

*Tennessee's Public-Private Psychiatric Delivery System:
A Joint Plan of Action*



AND



Approved February 22, 2017

Executive Summary

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) and Tennessee Hospital Association (THA) brought together a public/private collaboration among community partners and formed a work group to review Tennessee's current psychiatric care delivery system. After a thorough analysis of all the information and data available in combination with a review of the national best practices related to treating patients in a state of psychiatric crisis, two areas for improvement were identified in Tennessee's current delivery system.

The first area for improvement in Tennessee's current psychiatric delivery system was attributed to when and where a patient in psychiatric crisis begins receiving their treatment. National research strongly indicates that the sooner a person's treatment can begin, the more effective their treatment will be. A key emphasis must be placed on providing treatment immediately at the point of entry into the system. Not only is this concept beneficial to the psychiatric delivery system as a whole, but more importantly it improves the quality of care for patients.

The most common point of entry into the delivery system for those in psychiatric crisis is through the hospital emergency departments (EDs). EDs have a crucial role to play in the treatment of those in a psychiatric crisis. In response to this need, the work group has developed a recommended set of Psychiatric Treatment Protocols for EDs. A select number of EDs have already agreed to implement these protocols and participate in a data collection effort as part of a pilot program to measure the success of the protocols. However, this work group encourages all EDs across the state to implement these psychiatric protocols in their hospitals.

By implementing these Psychiatric Treatment Protocols in EDs, we expect that the delivery system will experience increased inpatient bed availability, a decrease in wait times, and most importantly a higher quality of care for those in psychiatric crisis.

The second area identified for improvement was the need to increase utilization of Crisis Stabilization Units (CSUs) in the state. On average, CSUs operate around 65-70% capacity while inpatient hospitals continue to operate at maximum capacity. When clinically appropriate, CSUs should be utilized more as a viable alternative to inpatient hospitalization for those in a psychiatric crisis. In addition, CSUs will be expanding their walk-in capacity to create more access to care.

To facilitate the higher utilization of CSUs across the State, TDMHSAS has begun increasing its education efforts related to community awareness and understanding of the CSUs capabilities

to provide treatment to those in a psychiatric crisis. CSUs are reevaluating their ability to admit higher acuity patients in a clinically appropriate manner. We expect better utilization of CSUs which should result in more inpatient bed availability, a decrease in wait times, and most importantly a higher quality of care for those in psychiatric crisis.

Background & Overview

Nationwide, the public and private psychiatric care delivery system has been experiencing increases in demand for services for those experiencing a behavioral health crisis. Increased demand on the entire system has been especially straining on the inpatient psychiatric hospital system. Often states reflect that persons experiencing a behavioral health crisis can wait for a week or even a month for placement in psychiatric care. Unfortunately, Tennessee is beginning to experience an increase in wait times and the number of persons waiting for placement as well. However, Tennessee continues to outperform the nationwide average related to wait time for patients experiencing a behavioral health crisis due to its already established practices. Last fiscal year in the public system, a percentage of all presentations were subject to delay. The average wait time for placement for those patients was approximately 25 hours in Tennessee.

Tennessee's existing resources in its public/private inpatient psychiatric delivery system continues to operate at maximum capacity which is contributing to wait times for patients in need of inpatient psychiatric care. Tennessee does not want to become like other States, with week or even month long wait times for those dealing with a psychiatric crisis. In order to proactively address this problem, Tennessee has taken a clinically appropriate, innovative, unprecedented, and hopefully trendsetting approach geared at working towards continuously improving the public/private psychiatric care delivery system.

TDMHSAS and THA have led the way and brought together a public/private collaboration among community partners and formed a work group to review Tennessee's current psychiatric care delivery system. For additional information related to the Background and Overview see Attachment A.

Mission of the Work Group:

To review the current Tennessee Public/Private psychiatric crisis system, community alternatives, and hospital delivery system to ensure Tennessee is providing the right treatment, at the right time, in the right place. Our aim is to not become like other state systems that average waits of weeks and months for assessments and placement in treatment for persons experiencing a behavioral health crisis. As such, we will review the current delivery system to promote quality, effective and efficient care for Tennesseans.

This collaborative work group identified four key areas to be addressed:

- Recommended Emergency Department Protocols for Treatment and Communication
- Crisis System Evaluation
- Inpatient Bed Availability
- Regulatory, Legal, and Operational Barriers

Collaborative Work Group Members co-chaired by Mike Dietrich, THA Vice President and Marie Williams, TDMHSAS Commissioner:

Meeting Hosts:

- Cookeville Regional Medical Center, Cookeville, TN (9/27/2016)
- Moccasin Bend Mental Health Institute, Chattanooga, TN (10/27/2016)
- Tennessee Hospital Association Headquarters, Brentwood, TN (11/28/2016 & 1/31/2017)

TDMHSAS:

- Marie Williams, Commissioner
- Sejal West, Deputy Commissioner
- John Arredondo, Assistant Commissioner of Hospital Services
- Mary Young, CEO Moccasin Bend Mental Health Institute
- Rob Cotterman, CEO Middle Tennessee Mental Health Institute
- Dr. Terry Holmes, Moccasin Bend Mental Health Institute
- Dr. Howard Burley, Medical Director
- Morenike Murphy, Director of Crisis Services
- Kurt Hippel, Director of Legislation/Assistant General Counsel
- Micheal A. Jones, Director of Communications

THA:

- Mike Dietrich, Vice President of Member Services
- Adrienne E. Nordman, Director of Member Services

Community Partners:

- Dr. Jeffrey Wood, DNP, CEO Trustpoint Hospital
- Curtis Newman, RN, Director, Emergency Services
Southern Tennessee Regional Health System
- Holly Kunz, MHCA, BSN, RN, CEN, Assistant Chief Nursing Officer/Adm. Director ED
Maury Regional Medical Center
- Dr. Sandy Herman, Past President Tennessee College of Emergency Physicians
- Dr. Jennie Mahaffey, Medical Director, Behavioral Health
Erlanger Health System

Cookeville Regional Medical Center:

- Dr. Sullivan Smith, Medical Director, Emergency Services

- Dr. John B. Averitt, Hospitalist
- Jason Brown, Social Services
- Barb Davis, R.N., Care Manager

The following report is a comprehensive review of the work that this collaborative group has accomplished to-date and the work it has identified that needs to be addressed moving forward.

TDMHSAS – THA Work Group Report

Tennessee’s Public/Private Psychiatric Delivery System

1) Recommended Emergency Department Protocols for Treatment & Communication

Findings:

- Increasing wait times in EDs for those in a psychiatric crisis
- Lack of Mental Health expertise in EDs
- Few practitioners are educated to provide psychiatric care in EDs

Summary:

The literature around ED boarding discusses the development of protocols for treatment of mental health issues similar to the ones currently in use for the management and treatment of trauma, strokes and heart attacks. Given the shortage of mental health professionals and services in Tennessee and the need for of mental health treatment expertise by emergency department staff, the ED Taskforce focused much of its efforts on recommended guidance that could be readily adopted by hospital emergency departments to immediately help de-escalate agitated patients and begin therapeutic treatment. TDMHSAS, THA, and other community partners have collaborated to develop recommended Emergency Department Psychiatric Protocols (hereafter “Protocols”). While the work group recommends the adoption of the Protocols, they are shared for educational purposes only and are not required. The voluntary use or adoption of the Protocols is left to the independent professional judgement of the providers and facilities receiving, treating, or otherwise interacting with psychiatric patients. The Protocols should not be taken as a directive or mandate from the State of Tennessee, the TDMHSAS, the THA, or any other member of the work group. TDMHSAS, the THA, and all other members of the work group shall not be represented as providing or dictating the care or treatment to any psychiatric patient under the care of any provider or facility following these voluntary protocols. Furthermore, TDMHSAS, THA, and all other members of the work group shall be held harmless and do not assume any responsibility or liability whatsoever for the use of this information, educational material, or any guidance provided regarding the Protocols.

Actions to Date:

A subcommittee of the ED Taskforce created recommended psychiatric treatment protocols (Attachment B) to facilitate effective treatment being provided at the right time in the right place. The pilot will be tested in several hospital emergency rooms in the state beginning in Q1 of 2017. These recommended protocols address standard treatment for mood stabilization, psychosis, extrapyramidal side effects as well as emergency treatment for patients experiencing various levels of agitation due to the fact that these are the most common symptoms involving ED visits.

The voluntary participants involved in piloting the recommended treatment protocols will also continue to monitor their established metrics and outcomes in order to evaluate the effectiveness. This data will be reported and aggregated on a quarterly basis and used by the taskforce to alter the recommended protocols as necessary over the course of the 1-year pilot program.

Although several sights have volunteered to pilot these recommended protocols in several hospitals, we will be disseminating and encouraging the use of these recommended protocols at all existing hospitals so that they can begin using this process as well.

Work Ahead:

The ED taskforce is currently developing training and education for the pilot hospitals to integrate the recommended treatment protocols into their hospital policies and practices. The education will incorporate other aspects of the taskforce's recommendations as well, including the crisis services FAQ document and best practices in gaining patient consent. The education will be open to any other hospitals interested in piloting the recommended treatment protocols and it is anticipated that additional hospitals will be brought into the pilot program throughout 2017 as the work advances.

The taskforce also identified substance abuse as a major component to this project. The taskforce will address it in subsequent meetings with a recommendation forthcoming.

Impact Statement:

Implementing Psychiatric Treatment Protocols in Emergency Departments across Tennessee will substantially improve the quality of care for those patients in a psychiatric crisis. These recommended protocols will ensure that patients are receiving the effective treatment at the right time. As Emergency Departments begin to implement these recommended protocols, we expect the psychiatric care delivery system as a whole will experience a reduced need for inpatient hospitalization, shortened wait times for patients, better collaboration between community providers and EDs facilitated by the Mobile Crisis Teams, and more effective and efficient care for those patients experiencing a psychiatric crisis.

2) Crisis System Evaluation

Findings:

- Inconsistent use of community resources
- Underutilization of some Crisis Stabilization Units (CSUs)
- Approx. 40% of all individuals seen Face-to-Face are uninsured

Summary:

TennCare and TDMHSAS jointly fund the crisis system for the state of Tennessee to respond to individuals who are experiencing a mental health crisis. The crisis system includes 13 mobile crisis team providers, 8 CSU's and walk-in centers, and 4 respite providers. The 13 mobile crisis providers are annually funded at approximately \$23.7 million (\$4.5 TDMHSAS, \$19.2 TennCare) who respond to adult and child crisis situations.

In FY15 there were a total of 110,869 crisis phone calls, of which 93,824 were adult related. These phone calls resulted in 62,145 adult face to face assessments by crisis teams of which 86.5% were responded to within the 2 hour state required timeframe.

These assessments resulted in 41,330 (66%) being cared for in the least restrictive appropriate community clinical treatment settings (csu, respite, outpatient, home, etc.) and 20,899 (34%) being referred for hospitalization.

The focus of the Crisis System Evaluation subcommittee is to assess and promote what best practices contribute to an efficient and effective crisis continuum. This includes shared partnerships between community mental health center crisis providers and local hospital systems, as well as among the statewide behavioral health community at large. Current action steps include the development and provision of professional trainings to ensure proper communication and coordination between the crisis services system, emergency departments, and hospitals; education and awareness activities among identified communities related to community-based crisis services; conceptualizing a plan for embedding mandatory prescreening agents (MPAs) in non-traditional environments; and utilizing telehealth technology among identified pilot site emergency departments.

Actions to Date:

- In an effort to standardize the processes involved in the psychiatric crisis delivery system, a Frequently Asked Questions (FAQs) document (Attachment C) was created in regards to Mobile Crisis, the hospitalization process, Mandatory Prescreening Agents (MPAs), and Crisis Stabilization Units (CSUs).
- The legality of the FAQs has been reviewed and approved by the State's Attorney General's Office; the FAQs document will ensure systemic understanding of the processes involved in the crisis delivery system.
- Initial aggregation of current capabilities and capacity of each CSU in the statewide continuum, regarding medication supply, acuity, telehealth, and substance abuse management

Work Ahead:

- Continue Training Models to support local community education
- Continued identification of barriers and needs of CSUs and strategies to overcome them to achieve optimal capability
- Further assessment of best practices in Tennessee for mobile crisis, the hospitalization process, MPAs, CSUs, and obtaining consent
 - Research & Data review
 - Identification of barriers/challenges
 - Identification of available resources (intradepartmental, stakeholders, community partners)

Impact Statement:

- By ensuring that all facets of the psychiatric crisis delivery system (Mobile Crisis Teams, CSUs, Walk-in Centers, and Respite Care Providers) are operating with the same standardized procedures, we anticipate that the psychiatric care delivery system as a whole will experience a reduced need for inpatient hospitalization, shortened wait times for patients, and a better continuum of care.

3) Inpatient Bed Availability

Findings:

- More inpatient beds in 2016 than 2010
- Public and private inpatient facilities continually operating at capacity
- Increasing wait times in the public system for those experiencing a psychiatric crisis

Summary:

Due to the current operation of the psychiatric care delivery system in Tennessee, Tennessee's public and private mental health hospitals have been operating at capacity. Continual operation at capacity, the lack of adequate cost per day reimbursement rates to care for the acutely ill, and severe shortages of mental health professionals appears to be primary drivers of the ED boarding crisis.

Actions to Date:

A committee of the Taskforce evaluated hospital data to help identify demographic and payer trends in patients being boarded in emergency rooms as well as overall inpatient mental health hospital bed and volume trends (Attachment D).

The Taskforce also worked with the Department of Health on upgrades to the mental health portal of the [Hospital Resource Tracking System \(HRTS\)](#). The portal was developed earlier in the year to assist crisis services staff, hospital discharge planners and others to identify available mental health beds in their area. THA has developed materials to help educate hospitals and other stakeholders on the use of the HRTS system and the mental health portal.

Work Ahead:

- Reimbursement. Adequate reimbursement for inpatient mental health services continues to be a problem in the state, especially for certain populations (e.g. pediatric and adolescent) and those patients with very high acuity.
- Child and Adolescent Needs. The Taskforce recommends that a specific child/adolescent task force be created because of the unique needs of this population. Leadership from TennCare will be invited to participate since many of these children have Medicaid coverage.
- Parity. The Taskforce also recommends that a system/process be established to evaluate and monitor the compliance of Tennessee payers with the federal Mental Health Parity and Addiction Equity Act laws.

Impact Statement:

By reviewing the current status in Tennessee related to inpatient bed availability, we feel that a review of funding for inpatient beds as well as implementing treatment protocols in EDs will help address the current wait time and bed availability situation. We expect that the standardization of the crisis delivery system and proper utilization of all community resources will result in a reduction of need for inpatient hospital beds which will alleviate the inpatient census issue. In addition more inpatient beds are being added to the private system, 76 Adult beds were approved through the Certificate of Need (CON) process in 2016 (52 in Murfreesboro & 24 in Chattanooga) and so far 50 Adult beds are pending CON review in 2017 (42 in Maury County & 8 in Jasper, TN). In addition, existing psychiatric hospitals are able to expand bed capacity by up to 10% pursuant to the new CON rules. Lakeside Behavioral Health System (Memphis, TN) and Moccasin Bend Mental Health Institute (Chattanooga, TN) have already taken advantage of this new exception and will be expanding bed capacity.

4) Regulatory, Legal and Operational Barriers**Findings:**

- Regulatory, legal, and operational barriers inhibit the psychiatric care delivery system

Summary:

The Taskforce identified a number of additional areas of need to help resolve the ED boarding crisis including workforce, hospital staff safety, and telehealth.

Actions to Date:

- Workforce. THA worked with the Bureau of TennCare to allow existing state grant monies to be used for recruitment of mental health professionals via the Tennessee Rural Partnership's residency stipend and community incentive programs. The TDMHSAS is also planning to hire a recruiting specialist.
- Staff Safety. THA has partnered with the Department of Health's Healthcare Preparedness Program to address workplace safety and security using federal funding for education, training

and other support. THA and the Department will host regional education meetings in 2017 for hospitals, EMS and other stakeholders around employee safety and seclusion and restraint legal issues and best practices.

Work Ahead:

Telehealth. The Taskforce recommends creating a work group to identify barriers to an effective telehealth system in the state and opportunities for resolution around key aspects related to hospital credentialing, connectivity, security, etc.

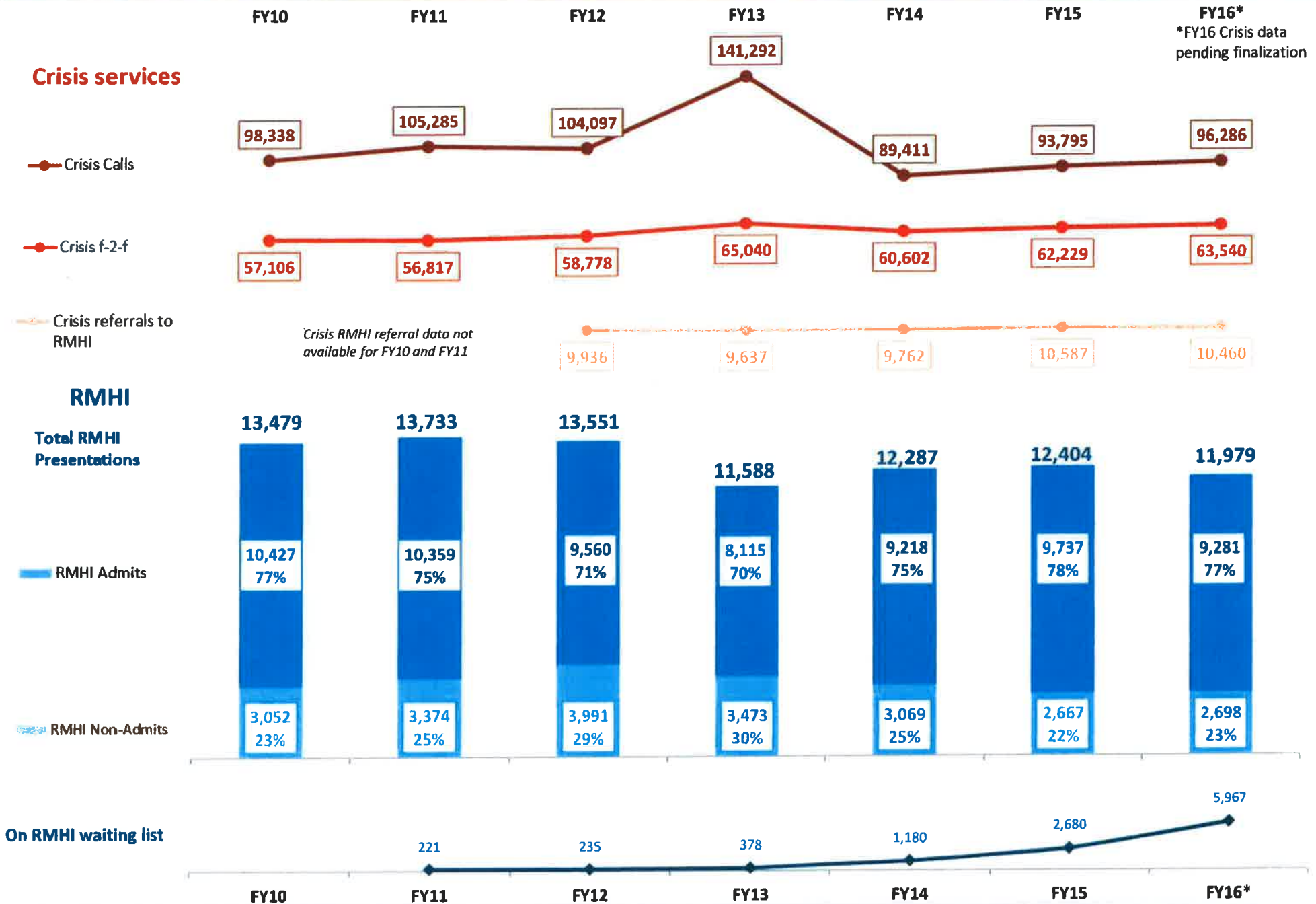
Impact Statement:

By addressing the regulatory and legal barriers associated with Telehealth, we believe it will facilitate the expansion of Telehealth utilization in the psychiatric care delivery system which should result in better collaboration among providers, the ability access to psychiatric expertise in traditional medical settings, and more efficient delivery of care.

Conclusion:

The results of this unprecedented public/private collaboration will be realized through a more effective and efficient psychiatric care delivery system. The overall goal is to ensure that delivery system is accomplishing the “4 R’s” by serving the **Right People**, with the **Right Treatment**, in the **Right Place**, at the **Right Time**. The impact of this collaboration will be monitored for improvement in better utilization of community resources and appropriate treatment options, number of patients diverted from an inpatient bed, an increase in the inpatient bed availability, and a decrease in wait time for the patients that are experiencing a delay in the public delivery system.

Comparison of RMHI Presentations and Adult Crisis Services

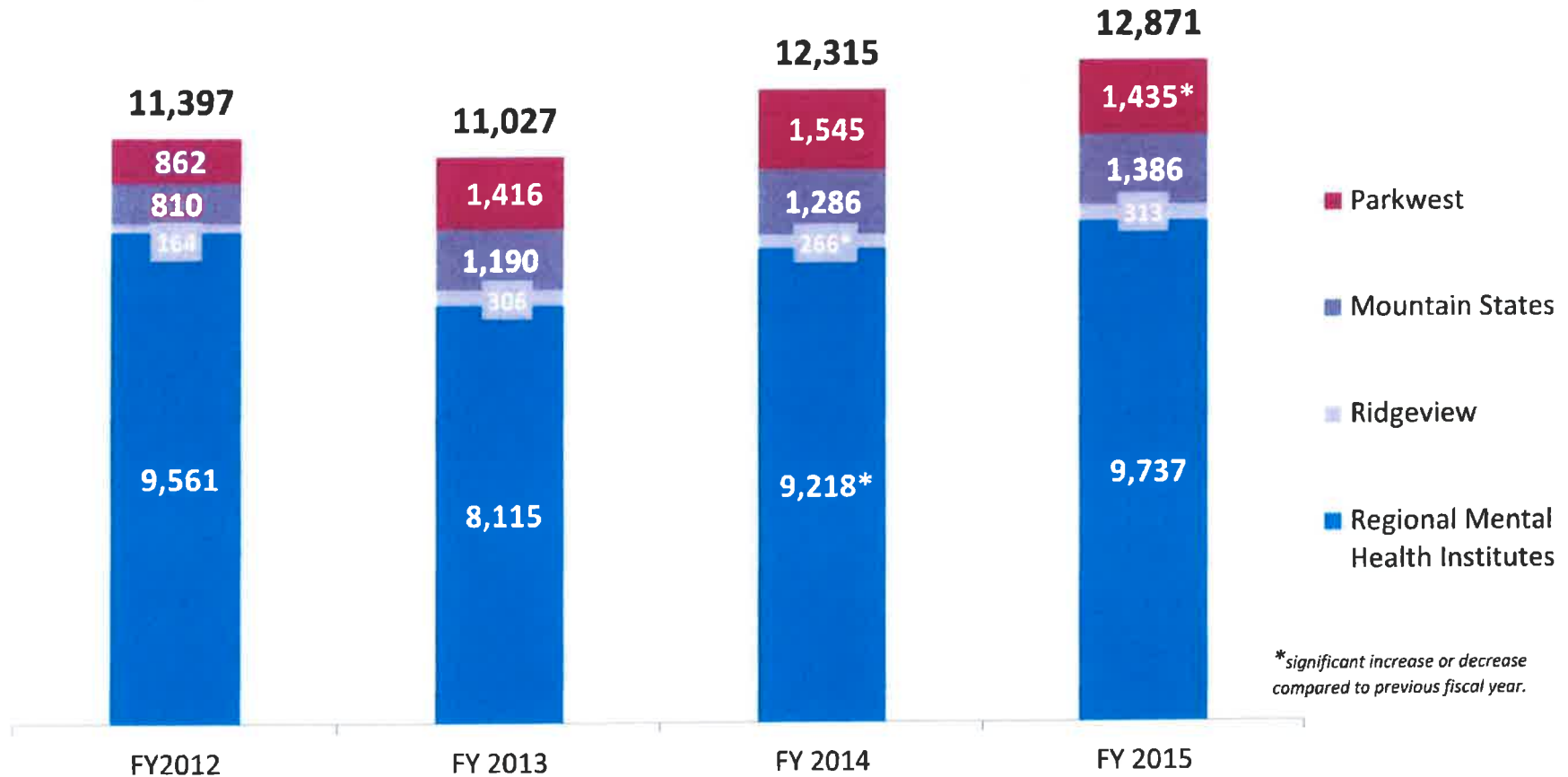


REGIONAL MENTAL HEALTH INSTITUTES AND PRIVATE PSYCHIATRIC HOSPITALS THAT CONTRACT WITH TDMHSAS

Table 43. TDMHSAS-funded admissions to psychiatric hospitals

	FY2012	FY 2013	FY 2014	FY 2015
Regional mental health institutes	9,561	8,115	9,218	9,737
Private psychiatric hospitals that contract with TDMHSAS	1,836	2,912	3,097	3,134
Statewide number of admissions	11,397	11,027	12,315	12,871

Chart 34. TDMHSAS-funded admissions to regional mental health institutes and private psychiatric hospitals that contract with TDMHSAS



**significant increase or decrease compared to previous fiscal year.*

Data source: TDMHSAS Division of Hospital Services.

Please note that Lakeshore Mental Health Institute closed with the end of FY2012; TDMHSAS started contracting private psychiatric hospitals in FY2012.

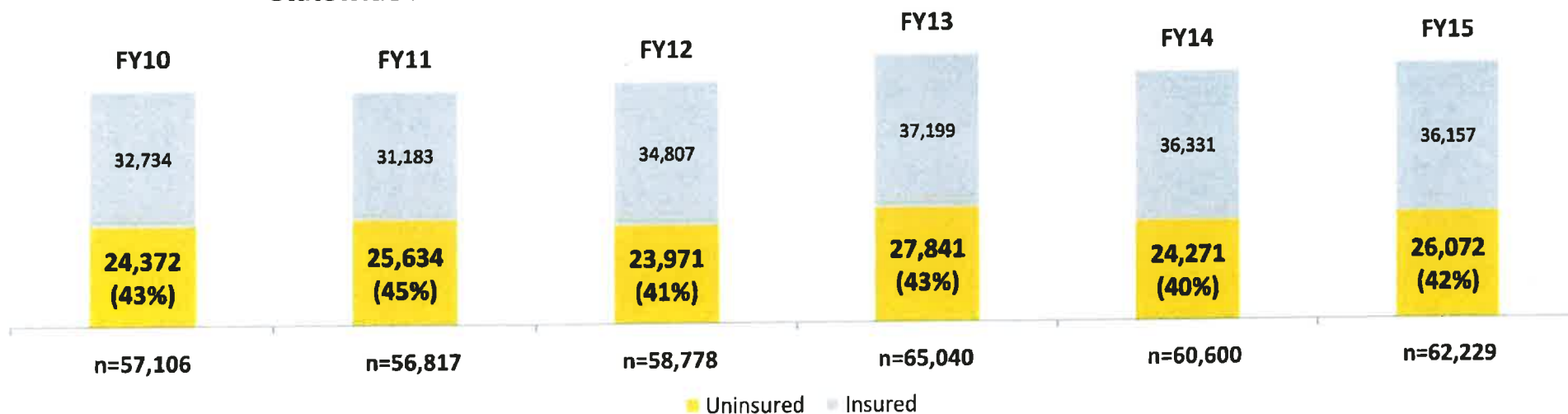
Statewide, the percentage of adult face-to-face assessments without any insurance was 42% in FY15.

Statewide percentage of adult face-to-face assessments without insurance

43% 45% 41% 43% 40% 42%

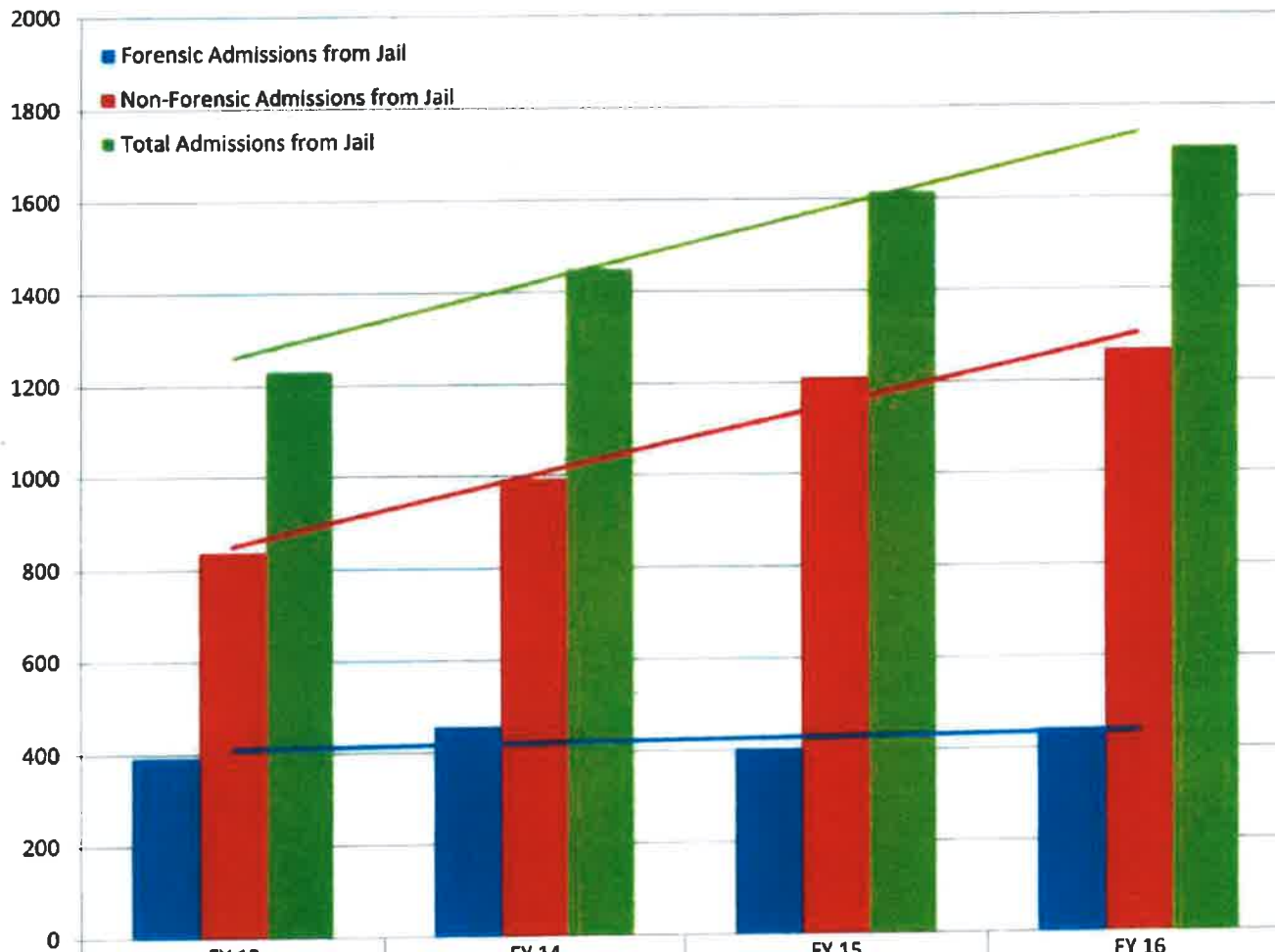
FY10 FY11 FY12 FY13 FY14 FY15

Statewide number of adult face-to-face-assessments with and without insurance



Data sources: Data was collected with Excel spreadsheets from FY10 to FY13. Crisis Database started in FY14.

RMHI Admissions from Jail (Forensic and Non-Forensic)

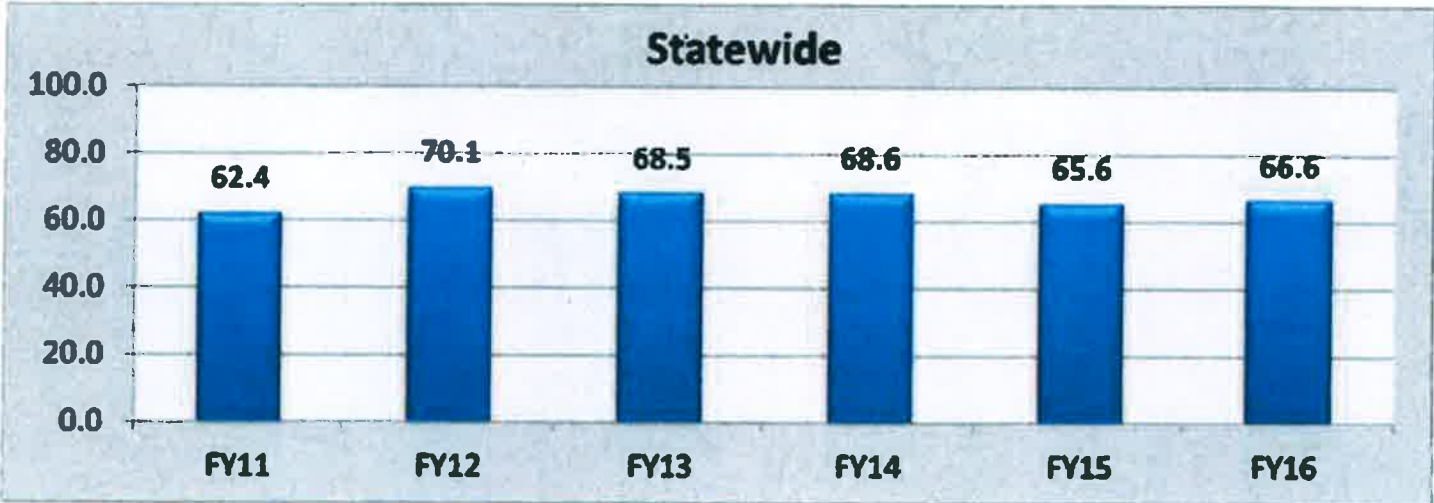


	FY 13	FY 14	FY 15	FY 16
Forensic Admissions from Jail	394	458	404	443
Non-Forensic Admissions from Jail	838	993	1212	1269
Total Admissions from Jail	1232	1451	1616	1712

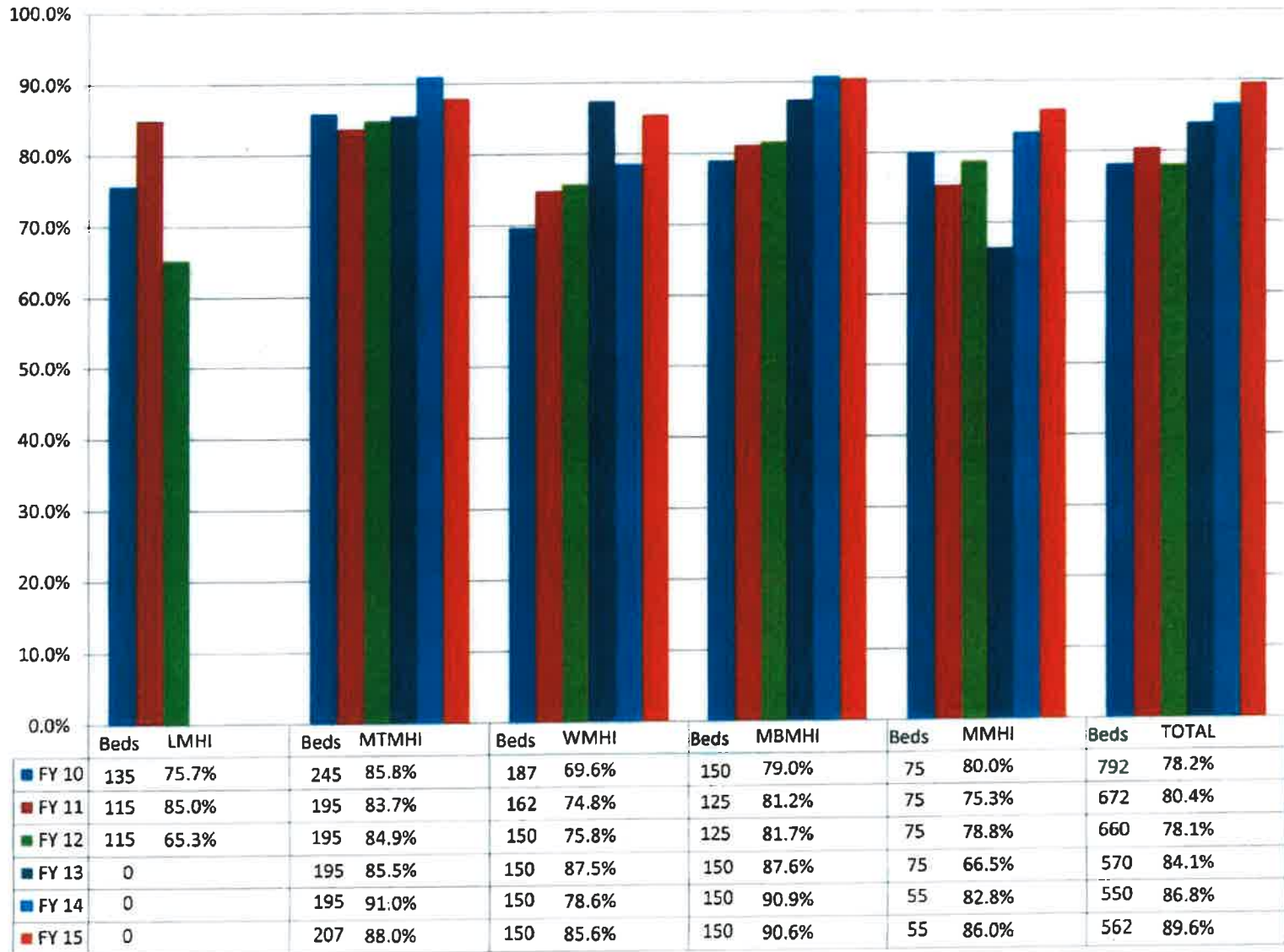
Statewide and Provider CSU Census-FY11 - FY16

Average % Occupancy

	FY11	FY12	FY13	FY14	FY15	FY16
Statewide	62.4	70.1	68.5	68.6	65.6	66.6



RMHI Occupancy Rate FY 10-15 and Staffed Beds



Utilization Review Data: AVATAR

F:\WINWORD\DATA UR FOR HOSPITALS\FY 16 Stats\Percent Occupancy 10-15 3-2

Division of Hospital Services: EBG

Change in Psychiatric Beds, 2011 – 2016

State of Tennessee, Private and Public Beds

Psychiatric Beds 2011 – 12*	Psychiatric Beds 2015 – 16**
2,509 (JAR-H = 2559 beds)	2,596
Bed Changes by Type: Overall increase of 87 beds	
Adult Psych	-23
Geropsych	+48
Child/Adolescent	+68
Unknown	-6
Total	+87

Data Sources:

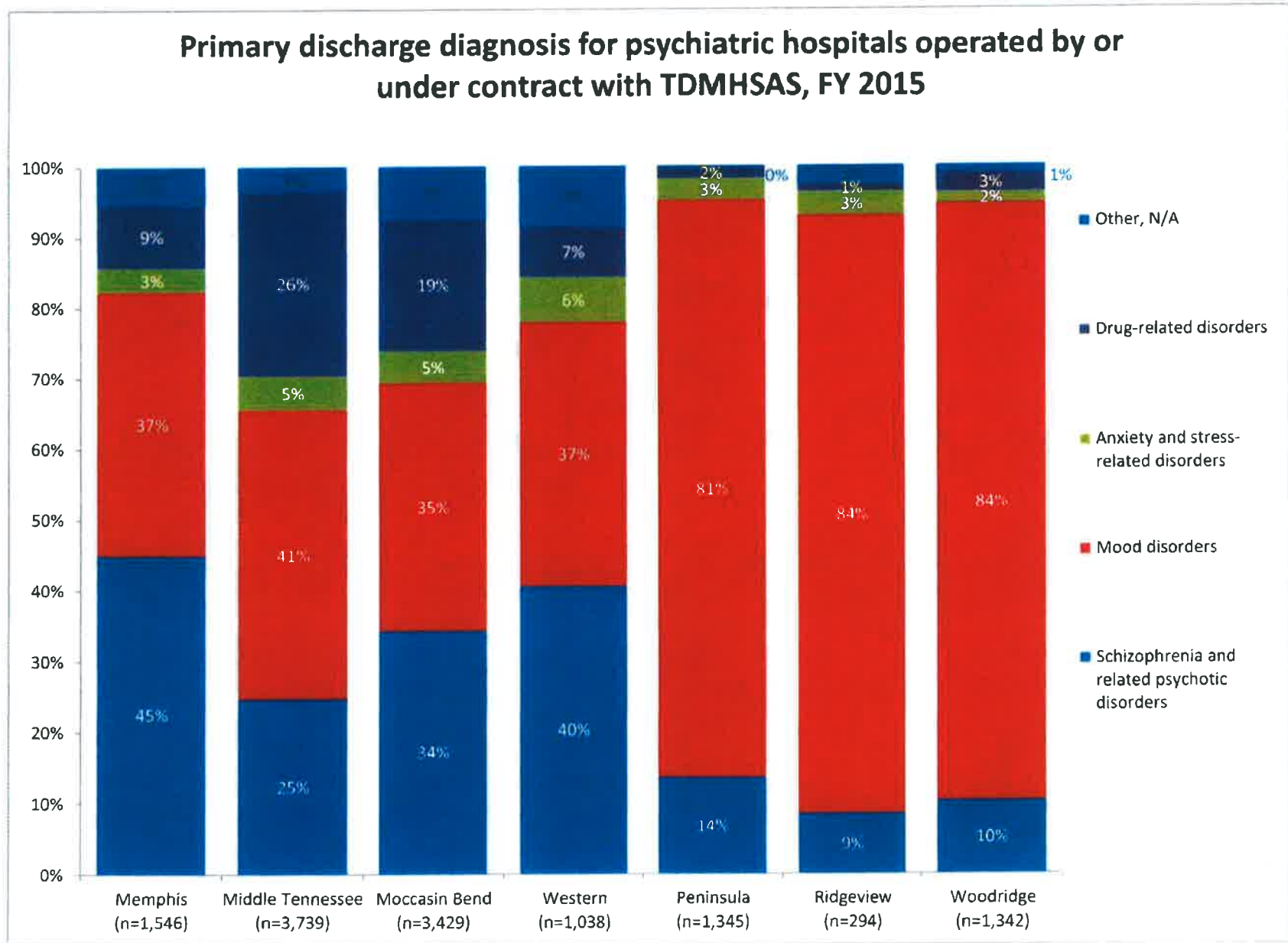
* Bed numbers for 2011 – 12 are based on the JAR-H 2011 data (from THA), corrected where indicated based on HSDA and TDMHSAS Licensure information.

** Bed numbers for 2015 – 16 are based on the JAR-H 2014 data (from THA), updated to 2016 and corrected where indicated based on HSDA and TDMHSAS Licensure information.

Note: The 2015 – 16 bed numbers include all CON-approved beds as of April, 2016, including beds that may not be implemented as of July, 2016. (The 76 new psychiatric beds that were approved in May for Erlanger to construct are not included in the above bed numbers.)

Considerations:

- Hospitals submit JAR-H data based on the hospital's fiscal year, which will vary from hospital to hospital. For example, the 2011 JAR-H reports may cover the time period of July 1, 2010 through June 30, 2011 OR the time period of January 1, 2011 through December 31, 2011.
- There is some obvious inconsistency across the JAR-H reports re: whether the number of beds reported are licensed beds or operating beds (aka "staffed beds").
- Operating beds ("staffed beds") can – and will – vary from time to time, based on utilization patterns and staff availability. Reports of operating beds should be considered a "point-in-time" picture of the number of beds.
- Some hospitals erroneously reported non-hospital beds in their JAR-H reports. For example, Pathways reported 25 beds on their JAR-H report, but only have 10 licensed hospital beds (the other 15 beds are licensed as crisis stabilization beds). These bed numbers were corrected based on TDMHSAS Licensure information.



PHYSICIAN'S ORDERS

Standard Psychiatric Treatment Protocol		
<i>Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician.</i>		
Date	Time	Additional Orders: (Dates/Times required)
		<input type="checkbox"/> Consult Crisis <input type="checkbox"/> Consult Psychiatry <input type="checkbox"/> Labs per Department of Mental Health medical clearance guidelines
FOR MOOD STABILIZATION: May use alone or in combination with next section (Treatment of Psychosis)		
		<input type="checkbox"/> Divalproex Sodium 1000mg PO at completion of physical and mental assessment (Contraindicated in severe hepatic impairment: Child-Pugh Class C) (Caution in women of childbearing age who may be or become pregnant.)
FOR MOOD STABILIZATION and/or TREATMENT OF PSYCHOSIS: (Choose only one therapy)		
		<input type="checkbox"/> Lurasidone 40mg PO daily (Consider use in women of child bearing age who may be or become pregnant)
		<input type="checkbox"/> Risperdone 1mg PO BID OR <input type="checkbox"/> Risperidone 0.5 PO BID (for patients with severe hepatic impairment)
		<input type="checkbox"/> Ziprasidone 40mg BID with food
		<input type="checkbox"/> Haloperidol 5mg PO BID (only indicated for psychosis)
FOR GERIATRIC AGITATION		
		<input type="checkbox"/> Quetiapine 50mg PO BID AND <input type="checkbox"/> Quetiapine 200mg at HS (hold if sedated)
FOR PREVENTION OF EXTRAPYRAMIDAL SIDE EFFECTS AND TO PROMOTE MILD SEDATION AND SLEEP:		
		<input type="checkbox"/> Diphenhydramine 50mg PO BID OR <input type="checkbox"/> Benztropine 1mg PO BID

[Insert Hospital Name Here]

Physician's Orders

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PHYSICIAN'S ORDERS

Behavioral Emergency Treatment Protocol		
THIS IS IN ADDITION TO STANDARD PROTOCOL FOR ALL PATIENTS		
<i>Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician.</i>		
Date	Time	Additional Orders: (Dates/Times required)
MILD TO MODERATE AGITATION:		
FOR PRN USE IN THOSE PATIENTS EXPERIENCING MILD TO MODERATE AGITATION OR DANGEROUS BEHAVIOR, CONSENTING TO ORAL MEDICATIONS.		
<i>(Check one regime only)</i>		
		<input type="checkbox"/> Haloperidol 5mg PO Q4 hrs PRN agitation
		<input type="checkbox"/> Ziprasidone 60mg PO Q12 hrs PRN agitation
		<input type="checkbox"/> Quetiapine 50mg PO Q2 hrs PRN agitation (Geripsych neurocognitive disorder)
		<input type="checkbox"/> Risperidone disintegrating tab 2mg PO q12 hours PRN agitation
		<input type="checkbox"/> Olanzapine disintegrating tab 10mg PO q12 hours PRN agitation
With optional addition of:		
		<input type="checkbox"/> Lorazepam 2mg PO q4 hours PRN agitation
OR		
EXTREME AGITATION OR DANGEROUS BEHAVIOR:		
FOR PRN USE IN THOSE PATIENTS EXPERIENCING MODERATE TO EXTREME AGITATION OR DANGEROUS BEHAVIOR AND WHO LIKELY LACK CAPACITY TO CONSENT TO TREATMENT.		
<i>(Check one regime only)</i>		
		<input type="checkbox"/> Haloperidol 5mg PLUS Lorazepam 2mg PLUS Diphenhydramine 25mg IM every 2 hours PRN agitation
		<input type="checkbox"/> Ziprasidone 20mg IM PLUS Lorazepam 2mg IM every 12 hours (Dose related QTc prolongation and risk of cardiac arrhythmias with Ziprasidone)
		<input type="checkbox"/> Olanzapine 10mg IM q 8 hours PRN agitation
ALTERNATIVE FOR EXTREME COMBATIVE/VIOLENT BEHAVIOR:		
		<input type="checkbox"/> Ketamine 4mg per kg IM
		OR
		<input type="checkbox"/> Ketamine 1.5mg per kg IV
* Monitor bp and O2 status. In most cases, only effective for initial control.		

[Insert Hospital Name Here]
Physician's Orders
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DISCLAIMER: *The following Frequently Asked Questions and Answers are provided for general advice and educational purposes only. They should not be taken as legal advice. Specific fact patterns and questions should be directed to your organization's legal counsel for review and guidance.*



Frequently Asked Questions - Mobile Crisis

1) Is mobile crisis involvement required for all individuals in need of hospitalization?

A: Typically, yes; however, during times of high call volume prioritization may be given to publicly funded individuals (TennCare and uninsured). This does not affect the crisis system's ability to provide phone or telehealth consultation anytime another professional has completed an assessment and feels the client needs hospitalization. Unless requested, mobile crisis does not have to be involved with commercially insured individuals, with the exception of the need for admission to a state funded hospital.

2) Is mobile crisis required to come to my location to complete a face to face assessment every time I call them?

A: No. Upon receiving a call, mobile crisis will ask a series of questions to determine the most clinically appropriate response. The person calling may be provided information for outpatient services, be directed to the walk-in center, the emergency room or 911 might be dispatched, depending on the circumstances of the call. A face to face assessment may not be conducted if the person's condition is sufficiently stable to seek non-emergent behavioral health care.

Additionally, if the person in crisis is in the presence of a physician or psychologist with HSP designation, mobile crisis may provide telephonic consultation to the physician or psychologist during times of high call volume.

3) Does mobile crisis involvement apply to both voluntary and involuntary hospitalizations?

A: Typically, yes; however, during times of high call volume prioritization may be given to publicly funded individuals (TennCare and uninsured). This does not affect the crisis system's ability to provide phone or telehealth consultation anytime another professional has completed an assessment and feels the client needs hospitalization. Unless requested, mobile crisis does not have to be involved with commercially insured individuals, with the exception of the need for admission to a state funded hospital.

4) What is the standard response time for mobile crisis?

A: The TDMHSAS's contractual expectation is that face to face response occur within 2 hours of receipt of the call requesting assistance at least 90% of the time, never to exceed 4 hours. Some

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flexibility is provided to account for circumstances beyond the control of the crisis provider (for example inclement weather, call volume that exceeds the capability of staff on duty, etc.). TDMHSAS believes telehealth is a viable option for access to behavioral health services and enhancing the efficiency of the crisis service delivery system.

5) Does the recommendation made by mobile crisis have to be followed by the emergency department physician?

A: No. Mobile crisis staff will provide treatment recommendations which may or may not be followed by an emergency room physician. However, due to the expertise and knowledge of the system, physicians are encouraged to follow the recommendations made by mobile crisis.

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¹**Frequently Asked Questions – Emergency Involuntary Admission Process**

1) Is a Certificate of Need (CON or 6404) required to detain an individual in need of psychiatric assessment?

A: No, a certificate of need is not required to detain an individual in need of psychiatric assessment. Individuals posing an **immediate** substantial likelihood of serious harm due to mental illness or serious emotional disturbance may be detained using the emergency involuntary admission process.

2) What is a 6401?

A: A process used to detain an individual for mental health examination.

3) When should the 6401 process be used?

A: When an individual is posing an **immediate** substantial likelihood of serious harm due to mental illness or serious emotional disturbance and needs to be detained until examination can occur.

4) Who is authorized to detain an individual under a 6401 until a psychiatric assessment can be completed?

A: Law enforcement officers authorized to make an arrest, physicians, psychologists or designated professionals (Mandatory Prescreening Agent). Detainment under a 6401 can be implemented in any setting, including hospitals, medical facilities, residences, etc.

5) How do I initiate a detainment under a 6401?

A: There is no legal form for initiation of detaining under this title; however, a sample form has been made available on the TDMHSAS website. Documentation justifying the need to detain an individual for examination can be made in the form of a progress note, doctor’s order, assessment form or other but must indicate why the person is believed to have a mental illness or serious emotional disturbance and how they are posing an **immediate** substantial likelihood of serious harm.

6) When does a 6401 expire?

¹ There is a separate process for non-emergency admissions. i.e. when the substantial likelihood of serious harm is NOT immediate.

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A: Title 33 indicates that the person is to be immediately examined. TDMHSAS has concluded that examination should occur as quickly as possible but not before the person is reasonably able to participate in examination. For example, the individual who comes in too intoxicated to participate in examination (but there is reason to believe there may be a mental illness or serious emotional disturbance and an **immediate** substantial likelihood of harm) may be detained until such time that he/she can participate in examination but no longer than is reasonable or necessary to get an examination completed.

7) What is a 6404 or Certificate of Need (CON)?

A: A certificate of need or 6404 is a legal document used in the involuntary commitment process for individuals posing an **immediate** substantial likelihood of serious harm due to mental illness or serious emotional disturbance based on the face to face examination of the person by a qualified professional.

8) Who is authorized to complete a CON or 6404 for Involuntary Hospitalization?

A: A physician, psychologist or designated professional (Mandatory Prescreening Agent) may complete the first (1st) Certificate of Need for Involuntary Hospitalization. See MPA FAQ for type of professional eligible for MPA designation. Please note, per TCA. 33-4-107 that, for private facilities, one of the two certificates of need must be completed by a disinterested professional who is not an employee of the admitting psychiatric hospital. Only the admitting physician of the receiving psychiatric hospital or treatment resource has the authority to complete the second (2nd) Certificate of Need for involuntary hospitalization.

9) Is screening by a Mandatory Prescreening Agent (MPA) required for all hospitalizations?

A: No. Screening by a MPA is required for anyone being referred for hospitalization at a state owned or operated hospital or treatment resource and any publicly funded person being admitted or committed to a private hospital. If a MPA is not available within two (2) hours of the request, then a licensed physician or psychologist with health service provider designation, in consultation with a member of the crisis response service, may provide one of the certificates of need for involuntary hospitalization.

10) Do Certificates of Need (6404s) expire?

A: No. Title 33 is silent on the issue; thus, the TDMHSAS interpretation is that CON's DO NOT expire.

As a matter of best practice, it is recommended that the person be re-assessed to ensure this level of care is still required if more than 24 hours has passed since the initial CON was written but this can be documented in a progress note, physicians' order, assessment form or other.

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11) Can a Certificate of Need (6404) be rescinded?

A: Yes. Title 33 is silent on the issue but it is the TDMHSAS interpretation that yes, CON's can be rescinded. The decision to rescind a CON shall always be based on a new face to face assessment.

It is recommended that an attempt be made to consult with the original CON writer about the decision anytime possible. If consultation is not possible, it should not prevent a revision to the persons' plan of care. The re-assessment and decision to rescind the original CON shall be documented but this can be in the form of a doctor's order, progress note, assessment, etc. The original CON should not be shredded or destroyed and should remain a part of the clinical record with the documentation of the reassessment that justifies why it was not executed.

12) Who is responsible for transportation once a Certificate of Need (6404) has been completed?

A: It is the law of this state that people with mental illness or serious emotional disturbance who are determined to be a danger to themselves and in need of physical restraint or vehicular security be transported by the sheriff or secondary transportation agents designated by the sheriff. People with a mental illness or serious emotional disturbance who do not present themselves as a danger to themselves or are not in need of physical restraint or vehicular security may be transported by one (1) or more friends, neighbors, other mental health professionals familiar with the person, relatives of the person or a member of the clergy; provided, that these persons are willing and able to provide such transport.

13) Does the second CON have to be written within a certain timeframe from completion of the 1st CON?

A: Title 33 is silent on this matter, however TDMHSAS recommends examination as soon as reasonably practicable. Once the individual has been evaluated by the receiving psychiatric hospital, though it may result in a non-admit decision, the first certificate of need cannot be reused.

14) Are CON's reviewed by a Judge?

A: Yes, upon admission the two completed certificates of need required for involuntary hospitalization are sent to the general sessions court where the hospital is located.

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If the judge is not available and all other requirements have been complied with, the admitting facility may hold the defendant for not more than twenty-four (24) hours pending a court order under § 33-6-413, and the staff may render only necessary emergency treatment.

15) Can I admit the person who arrived at my hospital with a CON voluntarily?

A: Yes. The admitting physician at the receiving psychiatric hospital or treatment resource shall examine the person upon arrival to determine whether the person meets criteria for an involuntary hospitalization. If the person is willing to receive treatment, the person could sign in for voluntary services. If admitted voluntarily, a second CON is not required.

16) When should I administer a telehealth assessment?

A: TDMHSAS believes telehealth is a viable option for access to behavioral health services and enhancing the efficiency of the crisis service delivery system. A determination must be made whether telehealth is a viable means of conducting the assessment based on the individual's behavior and psychiatric condition. If the individual's presenting condition is inappropriate for a telehealth assessment or if visual or sound quality is inadequate, the professional should proceed with an on-site, face-to-face assessment. This option is available for admission to a Regional Mental Health Institute. Telehealth connections to the Regional Mental Health Institutes will only occur with the involvement of a TDMHSAS designated crisis service provider.

17) What if the person I admitted voluntarily decides to leave against medical advice (AMA) but presents a risk of harm to self or others?

A: If the person who signed in voluntarily chooses to leave but poses an **immediate** substantial likelihood of serious harm due to a mental illness or serious emotional disturbance, the person may be detained for examination under an emergency involuntary admission process.

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Frequently Asked Questions- Mandatory Prescreening Agents

1) Who is qualified to be a Mandatory Prescreening Agent?

A: To be considered for eligibility for designation as an MPA you must be licensed to practice in Tennessee and be a Qualified Mental Health Professional (QMHP). MPA designation is limited to Qualified Mental Health Professionals (QMHP) who is employed to provide crisis services by a state provider.

Qualified mental health professionals:

- Psychiatrist
- Physician with expertise in psychiatry
- Psychologist with health service provider designation
- Licensed psychological examiner
- Licensed senior psychological examiner
- Licensed master's social worker with two years of mental health experience
- Licensed clinical social worker
- Licensed or certified marital and family therapist
- Licensed professional counselor
- Licensed nurse with a master's degree in nursing who functions as a psychiatric nurse
- Licensed Physician's Assistant with a master's degree and expertise in psychiatry as determined by training, education or experience

2) I work for a private psychiatric hospital. Can I become designated as a Mandatory Prescreening Agent?

A: Currently, the Commissioner has set designation limits, in accordance with Tennessee Code Annotated §33-6-104, to professionals working for a state contracted crisis provider. Tennessee Code Annotated §33-6-104 allows the commissioner to set limits on an agent's authority, decline to

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designate a person who satisfies the requirements of § 33-6-427, and/or remove authority as a mandatory pre-screening agent from a person without cause.

3) Does a Mandatory Prescreening Agent have to be involved for voluntary and involuntary hospitalizations?

A: Yes. A review of a previous Attorney General's opinion (No. 01-078), indicates that a publicly funded or potentially publicly funded person with mental illness or serious emotional disturbance cannot be voluntarily admitted or involuntarily committed to inpatient treatment without the approval of a mandatory prescreening agent.

4) Is a Mandatory Prescreening Agent required to screen an individual in need of hospitalization at a private facility?

A: It depends. If the person being admitted to a private facility is publicly funded (TennCare or state grant funded), a Mandatory Prescreening Agent would need to be involved. If a mandatory pre-screening agent cannot examine the person within two (2) hours of the request to examine the person, then a licensed physician or a licensed psychologist with health service provider designation may examine the person and may provide one of the certificates if the physician or psychologist, in consultation with a member of a crisis response service designated by the commissioner to serve the county, determines that all available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person.

5) Does designation as Mandatory Prescreening Agent ever expire?

A: Yes. Mandatory Prescreening Agents are required to renew their designation every two years as their professional licenses are renewed. Every two years, existing MPA's are required to complete an online refresher course and to provide updated status reports regarding current place of employment and contact information. Failure to complete the required activities, results in expiration of designation.

6) Are MPA's required to complete any special training before being designated?

A: Yes. Before initial designation, professionals are required to attend a 6 hour, in person training. Training is designed to ensure MPAs carefully consider all less drastic alternatives to hospitalization appropriate to meet the needs of the individual.

7) Do I have to wait for 2 hours for a Mandatory Prescreening Agent to arrive?

A: No. As long as you get a verbal confirmation that a MPA will not be available within 2 hours then a licensed physician or a licensed psychologist with health service provider designation may examine the person and may provide one of the certificates if the physician or psychologist, in consultation with a member of a crisis response service designated by the commissioner to serve the county. This

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applies to individuals who are uninsured, receiving TennCare or in need of admission to a state hospital (regardless of payer source).

8) Are all crisis responders an MPA?

A: No. However, it is the TDMHSAS expectation that every crisis team have an MPA available at all times. Availability may occur in person or by utilizing telehealth, a viable option for access to behavioral health services.

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Frequently Asked Questions – Crisis Stabilization Units

1): What is a Crisis Stabilization Unit?

A: A Crisis Stabilization Unit (CSU) is a twenty-four hour per day, seven day per week community based service that offers an inpatient like experience for individuals at risk of hospitalization who are willing to receive services. The average length of stay is three (3) days and is free of charge.

The staffing ratio for a CSU is 1:5 and a registered nurse is on duty twenty-four hours a day to administer meds. Groups specific to the needs of the milieu are provided daily and a prescriber is available to provide medication management services.

2): How are referrals made to the CSU?

A: Anyone considering the CSU as an option can contact crisis to make a referral.

3): Are there any exclusionary criteria for admission to the CSU?

The most common reasons a CSU may be unable to meet the needs of someone in need of service are listed below.

- Medical acuity
- Complex detox
- Too aggressive

4): How long can a person stay in the CSU?

A: Ninety-six (96) hours with the ability to extend the stay for one additional twenty-four (24) hour period if complications in discharge planning occur.

5): What do I need to bring with me if I'm being admitted to the CSU?

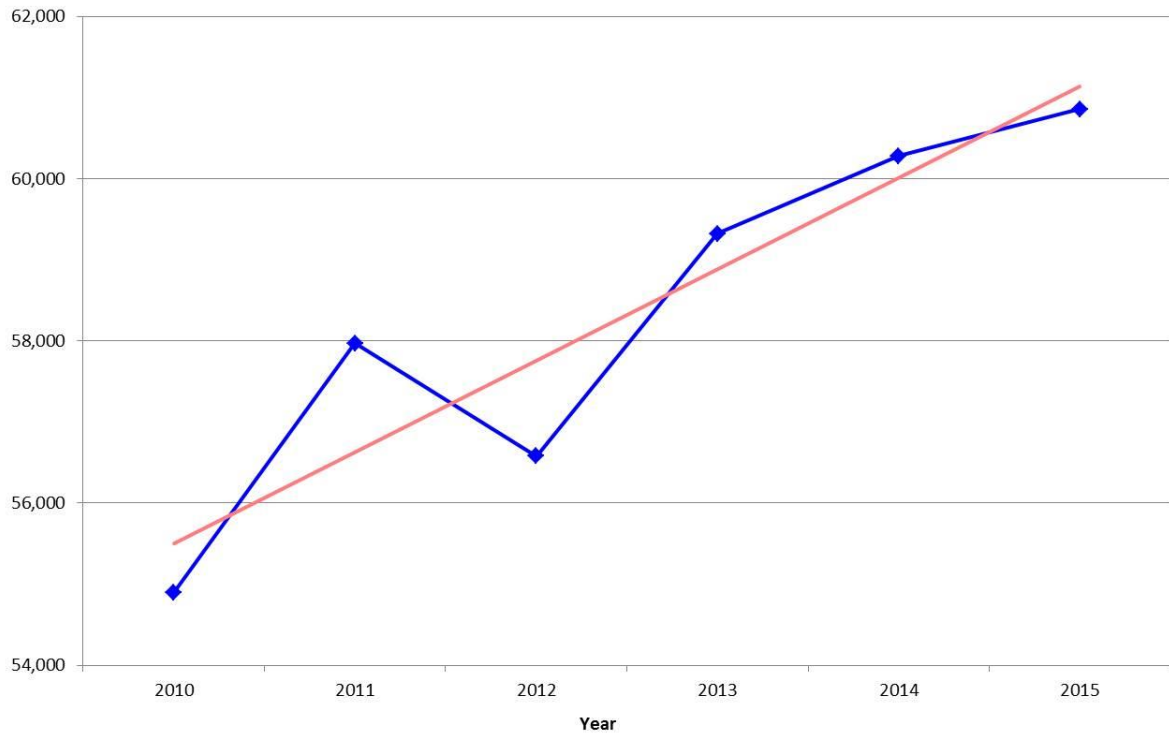
A: It is encouraged to bring all prescribed medications that you are currently taking, including any rescue inhalers, any equipment necessary to ensure health and safety (i.e. CPAP, walker, etc.) and at least three days' worth of clothing. However, it is not necessary to have these items to be considered for admission to a CSU.

6): There is not a CSU in my area, are there other resources?

A: Check with your local crisis provider to determine all available resources in your area.

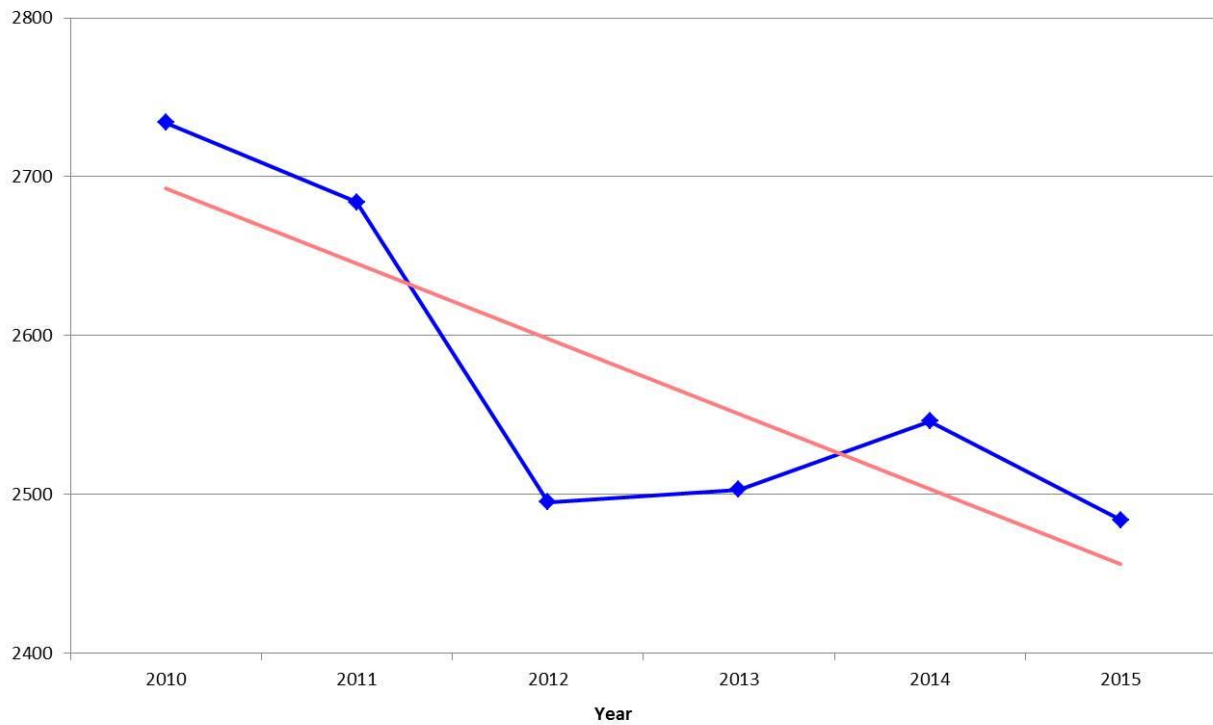
Total Number of Mental Health Inpatients in Tennessee by Year

Source: Tennessee Joint Annual Report of Hospitals



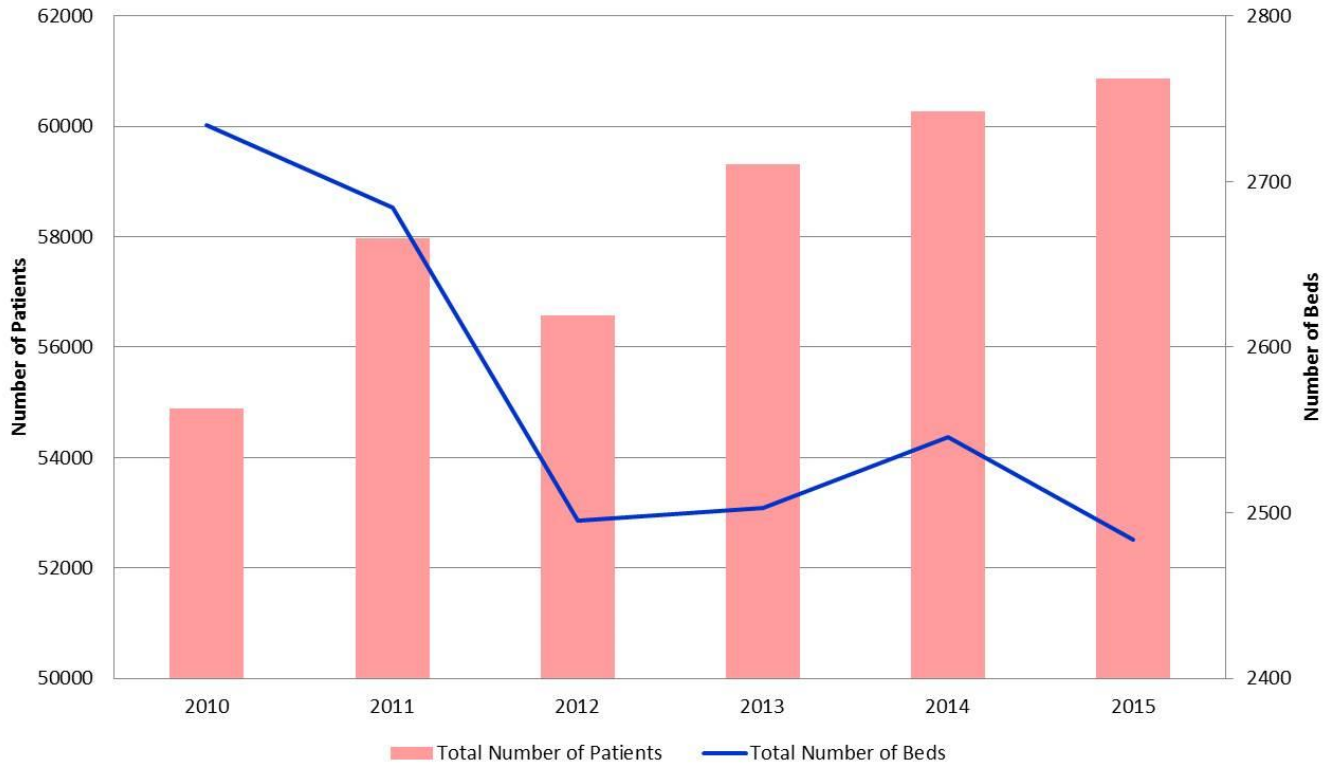
Total Number of Staffed Inpatient Mental Health Beds in Tennessee by Year

Source: Tennessee Joint Annual Report for Hospitals



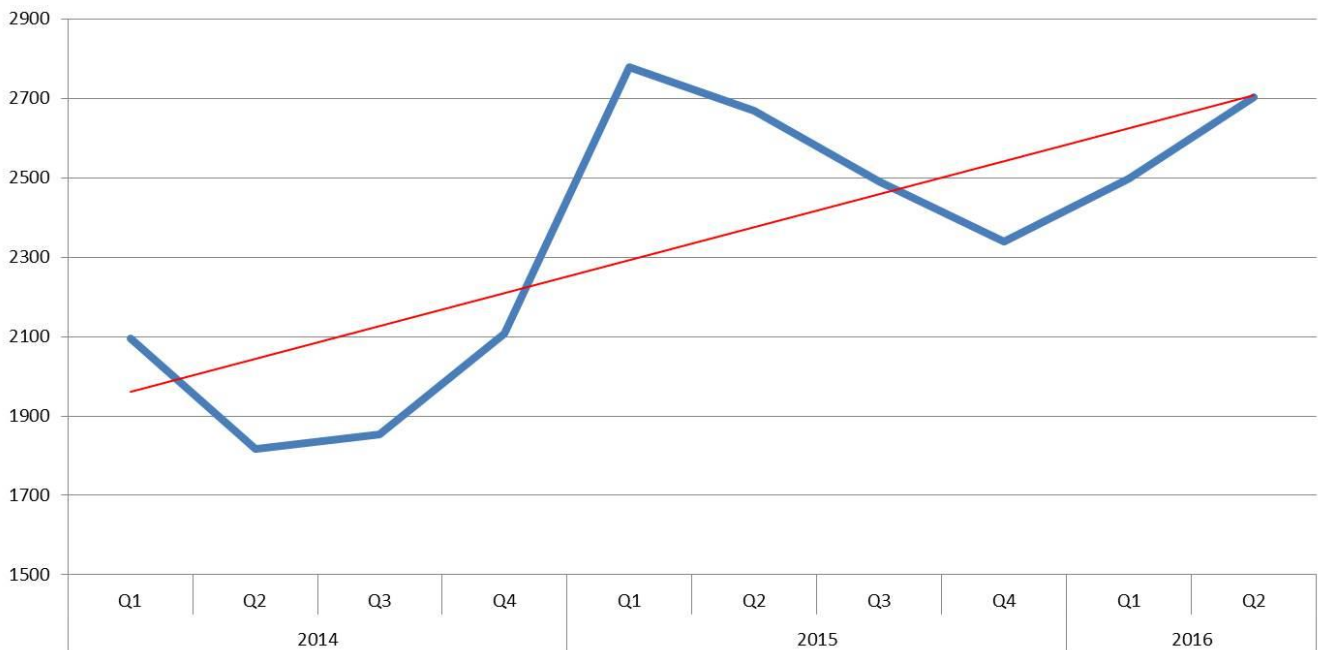
Total Number of Mental Health Inpatients and Staffed Beds in Tennessee by Year

Source: Tennessee Joint Annual Report for Hospitals



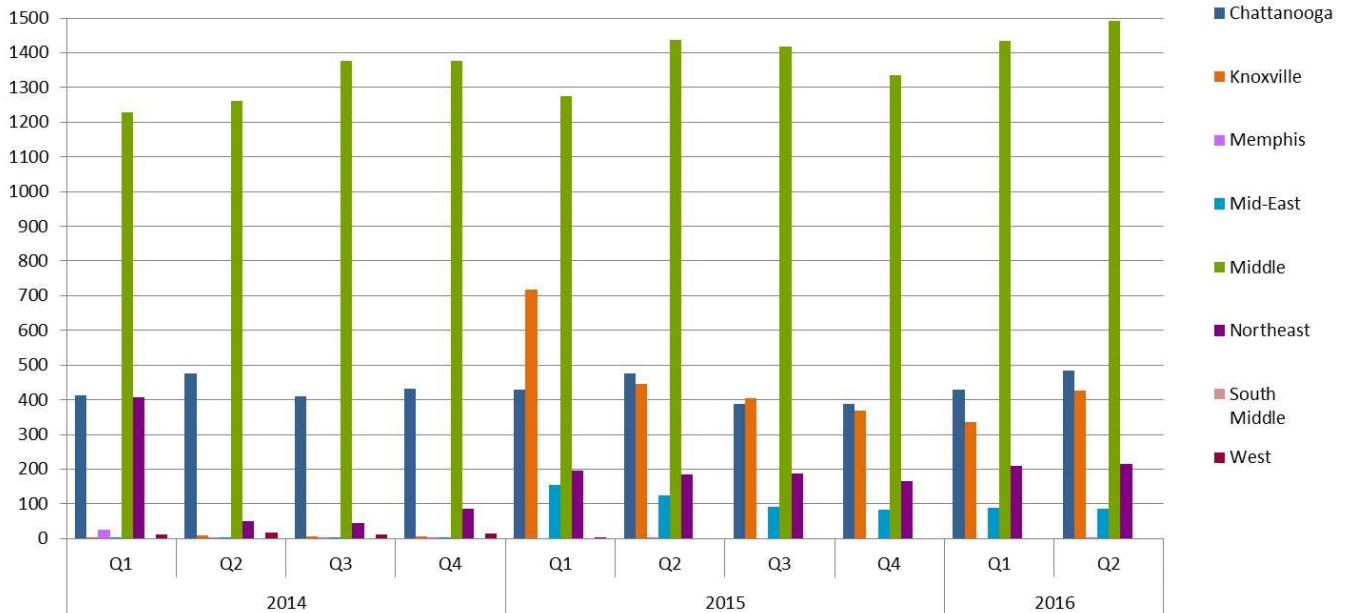
Total Number of People with a Mental Health Diagnosis Waiting More than a Day in Tennessee Emergency Departments by Quarter

Source: TN Health Information Network



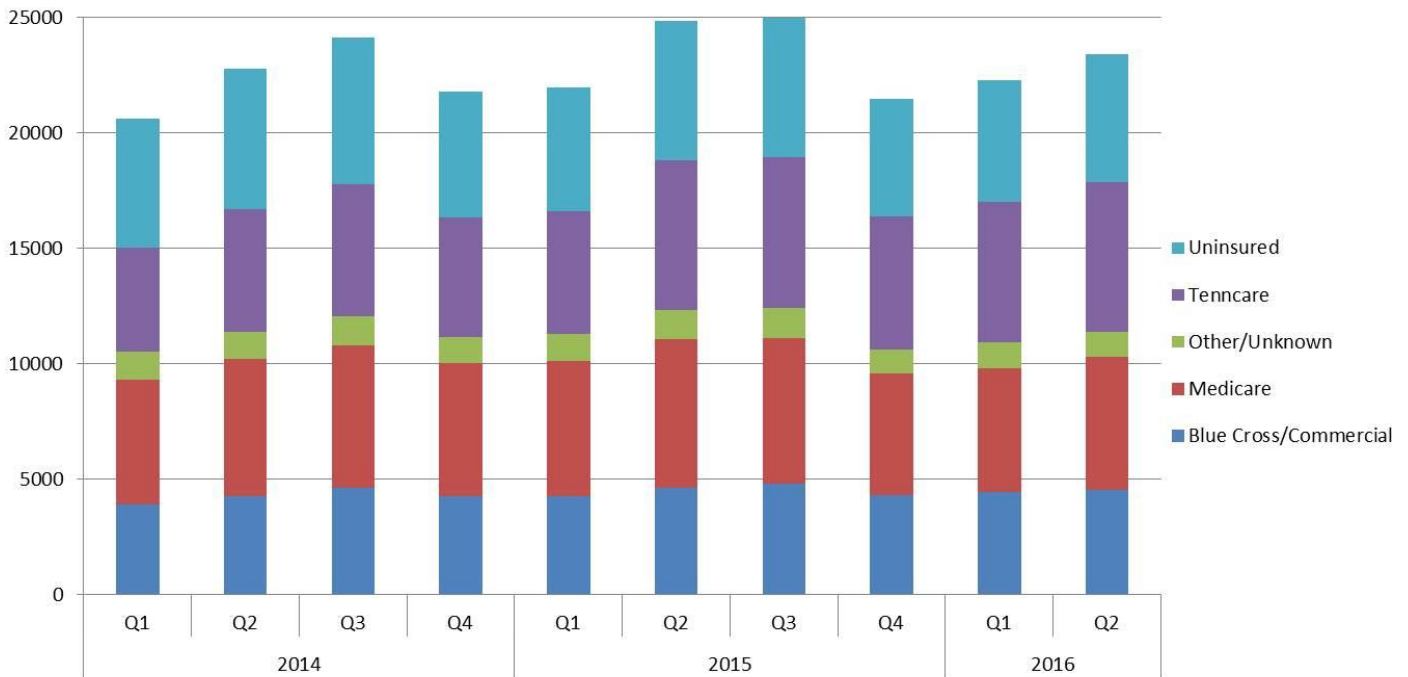
Total Number of People with a Mental Health Diagnosis Waiting More than a Day in TN Emergency Departments by Region by Quarter

Source: TN Health Information Network



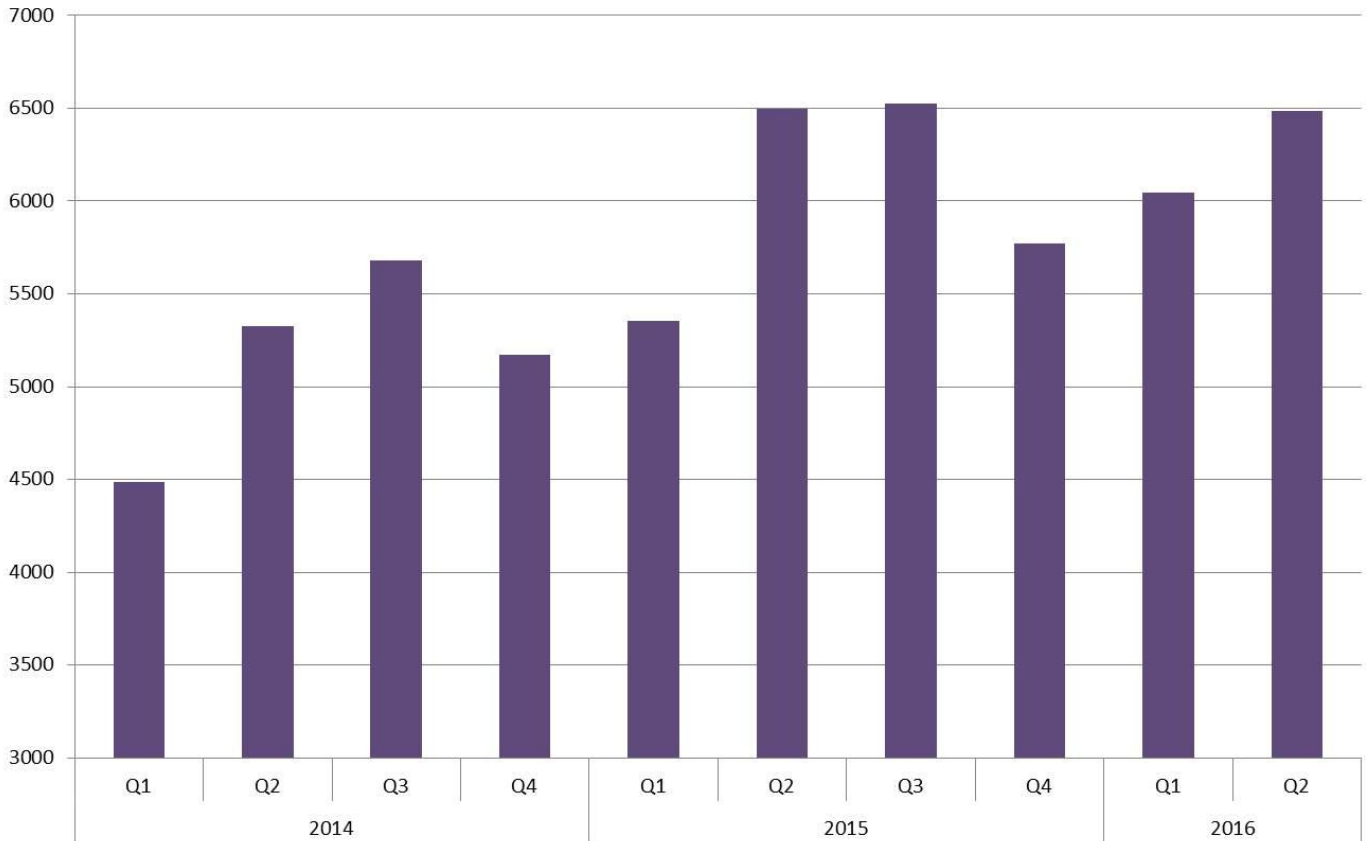
Total Number of People with a Primary Behavioral Health Diagnosis in Tennessee Emergency Departments by Payer by Quarter

Source: TN Health Information Network



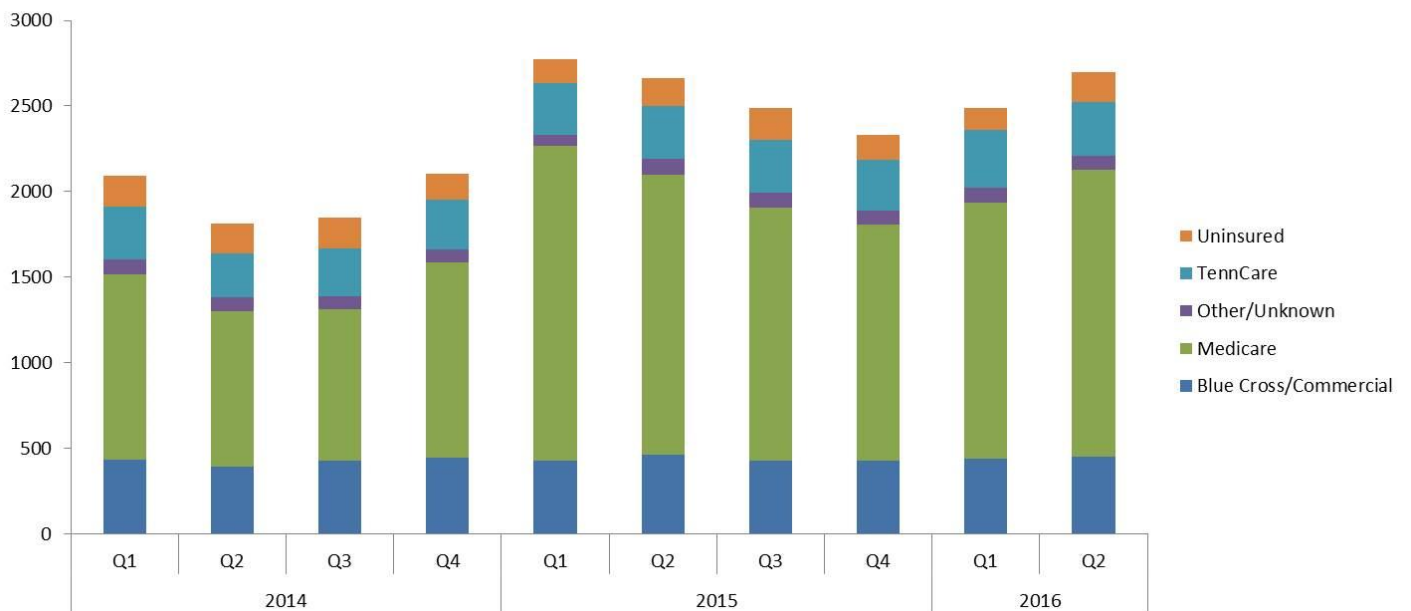
Total Number of TennCare Enrollees with a Primary Behavioral Health Diagnosis in Tennessee Emergency Rooms by Quarter

Source: TN Health Information Network



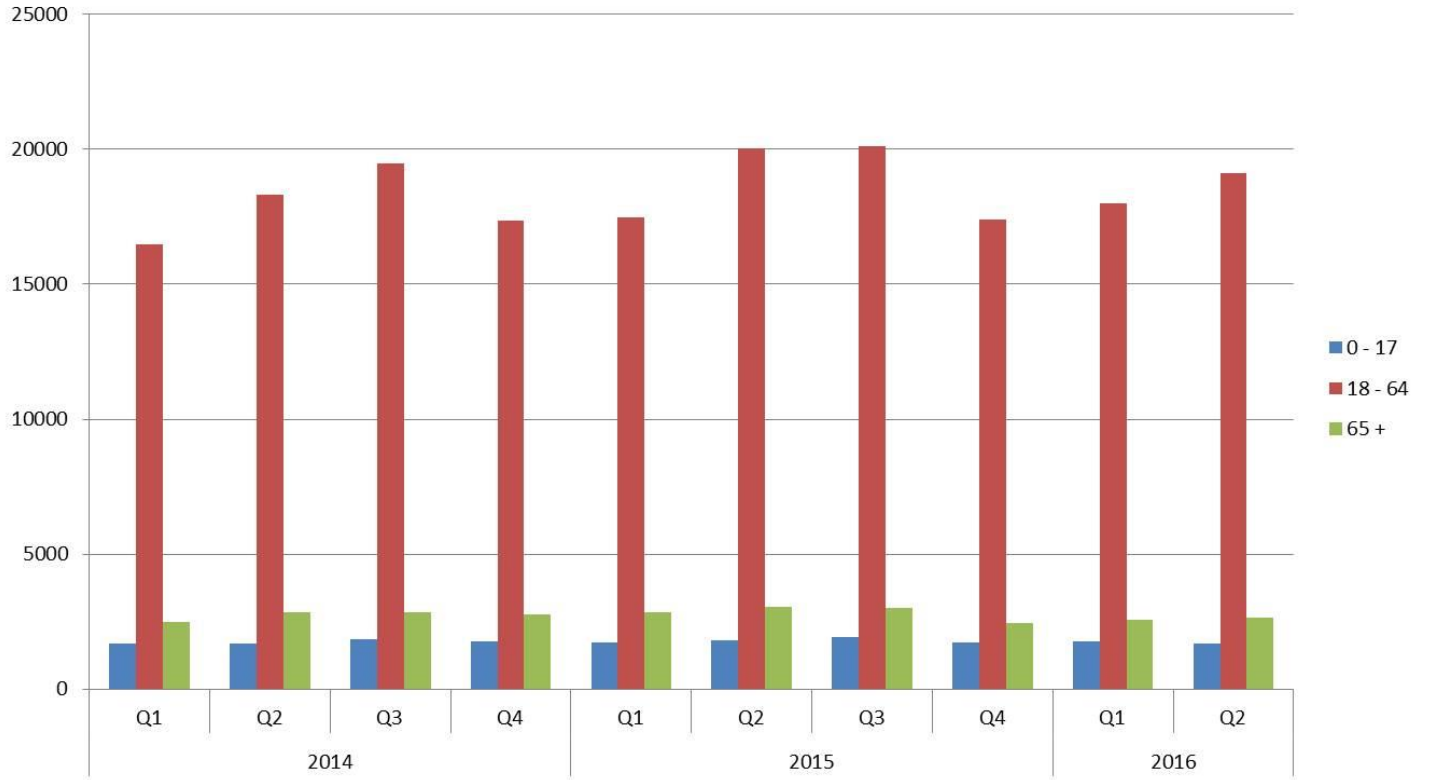
Total Number of People with a Mental Health Diagnosis Waiting More than a Day in TN Emergency Departments by Payer per Quarter

Source: TN Health Information Network



Total Number of Patients with a Primary Mental Health Diagnosis in Tennessee Emergency Departments by Age by Quarter

Source: TN Health Information Network



Medical Clearance Guidelines

In today's mental health system, there has been an increase of utilization of community-based mental health services. This has resulted in more Regional Mental Health Institutes (RMHI) referrals coming directly from the community.

RMHIs are structured to deal with chronic and persistent mental illness in a population that is presumed to be relatively medically stable. While, we have a physician available on-site, twenty-four hours a day, seven days a week, to deal with both medical and behavioral issues, we are limited in the medical services we can provide. Most serious illnesses demand expertise beyond the capabilities of the clinical staff. Therefore, when determining the medical stability of individuals referred to State RMHIs, we continue to rely on the local emergency room as our primary resource. We recognize that these same emergency rooms are under increase pressure to avoid inappropriate referrals and reduce the provision of routine healthcare service.

The RMHIs are committed to reducing needless referrals to these emergency rooms. In an attempt to do this, we have identified certain individuals that can be referred directly to the RMHIs for assessment without medical screening.

❖ **INDIVIDUALS ELIGIBLE FOR DIRECT REFERRAL TO RMHIs**

- Under Age 55
 - No known health issues or medical complaint and prior history of psychiatric treatment
 - Patients transferring from a Crisis Stabilization Unit (CSU) with or without chronic medical conditions that have been stable for more than 48 hours.
 - No report or indication of alcohol or Benzodiazepines use within twenty-four (24) hours of the referral and absence of any withdrawal symptoms
 - No recent history of head trauma or loss of consciousness
 - No history of recent drug overdose

❖ **INDIVIDUALS WITH KNOWN MENTAL HEALTH AND A KNOWN CHRONIC HEALTH CONDITION**

- Who May Be Eligible for a Direct Referral;
 - Based on a known history of compliances with treatment
 - Vital signs within normal limits
 - Blood glucose level for diabetics within the last hour
 - Individual with known history of substance abuse would require urine drug screening and breathalyzer

❖ **INDIVIDUALS REFERRED FROM JAILS**

- Breathalyzers can be used as an alternative for blood alcohol testing when patients are referred from a non-ER setting
- Referrals from correctional settings should not be routinely referred for medical clearance, but should be done on an individual basis. Utilize same criteria used for those coming from the community

Individuals referred for medical clearance should receive diagnostic testing based upon the emergency provider's determination of need. In order for the RMHIs to expedite the referral process, it would be helpful if the following were obtained:

- Vital Signs
- Urine Drug Screen
- Complete Blood Count
- Comprehensive Metabolic Panel (CMP)
- Pregnancy Test
- Blood Alcohol
- Drug Levels i.e., Lithium, Depakote, etc.

The requesting RMHI will provide in writing upon request, the rational for any other diagnostic testing.