

## 2018 JMGBL Awards Application

<b>Submission Date</b>	2018-06-22 15:43:04
<b>This application is for:</b>	J. Mitchell Graham Memorial Award
<b>Project Title</b>	Charleston County EMS/Mobile Crisis Telehealth Project
<b>County/Countries</b>	Charlest
<b>Staff Contact</b>	Terri Fife
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<b>Please provide a summary of your entry (no more than 100 words) to be used in a handout for the awards competition and included in press releases/publications. You may either type the summary in the text box or upload it as an attachment below.</b>	<p>The Charleston County EMS / Mobile Crisis Telehealth Project links mental health professionals to patients in the field using telehealth technology. This project allows mental health patients to get the right level of mental health care and avoid costly and lengthy “housing” in the emergency rooms. Mental health evaluations are performed in the field, using a digital connection between the patient and a mental health professional, thereby diverting patients away from the emergency rooms. This program has shown drastic promise as a benchmark for mental health care and treatment.</p>
<b>Presentations may include more than one speaker; however, each speaker should be aware that the 10-minute time limit is strictly enforced. Please list the name, title, and e-mail address of each speaker:</b>	<p>David Abrams, Director, Charleston County EMS; DAbams@charlestonconty.org</p>
<b>Will any of the speakers need accommodations (wheelchair accessibility, etc.) during the competition?</b>	No

The Charleston County EMS / Mobile Crisis Telehealth Project links mental health professionals to patients in the field using telehealth technology. This project allows mental health patients to get the right level of mental health care and avoid costly and lengthy “housing” in the emergency rooms. Mental health evaluations are performed in the field, using a digital connection between the patient and a mental health professional, thereby diverting patients away from the emergency rooms. This program has shown drastic promise as a benchmark for mental health care and treatment.



# 2018 J. Mitchell Graham Memorial Award Competition

Submitted by Charleston County Government

## Charleston County EMS/Mobile Crisis Telehealth Project



Benefit/Importance of Project



### *Why was this project undertaken?*

Psychiatric care needs are sharply increasing in our community, and these patients do not receive prompt specialized care in an emergency room/department (ER/ED), which was previously the only destination choice for ambulances in a 9-1-1 setting. Recognizing more access for the patients in an emergency setting is crucial to their care. To address this issue Charleston County EMS (EMS) partnered with Mobile Crisis at Charleston-Dorchester Mental Health Center (CDMHC) for a telehealth pilot that began on May 1, 2017. The EMS/Mobile Crisis Telehealth Project aims to ensure psychiatric patients receive the correct care from the field while reducing transports of these patients to the area's ER/EDs.

Though EMS and the Mobile Crisis team at CDMHC have worked together for decades, the addition of technology and community collaboration has yielded a Telehealth Mental Health Project. The project was created to divert behavioral health patients from local ER/EDs and get these patients acute psychiatric consultation and care without using ambulance resources.

Hospitals in South Carolina have been experiencing a shortage of psychiatrists and associated clinicians (psychiatrists, psychologists, social workers, counselors, and psychiatric nurses). This has resulted in an increase in the number of undiagnosed and untreated mentally ill patients. Such understaffing leaves patients waiting in ER/EDs for treatment from health care professionals who do not have sufficient behavioral health care training or experience to best treat patients in mental health crisis. In many cases, the psychiatric patient can wait days for psychiatric care, and occupying a valuable ER/ED bed better used for a patient with a medical or traumatic injury.

Prior to this program, there was an overutilization of ER/EDs to assess this patient population and a gross underutilization of the Mobile Crisis resources designed to support them in the field. This stemmed from inefficiencies in calling mobile crisis and waiting for them to arrive at a scene. In short, it was easier to transport the patient to the ER/ED. This program has shown tremendous promise as a benchmark for mental health care and treatment; its efficient use of scarce resources and extensive cost savings has resulted in its adoption as a best practice throughout the state of South Carolina. This marks a trend around the nation for technology facilitated patient care.

EMS uses the telehealth technology on all 9-1-1 calls that are identified as psychiatric in nature. Due to the success of the program, EMS dedicates two independent specially trained paramedics in qualified response vehicles (QRV) - one during the day and one at night to respond to qualifying psychiatric complaints. Often, one of these QRV's is sent along with an ambulance, or the ambulance crew may request a telehealth resource after evaluating a patient. There is no delay in patient care for emergencies. If there are no physical medical concerns, an EMS telehealth unit arrives on scene with the telehealth equipment. Once, the ambulance is able to return to service for other calls. The telehealth medic contacts the Mobile Crisis team via video connection using a Health Insurance Portability and Accountability Act (HIPAA) compliant software that provides data privacy and security provisions for safeguarding medical information. Mobile Crisis clinicians are able to conduct face-to-face video conferencing with the on-scene medics, the patient, or any other on-scene personnel. Mobile Crisis provides a full emergency mental health assessment, and coordinates linking the patient to the appropriate level of care. Possible dispositions include follow-up with outpatient treatment, admission to the Tri-County Crisis Stabilization Center, inpatient treatment (voluntary and involuntary), or a link to treatment for substance use disorders.

If a patient requires an involuntary commitment, our field telehealth medics are all notaries and can sign commitment papers for on-scene law enforcement to transport the patient directly to an inpatient psychiatric facility.

*What is the significance of this project to your community as a whole? How does it relate in importance to the other problems in your community?*



One (1) in five (5) adults has a mental health condition.<sup>1</sup> That is over 40 million Americans. Fifty-six percent of American adults with a mental illness do not receive treatment.<sup>2</sup>

The need for greater access to psychiatric care surpasses the resources available. South Carolina ranks 50 out of 51 states and Washington, D.C. in matching access to needs for psychiatric care.<sup>3</sup> South Carolina ranks last in percentage of mental health populations with health insurance that can increase access.<sup>3</sup> Forty-two (42) percent of South Carolina mental health populations receives no mental health care or treatment.<sup>3</sup>

Telepsychiatry can help improve these dire statistics. There is a serious mental health workforce shortage. The lack of access to psychiatry for many individuals is a well-documented problem. Telepsychiatry, a subfield of telemedicine, uses videoconferencing tools to link psychiatric care via electronic communication to mental health experts and patients.

Telepsychiatry provides access to psychiatric care for patients and leads to positive clinical outcomes.<sup>4</sup> It has been effective for treating many mental health conditions, including panic disorders, depression, and post-traumatic stress disorder. Patients who have used telepsychiatry have shown satisfaction with the technology, expressing confidence that they can communicate the same information over video as they would communicate in person.

*How much of the county's population is benefited by the project? In what specific ways are different groups of citizens within the county better off than before?*

All of the population benefits from this program. Access to ER/ED's and their services is a cornerstone of healthcare in the United States. The concept of receiving prompt treatment for an emergency is conditioned on reducing abuse or overuse of limited services, including emergency resources. By keeping ambulances and emergency room beds available, the entire population benefits by prompt access to services. Additionally, specific mental health populations benefit by obtaining prompt treatment and long-term solutions to chronic mental health conditions.

Patients with mental health complaints are frequent utilizers of emergency services in Charleston County. Unfortunately, the ER/ED's are ill equipped to effectively address mental health needs in the acute setting, leading to frustration for both patients and staff. Patients are subjected to extended housing in ER/EDs for hours or days to obtain access, evaluation, and disposition for mental health treatment. In many cases, ER/ED services are not needed, and the patient's mental condition may be exacerbated in that stressful setting. By diverting patients around this "system", through matching them with an expert in video conference and transporting them to an appropriate mental health facility (or setting up a clinic appointment), this care is initiated appropriately. There is a great need to link these patients to the right treatment plans and our program does this.

The EMS/Mobile Crisis Telehealth Project treats approximately 50 to 60 patients per month. The population of Charleston County benefits as a whole due to the increased availability of ambulances, and the reduced number of unnecessary patients in the ER/ED setting.

The Charleston County EMS/Mobile Crisis Telehealth Project brings expert care to a patient's bedside in minutes. The paramedic screens the patient and establishes a digital connection between the patient and a mental health professional, who helps determine a proper disposition for the patient.

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<sup>1</sup> Mental Illness (AMI) Among Adults. (n.d.). Retrieved October 23, 2015, from <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml>

<sup>2</sup> Substance Abuse and Mental Health Services Administration, *Results from the 2014 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration. (2015). Retrieved October 27, 2015 from <http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>

<sup>3</sup> <http://www.mentalhealthamerica.net/issues/mental-health-america-access-care-data>

<sup>4</sup> <https://www.ncbi.nlm.nih.gov/pubmed/27354970> (A large evidence base supports telepsychiatry as a delivery method for mental health services)



The benefits to patients is measured both qualitatively and quantitatively. Patients are spared the denial of service claims of medical insurers, who will often deny the billing of ambulance transport in a mental health crisis. Patients also forego expensive ER/ED bills from the hospital and separate physician charges from the MD group.

*What degree of success did the project attain? What major objectives were achieved?*

9-1-1 calls for psychiatric conditions make up 6.3% of the total EMS call volume, and historically, 80% of these patients were transported to an emergency department.

In May 2017, the first month the EMS/Mobile Crisis Telehealth Project yielded:

- Total Calls to Mobile Crisis: 53
- Diversion away from EMS transport: 39
- Diversion away from ER Visit: 28
- Diversion away from hospital stay: 26
- Involuntary commitments: 5
- Direct admissions to psychiatric facilities: 3
- Patients transported by EMS because they refused to cooperate with evaluation/safety planning: 5

This results in a 74% diversion away from EMS; a rough cost savings of \$12,675 in ambulance transports and \$56,000 in ER/ED visits. There are additional cost savings from inpatient admissions not accounted for from this first month. This further excludes the impact associated with adding to the ER/ED workload and bed management.

Our program avoids around 60 unnecessary ER/ED transports per month by diverting patients to clinics, psychiatric services, and even direct admissions to hospital psychiatric facilities.

Preliminary results show a dramatic improvement to citizen services and more efficient use of healthcare dollars. In addition to a significant reduction in EMS transports, the program has also kept hundreds of patients out of local ER/EDs, while directing them to resources that are more appropriate.

By implementing a collaborative approach to a common healthcare crisis, EMS began performing the Telehealth Project on May 1, 2017 and totaled 772 calls through the first 12 months. Of those, 56% were diverted from the Emergency Department, 49% were diverted from the Hospital, and only 8% were transported by EMS after telehealth assessment. The number of patients transported by EMS after telehealth assessment fell drastically after the initial months. This accounts for an approximate savings of \$1,117,550 in unnecessary medical bills over the first year. The direct cost savings for patients, first responders, and hospitals is easily recognized, but the vast indirect savings by stabilizing a mental health condition in a longer-term program ensures compliance with treatment. This reduces reliance on emergency services and resources by these patients.

Patients no longer get transport bills due to denials on ambulance services deemed not meeting medical necessity. Patients are getting treatment quicker, ambulances are getting back into service quicker and the ER/ED's provide available beds to patients with other life-threatening illnesses.

This program has been awarded the Leaders in Telehealth Award by Vidyo at their annual national summit, as well as the Innovation Award with Palmetto Care Connections at their state telehealth summit.

This program has helped to lay the groundwork for expansion of a statewide mental health initiative to include telehealth and Mobile Crisis services across South Carolina titled Community Crisis Response & Intervention.

Project Effort/Difficulty



### *What did your county have to do to accomplish its objectives?*

The County received Telehealth Alliance grant funds for notary application fees and supplies for each EMS employee who serves in the capacity of a Telehealth paramedic. The Medical University of South Carolina (MUSC) provided portable printers, cases and ink to produce needed documentation on-site.

The County collaborated with community partners to solve a problem stemming from over using law enforcement, overwhelming EMS, inundating the hospitals and underutilizing mobile crisis and psychiatry services. Having vested physicians supporting these measures, including augmenting EMS medical protocols, the patients are best served. Nearly sixteen separate agencies came around the same table to ensure each stage; from the 9-1-1 call to long-term follow up, care was mapped and supported by one another. This is a true example of community partners coming together to support the needs of specific group of citizens.

Emergency Medical Technicians (EMT) and Paramedics are trained healthcare professionals who respond to medical and traumatic emergencies in a pre-hospital setting. Little or no additional training is required for them to implement the EMS/Mobile Crisis Telehealth Project other than a willing community to join in support of doing what is right for the patient

### *What challenges occurred during the project?*

The Telehealth software only works on Dell computers. There are times when a Telehealth consult may seem appropriate but there is no practical way for a qualified person to be there in a timely manner. Due to our geographical challenges, there are areas of the county that will not have adequate bandwidth for this to work. If the connection is less than 1Mbps, video conferencing may not be feasible. When this happens, we have to transport the patient to the ED/ER.

Ambulance crews are encouraged to make the request for a QRV through dispatch early, perhaps even prior to arriving on scene if the call information seems appropriate. Once on site, the paramedic performs an initial screening to be sure that the patient will cooperate with the process, and has no medical issues requiring emergency physician evaluation. They also determine if there is adequate internet bandwidth. It is important that they evaluate the patient where they are; once the patient is inside the ambulance it may be difficult to release the ambulance from the scene. The goal is to free the ambulance as soon as possible and work towards an alternate disposition that is more appropriate for the patient's condition.

Intoxicated patients may also present challenges. As with any call, alcohol is not an absolute exclusion from psychiatric treatment. There are obviously varying levels of intoxication. If a patient has been drinking, they may be a candidate for mobile crisis if they are not overly intoxicated. Most psychiatric facilities cannot perform a medical detox if the patient is at risk for withdrawal symptoms. It is important for ambulance crew to ask, "Have you ever had a seizure coming down from alcohol or drugs?" and "Do you sometimes get confused when coming down from alcohol or drugs?"

Mobile Crisis advised that special needs children and adults with dementia who act out are not ideal candidates for this program. Any physical medical condition requiring acute evaluation and potential treatment are also not candidates.

Every minute counts in an emergency. First responders are trained to arrive at an emergency scene and deliver life-saving treatment as quickly as possible. EMT's and paramedics are trained to recognize the difference between a medical emergency and a mental health crisis, because the two scenarios require different modes of treatment. In Charleston County, the Department of Mental Health (DMH) and EMS have partnered to get mental health patients to the correct facilities faster than ever before.

Together they operate the EMS/Mobile Crisis Telehealth Project that gives paramedics the ability to connect to a psychiatrist or mental health professional on a computer in the EMS vehicles. Once connected, the psychiatrist can see the patient and assess their mental state. DMH administrators say this program's goal is to keep mental health patients out of the ER/ED, where they might have to wait for



several hours, even days, before receiving the care they need. Mobile Crisis also cuts down on paramedics' time at the scene, releasing them for response to the next call.

The EMS/Mobile Crisis Telehealth Project started with using EMS staff during the busiest hours of the day from 10 am until 10 pm; due to the success of the telehealth project, EMS has now added night service.

*Were there any Community Concerns?*

Charleston County's rapid growth has increased spending on public safety. The population along with the number of tourists have grown, resulting in ever-increasing number of emergency calls for EMS.

The very nature of mental illness often means challenges with appointment scheduling, compliance with medications, and long-term solutions; not enhancing resources and access merely compounds the crisis. Untreated patients may be a danger to themselves or others.

The primary concern internally was how this process, without help for this patient population, would be relegated to seeing the same patients repeatedly. To our surprise, we predominantly respond to first-time 9-1-1 callers, introducing new previously undiscovered patients into this system of proper treatment, and follow-up care. It is no longer about transport, treat and release. It's about connecting with the patient, meeting their needs, and getting them the follow up care they deserve and need.

*What were the nature and extent of the county government's efforts to alleviate the problem(s)? How difficult was it to accomplish the project's goals and/or objectives?*

The county identified opportunities to reduce ambulance demand and improve patient services. For patients to receive Telehealth services there is a set criteria, the patient must be greater than 12 years old, request for an ambulance without acute medical/trauma complaint and have stable vitals.

The most difficult task was getting all interested parties to buy into this program, and then to discover the workflow that best serves the patient.

EMS also identified paramedics with a keen interest to serve in this capacity.

*Was financing the project an obstacle? Were there any unusual factors inherent in financing the project?*

The Mobile Crisis team at CDMHC manages a telehealth Program with EMS. Funded by MUSC Telehealth Grant, the pilot project was created in an effort to divert behavioral health patients' from local ER/ED's and hospitals. The cost reimbursement money received from MUSC for \$2,094.00 was used for notary application fees and supplies, portable printers, cases, and ink.

As stated in response to an earlier question, direct savings to EMS and local hospitals has surpassed \$1 million. The seed money MUSC invested in this program has yielded extraordinary cost savings.

*Did any agencies, citizen groups, or other organizations assist your county with this project? Did their participation pose any particular challenges or offer any unique contributions or benefits?*

At the core of our success, the program consists of partnerships with several agencies and organizations below:

- Charleston County EMS, first responders to medical emergency, evaluates patient and contacts the Mobile Crisis Team
- Medical University Hospital Authority, (MUHA) an authority of the State of SC and operates as the fiscal agent of the SC Telehealth Alliance



- SC Telehealth Alliance, an unprecedented collaboration of SC hospitals, providers, government leaders and other entities working together to improve access to quality, cost-effective care through the use of telehealth services
- SC Department of Mental Health
- Charleston County Consolidated Dispatch Center (9-1-1)
- The Charleston Center, a substance abuse prevention, intervention, education and treatment center
- Charleston Dorchester Mental Health Center (CDMHC) Assessment/Mobile Crisis, the only 24/7 psychiatric emergency response and intake team in the state, serving both Charleston and Dorchester counties
- Roper St. Francis, area hospital
- Medical University of South Carolina, area hospital
- Trident Medical Center, area hospital
- East Cooper Medical Center, area hospital
- Charleston County Sheriff's Office Therapeutic Transportation Unit works directly with the Commitment Division of the Charleston County Probate Court, hospitals and CDMHC for mental or chemical dependency evaluations
- Other local law enforcement and public safety agencies in the Tri-County area

*Are there any unresolved problems or other goals left to tackle?*

The program has been so successful that the South Carolina Department of Mental Health is looking to expand its Mobile Crisis teams across the state and further incorporate telemental health as an outreach and assessment tool.

EMS continues to evaluate the impact on the telehealth medics and how they cope responding primarily to mental health complaints in the field.

*Justify the uniqueness of this project.*

In a 9-1-1 emergent setting, the EMS/Mobile Crisis Telehealth Project bridges multiple disciplines using technology for real time mental health evaluation and disposition.

This innovative program is unique and would not have been possible without the remarkable teamwork shown by our community partners. By working together without concern for egos, disciplinary boundaries, or departmental designation we have created a profoundly effective program, which is already being used as a template throughout South Carolina. Through the adoption of our model in other parts of the state, we hope to become less unique every day.

It is imperative to note this is a model program and unique as one of the first in the nation.

*What makes it different from other projects designed to achieve the same objective?*

This program is truly revolutionary and we are not aware of anywhere else in the country that has tried something similar. It's new; it's different; and it's exciting. The word has gotten out, there are several other emergency medical systems and mental health systems from around the U.S. that currently have their eyes on Charleston County EMS and Charleston-Dorchester Mental Health. This program has promise to be something special and we all should be proud to be a part of its inception.

*Do you know of any other similar programs in South Carolina? If so, how is your program different?*

ER/ED's, Psychiatric Hospitals, and Community Health Centers each serve a vital function in our country's healthcare system. Although they are dramatically different from one another, we have found that each can, and does, benefit from telepsychiatry.

Telepsychiatry programs give ER/EDs the opportunity to manage psychiatry crises by referring the patient to an experienced psychiatric clinician. In effect, telepsychiatry networks not only increase the quality of care, but also dramatically decrease the internal stress of ER/ED staff who essentially house the patient pending psychiatry services.

Charleston County EMS/Mobile Crisis Telehealth Project is different as the patient receives care at the site of the emergency instead of being transported to a facility.

*What innovations were required in accomplishing your objectives?*

Technology in the field and collaboration with law enforcement, mental health and the medical community.

*Who provided the creativity and imagination in your project?*

In the first quarter of 2018, DMH established the infrastructure required to implement its Community Crisis Response and Intervention Program (CCRI), which is modeled after the Mobile Crisis Unit operating in Charleston. The CCRI program will initially be deployed throughout the broader Charleston, Dorchester, and Berkeley counties. After initial implementation of CCRI, DMH plans to expand to the remainder of the SC coastal areas, with the eventual goal of scaling the program statewide.

Charleston County EMS purchased iPad's for telehealth assessments, using mental health trained counselors, EMS puts the pieces together to benefit patient care and treatment.

This program would not be possible without the professionals from Charleston Dorchester Mental Health (Deb Blalock), Mobile Crisis (Melissa Camp), our Consolidated Dispatch Center (Jim Lake), the Charleston County EMS Medical Director (David French, MD), and the countless people working each day to get patients the right care right now. As technology continues to change, our idea of innovation can still be nourished by the unknown possibilities traditional collaboration.

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<http://abcnews4.com/news/local/new-telepsych-program-offers-mental-health-treatment-by-phone-in-charleston-county>



## New TelePsych program offers mental health treatment by phone in Charleston County

by Caroline Balchunas



TelePsych (WCIV)

AA

CHARLESTON, S.C. (WCIV) —

It's the first of its kind in the country and it's right here in Charleston County. A new program called TelePsych is making mental illness treatment and help much more accessible. When EMS responds to a 911 call, they can call the county's mobile crisis unit if they suspect a mental health issue.

Before the program, the only option was taking the individual to the emergency room. Instead of going to the emergency room, they are now connected directly with a counselor through video chat, getting them the actual help they need.

"When the supervisor gets there, the ambulance can get back into service, which is really important for the citizens of our county because then we have more ambulances on the street," said Deborah Blalock, Executive Director of the Charleston Mental Health Center.

Blalock said since the program started in May, 54-percent of EMS calls have been diverted from the emergency room.

"Folks with behavioral health issues can sit and wait you know eight hours, ten hours until somebody can give them some attention because they have other life-threatening illnesses they have to take care of," said Blalock.

EMS Director David Abrams said more than half of 911 calls are for suicidality.

"Mental illness is real, it requires real experts, real qualified medical professionals and requires just as much care as any other medical issue that goes on," Abrams said.

The program is made possible through partnerships with several agencies and organizations including Charleston County DAODAS, Charleston Dorchester Mental Health, Roper St. Francis, Medical University of South Carolina, Trident Medical Center, East Cooper Medical Center, all law enforcement and public safety agencies in the Tri-County area.

"I believe people around the nation are watching what happens here to see how we can best serve from a national standpoint this growing epidemic of mental illness," said Abrams.

# New mental health crisis response program planned for South Carolina, Upstate

[Liv Osby](#), losby@greenvillenews.com Published 6:42 a.m. ET March 9, 2018 | Updated 4:31 p.m. ET March 9, 2018



Mental illness(Photo: Malombra76, Getty Images/iStockphoto)

While the city of Greenville plans to launch its own intervention program this summer for people suffering from a mental health crisis, those in surrounding communities still have few alternatives to the ER or jail.

But the state Department of Mental Health now has plans to help them, too.

Modeled on a similar program in Charleston, the Community Crisis Response & Intervention program aims to fill the gap for nighttime emergency psychiatric interventions, said its director Amanda Gilchrist.

“We will have a 1-800 number statewide where a family member, law enforcement, a patient or EMS can call for help with someone in psychiatric crisis,” she said. “Then the call will be triaged by a clinician on the phone ... and a determination will be made if an onsite response is needed.”

If it is, she said, a team of two master's level clinicians will respond within 60 minutes along with law enforcement.



Amanda Gilchrist (Photo: SC Department of Mental Health)

Once there, they will assess the patient to determine what level of care is needed, said Deborah Blalock, deputy director of DMH and director of community mental health services.

“We don’t want people to go to the ER if they don’t need ER level of care, and it’s not fair for it to always be law enforcement,” she said. “Sometimes a person needs 911. Some people do go to jail and some go to the hospital.

“But some are diverted,” she added. “Crisis stabilization gives you one more option.”

Follow-up will be provided for two weeks to ensure patients are connected to the resources they need, Gilchrist said.

Ken Dority, executive director of the Greenville chapter of the National Alliance on Mental Illness, said the program fills a gap in services and will augment what the city of Greenville is doing.

“I’m excited about the additional services and the thoughtful process that has gone into it,” he said. “It increases the area of coverage once they start this process and that’s important because they will be getting services to areas where there are no services at all for those hours.”

DMH is planning a program for each of four regions in the state, including the Upstate.

Piggybacking off the success of the Charleston program, the coastal region will be first to launch, which is expected in late spring, Blalock said. The rest are expected to be activated over the next year. There is no target date yet for the Upstate.

“The big thing about this program is it depends on community partnerships,” she said. “We have to have probate judges and law enforcement on board before we can start.”

The teams are equipped to be mobile with laptops and iPhones, and DMH is in the process of hiring them now. It’s unclear how many will be hired statewide, Gilchrist said.





Deborah Blalock (Photo: SC Department of Mental Health)

The average number of times the Charleston team was called out last year was 1.5 a day, Blalock said. While the program saves money for hospitals and for taxpayers by keeping people out of jails, it's expensive to operate and generates little revenue, Blalock said. So the state Department of Health and Human Services is partnering on the program by allocating \$3.6 million a year to fund it, Gilchrist said.

The service will be particularly important in rural areas where the nearest hospital may be more than an hour away, Gilchrist said. Hospital emergency room staffs are excited about the program, she said, especially those in rural areas that don't feel like they're equipped for psychiatric emergencies, even with the statewide telepsychiatry program. "There's a definite need for it (CCRI)," said Blalock. "Families need to know where they can turn. And it gives law enforcement another tool to serve the community."

## Suicidal? Be prepared to wait for care.

Emergency departments are terrible places to keep psychiatric patients. (iStock)

by Nathaniel Morris May 19

“Your son needs to be in the hospital, but we don’t have any open beds,” I tell the patient’s family in the hallway. It’s another busy night in the emergency department, and I’m the on-call psychiatrist.

“What do you mean you don’t have beds available?” The patient’s mother says, “He just tried to kill himself!”

“He’ll have to wait in the emergency department until either a bed opens up here or we find one at another hospital and transfer him.”

“When will that happen?” she asks.

“Possibly by tomorrow morning,” I say, knowing that’s unlikely, “Or a couple days. There are a few patients ahead of him on the list.”

I’ve lost count of how many times I’ve had some version of this conversation. Still, it’s always difficult to give this bad news. Looks of disbelief and exasperation come over my patients and their families.

This awful reality is called “psychiatric boarding.”

Psychiatric boarding — when patients in need of psychiatric treatment wait for prolonged periods in emergency departments due to shortages in mental-health resources, particularly inpatient beds — has become a catastrophe for the U.S. health-care system. In a 2016 survey, roughly three-quarters of emergency physicians reported that psychiatric patients had been waiting for beds during their last shift. Studies suggest that psychiatric patients wait for hospital beds far longer than other patients in emergency departments, sometimes for days or even weeks at a time. Mental-health experts point to deinstitutionalization — a national trend since the 1950s to shift psychiatric services out of hospitals and into community settings — as a driver behind the current crisis. Deinstitutionalization has led to significantly fewer psychiatric hospital beds across the country: The number of state psychiatric hospital beds per 100,000 population fell by nearly 97 percent from 1955 to 2016, according to a report by the Treatment Advocacy Center.

Yet community mental-health resources have failed to keep up with surging demand, leading many psychiatric patients to turn to emergency departments for care. According to the Agency for Healthcare Research and Quality, the rates of emergency department visits for psychiatric conditions such as depression, anxiety, bipolar disorder and psychotic disorders increased by more than 50 percent between 2006 and 2013. The 2015 National Hospital Ambulatory Medical Care Survey estimated that almost 6 million visits to emergency departments carried a mental disorder as the primary diagnosis.

This combination — falling numbers of psychiatric hospital beds coupled with rising use of emergency departments by psychiatric patients — has made psychiatric boarding commonplace across the country. Every day, patients suffering from psychiatric crises are trapped in emergency departments, too sick to go home but with nowhere else to go.

And emergency departments are terrible places to keep psychiatric patients. If you were to design a way to worsen a person’s psychiatric crisis, boarding someone in an emergency department might be one way to do it. It’s crowded and loud. Patients have little or no privacy, lying on stretchers in hallways or separated from other patients by mere curtains. Hospital staff are constantly changing shifts. It’s an unnatural environment, frequently without windows, sunlight or plants.

Some patients become so distressed while boarding that emergency staff have to put them in restraints or give them intramuscular injections. Patients may hurt themselves or lash out at those around them. In 2008, a woman fell out of her chair in a Brooklyn emergency department and died of a blood clot after waiting nearly 24 hours for a psychiatric bed.

Beyond the toll that boarding can have on individual patients, psychiatric boarding has a major impact on the health-care system at large. According to a 2014 survey, 91 percent of emergency physicians felt that psychiatric boarding



led to harmful situations, such as violence or staff distractions. Boarding clogs up emergency departments and delays care for other patients as well.

Some argue that the practice should be outlawed. In 2014, the Washington State Supreme Court ruled that psychiatric boarding was illegal, citing failures to provide adequate care to patients with mental illness. Shortly after, Gov. Jay Inslee authorized \$30 million to alleviate the problem, and the state added dozens of psychiatric hospital beds. But these efforts didn't fully resolve the issue, based on reports that boarding continued in the state. Psychiatric boarding has also faced legal challenges in places such as New Hampshire and South Carolina. Meanwhile, medical organizations and health-policy analysts are scrambling to address what all acknowledge is a major problem.

Increasing the number of psychiatric hospital beds may seem like an obvious solution; however, it's logistically challenging and, as seen in Washington state, might not completely fix the problem. In particular, adding new beds costs money, which may not be feasible when many mental health services are already underfunded. Calls for more comprehensive community mental-health services face similar hurdles.

Another approach is to use existing psychiatric beds in more efficient ways. The Centers for Medicare and Medicaid Services recently changed its policies to allow payments for Medicaid patients to receive short-term treatment in certain mental-health facilities. Such reforms might speed up discharge planning for patients who are already hospitalized and may help find beds for patients who may otherwise have been stuck in emergency departments with limited options.

Strengthening mental-health services in emergency departments may relieve some of the deleterious effects of psychiatric boarding. In the 2016 survey of emergency physicians, almost 1 in 8 reported not having any on-call mental health professionals available to them. Embedding more psychiatrists, psychologists and other mental-health specialists into emergency departments could help provide patients better treatment and get them to their next steps in care more quickly. Telepsychiatry has been proposed as an alternate way of enhancing access to psychiatric services for patients who are boarding.

Specialized psychiatric emergency departments have also attracted attention. Some hospitals have had separate psychiatric emergency services since the 1980s, and researchers are exploring how these models might be used to decrease psychiatric boarding in local emergency rooms. In a 2014 study, patients transferred to a regional psychiatric emergency service waited for less than two hours, on average, compared with the state average of more than 10 hours for patients in general emergency departments; further, the majority of transferred patients were eventually discharged home without need for hospitalization, suggesting that specialized psychiatric emergency departments can help triage which patients need higher levels of care.

Hopefully, these kinds of changes can cut down on psychiatric boarding across the country. But for now, when the parents of a suicidal patient in one of the emergency departments where I work ask me, "Please, what does he have to do next?" I too often have to say, "Just wait. We're doing everything we can." I turn toward the maze of stretchers and introduce myself to the next patient and family on my list.

Morris is a resident physician in psychiatry at the Stanford University School of Medicine.



*State of South Carolina*  
*Department of Mental Health*

**MENTAL HEALTH COMMISSION:**

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Charleston, SC 29414

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Jennifer Roberts, LPC, CPM Executive Director

June 20, 2018

To whom it may concern:

The Charleston Dorchester Mental Health Center (CDMHC) supports the submission of the EMS/Mobile Crisis Telehealth Project for the J. Mitchell Graham Award. This innovative project has been groundbreaking in increasing access to care for residents throughout Charleston County, by linking them to an emergency mental health assessment with the Assessment Mobile Crisis team while in the community with Charleston County EMS (CCEMS). The project is a true example of collaboration in Charleston County, as it was brought to life through the combined efforts of CDMHC, CCEMS, Medical University of South Carolina, and the South Carolina Telehealth Alliance.

In the first year of this project, 772 assessments have taken place through this program. Of these assessments, approximately 56% were diverted from the local Emergency Department and to the appropriate level of care in the community. This direct connection to treatment saves community resources and helps our residents to access the care needed. In the first year, this project is estimated to have saved the Charleston County healthcare community over \$1 million!

**MISSION STATEMENT**

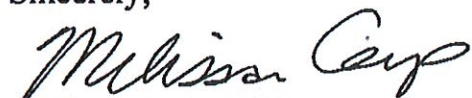
To support the recovery of people with mental illnesses.





When we discuss the need for healthcare reform, these are the types of programs that are on the cutting edge of that reform and deserve to be recognized for their success. Please let me know if I can be of any further assistance.

Sincerely,

A handwritten signature in black ink that reads "Melissa Camp". The signature is written in a cursive, flowing style.

Melissa Camp, LPC  
Director of Special Operations  
Charleston Dorchester Mental Health Center

A handwritten signature in blue ink that reads "Jennifer Roberts". The signature is written in a cursive, flowing style.

Jennifer Roberts, LPC, CPM  
Executive Director



Chanda F. Brown, Ph.D. LMSW  
Director

CHARLESTON CENTER

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June 4, 2018

J. Mitchell Graham Award Judges  
South Carolina Association of Counties  
1919 Thurmond Mall  
PO Box 8207  
Columbia, SC 29202-8207

Distinguished Judges,

On behalf of the Charleston Center, Charleston County's Department of Alcohol and Other Drug Abuse Services (DAODAS), this letter is sent in support of the Emergency Medical Services (EMS) TelePsych Program. The use of available technology has allowed EMS staff to have easier access to professionals who can properly screen for mental health issues. Easier access to such information allows EMS to get patients to the service(s) they need in a timelier manner, avoiding or reducing visits to the Emergency Department (ED) if unnecessary.

The TelePsych Program not only reduces wait time at the ED and helps to alleviate additional stress on the patient, but also saves time and resources in transportation and labor hours. In fact, the Charleston Dorchester Mental Health Center (CDMHC) reports that since May 1, 2017 to June 5, 2018, they have received a total of 846 TelePsych calls. Of those 846 calls made from EMS to CDMHC, 473 of them were diverted to services other than the ED. An average call of 16 to 30 minutes can save hours of wait time in the ED, and lessens the burden on medical staff.

Though the above statistics speak to the value of the TelePsych Program, it is the unquantifiable value to the citizens of Charleston County that make the TelePsych Program successful. The Program is undoubtedly an asset for the Charleston County and its citizens.

Please contact me if you have any questions regarding this letter of support.

Sincerely,

Chanda F. Brown  
Director