Public Hearing on Mental Health Access in Western New York

New York Attorney General Letitia James

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Thank you for the interest in helping the mental health community improve access to treatment for Western New Yorkers and thank you for this opportunity to provide input into this process.

As the Medical Director of the Erie County Medical Center's Comprehensive Psychiatric Emergency Program (CPEP) for the past 9 years, I have seen our department grow both related to an increase in the need for crisis intervention and emergent psychiatric care, but also as ECMC has endeavored to meet that need for our community. ECMC houses the only CPEP as defined by NYS Mental Hygiene Law. ECMC provides the highest level of psychiatric care in Western New York and often gets referrals from other institutions like Niagara Falls Memorial Medical Center and UPMC Chautauqua (formerly WCA). Due to our inability to discharge patients to state-supported programs for weeks and months, coupled with inadequate Medicaid reimbursements, ECMC continues to experience high patient volume challenges in our CPEP.

As the largest provider of behavioral health services in Western New York, ECMC has advocated for more funding and greater access to outpatient services and long-term psychiatric beds for years. In fact, in 2021 our losses for behavioral services were $15.7 million and we expect similar losses for 2022. In order for ECMC and other hospitals across the state to increase capacity, significant increases are needed for inpatient reimbursement, as well as state funding for capital improvements to achieve that goal. We look forward to the efforts of the state to provide these resources to hospitals. Recently, Governor Hochul announced a plan that addresses increased access, which is critical to reducing overcrowding in psychiatric emergency rooms across the state.

We in CPEP continually work together with the hospital administration, nursing and social work leadership, the Commissioners of Mental Health for Erie & Niagara Counties, regional leadership from the NYS Office of Mental Health and community providers of mental health services and peer advocacy groups to identify areas of improvement both internally and within the larger system. We incorporate feedback from patients, families and regulatory bodies into ongoing quality improvement projects, and plan to continue those internal efforts indefinitely. In fact, there's a meeting scheduled next week that brings together ECMC Behavioral Health leadership, and leadership from peer organizations to discuss feedback and collaborate on problem solving surrounding the exponential increase in the use of CPEP during recent years, in advocacy for change.

It has become increasingly clear that part of this effort should strive to clarify, as well as educate related to realistic expectations of CPEP by the community, which have become progressively blurred in part due to chronic challenges accessing care in other ways. We recognize the limits inherently imposed by the definition of an emergency service such as CPEP, especially the implausibility of providing all levels of care within in this setting. We therefore continually look at ways to improve communication with community providers, working toward a model of collaborative care and we prioritize the maintenance of those partnerships to facilitate close follow-up should clients to whom they are providing services require emergent, hospital-level, psychiatric intervention. However, because we also appreciate the potential traumatization inherent to crisis care and involuntarily admission to a locked unit, we recognize all efforts should support diversion from the emergency room whenever possible and have participated in efforts to generate such alternative crisis care opportunities.

As a result, ECMC has invested and raised almost $2million from private philanthropy to grow our Help Center urgent care clinic, which is now established in the ECMC outpatient Behavioral Health building and our Intensive Outpatient Program. It speaks volumes that we had to raise money for these services because these services are not reimbursed by the State or private payers at levels that would sustain these vitally important behavioral health services.

Those efforts to date have been promising but remain limited. It may be prudent at this juncture to consider shifting the focus of service-improvement conversations from how to bolster CPEP, to the perspective that CPEP is one part of the broader mental health system in our community, recognizing CPEP's role as finite and the last resort when all other possible interventions have failed to provide stability or restore health.

Conversations about program development and even funding to support the ideas generated have been dedicated to support diversion and crisis intervention projects outside of the hospital setting, but there is an apparent need to enhance oversight to ensure these come to fruition and actually serve the purpose of their design. Historical and developing gaps remain in supporting transitions of care within the system. Ideally, care management should coordinate and ensure access to care. However, individuals continue to come to CPEP who are linked with Health Homes. We then face the same challenge those patients likely face as well, struggling to connect with those resources when needed after hours and on weekends. The nature of CPEP as an emergency service operating 24 hours a day, 7 days a week, has long been the easiest path to access a clinical ear, even when hospital-based treatment may not be necessary. We regularly do and will continue to work with these patients when they come to clinical attention in crisis, but proactively attending to patient needs in the community and bridging gaps with existing care providers, while simultaneously developing tighter system oversight, may reduce the potential for emergent care. Moreover, easy-to-access on-call systems that are specific to the appropriate agency, allowing for constructive information sharing, and meaningful treatment planning in service of individuals for whose care those agencies have assumed responsibility would be invaluable in tracking accountability and improve access to care as well as outcomes.

Broader attention directed toward those system gaps could also improve engagement of individuals in community-based programs, minimize drop-out rates, facilitate early and urgent access to prescribers/medication management by encouraging ownership of care, and the heath of agency clients. The development of supported residential treatment and other intermediate levels of care has potential to facilitate hospital discharge planning and minimize recidivism, while maximizing comprehensive follow up care within an adequate community-based system organized to reasonably manage that care (i.e., not over-booked or stretched thin).

Other factors have contributed to the current misguided expectations placed on CPEP created by the lack of funding and community services. Certainly, every change to a system may have both positive and negative impacts and/or consequences. Namely, for however good the intentions and anticipated up-side may be, the effects of these specific factors often expose new deficiencies contributing to the utilization of the emergency room for purposes other than its design. For example, deinstitutionalization has reduced availability of intermediate or long-term inpatient treatment resources in New York State, and there remains often inadequate services to support the community success of some individuals with chronic mental illness. Without residential and dedicated intensive programs to ensure continued

access to medication management, transportation, and supervision, the outcome is invariably to decompensate, and return to requiring acute hospitalization, or worse. This is neither good for the individuals, nor the overburdened acute hospital setting, then too strapped to efficiently provide care to other acutely ill individuals.

While well intended, bail reform has also had an impact on our CPEP because law enforcement often uses CPEP as an alternative to taking individuals to jail because they know we are required to hold these individuals sometimes for an extended period of time until they are placed in an appropriate setting. Collaboration with law enforcement in this region has actually improved immensely in recent years with the extremely positive results demonstrated by the establishment of Behavioral Health Teams who provide expert input while paired with police responding to mental health calls in the community, facilitating diversion efforts, and providing education to officers as well as patients and families. However, without the option to remove disruptive individuals from the community to custody in local jails, police have at times felt the transport to the locked psychiatric emergency room in certain cases may be a healthier alternative for the community. However, this comes at a cost of increased wait times in the psychiatric emergency room. It remains imperative for the community to find ways to maximize the benefits of bail reform while minimizing the potential risk of reversing anti-stigma efforts in mental health that have been steadfastly achieved.

Restrictive processes in scheduling with prescribers in the community also contribute to gaps in continuity of care. The ECMC MAP Clinic remains an invaluable resource to this community for patients seeking refills, providing medication when lack of access to prescriber appointments (and thereby medication) risks decompensation; however, this resource can only extend so far, and is yet another function of fragmented care, far from the ideal coordination of care we would all agree is the standard we should seek to attain.

As suggested by the above observations, our perspective is that improvements to the ability to access mental health care in this community will require first and foremost adequate reimbursement for services. Medicaid woefully underpays safety net hospitals, who treat the poorest and most diverse in our community, for mental health care services. It is simply an equity issue. We will also need involvement of not only the health care providers to produce solutions, but also coordinated collaboration and cooperation with law enforcement, the Department of Social Services, the Office of Child Welfare, the Office for People with Developmental Disabilities, and political energy to eliminate the potential for disconnection and encourage accountability. The responsibility to fix the system must not be an independent venture, rather it is shared, with each inherently working together in shoring up the system of care around us, of which we are all a part. In the same spirit, the CPEP program should not be compelled to serve as the sole focus or bear the onus of responsibility for our larger system, while nonetheless ECMC will represent our place within the system appropriately; embracing our mission and continually striving to provide the most therapeutic, comprehensive psychiatric assessment and referral resource we are capable of, in collaboration with all other agencies.