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

Tennessee Department of Mental Health & Substance Abuse Services

AND

Tennessee Hospital Association

AND

Tennessee College of Emergency Physicians

Approved August 2019
Executive Summary

In 2017, the ED Boarding workgroup was convened in order to assess the state's current psychiatric care delivery system. This report was originally developed and drafted in 2017 in order to catalog the analysis of the psychiatric delivery system as well as what opportunities existed within the system to improve upon. These findings are included below in black text. In 2019, this workgroup reconvened in order to identify what improvements have been made to the psychiatric system in the intervening time. For continuity and easy comparative reference, updates, improvements, changes, and ongoing opportunities for improvement are listed in each relevant section in blue text.

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 workgroup 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.

As noted in this updated report, many of the 2017 recommendations from the workgroup have been implemented over the last two years resulting in tremendous progress on the issue of ED boarding. In particular, the improvements have been felt in both a decrease in wait times as well as a decrease in the number of those being referred into the public system. Furthermore, this work continues under the Lee Administration and the work of the General Assembly. In 2019, funding was allocated to the Department of Mental Health & Substance Abuse Services to hire a Community Behavioral Health Medical Director, Dr. Sandy Herman, to serve in the community and build relationships, train and educate emergency rooms on these ED protocols as well as the treatment of those with substance abuse services in the ED. Dr. Herman is a Board Certified Physician in Emergency Medicine with over 30 years of experience in the Emergency Room, and former President of the Tennessee College of Emergency Physicians. Our work continues and the updates in this report highlight the key areas of focus needed for all stakeholders.

**Mission of the Work Group**

The mission is 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 keep our system from developing average wait times 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.
2019 Workgroup Topline Recommendations:

- There is not a need for new beds in the State’s Regional Mental Health Institutes, beyond those currently planned. The workgroup recommends real investments should be made instead into:
  o RMHI staff and resources to improve processing and throughput capabilities for patient admissions.
- There is a need for additional resources to RMHIs to facilitate the widespread use and immediate expansion of Telehealth services.
- There is need for payment reform in a number of areas:
  o Increased private and public payments to the existing inpatient psychiatric providers to allow them to expand care for the highest need patients, to include adolescents.
  o Request private and public payment systems to review the current inpatient mental health payment rates for adults, in addition to rates for adolescents and those with intellectual and developmental disabilities to assure a robust provider networks exist.
- Additional funding for the demand of Crisis Stabilization Units and walk-in centers as a viable alternative to EDs.
- There is a need to streamline the medical clearance process by convening clinical specialists from EDs, RMHIs, private inpatient facilities and CSUs.
  o Establish protocols for receiving psychiatric facilities to address liability concerns.
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

TDMHSAS

- Marie Williams, Commissioner
- Bo Turner, Deputy Commissioner
- Mary Young, CEO Moccasin Bend Mental Health Institute
- Rob Cotterman, CEO Middle Tennessee Mental Health Institute
- Dr. Terry Holmes, Moccasin Bend Mental Health Institute
- Morenike Murphy, Director of Crisis Services

THA

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

Community Partners

- Candice Watson, ED Director, Southern TN Regional Health System (Winchester)
- Dr. Jeffrey Wood, Division President, Acadia Healthcare
- Dr. Jennie Mahaffey, Erlanger Health System
- Kathy Beckett, Ed Director, Maury Regional
- Kathy Rhodes, Director, TriStar Call Center
- Keith Jackson, Regional VP, HCA/TriStar Behavioral health Services

TN College of Emergency Physicians (TCEP)

- Dr. Sandy Herman, TCEP Past Chairman
- Dr. Sullivan Smith, TCEP Chairman, Cookeville Regional

The following report is a comprehensive review of the work that this collaborative group. While first drafted and made public in February 2017, it has since been updated in March 2019 to reflect the impact these recommendations and other work has had on the system related to ED Boarding (See Attachment A for updated data).
Report: Tennessee’s Public/Private Psychiatric Delivery System

I. 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 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.
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.

Actions up to 2017
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.

**Updates in 2019**
Hospitals across the state have been successfully using the protocols since the project roll-out, with reported decreases in violent events, the use of seclusion and restraints and the need for staff security or sitters. At the same time, patients who are placed on the protocols are often able to be discharged to a lower level of care, such as a crisis stabilization unit or home with follow-up care, ultimately avoiding an inpatient stay all together. It is estimated as of April 2019 that more than 25 hospitals and hospital systems in the state are using the protocols (or some version of them).

**Furthermore,** an initial webinar training on the use of the protocols was held in the spring of 2017, with over 150 hospital and crisis professionals participated in. Since that time, the protocols have been shared with a number of groups, including the THA Quality and Patient Safety Committee, the THA Chief Medical Officers Committee, the THA Psych Section, and the THA Board of Directors.

The reconvened 2019 ED boarding workgroup intends to prioritize increased adoption of these protocols in additional EDs. As part of this, TDMHSAS has received funding for a new position for a physician, Dr. Sandy Herman, whose responsibility will be to coordinate with THA to train and provide ongoing technical assistance to new hospitals and ED teams on the use and functionality of the protocols.

**As it relates to the role of Substance Abuse,** the state convened a public private partnership to create no wrong door to access substance abuse treatment. In the process of developing recommended protocols for the use of Medication Assisted Treatment (MAT) in hospitals to help begin the opioid addiction recovery process before patients are discharged to the community. In order to facilitate the implementation of these protocols in emergency rooms, additional work is required to ensure linkages to community care are available. The expansion of the Tennessee Recovery Navigators will be one piece to facilitate linkages from the ED to the community. Ongoing evaluation and coordination with the Board of Pharmacy will support this initiative to ensure a thoughtful implementation that facilitates more Tennesseans receiving the care they need.
Expanded use of the protocols will have a positive impact on both the delivery system and the people it serves. At the same time it is important to recognize that increasing the utilization of the protocols alone is not the answer. Real investments also need to be made in services that align with and support the use of the protocols, including telehealth, crisis units and mental health walk-in centers, and case management (wrap-around) services to keep people from decompensating to the point of needing the emergency department in the first place.
II. Crisis System Evaluation

Findings
- Inconsistent use of community resources
- Underutilization of some Crisis Stabilization Units (CSUs)
- Approximately 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 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.

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 delivery system will experience a reduced need for inpatient hospitalization, and shortened wait times for patients.
Crisis System Profile & Adults Served

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<tr>
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<th>FY15</th>
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<tr>
<td>Funding</td>
<td>$25.7 million ($6.5 TDMHSAS, $19.2 TennCare)</td>
<td>$29.4 million ($10.2 TDMHSAS, $19.2 TennCare)</td>
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<tr>
<td></td>
<td>*Includes Mobile Crisis &amp; Walk-In Centers</td>
<td>*Includes Mobile Crisis &amp; Walk-In Centers</td>
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<tr>
<td>Total Providers</td>
<td>13</td>
<td>13</td>
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<tr>
<td>Total Crisis Phone Calls</td>
<td>110,869</td>
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<td>Adult Calls</td>
<td>93,824</td>
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<td>Adult Face-to-Face Assessments</td>
<td>62,145</td>
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<tr>
<td>Response Time within 2 Hours</td>
<td>86.5%</td>
<td>82%</td>
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<td>Receiving care in the least restrictive treatment setting - i.e. CSU, respite, outpatient, home, etc.</td>
<td>41,330 (66%)</td>
<td>38,403 (56%)*</td>
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<tr>
<td>Referrals to Hospitalization</td>
<td>20,899 (34%)</td>
<td>29,785 (44%)</td>
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*Please note – the definition of assessments between FY15 and FY18 was changed from as “assessments NOT resulting in hospitalization” and “resulting in hospitalization” whereas now, it is defined as “assessments NOT referred for hospitalization” and “referred for hospitalization”

Actions up to 2017

- In an effort to standardize the processes involved in the psychiatric crisis delivery system, Frequently Asked Questions (FAQs) were created in regards to Mobile Crisis, the involuntary commitment, Certificate of Need (CON) 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
  o Research & Data review
  o Identification of barriers/challenges
  o Identification of available resources (intradepartmental, stakeholders, community partners)

Updates in 2019
The issue of medical clearance for patients in mental health crisis continues to be a barrier to access timely mental health services. The TDMHSAS Chief Medical officer has been working with the physicians at each RMHI to clarify and standardize medical clearance expectations across the RMHIs. The TDMHSAS also instituted a new policy in late 2018 that requires a physician to physician discussion between the ED and the RMHI if/when medical clearance issues arise. Removing the mobile crisis teams from this process should significantly enhance communication and coordination between clinicians and streamline the RMHI admission.

At the same time medical clearance at the CSUs is frequently a problem for EDs resulting in significant delays in admission. The workgroup also expressed interest in working with private inpatient mental health providers in the state to identify any opportunities to streamline this process. This workgroup recommends specific, dedicated efforts to address medical clearance between all stakeholders in an effort to streamline the referral process and reduce laboratory testing costs.

Additionally, updates to the Mobile Crisis Continuum include an increase of $3.5 additional recurring dollars in the 2017-2018 state budget. This funding increase serves to enhance a range of crisis services by allocating funding to Tennessee’s eight (8) walk-in triage centers. The additional funding expanded access to community crisis services, allowing the walk-in centers to expand capacity and enhance the level of screening and treatment they are able to provide.
As a direct result of this increased funding, in addition to receiving a face-to-face evaluation with a professional crisis responder, individuals also have access to a psychiatric medication prescriber, access to 24/7 nursing assessments, access to 23 hour observation services, and other needed services and supports.

These services are also beneficial to law enforcement officials by offering easy/prompt access to mental health assessments and referrals. Additionally, the walk-in capability provides an alternative treatment resource for individuals in a behavioral health crisis, which potentially defers patients from Tennessee’s emergency departments and increases options for pre-arrest diversion. As a result of the $3.5 million appropriated to Tennessee’s walk-in centers, in FY2018 20,651 individuals received services; a 17% increase from FY2017 (See Walk-In Center Survey Results – Attachment C). Additionally, in FY18 as a result of the enhanced treatment services, 2,568 individuals were assessed at community locations and referred to the Walk in Center for treatment.

Furthermore, the state continues to invest in Pre-Arrest Diversion. In the FY18 budget, Governor Haslam and the Tennessee General Assembly provided $15 million in funding for pre-arrest diversion infrastructure. This non-recurring funding was competitively bid to grantees with a goal of supporting local communities in infrastructure development aimed at reducing or eliminating the time individuals with mental illness, substance use, or co-occurring disorder spend incarcerated by redirecting them from the criminal justice system to community-based treatment and supports. An essential component of the process was leveraging local funding to support the state’s investment. Through this process, local partners were able to commit $4 million to supplement the funding from TDMHSAS.

This program’s objectives are to:
1) Successfully develop infrastructure and services aimed at diverting individuals with behavioral health needs away from jail to appropriate community-based treatment.
2) Implement effective community strategies to better serve individuals in psychiatric crisis, safely reduce the prevalence of individuals with behavioral health needs in local jails, and reduce costs related to prosecution and incarceration.
3) Demonstrate a collaborative and coordinated system-wide approach among local behavioral health providers, law enforcement, and the judicial system within the community to pre-arrest diversion.

These objectives have led to the following outcomes as of March 2019:

- 5,444 individuals diverted from jail
- Current estimated cost savings to local criminal justice system: $7.6 Million
III. 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.

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.

Actions up to 2017
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.

**Updates in 2019**
The Tennessee Department of Health (TDH) has committed federal grant funds to
implement a new bed tracking or “patient matching” system in the state. A
workgroup including TDH, TDMHSAS, THA, acute care hospitals, psychiatric
hospitals and community providers was created in late 2018 to review the TDH’s
vendor options, help develop the administrative and operational details within the
new system and create a roll-out plan for statewide adoption. The new system is
anticipated to go live in the fall of 2019 and its initial focus will be improved
coordination for patients in need of inpatient mental health services.

It is also important to note that when hospitals board psych patients, the
reimbursement schedule is minimal during the duration of the patient stay. At the
same time, the cost to provide care for these patients during their stay in the ED is
very high due to staff time, labs and diagnostic testing necessary for medical
clearance.

Available funding for current inpatient psychiatric beds for adult, high-acuity
patients continue to prove challenging. It is the workgroup's belief that if all payers
invested in a tiered or acuity-based inpatient payment system that recognizes the
significant needs of these patients and provides enough reimbursement to enable
the private hospitals to make the necessary facility and staffing enhancements to
care for them.

This workgroup also recommends a similar evaluation of private and public rates
for children and adolescents, to increase the availability of beds for these patients.
Again, improving the reimbursement for the most vulnerable patients will likely increase the number of hospitals able to care for them.

**Furthermore, a child/adolescent taskforce** was convened, which included representatives from TennCare, the Department of Children’s Services, the TN College of Emergency Physicians and the Children’s Hospital Alliance of Tennessee (CHAT). The workgroup created tools and resources for hospital EDs to better care for children in mental health crisis, including safety protocols, seclusion and restraint guidelines, and psychiatric medication protocols. The CHAT hospitals continue to pilot the resources which, once finalized, will be made available to all hospitals EDs to help them care for these patients and their families while an available inpatient or community mental health service is being identified.

Finally, TDMHSAS, in collaboration with THA, made a number of updates to the involuntary commitment process under the Certificate of Need (CON) in order to simplify and streamline it. This redesign combines all three steps into one document. The new combined document is more efficient as it streamlines this important process, which may contribute to increased options for treatment and shortened wait times.

Additionally, in accordance with Title 33 of the Tennessee Code Annotated, the form has been redesigned to clarify that you may initiate an emergency detainment instead of completing a first CON, if the purpose of the detainment is to obtain an immediate examination to determine whether the person meets the criteria for emergency involuntary admission or commitment.
IV. 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.

Impact Statement
By continuing to address 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.

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.

**Updates in 2019**
Initial pilots indicate enormous opportunity for time and resource savings to prevent non-admissions to RMHIs. The pilot between St. Thomas Rutherford and Middle Tennessee Mental Health Institute (MTMHI) showed promising results. Between September 2018 and March 2019, there were a total of 304 referrals from...
the St. Thomas Rutherford ED, of which 243 were eligible for a telehealth evaluation. Through this evaluation, 118 patients were identified as not meeting admission criteria and thus avoided an unnecessary transport to MTMHI. In addition, because 125 patients were successfully assessed through telehealth, once transported to MTMHI, the sheriff did not have to wait the statutory 1 hour and 45 minutes for an on-site assessment as the patient was already guaranteed an admission.

Ensuring that physicians in EDs have the tools to properly document the reasons for not sending a patient to the RMHI will be a significant step in ensuring compliance and reducing legal barriers (Attachment E).

**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.
ED Boarding Workgroup
THA & TDMHSAS

February 19, 2019
Comparison of Hospital Admissions and Adult Crisis Services

Crisis Services

- Crisis Calls
- Crisis f-2-f
- Crisis assessments referred to an RMHI

Private Psychiatric Hospitals (PPH)

- Data not available for FY10 - FY11, partial year data for FY2012

Regional Mental Health Institutes (RMHI)

- RMHI Admits
- RMHI waiting list

Sources: (1) Crisis provider report FY2010-FY2013 and the Crisis Management System FY2014-FY2018; (2) Private psychiatric admission reports (FY2010-FY2017) and Forensic Billing System (11/20/2018); (3) Avatar RMHI annual statistical reports FY2010-FY2018; (4) Wait list information provided by Budget Office. Note: (1) The Crisis Management System began collecting data in FY2014. Prior to FY2014, each provider supplied self-reported data which may have included duplicates and children. (2) The RMHI wait list includes referrals to process prior to April of 2017. Individuals shall be considered waiting if the RMHI receiving the referral has no available, suitable accommodations.
Statewide Face-to-Face Assessments with and without Insurance

Source: Crisis provider report FY2010-FY2013 and the Crisis Management System FY2014-FY2018
Notes: Without insurance includes no insurance, unknown insurance. Insurance includes TennCare, VA and commercial payers.
Crisis Stabilization Unit Occupancy Rates

Statewide Crisis Stabilization Units, Average Occupancy FY11-FY18 (excludes Cherokee)

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<th>Year</th>
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<td>FY18</td>
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Source: Provided by Crisis Services, 2/5/2019
Crisis Stabilization Unit Occupancy Rates

Statewide Crisis Stabilization Units, Average Occupancy FY11-FY18 (includes Cherokee)

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<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
<th>FY18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupancy (%)</td>
<td>62.4</td>
<td>70.1</td>
<td>68.5</td>
<td>68.6</td>
<td>65.6</td>
<td>66.6</td>
<td>68.1</td>
<td>69.7</td>
</tr>
</tbody>
</table>

Source: Provided by Vicki Carter from weekly reports, 11/20/2018
Comparison of RMHI Occupancy Rates

Source: Avatar RMHI annual statistical reports FY2010-FY2018.
Note: Occupancy rates exclude leaves.
### Avatar Daily Census Report – 2/14/19

**AVATAR PM**

**Daily Census Report**

**Midnight Census for Thursday 2/14/2019**

Report reflects the previous day's midnight census, current as of 2/15/2019 6:00:06AM.

Census, Available Beds, and Occupancy include patients who are on leave.

#### ALL PATIENTS (INCLUDING FORENSIC)

<table>
<thead>
<tr>
<th>Excluding Leaves</th>
<th>Census</th>
<th>Available Beds</th>
<th>Total Beds</th>
<th>Occupancy Rate</th>
<th>Admitted 02/14/19</th>
<th>Discharged 02/14/19</th>
<th>NET CHANGE</th>
<th>LEAVES</th>
<th>FORENSIC CAP</th>
<th>FORENSIC Occ Rate</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTMHI FSP</td>
<td>16</td>
<td>17</td>
<td>30</td>
<td>57%</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>18</td>
<td>44%</td>
</tr>
<tr>
<td>---MTM OTHER</td>
<td>135</td>
<td>146</td>
<td>177</td>
<td>82%</td>
<td>10</td>
<td>8</td>
<td>2</td>
<td>11</td>
<td>27</td>
<td>30</td>
<td>90%</td>
</tr>
<tr>
<td>WMHI</td>
<td>131</td>
<td>139</td>
<td>150</td>
<td>93%</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>8</td>
<td>48</td>
<td>46</td>
<td>104%</td>
</tr>
<tr>
<td>MBMHI</td>
<td>119</td>
<td>123</td>
<td>165</td>
<td>75%</td>
<td>5</td>
<td>11</td>
<td>-6</td>
<td>4</td>
<td>16</td>
<td>12</td>
<td>133%</td>
</tr>
<tr>
<td>MMHI</td>
<td>34</td>
<td>34</td>
<td>55</td>
<td>62%</td>
<td>3</td>
<td>5</td>
<td>-2</td>
<td>0</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>435</td>
<td>459</td>
<td>577</td>
<td>80%</td>
<td>22</td>
<td>27</td>
<td>-5</td>
<td>24</td>
<td>107</td>
<td>114</td>
<td>94%</td>
</tr>
</tbody>
</table>

FSP = Unit Code of 'FSE' or 'FST'

Forensic If legal status code is one of the following: 2, 2M, 3, 3M, 3P, 18, 18M, 19, 19M, 20, 20M, 46F
## RMHI Admissions from Jail

<table>
<thead>
<tr>
<th></th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
<th>FY18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forensic Admissions from Jail</td>
<td>394</td>
<td>458</td>
<td>404</td>
<td>443</td>
<td>453</td>
<td>518</td>
</tr>
<tr>
<td>Non-Forensic Admissions from Jail</td>
<td>838</td>
<td>993</td>
<td>1,212</td>
<td>1,269</td>
<td>1,313</td>
<td>1,383</td>
</tr>
<tr>
<td>Total Admissions from Jail</td>
<td>1,232</td>
<td>1,451</td>
<td>1,616</td>
<td>1,712</td>
<td>1,766</td>
<td>1,901</td>
</tr>
</tbody>
</table>

Source: Avatar legal status reports FY2010-FY2018.
Comparison of Admissions by Facility

Sources: (1) Private psychiatric admission reports (FY2010-FY2017) and Forensic Billing System (11/20/2018); (2) Avatar RMHI annual statistical reports FY2010-FY2018.
Primary Diagnosis by Facility, FY2018 All Patients

Source: Avatar FY2018.

Notes: (1) Other mental health diagnoses include personality disorders, dementia and behavioral issues. (2) Substance abuse disorders include alcohol, stimulants, opioids, cannabis, sedatives, hypnotics, hallucinogens and inhalants. (3) All FY2018 diagnoses utilize the ICD-10 diagnosis coding system.
# Standard Psychiatric Treatment Protocol

*Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician.*

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Additional Orders: (Dates/Times required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Consult Crisis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Consult Psychiatry</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Labs per Department of Mental Health medical clearance guidelines</td>
</tr>
</tbody>
</table>

## FOR MOOD STABILIZATION: May use alone or in combination with next section (Treatment of Psychosis)

- ☐ 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)

- ☐ Lurasidone 40mg PO daily  
  (Consider use in women of child bearing age who may be or become pregnant)
- ☐ Risperdone 1mg PO BID  
  **OR**  
  ☐ Risperidone 0.5 PO BID (for patients with severe hepatic impairment)
- ☐ Ziprasidone 40mg BID with food
- ☐ Haloperidol 5mg PO BID (only indicated for psychosis)

### FOR GERIATRIC AGITATION

- ☐ Quetiapine 50mg PO BID  
  **AND**  
  ☐ Quetiapine 200mg at HS (hold if sedated)

## FOR PREVENTION OF EXTRAPYRAMIDAL SIDE EFFECTS AND TO PROMOTE MILD SEDATION AND SLEEP:

- ☐ Diphenhydramine 50mg PO BID  
  **OR**  
  ☐ Benztropine 1mg PO BID
### Behavioral Emergency Treatment Protocol

**Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician.**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Additional Orders: (Dates/Times required)</th>
</tr>
</thead>
</table>

#### MILD TO MODERATE AGITATION:

FOR PRN USE IN THOSE PATIENTS EXPERIENCING MILD TO MODERATE AGITATION OR DANGEROUS BEHAVIOR, CONSENTING TO ORAL MEDICATIONS.

*(Check one regime only)*

- Haloperidol 5mg PO Q4 hrs PRN agitation
- Ziprasidone 60mg PO Q12 hrs PRN agitation
- Quetiapine 50mg PO Q2 hrs PRN agitation *(Geripsych neurocognitive disorder)*
- Risperidone disintegrating tab 2mg PO q12 hours PRN agitation
- Olanzapine disintegrating tab 10mg PO q12 hours PRN agitation

With optional addition of:

- 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.

*(Check one regime only)*

- Haloperidol 5mg PLUS Lorazepam 2mg PLUS Diphenhydramine 25mg IM every 2 hours PRN agitation
- Ziprasidone 20mg IM PLUS Lorazepam 2mg IM every 12 hours *(Dose related QTc prolongation and risk of cardiac arrhythmias with Ziprasidone)*
- Olanzapine 10mg IM q 8 hours PRN agitation

#### ALTERNATIVE FOR EXTREME COMBATIVE/VIOLENT BEHAVIOR:

- Ketamine 4mg per kg IM
  - OR
  - Ketamine 1.5mg per kg IV  
  - *Monitor bp and O2 status. In most cases, only effective for initial control.*
**Program Enhancements**

**Enhancement Services**: To provide recurring funds to enhance the continuum of crisis services and expand the function of the states eight walk-in centers to allow a 23-hour observation component, access to a psychiatric medication prescriber, 24-hour nursing assessments, and other needed services and supports.

**FY18 Additional Funding**: 3.5 million additional recurring dollars was allocated to Tennessee’s current (8) Crisis Walk-In Centers across the state to assist with enhancement expenses.

- Total State Funding: $5,308,246
- Infrastructure: approximately 3% of total funding was provided for infrastructure

<table>
<thead>
<tr>
<th>TDMHSAS Funded Crisis Walk-In Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance Healthcare -Memphis</td>
</tr>
<tr>
<td>Mental Health Cooperative-Nashville</td>
</tr>
<tr>
<td>Cherokee Health Systems-Morristown</td>
</tr>
<tr>
<td>Pathways of Tennessee-Jackson</td>
</tr>
<tr>
<td>Frontier Health-Johnson City</td>
</tr>
<tr>
<td>Volunteer Behavioral Health - Chattanooga</td>
</tr>
<tr>
<td>Helen Ross McNabb-Knoxville</td>
</tr>
<tr>
<td>Volunteer Behavioral Health- Cookeville</td>
</tr>
</tbody>
</table>

**Summary of FY18- December FY19 WIC Program Enhancement Data**

Services were not available at all (8) WICs prior to the additional $3.5 million allocation. Due to the program enhancements, individuals can now be referred to a WIC from a community location.

31,972= Total number of individuals (unduplicated) who received at least one service at a WIC

- 10,962 individuals (duplicated) were placed under 23-hour observation
- 14,034 individuals (duplicated) were assessed by a psychiatric medication prescriber
- 7,650 of those assessed (duplicated) by a psychiatric medication prescriber received medications
- 21,313 individuals (duplicated) received a nursing assessment
- 1,103 individuals (duplicated) received other supports and services (i.e. transportation, discharge planning services)

* WIC Assessments = number of individuals assessed by a crisis responder at a WIC
* WIC Referrals = number of individuals who were assessed by a crisis responder at a WIC OR were referred to a WIC & received any service
* Duplicated = An individual may receive more than one service

Data Source: Crisis Tracking System and Deliverables / 3.14.19
**AVATAR PM**  
**Daily Census Report**  
**Midnight Census for Thursday 2/14/2019**

Report reflects the previous day’s midnight census, current as of 2/15/2019 6:00:06AM.  
Census, Available Beds, and Occupancy include patients who are on leave.

### ALL PATIENTS (INCLUDING FORENSIC)

<table>
<thead>
<tr>
<th>Excluding Leaves</th>
<th>CENSUS</th>
<th>Available Beds</th>
<th>Total BEDS</th>
<th>Occupancy Rate</th>
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<th>Discharged 02/14/19</th>
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<td>1</td>
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<td>18</td>
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</tr>
<tr>
<td>—MTMHI OTHER</td>
<td>135</td>
<td>146</td>
<td>31</td>
<td>177</td>
<td>82%</td>
<td>76%</td>
<td>10</td>
<td>2</td>
<td>27</td>
<td>30</td>
<td>90%</td>
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</tr>
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<td>11</td>
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<td>3</td>
<td>0</td>
<td>48</td>
<td>46</td>
<td>104%</td>
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<td>-2</td>
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<td></td>
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<tr>
<td>MBMHI</td>
<td>119</td>
<td>123</td>
<td>42</td>
<td>165</td>
<td>75%</td>
<td>72%</td>
<td>3</td>
<td>-6</td>
<td>16</td>
<td>12</td>
<td>133%</td>
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<tr>
<td>MMHI</td>
<td>34</td>
<td>34</td>
<td>55</td>
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<td>62%</td>
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<td>5</td>
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<td></td>
<td>435</td>
<td>459</td>
<td>118</td>
<td>577</td>
<td>80%</td>
<td>75%</td>
<td>21</td>
<td>27</td>
<td>107</td>
<td>114</td>
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<td></td>
<td></td>
<td></td>
<td>-5</td>
<td>24</td>
<td>7</td>
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</tr>
<tr>
<td>Psychiatric Beds 2011 – 2012*</td>
<td>Psychiatric Beds 2018*</td>
<td></td>
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</tr>
<tr>
<td>2,509 (JAR-H = 2559 beds)</td>
<td>3,119</td>
<td></td>
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</tr>
</tbody>
</table>

**Bed Changes by Type:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall increase</td>
<td>610 beds</td>
</tr>
<tr>
<td>Adult Psych</td>
<td>+315</td>
</tr>
<tr>
<td>Geropsych</td>
<td>+153</td>
</tr>
<tr>
<td>Child/Adolescent</td>
<td>+202</td>
</tr>
<tr>
<td>Unknown</td>
<td>-60</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>+610</strong></td>
</tr>
</tbody>
</table>

**Potential New RMHI Beds**

|                   | 85*       |

**Overall Increase in Beds**

|                   | 695       |

**Total Potential Psychiatric Beds**

|                   | 3,204     |

Please note that Phase II plans are in process that would add 25 beds to WMHI in Bolivar, TN, as well as, new facility plans that will increase beds at MBMHI in Chattanooga, TN by 35 (moving from 165 beds to 200 beds), if approved and funded. Additionally, plans are currently underway to relocate the crisis continuum currently located within MMHI which will make an additional 25 beds available upon completion. These additional beds have not been included in this psych bed count.

**Data Sources:**

* Bed numbers for 2011 – 12 are based on the JAR-H 2011 data (from THA), corrected where indicated in July, 2016 based on HSDA and TDMHSAS Licensure information.
* Bed numbers for 2018 are based on the JAR-H 2017 data, updated in November, 2018 and updated or corrected where indicated based on HSDA and TDMHSAS Licensure information.

**NOTE:** The 2018 bed numbers include all CON-approved beds as of November, 2018, including beds that have not yet been implemented as of December, 2018. The following beds are not currently available – Cumberland Behavioral Health, 76 beds and Unity Psychiatric Services Clarksville, 48 beds.

**Considerations:**

- Reports of operating beds will vary from time to time, as this is a “point-in-time” picture of the number of beds, and assumes providers are reporting those beds accurately.
RATIONALE FOR NON-ADMISSION

No Evidence of Mental Illness:
☐ Does not meet criteria for psychotic or mood spectrum Disorder diagnosis
☐ Primary and exclusive issues are alcohol and drug related
☐ Disruptive behavior driven by personality disorder and/or mental retardation
☐ Other: __________________________________________________________

Absence of Disabling Psychiatric Symptoms:
☐ No longer dangerous to self or others
☐ Appears to be malingering to avoid imprisonment, to obtain benefits, or to obtain medication
☐ Other: __________________________________________________________

Need for Treatment in an Inpatient Setting:
☐ Training, education, and/or medication management is not necessary
☐ Training, education, and/or medication management is most appropriately managed in an outpatient setting
☐ Other: __________________________________________________________

Medically Unstable:
☐ Medical treatment needs exceed the ability of the RMHI to manage
☐ Other: __________________________________________________________

Referral to Less Restrictive Environment:
☐ Home
☐ Shelter/Mission
☐ Crisis Respite
☐ Crisis Stabilization Unit
☐ Inpatient Alcohol and Drug Treatment
☐ Outpatient Alcohol and Drug Treatment
☐ Medical Treatment Facility
☐ Other: ________________________________

Recommendations Discussed with the Individual:
☐ No mental health or substance use treatment is indicated at this time
☐ Seek counseling at the community mental health agency
☐ Contact case manager
☐ Take medications prescribed by the community mental health agency
☐ Seek outpatient alcohol and drug treatment
☐ Abstain from substances of abuse, including alcohol
☐ Follow-up with primary care physician
☐ Other: __________________________________________________________

Comments: _______________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Date: ________________ Time: _______

Assessing Physician

PATIENT IDENTIFICATION (Label)

MH-5509

Dept. of Mental Health and Substance Abuse Services

RATIONALE FOR NON-ADMISSION

Page 1 of 1  RDA-2305