

Comments by health care providers regarding adult mental health services needs and Issues

Good Morning

My name is Rachel Fleissner. I am a medical doctor, my specialty is psychiatry and I am the Service Chair for Behavioral Health at Stanford.

I am here to represent the Behavioral Health Department at Sanford which includes inpatient and PHP in addition to the outpatient specialty clinics. In addition I am here to represent the ED and primary care clinic and clinicians.

My comments come from liaising with other doctors, triage therapists, nurses and social workers all of whom work on a daily basis with seriously mentally ill persons and dual diagnosed persons.

The size of our concern is enormous as 24 hours a day 7 days a week Sanford is being inundated with patients they either do not have the capacity to manage ( bed wise or physician wise ) and/ or do not have the ability to offer case management services as we cannot be reimbursed for them

I will break my comments into 4 major areas of concern

1.

We have repeatedly asked to be provided by SEHSC the **specific criteria** and **assessment tool** they use to make the determination if a patient meets for case management services.

Case management services can only be reimbursed when provided by the Human Service Center and CANNOT be reimbursed for services provided by an outside entity.

Many patients who appear to meet criteria for case management services are rejected by the Human Service Centers without our ability to understand why as they do not make their specific criteria available placing an onerous burden on Sanford to provide services for patients for which no financial reimbursement can be obtained.

There is great concern that in the last few weeks we were informed that SEHSC would be diverting their resources into pregnant women and “acutely active “seriously mentally ill , indigent and IV substance abusers . The expectation is that there will be less availability and fewer resources from DHS for the chronically seriously mentally ill patients we see day in day out and who are not accepted into case management by SEHSC.

We have repeatedly asked for more services for case management or the uncoupling of case management to the DHS and the Human Service Centers. The Schulte report made it very clear that there be increased availability of case management services

2.

There is much concern over the very limited funding and resources for Chemical Dependency patients particularly the need in the state for programs that are for longer duration than an acute hospitalization such as Residential Chemical Dependency Services reducing the recidivism rate and extensive use of repeated in patient acute hospitalizations

3.

The lack of available man/womanpower at the SEHSC is placing patients at risk .Psychiatry, Therapy and case management services are in dire need of increasing their workforce. Calling for an appointment for a patient coming out of an acute hospital stay and being told that they are scheduling out 3 months for a psychiatrist is not effective treatment for patients. The cost to the state is that the patient often is back in the hospital before even seeing the psychiatrist. In addition Open Assess which we were informed is now going to happen may lead patients to not being seen within the designated time after admission and then the refusal of the state to pay for their hospital stay as payment for the stay is linked to the patient making it to their follow up appointment.

In addition when a patient is discharged to ACS (Acute Crisis Services) Sanford is held financially responsible to pay and provide for a 5-7 day supply medication.

4.

For a patient on the Sanford In patient unit at this time SEHSC no longer comes to screen the patient for eligibility for mental services through SEHSC after discharge. This should be an important part of discharge planning but is no longer something SEHSC is providing. They are providing screening for Chemical Dependency Services but not Mental Health Services.

Sanford Inpatient Psychiatric Unit is a short term community psychiatric Unit however the transfer of patients from this acute unit into the state hospital is often taking 2 plus weeks after they have been evaluated by the SEHSC screening team and approved for admission . This is 2

weeks of bed utilization that the inpatient unit at Sanford could be using to accommodate one of the 29 patients from North Dakota diverted per month out of the Sanford ED due to lack of available acute psychiatric beds at the Sanford psychiatric Unit . (A total of 346 patients per year from North Dakota who need psychiatric admission cannot be admitted to Sanford due to space limitations)

Once admitted to the state hospital the average length of stay of these very ill patients appears to be reducing to the extent that we are now seeing patients who have had dozens of stays in Sanford Psychiatry Unit and the state hospital within a 2 -3 year window begging to pose the question as to what long term facilities are available in North Dakota who would be safer in much longer term hospitalization instead of dozens of repeated trips to the ED and excessive uses of acute psychiatric units .