



# New Laws Regarding Mental Health Patients, Part 2

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## 5150: “Serial Holds” and Other Inventions – 1<sup>st</sup> Challenge: **When Does the 72 Hour Clock Start?**

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- **W&I 5150**: the moment the custodial hold begins?
- **W&I 5151**: the moment the person is admitted into a designated LPS-facility?



## If the 72-Hour Clock Starts at 5150... and Hour 73 is Approaching

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- What do you do when the patient is still in your ED awaiting test results, or has been medically cleared (is medically “stable” but psychiatrically “unstable”) and you have still been unable to find a psych bed in a locked facility?
- What if you’ve found a bed, but the transfer is to a location far away, out of county, and you haven’t been able to arrange for safe transport?





## When the Clock Runs Out in Your ED ...

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- Some County Counsel have told their MH Directors to write policies that allow them to “*refresh the hold*” or “*extend the hold*” (re-assess, document continuing probable cause reasons, etc.)
- Others have recommended a brand new hold, aka a “*serial hold(s)*” (new 5150 application, new probable cause, etc.)
- Others have changed their mind about the clock start time and decided that *clock starts at 5151*, and the time spent in your ED is not counted



## When the Clock Runs Out in the ED ...

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- **Health and Safety Code 1799.111** - “hold” initiated by hospital staff
  - Meant to be used as a safety-gap measure when there is probable cause that a person is a danger to self or others, or gravely disabled (W&I 5150 criteria) and the person cannot be safely released, but no one with authority to “write a 5150 hold” is available





## H&S Code 1799.111

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- Applies only in non-LPS designated hospitals
- Allows licensed professional staff of those hospitals, or any physician and surgeon providing emergency medical services in any department of those hospitals, to detain a person receiving treatment at that hospital for up to 24 hours
- Staff doing this must have made and documented repeated unsuccessful efforts to find appropriate mental health treatment for the person



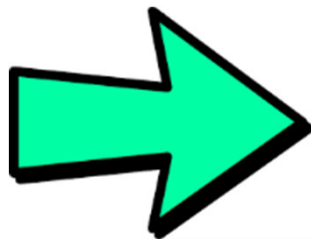
## H&S Code 1799.111 (cont.)

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- Telephone calls or other contacts must “commence at the earliest possible time” once the treating doctor has determined when the person will be medically stable for transfer
- If person is detained beyond 8 hours, the reason for the detainment must be due to the need for continuing and ongoing care, observation and treatment that the hospital is providing, and in the opinion of the treating physician, or a clinical psychologist with staff privileges, the person, as a result of a mental health disorder, is still a danger to him/herself or others, or is gravely disabled. (Document this!)



# H&S 1799.111 – Use CHA form 12-12



FORM 12-12

## DETENTION OF PATIENT WITH PSYCHIATRIC EMERGENCY IN A NONDESIGNATED HEALTH FACILITY *(Health and Safety Code Section 1799.111)*

A licensed general acute care or psychiatric hospital (that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code), licensed professional staff of those hospitals, and physicians, providing emergency medical services in any department of those hospitals will not be held civilly or criminally liable for detaining a patient if all of the following conditions exist during the detention.

Name of Patient: \_\_\_\_\_

1. The law requires probable cause for detaining the patient/believing the patient is, as a result of a mental disorder, a danger to self or others or gravely disabled. Describe the patient's behavior and/or statements, and circumstances under which the patient was detained (use direct quotes from the patient, law enforcement officers, and/or others when appropriate).

\_\_\_\_\_  
\_\_\_\_\_

2. Based upon the above information, I believe that the patient named above cannot be safely released from the hospital because he or she is, as a result of a mental disorder, one or more of the following:

A danger to self

A danger to others

Gravely disabled (for purposes of a detention under Health and Safety Code Section 1799.111, "gravely disabled" means an inability of the patient to provide for his or her basic personal needs for food, clothing, or shelter)

Signature of treating physician and surgeon (or clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Health and Safety Code Section 1316.5\*)

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

(over)





## H&S 1799.111 (cont.)

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- Provides immunity to hospital staff that initiated the “detainment” from liability for false imprisonment
- Provides that the patient be “credited” with time spent detained pursuant to 1799.111, should the person be placed on a subsequent 72-hour hold
- The “credit” language of H&S 1799.111 suggests that it cannot be used sequentially to *follow* a 5150 when the clock has run “out” because 72 hours have passed



## When “The Clock Has Run” – Some Final Thoughts



- Unfortunately, the Legislature still has not provided direction on which clock is correct, so it is up to us to figure out what is right legally and ethically
- You need to have a good plan and policy on this because it will surely happen to you at some point (if not already)
- And, try to coordinate with others in your area so that everyone agrees





## So, When Time Runs Out, You Need to Decide:

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- Are you going to “extend the hold”? **or**
- Write a new one (“serial hold”)? **or**
- “Ignore the clock” (start it at 5151)? **or**
- Just let a person who is at risk walk out the door at 72 hours? (**NOT** recommended)



# The “5150 Clock” Problem – Suggestions

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- Work with community partners, including:
  - County mental health agency
  - Local crisis stabilization units
  - Your county Patients’ Rights Advocate
  - Law enforcement
  - Transport staff
  - Volunteers and NAMI



## 5150 Clock “Solutions” – Options When Time Runs Out, and Issues to Consider

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- ❑ Option 1 - Ignore the clock (clock starts at 5151)
- ❑ Option 2 –Time’s up (clock started at 5150)
  - ❑ “Extend” the initial hold? How will you document this?
  - ❑ Write a new hold (“back to back” or “serial hold”)?
    - ❑ Who has authority to write a new hold?
    - ❑ How will you notify them?
    - ❑ What if they don’t come?



## 5150 Clock “Solutions” – Options When Time Runs Out, and Issues to Consider

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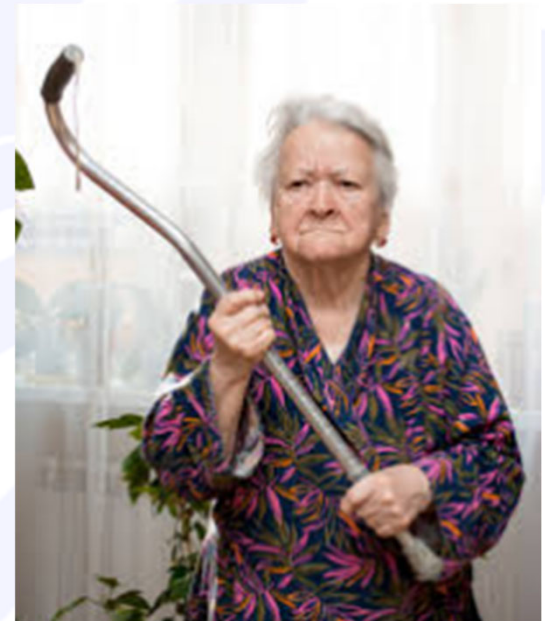
- ❑ Option 3 – “Parking Lot hold” (gap in time separates events)
  - ❑ Let the person walk out the door, thereby ending the first “hold” (but follow them); then, quickly stop them and write a brand new hold; or,
  - ❑ Discharge them on paper, and “virtually” let them “walk out the door” – safer option
  - ❑ If no one is there to write a new hold, consider using H&S 1799.111, since you are now in a totally new time frame (at least on paper)?



## To Do's – If Person Insists on Leaving ...

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- ❑ Have policy/training for staff when dangerous person wants to leave, has left AMA who is:
  - ❑ Still on a 5150 hold
  - ❑ Subject to Health & Safety 1799.111 detention
  - ❑ No longer considered to be “on a hold”





## To Do's – If Person Wants to Leave

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- ❑ Have policy and train staff on:
  - ❑ Non-coercive means to “buy time”
  - ❑ (Not) using restraints to hold a person on mental health hold (including locked doors) if you are not a designated facility
  - ❑ (Not) chasing a person out the door and into your parking lot, or down the street
  - ❑ When to call security, or 911, when a person leaves AMA







## When EMTALA and 5150 Laws Clash – The Surveyor's View

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- State law lets law enforcement initiate a custodial hold under W&I Code 5150 based upon “probable cause” decision – it is a *legal decision* based upon “*probable cause*” *criteria*
- Federal law requires hospital ED to “offer” a medical screening exam, and if the person has an emergency medical condition, to offer stabilizing treatment – decisions as to whether there is an emergency, and whether/when stability has been achieved are *medical decisions* based upon *clinical criteria*





## EMTALA vs. 5150 (cont.)

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- Once the patient has been stabilized, the hospital no longer has an EMTALA obligation
  - So what happens when your ED doctor believes that the emergency has been stabilized but County staff disagree and refuse to “lift the hold”
  - Note: CMS surveyors may use 5150 status to conclude the psychiatric emergency is unstable, and cite you for failing to stabilize the patient prior to discharge – this conflict does not have an easy answer – so, DO document these situations as though a surveyor will read it!





## EMTALA vs. 5150 (cont.)

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- Things that may be persuasive when there is an impasse:
  - Things change over time and with appropriate care, crisis stabilization can and does occur (even in our EDs!)
  - Those treating the patient most recently have the most accurate “read” on stability and resolution of a psychiatric crisis (vs. someone who wrote a hold hours, or days ago)
  - County MH controls which professionals are “authorized” to “reassess” the patient on a hold to determine whether the person can be properly served without further detention; failure to “lift hold” may be entirely due to personnel issues





## Another Myth – Patients on a Hold Will Always Consent to Related Medical Care

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- Under EMTALA a patient has a right to refuse the medical screening exam and stabilizing treatment
- Under 5150 law the patient does not have a right to refuse admission to a locked designed LPS facility; but the facility will not admit unless the person has been medically cleared
  - What do you do when the patient refuses medical clearance diagnostic procedures (e.g., lab tests)?
  - The law simply does not address this issue (or any other issues related to “medical clearance”)





## “Denial of Rights” and Patients with Mental Illness – When do These “Rights” Attach?

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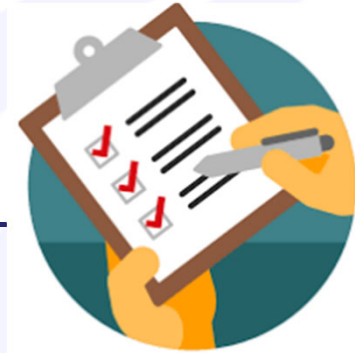
- **LPS Act** (Lanterman-Petris-Short Act) – two sets of specific rights for mental health patients\*
  - **W&I 5325** – rights of persons with mental illness that may be denied for good cause
  - **W&I 5325.1** – “intent of the legislature” that persons with mental illness have certain rights and that *these* specified rights are not subject to denial

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\* also, other rights are afforded all patients under other laws such as HIPAA and CMS Conditions of Participation



# Patients' Rights – Who? Where?



- W&I 5325 outlines rights for:
  - Each person *involuntarily* detained for evaluation and treatment under the provisions of the LPS Act, and
  - Each person admitted as a *voluntary* patient for psychiatric evaluation or treatment to any health facility (H&S 1250) in which psychiatric evaluation or treatment is offered
  - Also, each person who is committed to a state hospital



## Rights Must be Communicated to Patient by the Facility Providing Those Services

- Prominently posted in predominant languages of the community and explained in a language or modality accessible to the patient or otherwise brought to the patient's attention by other means as the DHCS Director may designate by regulation





## § 5325 Rights Include the Right to:

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- Wear own *clothing*, keep and use *personal possessions* like toilet articles, to keep and spend small sums of *money*
- *Storage space*
- *Visitors* each day
- Reasonable access to *telephones*, to make and receive confidential calls or have calls made for them







## 5325 Rights (cont.)

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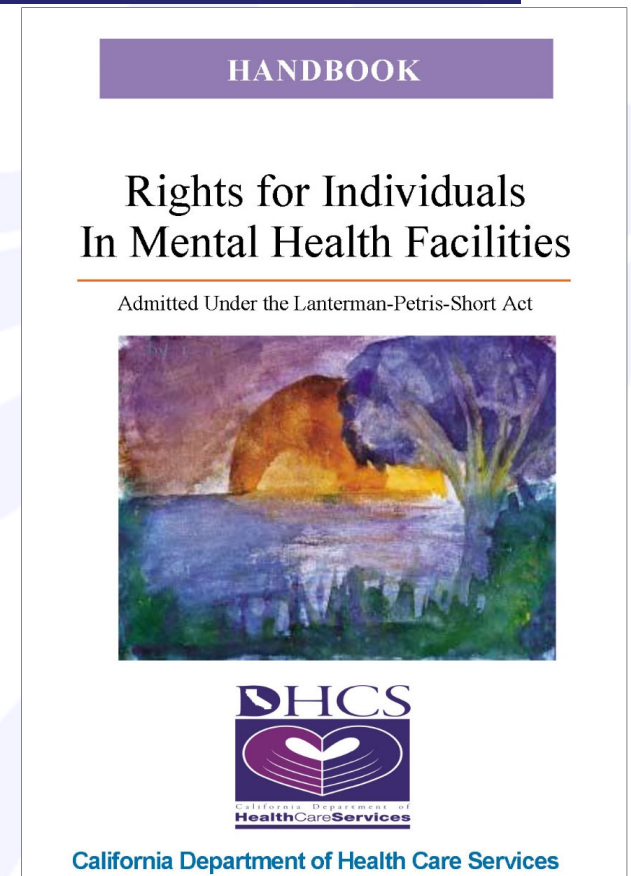
- Ready access to *writing materials*, including stamps, and to mail and receive unopened correspondence
- To *refuse* any convulsive treatment, psychosurgery
- To see and receive services of a *patient advocate*
- *Other rights*, specified by regulations; including notification of constitutional or statutory rights found by DHCS to be frequently misunderstood, ignored or denied





## How?

- Each patient, upon admission, shall be offered the DHCS patients' rights handbook
- Rights cannot be waived by parent, guardian or conservator





## 5325.1 – Patients' Rights (Which Cannot be Denied)

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- Treatment that is least restrictive and promotes independence
- Dignity, privacy, and humane care
- Free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse or neglect; medication cannot be used as a punishment, for convenience of staff or as a substitute for a treatment program
- Prompt medical care and treatment
- Religious freedom and practice
- To participate in appropriate programs of publicly supported education
- Social interaction and participation in community activities
- Physical exercise and recreational opportunities
- To be free from hazardous procedures



## Imbedded County PET Team in Your ED

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- Rideout Hospital and Sutter-Yuba Mental Health – experiment that is working well!
- PET team has room in the ED to assess and treat patients with behavioral health issues – they can write a hold and lift a hold, and help with arranging transfers (“getting a bed”)
- The hospital is very pleased with the results, and more behavioral health patients are being successfully stabilized without the need for intensive inpatient treatment



# Ligature Risk Reduction Concerns

- **Two memos from CMS**
  - December 8, 2017 – “CMS is in the process of drafting comprehensive ligature risk guidance, primarily for psychiatric units/hospitals.” In the meantime, State Survey Agencies (SA’s) should use their own judgement to identify ligature and other safety risk deficiencies.

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1850



Center for Clinical Standards and Quality/Survey & Certification Group

S&C Memo: 18-06- Hospitals

**DATE:** December 08, 2017

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Clarification of Ligature Risk Policy

## Memorandum Summary

- **Ligature Risks Compromise Psychiatric Patients’ Right to Receive Care in a Safe Setting:** The care and safety of psychiatric patients and the staff that provide that care are our primary concerns. The Centers for Medicare & Medicaid Services (CMS) is in the process of drafting comprehensive ligature risk interpretive guidance to provide direction and clarity for Regional offices (RO), State Survey Agencies (SAs), and accrediting organizations (AOs).
- **Definition of a Ligature Risk:** A ligature risk (point) is defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes, and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures.
- **Focus of Ligature Risks:** The focus for a ligature “resistant” or ligature “free” environment is primarily aimed at Psychiatric units/hospitals.
- **Interim Guidance:** Until CMS’ comprehensive ligature risk interpretive guidance is released, the ROs, SAs and AOs may use their judgment as to the identification of ligature and other safety risk deficiencies, the level of citation for those deficiencies, as well as the approval of the facility’s corrective action and mitigation plans to minimize risk to patient safety and remedy the identified deficiencies.
- **Timeframe for Correction of Ligature Risk Deficiencies:** All deficiencies are expected to be corrected within the timeframe designated by the CMS RO, SA or AO. In cases where it is determined that it is not reasonable to expect compliance within the designated timeframe, only CMS may grant additional time for correction.
- **Ligature Risk Deficiencies Do Not Qualify for Life Safety Code (LSC) Waivers:** Ligature risks are not LSC deficiencies. Therefore, a LSC waiver may not be granted.
- **Monitoring of Progress:** When additional time for correction is granted, the hospital is required to provide monthly electronic progress reports to the SA or AO, including substantiating evidence of progress towards compliance. The SA or AO will update the RO or Central Office (CO) monthly, respectively.



# Ligature Risk Reduction Concerns

July 20, 2018 – announcing cancellation of the proposed Psychiatric Care Task Force to address environmental risks related to inpatient care of patients experiencing a psychiatric illness; instead, The Joint Commission (TJC) Suicide Panel efforts to clarify and refine the issues of ligature and safety risks will be incorporated into the revisions of the new Interpretive Guidelines for State Survey Agencies

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1850



Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

QSO: 18-21-All Hospitals

**DATE:** July 20, 2018  
**TO:** State Survey Agency Directors  
**FROM:** Director  
Quality, Safety & Oversight Group (*former Survey and Certification Group*)  
**SUBJECT:** CMS Clarification of Psychiatric Environmental Risks

#### Memorandum Summary

- **Proposed Psychiatric Task Force:** The Proposed Psychiatric Task Force to address the environmental risks associated with the care of psychiatric inpatients is not the most appropriate vehicle to foster the changes that are required.
- **Ligature Risks Compromise Psychiatric Patients' Right to Receive Care in a Safe Setting:** The care and safety of psychiatric patients and the staff that provide that care are our primary concerns. CMS is incorporating the outcomes of the TJC Suicide Panel (in which CMS participated) into comprehensive ligature risk interpretive guidance to provide improved direction and clarity for state survey agencies (SAs) and accrediting organizations (AOs).
- **Interim Guidance:** Until CMS' comprehensive ligature risk interpretive guidance is released, the SAs and AOs may use their judgment as to the identification of ligature and other safety risk deficiencies, the level of citation for those deficiencies, as well as the approval of the facility's corrective action and mitigation plans to minimize risk to patient safety and remedy the identified deficiencies.

#### Background

The proposed CMS Psychiatric Care Task Force to address environmental risks related to the inpatient care of patients experiencing a psychiatric illness, will not be convened as planned. We will continue to seek your input, but have determined that a workgroup would not be the most appropriate vehicle to foster the required changes. The successful efforts by the TJC Suicide Panel to clarify and refine the issues involving ligature and safety risks are being incorporated into the revisions of the Interpretive Guidance. CMS felt that to repeat the work of TJC Suicide Panel (in which CMS participated) would not provide any substantive additional gains and would not be a productive use of the time and expertise of the participants. The goal of revising the Interpretive Guidance is to incorporate and clarify standards, ligature risks, and safety issues that will assist providers/AOs in complying with the Conditions of Participation for Medicare (CoPs). Expectations regarding ligature risks and safety issues for patients receiving care and treatment for psychiatric disorders are included in the Hospital CoPs for Patient's Rights to Care in a Safe Setting.



# Ligature Risk and Patient Safety – Conditions of Participation (CoPs)

- 42 CFR 482.13(c)(2) The patient has the right to receive care in a safe setting.
- 42 CFR 482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well being of patients are assured.
- The CoPs haven't changed – the interpretive guidance has!

The screenshot shows the CMS.gov website. The header includes navigation links for Home, About CMS, Newsroom, Archive, and social media icons for Share, Help, and Print. A search bar is present with the text 'type search term here'. Below the header is a navigation menu with tabs for Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Private Insurance, Innovation Center, Regulations & Guidance, Research, Statistics, Data & Systems, and Outreach & Education. The main content area is titled 'Conditions for Coverage (CFCs) & Conditions of Participations (CoPs)'. It includes a left sidebar with a list of links: Spotlight, Hospice, Hospitals, Life Safety Code, Organ Procurement Organizations (OPOs), Rural Health Clinic/Federally Qualified Health Center, Transplant Centers, Home Health Agencies, End-Stage Renal Disease Facilities, Long Term Care Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Ambulatory Surgical Centers (ASCs), Religious Nonmedical Health Care Institutions, Comprehensive Outpatient Rehabilitation Facilities (CORFs), Clinics, Rehab Agencies, & Public Health Agencies as Providers of Outpatient PT and Speech Language, and Community Mental Health Centers. The main content area contains the following text: 'CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CFCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs / CFCs.' Below this text is a list of health care organizations that CoPs and CFCs apply to: Ambulatory Surgical Centers (ASCs), Community Mental Health Centers (CMHCs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Critical Access Hospitals (CAHs), End-Stage Renal Disease Facilities, Federally Qualified Health Centers, Home Health Agencies, Hospices, Hospitals, Hospital Swing Beds, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Organ Procurement Organizations (OPOs), Portable X-Ray Suppliers, Programs for All-Inclusive Care for the Elderly Organizations (PACE), Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services, Psychiatric Hospitals, Religious Nonmedical Health Care Institutions, Rural Health Clinics, Long Term Care Facilities, and Transplant Centers. At the bottom right, it says 'Page last Modified: 11/06/2013 9:36 AM' and 'Help with File Formats and Plug-Ins'.



## Ligature and Safety Risk (cont.)

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- *Joint Commission Journal*, 2018 – Incidence and Method of Suicide in Hospitals in the US
  - No reliable estimates: from data we know to focus on hanging risk and risk of suicide immediately following discharge
  - Expert panel: agreed on terminology (e.g., ligature-resistant vs. ligature-free) and provided guidance to psychiatric settings as well as other areas of the hospital







# TJC Panel Recommendations

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- Inpatient psych (psych units, psych hospitals, dedicated spaces) – must be ligature resistant
- Other areas where suicidal patients might be (EDs, med/surg units, residential, partial hospitalization, etc.) do not have to be ligature resistant, but need risk assessment and appropriate steps to make environment more safe





## To Do's



- Based on prior corrective actions (1585 were reviewed), TJC Panel recommends for all facilities:
  - Environmental risk assessment
  - Environment of Care rounds by leadership
  - Policy/procedure regarding suicide risk assessment (who, when, how, what to do if risk is there)
  - Monitoring/precautionary actions
  - Staff training and demonstrated competency



## To Do's (cont.)

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ED of general acute care hospital – since we know that behavioral health patients (including 5150 “danger to self”) are frequently brought in, specifically look at the following:

- Does your patient safety policy specifically address the patients who come to your ED with behavioral health issues that put them at risk?
- Does your policy include ways to mitigate risk of harm; for example,
  - Individual patient risk assessment
  - Removal of objects that could be used to harm self or others
  - 1:1 monitoring



# TJC Revision of National Patient Safety Goals 15.01.01

The screenshot shows the Joint Commission website interface. At the top, there is a navigation bar with 'Accreditation', 'Certification', 'Standards', 'Measurement', 'Topics', 'About Us', and 'Daily Update'. Below this, a 'Topic Details' section is visible, including a 'Sign up for News and Alerts' button and a 'Topic Library Item' for 'NPSG 15.01.01 Suicide Prevention Resources'. A red arrow points from the 'Download This File' button in the screenshot to the table on the right.

Suicide Prevention Resources to support Joint Commission Accredited organizations implementation of NPSG 15.01.01	
EP1 – Environmental Risk Assessment	
Tools	Brief Description
<p><a href="#">ASHE Patient Safety and Ligature Identification Checklist</a></p> <p><a href="#">ASHE On Demand: A Safe Health Care Environment: Suicide, Self-Harm, and Ligature Risk Assessments</a></p> <p><b>ASHE Virtual Rounding Tools</b></p> <ul style="list-style-type: none"> <li><a href="#">Virtual Rounding Tool: General Acute Care Patient Room</a></li> <li><a href="#">Virtual Rounding Tool: General Acute Patient Care Bathroom</a></li> </ul> <p><b>ASHE Three-step ligature risk guidance for general acute care or emergency departments</b></p> <p><b>Settings:</b> Hospital, other</p> <p><b>Availability:</b> Free to ASHE members</p>	<p><b>The American Society for Health Care Engineering of the American Hospital Association (ASHE)</b> developed multiple tools and resources on ligature risks in the physical environment to help hospitals and other health care facilities understand and implement CMS guidance and Joint Commission recommendations related to establishing a policy to perform an environmental-risk assessment when an at-risk patient is present. The tools are available free of charge to ASHE members. Information about the tools can be found on the ASHE News and Resources web page: <a href="http://www.ashe.org/resources/preventing-self-harm-and-ligature-risks.shtml">http://www.ashe.org/resources/preventing-self-harm-and-ligature-risks.shtml</a></p> <ul style="list-style-type: none"> <li>The ASHE Patient Safety and Ligature Identification Checklist can be used to create ligature-resistant environments when 1:1 continuous observation is not practical. While it is not meant to be exhaustive, it is intended to help understand the possible patient and staff safety risks, potential ligature points and other self-harm concerns for behavioral health areas. It is categorized by room type and contains items that are known to pose specific ligature or self-harm risks.</li> <li>The ASHE On Demand: <a href="#">A Safe Health Care Environment: Suicide, Self-Harm, and Ligature Risk Assessments</a> is a recording that focuses on the process of risk assessment and mitigation of behavioral health patient safety physical risks.</li> <li>The ASHE Three-step ligature risk guidance for general acute care or emergency departments provides a three-step approach (<b>Identify; Observe; Remove</b>) to managing ligature risks and preventing patient self-harm in general acute care or emergency departments. These steps do not apply for psychiatric units.</li> </ul> <p><b>Recommending Organizations:</b></p> <ol style="list-style-type: none"> <li>The American Society for Health Care Engineering of the American Hospital Association</li> </ol>
<p><b>The Mental Health Environment of Care Checklist (MHEOCC) (05/24/2018, XLS)</b></p>	<p>The US Department of Veteran Affairs (VA) developed the <a href="#">Mental Health Environment of Care Checklist (MHEOCC)</a> for VA Hospitals to review inpatient mental health units for environmental hazards. The purpose is to identify and abate environmental hazards that could increase the chance of patient suicide or self-harm. The checklist has been used in all VA mental health units since October 2007. Contact <a href="mailto:Peter.Mills@va.gov">Peter.Mills@va.gov</a> for more information.</p>



## AB 2861 – Drug Medi-Cal Providers and Telehealth

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- Requires reimbursement to certified drug Medi-Cal provider when substance use disorder (SUD) services are provided through *telehealth*, when medically necessary and in accordance with state plan, to extent federal financial participation is available
- Requires DHCS to adopt regs by July 1, 2022 to implement this bill (3-1/2 years notice!!)





# Other Telepsychiatry Developments

- California Drug Medi-Cal (DMC) Organized Delivery System Waiver (ODS) – reorganized system for treating patients with substance use disorder
  - Will pay for telemedicine services to certain populations (e.g. patients receiving Intensive Outpatient Services)
- Seeing more and more rural/frontier health facilities utilizing VSEE and other technologies in order to bring mental health assessment and care coordination to underserved communities
  - Use in EDs varies, but consultations have proven to be extremely helpful in stabilizing patients and reducing the need for inpatient beds, in some cases by 75% or more!





## Looking to the Future

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- **Mayor Darrell Steinberg** of Sacramento (formerly, President Pro Tempore, 2008-2014, CA State Senate), helped chair and start in early 2017, together with CHA and NAMI, *Behavioral Health Action* (formerly, “Leading the Way”) – multiple stakeholders with common goals for improvement of mental health delivery system, and reduction of stigma for those who suffer from mental illness and substance use disorder
- **Governor Newsom** in January 2019 stated that he will make “brain health” a priority for his administration and established a brain health task force to focus on Alzheimer’s Disease (with \$3M annually from State Budget)



## Future Legislation? A Sample of Current Issues Before the CA Legislature This Year

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- SB 428 – Youth Mental Health First Aid – would require teachers to take CE course in order to get a teaching credential and at recredentialing; also training for lay people on recognizing and assisting youth experiencing mental health issues (many groups supporting this including Lady Gaga’s “Born This Way” foundation)
- AB 8 – Pupil Mental Health – school districts would have at least one MH professional/400 students by December 31, 2022





## Future Legislation (cont.)

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- AB 389: Peer Navigators in EDs – Would establish pilot program for SUD and MH peer navigators to help behavioral health patients in hospital emergency departments, if funds are there
- SB 590: Involuntary SUD treatment – parent, legal guardian or spouse could petition court for involuntary SUD inpatient treatment if person is “imminent danger to self or others” and “can reasonably be expected to benefit from the treatment”



Questions?





Thank You

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