]

Specialty designations also exist for NPs. The American Nurses Credentialing Center offers the Psychiatric Mental Health Nurse Practitioner (PMH NP) designation to NPs who complete their graduate nursing education specifically in psychiatric-mental health NP program accredited by the Commission on Collegiate Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN).[41] This differs from the educational requirement for PAs, who obtain a general PA degree and then, if desired, obtain a CAQ later in their careers.

There are an estimated 17,534 PMH NP's nationwide.[42] While it is unclear how many PMH NPs are working throughout the Commonwealth (as sources of workforce data do not break down the NPs specialty), the federal Health Resources and Services Administration (HRSA) estimated that Pennsylvania had 430 practicing PMH NPs in 2016. However, this figure was "approximated based on the distribution of NPs across states," meaning the HRSA simply divided all PMH NPs in the country by the proportion of non-psychiatric NPs practicing in each state.[43]

The PMH NP workforce is set to grow rapidly. According to data from the American Association of Colleges of Nursing (AACN), there were 6,377 students enrolled in PMH NP programs in 2017, a 63 percent increase over the 3,039 enrolled in such programs in 2014. In 2016, roughly 1,500 students graduated from a PMH NP program, a 56 percent increase over 2014. New PMH NP certifications stood at 1,563 in 2017, representing a 12 percent increase over the previous year. Growth in the number of available PMH NP programs has also been strong. Between 2015 and 2018, 29 new programs have opened across the country, bringing the total to 150.[44]

As an example of the resources provided by PMH NPs, Johns Hopkins hospitals employ PMH NPs in their psychiatric emergency departments, which are eight- to twelve-bed wards in the general emergency department separated by locked doors. The PMH NPs

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[40] National Commission on Certification of Physician Assistants, "2018 Statistical Profiles of Certified PAs by Specialty," (July 2019), 114-115.
https://prodcmsstoragesa.blob.core.windows.net/uploads/files/2018StatisticalProfileofCertifiedPAsbySpeci
alty1.pdf.
[41] "Psychiatric-Mental Health Nurse Practitioner (Across the Lifespan) Certification (PMHNP-BC)," *American Nurses Credentialing Center*, accessed July 15, 2020, https://www.nursingworld.org/our-certifications/psychiatric-mental-health-nurse-practitioner/.
[42] Bethany J. Phoenix, "The Current Psychiatric Mental Health Registered Nurse Workforce," *Journal of the American Psychiatric Nurses Association* 25, no. 1 (January/February 2019): 38-48, DOI: 10.1177/1078390318810417.
[43] U.S. Department of Health and Human Services, Health Resources and Services Administration, "State-Level Supply and Demand for Behavioral Health Occupations: 2016-2030," (September 2018), 19, https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/state-level-estimates-report-2018.pdf.
[44] Kathleen R. Delaney and Dawn Vanderhoef, "The Psychiatric Mental Health Advanced Practice Registered Nurse Workforce: Charting the Future," *Journal of the American Psychiatric Nurses Association* 25 no. 1 (Jan./Feb 2019): 11-18, at 12.

develop provider-client relationships with their patients and are trained to take a complete psychiatric history of each. They also make recommendations to the emergency physicians on staff.[45]

Role of First Responders

When studying the impact of mental health and substance use disorder treatment needs and system capacity on hospital emergency departments and patient health, it is important to evaluate attendant impact on Emergency Medical Services (EMS) providers. This is especially true in light of the fact that EMS providers, such as paramedics, are often a first point of access to the health care system for those suffering from mental health and substance use disorder emergencies, and one of the few health professionals who encounter patients in their everyday settings.[46] They provide care in the field, in route to the hospital, and more increasingly, in community settings.[47] While providing this care, EMS providers experience critical, high-stress incidents which often necessitate measured judgment and quick action.

Under the National Emergency Medical Services Education Standards,[48] the lowest level of medical responder, the emergency medical responder (EMR), needs only to be able to recognize behaviors that pose a risk to the EMR, patient, or others. Emergency medical technicians (EMT) and advanced emergency medical technicians (AEMT), in addition to being able to recognize dangerous behavior, are expected to be trained in the assessment and management of acute psychosis, suicidal/risk and agitated delirium.

Only paramedics are required to have training that includes acute psychosis, agitated delirium, cognitive disorders, though disorders, mood disorders, neurotic disorders, substance-related disorders/addictive behavior, somatoform disorders, factitious disorders, personality disorders, patterns of violence/abuse/neglect and organic psychoses.

EMRs, EMTs, and paramedics comprise 94 percent of the emergency services provider workforce in Pennsylvania, with EMTs constituting the majority, at 70 percent. Paramedics comprise 17 percent, with EMRs following at seven percent. The remainder of Pennsylvania's certified workforce is made up of EMS vehicle operators, AEMTs, and pre-hospital registered nurses (PHRN).

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[45] Karen Nitkin, "The Changing Dynamics of Emergency Psychiatric Care," *Dome* Blog, Johns Hopkins Medicine, (September/October 2018), https://www.hopkinsmedicine.org/news/articles/the-changing-dynamics-of-emergency-psychiatric-care.

[46] Polly Christine Ford-Jones and Claudia Chaufan, "A Critical Analysis of Debates around Mental Health Calls in the Prehospital Setting," *Inquiry* (May 3, 2017), DOI: 10.1177/00446958017704608 *citing* J. Porter, "EMS Workers Overloaded with Mental Health, Addiction Calls," *CBC News*, last modified July 6, 2012, http://www.cbc.ca/news/canada/thunder-bay/ems-workers-overloaded-with-mental-health-addictions-calls-1.1171833.

[47] *Ibid.*

[48] National Highway Traffic Safety Administration, "National Emergency Medical Services Education Standards, https://www.ems.gov/pdf/National-EMS-Education-Standards-FINAL-Jan-2009.pdf

Increase in Mental Health and Substance Use Disorder-Related EMS Calls

Within the past decade, new attention has been drawn, both within the U.S. and internationally, to the increasing volume of emergency mental health calls received by EMS providers. According to a 2016 national survey on EMS mental health services, EMS providers are more routinely being "subjected to threats of violence from a would-be patient who is under the influence of drugs or alcohol, suffering from a mental health disorder, or [a patient who] has criminal intent."[49] Moreover, paramedics in particular are being called on more frequently to provide care to patients with mental health and/or alcohol and other drug-related emergencies.[50] These observations have been reinforced by the National Emergency Medical Services Information System (NEMSIS), a national database used to store EMS data from U.S. states and territories. The NEMSIS found that across the U.S. mental health and psychiatric disorders, along with substance use disorder, combined for the second highest percentage (11.3 percent) of EMS calls or "primary impressions,"[51] trailing only traumatic injuries (21.4 percent).[52]

In 2018, "altered mental status"[53] was the third highest reason for EMS medical encounters or "primary impressions" within the Commonwealth at 91,559 calls for EMS service, with "alcohol use, with intoxication" adding another 11,051 calls. The total number of altered mental state calls for service were only behind that of "injury, unspecified" and "generalized abdominal pain" calls. It should be noted that calls for altered level of consciousness are not necessarily mental health calls but may be related to medical etiologies.

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[49] National Association of Emergency Medical Technicians, "2016 National Survey on EMS Mental Health Services," (2016), 4.

[50] Terence V. McCann *et al.*, "Paramedics' Perceptions of their Scope of Practice in Caring for Patients with Non-Medical Emergency-Related Mental Health and/or Alcohol and other Drug Problems: A Qualitative Study," *PLOS One* (Dec. 13, 2018), https://doi.org/10.1371/journal.pone.0208391.

[51] The term "primary impression" is often used by the NEMSIS to refer to the symptom, problem, or condition that is the reason for an EMS medical encounter.

[52] "911 Call Complaint vs. EMS Provider Findings Dashboard," *National Emergency Medical Services Information System,* accessed August 30, 2019, https://nemsis.org/view-reports/public-reports/version-2-public-dashboards/v2-911-call-complaint-vs-ems-provider-findings-dashboard/.

[53] Altered mental status is a vague term, common among older emergency department patients and has several synonyms such as confusion, not acting right, altered behavior, generalized weakness, lethargy, agitation, psychosis, disorientation, inappropriate behavior, inattention, and hallucination. - Jin H. Han and Scott T. Wilber, "Altered Mental Status in Older Emergency Department Patients," *Clinical Geriatric Medicine* 29, no. 1, (Feb. 2013): 101-136, DOI: 10.1016/j.cger.2012.09.005.

Table 2
Top 25 EMS Provider Primary Impression
January 1, 2018 – December 31, 2018

Primary Impression	Count
Injury, unspecified	138,664
Generalized abdominal pain	136,773
Altered mental status	91,559
Weakness	78,315
Respiratory distress, acute	68,413
Chest pain, other [non-cardiac]	57,997
Encounter, adult, no findings or complaints	47,258
Acute pain not elsewhere classified	37,948
Syncope and collapse	33,980
Respiratory disorder	29,381
Cardiac arrhythmia/dysrhythmia	26,604
Malaise	19,719
Seizures with status epilepticus	19,041
TIA	18,182
Reduced mobility	17,802
Hypoglycemia	17,409
Back pain	14,771
Cardiac arrest	14,687
Injury of head	13,986
Alcohol use, with intoxication	11,051
Seizures without status epilepticus	10,894
Angina	9,413
Death	9,169
Headache	8,188
Fever	8,008

Source: Compiled by the Commission staff from the Pennsylvania Department of Health, Bureau of Emergency Medical Services, "2018 Year End EMS Data Report," (Mar. 2019), p. 25 citing Pennsylvania State EMS Data Bridge, 2019.

The worsening opioid crisis has also become a contributing factor to the increase in call volume related to mental illness and substance use disorder. Between January 1, 2018 and August 10, 2019, Pennsylvania emergency departments (ERs) received approximately 15,987 visits for opioid overdoses.[54] Within the same timeframe, Pennsylvania EMS providers administered over 24,000 doses of Naloxone (commonly known through the brand name "Narcan") to substance use disorder EMS patients to help counteract overdoses.[55]

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[54] "Opioid Data Dashboard: Pennsylvania Quick Stats," *Pennsylvania Department of Health, Open Data PA*, accessed July 15, 2020, https://data.pa.gov/stories/s/9q45-nckt/.

[55] *Ibid.*

The increase in emergency mental health and substance use disorder calls is not solely confined to the U.S. A 2012 Canadian report highlighted that, in some of its communities, mental health calls had made up more than 40 percent of ambulance runs.[56] It has been estimated that people experiencing mental health problems make over one million visits to Accident and Emergency (A&E) departments every year in the United Kingdom, prompting the commissioning of a new National Medical Director pilot program to allow for the provision of emergency care to individuals experiencing a mental health crisis within one hour of arrival at an A&E department.[57] Paramedics in Australia have reported that a significant proportion of their workload is related to attending behavioral health calls. Australian studies have found that such calls accounted for between 10 percent and 20 percent of ambulance calls.[58] In 2013, the New South Wales Ambulance reported attending more than 60,000 calls classified at the call-taking stage as mental health or psychiatric incidents.[59]

Given the growing frequency of mental health emergencies, any review analyzing the impact of the Commonwealth's current mental health and substance use disorder health care treatment needs and system capacity within Pennsylvania hospital emergency departments must also address the profound impact of these needs on the supply and capabilities of EMS providers.

EMS Provider Workforce in Pennsylvania

As of 2018, the EMS system in Pennsylvania included 1,258 agencies that responded to over two million calls for service.[60] Within these 1,258 agencies, there are several different types of EMS providers certified to provide service within the Commonwealth. The Pennsylvania Emergency Medical Services System Act (EMSSA) defines "EMS provider" to include any of the following:

- Emergency medical responder (EMR)

- Emergency medical technician (EMT)

- Advanced emergency medical technician (AEMT)

- Paramedic

- Prehospital registered nurse (PHRN)

- Prehospital physician extender

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[56] Ford-Jones and Chaufan, "Critical Analysis."

[57] National Health Service News, "NHS to test new rapid care measures for patients with the most urgent mental and physical health needs," 11 March 2019, https://www.england.nhs.uk/2019/03/nhs-to-test-new-rapid-care-measures-for-patients-with-the-most-urgent-mental-and-physical-health-needs/

[58] Nyssa Ferguson *et al.*, "'I Was Worried if I Don't Have a Broken Leg They Might Not Take it Seriously': Experiences of Men Accessing Ambulance Services for Mental Health and/or Alcohol and Other Drug Problems," *Health Expectations* no. 22, (March 13, 2019): 565-574, DOI: 10.1111/hex.12886.

[59] Mccann, "Paramedics Perceptions."

[60] Pennsylvania Department of Health, *2018 Year End EMS Report* (PADOH, March 2019), 3.

- Prehospital emergency medical services physician

- Individual prescribed by regulation of the Pennsylvania Department of Health (DOH) to provide specialized emergency medical services.[61]

All of the above providers are certified by DOH and their roles and responsibilities are specifically provided for within DOH regulations. The provider roles are largely similar to one another, but have certain differences in scope and capabilities.

According to the Bureau of Emergency Medical Services (BEMS), the Commonwealth had a total of 42,068 certified EMS providers who are considered a part of the available[62] EMS workforce as of January 15, 2019.[63] It should be noted that while the EMSSA definition of "EMS provider" shown above includes prehospital physician extenders (PHPEs) and prehospital physicians (PHPs), the BEMS appears to exclude these professionals from its 2018 workforce count. In addition, the BEMS includes EMS vehicle operators (EMSVOs) within its workforce count, whereas the EMSSA does not. A breakdown of the 2019 EMS workforce according to the BEMS is shown below in Table 3.

Table 3 PA Certified EMS Workforce as of January 15, 2019		
Primary Certification	Number of Certification Holders	Net Change from 2017
EMSVO	947	47
EMR	3,256	(342)
EMT	29,462	(1,167)
AEMT	245	64
Paramedic	6,948	(169)
PHRN	1,210	(20)
Total	**42,068**	**(1,587)**
Source: Pennsylvania Department of Health, Bureau of Emergency Medical Services, "2018 Year End EMS Data Report," (Mar. 2019), p. 53.		

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[61] Act of August 18, 2009, (P.L. 308, No. 37), § 1; 35 Pa.C.S. § 8103.
[62] The term "available" as used by the BEMS does not necessarily mean the individual provider is "active."
[63] PADOH, *2018 Year End EMS Report*, 47, 53.

Table 4 also provides the net change from 2017, which shows that when comparing the workforce numbers for year ending 2018, to those numbers reported in the 2017 BEMS year-end report, there were decreases in workforce numbers for four out of the six EMS workforce certifications for a total decrease of almost 1,600 providers.

The Effect of Increasing Volume of Mental Health EMS Calls

Since medical emergencies come in many different forms and scenarios, EMS providers are routinely tasked with the responsibility of wearing many hats within the field of medicine. As such, they are trained in cardiology, pulmonology, gastroenterology, neurology, gerontology, pediatrics, trauma, and pharmacology.[64] Despite their widespread training, EMS providers have historically received very little training in the area of mental health and psychology.[65] Stated more plainly, there is no official EMS training or guidebook on what to say or not say as an impromptu counselor to a freshly grief-stricken widow attempting to cope with her incalculable loss or a deeply depressed individual in the middle of a suicide attempt.[66]

There has been some debate as to whether mental health calls are a "misuse" of the emergency medical service system, essentially pulling resources away from other emergencies that EMS providers are more appropriately trained to handle.[67]

The limited level of training for EMS providers on mental illness may also result in an amplified level of stress in an otherwise already stressful profession, rife with pressure to exercise quick judgment. For instance, paramedics surveyed in Australia have reported "working under considerable uncertainty and both professional and personal distress in the pre-hospital care setting when it came to managing the mentally ill."[68] Australian researchers have linked the cause of increased uncertainty and stress to a number of factors including: rapid role expansion, poor education, and training; increasing exposure to the mentally ill; increasing complexity of mental illness; lack of wider mental health services and infrastructure; significant unmet mental services needs among the those suffering from mental health symptoms and a failure of community mental health services to manage those with chronic mental illness.[69] Increased levels of uncertainty and stress can also in turn, lead to damaging impact on a provider's own mental health.

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[64] "Interacting with the Mental Health Crisis Victim," *EMSWORLD*, last modified September 5, 2017, https://www.emsworld.com/article/21858/interacting-mentla-health-crisis-victim.

[65] *Ibid.*

[66] *Ibid.*

[67] Ford-Jones and Chaufan, "Critical Analysis."

[68] Ramon Shaban, "Chapter 7: Paramedics and the Mentally Ill," *Paramedics in Australia: Contemporary Challenges of Practice* (Australia: Pearson Education, 2009), http://www.pearson.com.au/9781442509115.

[69] *Ibid.*

Depression is commonly reported among EMS providers. For example, "in a case-control study of certified EMS professionals, depression was reported 6.8 percent, with mild depression the most common type (3.5 percent)."[70] In a separate 2015 study, it was reported that 37 percent of fire and EMS professionals contemplated suicide; an amount that is nearly ten times the rate of American adults.[71] A Canadian report indicated that there were 16 cases of suicide among Canadian paramedics in 2017, which was 60 percent higher than suicides that year by members of Canada's military and about 45 percent higher than those by Canada's firefighters.[72] The same report did indicate that in 2015 and 2016, suicides among paramedics were largely consistent with suicides among military members.[73] Legislation introduced in Pennsylvania in 2019 would create a Statewide Critical Incident Stress Management Program in the Department of Health to provide assistance to emergency responders who are suffering from post-traumatic stress from their work experiences. House Bill 1459, P.N. 3945 passed the House 198-0 on October 30, 2019. The bill was amended in, and passed the Senate 49-0 on July 14, 2020. The House concurred in the Senate amendments on July 14, 2020. The bill was presented to the Governor on July 15, 2020, who signed Act 69 into law on July 23, 2020.

The added stress to an already stressful profession could cause the supply of EMS providers within the Commonwealth to continue to dwindle. Further, the number of certified EMS providers within the Commonwealth allowing their certifications to expire could continue to increase if the rising number of emergency mental health calls is not addressed.

Addressing the Impact of Increased Mental Health
  and Substance Use Disorder-Related Calls

While the coverage of academic literature on mental health EMS calls is a bit scant, there has been some analysis on the notion that EMS providers need more and better mental health training.[74] The premise behind the "more mental health training" argument is that since EMS provider training generally involves physical findings on assessment, and since physical findings are largely non-existent in mental health calls, EMS providers would substantially benefit from more mental health training.[75] In support of expanding the role of EMS providers, it has been suggested that paramedics in particular need more undergraduate and in-service education about the proper way to care for patients with mental health and/or substance problems.[76] Additional logic behind expanding the knowledge base of a paramedic to include mental health is that it would better prepare them for unavoidable encounters with patients experiencing mentally health emergencies, while

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[70] Substance Abuse and Mental Health Services Administration, "Disaster Technical Assistance Center Supplemental Research Bulletin – First Responders: Behavioral Health Concerns, Emergency Response, and Trauma," (May 2018), 4.

[71] *Ibid*., 5.

[72] Rhytha Zahid Hejaze, "Saving Lives, Losing Themselves," *U.S. News & World Report*, last modified May 23, 2018.

[73] *Ibid.*

[74] Ford-Jones and Chaufan, "Critical Analysis."

[75] *Ibid.*

[76] Mccann, "Paramedics Perceptions."

improving the quality of care and reducing the need for transportation to emergency departments, thus decreasing clinicians' workloads in ERs.[77]

Other literature has discussed the need for more mental health services at the community level through a new model commonly referred to as "Mobile Integrated Healthcare/Community Paramedicine" (MIH-CP). MIH-CP is essentially the provision of health care using patient-centered, mobile resources in the out-of-hospital environment.[78] MIH is generally provided by health care entities and practitioners that are administratively or clinically integrated with EMS agencies.[79] CP is generally one or more services provided by EMS agencies and practitioners that are administratively or clinically integrated with other health care entities.[80]

The Role of and Impact on Call Takers, Emergency Dispatchers, and 911 Center Supervisors

It is important to note, that, while state definitions of EMS professionals appear to exclude call takers, emergency dispatchers, and 911 center supervisors, such personnel in many cases do play a key role in establishing the first line of communication with individuals experiencing mental health and substance use disorder health crises and emergencies. To understand this role, a cursory review of these individual's training and testing requirements is critical.

Mandated Training and Testing

The Pennsylvania Emergency Management Agency (PEMA) is authorized under the Commonwealth's Emergency Communications Act (PECA) to regulate call takers, emergency dispatchers, and 911 center supervisors and their facilities.[81] Regulations promulgated by PEMA pursuant to the PECA require that a call taker, emergency dispatcher, or 911 center supervisor must "demonstrate proper usage of the equipment applicable to his area of assignment."[82]

In Pennsylvania, there are some key differences between call takers, emergency dispatchers, and 911 center supervisors. Call takers are responsible for taking all calls made by the general public to a 911 emergency communications center. They also gather all essential information from the caller to determine whether or not emergency response

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[77] *Ibid.*

[78] Jonathan S. Feit, "It's Not the Money that Keeps a Community Paramedicine Coordinator Awake at Night," *Journal of Emergency Medical Services*, last modified September 15, 2018, https://www.jems.com/2018/09/15/it-s-not-the-money-that-keeps-a-community-paramedicine-coordinator-awake-at-night/.

[79] *Ibid.*

[80] *Ibid.*

[81] Act of November 23, 2010, P.L. 1181, No. 118, § 2.1; 35 Pa.C.S. § 5303.

[82] 4 Pa. Code § 120c.110(a)-(b).

services are needed.[83] On the other hand, an emergency dispatcher is responsible for taking the information gathered by a call taker, determining the appropriate response to the situation and dispatching the available emergency services (such as emergency fire, police, ambulance, emergency management or other resources).[84] 911 center supervisors are responsible for managing the 911 emergency communications center operations all-together. A supervisor oversees the activities of all call takers and emergency dispatchers present in the 911 center, provides decision making, direction and control, and other authority for the operation of the 911 center, and handles other duties and responsibilities as assigned by proper authority.[85]

To ensure these skills are being satisfied during emergency 911 phone calls, the law mandates that a practical skills test be conducted by the lead or master instructed used by the county, city, borough, or township within which the call center is situated. There are three separate individual tests – one for call takers, one for emergency dispatchers, and one for 911 center supervisors. Each test requires a showing of skill knowledge in the following areas: telephone operations, complaint card system, TDD/TTY (telecommunications devises for the deaf/text telephones) operations, local forms and if available, computer aided dispatch (CAD) system.[86]

Call Takers

A call taker practical skills test evaluates the call taker's knowledge in the use of emergency and nonemergency lines, hotlines, call transferring, line tracing, conference and call holding. Moreover, the call taker must demonstrate the use of the complaint card system to include location and types of incidents, caller information and supplemental information. TDD/TTY operations will evaluate knowledge of TDD/TTY call recognition, the use of preprogrammed messages and communication. If available, the call taker is also required to demonstrate CAD operations related to call-taking.[87] To be fully certified, a call taker must also take 104 hours of classroom and hands-on training on the following telephone techniques:

- Crisis call taking

- Incident specific information

- Interrogation skills

- Prioritization of calls

- Non-English speaking calls

- Text telephone for the deaf

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[83] 4 Pa. Code § 120c.105(a).
[84] 4 Pa. Code § 120c.106(a).
[85] 4 Pa. Code § 120c.107(a).
[86] 4 Pa. Code § 120c.104.
[87] 4 Pa. Code § 120c.110(b).

- Hearing and speech impaired

- Abandoned 911 calls

- Silent 911 calls

- Roles and responsibilities of the call taker

- Interpersonal skills and stress management

- 911 center terminology

- Verification skills

- Use of 911 center equipment

- 911 center documentation skills

- Geography of 911 center service area

- Other material considered necessary by the instructor which has been approved by the Agency.[88]

It is worth noting that the general set of questions (both post-dispatch and pre-arrival) that call takers and sometimes dispatchers ask during emergency calls was developed by EMS expert, Dr. Jeff Clawson. Clawson promoted the idea of a unified protocol for EMS dispatch and advanced one of several proprietary programs used to train dispatchers in Pennsylvania.[89]

Emergency Dispatchers

An emergency dispatcher practical skills tests requires a demonstration of knowledge in the following areas: radio dispatch operations, complaint card system and standard operating procedures (SOPS) relating to the area of dispatch. State law also requires an emergency dispatcher medical test which evaluates the dispatcher's knowledge of the EMS complaint cards to include location and types of incidents, response information and supplemental information. Radio dispatch operations also evaluate knowledge of a dispatcher pertaining to the types of emergency department class responses, medical patches, response unit prioritization and unit tone and paging systems.[90]

Pennsylvania law also requires that, if available, the emergency dispatcher demonstrate CAD operations related to medical dispatching. In addition, a dispatcher must pass dispatcher fire tests that evaluate knowledge of the fire complaint cards to include dispatch and response times, unit status, location and types of incidents, and supplemental information.[91]

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[88] 4 Pa. Code § 120c.105(c)(1)-(18).
[89] "About the Academy," *International Academies of Emergency Dispatch*, accessed July 15, 2020, https://www.emergencydispatch.org/AboutTheAcademy.
[90] 4 Pa. Code § 120c.110(c).
[91] *Ibid.*

911 Center Supervisors

A 911 center supervisor practical skills test evaluates supervisors in all the above-mentioned areas – call-taking, emergency fire, police and medical dispatching.[92]

Lack of Mental Health and Substance Use Disorder Specific Training

Like EMS professionals, 911 call takers, dispatchers, and center supervisors appear to lack a more specified training focused purely on mental health and substance use disorder crises. The consequence of this is that many 911 dispatch professionals may lack the necessary level of training to receive certain mental health and substance use disorder emergency calls. Familiarity with EMS complaint cards, along with intensive training in telephone techniques is critically important to properly direct an emergency patient to the proper health care venue and provider. However, it is equally important that a dispatch professional know how to speak with distressed individuals experiencing mental health and substance use disorder emergencies and trauma.

For some distressed individuals, the right words and tone could prevent severe injuries and may sometimes even be the difference between life and death. As the number of 911 emergency calls from individuals experiencing mental health or substance use disorder crises rises, so too will the challenges for call takers, dispatchers, and center supervisors when accepting such calls and subsequently attempting to properly direct the appropriate medical services.

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[92] 4 Pa. Code § 120c.110(d).

While emergency department boarding is a highly visible symptom of problems in the Commonwealth's mental health and substance use disorder system, a number of factors contribute to inadequacies found in the system.

Diagnostic and Evaluation Issues

Emergency department boarding can occur with patients with strictly physical health symptoms, but most frequently happens in the case of patients with mental health and substance use disorder conditions. It can occur in two different ways: (1) a person comes into the emergency in some form of crisis – mental health or substance use disorder or both, and needs an admission appropriate to their crisis condition or (2) a person comes to the emergency department with an injury or illness, but because of his or her mental health or substance use disorder condition, needs a medical admission that can also accommodate the person's mental health or substance use disorder needs. For example, a room or unit staffed with individuals who are equipped to treat mental health or substance use disorder symptoms may be needed, or a secure room or unit may be necessary for a person who is a danger to self or others.

One of the first determinations that must to be made when an individual either appears in an emergency department or when emergency medical services personnel are dispatched to transport a person to an emergency department via ambulance is a preliminary diagnosis. Even with obvious physical injuries or illnesses, or extreme agitation, an initial assessment is needed to understand the person's treatment needs.

Standards for Involuntary Treatment

The American College of Emergency Physicians' (ACEP) State Legislative/Regulatory Committee evaluated legislative and regulatory roadblocks that reduce the efficacy of processing an emergency psychiatric patient and developed the following recommendations:

- Defining the criteria for when psychiatric patients can be involuntarily held for emergency treatment.

- Providing emergency physicians with the authority to act unilaterally in issuing an emergency involuntary hold on a psychiatric patient.

- Defining the length of time a psychiatric patient can be involuntarily held for a psychiatric evaluation.

- Providing physicians with immunity from liability for issuing, or not issuing, an emergency involuntary hold on a psychiatric patient.[93]

Clear and precise definitions of what conditions necessitate an involuntary hold are important components of expediting the treatment of emergency psychiatric patients. The ACEP committee found that the definition should be narrow and include only those who present a danger to themselves or others. One term that is used in many state laws on qualifying for involuntary holding is "gravely disabled."[94] The ACEP committee found this definition to be too broad and open for interpretation. It could lead to an unnecessary increase in involuntary holding as physicians err on the side of caution so they are not liable for a patient who could be deemed by someone as "gravely disabled."[95]

The ACEP committee determined that 72 hours is an appropriate time limit for involuntary holding before evaluation by a physician. Florida is one state where the statute requires that a patient "may not be held in a receiving facility for involuntary examination longer than 72 hours."[96] Current Pennsylvania law requires that a person taken to a facility shall be examined by a physician within two hours of arrival in order to determine if the person is severely mentally disabled and in need of immediate treatment.[97] Persons admitted through this involuntary procedure are to be discharged whenever it is determined that the person no longer is in need of treatment and in any event must be discharged within 120 hours, unless a further involuntary commitment order is obtained. Another way to decrease unnecessary involuntary holding is to give liability protection to physicians who determine that a person does not need to be involuntarily held. Some states already provide protections for a physician who decides to involuntarily hold a patient, but the ACEP Committee recommended adopting the liability protection as well.[98]

Pennsylvania's Mental Health Procedures Act (MHPA) provides for involuntary examination and treatment when a person is severely mentally disabled and in need of immediate treatment. "A person is severely mentally disabled when, as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses

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[93] ACEP State Legislative/Regulatory Committee, "State Legislative Options to Facilitate Emergency Involuntary Psychiatric Evaluation," accessed December 19, 2019,
https://www.acep.org/globalassets/uploads/uploaded-files/acep/advocacy/state-issues/psychiatric-hold-issues/state-legislative-options-to-facilitate-emergency-involuntary-psychiatric-evaluation.pdf.
[94] *Ibid.*
[95] *Ibid.*
[96] *Ibid.*
[97] MHPA, §302(b).
[98] ACEP, "State Legislative Options."

a clear and present danger of harm to others or to himself."[99] "Clear and present danger of harm to self or others" has been the standard for involuntary treatment in Pennsylvania for decades.

Assisted Outpatient Treatment (AOT)

In 2018, the MHPA was amended to provide for assisted outpatient treatment. It is intended for people whose life becomes a cycle of hospitalization, temporary improvement thanks to treatment, followed by a decline that is often attributed to skipped medication, which leads to another crisis and another hospitalization. The amended law provides for court ordered treatment for patients who are not hospitalized. Caseworkers monitor their patients intensively and ensure that patients attend therapy and adhere to their medication as prescribed.

In New York, a similar program is known as Kendra's Law – named after Kendra Webdale, a woman who was pushed to her death on the New York subway tracks by a man with untreated schizophrenia. A few studies of the impact of Kendra's Law have found some positive outcomes among suicide risk, violent behavior, and illness-related social functioning. However, some opponents believe that outpatient commitment infringes on civil liberties of individuals who have not been involuntarily committed to hospital treatment. Opinions of patients who participate in the program and of their families also vary: some regard it as a welcome solution to their long-standing problems while others believe it is a violation of their civil rights.

A study funded by the New York Office of Mental Health in 2010 concluded that

Assisted outpatient treatment is a 'package deal' that includes coerced treatment but also access to enhanced services. Although our analysis found no differences when we controlled for the presence of an intensive case manager, assisted outpatient treatment clients also received other enhanced services, such as priority for housing and vocational services. We cannot conclude which of these elements of the package deal contributed most to the generally positive outcomes for participants.[100]

Given the insufficiency of community mental health services available to support individuals receiving assisted outpatient treatment in Pennsylvania, the consensus of the Advisory Committee is that, as currently structured, the coercive aspects of AOT outweigh the scarcity of enhanced community services such as housing and vocational services that contribute to the successful use of AOT. Accordingly, AOT should be repealed in Pennsylvania.

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[99] MHPA §301(a).

[100] Jo C. Phelan Ph.D., Marilyn Sinkewicz Ph.D., Dorothy M. Castille Ph.D. *et al*.,"Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State," *Psychiatry Online* (February 2010), DOI: 10.1176/ps.2010.61.2.137.

House Bill 1895 would amend the Mental Health Procedures Act to enshrine the right to be free from abuse or neglect in treatment and to bring in court actions challenging the legality of their detention or the degree or restraint used, including injunctions, petitions for habeas corpus, and actions for money damages. The bill passed the House April 20, 2020 (202-0), and was introduced and referred to the Senate Health and Human Services Committee on April 28, 2020.[101]

The Role of Frequent Readmissions

The frequency of mental health or substance use disorder readmission has a significant impact on current needs and system capacity, thus the need to discuss readmissions and their causative factors is imperative because "readmission rates are a commonly used indicator of the quality of care and a focus of interest for all health sector policymakers."[102] In addition, frequent mental health or substance use disorder readmissions may also be a key factor disturbing the current functionality of hospital emergency departments and the sometimes inadequate provision of care provided to those experiencing mental health or substance use disorder crises.

Definition and Prevalence

The term "readmission," sometimes also referred to as "rehospitalization" or "recidivism," is used in the health care industry to describe repeated episodes of inpatient care.[103] The phenomenon of readmission itself and its growing frequency in hospitals has been more broadly referred to as "the Revolving Door Syndrome." The "revolving door" of patients in hospitals and other health care facilities is both financially and logistically taxing on health care systems. For severe mental disorders, the topic of readmissions is particularly relevant due to its high frequency. For instance, a national study conducted in 2013 found that "mood disorders and schizophrenia have the highest number of all-cause 30-day hospital readmissions among adult Medicaid patients."[104] Moreover, in 2014, U.S. researchers found (based on nationwide readmissions data) that patients with serious mental illnesses were nearly twice as likely to have an unplanned 30-day medical and surgical hospital readmission than those without serious mental illness.[105] An international study conducted in 2011 likewise found that "the overall 30-day unplanned readmission rate was 13 per 100 discharged patients for schizophrenia and 11 per 100 discharged

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[101] House Bill 1895, Printer's No. 2634.

[102] Valeria Donisi *et al.*, "Pre-Discharge Factors Predicting Readmissions of Psychiatric Patients: A Systematic Review of the Literature," *BMC Psychiatry* 16 (December 2016): 449, DOI: 10.1186/s12888-016-1114-0.

[103] Raluca Sfetcu *et al*., "Overview of Post-Discharge Predictors for Psychiatric Re-Hospitalisations: A Systematic Review of the Literature," *BMC Psychiatry* 17 (June 24, 2017): 227, DOI: 10.1186/s12888-017-1386-z.

[104] *Ibid.*

[105] Hayley D. Germack *et al.,* "Association of Comorbid Serious Mental Illness Diagnosis With 30-Day Medical and Surgical Readmissions," *Journal of American Medical Association Psychiatry* 76, no. 1 (November 26, 2018): 96-98, DOI:10.1001/jamapsychiatry.3091.

patients for bipolar disorders in 15 OECD countries."[106] It is important to note that although the type of mental health or substance use disorder itself may be a contributing factor to readmission, under-treatment and lack of an integrated handoff to the proper intensity of care plays an important role in readmissions. The Pennsylvania Department of Drug and Alcohol Program's efforts to develop warm handoff policies and programs are intended to address some of these concerns. Another Advisory Committee of the Joint State Government Commission will be issuing a report in Fall 2020 that explores the warm handoff issue in great depth.

Types of Readmission Factors Commonly Evaluated

Public health researchers have examined the causes behind readmissions in a number of different ways. However, increased risk associated with readmission has been evaluated primarily based on two different types of factors: pre-discharge factors and post-discharge factors. A pre-discharge factor is often referred to as "the index admission period until discharge or to the period before index admission, including the discharge phase itself."[107] Alternatively, post-discharge factors are often referred to as "the time interval between an index discharge and the first readmission."[108] In certain instances there may be no clear separation between pre-discharge and post-discharge factors, and studies group certain factors under these two categories differently.[109]

Pre-Discharge Factors

Commonly reviewed pre-discharge factors in both U.S. and international studies on mental health and substance use disorder readmissions were generally related to demographic, social, and economic characteristics; clinical and historical characteristics; environmental characteristics; hospitalization characteristics; and admission and discharge characteristics.

Regarding demographic, social, and economic characteristics, one 2016 psychiatric journal article highlighted a number of studies that consistently found that risk of psychiatric hospital readmission was associated with individuals of a younger age. In other words, mental health readmissions were more common among younger individuals. The same could not be concluded for the characteristic of gender however, as studies reviewing gender association with increased readmission risks have tended to show mixed results. The same study did find a bit more consistency with one's marital status –those who were not married generally had a higher risk for readmission than those individuals who were married.[110] Another older national study from 2007 found that divorced people were at an even higher risk for psychiatric hospital readmission than were married and single

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[106] Donisi, "Pre-Discharge Factors," The OECD stands for the Organiation for Economic Cooperation and Development. The OECD is an association consisting of 35 nations in Europe, the Americas, and the Pacific. The association's goal is to promote the economic welfare of its members. It coordinates its efforts to aid developing countries outside of its membership.

[107] Donisi, "Pre-Discharge Factors," 2.

[108] Sfectu, "Overview of Post-Discharge Predictors," 2.

[109] Donisi, "Pre-Discharge Factors," 2.

[110] *Ibid.*, 7.

individuals.[111] The marital status finding could suggest that those who are married have an intimate person available to serve as their support system – a support system that can have the practical effect of reducing one's chances of readmission. The correlation of an individual's divorce to higher risk of mental health readmission could arguably be tied to the intense emotional impact of the divorce process itself.

Living situation was also examined in multiple studies. In particular, several studies reviewed whether an individual who was readmitted owned a home, lived in an institution, or was indigent or homeless. Homelessness was commonly found to be a major risk factor for readmission. A low level of education, and unemployment were also found to be risk-increasing factors. Regarding ethnic groups, African Americans were found to be "significantly associated with a higher risk of readmission" in two particular studies, while another study actually found white individuals to be at higher risk than other racial or ethnic groups. It should be noted, however, that readmission studies on race are very limited and have often generated mixed results. A 2019 study analyzing a sample of 60,254 discharges from 127 state psychiatric hospitals in 39 states found the demographic readmission characteristics shown in Table 4 below:

Table 4
Percent of Psychiatric Readmission from State Psychiatric Hospital Discharges
United States, 2019

Demographic Characteristics	Readmitted within 30-days of Discharge	Total # of Discharges
Male	61.7%	63.1%
Female	38.3%	36.9%
White	73.1%	70.1%
Black	26.9%	29.9%
Hispanic	7.0%	9.4%
Non-Hispanic	93.0%	90.6%
Married	6.8%	10.0%
Not Married	93.2%	90.0%

Source: Compiled by Commission staff from Glorimar Ortiz, "Predictors of 30-day Postdischarge Readmission to a Multistate National Sample of State Psychiatric Hospitals," *Journal of Healthcare Quality*, (Jul./Aug. 2019): 41, No. 4, pp. 231.

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[111] Alon Grinshpoon *et al*., "Re-Hospitalization of First In-Life Admitted Schizophrenic Patients Before and After Rehabilitation Legislation: A Comparison of Two National Cohorts," *Social Psychiatry and Psychiatric Epidemiology* 23 (2007): 355–9.

Although lower levels of education and unemployment were generally associated with a higher risk of readmission, socioeconomic and financial status did not appear to have a significant association to readmission.[112]

One common factor found in numerous studies related to an individual's clinical characteristics and patient history was the presence of a secondary diagnosis of substance use disorder. Individuals with a history of substance use disorder, along with mental health disorders due to psychoactive substance use, were more likely to be readmitted. However, in general, studies have found that one of the most salient pre-discharge factors for readmission is an individual's prior admission history. This importance was illustrated in an article that reviewed over 30 studies on readmission. According to the article, 32 out of 37 studies demonstrated that prior admission history demonstrated proved to be an increased risk for readmission – "[i]n 20 of these studies such relationship was found in all the multivariate analyses performed…"[113] Another study on predictors of psychiatric admission in substance use disorders concluded that "when all statistically significant predictors are entered together in a logistic regression model, the number of 'admissions' still revealed to be the factor most strongly associated with the risk of readmission." In fact, the same study revealed the risk to be readmitted increased by a factor of two or more after the second admission and individuals with a history of four or more previous admissions had a five times higher risk of readmission within the following 12 months.[114]

Regarding hospitalization characteristics, it has been found that "being discharged from medical centers or not-for-profit hospitals was a protective factor, while patients discharged from regional and public hospitals had the highest readmission rates."[115]

One key admission characteristic that has been reviewed in past studies has been voluntary versus involuntary admission of an individual seeking emergency treatment. Research has shown that there generally appears to be a higher risk for voluntarily admitted patients as opposed to those admitted pursuant to court orders. It is worth noting however that reviews of voluntary versus involuntary admission have occasionally demonstrated mixed results. Reviews of discharge characteristics on the other hand have found with some consistency that escapes from a hospital or discharges against medical advice resulted in an increased risk of readmission.[116]

Based on the studies discussed above, the top psychiatric readmission pre-discharge factors appear fall into three groups:

- Clinical Characteristics and History:

    o History of previous admissions

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[112] Donisi, "Pre-Discharge Factors," 7-8.

[113] *Ibid.*, 8-10.

[114] Volker Bockmann *et al.*, "Patient-Level Predictors of Psychiatric Admission in Substance Abuse Disorders," *Frontiers in Psychiatry* (Nov. 26, 2019), https://doi.org/10.3389/fpsyt.2019.00828.

[115] Donisi, "Pre-Discharge Factors," 10-11.

[116] *Ibid.*, 12-13.

- o Substance use disorder comorbidity to an existing mental health disorder

- • Demographic, Social, and Economic Characteristics

  - o Homelessness/indigence

  - o Younger age

  - o Divorced status

  - o Unmarried status

  - o Lower level of education

  - o Unemployment

- • Prior Discharge Characteristics

  - o Elopement from hospital or discharge against medical advice

  - o Discharge from regional and public hospitals as opposed to medical centers and non-profit hospitals

While these various pre-discharge factors have been highlighted in many studies as being linked to higher risk of readmission, it is important to note that such factors are no guarantee of readmission. Moreover, the vast majority of the studies and articles reviewed and cited to in this section have pointed out that there are often varying results. These factors simply represent common instances of readmission that recurrently showed up in survey-based studies.

Post-Discharge Factors

There has been a steady increase in research conducted on the connection between post-discharge factors and readmission "as post-discharge factors have started to be studied as predictors for rehospitalization, distinctively from pre-discharge factors."[117]

A 2017 study on post-discharge readmission factors found that "psychiatric medication adherence and compliance with follow-up appointments were … significant predictors of readmission … being some of the most researched and confirmed individual vulnerability factors."[118] The inference that can be drawn from this finding is that those individuals who were not compliant with their medication directives and failed to adhere to follow-up appointments were more likely to be readmitted to the emergency department.

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[117] Sfectu, "Overview of Post-Discharge Predictors," 2.
[118] *Ibid.*, 5.

A more recent 2019 study (one which was mentioned previously above) analyzing a sample of discharges from state psychiatric hospitals in 39 different states found that a short length of stay was the strongest predictor of readmission within 30 days. For instance, the study highlighted that an increase in the length of stay from 31 to 89 days was associated with 25 percent reduction in the proportion of discharges with rapid readmission, which is consistent with the findings of a 2009 study that found that shorter length of stay was associated with quicker readmission. According to the 2019 study, 45 percent of the patients with a diagnosis of schizophrenia were discharged within 31 days or less after admission - suggesting that a large number of individuals with schizophrenia continue to be discharged without proper crisis stabilization.[119]

Shorter length of stay is an important factor in effective substance use disorder treatment as well.

The appropriate duration for an individual depends on the type and degree of the patient's problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.[120]

While the presence of substance use disorder comorbidity for an individual was mentioned above as a pre-discharge readmission risk factor, it has also been categorized as a post-discharge risk factor when the substance use disorder persists after an individual's discharge. In one journal article, it was highlighted that in 10 case studies, the negative impact of alcohol or substance use disorder comorbidity on increased readmission was confirmed in six as a risk factor.[121]

The type of housing individuals were discharged to was also found to be a significant post-discharge factor impacting readmission rates. For example, those who were discharged into the care of another person or home had a higher risk of readmission than those who were discharged to their own home. The role of family support provided to an individual after discharge contributed to both an increased risk of readmission in some ways, as well as a reduced risk in readmission in others. For instance, a "family's stigma was found to increase the one-year readmissions of individuals with bipolar and psychotic

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[119] Glorimar Ortiz, "Predictors of 30-day Postdischarge Readmission to a Multistate National Sample of State Psychiatric Hospitals," *Journal of Healthcare Quality* 40, no. 4 (July/August 2019): 230-231, DOI: 10.1097/JHQ.0000000000000162.

[120] United States Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, "Principles of Drug Addiction Treatment: A Research-Based Guide" (3rd Ed.), revised January 2018, https://www.drugabuse.gov/download/675/principles-drug-addiction-treatment-research-based-guide-third-edition.pdf?v=87ecd1341039d24b0fd616c5589c2095

[121] Sfectu, "Overview of Post-Discharge Predictors," 5-6.

disorder in need of hospitalization, and maladaptive family system functioning was the strongest independent predictor of geropsychiatric rehospitalisation." Strong family criticism was also found to be associated with a higher risk for readmission. On the other hand, familial support of an individual decreased his or her chances of readmission. In addition to familial support, peer support or the support of a mentor appeared to reduce the risk of readmission as those with peer mentors were reported as having significantly fewer readmissions.[122]

Some of the top psychiatric readmission post-discharge factors include:

- Failure to adhere to medication directives and lack of compliance with follow-up appointments.

- Short length of stay prior to discharge.

- Comorbidity of substance use disorder.

- Discharge into the care of another person or to home.

- Family stigma and criticism.

- Lack of peer support.

The body of research on post-discharge risk factors and their impact on readmission rates "is unequally developed," with some factors being more extensively researched than others. As is the case with pre-discharge readmission risk factors, the high complexity and inter-relatedness of the topic makes it difficult to advance definitive conclusions regarding the impact that even the more commonly researched post-discharge factors have on readmission rates.[123] Despite this complexity, the data gleaned from these reviews can potentially assist in the improvement of care for those facing mental health and substance use disorder crises. Moreover, identifying the increased risk factors contributing to readmission can help to better equip health policy experts in their fight to find solutions to the revolving door syndrome as it relates to emergency departments.

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[122] *Ibid.*
[123] *Ibid.*, 12.

Privacy and confidentiality rules are frequently misunderstood and the perception of these rules as barriers can impede treatment unnecessarily. These rules change frequently and are specific to certain populations that vary based on the setting and procedures. Some of these misunderstandings could be addressed through training among allied disciplines to aid in determining appropriate application in various situations. In general, the Advisory Committee did not find that these rules are a substantial factor in ED boarding.

Federal Regulations

At the federal level, the Health Insurance Portability and Accountability Act (HIPAA) prescribes the minimum standard for maintaining the privacy of an individual's protected health information.[124] HIPAA, enacted in 1996, incorporated protections of substance use disorder treatment information that had been enacted in the early 1970s as part of the federal plan to provide grants to states to create programs to address alcohol abuse, prevention, treatment, and rehabilitation.[125] The conference report on the final version of the 1972 enactment stressed that "the strictest adherence to the provisions of this section is absolutely essential to the success of all drug abuse prevention programs. Every patient and former patient must be assured that his right to privacy will be protected. Without that assurance, fear of public disclosure of drug abuse or of records that will attach for life will discourage thousands from seeking the treatment they must have if this tragic national problem is to be overcome."[126] Additionally, the U.S. Supreme Court emphasized the need for specific psychotherapy note protections in order to maintain the atmosphere of confidence and trust that is necessary for psychotherapy to be effective.[127]

HIPAA included administrative simplification provisions that required the U.S. Department of Health and Human Services (HHS) to issue the provisions for what is now known as the "Privacy Rule," which HHS published in December 2000 and subsequently modified in August 2002. This rule sets national standards for protecting identifiable health information of individuals and sets limits and conditions on its use and disclosures without patient authorization by three types of covered entities: health plans, health care clearinghouses, and health care providers who conduct standard health care transactions electronically.[128] The regulations also expressly state that "[w]here provided, the

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[124] Health Insurance Portability and Accountability Act of 1996, PL 104-191, 110 Stat 1936.

[125] § 408, 86 Stat. 65, Pub. L. 92-255, March 21, 1972, known as the Drug Abuse Office and Treatment Act of 1972, and 88 Stat. 125, Pub. L. 93-282, May 14, 1974, known as the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Prevention, Treatment and Rehabilitation Amendments of 1974.

[126] H.R. REP. 92-775, H.R. Rep. No. 775, 92ND Cong., 2ND Sess. 1972, 1972 U.S.C.C.A.N. 2045, 1972 WL 12582 (Leg.Hist.)

[127] *Jaffee v Redmond*, 518 U.S. 1 (1996).

[128] "HIPAA for Professionals," *HHS.gov*, accessed July 15, 2020, https://www.hhs.gov/hipaa/for-professionals/index.html; "Health Information Privacy," *HHS.gov*, accessed July 15, 2020, https://www.hhs.gov/hipaa/for-professionals/privacy/index.html; 45 C.F.R. Part 160 *et seq.*

standards, requirements, and implementation specifications adopted under this subchapter apply to a covered entity's business associate."[129]

The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.[130] Individually Identifiable Health Information, according to HIPAA regulations, is information that is a subset of health information,[131] including demographic information collected from an individual, and:

> (1)   Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
>
> (2)   Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and;
>
> (3)   Identifies the individual; or
>
> (4)   With respect to which there is a reasonable basis to believe the information can be used to identify the individual.[132]

However, HIPAA permits disclosure of mental health information without a patient's consent if the covered entity is disclosing the information for the following purposes: disclosure to the individual (unless required for access or accounting of disclosures); *disclosure for treatment*, payment, and health care operations; disclosure pursuant to an agreement; disclosure for any reason incident to an otherwise permitted use and disclosure; disclosure for the public interest and benefit activities; and disclosure for limited data set for the purposes of research, public health, or health care operations (emphasis added).[133]

Another set of federal regulations regarding the protection of individual mental health information pertains specifically to confidentiality of substance use disorder patient records.[134] Concerns about persons with substance use disorders avoiding treatment

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[129] 45 C.F.R. § 160.102(a)(1)-(3), (b).

[130] "Health Information Privacy Summary of the HIPAA Privacy Rule," *HHS.gov*, accessed July 15, 2020, https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

[131] Health Information is defined under 45 C.F.R. §160.103 as "any information, including genetic information, whether oral or recorded in any form or medium, that: (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

[132] 45 C.F.R. § 160.103.

[133] 45 C.F.R. § 164.502(a)(1); "Health Information Privacy," *U.S. Department of Health and Human Services*, last modified July 26, 2013, https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

[134] 42 C.F.R. Part 2.

because they have a history of illegal substance use or wish to avoid being stigmatized prompted this higher level of protection. Under the purpose and effect provisions of Part 2, the regulations state:

> The regulations in this part are not intended to direct the manner in which substantive functions such as research, treatment, and evaluation are carried out. They are intended to ensure that a patient receiving treatment for a substance use disorder in a part 2 program is not made more vulnerable by reason of the availability of their patient record than an individual with a substance use disorder who does not seek treatment.[135]

Disclosure of such information may put the patient's housing, custody, job, or insurance at risk, or increase stigma. These regulations prohibit the disclosure and use of such patient records without patient consent except under certain circumstances which include *medical emergencies*, research, and certain audits and evaluations (emphasis added).[136] The protections provided under these regulations apply to federally assisted "Part 2 programs," which includes a majority of the drug and substance use disorder treatment centers, but generally not hospital emergency departments.[137] Exceptions to these covered programs are the U.S. Department of Veterans Affairs and the U.S. Armed Forces.[138]

State Regulations

While federal laws like those listed above set the minimum standards for mental health information confidentiality, states are free to pass laws that may be more exact or restrictive. State laws generally tend to be more defined than HIPAA regulations in general, but are rarely stricter than the disclosure restrictions for substance use disorders.[139]

With respect to mental health records, the MHPA provides that all documents regarding individuals in treatment shall be confidential and, without the individual's written consent, may not be released or their contents disclosed to anyone. However, there are exceptions which allow disclosure of treatment records for "those engaged in providing treatment for the person."[140] Regulations implemented pursuant to the MHPA also allow a Pennsylvania practitioner to disclose patients' mental health information, without consent, to "those actively engaged in treating the individual, or to persons at other facilities … when the person is being referred to the facility and a summary or portion of the record is necessary to provide for continuity of proper care and treatment."[141] Although the MHPA and its accompanying regulations only apply to inpatient facilities and

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[135] 42 C.F.R. §2.2(b)(2)
[136] 42 C.F.R. §§ 2.2(b), 2.51, 2.52, 2.53; *See also* John Petrila, "Clinical Practice and Information Sharing: HIPAA, State Confidentiality Laws and Other Legal Issues," (December 3, 2013), http://www.pacenterofexcellence.pitt.edu/documents/HIPAA%20Harrisburg%20Presentation.pdf.
[137] 42 C.F.R. § 2.11.
[138] 42 C.F.R. § 2.12.
[139] Petrila, "Clinical Practice and Information Sharing."
[140] Act of July 9, 1976 (P.L. 817, No. 143, § 111); 50 P.S. § 7111(a)(1).
[141] 55 Pa. Code § 5100.32(a)(1).

involuntary outpatient treatment, its regulations regarding confidentiality have been incorporated by reference into the licensing regulations for outpatient psychiatric clinics and partial hospitalization programs.[142]

Pennsylvania has more defined disclosure restrictions regarding drug and alcohol use disorder health information than for mental health information, and these restrictions are also more specific than the corresponding federal provisions. The Pennsylvania Drug and Alcohol Abuse Control Act (PDAACA) requires that:

> All patient records (including all records relating to any commitment proceeding) … shall remain confidential, and may be disclosed only with the patient's consent and only (i) to medical personnel exclusively for purposes of diagnosis and treatment of the patient or (ii) to government or other officials exclusively for the purpose of obtaining benefits due the patient as a result of his drug or alcohol abuse or drug or alcohol dependence except that in emergency medical situations where the patient's life is in immediate jeopardy, patient records may be released without the patient's consent to proper medical authorities solely for the purpose of providing medical treatment to the patient. Disclosure may be made for purposes unrelated to such treatment or benefits only upon an order of a court of common pleas after application showing good cause therefor.[143]

Unlike the federal regulations regarding drug and alcohol abuse health information, the PDAACA essentially requires a patient's consent to disclose such information and only allows disclosure without patient consent in an emergency medical situation where the patient's life is in immediate jeopardy. Aside from this scenario, a health care provider would have to obtain a court order permitting disclosure.[144]

According to a report by the National Council for Behavioral Health (NCBH) confidentiality regulations that are more restrictive for mental health and substance use disorder information than for general medical information make it less likely that general medical providers will have access to behavior health assessments and recommendations regarding a patient, which can lead to duplicative referrals for additional and potentially unnecessary assessments.[145]

The NCBH report suggested that overly restrictive confidentiality regulations can also impede a health care provider's ability to obtain critical information about a patient in a timely manner, which could have life-threatening consequences. The NCBH recommended revising state confidentiality regulations so that restrictions on mental health and substance use disorder records like the ones found in these statutes are aligned more

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[142] 55 Pa. Code §§ 5200.41(c) and 5210.56.
[143] 71 P.S. § 1690.108(b).
[144] *Ibid.*
[145] "The Psychiatric Shortage: Causes and Solutions," National Council for Behavioral Health, National Council of Medical Directors Institute (Washington, DC, March 28, 2017). 39, https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf?daf=375ateTbd56.

equally with HIPAA and the regulations governing substance use disorder information under federal regulations.[146]   According to the NCBH, the lessening of restrictions on information sharing at the state level could help reduce barriers to a timely exchange of electronic health records, which is critical for effective interventions and collaborations with others.[147]

However, loosening the regulations governing confidentiality of mental health and substance use disorder patients is not universally supported. The Legal Action Center, a New-York based coalition whose mission is to LAC seeks to end punitive responses to health conditions like addiction, mental illness, and HIV or AIDS, and to create equitable access to affordable, quality treatment, strongly advocates to protect privacy rights and sees confidentiality rules as foundational to encourage those with opioid and other substance use disorders to enter treatment.[148] Data supports the view that fear of disclosure deters patients from treatment. The National Study on Drug Use and Health in 2018 showed that of those who recognized a need but did not seek specialty facility care, 16 percent said treatment would negatively affect their job and 15 percent feared social stigma.[149] HIPAA opens up patients to legal sanctions and fails to offer protections for illegal drug use. SAMHSA agrees that while "behavioral health information should be integrated with physical health information to support improved care coordination," practitioners must respect the privacy and security of patients' sensitive information. SAMHSA instead recommends health information exchanges or networks, and provides examples of pilot projects that facilitate provider-to-provider communication while complying with existing federal law regarding privacy.[150]

In its 2018 report to the U.S. Congress, the Medicaid and Chip Payment and Access Commission (MACPAC) made recommendations to support information exchange among health care providers under the federal substance use disorder (SUD) confidentiality regulations.

> Part 2 has been criticized as confusing, restrictive, and challenging to implement; according to the Commission, additional guidance, education, and technical assistance to clarify these regulations would be a meaningful step to help providers, payers, and patients understand their legal rights and

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[146] *Ibid.*

[147] *Ibid.*, 33.

[148] Deborah A. Reid, Legal Action Center, "Campaign to Protect Privacy Rights Principles," August 2018, https://www.lac.org/news/campaign-to-protect-privacy-rights-principles.

[149] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health," (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

[150] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "The Current State of Sharing Behavioral Health Information in Health Information Exchanges," (September 2014), https://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf.

obligations and opportunities for information sharing that would facilitate integration of care.[151]

The CARES Act of 2020 amended the Public Health Services Act (PHSA) to revise and add to the section that governs confidentiality of records and under which the Part 2 Regulations were authorized.[152] The amendments added a new subsection to § 543 to prohibit discrimination against an individual on the basis of confidential substance use information by any entity received due to a disclosure of records in: admission, access to, or treatment for health care; hiring, firing, or terms of employment, or receipt of worker's compensation; the sale, rental, or continued rental of housing; access to Federal, State, or local courts; or access to, approval of, or maintenance of social services and benefits provided or funded by Federal, State, or local governments. Recipients of Federal funds are also specifically prohibited from discrimination on the same basis and in the same areas.[153]

These amendments require revisions to regulations to implement and enforce these new provisions, to be effective within 12 months of the CARES Act passage. Additionally, updated notice of privacy practices regulations are to be implemented with 12 months and contain plain language disclosures, to wit:

- a statement of the patient's rights, including self-pay patients, with respect to protected health information and a brief description of how the individual may exercise these rights; and

- a description of each purpose for which the covered entity is permitted or required to use or disclose protected health information without the patient's written authorization.[154]

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[151] "MACPAC Makes Recommendations to Strengthen Medicaid Drug Rebate Program; Address Opioid Epidemic," Press Release, (June 15, 2018), https://www.macpac.gov/news/macpac-makes-recommendations-to-strengthen-medicaid-drug-rebate-program-address-opioid-epidemic/. The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).

[152] Coronavirus Aid, Relief, and Economic Security Act (CARES Act), Public Law 116-136, March 27, 2020, § 3221.

[153] PHSA §543(i); 42 U.S.C. §290dd-2; amendments found in CARES Act § 3221(g).

[154] CARES Act, § 3221(i).

The question frequently arises as to what impact, if any, the type of insurance coverage or the lack of insurance coverage has on ED boarding and lengths of stay. A few studies have a looked at the issue in depth. An older literature review, commissioned and published by the U.S. Department of Health and Human Services in 2008, looked into the matter. Reviewing literature primarily from the early 2000s, the report study found that while type of insurance may not be indicative of whether a person is boarded, it does have an impact on the length of boarding. Specifically, the study suggested that uninsured boarded patients may board longer than insured boarded patients due to the difficulty in finding an outpatient facility willing to accept the transfer.[155]

A study in Massachusetts looked at persons receiving ED psychiatric consultations at one of five general hospitals that are all part of an integrated health care system. Two of the hospitals were academic medical centers and three were community hospitals. The study was conducted over the period June 2008 to May 2009 and over 1,000 cases were reviewed. The study found that publicly insured patients boarded longer than those with private insurance.[156]

A study in Illinois of ED boarding of 910 patients from July 1, 2010 to June 30, 2012, arrived at a different conclusion than the Massachusetts study. The studies agreed that uninsured individuals had the longest boarding time in EDs, but they differed on the role of public versus private insurance in terms of wait times. The Illinois study found that patients with private insurance boarded longer than those with Medicare/Medicaid. Private insurance pre-authorization procedures were cited as a possible source of the delay for persons with private insurance. A secondary analysis found that patients who were transferred to publicly funded facilities had significantly longer ED lengths of stay than patients transferring to private facilities.[157]

Reimbursement Rates

According to a report commissioned by the Mental Health Treatment and Research Institute, there are still identifiable disparities in both out-of-network utilization and reimbursement rates for other medical or surgical providers when compared to mental health care providers. For example, the report highlighted that between 2013 and 2015, the proportion of inpatient facility services for mental health care that were provided out-of-network was 2.8 to 4.2 times higher than for other medical or surgical services.

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[155] David Bender, Nalini Pande, and Michael Ludwig, "A Literature Review: Psychiatric Boarding," prepared under contract to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, October 29, 2008, https://aspe.hhs.gov/system/files/pdf/75751/PsyBdLR.pdf.

[156] Grace Chang, Anthony Weiss, Joshua M. Kosowsky *et al*., "Characteristics of Adult Psychiatric Patients With Stays of 24 Hours or More in the Emergency Department," *Psychiatry Services* 63, no.3 (March 2012):283-6, DOI: 10.1176/appi.ps.201000563.

[157] Ryan K. Misek, Ahsley E. DeBarba, and April Brill, "Predictors of Psychiatric Boarding the Emergency Department," *Western Journal of Emergency Medicine* XVI, no. 1 (January 2015), DOI: 10.5811/WESTJEM.2014.10.23011

Moreover, the proportion of out-of-network outpatient facility services for mental health care was 3.0 to 5.8 times higher than for other medical or surgical services, and the proportion of out-of-network mental health care office visits was 4.8 to 5.1 times higher than for other medical or surgical primary care office visits.[158]

Regarding reimbursement rates, the report ascertained that between 2013 and 2015, primary care providers were paid 20.7 percent to 22 percent higher rates for office visits than mental health care providers, while medical and surgical specialty care providers were paid 17.1 percent to 19.1 percent higher rates for other office visits than were mental health care providers.[159] Further evidence supporting the notion that the current rates offered by insurance providers are below the actual market value of the mental health care services provided is that 40 percent of psychiatrists across the country have opted to run cash-only practices in order to avoid the low insurance reimbursement.[160]

Medicaid Managed Care Coverage

Persons eligible for Medicaid (Medical Assistance, or MA, in Pennsylvania) may receive mental health and substance use disorder benefits through the state's HealthChoices Managed Care program (akin to a health maintenance organization or HMO). This is identified in the literature as a "carve-out" program. Each county's behavioral health program contracts with one of five management care organizations that are authorized to provide MA managed care coverage in Pennsylvania. Consumers are assigned a behavioral health managed care organization on the basis of county of residence.[161]

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[158] Stephen P. Melek *et al*., "Addiction and Mental Health vs. Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates," (Mental Health Treatment and Research Institute LLC: December 2017), 1-2, https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/uploadedfiles/insight/2017/nqtldisparityanalysis.ashx.

[159] *Ibid.,* 2.

[160] NCBH, "The Psychiatric Shortage: Causes and Solutions."

[161] "Managed Care Organization Information, Behavioral Health Services," *Pennsylvania Department of Human Services*, accessed July 15, 2020, https://www.dhs.pa.gov/contact/DHS-Offices/Pages/MCO-Information.aspx.

<table>
<tr><td colspan="2" align="center">**Table 5**

Behavioral Health Managed Care Organizations in Pennsylvania

July 18, 2020</td></tr>
<tr><td align="center">**MCO Name and Affiliations**</td><td align="center">**Counties Served**</td></tr>
<tr><td>Community Care Behavioral Health Organization (CCBHO), affiliated with UPMC</td><td>Adams, Allegheny, Bedford, Bradford, Berks, Blair, Cameron, Carbon, Centre, Chester, Clarion, Clearfield, Clinton, Columbia, Elk, Erie, Forest, Huntingdon, Jefferson, Juniata, Lackawanna, Luzerne, Lycoming, McKean, Mifflin, Montour, Monroe, Northumberland, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Warren, Wayne, Wyoming, York</td></tr>
<tr><td>Value Behavioral Health (Beacon Health Options of Pennsylvania)</td><td>Armstrong, Beaver, Butler, Crawford, Fayette, Greene, Indiana, Lawrence, Mercer, Washington, Westmoreland, Venango</td></tr>
<tr><td>Magellan Behavioral Health of Pennsylvania (MBH), affiliated with Magellan Health</td><td>Cambria, Bucks, Delaware, Lehigh, Montgomery, Northampton</td></tr>
<tr><td>PerformCare, member organization of AmeriHealth Caritas (formerly Community Behavioral HealthCare Network of Pennsylvania (CBHNP))</td><td>Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry</td></tr>
<tr><td>Community Behavioral Health, a division of the Philadelphia Department of Behavioral Health and Intellectual Disability Services</td><td>Philadelphia</td></tr>
<tr><td colspan="2">Source: See footnote 161.</td></tr>
</table>

Pennsylvania's carve-out program was introduced after an unsuccessful attempt at a carve-in program in the 1980s. In 2019, Pennsylvania was listed as one of nine states with a behavioral health Medicaid carve-out model of funding. Generally, carve-out programs have been criticized on the basis of concerns that they can lead to less-coordinated care, as the individual does not receive all of their physical and mental health and substance abuse disorder care from the same entity. This is believed to lead to fragmentation, lack of coordination, missed symptoms, and overall increased costs to the state and federal government.[162] Carve-in models, meanwhile, come with their own

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[162] Kim Tuck and Erin Smith, *Behavioral Health Coverage in Medicaid Managed Care*, (Institute for Medicaid Innovation, April 2019), 6-9, https://www.medicaidinnovation.org/_images/content/2019-IMI-Behavioral_Health_in_Medicaid-Report.pdf#:~:text=in%20Medicaid%20Managed%20Care%20.%20Approximately%20one%20in,an%20increase%20from%2065.5%20percent%20in%202015.%20Behavioral.

drawbacks. While it has been suggested that carve-in models can be useful in bridging health care "silos" of physical health and mental health, their implementation in other states has been less than optimal, particularly in areas of collaboration between state agencies, lack of health information technology investment and adoption, and a general lack of administrative infrastructure in many small provider agencies to handle the merged services.[163]

In 2020 a study by the National Council for Behavioral Health (NCBH) examined Pennsylvania and Maryland's carve-out programs. Conditions that were found to support success in the carve-outs included:

- Existence of strong county-based systems that are able to focus on managing behavioral health (BH) services. The ability of existing (BH carve-out systems to create a robust specialty BH provider network.

- Specialty BH systems' ability to achieve state goals for increased access and service penetration for BH services while achieving BH system savings.

- The ability to reinvest system savings and fund essential county services for persons with BH needs.

- Specialty MBHOs having more than 30 years of experience addressing social determinant of health issues for clients.

- Carve-out arrangements allowing for more focus on innovation in outcome measures and development of solid outpatient measurement systems for mental health services.

- Lack of evidence of carve-in arrangements improving lives of people with BH and physical health conditions.[164]

The NCBH further noted that stakeholders in these carve-out states "believe that issues regarding the need for improved service integration with physical health care services can be addressed through clearer contractual requirements or implementation of new benefits that promote whole-person care (e.g. Medicaid health home services)."[165]

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[163] Alicia D. Smith, Barbara Coulter Edwards, and David Frederick, *The Transition of Behavioral Health Services into Comprehensive Medicaid Managed Care: A Review of Selected States,* (National Council for Behavioral Health, June 2020), 21-22,
https://engage.thenationalcouncil.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=9eac4984-1bfd-4b92-8bfa-402d711e4752
[164] Ibid. 11.
[165] Ibid. 13.

Pennsylvania's carve-out model, HealthChoices, has been recognized for its superior integration, quality of care, and cost savings relative to other states' models. These and other benefits of the Health Choices carve-out model contributed to Mental Health America ranking Pennsylvania number one overall nationally based on lower prevalence of mental illness and higher rates of access to mental health care and addressing the mental health needs of the population. In terms of meeting the mental health needs of the population, Pennsylvania place ninth in the adult ranking and second in the youth ranking.[166]

An example of the success of Pennsylvania's model includes a study of diabetes treatment among persons with and without serious mental illness (SMI) that found that the presence of a mental disorder was associated with: higher use of outpatient and primary care services for diabetes, lower rates of hospitalizations for diabetes and higher odds of receiving three or more quality measures for diabetes care. Overall, patients with SMI had better diabetes care compared with patients with other mental disorders and patients with no mental disorders. The authors conclude that "managed care behavioral health carve-out systems may be as effective in coordinating general medical and mental health care for persons with serious mental disorders as a primary care medical care home that focuses primarily on the general medical problem."[167]

In the ED, a behavioral health carve-out model may help healthcare professionals to obtain mental health history records of enrolled persons. However, the experience has not been uniformly positive for health care professionals as they attempt to place persons with substance use disorder in an appropriate level of care.

Impact of Parity Laws

The concept of mental health parity has been discussed since the early 1960s.[168] It is the notion that mental health conditions and substance use disorders should be treated equally within health insurance plans.[169] In other words, insurance companies must provide the same level of benefits for mental illness or substance use disorder as it does for other physical disorders and diseases. Equal application of benefits would include visit limits, deductibles, and copayments, as well as lifetime and annual limits.

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[166] Mental Health America, *Overall Ranking,* accessed July 18, 2020, https://www.mhanational.org/issues/ranking-states
[167] Elizabeth L. Noll, Aileen B. Rothbard, Trevor Hadley and Matthew O. Hurford, "Quality of Diabetes Care Among Adult Medicaid Enrollees with Mental Disorders," *Psychiatric Services*, 29 Feb 2016 https://doi.org/10.1176/appi.ps.201500060.
[168] "Parity Policy and Implementation," *U.S. Department of Health and Human Services*, last modified December 27, 2018, https://www.hhs.gov/about/agencies/advisory-committees/mental-health-parity/task-force/resources/index.html.
[169] "What is Mental Health Parity?" *National Alliance on Mental Illness*, accessed July 15, 2020, https://www.nami.org/find-support/living-with-a-mental-health-condition/understanding-health-insurance/what-is-mental-health-parity.

Insurers and employers have traditionally covered treatment for mental health conditions differently from treatment for physical conditions. For instance, mental health care coverage had its own (usually higher) cost-sharing structure, higher restrictions limiting the number of inpatient days and outpatient visits permitted, separate annual and lifetime caps on coverage, and different prior authorization requirements than coverage for other medical care.[170] These restrictive coverage rules had the effect of making mental health benefits "substantially less generous than benefits for physical health conditions."[171]

Recognizing the unequal treatment of mental health conditions over the years, both Congress and a number of presidential administrations sought solutions through federal legislation and policies. According to the U.S. Department of Health and Human Services (HHS), President John F. Kennedy first sought to implement a parity policy within the Civil Service Commission (now known today as the Office of Personnel Management). However, this policy had been scaled back in the mid-1970s. During the 1970s, many individual states began enacting parity laws, mostly limited to small group health plans, while others applied to certain individual policies. Some states established minimum benefit level requirements for both mental health and substance use disorders.[172]

In 1992, Senators Pete Domenici and John Danforth introduced the first federal parity legislation in Congress known as the Equitable Health Care for Severe Mental Illnesses Act (S.2696).[173] This proposed legislation was referred to the Committee of Labor and Human Resources on May 12, 1992. However, the bill never became law.[174]

In 1996, the Mental Health Parity Act (MHPA), championed by Senators Paul Wellstone and Pete Domenici, was enacted to prohibit large group health plans from imposing annual or lifetime dollar limits on mental health benefits that are less favorable than those limits imposed on other medical or surgical benefits. The MHPA applied to fully insured group health plans and self-insured group health plans. The law contained an exemption that permitted group health plans to waive some of its key requirements if the plans were able to demonstrate that compliance would result in cost increases of at least one percent. The MHPA did not outright mandate coverage for mental health treatment. Instead, its parity requirements only applied to group health plans that provided mental health coverage.[175]

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) largely superseded the 1996 MPHA, with the promise of making both mental health and substance use disorder treatment just as accessible as care for physical health conditions. In general, the MHPAEA was designed to prevent group health

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[170] Sarah Goodell, "Health Policy Brief: Mental Health Parity," *Health Affairs* (Apr. 3, 2014), https://www.healthaffairs.org/do/10.1377/hpb20140403.871424/full/.
[171] *Ibid.*
[172] "Parity Policy and Implementation."
[173] *Ibid.*
[174] "S.2696 – Equitable Health Care for Severe Mental Illnesses Act of 1992," 102nd Congress (1991-1992), https://www.congress.gov/bill/102nd-congress/senate-bill/2696.
[175] U.S. H.R. 4058 (104th Congress, 2nd Sess.), Sept. 11, 1996.

plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on other medical or surgical benefits. The MHPAEA essentially preserves existing parity requirements and added significant new protections. Specifically and most notably, it extended its parity requirements to substance use disorders, and added the concepts of qualitative treatment limits (QTLs) and non-quantitative treatment limits (NQTLs) to the parity analysis, giving regulators the ability to more comprehensively review policies such as prior authorization and step therapy.

Initially the MHPAEA only applied to group health plans and group health insurance coverage, but it was later amended by the Affordable Care Act and again by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the ACA) to apply to individual and small group health insurance coverage through explicit language and by adding mental and behavioral health services to the ten Essential Health Benefit categories that all new small group and individual market plans are required to cover by 2014, thus negating previous exemptions available to small groups.

Legislation in Pennsylvania during the 2019-2020 session would further strengthen these coverage requirements. House Bill 470 would amend the Insurance title of the Consolidated Statutes to prohibit annual and lifetime limits on "essential health benefits." It would also define "essential health benefits" to include treatments and service for mental health and substance use disorder services. House Bill 470 was referred to the Health Committee on April 27, 2020.

House Bill 2434 would add a chapter to the Insurance title of the Consolidated Statutes providing that "on-exchange" health insurers must include coverage for mental health and substance use disorder treatments as "essential health services." As of April 28, 2020, the bill was awaiting action in the Insurance Committee. House Bill 469 would amend the Insurance title to require all health insurance policies offered, issued, or renewed in the Commonwealth to provide mental health and substance use disorder treatments and services as "essential health benefits." As of April 27, 2020, this bill is awaiting action in the Insurance Committee. These bills go beyond existing parity regulations and the federal parity law, as they would require health coverage of treatments and services for mental health and substance use disorder symptoms where such a mandate did not already exist. It should be noted that inclusion of mental health and behavioral health is federally mandated as an "essential benefit" under the ACA and thus is already in force in state Medicaid/Medical Assistance programs. However, enshrining in it Pennsylvania statutory law will protect its status as an essential benefit for Pennsylvania residents if the ACA were to fall to ongoing litigation.

Parity in Other States

Individual states began enacting laws intending to achieve mental health parity in the 1970s. Many of these states' laws varied to some degree. Some laws applied solely for small group health plans, while others applied to individual policies. Employer-sponsored group health plans have generally been exempted under state established parity

laws.[176] Pennsylvania adopted the federal parity laws into the state's insurance law in 2010.[177]

Numerous states have enacted purely equal coverage laws while essentially expanding the definition of mental health care. These types of laws vary throughout the U.S., ranging from limited (requiring coverage of only a few specific mental illnesses) to comprehensive (requiring broad coverage for all mental illnesses) which under certain state laws includes substance use disorders.[178] Parity of covered benefits under these laws often include duration or frequency of coverage, dollar amount of coverage, and beneficiary financial requirements. Some of the states with equal coverage parity laws include Arkansas,[179] Connecticut,[180] Delaware,[181] and New Jersey.[182]

Other states have established minimum benefit level requirements for mental health and substance use disorders. These laws require that there be some minimum level of coverage for mental illnesses or substance use disorders if coverage for those types of conditions is being provided. An example of these minimum benefits would be equal copayments and deductibles up to the required level of benefits provided by the carrier.[183] Currently Pennsylvania has minimum mandated benefits requirements for "alcohol or drug abuse."[184] Other states with currently enacted minimum mandated benefits requirements include Alaska,[185] California,[186] and Maine.[187]

Mandated offering laws generally require that an insurance carrier provide an option of coverage for mental illness, serious mental illness, substance use disorder, or a combination thereof. The insured individual can either accept or reject the option. Moreover, these laws typically require that if mental health coverage benefits are offered they must be equal to non-mental health benefits. Alabama's mental health parity law is one example of a mandated offering law that requires all group health benefit plans offer to provide, at a minimum, additional mental health benefits for a person receiving medical treatment for certain mental illnesses diagnosed by an appropriately licensed provider.[188]

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[176] "Mental Health Benefits: State Laws Mandating or Regulating," *National Conference of State Legislatures*, last modified May 30, 2017, http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx.

[177] Article VI-B (Health Insurance Coverage Parity and Nondiscrimination Act) of the Act of May. 17, 1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921, as added by the act of March 22, 2010 (P.L. 147, No.14); 40 P.S. §908-11 et seq.

[178] *Ibid.*

[179] 1997 Ark. Legis. Serv. 1020; Ark. Code Ann. § 23-99-501 *et seq*.

[180] Conn. Gen. Stat. Ann. § 38a-514.

[181] Del. Code Ann. Tit. 18 § 3343.

[182] 2019 N.J. Laws Ch. 58, No. 2031; N.J. Stat. Ann. 17:48-6v.

[183] "Mental Health Benefits," *NCSL*.

[184] Act of Dec. 22, 1989 (P.L. 755, No. 106, § 8); 40 P.S. §§ 908-1—908-8.

[185] Alaska Stat. § 21.55.110.

[186] Cal. Ins. Code § 10112.27.

[187] ME. Rev. Stat. tit. 24-A § 4234-A.

[188] Ala. Code § 27-54-4.

In an effort to promote greater transparency and accountability, some states have enacted parity laws requiring annual reporting from insurance carriers to ensure mental health parity compliance and to strengthen overall enforcement. Generally, reporting requirements direct insurance providers to file an annual report with the state's insurance enforcement agency containing a description of the process used to develop or select the medical necessity criteria for mental illness, drug and alcohol dependency benefits, and medical and surgical benefits, along with other processes utilized by the insurance provider to comply with the MHPAEA.[189] Jurisdictions with annual reporting requirements include Colorado,[190] Delaware,[191] District of Columbia,[192] Illinois,[193] New Jersey,[194] and New York.[195]

Enforcement of Parity

Despite the enactment of federal and state legislative measures many states, including Pennsylvania, are not achieving true parity. Furthermore, states are only just starting to enact laws to strengthen enforcement of parity, such as through annual reporting requirements. One of the key reasons that true parity has continued to evade Pennsylvania, along with many other states, is lack of effective enforcement tools. To fully understand the issue of enforcement as it relates to parity, it is critical to understand the interplay between federal parity requirements and the role of the states.

While parity is mandated under federal law (the MHPAEA), states are given primary enforcement authority for health plans entered into within their jurisdiction (individual and small group health plans, fully insured large group health plans, and Medicaid plans), while the federal government, through the Department of Labor, enforces parity among self-insured employer plans known as ERISA plans.[196] State enforcement of the MHPAEA is usually administered through a state's respective insurance departments or state banking agencies.

Under the final rules of the MHPAEA, any processes, strategies, evidentiary standards, and other factors used by an insurance carrier in managing mental health and substance use disorder benefits must be comparable to, and applied no more stringently than, those used in managing other medical or surgical benefits.[197] This also includes medical management standards, prescription drug formulary design, network adequacy, provider fee levels, and step therapies, among other processes. These standards and

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[189] *See* Delaware S.B. 230, 149th General Assembly (2017-2018); 18 Del. C. § 3343.

[190] Colo. Rev. Stat. Ann. § 10-16-147.

[191] Del. Code Ann. Tit. 18 § 3343(g).

[192] D.C. Code § 31-3175.03.

[193] 215 Ill. Comp. Stat. 5/370c.1(k).

[194] 2019 N.J. Laws Ch. 58, No. 2031.

[195] N.Y. Ins. Law § 343.

[196] Lindsey Vuolo, Robyn Oster, and Ellen Weber, "Evaluating the Promise and Potential of the Parity Act on its Tenth Anniversary," *Health Affairs* (blog), (Oct. 10, 2018), doi: 10.1377/hblog20181009.356245.

[197] Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, Fed. Reg. 68240, (Nov. 13, 2013) (to be codified at 45 C.F.R. Parts 146 and 147), https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf.

processes are known under the MHPAEA as non-quantitative treatment limitations (NQTLs).[198] Quantitative treatments limits (QTLs), such as number of days of inpatient care per year, and office visit limitations are also subject to review for parity purposes under the MHPAEA.

State insurance departments often have to examine these NQTLs to determine compliance with the MHPAEA by conducting a careful qualitative review of a plan's or health plan issuer's care management protocols. Due to the complexity of the NQTLs, competent clinical and legal professionals must conduct these reviews.[199] Unfortunately, studies have revealed that there is more than can be done with state review of NQTLs.

It should be emphasized that parity of provider reimbursement under the MHPAEA does not mean equal reimbursement. Parity requires that the process by which payer establishes the reimbursement rates for mental health services must be comparable to that of the process for other medical or surgical reimbursement rates.[200] Large disparities reported between mental health care services and other medical or surgical services[201] leaves open the question of whether insurance companies are complying with the MHPAEA, and further, whether state-level insurance departments are able to adequately enforce the law's provisions.

State insurance regulators who are directed to enforce parity for state-regulated commercial plans often "rely on traditional tools, such as form review and consumer complaints, which are reactive and insufficient for parity enforcement." Overreliance on consumer complaints is an ineffective way of enforcing parity laws because patients may be unaware of the MHPAEA or its state law equivalent, may not understand the intricacies of the law or what constitutions a violation, and may not be aware of any rights afforded by state laws, or the path necessary to enforce those rights. Essentially, many "[c]onsumers are generally unable and uninterested in navigating a burdensome and confusing complaint process in the midst of a health crisis." Further, parity is inherently comparative, which requires more data points than an individual complaint can offer. It is this lack of effective enforcement at the state level which has the effect of making even strong parity laws toothless.[202]

A lack of effective enforcement has contributed to a steady stream of psychiatric unit closures due to an inability to recruit and retain psychiatrists.[203] One study surveying the perspective of primary care physicians (PCPs) on the barriers that patients encounter in gaining access to mental health services found that "shortage of providers" was just as

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[198] Melek, "Addiction and Mental Health vs. Physical Health."
[199] "Advocacy — Insurance Equity in Pennsylvania," *Mental Health Partnerships*, accessed December 16, 2019, https://www.mentalhealthpartnerships.org/insurance-equity-pa/.
[200] Tim Clement *et al*., "The 'Six-Step' Parity Compliance Guide for Non-Qualitative Treatment Limitation (NQTL) Requirements," *Kennedy Forum Issue Brief* (Sept. 2017), 86, https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/faq-38/00018.pdf.
[201] Melek, "Addiction and Mental Health vs. Physical Health."
[202] Vuolo, 'Evaluating the Promise and Potential of the Parity Act."
[203] Melek, "Addiction and Mental Health vs. Physical Health," 19.

common a barrier to outpatient mental health services as "lack of or inadequate coverage" (at 59 percent of PCPs so reporting). The data further indicated that PCPs in states with parity laws were more likely than PCPs in states with no parity laws to report problems due to a shortage of providers. This would indicate that parity laws may exacerbate problems with provider shortages if parity laws — or more effective enforcement of such laws — have the effect of increasing demand for services and there is no concurrent rise in the number of providers.[204]

This study also found that PCPs in states with mandatory parity were eight percent less likely to report access problems due to health plan barriers and five percent less likely to report problems arising from inadequate coverage. Overall, more effective enforcement parity laws benefits patients and providers and may be part of the solution in easing a mental health care provider shortage.[205]

Recent Efforts to Improve Parity Enforcement in Pennsylvania

In January 2020, Governor Tom Wolf announced a new initiative of his administration, "Reach Out PA: Your Mental Health Matters," designed to expand resources and improve the Commonwealth's comprehensive support of mental health and related health care priorities. The initiative includes efforts by the Departments of Human Services, Health, Insurance, and Labor and Industry to improve access and coordination of mental health services. The Pennsylvania Insurance Department's focus is on parity.[206] Currently, reviews of insurance company parity practices occur primarily upon complaint by a consumer of suspected unequal treatment of claims. The Office of Market Regulation is responsible for researching and resolving consumer complaints, among other enforcement activities.[207]

In addition, over the past few years, the Insurance Department has been in the process of completing comprehensive market conduct examinations on all of the major health insurers in the commercial market, with a significant focus on parity. These examinations are robust and generally considered the most extensive exams of their kind performed by any state insurance department in the country. Pennsylvania is, in fact, a national leader in examining the insurance market. The Insurance Department leads a multi-state working group through the National Association of Insurance Commissioners (NAIC) in which both state and federal regulators from around the country share information and collaborate on building resources for better enforcement. The Insurance

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[204] Peter J. Cunningham, "Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care," *Health Affairs* 28, no. 3 (April 14, 2009), DOI: 10.1377/hlthaff.28.3.w490. The survey took place in 2008, before the implementation of the federal MHPAEA.

[205] *Ibid.*

[206] Pennsylvania Governor's Office, "Pennsylvania Launches 'Reach Out PA: Your Mental Health Matters'" Press Release, (January 2, 2020), https://www.governor.pa.gov/newsroom/pennsylvania-launches-reach-out-pa-your-mental-health-matters/.

[207] *Office of Market Regulation Monthly Report,* (Pennsylvania Insurance Department, May 2019), https://www.insurance.pa.gov/Regulations/Regulatory%20Actions/Documents/Commissioners%20Reports/2019/May%202019%20OMR%20Monthly%20Report.pdf.

Department's examiners have developed tools to assist with parity analyses and have shared those tools widely. Among other topics, these exams have allowed the Insurance Department to gain insights into management and operations, complaints, and claims handling processing. To date, exams have resulted in companies taking corrective action to address the problems identified by the department, some fines, and significant restitution payments to consumers for erroneously processed mental health and substance use disorder claims. In addition to restitution, the Insurance Department will perform reexaminations on all of the insurers to ensure the corrective actions were implemented adequately.

One of the key issues identified through the above examination process was a lack of documentation of the internal processes and decisions that determine whether or not a carrier is in compliance with parity. In February 2020, the Insurance Department published proposed regulations that would increase the department's ability to review and analysis parity compliance by health insurance providers.[208] New Chapter 168, Mental Health Parity Analysis Documentation would require insurers subject to parity rules to annually (by April 30) submit to the department a statement attesting to the insurer's documented analyses of its efforts to comply with all parity regulations.[209] Additionally, each insurer must document parity information, including a baseline parity analysis to demonstrate compliance with federal parity regulations for each quantitative treatment limitation (QTL) and each non-quantitative treatment limitation (NQTL) and a parity analysis of each change to a QTL or NQTL. Further specific details must be provided for individual NQTLs, including medical management. This documentation must be maintained by the insurer and made available to the department upon request, and also to an insured or provider (subject to some limitations) in response to a good faith request.[210]

In furtherance of the goals of the Reach Out initiative, it was announced on February 7, 2020, that the Insurance Department, in conjunction with the Departments of Health, Human Services, Drug and Alcohol Programs, State, Aging, the Office of Attorney General, and the Governor's Office, was conducting a survey of health care providers regarding their experiences with barriers to mental health and substance use disorder treatment in an effort to provide education and resources to inform Pennsylvania providers and consumers about their rights under state and federal parity laws.[211] Prior to the survey, the Insurance Department developed and disseminated web content and educational videos on parity to increase awareness of parity.

On May 4, 2020, the House, by a vote of 202-0, passed House Bill 1439, which would amend the Insurance title of the Pennsylvania Consolidated Statutes to require that insurers "annually file with the department a statement attesting to the insurer's documented analyses of efforts to comply with MHPAEA and the federal regulations

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[208] 50 Pa. Bulletin 798, Saturday, February 8, 2020. Proposed Rulemaking amending Title 31 (Insurance) of the Pennsylvania Code.
[209] Proposed Regulation §168.3.
[210] Proposed Regulation §168.4.
[211] Pennsylvania Governor's Office, "Reach Out PA: Wolf Administration Seeks Input from Providers on Barriers to Mental Health and Substance Use Disorder Treatment," Press Release, (February 7, 2020), https://www.governor.pa.gov/newsroom/reach-out-pa-wolf-administration-seeks-input-from-providers-on-barriers-to-mental-health-and-substance-use-disorder-treatment/.

relating to mental health and substance use disorder parity."[212] The bill has received second consideration in the Senate and was re-referred to the Appropriations Committee on July 13, 2020.

House Bill 1696, also passed by the House on May 4, 2020 by a vote of 202-0, would amend the Insurance title of the Pennsylvania Consolidated Statutes to require that insurers provide an attestation of compliance with MHPAEA. However, House Bill 1696 also lays out what information must be included in such an attestation in greater detail. For instance, under House Bill 1696, a health insurer would be required to conduct a baseline parity analysis and a parity analysis to demonstrate compliance with the federal MHPAEA and prepare disclosure documentation which must include an identification of any non-qualitative treatment limitation of MH/SUD benefits and which is also applied to medical and surgical benefits. Further, health insurers must "describe the process used to develop, select or continue the use of the limitation for MH/SUD benefits and the process used to develop, select or continue the use of that limitation for medical and surgical benefits."[213] The bill has received second consideration in the Senate and was re-referred to the Appropriations Committee on July 13, 2020.

Funding Issues

As is the case with the mental health and substance use disorder delivery system, funding to the various components of that system are fragmented, based upon the type of entity providing the service.

In Pennsylvania, individual counties provide mental health services, including crisis intervention and management through the county mental health and intellectual disability agency. While some counties are direct providers, many contract services out to local providers. The funding for these programs come from federal and state monies allocated to each county via either the Human Services Development Fund or Human Services Block Grants.

All counties receive funding via the Human Services Development Fund for adult day care services, chore services (home maintenance help), counseling service, employment services, home delivered meals service, homemaker service, employment services, housing, life skills education services, protective services, service planning/case

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[212] House Bill 1439, P.N. 3629, referred to the Senate Banking and Insurance Committee on May 7, 2020. Two companion bills to this piece of legislation, House Bill 1438, P.N. 1776, and House Bill 1440, P.N. 1778 also call for insurance transparency. HB 1438 revises the disclosure requirements of companies and HB 1440 mandates companies provide notice of addiction treatment coverage under the plan and how to access it. Both bills were referred to the House Insurance Committee on May 8, 2019, where they remain.

[213] House Bill 1696, P.N. 3630, referred to Senate Banking and Insurance Committee May 7, 2020.

management services, and transportation services. Funding for mental health, intellectual disability and substance use disorder programs are funded via separate funding streams.[214] Other significant sources of funding for county human services programs are not included in the Block Grant. Examples of funding not included in the Block Grant are: Intellectual Disabilities Waiver programs, Behavioral Health HealthChoices Program, Early Intervention Services, and County Child Welfare Needs-Based funded services.[215]

Human Services Block Grants

Counties have the option of participating in the Human Services Block Grant program, which is designed to allow counties to move funds between allocations to meet the needs of their county. The funds within the Block Grant include:

- Mental Health Community Base Funded Services

- Behavioral Health Services Initiative

- Intellectual Disabilities Community Base Funded Services

- Act 152 Drug and Alcohol Services

- Homeless Assistance Program Funding

For fiscal year 2017-2018 (the most recent report available) 36 counties were participating in the Human Services Block Grant program:[216:]

Allegheny	Crawford	Lancaster	Potter
Beaver	Cumberland	Lebanon	Schuylkill
Berks	Dauphin	Lehigh	Tioga
Blair	Delaware	Luzerne	Venango
Bucks	Erie	McKean	Washington
Butler	Franklin	Montgomery	Wayne
Cambria	Fulton	Northampton	Westmoreland
Centre	Greene	Northumberland	Wyoming
Chester	Lackawanna	Perry	York

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[214] "Human Services Development Fund," *Pennsylvania Department of Human Services*, accessed June 29, 2020, https://www.dhs.pa.gov/about/DHS-Information/Pages/Human-Services-Developmental-Fund.aspx.

[215] "Human Services Block Grants," *PA Department of Human Services*, accessed June 29, 2020, https://www.dhs.pa.gov/docs/Block-Grants/Pages/default.aspx#:~:text=%20The%20funds%20within%20the%20Block%20Grant%20include%3A,6%20Human%20Services%20Development%20Funds%20%28HSDF%29%20More%20.

[216] *Report of the Expenditures of Block Grant Funds by County Governments, Human Services Block Grant Program, 2017-2018 Fiscal Year*, (PA Department of Human Services, 2017-2018), https://www.dhs.pa.gov/docs/Block-Grants/Documents/CP%2017-18/2017-18BlockGrantReport_ERPfinal_Jan27.pdf.

Mental health and substance use disorder funding has been chronically underfunded for decades. The last budget increase in Pennsylvania occurred in 2009, and funding was cut by 10 percent across the board in fiscal year 2012-2013. As the need and desire for community services has continued to increase, sustained higher levels of funding are necessary.[217]

SAMHSA is responsible for two federal block grant programs that provide funding to states to assist in providing mental health and substance use disorder services. The Community Mental Health Services Block Grant (MHBG) provides funds and technical assistance to provide comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system. The Substance Abuse Prevention and Treatment Block Grant (SABG) program provides funds and technical assistance to plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health. During the period 2005-2015, SABG did not keep up with health care inflation, resulting in a 24 percent decrease in actual funding since 2009.[218] Pennsylvania has consistently received approximately $58 million per year in SABG funding since 2014 with no increases. MHBG funding ranged between $16 million and $18 million between 2014 through 2017, but has averaged $23 million in 2018 and 2019.[219]

A recent article pointed out that although various areas of human services have received federal Covid-19 funding, special funding has not been allocated to Medicaid providers, leaving many in a financially precarious position.[220] In June 2020, the U.S. Department of Health and Human Services announced that it would distribute approximately $15 billion to eligible providers that participate in state Medicaid and CHIP programs and an additional $10 billion to safety net hospitals (Disproportionate Share Hospitals, or DSH).[221]

Rural and safety net hospitals have also experienced funding shortfalls. A 2017 report indicated that in 2016, Pennsylvania's 42 rural hospitals are at risk, with 56 percent experiencing negative total margins, 27 percent operating at 0.1 percent to 4 percent margins, and 17 percent with margins of 4.1 percent to 8 percent. Concerns were expressed

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[217] RCPA, "RCPA Members Advocating to Restore FY 12/13 County MH Budget Cuts," last modified October 18, 2019, http://www.paproviders.org/rcpa-members-advocating-to-restore-fy-1213-county-mh-budget-cuts/.

[218] National Association of State Alcohol and Drug Abuse Directors, "Dear Colleague Letter on SAPT Block Grant," March 26, 2019, https://nasadad.org/2019/04/dear-colleague-letter-on-sapt-block-grant/ https://www.samhsa.gov/grants-awards-by-state?year=2019

[219] SAMHSA, Grant Awards by State, accessed July 19, 2020, https://www.samhsa.gov/grants-awards-by-state?year=2019

[220] Julie Rovner, "Medical Providers at the End of the Line for Federal COVID Funding," *Kaiser Health News,* last modified May 18, 2020, https://khn.org/news/medicaid-providers-at-the-end-of-the-line-for-federal-covid-funding/.

[221] U.S. Department of Health and Human Services, "HHS Announces Enhanced Provider Portal, Relief Fund Payments for Safety Net Hospitals, Medicaid & CHIP Providers," Press Release, (June 9, 2020), https://www.hhs.gov/about/news/2020/06/09/hhs-announces-enhanced-provider-portal-relief-fund-payments-for-safety-net-hospitals-medicaid-chip-providers.html.

over mounting federal funding cuts. Recommendations included maintenance of federal payments designed to support financial challenges of rural hospitals, the expansion of telehealth, regulatory flexibility in workforce, and length of stay limitations.[222]

Much of the concern about additional federal cutbacks has been attributed to the Affordable Care Act's passage in 2010. Intended to extended health care coverage through Medicaid expansion efforts and affordable commercial health insurance, the act assumed that this would mean less hospital spending on charitable care and accordingly made cuts to those funds. Actions to make Medicaid expansion optional for states and ultimately removing the requirement that everyone enroll in an insurance plan left many people uninsured and in need of the type of charitable care that would no longer be funded at the pre-ACA levels. This $4 billion dollar cut to DSH (rural and safety-net hospitals) in the first year and $8 billion for the following four years[223] has been delayed by the CARES Act of 2020 for the fifth time and currently is scheduled to take effect December 1, 2020.[224] Federal legislation was introduced in 2019 to eliminate the DSH cuts completely. The bill was the subject of subcommittee hearings on June 4, 2019.[225] Additional legislation was introduced and referred to committee in April 2020 that would provide temporary increases to DSH funding during the Covid-19 period.[226]

Pennsylvania has 41 hospitals designated as safety net hospitals under federal definitions.[227] They include:

Hospital Name	County
UPMC Children's Hospital of Pittsburgh	Allegheny
UPMC Presbyterian Shadyside	Allegheny
UPMC Mercy	Allegheny
UPMC Magee Women's Hospital	Allegheny
UPMC McKeesport	Allegheny
Reading Hospital	Berks

Hospital Name	County
Lower Bucks Hospital	Bucks
St. Luke's Quakertown Campus	Bucks
Geisinger Bloomsburg	Columbia
Meadville Medical Center	Crawford
Penn Highlands Dubois	Crawford
Penn State Milton S. Hershey Medical Center	Dauphin

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[222] "Pennsylvania Rural Communities and Hospitals in Distress," *HAP*, last modified October 2017.

[223] Rich Daly, "A 5-Month Delay of the DSH Payment Cut is Among New Federal Budget Provisions," *Healthcare Financial Management Association*, last modified December 19, 2019, https://www.hfma.org/topics/news/2019/12/a-5-month-delay-of-the-dsh-payment-cut-is-among-new-federal-budget-provisions.html.

[224] CARES Act, § 3813, amending 42 USC §1396r-4(f)(7).

[225] H.R. 3022 (116th Cong. 2019-2020) known as the Patient Access Protection Act.

[226] H.R. 6584 (116th Cong. 2019-2020)

[227] "Safety-Net Hosptials Map," *Safety-Net Association of Pennsylvania*, accessed June 29, 2020, https://pasafetynet.org/about-us/safety-net-hospitals-map.html.

Hospital Name	County		Hospital Name	County
Crozier-Chester Medical Center Upland	Delaware		UPMC Susquehanna Sunbury	Northumberland
Delaware County Memorial Hospital	Delaware		Albert Einstein Medical Center	Philadelphia
Mercy Fitzgerald Hospital	Delaware		Children's Hospital of Philadelphia	Philadelphia
Millcreek Community Hospital	Erie		Hospital of the University of Pennsylvania	Philadelphia
Highlands Hospital	Fayette		Mercy Philadelphia	Philadelphia
Uniontown Hospital	Fayette		Penn Presbyterian Medical Center	Philadelphia
Washington Health System	Greene		Pennsylvania Hospital	Philadelphia
Penn Highlands Huntingdon	Huntingdon		St. Christopher's Hospital for Children	Philadelphia
Moses Taylor Hospital	Lackawanna		Temple University Hospital	Philadelphia
Lehigh Valley Hospital	Lehigh		Thomas Jefferson University Hospital	Philadelphia
St. Luke's Sacred Heart Campus	Lehigh		Lehigh Valley Hospital Schuylkill South	Schuylkill
Bradford Regional Medical Center	McKean		UPMC Somerset	Somerset
Lehigh Valley Hospital Pocono	Monroe		Warren General Hospital	Warren
Einstein Medical Center	Montgomery		Wellspan York	York
Geisinger Medical Center	Montour			

Special Funding

Senate Bill 1148, Printer's No. 1685, allocates $11,350,000 of Pennsylvania's federal appropriation for Covid-19 relief for mental health services. The bill received second consideration in the Senate on May 12, 2020, and then was re-referred to the Senate Appropriations Committee.

A number of communities in various states have established psychiatric emergency response models that address crisis intervention needs and diversion from inpatient hospitalization, alternative treatment facilities and programs, provider access, and integrated care. This chapter will look at models from these states and similar efforts currently occurring in Pennsylvania.

Use of Integrated Care Models

Integrated care is the "the systematic coordination of general and behavioral healthcare." In practice, this generally means having mental health care practitioners providing care in the same setting as primary care physicians, such that a patient can consult both practitioners in one visit. This can be accomplished through team-based care or through telephonic or Internet-enabled consultations (i.e. telepsychiatry). Primary care settings are often the first place people seek help for mental health problems, making the integration of mental health care with primary care an ideal way to increase the availability of mental health care to patients.[228]

There have been numerous studies investigating integrated care models, with these studies generally showing the effectiveness of these models in improving mental health care access and mental health outcomes as compared to usual primary care.[229] The volume of randomized controlled trials and other studies is so great that literature reviews may provide better examples of the benefits of integrated care. One review of the existing literature looked at whether integrated mental health and primary care for children and adolescents improved mental health outcomes as compared to usual models of care. The study authors concluded that "[b]enefits of integrated medical-behavioral treatment were observed for interventions that target diverse mental health problems (depression, anxiety, and behavior)," calculating a 73 percent probability that a randomly selected youth would have a better outcome after receiving integrated care than a randomly selected youth receiving usual care. The authors came to this conclusion after reviewing 31 studies and completing their own statistical analysis. According to the authors, this is the first known

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[228] "What is Integrated Care?" *U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration*, accessed February 7, 2020, https://www.integration.samhsa.gov/about-us/what-is-integrated-care.

[229] Wayne Katon, Jurgen Unutzer, Kenneth Wells *et al.*, "Collaborative Depression Care: History, Evaluation and Ways to Enhance Dissemination and Sustainability," *General Hospital Psychiatry* 32, no. 5 (September/October 2010): 456-464, DOI: 10.1016/j.genhosppsych.2010.04.001.

meta-analysis of the effects of integrated mental health and primary care in the adolescent population.[230]

Another study examined data from 79 randomized controlled trials of integrated care for patients with depression or anxiety. The data analyzed consisted of 24,308 patients in total. The researchers discovered "significantly greater improvement in depression outcomes for adults with depression treated with the collaborative care model in the short-term … and long-term," as well as "significantly greater improvement in anxiety outcomes for adults with anxiety treated with the collaborative care model in the short-term … medium-term … and long-term."[231] In this study the authors use the term "collaborative care," which is effectively a synonym of "integrated care." However, the National Institute of Mental Health separately defines "collaborative care" as a form of integrated care which "adds two new types of services to usual primary care: behavioral health care management and consultations with a mental health specialist."[232]

Studies typically used a qualitative metric, such as the PHQ-9 (a 9- question survey given to patients to measure the presence and severity of depression), to gauge the effectiveness of integrated care models.[233] For instance, a study of an integrated model where mental and medical health care needs were "coordinated by co-locating a Behavioral Health Consultant (BHC) within a primary care setting" concluded that the model led to improvement in the condition of mood disordered patients. This was determined by giving PHQ-9 depression screening surveys to existing primary care patients before and after the introduction of the integrated care model.[234]

Another study, evaluating the cost-effectiveness of a collaborative treatment program as compared to usual primary care for outpatients with depression and poorly controlled diabetes mellitus or coronary heart disease, found that the patients treated in the collaborative treatment program had lower mean outpatient costs and markedly improved quality-adjusted life-years than patients treated with usual primary care. The study followed 214 adults over a period of 24 months and evaluated depressive symptoms, systolic blood pressure, low-density lipoprotein cholesterol, and hemoglobin A1c levels at 12 and 24 month intervals.[235]

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[230] Joan Rosenbaum Asarnow *et al*., "Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health, A Meta-Analysis," *JAMA Pediatrics* 169, no. 10 (October 2015): 929-937, DOI: 10.1001/jamapediatrics.2015.1141.

[231] Janine Archer *et al*., "Collaborative Care for Depression and Anxiety Problems," *The Cochrane Database of Systematic Reviews* (Oct. 17 2012).

[232] "Integrated Care," *U.S. Department of Health and Human Services, National Institute of Mental Health*, accessed February 10, 2020, https://www.nimh.nih.gov/health/topics/integrated-care/index.shtml.

[233] The PHQ-9 is a patient questionnaire used for screening, diagnosing, monitoring, and measuring the severity of depression. "The Patient Health Questionnaire (PHQ-9)," *Center for Quality Assessment and Improvement in Mental Health*, accessed April 20, 2020, http://www.cqaimh.org/pdf/tool_phq9.pdf.

[234] Bill McFeature and Thomas W. Pierce, "Primary Care Behavioral Health Consultation Reduces Depression Levels among Mood-Disordered Patients," *Journal of Health Disparities Research and Practice* 5, no. 2 (Summer 2012): 36-44.

[235] Wayne Katon *et al*., "Cost-Effectiveness of a Multicondition Collaborative Care Intervention — A Randomized Controlled Trial," *Archives of General Psychiatry* 69, no. 5 (May 2012): 506-514, DOI: 10.1001/archgenpsychiatry.2011.1548.

Impediments to wider adoption of integrated care models are generally not driven by questions surrounding its clinical efficacy but rather practical concerns about its implementation and financial reimbursement for services. In the words of one study researching organized efforts to disseminate integrated care models, providers "need predictable ways to cover program startup and operational costs" as well as technical and institutional support that helps their practices change how the health care providers work.[236] In an effort to support implementation of integrated care models by providers, several regional and national purchasing and quality improvement collaboratives have been organized. These include the Pittsburgh Regional Health Initiative, Institute for Clinical Systems Improvement, The California Endowment's Integrated Behavioral Health Project, and the John A. Hartford Foundation.[237]

The U.S. Department of Veterans Affairs (VA) has been utilizing an integrated care model for over a decade, adding several hundred staff to transition to collaborative care for depression in its primary care clinics throughout the VA system. Kaiser Permanente has been able to successfully implement integrated behavioral care into its primary care system for patients with cardiovascular and other chronic medical conditions in southern California. However, researchers have conceded that smaller providers who bill a large number of different health insurance plans in a fee-for-service model have had a more difficult time with the integrated care model and that this model of care works best in large capitated health care organizations like the VA or Kaiser Permanente.[238]

Integrated care models are not new, and they are being implemented by some providers — with reportedly successful outcomes — around the Commonwealth. For instance, Children's Hospital of Philadelphia (CHOP) co-locates its primary care and behavioral care practitioners within one practice setting. Currently, six offices have been integrated this way. According to CHOP, this integrated care model is "convenient for families and reduces stigma."[239]

Medicaid Health Homes

Established by the Affordable Care Act of 2010, Medicaid Health Homes are "an optional Medicaid State Plan benefit for states … to coordinate care for people with Medicaid who have chronic conditions."[240] People who have one "serious and persistent mental health condition" are eligible to participate in a Medicaid Health Home, and participating states can target the Health Home model to particular geographic areas. Health Home services include:

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[236] Katon, "Collaborative Depression Care."

[237] *Ibid.*

[238] *Ibid.*

[239] Innovative Solutions at CHOP are Removing Barriers to Mental Health Care," *Children's Hospital of Philadelphia,* last modified June 18, 2018, https://www.chop.edu/news/innovative-solutions-chop-are-removing-barriers-mental-health-care.

[240] "Health Homes," *Centers for Medicare and Medicaid Services*, accessed February 11, 2020, https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html.

- Comprehensive care management;

- Care coordination;

- Health promotion;

- Comprehensive transitional care/follow-up;

- Patient and family support; and

- Referral to community and social support services

States that participate in the Medicaid Health Home option receive a 90 percent enhanced Federal Medical Assistance Percentage for the Health Home services provided, although the match does not apply to the underlying Medicaid services also provided to people enrolled in a Health Home.[241] As of fiscal year 2019, Pennsylvania does not participate in the Medicaid Health Home option.[242]

Centers for Excellence

A Center for Excellence is a unit within a healthcare organization which provides "exceptionally high concentrations of expertise and related resources centered on particular medical areas and delivered in a comprehensive, interdisciplinary fashion."[243] In 2016, the Commonwealth introduced a Centers of Excellence for Opioid Use Disorder program. The Pennsylvania DHS selected 45 centers including primary care practices, hospitals, Federally Qualified Health Centers, substance use disorder treatment facilities, and single county health authorities to "engage the community to identify all persons with OUD and make sure every person with OUD achieves optimal health." The Centers of Excellence are charged with taking care of the whole person's health, including mental health and physical health diagnoses. Each person with an OUD is also provided a peer for support to walk them through each step of the recovery process. Further, each of the 45 Centers of Excellence use community-based care management teams consisting of licensed clinical social workers, nurses, certified recovery specialists, peer navigators, care mangers, and physicians.[244]

[241] *Ibid.*

[242] "States That Reported Health Homes in Place, SFY 2015-2019, Pennsylvania," *Kaiser Family Foundation*, accessed July 15, 2020, https://www.kff.org/medicaid/state-indicator/states-that-reported-health-homes-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[243] James K. Elrod and John L. Fortenberry, Jr., "Centers of Excellence in Healthcare Institutions: What are They and How to Assemble Them," *BMC Health Services Research* 17, Suppl. 1 (Jul. 11, 2017): 425.

[244] "Centers of Excellence," *Pennsylvania Department of Human Services*, accessed May 7, 2020, https://www.dhs.pa.gov/Services/Assistance/Pages/Centers-of-Excellence.aspx.

Certified Community Behavioral Health Clinics (CCBHCs)

Certified Community Behavioral Health Clinics (CCBHCs) were created through Section 223 of the Protecting Access to Medicare Act (PAMA), which established a demonstration program based on the Excellence in Mental Health Act. The Excellence in Mental Health Act demonstration program – also known as the Excellence Act or the Section 223 demonstration program – is an initiative to expand Americans' access to mental health and addiction care in community-based settings.[245]

There are more than 200 CCBHCs operating in 33 states. This includes 66 CCBHCs in the eight states selected for the original Medicaid demonstration program: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon and Pennsylvania. Since 2018, Congress has appropriated yearly funds for two-year CCBHC Expansion Grants. Sixty-three grantees (including 16 that are also original Medicaid demonstration participants) are currently operating in 21 states: the eight demonstration states plus Colorado, Connecticut, Indiana, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, North Carolina, Rhode Island, Texas and Virginia.

The Excellence Act established a federal definition and criteria for CCBHCs and stipulated that they may receive an enhanced Medicaid reimbursement rate based on their anticipated costs of care. CCBHCs are responsible for directly providing (or contracting with partner organizations to provide) nine required types of services:

- Crisis mental health services

- Screening, assessment and diagnosis, including risk assessment

- Patient-centered treatment planning

- Outpatient mental health and substance use services

- Primary care screening and monitoring of key health indicators/health risk

- Targeted case management

- Psychiatric rehabilitation services

- Peer support and family supports

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[245] "CCBHC," *National Council for Behavioral Health*, accessed July 15, 2020, https://www.thenationalcouncil.org/topics/certified-community-behavioral-health-clinics/#:~:text=Certified%20Community%20Behavioral%20Health%20Clinics%20%28%20CCBHCs%29%20were,mental%20health%20and%20addiction%20care%20in%20community-based%20settings.

- Intensive, community-based mental health care for members of the armed forces and veterans[246]

The original organizations that were part of the initial 2016 pilot in Pennsylvania are:

- Berks Counseling Center, Berks County

- CenClear Child Services, Clearfield and Jefferson Counties

- Northwest Treatment Centers (NET Centers), Philadelphia County[247]

- Pittsburgh Mercy, Allegheny County

- Resources for Human Development (RHD), Montgomery County

- The Guidance Center, McKean County[248]

Under Section 3814 of the CARES Act of 2020, additional funding became available for CCBHCs. SAMHSA awarded grants totally $12 Million to five of the original Pennsylvania CCBHCs including $2M to a new participant, Wellspan York, to expand CCBHCs in response to the Covid-19 pandemic.[249]

Keystone Initiative for Network Based Education and Research

The Keystone Initiative for Network Based Education and Research, or KINBER, is the information technology provider for many of the Commonwealth's social services organizations. A non-profit, it provides "network-based connectivity and services to over 135 organizations and programming to many more, including higher education, K12, healthcare, communities, libraries, public media, museums, government, non-profit organizations, as well as commercial organizations consistent with its mission." KINBER is "Pennsylvania's only statewide research, education, and community network."[10]

Comprehensive Psychiatric Emergency Program, New York

In 1982, New York developed the Comprehensive Psychiatric Emergency Program (CPEP) to combat an increase of psychiatric patients in the ED at hospitals throughout New York. The system focused on providing "coordinated and comprehensive emergency

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[246] *Ibid.*

[247] Name changed to Merakey Delaware County in 2018-"About Our Organization," *Merakey*, accessed July 15, 2020, https://www.merakey.org/about.html.

[248] "CCBHC," *Pennsylvania Department of Human Services*, accessed June 29, 2020, https://www.dhs.pa.gov/providers/Providers/Pages/CCBHC.aspx.

[249] U.S. Department of Health and Human Services, "SAMHSA Awards Grants Expanding Community-Based Behavioral Health Services, Strengthens Covid-19 Response," Press Release, (April 27, 2020), https://www.hhs.gov/about/news/2020/04/27/samhsa-awards-grants-expanding-community-based-behavioral-health-services-strengthens-covid-19.html.

service" to psychiatric patients.[250] CPEPs provide comprehensive psychiatric support, which ranges from triage in the hospital emergency department, to observation beds at the hospital that can be occupied for up to 72 hours, to community "crisis outreach services," to residential treatment for up to five days in the community.[251]

When a psychiatric patient enters an ED with a CPEP, they are triaged by a trauma team which must include a physician in order to properly diagnose and treat the patient based on their symptoms. CPEP also attempts to track "high priority" patients—those who are not a danger to themselves or others but have a risk of being readmitted without follow-up care—to reduce their chances of coming back to the ED.[252] In the Extended Observation Unit (EOU), patients can be held and stabilized for up to 72 hours, which allows for more accurate diagnoses and more specifically tailored treatments. It also gives the staff time to make preparations for discharge to ensure that patients are given support as they reenter the community. Most of the patients utilizing EOU were those with SUDs. The 72 hours was helpful in allowing the patients to come down from their intoxication so that they could be safely transferred to a facility that could handle their specific symptoms.[253]

In the community, CPEP utilizes a Mobile Crisis Unit (MCU) to follow up with discharged patients as well as bring in patients from the community who need care from CPEP. Beyond the MCU, CPEP also includes crisis residence services where patients are able to reside for up to five days to receive continuing treatment. The residential services are difficult to fund as they are not covered by Medicaid and thus they are not utilized by hospitals as often as the other elements of CPEP. From October 2011 to September 2012, EDs with CPEP were able to triage 85 percent of patients within an hour of their arrival. 49 percent were discharged within six hours and 68 percent of the patients who did get admitted to EOU were released within 48 hours.[254] According to the New York City Department of Health, approximately two dozen mobile crisis teams exist in the city and they are available in the Bronx, Brooklyn, Manhattan, and Queens.[255]

Rhode Island Continuum of Care

A Special Senate Commission appointed by the Rhode Island State Senate to study Rhode Island Emergency Department Room Diversion reported its findings to the Senate in 2012. The Commission recommended "state-wide care partnerships to enhance patient-centered systems of care."[256] A "comprehensive continuum of care" would reduce the need

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[250] *2012 Annual Report to the Governor and Legislature of New York State on Comprehensive Psychiatric Emergency Programs*, New York State Office of Mental Health, accessed January 3, 2020, https://www.omh.ny.gov/omhweb/statistics/cpep_annual_report/2012.pdf.

[251] *Ibid.*

[252] Anne Marie Sullivan and James Rivera, "Profile of a Comprehensive Psychiatric Emergency Program in a New York City Municipal Hospital," *Psychiatric Quarterly* 71, no. 2 (Summer 2000): 123-138, https://link-springer-com.ezproxy.liberty.edu/content/pdf/10.1023/A:1004624319072.pdf.

[253] *Ibid.*

[254] *2012 Annual Report*, Office of Mental Health.

[255] "Crisis Services/Mental Health: Mobile Crisis Teams," *NYC Health*, accessed June 7, 2020, https://www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-mobile-crisis-teams.page.

[256] *2012 Annual Report*, Office of Mental Health.

for substance use patients to be treated in the ED.[257] The Commission specifically referenced the "Cambridge and Somerville Program for Alcoholism and Drug Rehabilitation (CASPAR, Inc)," which utilizes patient-centered relapse and recovery treatment and has a variety of mobile services that allow for outreach into the community.[258] Replicating such a system of care would be beneficial for diversion from EDs, but the facilities would have to be equipped to support the needs of patients who are intoxicated or under the influence. This could present additional challenges to making such a facility operational with limited funds.[259]

An additional recommendation was a pilot program that would train first responders such as law enforcement and healthcare providers in how to handle a patient who will not go willingly to treatment or an ED, and also implement a tool that would assess mental health in an attempt to predict suicidal behavior. A standardized assessment tool would allow healthcare providers and emergency responders across the state to make an objective decision regarding the continuing treatment of a patient. One such assessment tool that could be implemented is the Columbia-Suicide Severity Rating Scale (C-SSRS).[260]

Rhode Island EMS protocol was also revised to include consideration for alternative mental health and opioid use disorder facilities if the patient is stable enough for the transport to occur. If an emergency responder encounters a patient with a substance use disorder that can be stabilized with adequate ventilation, or a patient presenting "acute exacerbation of their condition" but not presenting danger to themselves or others, the responder should "consider transport to the recovery navigation program or mental health and opioid use disorder facility."[261] Before making this determination, the first responder should follow an "Alternative Transportation Algorithm," which is included in Rhode Island's EMS protocol and ensures that the patient is stable enough to be diverted from the ED.[262]

The Rhode Island Commission also recommended creating a pilot program that would allow patients who are under the influence to be examined outside of the ED setting if possible. The language of *Rhode Island General laws 23-1.10.10. Treatment and services for intoxicated persons and persons incapacitated by alcohol*, was amended to use the term "approved public treatment facility" instead of "emergency department."[263] This allows patients to be transferred to an alternative facility approved by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals and diverted from the emergency department while still under the influence or intoxicated.[264]

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[257] *Ibid.*

[258] *Ibid.*

[259] *Ibid.*

[260] *Ibid.*

[261] Rhode Island Ambulance Service Coordinating Advisory Board, "Rhode Island Statewide Emergency Medical Services Protocol," January 2020, accessed December 18, 2019, https://health.ri.gov/publications/protocols/StatewideEmergencyMedicalServices.pdf.

[262] *Ibid.*

[263] R.I. Gen. Laws § 23-1.10-10.

[264] *Special Senate Commission to Study Rhode Island Emergency Department Room Diversion*, Rhode Island State Senate, (Providence, Rhode Island: Rhode Island State Senate, February 16, 2012),

Arizona Regional Behavioral Health Authorities

A 2015 report by the Arizona Hospital and Healthcare Association on psychiatric boarding in Arizona provided recommendations for reducing boarding and lengths of stay. The study noted that Arizona's Regional Behavioral Health Authorities were attempting to move toward an integrated care model, which would place emphasis on both physical and mental health. These programs would be incentivized to provide better comprehensive care to patients because they assume more financial responsibility for the patient's outcome. A more well-rounded behavioral health treatment plan for a patient ought to reduce the chance that they would need to be boarded in an ED for a severe behavioral health concern. The study also advocated for a behavioral center made especially for children and adolescents.[265]

The study mentioned that providers in Arizona are moving toward this integrated healthcare system by cooperating with other kinds of mental health facilities that can provide more individualized and precise treatment. One example of a different treatment type is Community Mobile Crisis Teams, which would provide a counselor who is trained to assess a patient in the field so that the patient can be immediately transported to the proper treatment facility instead of the ED. Diversity of providers can remove pressure from EDs and provide treatment to patients more efficiently. Providers can also invest in more beds and facilities to host psychiatric patients in crisis. The study also noted an upward trend in access to insurance, which allows hospitals to increase revenue and continue to invest in solving the problems posed by psychiatric boarding.[266]

New Jersey Clinical Facilitators

New Jersey enacted a statutory provision in 2010 that requires that a staff member of a hospital be designated to be notified when a patient over the age of eighteen in that hospital has been waiting for proper behavioral health treatment for more than 24 hours.[267] A staff member will also be appointed as a "clinical facilitator" who places the patient in the behavioral health facility that is best suited to meet the particular patient's needs.[268] The department must continually monitor the patient experience to ensure that patients are moving swiftly through the department and on to facilities that can better assist them, and create "objective criteria" that would allow the department staff to pinpoint what resources would be crucial to a faster flow of patients.[269] The act also requires the Commissioner of Human Services to communicate with the Department of Corrections, the Department of Health and Senior Services, the New Jersey Hospital Association, the Hospital Alliance of New Jersey, the New Jersey Council of Teaching Hospitals, and other local and statewide

http://www.rilin.state.ri.us/Reports/Report%20overall.pdf.

[265] Arizona Hospital and Healthcare Association, *Waiting for Care: Causes, Impacts and Solutions to Psychiatric Boarding in Arizona* (July 2015), accessed December 30, 2019,
http://www.mentalhealthportland.org/wp-content/uploads/2018/11/Waiting-for-Care-Causes-Impacts-and-Solutions-to-Psychiatric-Boarding-in-Arizona.pdf.

[266] *Ibid.*

[267] NJ Rev Stat § 30:4-177.60 (2018).

[268] *Ibid.*

[269] *Ibid.*

mental health organizations in order to craft further policy recommendations. The commissioner was required to report his findings to the Governor and the Senate within a year.[270]

Another provision of those 2010 enactments requires the commissioner to consult with groups that have expertise in behavioral health treatment to "develop standardized admission protocols and medical clearance criteria for transfer or admission of a hospital emergency department patient to a State or county psychiatric hospital or a short-term care facility."[271] Medical clearance does not indicate that the patient has no ongoing medical issues, it is a determination made in the context of transferring a patient from the ED to a more appropriate mental health or substance use disorder facility. The physician should have flexibility to make a determination based on clinical discretion, and should be in communication with the physician at the receiving facility.[272] Communication between the hospitals and facilities was recommended, on issues of both patient satisfaction and logistics. The Emergency Medical Treatment and Labor Act (EMTALA) definition for stabilization must be adhered to, which requires that "a patient must be medically stable for transfer or that the benefits of transfer outweigh the risk."[273] A system that categorizes all available psychiatric care and the specific qualifications for each one is also recommended. The recommendations also clearly define the fine points of the medical clearance exam.[274]

Massachusetts College of Emergency Physicians Medical Clearance Recommendations

The Massachusetts College of Emergency Physicians gave official approval of Joint Task Force Consensus Guidelines on medical clearance, warning that the term medical clearance may provide false security to a patient. As stated previously, medical clearance indicates there are no short-term medical emergencies, but does not guarantee this medical stability long term. The physician granting medical clearance should be certain that the root of the presenting psychiatric patient's complaint is not medical, there is not a medical emergency, and the patient is stable enough for transfer to a psychiatric facility.[275] This clearance does not indicate the patient has no ongoing or undiagnosed medical issues.

The task force formulated "Criteria for Psychiatric Patients with Low Medical Risk," which included,

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[270] *Ibid.*
[271] NJ Rev Stat § 30:4-177.61 (2018)
[272] "Consensus Statement Medical Clearance Protocols for Acute Psychiatric Patients Referred for Inpatient Admission," New Jersey Hospital Association and New Jersey Chapter of American College of Emergency Physicians, accessed December 19, 2019,
http://www.njha.com/media/33107/ClearanceProtocolsforAcutePsyPatients.pdf.
[273] *Ibid.*
[274] *Ibid.*
[275] Massachusetts College of Emergency Physicians and Massachusetts Psychiatric Society, "The Medical Clearance Exam," accessed December 18, 2019, https://www.acep.org/globalassets/uploads/uploaded-files/acep/advocacy/state-issues/psychiatric-hold-issues/ma-medical-clearance-guidelines-toxic-screen-ma.pdf.

Age between 15 and 55 years old, no acute medical complaints, no new psychiatric or physical symptoms, no evidence of a pattern of substance (alcohol or drug) abuse, normal physical examination that includes at the minimum: a. normal vital signs (with oxygen saturation if available.), b. normal (age appropriate) assessment of gait, strength and fluency of speech, c. normal (age appropriate) assessment of memory and concentration.[276]

The task force recommended that those who meet this criteria not be diagnostically screened, and those who do not meet this criteria have a more in-depth medical evaluation, but not be immediately considered high risk.[277] Once a patient is medically cleared and transferred to a psychiatric facility, the facility may request that the ED provide additional laboratory testing, but only if it will directly contribute to the continuing treatment of the patient during their time in the facility. The timing of the psychiatric evaluation should be subject to clinical judgement, not based on receiving results from laboratory tests, which can add excess delay to processing the patient.[278]

The physician should endeavor to place the patient in the facility that is best suited to their medical needs. In order to facilitate this process, the task force recommended compiling a list of all the facilities in Massachusetts that includes the different capabilities of each one that a physician could reference quickly. Once a facility is chosen, the task force finds that it is beneficial to have direct communication between the physician who made the determination and the psychiatrist at the receiving facility.[279] This communication was crucial regarding: "a. the need for an inpatient psychiatric hospitalization; b. the appropriateness of one facility versus another; c. a request for certain diagnostic testing; d. any general clinical disagreement; e. significant ongoing medical issues or treatment recommendations."[280]

Regional Dedicated Psychiatric Facilities

In a sense, every mental health facility is "regional" in the sense neighboring communities naturally are drawn to the closest facility for treatment, and insurance provider networks create a form of regionalism. However, purposeful coordination and referral of all persons in need to treatment to a central facility where they can be appropriately evaluated and directed to follow-up treatment has been a relatively new development.

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[276] *Ibid.*

[277] *Ibid.*

[278] *Ibid.*

[279] *Ibid.*

[280] *Ibid.*

Children's [281]Hospital of Philadelphia (CHOP) Children's Intensive Emotional and Behavioral Services

CHOP provides Children's Intensive Emotional and Behavioral Services (CIBES), which is a partial psychiatric hospitalization for children in "a trauma-informed, behaviorally based therapeutic setting." The services of CIBES appear to be limited to children from the Atlantic, Cape May, Cumberland and Ocean Counties of New Jersey, however.[282]

Alameda County, California

While police in California normally take patients in crisis directly to the Emergency Department (ED) with an involuntary hold, Alameda County employs a different method in which the police summon EMS to their location where a patient is in crisis. The EMS workers arrive at the scene, assess the patient, then take them immediately and directly to a Psychiatric Emergency Service (PES), or Emergency Psychiatric Assessment, Treatment and Healing (EmPATH) unit if necessary. These centers consist of a large open space where patients are housed together in a room with high ceilings, ambient light, recliners for each patient instead of beds, and food, drinks and other ways to stay entertained are accessible to the patients. Symptoms that would cause a patient to be sent to the ED instead include "age (older than 65), a medical complaint, depressed level of consciousness, a heart rate of higher than 120, glucose below 60 or above 250, or blood pressure of above 190/110."[283]

A study of the success of this program using data from all adult EMS encounters from November 2011-2016 found that out of 22,074 involuntary holds that were diverted to a PES, only 60 were considered failed diversions, meaning they had to be taken to a medical emergency department within twelve hours of admission. 54 of these 60 were a result of new symptoms the developed at the PES, while 6 were designated "true protocol failures."[284] After the implementation of this protocol, in Alameda County the average psych patient boarding length of stay was one hour and forty-eight minutes compared to the California average of ten hours and three minutes.[285]

The use of PEM or EmPATH units provides benefits to both the patient and the hospital. The patient receives immediate care in a calm environment in stark contrast to the ED. The team that tends to patients is specially trained to help connect the patient to resources outside of the unit and provide individualized planning and treatment for each patient, which reduces the chance of that patient returning to the ED in crisis on another occasion. The hospital benefits from relieving the pressure in EDs and making space for

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[281] "About," *Kinber*, accessed May 1, 2020, https://kinber.org/about/.

[282] "Children's Intensive Emotional and Behavioral Services," *Children's Hospital of Philadelphia*, accessed May 1, 2020, https://www.chop.edu/centers-programs/childrens-intensive-emotional-and-behavioral-services.

[283] Tarak Trivedi and Scott Zeller, "Improving Care in Psychiatric Emergencies: Focus on Structure of Care Delivery," (EMSAAC).

[284] *Ibid.*

[285] *Ibid.*

other patients with critical physical needs. With the implementation of these units, there can be up to an 80 percent reduction in admissions to the ED.[286] The Alameda model has come under fire since its inception with concerns about overcrowding in the waiting area contributing to safety concerns.[287]

Using the Alameda method, Providence Little Company of Mary Medical Center in San Pedro, California saw over 3,000 patients in 2018 and discharged 81 percent of patients with an average length of stay (LOS) of sixteen hours. There was also a 90 percent decrease in time boarding. The Psychiatric Stabilization Unit at the Billings Clinic in Montana used a separate calming space for psychiatric patients and experienced lower rates of patient recidivism by almost 50 percent and reduced the length of stay by more than five hours. Portland's Unity Center for Behavioral Health saw 79 percent of patients discharged after 20 hours, 70 percent less boarding time in EDs, and a twelve percent decrease in patients who are being discharged from inpatient care.[288]

Burke Mental Health Emergency Center, East Texas

The Burke Mental Health Emergency Center (MHEC) serves twelve rural counties in East Texas that are underserved and have a low percentage of the population insured. MHEC is the "first free-standing rural emergency program where psychiatric services are performed exclusively through telemedicine."[289] Like the stabilization units in California, the center does not use restraints and is not coercive. It is equipped with eight beds for involuntary patients and sixteen beds for voluntary patients. It is accredited by the Joint Commission and is one of many components of Burke, which is a mental health and developmental disability service provider in East Texas.[290]

Logistically, patients are accepted and admitted by registered nurses who perform telephone triage, or a mobile crisis team that can travel to a patient. The center gives priority to those patients coming from EDs or being brought in by law enforcement. The center is only able to accept certain kinds of patients, which eliminates the need for medical clearance at the center. The staff is specifically trained to handle a certain set of symptoms. Patients are triaged before arrival at the center and if they require medical clearance they will be transferred to the ED or held at the agency that brought in the patient until they can be assessed by a member of the Burke staff. The use of telemedicine allows the patients to be seen by an expert within half an hour of arrival and be checked on twice daily.[291] In response to the Covid-19 pandemic, the state of Texas temporarily waived restrictions on

[286] Zeller, Scott *et al*., "Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments," *The Western Journal of Emergency Medicine* 15, no. 1 (2014): 1-6. DOI:10.5811/westjem.2013.6.17848.

[287] Molly Harbarger, "Sales Pitch for Portland's Mental Health ER Omitted Numerous Red Flags", *The Oregonian,* last modified February 7, 2020, https://www.oregonlive.com/health/2020/02/portlands-psychiatric-er-troubles-echo-those-of-california-hospital-sold-as-a-best-practice.html.

[288] Trevedi and Zeller, "Improving Care."

[289] Avrim Fishkind and Susan Rushing, "Pushing Point of Service into the Community."

[290] *Ibid.*

[291] *Ibid.*

telehealth, allowing expansion of services and reimbursement for online appointments. A mental health hotline was also developed.[292]

In 2018, Burke had 1,115 patients who stayed at the center for an average of three and a half days. 84 percent of patients arriving at inpatient psych hospitals were diverted to MHEC, with fifteen percent of these patients eventually being transferred to inpatient psych hospitals. The remaining 69 percent were treated at MHEC. When patients leave MHEC, they have access to Burke's outpatient services and steps are taken to link them with proper medical care for comorbid conditions by the Burke Care Coordination team. The MHEC also meets periodically with the ED, LEOs, and Burke officials to discuss comprehensive solutions to the problems the community and the center are experiencing. As far as the perception by patients of the center, 88 percent said that care was improved and 84 percent considered themselves satisfied with the telemedicine service. The patients noted that the staff was well experienced for the roles, and the treatment was "trauma informed, recovery oriented." Patients also appreciated that Burke gives special consideration to care transitions.[293]

Michigan Medicine, the University of Michigan's medical center located in Ann Arbor, through its Department of Psychiatry, offers psychiatric emergency services for adult patients of Michigan Medicine. Emergency/urgent walk-in evaluations and crisis phone services are available 24/7. Services include psychiatric evaluation, treatment recommendations, crisis intervention, screening for inpatient psychiatric hospitalization, and mental health referral information.[294]

Crisis Response Services

The ability to respond quickly to persons in crisis, help to stabilize their condition and assist in appropriate follow-up referrals is vital to help ease the inflow of behavioral health patients to the emergency department.

Allegheny County resolve Crisis Services

Operated by UPMC, resolve Crisis Services (the lowercase "r" in the name is intentional) provides a 24-hour hotline, a mobile crisis team who can respond to a crisis anywhere in Allegheny County, and a walk-in center in Pittsburgh which also offers residential services for those who qualify. Resolve is free to Allegheny County Residents regardless of their ability to pay and is sponsored by Allegheny County and UPMC's

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[292] Raga Justin, "In Rural Texas, the COVID-19 Pandemic has Brought More Accessible Mental Health Care," *The Texas Tribune,* last modified June 9, 2020, https://www.texastribune.org/2020/06/09/coronavirus-texas-rural-mental-health-telehealth/.

[293] *Ibid.*

[294] "Emergency Mental Health and Psychiatry," Michigan Medicine, University of Michigan, accessed June 7, 2020, https://www.uofmhealth.org/conditions-treatments/emergency-mental-health-and-psychiatry.

Western Psychiatric Hospital. Resolve has a 150-member crisis team which provides crisis counseling, referral, and intervention services.[295]

Medical Mobile Crisis Units

Under the Mental Health and Intellectual Disability Act of 1966 each county mental health/disability service office is required to provide emergency response services.[296] Most of Pennsylvania's county mental health offices have mobile medical crisis units. Some of these units are called something other than "mobile crisis units" but their functionality is that of a mobile crisis unit. Some of the counties outsource this responsibility to private non-profit organizations. Montgomery, Lehigh, Northampton, Bucks, Philadelphia, Delaware, Dauphin, Westmoreland and Allegheny are some of the counties which advertise as having medical mobile crisis units.

Adult Residential Crisis Facilities

Pennsylvania's adult residential crisis facilities, also known as long term structured residences (LTSRs), are "highly structured therapeutic residential mental health treatment facility designed to serve persons 18 years of age or older who are eligible for hospitalization but who can receive adequate care in an LTSR."[297] LTSRs are run by private non-profit organizations which contract with each county and are licensed and regulated by the Department of Human Services (DHS). There were 35 LTSRs licensed by the DHS in Pennsylvania in 2015.[298] There are 37 such licensed LTSRs as of May 2020.[299]

Montgomery County Emergency Service

Montgomery County Emergency Service, Inc. (MCES) is a "a nonprofit behavioral health emergency service that meets the needs of persons experiencing a psychiatric emergency or serious mental health crisis in Montgomery County and adjacent communities on a 24/7 basis." MCES offers a crisis hot line, walk-in crisis center, acute inpatient psychiatric care, crisis residential program, and a psychiatric emergency medical service. MCES also assists local and state police in responding to calls involving persons with mental health symptoms.[300]

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[295] "Resolve Crisis Services," *UPMC*, accessed April 30, 2020,
https://www.upmc.com/services/behavioralhealth/resolve-crisis-services.
[296] §301(d)(4) of the act of October 20, 1966, Special Session 3 (P.L.96, No.6), known as the Mental Health and Intellectual Disability Act of 1966; 50 P.S. §4301(d)(4).
[297] 55 Pa. Code § 5320.2.
[298] Pennsylvania General Assembly, House Human Services Committee, Testimony of Denns Marrion and Julie Barley on the Department of Human Services' Mental Health Facilities Licensing Procedures, (April 9, 2015), https://www.legis.state.pa.us/WU01/LI/TR/Transcripts/2015_0054_0001_TSTMNY.pdf.
[299] "Directory," *Pennsylvania Department of Human Services, Bureau of Human Services Licensing*, accessed May 1, 2020,
https://www.humanservices.state.pa.us/HUMAN_SERVICE_PROVIDER_DIRECTORY/.
[300] "About MCES," *Montgomery County Emergency Service, Inc.*, accessed May 4, 2020,
http://www.mces.org/pages/about_main.php.

Crisis Stabilization Units

The University of Iowa Health Care (UIHC) opened a Crisis Stabilization Unit (CSU) in October of 2018 that can house twelve patients at a time. The space is used to stabilize patients with an active mental illness who are above the age of eighteen and are medically stable at the time of admission. The most important features of the CSU are the open space the patients are treated in, an open nursing station, and the use of recliners instead of beds. The unit also has two calming rooms where patients can stabilize individually if necessary.[302] The staff, which moves about the room freely and mingles with the patients in the CSU, will immediately assess a patient upon admission to the CSU. The staff then takes the necessary steps for treatment as soon as possible and also prepares the patient for release and equips them with tools for a safe transition back into their community. Patients that are not able to be treated in the CSU include those that are not medically stable, delirious, intoxicated by any substance, experiencing symptoms or withdrawal or needing detox, and prisoners that are currently in state custody.[303]

After the implementation of the CSU, the ED psych boarding hours fell from around 30 hours down to about nine hours. Boarding hours fluctuated in the next five months from three to eight hours. For the first six months of the CSU, in every month except for December over 70 percent of patients did not need to be transferred to psychiatric inpatient care.[304] UIHC did encounter some difficulties in the early months of the CSU. One was the discrepancy between medical clearances in psychiatry and emergency medicine. ED doctors are required to provide medical clearances for patients who come to the ED with psychiatric needs and a comorbid medical condition before they can be transferred to a psychiatric facility. Because there is not a standard definition for both ED doctors and psychiatrists, comorbidities are often overlooked in psychiatric patients in the ED.[305] UIHC staff was also initially overwhelmed by the amount of time discharge planning took. The initial goal of therapeutic interventions was temporarily overridden by this heavy demand for time and resources.

Maryhaven, a comprehensive behavioral health services provider specializing in addiction recovery headquartered in Columbus, Ohio opened a dedicated addiction stabilization center in the fall of 2017. The 57-bed facility provides crisis stabilization, detox and treatment. Five beds are dedicated to people who have recently suffered an overdose. The premise of those dedicated beds is that some persons experiencing an overdose and receiving emergency naloxone doses can appropriately go to the center rather than the emergency room. An update released in 2018 reported that approximately 1,100 people had come to the facility and around 1,000 of those chose to continue treatment. It was also reported that 30 pregnant women, many of who had not received any treatment

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[302] Levi Kannedy, "Crisis Stabilization Unit," May 8, 2019.

[303] *Ibid.*

[304] *Ibid.*

[305] Tori Rodriguez, "Medical Clearance of Psych Patients in the ED: Consensus Recommendations," Psychiatry Advisor, last modified June 22, 2018,
https://www.psychiatryadvisor.com/home/practice-management/medical-clearance-of-psych-patients-in-the-ed-consensus-recommendations/.

support previously in their pregnancies were able to receive assistance and deliver healthy babies.[306]

Emergency Triage, Treat, and Transport (ET3) Model

ET3 is a voluntary, five-year payment model that permits greater flexibility for ambulance care teams to address emergency health care needs of Medicare fee-for-service beneficiaries following a 911 call. The program is operated under the Centers for Medicare and Medicaid Services. The intent of the program is to reduce avoidable transports to the ED and unnecessary hospitalizations that can result from the transport. The model provides reimbursement for participating ambulance suppliers and providers for one of three actions in response to a 911 call:

- Transport to a hospital emergency department

- Transport to an alternative destination, such as a primary care office or urgent care facility

- Provide treatment on-site with the assistance of a qualified health care provider, either on the scene or using telehealth.

The model also encourages local government to with authority over 911 dispatches to establish a medical triage line for low-acuity 911 calls.[307]

The application period has been closed, but a final list of participants has not been released, and CMS announced that implementation had been move to Fall 2020 from the original start date of May 1, 2020. Five Pennsylvania EMS companies are among the applicants:

- City of Philadelphia Fire Department (Philadelphia County)

- Community LifeTeam EMS, Inc. (Dauphin and York Counties)

- Milton S. Hershey Medical Center (Berks, Dauphin, and Lebanon Counties)

- Second Alarmer's Association & Rescue Squad of Montgomery County, Inc. (Montgomery County)

- West Shore Advanced Life Support Services, Inc. (Columbia, Cumberland, Dauphin, Franklin, Luzerne, Montour, Northumberland, Schuylkill, and York Counties[308]

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[306] "Mary Haven Addiction Stabilization Center," *Mary Haven*, accessed June 7, 2020, https://maryhaven.com/addiction-stabilization-center/.

[307] "Innovation Center, Emergency Triage, Treat, and Transport (ET3) Model," *CMS.gov*, accessed June 29, 2020, https://innovation.cms.gov/innovation-models/et3.

[308] *Ibid.*

In 2018, the General Assembly amended Pennsylvania's insurance law to provide that managed care plans may not deny a claim by licensed emergency service agencies solely because the enrollee did not require transport or refused it.[309] However, there are concerns that this mandate is not applied uniformly by insurers and managed care organizations.

Wake County, North Carolina Advanced Practice Paramedics Program

The Wake County, North Carolina APP program was initiated in January 2009. Advanced practice paramedics are authorized to evaluate a patient along with other paramedics to determine if a person who is experiencing a mental health or substance abuse crisis with no other medical emergency can be redirected to treatment at an appropriate treatment facility, rather than a hospital ED. During one six-month period of the program, 167 patients were referred/diverted to non-ED facilities, which the program estimates freed approximately 2,400 bed-hours in local EDs.[310]

Peer Support

A Certified Peer Specialist (CPS) is, "a person who is willing to self-identify as a person with a serious behavioral health disorder… with lived experiences."[311] This person acts a support to peers who are moving through the recovery process. Their work with those in recovery, "is characterized by mutual trust and respect, sharing of experiences, and moving toward a more meaningful life in the community."[312] CSPs use their lived experience as a way to connect with and support peers in recovery.[313] CPSs work mostly one-on-one with peers, but some peers work with groups as well. This varies from program to program. Some of the most common activities of CPSs surveyed in 2010 included peer support, "encouragement of self-determination and personal responsibility, health and wellness, addressing hopelessness, communication with providers, illness management, addressing stigma in the community, developing friendships, leisure and recreation, education, transportation, and developing wellness recovery action plans."[314] Some other functions occasionally employed by CPSs included "family relationships… spirituality and

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[309] § 2116(b) of the act of May 17, 1921 (P.L. 682, No. 284), known as the Insurance Company Law of 1921, as added by the act of October 24, 2018 (P.L. 681, No. 103); 40 P.S. §991.2116.

[310] "Advanced Practice Paramedics," *WakeGOV*, accessed June 29, 2020,

http://www.wakegov.com/ems/about/staff/Pages/advancedpracticeparamedics.aspx.

[311] "Certified Peer Specialist Training," *DBHIDS*, accessed May 26, 2020,

https://dbhids.org/about/organization/strategic-planning-division/peer-culture-and-community-inclusion-unit/certified-peer-specialist-training/.

[312] *Ibid.*

[313] Wendy Kuhn, Jillian Bellinger *et al.*, "Integration of Peer Specialists Working in Mental Health Service Settings," *Community Mental Health Journal* 51 (2015): 453-458, DOI: 10.1007/s10597-015-9841-0.

[314] Mark S. Salzer, Edward Schwenk *et al.*, "Certified Peer Specialists Roles and Activities: Results from a National Survey," *Psychiatric Services* 61, no. 5 (2010): 520-523.

religion… and parenting."[315] CPSs encourage health and wellness for their peers and teach self-management as a method of prevention.[316]

One challenge with integrating CPSs into traditional medicine is balancing the non-traditional peer relationship with more traditional aspects of medicine like confidentiality and other patient-doctor boundaries. Peers can encounter difficulties in executing their work properly if their roles are not clearly and properly defined by their supervisor. It is also helpful for peers to be recognized as part of the team that provides care to a patient.[317] In cooperation with those providing medical care to a patient, CPSs can treat a peer with compassion and understanding and provide them with hope and inspiration as they move through treatment.[318]

To become certified to be a CPS in Pennsylvania, an applicant must first complete the Certified Peer Specialist Training and then receive credentials from the Pennsylvania Certification Board (PCB). The training program consists of 75 hours over two weeks, and teaches skills required to lend effective and useful peer support. These trainings can be offered in Pennsylvania only by the Institute for Recovery, RI Consulting, and the Copeland Center for Wellness and Recovery.[319] To receive credentials from the PCB, an applicant must take a 50-question, multiple-choice examination that includes content from SAMHSA's Core Competencies for Peer Workers in Behavioral Health Services. To pass the exam, the applicant must score at least a 37 out of 50. If an applicant fails the exam, they may retake it within a year of the date of their first attempt.[320]

In Pennsylvania, a survey of a 2004-2006 CPS initiative found that it had achieved its goals in recruiting peers as well as equipping them with training that allowed them to execute their function well. Pennsylvania's trainees showed an increase in knowledge of 22 percent from their entrance exam of twenty questions to their post-test of 60 questions. Ninety-seven percent of those who took the training became certified. Eighty-one percent of those who were able to be contacted after completing the training and receiving certification were working as a Peer Support Specialist within a year. Those who were working in the field reported high levels of job satisfaction and enjoyed a positive and supportive working environment.[321]

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[315] *Ibid.*

[316] "Peer Providers," *SAMHSA-HRSA Center for Integrated Health Solutions*, accessed May 27, 2020, https://www.integration.samhsa.gov/workforce/team-members/peer-providers#role%20of%20peer%20providers.

[317] Kuhn, "Integration of Peer Specialists."

[318] "Peer Providers," *SAMHSA-HRSA*.

[319] "Education," *Pennsylvania Peer Support Coalition*, accessed May 26, 2020, https://papeersupportcoalition.org/education/.

[320] *Candidate Guide: Certified Peer Specialist* (Harrisburg, PA: Pennsylvania Certification Board, 2019).

[321] Mark S. Salzer, Jason Katz *et al.*, "Pennsylvania Certified Peer Specialist Initiative: Training, Employment and Work Satisfaction Outcomes," *Psychiatric Rehabilitation Journal* 32, no. 4 (2009): 301-305, DOI: 10.2975/32.4.2009.301.305.

Peer support services are a covered benefit through Medical Assistance (Pennsylvania's version of Medicaid).[322] At least 36 states allow providers to bill Medicaid for mental health peer support services.[323]

A study conducted in Florida between July 2013 and June 2015 sought to identify the relationship of peer specialists to mental health outcomes in South Florida. The study looked at two groups, the first including peer specialists in their treatment, and the second termed "treatment as usual." The authors focused on service utilization and mental health functioning. The study found that the peer specialist group used more ambulatory/lower level services and crisis stabilization services, but overall worsening functioning in most functional assessment domains, such as depression, hyper affect, interpersonal relationships, and activities of daily living, among others. The authors found that the use of peer specialists had mixed results. They cautioned, however, that further study and analysis of outcomes were needed, and that many factors that are personal to each individual can confound attempts to quantify outcomes. They further concluded that the arbitrariness of findings in their study and others may be attributed to inconsistency in training, role descriptions, practices and supervision.[324]

Lehigh County Peer Support/Peer Mentoring

The Lehigh County Department of Human Services offers two types of peer support or peer mentoring to county residents facing a mental health crisis. Certified Peer Specialists are funded by Magellan Health, a private insurer, and must be recommended to the service by a physician or a nurse. The other, Peers Assisting in Recovery (PAIR) does not have the referral requirements. The county contracts with five providers for these peer support services — Merakey, Peerstar LLC Support Services, Recovery Partnership, Salisbury Behavioral Health, and The Advocacy Alliance. Except for The Advocacy Alliance, which is located in Allentown, all contracted peer support providers are located in Bethlehem.[325]

Peer Support and Advocacy Network

The Peer Support and Advocacy Network (PSAN) is a Pittsburgh area non-profit "offering peer support to individuals with mental illness through a variety of programs." These programs include a physical office for drop-in visits located in Bellevue where PSAN provides Certified Peer Specialists who provide "a wide variety of tasks to assist individuals to regain control over their lives and their own recovery and wellness process,"

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[322] "Peer Support Services – Revised," *PA Department of Human Services, Office of Mental Health and Substance Abuse Services Bulletin*, OMHSAS-19-05, issued December 10, 2019.

[323] Emily Heller, "Using Peers to Improve Mental Health Treatment," National Conference of State Legislatures, *Legisbrief*, 14, no. 10, (March 2016).

[324] Daniel Castellanos, Mayte Campos, Diana Valderrama, Melissa Jean-Francois and Aniuska Luna, "Relationship of Peer Specialists to Mental Health Outcomes in South Florida," *International Journal of Mental Health Systems* 12, no. 59 (2018), https://doi.org/10.1186/s13033-018-0239-6.

[325] "Peer Support/Peer Mentoring," *Lehigh County Department of Health and Human Services*, accessed April 30, 2020, https://www.lehighcounty.org/Departments/Human-Services/Mental-Health/Adult-Mental-Health/PeerSupport.

as well as the Allegheny County Warmline and the Warm and Friendly Calling Program, which is an extension of the Warmline program where PSAN places calls to consumers.[326]

Expanded and Enhanced Community Services

The College of Public Health and Human Sciences at Oregon State University studied psychiatric boarding in the EDs at hospitals across the state in 2016. The researchers interviewed key stakeholders and presented that information in combination with data and analysis of the current psychiatric boarding system in Oregon and also provided some solutions to the shortcomings of psychiatric boarding.[327] Though many Oregon policymakers were calling for an increase in beds that could serve the needs of psychiatric patients, the study found that there were more causes at play and therefore more solutions Oregon could benefit from implementing. The first solution was to expand community mental health services, which would simultaneously take pressure off of EDs by sending patients to an alternative location to be treated, and keep future patients from being admitted to the ED with preventative measures within the community. This expansion would also include either additional mental health workers or the implementation of telemedicine as well as additional mobile crisis units to respond to patients in the community.[328]

The study also found that .370 patients—those accused of a crime who are not mentally stable enough to appear at their trial without treatment—were occupying a growing amount of the inpatient psychiatric beds at the state hospital.[329] Those interviewed suggested an alternative community location that could hold these patients until they were able to stand trial. They also suggested law enforcement officers making less arrests for misdemeanors committed by those with mental health concerns. Another solution presented was a new method of service delivery in the ED which maximizes efficiency by using electronic medical records and quickly evaluating psychiatric patients. This new method could also incorporate the use of a different kind of holding space for these patients instead of an isolation room, and peer support where patients are accompanied by someone who has previously gone through a similar situation.[330]

Other suggestions included community treatment centers instead of using inpatient beds for medically stable patients, staff that would help a patient transition into the community and connect them with the proper resources, and providing supportive services

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[326] "About," *Peer Support and Advocacy Network*, accessed April 30, 2020, http://www.peer-support.org/?page_id=4.

[327] Jangho Yoon, Jeff Luck, Megan Cahn *et al*., "ED Boarding of Psychiatric Patients in Oregon: A Report to Oregon Health Authority," last modified October 28, 2016, http://www.mentalhealthportland.org/wp-content/uploads/2018/11/OHA-Psychiatric-ED-Boarding-Full-Report-Final.pdf.

[328] *Ibid.*

[329] "Aid and Assist Orders," *Oregon Health Authority*, accessed December 20, 2019, https://www.oregon.gov/oha/OSH/LEGAL/Pages/Aid-Assist-Orders.aspx.

[330] *Ibid.*

such as housing, employment placement, and substance use disorder programs. Insurance was another area that caused backlog in the ED, as community centers were not adequately reimbursed for the services provided and therefore sent patients to the ED when possible. The interviews also revealed the importance of a bed registry, which may not reduce boarding time but would give placement staff a better idea of what options were available for their patients quickly.[331]

Portland's Unity Center opened in 2017 shortly after the report was published. Those interviewed expressed support for a new model of care that could reduce ED boarding, but worried that it would only lead to a buildup of boarding in a new location, and that its impact could only be local to a certain extent. It would alleviate pressure on EDs in Portland, but not elsewhere in the state.[332] Though the Unity Center has experienced success, since its opening three patients have died at the clinic. The center has also been plagued by reports of poor working conditions, sexual assaults, and patients becoming a danger to themselves and others.[333] These poor reports are compounded by the fact that the center and local government officials were not transparent in addressing the problems and investigating the center.[334] The Unity Center continues to struggle financially in 2020, amid safety concerns and allegations that patients are not properly protected from Covid-19.[335]

Florida implemented a housing assistance pilot project in December 2019 to assist Medicaid recipients who are homeless or at risk of homelessness and who have a serious mental illness or substance use disorder. Limited to two Medicaid regions of the state,[336] the pilot program will support transitional housing services, tenancy sustaining services, mobile crisis management, self-help/peer support, and one-time cash assistance for incidentals such as deposits, rent and utilities.[337]

Minnesota implemented its Housing Stabilization Services for Medicaid recipients who are at risk of homelessness due to one of several risk factors, including:

- The person is currently transitioning, or has recently transitioned, from an institution or licensed or registered setting (registered housing with services

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[331] *Ibid.*

[332] *Ibid.*

[333] Kristian Foden-Vencil, "Patient Dies at Unity Center, Mental Health Facility in Portland," *Oregon Public Broadcasting*, last modified July 31, 2019,
https://www.opb.org/news/article/patient-death-unity-center-mental-health-portland/.

[334] Molly Harbarger, "Complaints Surfaced about Unity Center within Months of Opening: Officials Failed to Act," *The Oregonian*, last modified 2018,
https://www.oregonlive.com/news/erry-2018/08/e042a0347d860/complaints-surfaced-about-unit.html.

[335] Molly Harbarger, "Sales Pitch for Portland's Mental Health ER Omitted Numerous Red Flags", *The Oregonian,* last modified February 7, 2020, https://www.oregonlive.com/health/2020/02/portlands-psychiatric-er-troubles-echo-those-of-california-hospital-sold-as-a-best-practice.html/.

[336] Region Five – Pinellas and Pasco Counties, including the communities of Tampa, St. Petersburg, Clearwater and Port Richey; Region Seven – Seminole, Orange, Brevard, and Osceola Counties, including the communities of Orlando, Kissimmee, Sanford and Titusville.

[337] "Housing Assistance Waiver," *State of Florida, Agency for Health Care Administration*,
https://ahca.myflorida.com/Medicaid/statewide_mc/Housing_Assist.shtml.

facility, board and lodge, boarding care, adult foster care or community residential setting, hospital, Intermediate Care Facility for persons with Developmental Disabilities (ICF-DD), intensive residential treatment services, the Minnesota Security Hospital, nursing facility, regional treatment center); or

- The person, previously homeless, will be discharged from a correctional, medical, mental health or substance use disorder treatment center and lacks sufficient resources to pay for housing, and does not have a permanent place to live; would be at risk of homelessness if housing services were removed.[338]

Services include housing consultation, transition and support.

Same Day Access Models

The National Council for Behavioral Health created a same day access multistate initiative designed to assist community behavioral health organizations to create efficient access-to-treatment processes. Participants in this initiative included agencies from Alaska, Arizona, Colorado, Iowa, Kansas, Maryland, Nebraska, Oregon, and Tennessee.[339]

In March 2019, the Governor of Virginia announced that same day access to mental health services in the community was available statewide. Community mental health services in Virginia are provided by 40 Community Services Boards (CSBs) under the umbrella of the Department of Behavioral Health and Developmental Services. Walk-in hours allow persons in need of a mental health evaluation to obtain an assessment without an appointment. This program is part of Virginia's System Transformation Excellence and Performance Initiative (STEP-VA), designed for individuals with behavioral health disorders and providing for a uniform set of required services, consistent quality measures, and improved oversight. The next steps planned are implementing primary care screening and monitoring at all CSBs and the acceleration of crisis services at CSBs statewide.[340]

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[338] "Housing Stabilization Services," *Minnesota Department of Human Services*, accessed June 29, 2020, https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelecti onMethod=LatestReleased&dDocName=DHS-316637#:~:text=%20Housing%20Stabilization%20Services%20%201%20Overview.%20Housing,refer%2 0or%20be%20supported%20by%20a...%20More%20.

[339] "Same Day Access Multistate Initiative," *National Council on Behavioral Health*, accessed June 7, 2020, https://www.thenationalcouncil.org/practice-improvement/same-day-access-multistate-initiative/.

[340] Office of Virginia Governor Ralph S. Northam, Commonwealth of Virginia, "Governor Northam Announces Same Day Access to Mental Health Services Now Available at All 40 Community Services Boards in Virginia," Press Release, (March 14, 2019), https://www.governor.virginia.gov/newsroom/all-releases/2019/march/headline-839427-en.html.

Interdisciplinary Rounds

Brigham and Women's Faulkner Hospital in Massachusetts implemented Interdisciplinary Rounds (IR) for mental health patients in the ED. IR is a strategy designed to increase the communication between the different kinds of caregivers of a patient so that they can provide the best and most efficient care. The group of caregivers makes rounds together and is able to corporately discuss the best method of care for each patient, giving all facets of well-rounded care an opportunity to provide input into the care plan in a way that can lead to a decrease in readmission and a lowering of the mortality rate.[341]

Brigham and Women's chose a system in which the group—including "ED attending, ED psychiatry attending, and ED charge nurse"—makes rounds at 9am each day, spending around five to ten minutes with each patient.[342] The group can then revisit the patient as necessary throughout the day. For each patient, the caregivers assess the "reason for higher level of psychiatric care, medications (psychiatric and non-psychiatric), evolution of symptoms while boarding, activities and behavioral issues, and collateral information."[343] Because of this process, the plan of care is able to be modified as needed from day to day. With the implementation of IR, Brigham and Women's Hospital found that patients felt they were receiving a higher quality of care, LOS decreased, and discharge rates increased.[344]

Telehealth

The use of telemedicine services for mental health treatment is generally referred to as "telepsychiatry." The American Psychiatric Association (APA) has identified telepsychiatry as a subset of telemedicine. According to the APA, telepsychiatry can provide "a range of services including psychiatric evaluations, therapy (individual therapy, group therapy, family therapy), patient education and medication management." Telepsychiatry can involve direct interaction between a psychiatrist and the patient. The practice itself also encompasses psychiatrists supporting primary care providers with mental health care consultation and expertise.[345]

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[341] Sandra Marlene Terra, "Interdisciplinary Rounds: The Key to Communication, Collaboration, and Agreement on Plan of Care," *Professional Case Management* 20, no. 6 (2015): 299-307, DOI: 10.1097/NCM.0000000000000116.

[342] Luis Lobón and Dana Im, "Interdisciplinary Rounding for Mental Health Care in the Emergency Department at Brigham and Women's Faulkner Hospital," ACEP Leadership & Advocacy Conference, Washington, D.C., May 2019.

[343] *Ibid.*

[344] *Ibid.*

[345] "What is Telepsychiatry?" *American Psychiatric Association*, last modified January 2017, https://www.psychiatry.org/patients-families/what-is-telepsychiatry.

Telemedicine has the ability to improve access to health care in the Commonwealth —especially in rural regions — because it eliminates many of the common access barriers found in underserved areas such as lack of primary care physicians and specialists, sparse population, geographic remoteness, limited financial resources, and inclement weather.[346] However, telemedicine is particularly well suited for the provision of mental health services. Telepsychiatry offers additional benefits beyond improving access to psychiatric care.

For instance, while one limitation of telemedicine in other contexts tends to be the lack of in-person contact between patient and provider, mental health diagnosis and therapy are generally conducted by interview without a physical examination. Therefore, the general absence of a need to undergo a physical examination makes telemedicine an ideal practice for mental health care.

Further, telepsychiatry can bring the provider to the patient, and "the ease of accessing a provider at a nearby facility or even in the home can facilitate treatment initiation and engagement."[347] Telemedicine provided directly to a patient while the patient is in the comfort and privacy of their own home can alleviate a patient's fear of potential public stigma associated with venturing out to a hospital or mental health facility.

Other benefits of telepsychiatry include reducing delays in care, reducing needed trips to the emergency department for mental health and substance use disorder symptoms, improving the continuity of care and physician follow-up, reducing the need to take time off from work or school or find childcare, and potentially helping to integrate primary medical care with mental health and substance use disorder care.[348]

The benefits of telemedicine use in mental health care appear to be resonating with patients nationwide. A recent study reviewing millions of privately insured enrollees from 2005 to 2017 found that "the majority of telemedicine visits were for mental health, with over 50% annual compound growth in the number of tele–mental health service visits over more than a decade, although overall use rates were less than two visits per 1,000 enrollees annually."[349] Telemedicine use was found to be much higher among populations with serious illnesses.[350]

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[346] "Pennsylvania Health Care Workforce Needs," JSGC, 109.

[347] Michael L. Barnett and Haiden A. Huskamp, "Telemedicine for Mental Health in the United States: Making Progress, Still a Long Way to Go," *Psychiatry Online* 71 no. 2, (Dec. 18, 2019): 197-198, doi: 10.1176/appi.ps.201900555.

[348] "What is Telepsychiatry?" APA.

[349] Michael L. Barnett *et al.*, "Trends in Telemedicine Use in a Large Commercially Insured Population, 2005–2017," *JAMA* 320, no. 20 (November 27, 2018): 2147-2149, Research Letter, DOI:10.1001/jama.2018.12354.

[350] A. Mehotra *et al.*, "Rapid Growth in Mental Health Telemedicine Use among Rural Medicare Beneficiaries, Wide Variation across States," *Health Affairs* 36, no. 5 (May 1, 2017): 909–917, DOI: 10.1377/hlthaff.2016.1461.

Recent Efforts to Expand Telemedicine in Pennsylvania

Senate Bill 857 of 2019 was passed by the General Assembly April 21, 2020 and would have required insurance coverage for telemedicine services. While he expressed support for inclusion of language in the bill to require health insurers to reimburse health care providers for telemedicine during the Covid-19 emergency at the same rate as in-person services, Governor Wolf vetoed the bill because of its delayed implementation of the coverage provisions and because the legislation "arbitrarily restricts the use of telemedicine for certain doctor-patient interactions. As amended, this bill interferes with women's health care and the critical decision-making between patients and their physicians."[351]

In February 2020, the Pennsylvania Department of Human Services, through the Office of Mental Health and Substance Abuse Services issued guidelines for the use of telehealth technology for the delivery of behavioral health services.[352] In response to the Covid-19 emergency declaration in Pennsylvania, OHMSAS issued a memorandum addressing further expansion of the telehealth technology approval for the duration of the state of emergency for Medical Assistance recipients. Important aspects of the memorandum include:

- Telehealth will allow the use of telephonic video technology commonly available on smart phones and other electronic devices. In addition, telephone only services may be utilized in certain situations where video technology is not available.

- Staff trained in the use of the telehealth equipment and protocols to provide operating support and staff trained to provide in-person clinical intervention will not be required to be present with the individual while they are receiving services.

- The practitioner types that can provide services through telehealth will not be limited to psychiatrists, licensed psychologists, Certified Registered Nurse Practitioners and Physician Assistants certified in mental health; Licensed Clinical Social Workers; Licensed Professional Counselors; and Licensed Marriage and Family Therapists. Other individuals providing necessary behavioral health services will be permitted to utilize telehealth for services that are within their scope of practice.

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[351] Governor's Veto Message, Veto No.4, April 29, 2020.
[352] "Guidelines for the Use of Telehealth Technology in the Delivery of Behavioral Health Services," *Pennsylvania Department of Human Services*, OMHSAS Bulletin OMHSAS-20-02, February 20, 2020, https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMHSAS/Final%20-%20OMHSAS%20Telehealth%20Bulletin%202.20.20.pdf.

- The provider types that can bill for telehealth under MA FFS will not be restricted to Psychiatric Outpatient Clinics, Psychiatric Partial Hospitalization Programs, and Drug & Alcohol Outpatient Clinics. BH-MCOs may continue to allow billing for any provider type they determine appropriate.

- The services (procedure codes) that can be provided through telehealth under MA FFS will not be restricted to the procedure codes identified in Attachment A of the Bulletin OMHSAS-20-02. BH-MCOs already have the flexibility to do this.

- Provision of telehealth services in homes will not be limited to Assertive Community Treatment, Dual Diagnosis Treatment Team, or Mobile Mental Health Treatment.

- Program requirements for the number or percentage of in-person contacts for various behavioral health services may be met with the use of telehealth.

- Program limits on the amount of service that can be provided through telehealth are temporarily suspended.[353]

Consistent with the February DHS guidelines, the Department of Drug and Alcohol Programs issued an information bulletin regarding the use of telehealth for outpatient drug and alcohol services. Single county authorities were authorized to use funding received from DDAP for outpatient substance use disorder treatment facilities during the duration of the emergency declaration.

> SUD Counselors who meet the qualifications provided in 28 Pa. Code § 704.7(b) are able to provide telehealth using real-time, two-way interactive audio-video transmission services in licensed Drug and Alcohol Outpatient clinics. While the two-way interactive transmission is the preferred method, services provided by telephone and in the home are also acceptable.[354]

Telephone Psychiatric Consultation Service Program

The Children's Hospital of Philadelphia (CHOP) offers a call-in center for primary care physicians to consult with a psychiatrist. Known as the Telephonic Psychiatric Consultation Service Program, or TiPS, the call center is staffed by psychiatrists and other members of CHOP's behavioral health care team. TiPS gives pediatricians and other primary care providers access to expertise which allows them to handle their patients'

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[353] "OMHSAS Memorandum Re: Telehealth Guidelines Related to COVID-19 (Updated)," *Pennsylvania Department of Human Services*, last modified May 5, 2020, https://www.dhs.pa.gov/providers/Providers/Documents/Coronavirus%202020/OMHSAS%20COVID-19%20Telehealth%20Expansion-%20Final%203.15.20.pdf.

[354] "Information Bulletin 01-20," *Pennsylvania Department of Drug and Alcohol Programs*, last modified March 18, 2020 , https://www.ddap.pa.gov/Documents/Information%20Bulletins/IB%2001-20.pdf.

mental health care needs, such as medication management. In addition to providing immediate "troubleshooting" for patients presenting to primary care physicians with behavioral health concerns, it helps primary care providers feel more comfortable handling their patients' mental health symptoms on their own.

Currently, TiPS is available to physicians treating Medicaid patients from the five-county Philadelphia region, which encompasses 400,000 children.[355]

It should be noted that CHOP is not the only institution to implement a TiPS program. There are five TiPS centers across the Commonwealth which are divided by region. Penn State Children's Hospital operates the TiPS hotline for central and northeastern Pennsylvania, and Children's Community Pediatrics operates the TiPS hotline for the northwestern and southwestern regions of the Commonwealth.[356]

North Carolina Statewide Telepsychiatry Program (NC-STeP)

In 2013, in response to increases in emergency department visits for behavioral health concerns, North Carolina implemented a telepsychiatry program. The vision of the program was: "If an individual experiencing an acute behavioral health crisis enters an emergency department, s/he will receive timely specialized psychiatric treatment through the statewide network in coordination with available and appropriate clinically relevant community resources."[357] The program is funded by a NC appropriation of $2 million annually as well as $1.5 million from the Duke Endowment. Providers who participate in this program are held to quality and outcome standards and are subject to peer review. Between 2013 and March 31, 2019, the program had supported 36,959 telepsychiatric assessments and overturned 4,942 involuntary commitments. It is estimated that this has led to over $26.5 million in savings through prevented hospitalizations.[358] In 2018, the North Carolina Department of Health and Human Services estimated that for each dollar granted to the program, there was an economic impact of $1.75, which is a 75 percent return on investment.[359]

[355] "Innovative Solutions at CHOP are Removing Barriers to Mental Health Care," *Children's Hospital of Philadelphia*, accessed June 18, 2018, https://www.chop.edu/news/innovative-solutions-chop-are-removing-barriers-mental-healthcare.

[356] "Telephonic Psychiatric Consultation Service Program (TiPS)," *Pennsylvania Department of Human Services*, accessed February 12, 2020, https://www.dhs.pa.gov/providers/Providers/Pages/TiPS.aspx.

[357] Sy Atezaz Saeed, "Using Telepsychiatry to Enhance Access to Evidence-Based Care: A North Carolina Experience," (Pathways 2 Progress, Raleigh, NC, June 10-11, 2019) accessed December 31, 2019, https://i2icenter.org/wp-content/uploads/2019/05/using-telepsychiatry-to-enchance-access-to-EBC.pdf.

[358] *Ibid.*

[359] "North Carolina Telepsychiatry Program," *NC Department of Health and Human Services*, accessed December 31, 2019,
https://files.nc.gov/ncdhhs/2018%20NC%20DHHS%20ORH%20Telepsychiatry%20Program%20One%20Pager_0.pdf.

Bed Registries

Bed registries for psychiatric patients or patients with substance use disorders were born out of the increasing need to quickly place a patient in a bed that is best equipped to treat their condition. The U.S. Department of Health and Human Services contracted with the Research Triangle Institute (RTI) in 2019 to identify and describe the bed tracking systems available in different states. Seventeen states had behavioral health bed registries, with five state making that information publicly available through an open access website.[360]

Bed registries consist of an online database routinely updated by providers that is either available to the general public or protected by a firewall requiring a secure login. At the time of RTI's research, no states had successfully linked their registries to the existing Electronic Health Record in a way that the data could be automatically updated. Therefore, there must be designated staff who manually enter the bed information to the database.[361] The kind of employee that may have this responsibility may differ from hospital into hospital and could range from administrative professional to nurse to social worker. The frequency of these updates could be once a day or up to three times in a day in different states. The cost of maintaining the registries also varies from state to state, with Iowa spending $120,000 to establish the system and Connecticut spending $25,000.[362]

There is a lack of formal research on the success or failure of these programs. However, anecdotally, providers find value in their respective states' systems. Massachusetts professionals told RTI that they believed the bed registry reduced emergency wait times and emergency department staff made good use of the system and complained when it was not properly maintained by hospitals. The system also tracked the demand for psychiatric services and helped hospitals justify expanding psychiatric services across the state.[363]

One challenge in the implementation of bed registries is ensuring the participation of all hospitals. A system that identifies open beds that is not utilized by every provider is hardly more helpful than the previous methods of locating beds. States like Maryland who made the registry voluntary faced difficulties incentivizing hospitals to use the system. Even states like Virginia who statutorily required participation in the registry system noted low levels of compliance.[364]

Some hospitals were hesitant to comply with the registry requirement because of the Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals participating in Medicare to accept the transfer of a patient that they are capable of treating.

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[360] Tami Mark *et al.*, *Inpatient Bed Tracking: State Responses to Need for Inpatient Care* (Washington, DC: U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy, 2019).

[361] *Ibid.*

[362] *Ibid.*

[363] *Ibid.*

[364] *Ibid.*

Some states have alleviated this concern by not tying EMTALA enforcement to the registry and conducting oversight separately.[365]

Another factor affecting the usefulness of a bed registry is the timeliness of updates to the registry. An update once a day may not be accurate since a patient's status could change throughout the day, freeing up or taking up an additional bed. Beds could become available or be taken up throughout the day and that would not be documented until the next morning. Because of this, systems that did not display real-time data still required someone to call a facility and check the availability of beds. It is also important to remember that the occasional need for calls to a facility cannot be completely eliminated because providers may need to use a phone call to ascertain whether a facility is the best equipped to treat their specific patient.[366] In its current iteration, a bed registry may be most useful as a tool that can help providers narrow down the list of calls they will make to place a patient.[367]

Gleaning information from its research of existing registries, RTI recommended conducting empirical studies on registries and their usefulness, adding registries of levels of care beyond hospital beds, improving timeliness of registry updates perhaps by providing financial incentives, creating a way for providers to reserve a bed, and evaluating current capacity as a registry does not solve a problem of limited capacity.[368]

Legislative enactments in New Jersey in 2010 requires the commissioner of health to inventory behavioral health facilities of any kind and include the number of beds available in such a facility. A mechanism must also be developed to quantify the annual use of psychiatric services in different regions in the state to determine the amount of resources necessary to adequately respond to the needs of the community. The funding available for mental health programs is also to be enumerated annually, and the commissioner must meet with local and state groups that are able to make recommendations for additional resources annually and provide a report to the Governor and the Senate that details the information compiled. [369]

The review of Massachusetts medical clearance task force discussed above, also includes information on the task forces bed registry recommendation.

House Bill 391, P.N. 375 was introduced on February 6, 2019 and referred to the House Committee on Health. The bill directs the Department of Health to create an acute care mental health bed registry. No further action has been taken on this bill.

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[365] Robert Gould Shaw, *Experiences and Lessons Learned in States with On-Line Databases (Registries) of Available Mental Health Crisis, Psychiatric Inpatient, and Community Residential Placements* (Alexandria, VA: National Association of State Mental Health Program Directors, 2018).

[366] Mark, *Inpatient Bed Tracking*.

[367] Shaw, *Experiences and Lessons Learned*.

[368] Mark, *Inpatient Bed Tracking*.

[369] NJ Rev Stat § 30:4-177.63 (2018)

House Bill 2331, P.N. 3436, would establish a publicly accessible statewide directory of mental health care providers and existing mental health resources, including relevant nonprofit organizations, support groups, and local hotlines, all organized by county. The directory would also include national hotlines and resources accessible through the Internet, existing mental health care services covered under MA and CHIP, and other relevant information. The Mental Health Care Services Clearinghouse would by created by the Departments of Human Services and Health, in consultation with the Department of Education. The clearinghouse is required to be easily accessible by school students, parents and the public. The bill received first consideration in the House on May 19, 2020 and tabled that same day. It was removed from the table on May 27, 2020, and no further action has occurred.

Alternatives to Traditional Payment Models

In 2016, Pennsylvania released its Health Innovation in Pennsylvania Plan, designed to promote multi-payer, multi-stakeholder health and health care delivery system transformation. One of the goals was to increase percentages of Medicare fee-for-service payments in alternative payment models.[370]

For instance, the Pennsylvania Rural Health Model is an alternative payment model designed to address the financial challenges faced by rural hospitals by transitioning participating hospitals from fee-for-service to global budget payments, providing a stable, steady, predictable stream of revenue. This aligns incentives for providers to deliver value-based care and provides an opportunity for rural hospitals to transform the care they deliver to better meet community needs. Thirteen rural hospitals are included in the model.[371] Although the Pennsylvania Rural Health Model is a CMS-sponsored program, it demonstrates a willingness to pursue alternative health care models and long-term goals.

Psychiatric Urgent Care Models for Children

Urgent psychiatric care for children and adolescents is rare. The Bellevue Hospital Center's Children's Comprehensive Psychiatric Emergency Program (CCPEP) at New York City Health + Hospitals/Bellevue is the only psychiatric emergency care environment in New York State and one of only three in the world dedicated solely to the care of children and adolescents. The program offers:

> . . . the only place where New York City's children and families can see a specialized child psychiatrist and receive effective, individualized

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[370] "Health Innovation in Pennsylvania Plan," *Commonwealth of Pennsylvania, Department of Health*, accessed July 15, 2020, https://www.health.pa.gov/topics/Health-Innovation/Pages/Health-Innovation.aspx.
[371] "Pennsylvania Rural Health Model," *Centers for Medicare and Medicaid Services*, last modified January 16, 2020, https://innovation.cms.gov/initiatives/pa-rural-health-model/.

treatment—at any time of day or night. Each child who walks through our doors immediately receives in-depth evaluation by our multidisciplinary clinical team, which consists of trained and experienced child and adolescent psychiatrists and psychologists, psychiatric social workers with advanced training in child mental health, experienced psychiatric nurses, psychiatric technicians, and case managers. This extensive, specialized evaluation allows accurate diagnosis and connection to the most effective, appropriate, and individually tailored services to stabilize the child and treat their specific ongoing mental health needs.

The CCPEP has three main components: the Emergency Evaluation Area, the Pediatric Observation Unit, and our Outpatient Acute Care Services. In the emergency evaluation area, children and their families are triaged by an experienced child psychiatric nurse and then seen by a child psychiatrist and a child psychiatric social worker for evaluation and diagnostic assessment. Over 60% of the youth evaluated in the CCPEP can be stabilized, connected with outpatient treatment and discharged that same day. Many of these children are seen for follow up in our Interim Crisis Clinic or Home-Based Crisis Intervention program . . .[372]

Another program providing a less intensive level of urgent care services, located in Queens, New York is the Cohen Children's Pediatric Behavioral Health Urgent Care. The program is designed as an alternative treatment setting for those who need urgent (same day) intervention, but do not necessarily require the services of the emergency room. Services provided include:

- Assessment: Our mental health clinician and child and adolescent psychiatrist will conduct a focused mental health evaluation, assessing immediate safety concerns and further mental health needs. If indicated and urgently needed, medication may be started in the urgent care setting.

- Coordination of care: Our team will reach out to the referring school, pediatrician, outpatient provider or case manager that may be working with the child and family to collaborate and communicate findings and recommendations.

- Referral: Our team will provide resources and help with linkage to community-based mental health treatment in your area, when indicated, including psychotherapy, psychiatry and case management services (for those not already in treatment).

- Transitional care: Our team provides in person bridging and/or telephonic follow up until a linkage with outpatient treatment can be established.[374]

[372] "Child and Adolescent Psychiatry," *Children of Bellevue*, accessed June 30, 2020, http://childrenofbellevue.org/new/child-adolescent-psychiatry/.

[374] "About Us," *Cohen Children's Medical Center Northwell Health*, accessed June 30, 2020,

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childrenshospital.northwell.edu/departments-services/pediatric-emergency-medicine/programs-services/pediatric-behavioral-health-urgent-care-center.

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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 268   Session of 2019

INTRODUCED BY STRUZZI, HOHENSTEIN, ULLMAN, SCHLOSSBERG, MERSKI,
JOHNSON-HARRELL AND GILLEN, APRIL 29, 2019

AS REPORTED FROM COMMITTEE ON HEALTH, HOUSE OF REPRESENTATIVES,
AS AMENDED, MAY 14, 2019

A RESOLUTION

1 Directing the Joint State Government Commission to study the
2   impact of this Commonwealth's current behavioral health needs
3   and behavioral health care system capacity on hospital
4   emergency departments and patient health.
5   WHEREAS, This Commonwealth is the fifth most populous state
6 in the United States with diverse demographics and ever-changing
7 health care needs; and
8   WHEREAS, Approximately 47.2% of adults receive behavioral
9 health services and 41.9% of children receive behavioral health
10 services; and
11   WHEREAS, This Commonwealth maintains a world-class health
12 care system dedicated to removing barriers between behavioral
13 health and physical health; and
14   WHEREAS, Patients experiencing behavioral health issues are
15 not well-served during long stays in hospital emergency
16 departments; and
17   WHEREAS, Hospital emergency departments are unable to find
18 timely and appropriate placements for individuals in need of

1 behavioral health services; and

2   WHEREAS, Prolonged and unnecessary hospital stays can have a

3 range of effects, including an increased dependency, a loss of a

4 patient's confidence in the patient's ability to cope and an

5 increased likelihood of long-term institutionalization;

6 therefore be it

7   RESOLVED, That the House of Representatives direct the Joint

8 State Government Commission to study the impact of this

9 Commonwealth's current behavioral health care treatment needs

10 and behavioral health care system capacity on this

11 Commonwealth's hospital emergency departments; and be it further

12   RESOLVED, That the Joint State Government Commission study

13 the impact of this Commonwealth's current behavioral health care

14 treatment needs and behavioral health care system capacity on

15 patient health; and be it further

16   RESOLVED, That the Joint State Government Commission study

17 how current Federal and State laws and regulations impact the

18 ability of this Commonwealth's health care system AND PROVIDERS <--

19 to treat behavioral health and physical health issues; and be it

20 further

21   RESOLVED, That the Joint State Government Commission study

22 the prevalence of psychiatric boarding, which ~~is the holding of~~ <--

23 ~~patients in hospital emergency departments for more than a 24~~

24 ~~hour period after a patient has been admitted but not physically~~

25 ~~transferred to an inpatient unit~~ ENCOMPASSES THE TIME PERIOD IN <--

26 A HOSPITAL EMERGENCY DEPARTMENT AFTER MEDICAL STABILIZATION OF A

27 PATIENT IN NEED OF PSYCHIATRIC CARE AND PRIOR TO THE ADMISSION

28 OR TRANSFER OF THAT PATIENT TO AN INPATIENT PSYCHIATRIC BED; and

29 be it further

30   RESOLVED, That the Joint State Government Commission study

1 this Commonwealth's current behavioral health care treatment
2 needs to determine the impact of psychiatric boarding on this
3 Commonwealth's behavioral health care system and patients; and
4 be it further
5   RESOLVED, That the study include recommendations to ensure
6 that this Commonwealth's health care providers are able to
7 adequately treat patients with co-occurring behavioral health
8 and physical health issues; and be it further
9   RESOLVED, That the Joint State Government Commission
10 establish an advisory committee comprised of, but not limited
11 to, all of the following individuals:
12   (1) A representative recommended by the Department of
13   Drug and Alcohol Programs.
14   (2) A representative recommended by the Department of
15   Human Services.
16   (3) A physician recommended by the Department of Health.
17   (4) A representative of a rural hospital recommended by <--
18   the Hospital and Healthsystem Association of Pennsylvania.
19   (5) A representative of an urban hospital recommended by
20   the Hospital and Healthsystem Association of Pennsylvania.
21   (6) A representative of a suburban hospital recommended
22   by the Hospital and Healthsystem Association of Pennsylvania.
23   (7) A representative recommended by the Pennsylvania
24   College of Emergency Physicians.
25   (8) A representative recommended by the Pennsylvania
26   Medical Society.
27   (9) A physician who is a member of the Pennsylvania
28   Psychiatric Society.
29   (10) A representative recommended by the Drug and
30   Alcohol Service Providers Organization of Pennsylvania.

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 1          (11)  A representative recommended by the Pennsylvania
 2    Recovery Organizations Alliance.
 3          (12)  A representative recommended by the Pennsylvania
 4    organization for the National Alliance on Mental Illness.
 5          (13)  A representative recommended by the Rehabilitation
 6    and Community Providers Association.
 7          (14)  A representative recommended by the Pennsylvania
 8    Psychiatric Leadership Council.
 9          (15)  A representative recommended by the Pennsylvania
10    State Nurses Association.
11          (16)  A representative recommended by the Pennsylvania
12    Osteopathic Medical Association.
13          (17)  Any
14          (4)  A REPRESENTATIVE RECOMMENDED BY THE DEPARTMENT OF    <--
15    HEALTH.
16          (5)  A REPRESENTATIVE OF A RURAL HOSPITAL RECOMMENDED BY
17    THE HOSPITAL AND HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA.
18          (6)  A REPRESENTATIVE OF AN URBAN HOSPITAL RECOMMENDED BY
19    THE HOSPITAL AND HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA.
20          (7)  A REPRESENTATIVE OF A SUBURBAN HOSPITAL RECOMMENDED
21    BY THE HOSPITAL AND HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA.
22          (8)  A REPRESENTATIVE RECOMMENDED BY THE PENNSYLVANIA
23    COLLEGE OF EMERGENCY PHYSICIANS.
24          (9)  A REPRESENTATIVE RECOMMENDED BY THE PENNSYLVANIA
25    MEDICAL SOCIETY.
26          (10)  A REPRESENTATIVE OF A BEHAVIORAL HEALTH MANAGED
27    CARE ORGANIZATION.
28          (11)  A PHYSICIAN WHO IS A MEMBER OF THE PENNSYLVANIA
29    PSYCHIATRIC SOCIETY.
30          (12)  A PHYSICIAN RECOMMENDED BY THE PENNSYLVANIA SOCIETY
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1   OF ADDICTION MEDICINE.

2   (13)   A REPRESENTATIVE RECOMMENDED BY THE DRUG AND

3   ALCOHOL SERVICE PROVIDERS ORGANIZATION OF PENNSYLVANIA.

4   (14)   A REPRESENTATIVE RECOMMENDED BY THE PENNSYLVANIA

5   RECOVERY ORGANIZATIONS ALLIANCE.

6   (15)   A REPRESENTATIVE RECOMMENDED BY THE PENNSYLVANIA

7   ASSOCIATION OF COUNTY DRUG AND ALCOHOL ADMINISTRATORS.

8   (16)   A REPRESENTATIVE RECOMMENDED BY THE PENNSYLVANIA

9   ORGANIZATION FOR THE NATIONAL ALLIANCE ON MENTAL ILLNESS.

10   (17)   A REPRESENTATIVE RECOMMENDED BY THE PENNSYLVANIA

11   ASSOCIATION OF COUNTY ADMINISTRATORS OF MENTAL HEALTH AND

12   DEVELOPMENTAL SERVICES.

13   (18)   A REPRESENTATIVE RECOMMENDED BY THE REHABILITATION

14   AND COMMUNITY PROVIDERS ASSOCIATION.

15   (19)   A REPRESENTATIVE RECOMMENDED BY THE PENNSYLVANIA

16   PSYCHIATRIC LEADERSHIP COUNCIL.

17   (20)   A REPRESENTATIVE RECOMMENDED BY THE PENNSYLVANIA

18   MENTAL HEALTH CONSUMERS' ASSOCIATION.

19   (21)   A REPRESENTATIVE RECOMMENDED BY THE PENNSYLVANIA

20   STATE NURSES ASSOCIATION.

21   (22)   A REPRESENTATIVE RECOMMENDED BY THE PENNSYLVANIA

22   OSTEOPATHIC MEDICAL ASSOCIATION.

23   (23)   ANY other representatives from other organizations

24   that are deemed appropriate by the Joint State Government

25   Commission;

26 and be it further

27   RESOLVED, That the Joint State Government Commission issue a

28 report with its findings and recommendations WITHIN 12 MONTHS OF <--

29 THE PASSAGE OF THIS RESOLUTION to all of the following:

30   (1)   The Health and Human Services Committee of the

1   Senate.
2   (2)   The Health Committee of the House of
3   Representatives.
4   (3)   The Human Services Committee of the House of
5   Representatives;
6 and be it further
7   RESOLVED, That the Joint State Government Commission solicit
8 input from representatives of all aspects of the health care
9 sector and continuum of care to assist the Joint State
10 Government Commission with its findings and recommendations in
11 the report.

Table A-1

Number of General Acute Care Hospitals and Psychiatric Beds

By County

2018

County	Total General Acute Care Hospitals	Age 0-17		Age > 17	
		Psychiatric Beds Set Up & Staffed	Psychiatric Bed Utilization Rate	Psychiatric Beds Set Up & Staffed	Psychiatric Bed Utilization Rate
Adams	1	0	--	0	--
Allegheny	14	58	87.29%	368	82.93%
Armstrong	1	0	--	15	71.43
Beaver	1	0	--	32	83.60
Bedford	1	0	--	0	--
Berks	2	0	--	40	87.78
Blair	3	0	--	34	87.30
Bradford	3	8	33.56	18	51.04
Bucks	6	0	--	64	26.71
Butler	1	0	--	41	62.99
Cambria	2	0	--	33	87.16
Cameron	0	0	--	0	--
Carbon	1	0	--	42	33.70
Centre	1	0	--	12	63.52
Chester	5	16	23.54	48	90.22
Clarion	1	0	--	0	--
Clearfield	2	10	81.84	44	71.38
Clinton	1	0	--	0	--
Columbia	2	0	--	34	64.83
Crawford	2	0	--	26	39.62
Cumberland	2	0	--	31	50.71
Dauphin	2	0	--	0	--
Delaware	4	0	--	73	77.75

Number of General Acute Care Hospitals and Psychiatric Beds

By County

2018

County	Total General Acute Care Hospitals	Age 0-17		Age > 17	
		Psychiatric Beds Set Up & Staffed	Psychiatric Bed Utilization Rate	Psychiatric Beds Set Up & Staffed	Psychiatric Bed Utilization Rate
Elk	1	0	--	0	--
Erie	4	30	45.77	84	71.24
Fayette	2	0	--	29	48.54
Forest	0	0	--	0	--
Franklin	2	0	--	26	59.79
Fulton	1	0	--	0	--
Greene	1	0	--	0	--
Huntingdon	1	0	--	14	83.83
Indiana	1	0	--	16	55.48
Jefferson	2	0	--	10	66.14
Juniata	0	0	--	0	--
Lackawanna	3	0	--	46	76.18
Lancaster	4	0	--	18	68.93
Lawrence	2	0	--	0	--
Lebanon	1	0	--	0	--
Lehigh	4	13	62.82	157	66.71
Luzerne	3	0	--	0	--
Lycoming	3	0	--	31	44.67
McKean	2	0	--	28	63.41
Mercer	4	12	63.52	25	71.97
Mifflin	1	0	--	14	73.80
Monroe	2	0	--	20	63.15
Montgomery	9	0	--	110	70.09
Montour	1	0	--	28	75.62
Northampton	3	0	--	16	90.29
Northumberland	1	0	--	14	64.07
Perry	0	0	--	0	--
Philadelphia	15	0	--	347	87.67

Table A-1

Number of General Acute Care Hospitals and Psychiatric Beds

By County

2018

County	Total General Acute Care Hospitals	Age 0-17		Age > 17	
		Psychiatric Beds Set Up & Staffed	Psychiatric Bed Utilization Rate	Psychiatric Beds Set Up & Staffed	Psychiatric Bed Utilization Rate
Pike	0	0	--	0	--
Potter	1	0	--	0	--
Schuylkill	2	10	86.22	50	84.43
Snyder	0	0	--	0	--
Somerset	3	0	--	18	66.79
Sullivan	0	0	--	0	--
Susquehanna	2	0	--	0	--
Tioga	1	0	--	0	--
Union	1	0	--	0	--
Venango	1	0	--	28	83.68
Warren	1	0	--	18	52.34
Washington	3	0	--	50	64.48
Wayne	1	0	--	0	--
Westmoreland	3	0	--	43	65.36
Wyoming	1	0	--	0	--
York	3	0	--	63	87.08
Total	154	157	66.05	2,258	73.14

SOURCE: "Hospital Reports," *Pennsylvania Department of Health*, Division of Health Informatics Data from the Hospital Questionnaire, accessed August 21, 2019, https://www.health.pa.gov/topics/HealthStatistics/HealthFacilities/HospitalReports/Pages/hospital-reports.aspx.

Table A-2
Number of Specialty and Federal Hospitals and Psychiatric Beds
By County
2018

County	Total Specialty and Federal Hospitals	Age 0-17		Age > 17	
		Psychiatric Beds Set Up & Staffed	Psychiatric Bed Utilization Rate	Psychiatric Beds Set Up & Staffed	Psychiatric Bed Utilization Rate
Adams	0	0	--	0	--
Allegheny	14	64	88.73%	49	65.78%
Armstrong	0	0	--	0	--
Beaver	1	0	--	0	--
Bedford	0	0	--	0	--
Berks	4	0	--	333	94.65
Blair	2	0	--	0	--
Bradford	0	0	--	0	--
Bucks	3	60	91.97	0	--
Butler	0	0	--	0	--
Cambria	2	0	--	0	--
Cameron	0	0	--	0	--
Carbon	0	0	--	0	--
Centre	2	32	81.62	87	95.16
Chester	6	49	59.41	36	70.84
Clarion	1	28	76.50	68	87.99
Clearfield	0	0	--	0	--
Clinton	1	0	--	0	--
Columbia	0	0	--	0	--
Crawford	0	0	--	0	--
Cumberland	1	0	--	0	--
Dauphin	4	20	85.81	64	91.92
Delaware	1	0	--	0	--
Elk	0	0	--	0	--
Erie	3	0	--	0	--
Fayette	0	0	--	0	--
Forest	0	0	--	0	--

Table A-2
Number of Specialty and Federal Hospitals and Psychiatric Beds
By County
2018

County	Total Specialty and Federal Hospitals	Age 0-17		Age > 17	
		Psychiatric Beds Set Up & Staffed	Psychiatric Bed Utilization Rate	Psychiatric Beds Set Up & Staffed	Psychiatric Bed Utilization Rate
Franklin	1	14	71.06	38	89.90
Fulton	0	0	--	0	--
Greene	0	0	--	0	--
Huntingdon	0	0	--	0	--
Indiana	0	0	--	0	--
Jefferson	0	0	--	0	--
Juniata	0	0	--	0	--
Lackawanna	2	0	--	203	85.18
Lancaster	2	0	--	48	49.66
Lawrence	0	0	--	0	--
Lebanon	2	38	81.05	65	95.28
Lehigh	3	70	97.19	50	12.71
Luzerne	4	49	44.73	100	73.79
Lycoming	0	0	--	0	--
McKean	0	0	--	0	--
Mercer	0	0	--	0	--
Mifflin	0	0	--	0	--
Monroe	0	0	--	0	--
Montgomery	6	99	90.01	669	86.23
Montour	3	0	--	161	92.97
Northampton	0	0	--	0	--
Northumberland	0	0	--	0	--
Perry	0	0	--	0	--
Philadelphia	16	60	84.90	422	76.49
Pike	0	0	--	0	--
Potter	0	0	--	0	--
Schuylkill	0	0	--	0	--

Table A-2

Number of Specialty and Federal Hospitals and Psychiatric Beds
By County
2018

| County | Total Specialty and Federal Hospitals | Age 0-17 | | Age > 17 | |
		Psychiatric Beds Set Up & Staffed	Psychiatric Bed Utilization Rate	Psychiatric Beds Set Up & Staffed	Psychiatric Bed Utilization Rate
Snyder	0	0	--	0	--
Somerset	0	0	--	0	--
Sullivan	0	0	--	0	--
Susquehanna	0	0	--	0	--
Tioga	0	0	--	0	--
Union	0	0	--	0	--
Venango	0	0	--	0	--
Warren	1	0	--	152	90.87
Washington	1	0	--	0	--
Wayne	1	0	--	90	79.73
Westmoreland	2	0	--	304	93.75
Wyoming	0	0	--	0	--
York	3	0	--	0	--
Total	92	583	81.85	2,939	85.03

Table A-3
Number of General Acute Hospitals
Alcohol/Drug Detox and Alcohol/Drug Rehab Beds and Utilization Rate
By County
2018

County	Total General Acute Care Hospitals	Alcohol/Drug Detox Beds Set Up & Staffed	Alcohol/Drug Detox Bed Utilization Rate	Alcohol/Drug Rehab Beds Set Up & Staffed	Alcohol/Drug Rehab Bed Utilization Rate
Adams	1	--	--	--	--
Allegheny	14	36	75.29	9	48.53
Armstrong	1	4	6.44	--	--
Beaver	1	--	--	--	--
Bedford	1	--	--	--	--
Berks	2	--	--	--	--
Blair	3	--	--	--	--
Bradford	3	--	--	--	--
Bucks	6	--	--	--	--
Butler	1	18	77.85	--	--
Cambria	2	--	--	--	--
Cameron	--	--	--	--	--
Carbon	1	--	--	--	--
Centre	1	--	--	--	--
Chester	5	--	--	--	--
Clarion	1	--	--	--	--
Clearfield	2	--	--	--	--
Clinton	1	--	--	--	--
Columbia	2	--	--	--	--
Crawford	2	--	--	18	58.54
Cumberland	2	--	--	--	--
Dauphin	2	--	--	--	--
Delaware	4	20	34.33	32	128.07
Elk	1	--	--	--	--
Erie	4	16	43.70	--	--
Fayette	2	--	--	--	--
Forest	--	--	--	--	--
Franklin	2	--	--	--	--
Fulton	1	--	--	--	--
Greene	1	--	--	--	--
Huntingdon	1	--	--	--	--
Indiana	1	--	--	--	--

Table A-3
Number of General Acute Hospitals
Alcohol/Drug Detox and Alcohol/Drug Rehab Beds and Utilization Rate
By County
2018

County	Total General Acute Care Hospitals	Alcohol/Drug Detox Beds Set Up & Staffed	Alcohol/Drug Detox Bed Utilization Rate	Alcohol/Drug Rehab Beds Set Up & Staffed	Alcohol/Drug Rehab Bed Utilization Rate
Jefferson	2	--	--	--	--
Juniata	--	--	--	--	--
Lackawanna	3	--	--	--	--
Lancaster	4	--	--	--	--
Lawrence	2	--	--	--	--
Lebanon	1	--	--	--	--
Lehigh	4	--	--	--	--
Luzerne	3	--	--	--	--
Lycoming	3	--	--	--	--
McKean	2	--	--	--	--
Mercer	4	--	--	--	--
Mifflin	1	--	--	--	--
Monroe	2	--	--	--	--
Montgomery	9	--	--	--	--
Montour	1	--	--	--	--
Northampton	3	--	--	--	--
Northumberland	1	--	--	--	--
Perry	--	--	--	--	--
Philadelphia	15	26	99.10	18	95.45
Pike	--	--	--	--	--
Potter	1	--	--	--	--
Schuylkill	2	--	--	--	--
Snyder	--	--	--	--	--
Somerset	3	--	--	--	--
Sullivan	--	--	--	--	--
Susquehanna	2	--	--	--	--
Tioga	1	--	--	--	--
Union	1	--	--	--	--
Venango	1	--	--	--	--
Warren	1	4	34.93	--	--
Washington	3	--	--	--	--
Wayne	1	--	--	--	--
Westmoreland	3	--	--	--	--
Wyoming	1	--	--	--	--

Table A-3
Number of General Acute Hospitals
Alcohol/Drug Detox and Alcohol/Drug Rehab Beds and Utilization Rate
By County
2018

County	Total General Acute Care Hospitals	Alcohol/Drug Detox Beds Set Up & Staffed	Alcohol/Drug Detox Bed Utilization Rate	Alcohol/Drug Rehab Beds Set Up & Staffed	Alcohol/Drug Rehab Bed Utilization Rate
York	3	--	--	--	--
Total	154	124	66.29	77	95.56

SOURCE: "Utilization Data by Hospital and County," *Pennsylvania Department of Health*, Division of Health Informatics Data from the Hospital Questionnaire, accessed September 11, 2019, https://www.health.pa.gov/topics/HealthStatistics/HealthFacilities/HospitalReports/Pages/hospital-reports.aspx.

Table A-4
Number of Specialty and Federal Hospitals
Alcohol/Drug Detox and Alcohol/Drug Rehab Beds and Utilization Rate
By County
2018

County	Total Specialty and Federal Hospitals	Alcohol/Drug Detox Beds Set Up & Staffed	Alcohol/Drug Detox Bed Utilization Rate	Alcohol/Drug Rehab Beds Set Up & Staffed	Alcohol/Drug Rehab Bed Utilization Rate
Adams	--	--	--	--	--
Allegheny	14	--	--	--	--
Armstrong	--	--	--	--	--
Beaver	1	--	--	--	--
Bedford	--	--	--	--	--
Berks	4	--	--	--	--
Blair	2	--	--	--	--
Bradford	--	--	--	--	--
Bucks	3	--	--	--	--
Butler	--	--	--	--	--
Cambria	2	--	--	--	--
Cameron	--	--	--	--	--
Carbon	--	--	--	--	--
Centre	2	--	--	--	--
Chester[a]	6	35	NA	140	59.55
Clarion	1	--	--	--	--
Clearfield	--	--	--	--	--
Clinton	1	--	--	--	--
Columbia	--	--	--	--	--
Crawford	--	--	--	--	--
Cumberland	1	--	--	--	--
Dauphin	4	--	--	--	--
Delaware	1	--	--	--	--
Elk	--	--	--	--	--
Erie	3	--	--	--	--
Fayette	--	--	--	--	--
Forest	--	--	--	--	--
Franklin	1	7	9.59	53	86.04
Fulton	--	--	--	--	--
Greene	--	--	--	--	--
Huntingdon	--	--	--	--	--

Table A-4
Number of Specialty and Federal Hospitals
Alcohol/Drug Detox and Alcohol/Drug Rehab Beds and Utilization Rate
By County
2018

County	Total Specialty and Federal Hospitals	Alcohol/Drug Detox Beds Set Up & Staffed	Alcohol/Drug Detox Bed Utilization Rate	Alcohol/Drug Rehab Beds Set Up & Staffed	Alcohol/Drug Rehab Bed Utilization Rate
Indiana	--	--	--	--	--
Jefferson	--	--	--	--	--
Juniata	--	--	--	--	--
Lackawanna	2	--	--	--	--
Lancaster	2	--	--	--	--
Lawrence	--	--	--	--	--
Lebanon	2	--	--	--	--
Lehigh	3	--	--	--	--
Luzerne	4	--	--	--	--
Lycoming	--	--	--	--	--
McKean	--	--	--	--	--
Mercer	--	--	--	--	--
Mifflin	--	--	--	--	--
Monroe	--	--	--	--	--
Montgomery	6	26	73.28	53	56.41
Montour	3	--	--	--	--
Northampton	--	--	--	--	--
Northumberland	--	--	--	--	--
Perry	--	--	--	--	--
Philadelphia[a]	16	43	89.63	174	97.41
Pike	--	--	--	--	--
Potter	--	--	--	--	--
Schuylkill	--	--	--	--	--
Snyder	--	--	--	--	--
Somerset	--	--	--	--	--
Sullivan	--	--	--	--	--
Susquehanna	--	--	--	--	--
Tioga	--	--	--	--	--
Union	--	--	--	--	--
Venango	--	--	--	--	--
Warren	1	--	--	--	--
Washington	1	--	--	--	--

Table A-4
Number of Specialty and Federal Hospitals
Alcohol/Drug Detox and Alcohol/Drug Rehab Beds and Utilization Rate
By County
2018

County	Total Specialty and Federal Hospitals	Alcohol/Drug Detox Beds Set Up & Staffed	Alcohol/Drug Detox Bed Utilization Rate	Alcohol/Drug Rehab Beds Set Up & Staffed	Alcohol/Drug Rehab Bed Utilization Rate
Wayne	1	--	--	--	--
Westmoreland	2	--	--	--	--
Wyoming	--	--	--	--	--
York	3	--	--	--	--
Total	92	111	71.71	420	77.36

a. The Malvern Institute in Chester County and the Girard Medical Center in Philadelphia County provided bed counts which are reflected in the table above, but did not provide data on bed usage. The utilization rates are only based on data from facilities that provided both the bed counts and bed usage.

SOURCE: "Inpatient Hospital Unit Data by Facility and County," *Pennsylvania Department of Health*, Division of Health Informatics Data from the Hospital Questionnaire, accessed August 21, 2019, https://www.health.pa.gov/topics/HealthStatistics/HealthFacilities/HospitalReports/Pages/hospital-reports.aspx.

APPENDIX C:
INPATIENT/RESIDENTIAL BEHAVIORAL HEALTH
FACILITIES IN PENNSYLVANIA

OMHSAS Licensed Private Psychiatric Hospitals 2020-07-02

Central: 5   Northeast: 4   Southeast: 12   Western: 3   TOTAL: 24

License #		Region	County	Facility Name	Capacity	Accreditation	Facility Address			
44737	0	Western	Allegheny	LifeCare Behavioral Health Hospital of Pittsburgh	49		225 Pennsylvania Avenue	Pittsburgh	PA	15221
42997	0	Western	Allegheny	Southwood Psychiatric Hospital	74	TJC	2575 Boyce Plaza Road	Pittsburgh	PA	15241
22215	0	Northeast	Berks	Haven Behavioral Hospital of Eastern PA	86	TJC	145 North Sixth Street	Reading	PA	19601
22916	0	Northeast	Berks	Tower Behavioral Health	144		201 Wellness Way	Reading	PA	19605
12978	0	Southeast	Bucks	Foundations Behavioral Health System	60	TJC	833 East Butler Avenue	Doylestown	PA	18901
36037	0	Central	Centre	The Meadows Psychiatric Center	119	TJC	132 The Meadows Drive	Centre Hall	PA	16828
12463	0	Southeast	Chester	St. John Vianney Center	50	TJC	151 Woodbine Road	Downingtown	PA	19335
11419	0	Southeast	Chester	The Devereux Children's Behavioral Health Institute	49	CARF	655 Sugartown Road	Malvern	PA	19355
47235	0	Western	Clarion	Clarion Psychiatric Center	112	TJC	Two Hospital Drive	Clarion	PA	16214
32548	0	Central	Dauphin	PA Psychiatric Institute - Inpatient	89	TJC	2501 North Third Street	Harrisburg	PA	17110
31823	0	Central	Franklin	Roxbury Treatment Center - Inpatient	52	TJC	601 Roxbury Road	Shippensburg	PA	17257
33417	0	Central	Lancaster	Lancaster Behavioral Health Hospital	126	TJC	333 Harrisburg Avenue	Lancaster	PA	17603
31855	0	Central	Lebanon	Philhaven Hospital	118	TJC	283 South Butler Road, PO Box 550	Mt. Gretna	PA	17064
23420	0	Northeast	Lehigh	Kidspeace Children's Hospital	110	TJC	5300 Kidspeace Drive	Orefield	PA	18069
22101	0	Northeast	Luzerne	First Hospital	149	TJC	Nesbitt Memorial Medical Center, 562 Wyoming Avenue	Kingston	PA	18704
12213	0	Southeast	Montgomery	Brooke Glen Behavioral Hospital - Inpatient Psych - EAC	146	TJC	7170 Lafayette Avenue	Fort Washington	PA	19034
17341	0	Southeast	Montgomery	Montgomery County MH/MR Emergency Service	73	TJC	50 Beech Drive, Gate 4	Norristown	PA	19403
19606	1	Southeast	Montgomery	The Horsham Clinic	206	TJC	722 East Butler Pike	Ambler	PA	19002
14161	0	Southeast	Philadelphia	Belmont Behavioral Hospital - Acadia Healthcare	180	TJC	4200 Monument Road	Philadelphia	PA	19131
11027	0	Southeast	Philadelphia	Fairmount Behavioral Health System	172	TJC	561 Fairthorne Avenue	Philadelphia	PA	19128
10438	0	Southeast	Philadelphia	Friends Hospital	192	TJC	4641 Roosevelt Boulevard	Philadelphia	PA	19124
14236	0	Southeast	Philadelphia	Girard Medical Center	65	TJC	801 West Girard Avenue	Philadelphia	PA	19122
14044	0	Southeast	Philadelphia	Haven Behavioral Hospital of Philadelphia	36	TJC	3300 Henry Avenue, Unit 4	Philadelphia	PA	19129
14575	0	Southeast	Philadelphia	Malvern Behavioral Health	22		1930 South Broad Street, 4th Floor	Philadelphia	PA	19145

OMHSAS Licensed Psychiatric Inpatient Units In a General Hospital 2020-07-02

Central: 14   Northeast: 10   Southeast: 21   Western: 29   TOTAL: 74

License #	Region	County	Facility Name	Capacity	Accreditation	Facility Address			
94059 0	Western	Allegheny	Alle-Kiski Medical Center	40	TJC	1301 Carlisle Street	Natrona Heights	PA	15065
94108 0	Western	Allegheny	Heritage Valley - Sewickley	16	TJC	720 Blackburn Road	Sewickley	PA	15143
94054 0	Western	Allegheny	Jefferson Regional Medical Center	24	TJC	565 Coal Valley Road	Pittsburgh	PA	15236
94019 0	Western	Allegheny	Ohio Valley General Hospital	21	TJC	25 Heckel Road	McKees Rocks	PA	15136
94036 0	Western	Allegheny	St. Clair Memorial Hospital	26	TJC	1000 Bower Hill Road	Pittsburgh	PA	15243
94031 0	Western	Allegheny	The Western PA Hospital - Forbes Regional Campus	37		2570 Haymaker Road	Monroeville	PA	15146
94032 0	Western	Allegheny	UPMC McKeesport	37	TJC	1500 5th Avenue	McKeesport	PA	15132
94081 0	Western	Allegheny	UPMC Western Psychiatric Hospital	289	TJC	3811 O'Hara Street	Pittsburgh	PA	15213
94037 0	Western	Armstrong	Armstrong County Memorial Hospital	17	DNV Heathcare	Box 50, RD 8	Kittanning	PA	16201
94111 0	Western	Beaver	Heritage Valley Beaver	32	TJC	1000 Dutch Ridge Road	Beaver	PA	15009
92052 0	Northeast	Berks	Reading Hospital	40	TJC	420 South 5th Street	Reading	PA	19611
93004 0	Central	Blair	UPMC Altoona IP Behavioral Health Unit	34	TJC	620 Howard Avenue	Altoona	PA	16603
92010 0	Northeast	Bradford	Robert Packer Hospital	26	TJC	One Guthrie Square	Sayre	PA	18840
91112 0	Southeast	Bucks	Lower Bucks Hospital	45	TJC	501 Bath Road	Bristol	PA	19007
91034 0	Southeast	Bucks	St. Luke's Quakertown Hospital	19	TJC	1021 Park Avenue	Quakertown	PA	18951
94038 0	Western	Butler	Butler Memorial Hospital	41	TJC	One Hospital Way	Butler	PA	16001
93020 0	Central	Cambria	Conemaugh Valley Memorial Hospital	35	TJC	1086 Franklin Street	Johnstown	PA	15905
92009 0	Northeast	Carbon	St. Luke's Hospital - Gnaden Huetten Campus	42	TJC	211 North 12th Street	Lehighton	PA	18235
93017 0	Central	Centre	Mt. Nittany Medical Center	12	TJC	1800 East Park Avenue	State College	PA	16801
91020 0	Southeast	Chester	Brandywine Hospital	20	TJC	201 Reeceville Road	Coatesville	PA	19320
94010 0	Western	Clearfield	Penn Highlands Clearfield Hospital	10		809 Turnpike Avenue, PO Box 992	Clearfield	PA	16830
94020 0	Western	Clearfield	Penn Highlands Dubois Regional Medical Center	44	DNV Heathcare	535 Sunflower Drive	Dubois	PA	15801
93011 0	Central	Columbia	Berwick Hospital Center	14	TJC	701 East 16th Street	Berwick	PA	18603
93058 0	Central	Columbia	The Bloomsburg Hospital	20	CARF	549 East Fair Street	Bloomsburg	PA	17815
94040 0	Western	Crawford	Meadville Medical Center	28	DNV Heathcare	1034 Grove Street	Meadville	PA	16335
93019 0	Central	Cumberland	Holy Spirit Hospital Community MH Center	31	TJC	503 North 21st Street	Camp Hill	PA	17011
91017 0	Southeast	Delaware	Crozer-Chester Medical Center	34	TJC	15th Street & Shaw Terrace	Chester	PA	19013
91017 0	Southeast	Delaware	Crozer-Chester Medical Center	20	TJC	15th Street & Shaw Terrace	Chester	PA	19013
91039 0	Southeast	Delaware	Mercy Catholic Medical Center – Mercy Fitzgerald Campus	21	TJC	1500 Lansdowne Avenue	Darby	PA	19023
94003 0	Western	Elk	Penn Highlands Elk Regional Health Center	10		763 Johnsonburg Rd	St. Mary's	PA	15857
94137 0	Western	Erie	Millcreek Community Hospital	85		5515 Peach Street	Erie	PA	16509
94043 0	Western	Erie	St. Vincent Community MH Center	38	TJC	232 West 25th Street	Erie	PA	16544
94066 0	Western	Fayette	Highlands Hospital	43		401 East Murphy Avenue	Connellsville	PA	15425
93023 0	Central	Franklin	Chambersburg Hospital	26	TJC	112 North Seventh Street	Chambersburg	PA	17201
93024 0	Central	Huntingdon	Penn Highlands Huntingdon Psychiatric Unit	14	TJC	1225 Warm Springs Avenue	Huntingdon	PA	16652
94123 0	Western	Indiana	Geriatric Care Center	16		PO Box 788, Hospital Rd	Indiana	PA	15701
94138 0	Western	Jefferson	Penn Highlands Brookville Hospital	10		100 Hospital Road	Brookville	PA	15825
92012 0	Northeast	Lackawanna	Community Medical Center - Behavioral Medicine Dept.	24	TJC	1822 Mulberry Street	Scranton	PA	18510
92034 0	Northeast	Lackawanna	Moses Taylor Hospital Senior Medical/MH Service	22	TJC	700 Quincy Avenue	Scranton	PA	18510
93027 0	Central	Lancaster	Ephrata Community Hospital	18	TJC	169 Martin Avenue	Ephrata	PA	17522
94028 1	Western	Lawrence	Ellwood Medical Center Operations (SHOWING CLOSED ON 10/8/20 IN DATABASE)	10		421 Chew Street	Allentown	PA	18102
92037 0	Northeast	Lehigh	St. Luke's Hospital - Sacred Heart Campus	109	TJC	421 Chew Street	Allentown	PA	18102
92015 0	Northeast	Lehigh/Northampton	Lehigh Valley Hospital	65	TJC	Behavioral Health Sciences Center, 2545 Schoenersville Road	Bethlehem	PA	18017
93029 0	Central	Lycoming	UPMC Williamsport Behavioral Health Unit – Divine Providence Campus	31	TJC	1100 Grampian Boulevard	Williamsport	PA	17701
94027 0	Western	McKean	Bradford Regional Medical Center	28	TJC	116-156 Interstate Parkway	Bradford	PA	16701
94026 0	Western	Mercer	Sharon Regional Health System	42	TJC	740 East State Street	Sharon	PA	16146
93030 0	Central	Mifflin	Geisinger Lewistown Hospital	14	TJC	400 Highland Avenue	Lewistown	PA	17044
92021 0	Northeast	Monroe	Lehigh Valley Hospital - Pocono	20	TJC	206 East Brown Street	East Stroudsburg	PA	18301
91040 0	Southeast	Montgomery	Abington Memorial Hospital	25	TJC	1200 Old York Road	Abington	PA	19001
91160 0	Southeast	Montgomery	Eagleville Hospital	34	TJC	100 Eagleville Road, PO Box 45	Eagleville	PA	19408
91161 0	Southeast	Montgomery	Holy Redeemer Hospital & Medical Center	24	DNV Heathcare	1648 Huntingdon Pk	Meadowbrook	PA	19046
91022 0	Southeast	Montgomery	Pottstown Hospital, LLC	28	TJC	1600 East High Street	Pottstown	PA	19464
91015 0	Southeast	Montgomery	Suburban Community Hospital	15	TJC	2701 Dekalb Pike	Norristown	PA	19401
91058 0	Southeast	Montgomery	The Bryn Mawr Hospital	20	TJC	130 South Bryn Mawr Avenue	Bryn Mawr	PA	19010
93031 0	Central	Montour	Geisinger Medical Center	28	TJC	100 North Academy Road	Danville	PA	17822
92032 0	Northeast	Northampton	Easton Hospital	16	TJC	250 South 21st Street	Easton	PA	18042
91044 0	Southeast	Philadelphia	Albert Einstein Medical Center	47	TJC	5501 Old York Road	Philadelphia	PA	19141
91024 0	Southeast	Philadelphia	Chestnut Hill Hospital, LLC	20	TJC	8835 Germantown Avenue	Philadelphia	PA	19118
91113 0	Southeast	Philadelphia	Mercy Catholic Medical Center - Mercy Philadelphia Campus	18	TJC	501 South 54th Street	Philadelphia	PA	19143
91117 0	Southeast	Philadelphia	Pennsylvania Hospital of the University of PA Health System	42	TJC	800 Spruce Street	Philadelphia	PA	19107
10325 0	Southeast	Philadelphia	Philadelphia Department of Prisons	64		7901 State Road	Philadelphia	PA	19136
91085 0	Southeast	Philadelphia	Presbyterian Medical Center of University of PA. Health System	22	TJC	39th & Market Street	Philadelphia	PA	19104
91025 0	Southeast	Philadelphia	Roxborough Memorial Hospital	0	TJC	5800 Ridge Avenue	Philadelphia	PA	19128
91150 0	Southeast	Philadelphia	Temple University Hospital - Episcopal Campus	118	TJC	100 East Lehigh Avenue	Philadelphia	PA	19125
91139 0	Southeast	Philadelphia	Thomas Jefferson University Hospital	30	TJC	11th & Walnut Streets	Philadelphia	PA	19107
92023 0	Northeast	Schuylkill	Lehigh Valley Hospital - Schuylkill	60	TJC	420 South Jackson Street	Pottsville	PA	17901
93032 0	Central	Somerset	UPMC Somerset Community Hospital	18	TJC	225 South Center Avenue	Somerset	PA	15501
94154 0	Western	Venango	UPMC Northwest	28	TJC	100 Fairfield Drive	Seneca	PA	16346
94057 0	Western	Warren	Warren General Hospital	18		2-12 Crescent Park West	Warren	PA	16365
94051 0	Western	Washington	Monongahela Valley Hospital	20	TJC	Rte 88, Country Club Road	Monongahela	PA	15063
94050 0	Western	Washington	The Washington Hospital	30	TJC	155 Wilson Avenue	Washington	PA	15301
94052 0	Western	Westmoreland	Latrobe Area Hospital MH Center	11	TJC	One Mellon Way	Latrobe	PA	15650
94053 0	Western	Westmoreland	Westmoreland Hospital Community MH Center	32	TJC	532 West Pittsburgh Street	Greensburg	PA	15601
93034 0	Central	York	York Hospital	63	TJC	1001 South George Street	York	PA	17405

Crisis Intervention Providers

Crisis Residential: 14   Telephone: 39   Walk-In: 50   Mobile: 49   Medical Mobile: 5

License #	Provider Name	Address	City	State	Zip	County	Region	Residential Facility	Service Details
44079	UPMC Western Psychiatric Hospital	333 North Braddock Avenue	Piittsburgh	PA	15208	Allegheny	Western		CI - Telephone; Walk-In; Mobile
43596	Mercy Behavioral Health	264 South 9th Street	Pittsburgh	PA	15203	Allegheny	Western		CI - Walk-In
44956	Pressley Ridge - Transition Age Mobile Crisis Services	1008 7th Avenue	Beaver Falls	PA	15010	Beaver	Western		CI - Mobile
44745	UPMC Western Psychiatric Hospital (Beaver County Crisis Center)	176 Virginia Avenue	Rochester	PA	15074	Beaver	Western		CI - Telephone; Walk-In; Mobile
32387	Bedford Crisis Intervention	1243 Shed Road	Bedford	PA	15522	Bedford	Central		CI - Telephone; Walk-In; Mobile
20682	Service Access & Management	19 North 6th Street, Suite 300	Reading	PA	19601	Berks	Northeast		CI - Telephone; Walk-In; Mobile
93013	UPMC Altoona Crisis	620 Howard Avenue	Altoona	PA	16601	Blair	Central		CI - Telephone; Walk-In; Mobile
14486	The Lodge Crisis Residential Lenape Valley Foundation	499 Bath Road	Bristol	PA	19007	Bucks	Southeast	Yes	Residential
18790	Lenape Valley Foundation	500 North West Street	Doylestown	PA	18901	Bucks	Southeast		CI - Telephone; Walk-In; Mobile
44268	Center for Community Resources	212-214 South Main Street, Suite 101	Butler	PA	16001	Butler	Western		CI - Telephone; Walk-In; Mobile
24528	Resources for Human Development New Perspectives	140 Neyhart Road	Stroudsburg	PA	18360	Carbon/Monroe/Pike	Northeast		CI - Telephone; Mobile; Medical Mobile
20157	Resources for Human Development New Perspectives	140 Neyhart Road	Stroudsburg	PA	18360	Carbon/Monroe/Pike	Northeast	Yes	Residential
33560	Center for Community Resources	2100 East College Avenue, Stuite A	State College	PA	16801	Centre	Central		CI - Telephone; Walk-In; Mobile
13464	Valley Creek Crisis Center	469 Creamery Way	Exton	PA	19341	Chester	Southeast	Yes	CI - Telephone; Walk-In; Mobile
33529	The Path Home	194 Fester Road	Bloomsburg	PA	17815	Columbia/Montour/Snyder/Union	Central	Yes	Residential
93114	Holy Spirit Hospital - Mental Health Service	503 North 21st Street	Camp Hill	PA	17011	Cumberland/Perry	Central		CI - Telephone; Walk-In; Mobile
30817	Dauphin County Crisis Intervention	100 Chestnut Street	Harrisburg	PA	17101	Dauphin	Central		CI - Telephone; Walk-In; Mobile
13991	Elwyn of Pennsylvania	111 Elwyn Road	Elwyn	PA	19063	Delaware	Southeast		CI - Mobile
10286	Natale Crisis Residential	111 Elwyn Road	Elwyn	PA	19063	Delaware	Southeast	Yes	Residential
91019	Crozer Chester Medical Center	One Medical Center Boulevard	Upland	PA	19013	Delaware	Southeast		CI - Walk-In
44409	Dickinson Center	43 Servidea Drive	Ridgway	PA	15853	Elk/Cameron	Western		CI - Telephone; Walk-In; Mobile
44307	UPMC Western Behavioral Health at Safe Harbor	2560 West 12th Street	Erie	PA	16508	Erie	Western		CI - Telephone; Walk-In; Mobile; Residential
46749	Chestnut Ridge Counseling Services	100 New Salem Road, Suite 116	Uniontown	PA	15401	Fayette	Western		CI - Telephone; Walk-In; Mobile
32416	Keystone Rural Health Center	112 North 7th Street	Chambersburg	PA	17201	Franklin	Central		CI - Telephone; Walk-In; Mobile
32570	True North Wellness Services Crisis Intervention	214 Peach Orchard Road	McConnellsburg	PA	17233	Fulton	Central		CI - Walk-in; Mobile
44472	The Open Door	65 Philadelphia Street, 2nd Floor, Suite 20	Indiana	PA	15701	Indiana/Armstrong	Western		CI - Telephone; Walk-In; Mobile
23602	Scranton Counseling Center	326 Adams Avenue	Scranton	PA	18503	Lackawanna/Susquehanna	Northeast		CI - Telephone; Walk-In; Mobile
33608	Lancaster County BH/DS	275 Hess Boulevard	Lancaster	PA	17603	Lancaster	Central		CI - Telephone; Walk-In; Mobile
46464	Human Services Center	130 West North Street	New Castle	PA	16101	Lawrence	Western		CI - Telephone; Walk-In; Mobile
31317	WellSpan Philhaven - Crisis Intervention	229 South 4th Street	Lebanon	PA	17042	Lebanon	Central		CI - Telephone; Walk-In; Mobile
20175	Lehigh County Crisis Intervention Unit	Government Center, 17 South 7th Street	Allentown	PA	18101	Lehigh	Northeast		CI - Telephone; Walk-In; Mobile
22150	Horizon House	910 East Emmaus Avenue	Allentown	PA	18103	Lehigh	Northeast	Yes	Residential
23866	Resources for Human Development - Hope House	3606 Hecktown Road	Bethlehem	PA	18020	Lehigh/Northampton	Northeast	Yes	Residential
23645	Children's Mobile Team	335 South Franklin Street	Wilkes-Barre	PA	18702	Luzerne/Wyoming	Northeast		CI - Mobile
22621	Northeast Counseling Services	121 Prospect Street	Nanticoke	PA	18634	Luzerne/Wyoming	Northeast		CI - Telephone; Walk-In; Mobile
23604	Children's Service Center TelePhone Crisis	335 South Franklin Street	Wilkes-Barre	PA	18702	Luzerne/Wyoming	Northeast		CI - Telephone; Walk-In; Mobile
22508	Community Counseling Services	575 North River Street	Wilkes-Barre	PA	18702	Luzerne/Wyoming	Northeast	Yes	Residential
22097	Community Counseling Services of Northeastern Pennsylvania	110 South Pennsylvania Avenue	Wilkes-Barre	PA	18701	Luzerne/Wyoming	Northeast		CI - Telephone; Walk-In; Mobile
32517	Lycoming-Clinton MH/ID	The Sharwell Building, 200 East Street	Williamsport	PA	17701	Lycoming/Clinton	Central		CI - Telephone; Walk-In; Mobile
42225	The Guidance Center	110 Campus Drive	Bradford	PA	16701	McKean	Western		CI - Telephone; Walk-In; Mobile
43488	Mercer County Behavioral Health Commission	8406 Sharon-Mercer Road	Mercer	PA	16137	Mercer	Western		CI - Telephone; Walk-In; Mobile
10305	Montgomery County MH/MR Emergency Service	50 Beech Drive	Norristown	PA	19403	Montgomery	Southeast		CI - Walk-In; Mobile; Medical Mobile
14416	Access Services, Inc.	4070 Butler Pike, Suite 900	Plymouth Meeting	PA	19462	Montgomery	Southeast		CI - Mobile
14267	Montgomery County Crisis Residential	419 West County Line Road	Hatboro	PA	19040	Montgomery	Southeast	Yes	Residential
10372	Montgomery County MH/MR Emergency Service	n State Hospital, 1001 Sterigere Street, Bu	Norristown	PA	19403	Montgomery	Southeast	Yes	Residential
33095	CMSU Crisis Intervention Program	507 East Market Street	Danville	PA	17821	Columbia/Montour/Snyder/Union	Central		CI - Telephone; Walk-In; Mobile

Crisis Intervention Providers

Crisis Residential: 14   Telephone: 39   Walk-In: 50   Mobile: 49   Medical Mobile: 5

License #	Provider Name	Address	City	State	Zip	County	Region	Residential Faciility	Service Details
22605	Northampton County Emergency Services	2801 Emrick Boulevard, 1st Floor	Bethlehem	PA	18020	Northampton	Northeast		CI - Telephone; Walk-In; Mobile
32295	Northumberland County BH & Intellectual Developmental Services	399 Stadium Drive	Sunbury	PA	17801	Northumberland	Central		CI - Telephone; Walk-In; Mobile
91010	Mercy Catholic Medical Center - Mercy Philadelphia Campus	501 South 54th Street	Philadelphia	PA	19143	Philadelphia	Southeast		CI - Walk-In
91033	Pennsylvania Hospital Crisis Response Center	801 Spruce Street	Philadelphia	PA	19107	Philadelphia	Southeast		CI - Walk-In
91028	Einstein Crisis Response Center	5401 Old York Road	Philadelphia	PA	19141	Philadelphia	Southeast		CI - Walk-In
18788	CATCH, INC - Crisis Residence	oor, Tower Building, 8th Street & Girard A	Philadelphia	PA	19122	Philadelphia	Southeast	Yes	Residential
14413	Philadelphia Children's Crisis Response Center	3300 Henry Avenue	Philadelphia	PA	19129	Philadelphia	Southeast		CI - Walk-In; Residential
13786	Friends Hospital	4641 Roosevelt Boulevard	Philadelphia	PA	19124	Philadelphia	Southeast		CI - Walk-In
18910	Northeast Community Center for Behavioral Health	Roosevelt Boulevard & Adams Avenue	Philadelphia	PA	19124	Philadelphia	Southeast		CI - Walk-In
91007	Temple University Hospital - Episcopal Campus	100 East Lehigh Avenue	Philadelphia	PA	19125	Philadelphia	Southeast		CI - Walk-In
14343	Elwyn Children's Mobile Crisis	3300 Henry Avenue	Philadelphia	PA	19129	Philadelphia	Southeast		CI - Medical Mobile
14329	Bethanna	2500 Wharton Street	Philadelphia	PA	19146	Philadelphia	Southeast		CI - Mobile
14323	PATH (People Acting to Help), Inc.	8220 Castor Avenue	Philadelphia	PA	19152	Philadelphia	Southeast		CI - Mobile; Medical Mobile
10293	Interventive Care Crisis Management Network	PO Box 544	Montgomeryville	PA	18936	Philadelphia	Southeast	Yes	Residential
18904	John F Kennedy Behavioral Health Center	112 North Broad Street	Philadelphia	PA	19102	Philadelphia	Southeast		CI - Walk-In; Mobile; Medical Mobile
44044	Dickinson MH Crisis Program	1 North Main Street, Gunzburger Annex	Coudersport	PA	16915	Potter	Western		CI - Telephone; Walk-In; Mobile
22685	The ReDCo Group - Safehaven	603 West Market Street	Pottsville	PA	17901	Schuylkill	Northeast	Yes	Residential
32388	Somerset Crisis Intervention	245 West Race Street	Somerset	PA	15501	Somerset	Central		CI - Telephone; Walk-In; Mobile
22549	Concern Counseling Services	63 Third Street	Mansfield	PA	16933	Tioga	Northeast		CI - Telephone; Walk-In; Mobile
43989	Venango County Integrated Crisis Services	1 Dale Avenue	Franklin	PA	16323	Venango	Western		CI - Telephone; Walk-In; Mobile
44411	SPHS Care Center	75 East Maiden Street	Washington	PA	15301	Washington	Western		CI - Telephone; Walk-In; Mobile
40017	Westmoreland Regional Hospital Comrehensive Counseling	532 West Pittsburgh Street	Greensburg	PA	15601	Westmoreland	Western		CI - Walk-In
40564	Westmoreland Human Opportunities	128 East Pittsburgh Street	Greensburg	PA	15601	Westmoreland	Western		CI - Telephone; Mobile
31287	True North Wellness Services	33 Frederick Street	Hanover	PA	17331	York/Adams	Central		CI - Telephone; Walk-In; Mobile
93121	Wellspan Behavioral Health	1001 South George Street	York	PA	17405	York/Adams	Central		CI - Telephone; Walk-In; Mobile

Facility Name	Location	Treatment Offered	Adults	Seniors	Young Adults	Children/ Adolescents
Behavioral Health Services Bradford Regional Medical Center	Bradford	Detoxification; substance use treatment	X		X	
Belmont Behavioral Hospital	Philadelphia	Detoxification; substance use treatment	X		X	X
Bowling Green Brandywine	Kennett Square	Detoxification; substance use treatment; co-occurring serious mental illness/emotional disturbance and substance use disorders	X		X	
Butler Regional Recovery Program Butler Memorial Hospital	Butler	Detoxification; substance use treatment; co-occurring serious mental illness/emotional disturbance and substance use disorders	X		X	
Crozer Chester Medical Center	Chester	Detoxification; substance use treatment	X		X	X
Eagleville Hospital Substance Abuse Services	Norristown	Detoxification; substance use treatment; co-occurring serious mental illness/emotional disturbance and substance use disorders	X	X	X	
Girard Medical Center Goldman Clinic	Philadelphia	Detoxification; substance use treatment	X		X	

Substance Use Disorder Inpatient Facilities
Primary diagnosis detoxification or substance use treatment; some facilities treat co-existing mental health disorders

			Age Groups			
Facility Name	**Location**	**Treatment Offered**	**Adults**	**Seniors**	**Young Adults**	**Children/ Adolescents**

Substance Use Disorder Inpatient Facilities
Primary diagnosis detoxification or substance use treatment; some facilities treat co-existing mental health disorders

Facility Name	**Location**	**Treatment Offered**	**Adults**	**Seniors**	**Young Adults**	**Children/ Adolescents**
Girard Medical Center The Return Program	Philadelphia	Detoxification; substance use treatment	X		X	
Horsham Clinic	Ambler	Detoxification; substance use treatment; co-occurring serious mental illness/emotional disturbance and substance use disorders				X
Just Believe Recovery Center	Carbondale	Detoxification; substance use treatment; co-occurring serious mental illness/emotional disturbance and substance use disorders	X	X	X	
Kensington Hospital Addiction Services	Philadelphia	Detoxification	X		X	
Mercy Catholic Medical Center Mercy Philadelphia Campus	Philadelphia	Detoxification; substance use treatment; co-occurring serious mental illness/emotional disturbance and substance use disorders	X		X	
Penn Presbyterian Medical Center	Philadelphia	Detoxification; substance use treatment; co-occurring serious mental illness/emotional disturbance and substance use disorders	X	X		
Stepping Stones Unit at Meadville Medical Center	Meadville	Detoxification; substance use treatment	X	X	X	

			Age Groups			
Facility Name	**Location**	**Treatment Offered**	**Adults**	**Seniors**	**Young Adults**	**Children/ Adolescents**
UPMC Mercy Hospital Acute Medical Detox	Pittsburgh	Detoxification	X		X	
Valley Forge Medical Center and Hospital	Norristown	Detoxification; substance use treatment	X		X	
Warren General Hospital	Warren	Detoxification	X		X	
Wilkes-Barre Behavioral Hospital Company/Choices Program of Northeastern PA	Kingston	Detoxification; substance use treatment	X		X	

Substance Use Disorder Inpatient Facilities
Primary diagnosis detoxification or substance use treatment; some facilities treat co-existing mental health disorders

APPENDIX D:
TYPES OF MENTAL
HEALTH FACILITIES IN PENNSYLVANIA

Table C-1
Mental Health Facilities
By Service Type and County

County	Psychiatric Emergency Walk-in	Hospital Inpatient	Outpatient	Partial Hospitalization/ Day Treatment	Residential
Adams	0	0	2	1	0
Allegheny	9	10	40	3	15
Armstrong	3	1	4	0	1
Beaver	1	1	2	1	0
Bedford	0	0	0	0	0
Berks	4	1	16	2	5
Blair	1	1	2	0	2
Bradford	1	1	2	1	1
Bucks	2	1	10	2	2
Butler	1	1	8	1	1
Cambria	0	1	2	0	0
Cameron	0	0	0	0	0
Carbon	0	1	3	0	3
Centre	3	2	5	0	0
Chester	3	3	11	7	3
Clarion	1	1	3	0	1
Clearfield	1	1	4	0	0
Clinton	0	0	1	0	0
Columbia	1	2	2	0	0
Crawford	0	1	2	1	1
Cumberland	2	1	6	0	2
Dauphin	1	0	14	1	4
Delaware	2	4	10	1	3

Table C-1
Mental Health Facilities
By Service Type and County

County	Psychiatric Emergency Walk-in	Hospital Inpatient	Outpatient	Partial Hospitalization/ Day Treatment	Residential
Elk	3	1	2	0	1
Erie	5	2	10	6	2
Fayette	3	1	8	0	3
Forest	0	0	0	0	0
Franklin	1	1	2	0	0
Fulton	1	0	1	0	0
Greene	3	0	4	0	1
Huntingdon	0	1	1	0	0
Indiana	1	1	2	0	1
Jefferson	1	1	2	0	0
Juniata	0	0	0	0	0
Lackawanna	3	2	5	0	3
Lancaster	5	2	12	0	2
Lawrence	1	1	4	0	0
Lebanon	1	1	3	1	1
Lehigh	4	1	10	2	5
Luzerne	6	2	6	3	3
Lycoming	1	1	3	0	1
McKean	1	1	3	0	1
Mercer	2	1	9	0	1
Mifflin	0	0	1	0	0
Monroe	2	1	3	1	1
Montgomery	4	4	17	5	4
Montour	0	1	1	0	1
Northampton	1	1	11	1	2
Northumberland	2	0	4	0	1
Perry	0	0	0	0	0
Philadelphia	22	12	54	7	21
Pike	0	0	1	0	0
Potter	1	0	1	0	1

Table C-1
Mental Health Facilities
By Service Type and County

County	Psychiatric Emergency Walk-in	Hospital Inpatient	Outpatient	Partial Hospitalization/ Day Treatment	Residential
Schuylkill	3	2	3	1	0
Snyder	0	0	0	0	0
Somerset	3	1	2	0	1
Sullivan	0	0	0	0	0
Susquehanna	0	0	0	0	0
Tioga	0	0	3	0	1
Union	0	0	2	0	0
Venango	0	1	2	0	1
Warren	0	2	4	1	0
Washington	3	1	5	1	3
Wayne	0	0	1	0	0
Westmoreland	4	3	12	1	3
Wyoming	1	0	1	1	0
York	3	1	10	1	2
Total	127	84	374	53	111

SOURCE: "Substance Abuse and Mental Health Services Administration (SAMHSA) Behavioral Health Treatment Services Locator," *U.S. Department of Health & Human Services*, accessed August 23, 2019, https://findtreatment.samhsa.gov/locator.

APPENDIX E:
POSITION STATEMENTS
OF NATIONAL ORGANIZATIONS

American Psychiatric Association

American College of Emergency Physicians

Position Statement on Emergency Boarding of Patients with Acute Mental Illness

"Policy documents are approved by the APA Assembly and Board of Trustees. . . These are . . . position statements that define APA official policy on specific subjects. . ." – *APA Operations Manual*

Issue:

Individuals with acute mental illness are increasingly seeking psychiatric care in emergency department (ED) settings. This situation is, in part, a culmination of a failure of states and localities to invest adequately in preventive mental health and substance use services, coupled with reductions in inpatient and crisis services. The inability or failure to access lower levels of care, such as outpatient services, respite care and subacute services, has led patients and families to seek more expensive emergency care during decompensated states. There are few psychiatric emergency services nationwide dedicated to the evaluation and treatment of patients during an exacerbation. Care is more often being provided by emergency medicine physicians who generally have received little training in the evaluation and management of psychiatric disorders. As a consequence, the default treatment disposition typically becomes psychiatric admission for these patients. Unfortunately, over the years, the number of psychiatric beds has been reduced, leading to a backup of patients in emergency departments awaiting an inpatient psychiatric bed. This is particularly true for the most vulnerable psychiatric populations, including children and adolescents, developmentally disabled individuals, and persons with serious and persistent mentally illness.
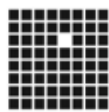
Once a patient has been evaluated and is awaiting disposition, the patient is considered to be "boarded" in the ED. The wait for boarded patients can be hours, and even days to weeks. During this time, there is often little active psychiatric treatment available. Furthermore, environmental factors in the ED may result in further exacerbation of underlying psychiatric symptoms.

POSITION:

Prolonged boarding of patients with acute mental illness in emergency departments leads to inadequate care, may be harmful, and is unacceptable. All efforts should be made to help place each patient at the appropriate level of psychiatric care. When boarding is unavoidable, the emergency department should ensure that the patient is receiving active, appropriate, and humane mental health treatment in a safe setting with periodic re-evaluation for any emerging physical health problems. Depending on the needs of each patient, this treatment may include appropriate interventions for agitation and other acute symptoms, supportive therapy, and initiation of medications for their primary mental illness. Attention should also be paid to patient comfort and the ED staff should provide regular updates for the patient and family. All emergency settings should have access to psychiatrists, on-site or via telepsychiatry, to assist in conducting an adequate evaluation and in providing optimal care.

Authors: Kimberly Nordstrom, Jon Berlin, Naomi Schmelzer, Sejal Shah, David Gitlin
Council on Psychosomatic Medicine

Adoption Date: July 2016

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Boarding of Admitted and Intensive Care Patients in the Emergency Department

Approved June 2017

Revised June 2017, April 2011, April 2008, January 2007.

Originally approved October 2000

Optimal utilization of the emergency department (ED) includes the timely evaluation, management, and stabilization of all patients. Once admitted, patient care is most effectively and safely delivered on inpatient units. Boarding of admitted patients in the ED represents a failure of inpatient bed management and contributes to lower quality of care, decreased patient safety, reduced timeliness of care, and reduced patient satisfaction. Additionally, it directly contributes to ED crowding due to the resultant loss of bed and resource capacity. As ED boarding is a hospital-wide problem, ED leadership, hospital administrators, EMS directors, community leaders, state and federal officials, hospital regulators and accrediting bodies must work together to find solutions to this problem. In order for the ED to continue to provide accessible and high quality patient care, the American College of Emergency Physicians (ACEP) believes that:

- Hospitals bear the responsibility of ensuring the prompt transfer of admitted patients to inpatient units as soon as the disposition decision by the treating emergency physician has been made. Additionally, in the event of ED boarding, hospitals must have established over-capacity contingency plans in place.

- If transfer of admitted patients to inpatient units is delayed, the hospital must provide the supplemental nursing staff necessary to care for the patients boarded in the ED.

- The care of patients boarding in the ED should be governed by the principles outlined in the ACEP policy statement 'Responsibility for Admitted Patients' (https://www.acep.org/Clinical-Practice-Management/Responsibility-for-for-Admitted-Patients/).

ACEP POLICY STATEMENT

*Boarding of Admitted and Intensive Care Patients
in the Emergency Department
Page 2 of 2*

- In the event that the number of patients needing evaluation or treatment in an ED is equal to or exceeds the ED's treatment space capacity, admitted patients should be promptly distributed to inpatient units regardless of inpatient bed availability, for example, to inpatient hallways.

- Hospitals should have staffing plans in place that can mobilize sufficient health care and support personnel to meet increased patient needs.

- Hospitals should develop appropriate mechanisms to facilitate availability of inpatient beds, nursing staff, and support personnel to meet the increased patient needs in the event of ED boarding.

- Emergency physicians and emergency medicine leadership should be involved in the hospital-wide efforts aimed at monitoring and improving inpatient resource utilization.

- Nurse staffing patterns applicable to other specialized areas/units of the hospital should apply equally to the boarded ED patients to assure that there is a consistent standard of care within the organization. These staffing patterns must not degrade the ability of the ED staff to provide emergency care and must be consistent with established guidelines, such as the Emergency Nurses Association (ENA) position statement 'Staffing and Productivity in the Emergency Department' (https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/staffingandproductivityemergencydepartment.pdf?sfvrsn=c57dcf13_6)

- Hospital diversion, as a temporary solution to ED boarding, should only be instituted if internal resources have been exhausted and outside community facilities have resources available to meet the needs of diverted patients. Additionally, all mechanisms for diversion must be consistent with ACEP policy on ambulance diversion.

- Hospital regulatory and accrediting bodies should mandate standards for prompt transfer of admitted patients from the ED to inpatient units.

- Hospitals should have established protocols and procedures related to the expeditious transfer of boarded patients to in-network facilities with acceptable, available inpatient beds when none are available at the hospital of origin.