Joint Commission's
Behavioral Healthcare Subcommittee
Gary S. Kavit M.D. FACEP
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My name is Gary Kavit. I am an Emergency Physician from Riverside Regional Medical Center in Newport News where I have been the Medical Director for over 10 years. I have served on the Interagency Civil Admissions Advisory Council and the Future Commitment Reforms Task Force. I have represented the Virginia College of Emergency Medicine on mental health issues for the past 4 years. Personally, I have an immediately family member who is Bipolar and a consumer of mental health services.

I believe there has been great effort in the past year to produce initiatives that will be meaningful for those requiring psychiatric services in the Commonwealth. The Task Force on Future Commitment Reforms has been working diligently to this end. Many of the issues being addressed by this committee however are issues not directly affecting the Emergency Medicine community that I represent. Emergency Physicians across the state still struggle with the delivery of care to there psychiatric patients. In light of budget cuts, we perceive the next 24 to 48 months will actually be a period of further deterioration of services, which will place an even greater burden on departments already struggling to be the healthcare safety net.

Our psychiatric patients deserve timely response to evaluations and disposition. The time to reach a disposition on a psychiatric patient, at around 8 hours on average, remains twice the time it did 6 to 7 years ago.

In a recent web survey sponsored by the Virginia College of Emergency Physicians 68% of those ED leaders that responded reported having experienced difficulties in CSB responding in person to perform prescreening when requested. In my area we have recently come to an understanding that this was not acceptable by meeting directly with our local CSB. It was made clear to me that this was a tenuous agreement in light of coming budget cuts. The fact may be that cuts may be so deep that this may prove difficult to maintain. In a medical sense, conducting an evaluation of a patient that is not face to face is sub-standard and **WILL** lead to medical errors. It was clear from our survey that this issue was widespread across geographic areas. There are areas that denied having an issue. I suspect that these

are areas that have also opened up a dialog with their local CSBs as we have done. It is my understanding that the law prescribes CSBs to provide performance contracts to the city or county they serve. Further they are to enter into contracts with other providers for the delivery of service. I do not think this is happening. I would encourage local dialog of CSBs and other providers. I am disappointed to see no product from the $500,000 allocated from last year's law reform for CSB oversight.

Even before we get into this year's budget cut we are very concerned of the lack of care provided for those consumers that are uninsured. If you present to an Emergency Department acutely as a mental health consumer, but do not meet TDO criteria you have a high degree of likelihood not to receive a psychiatric intervention. This is especially true if you do not have a pre-existing relationship with CSB. In light of the current economic climate, one can only assume we will be seeing clients new to mental health. There are instances where patients are being admitted under a TDO, in order to get services, where they might otherwise have been admitted voluntary. When they have their hearing days later they are often change to voluntary but are deemed ineligible for HPR-V funding. The psychiatric facilities are suffering significant losses to charity work, undermining their financial stability and health. In **one month** over the summer, the psychiatric hospital associated with our health system suffered losses equal to ½ of all of their charity work for 2007. This is not a recipe for survival. Dr Chris Nogues is here from Riverside Behavioral Health and could speak to this.

On a positive note, I do believe the crisis stabilization units are meeting the needs of some of the patients. Unfortunately open beds are few and qualifying patients often are left stagnant in the ER. In our case, our health system psychiatric facility will often absorb such a charity case as an inpatient, increasing their losses to benefit the patient and the health system.

Having given you my perspective on the current state of affairs, I would suggest the following points make reasonable sense and should be considered:

Begin monitoring strategies to focus on Performance Contracts with CSB's around the state. (The $500,000 allocated should be used for this project)

Require CSB Regions meet with key healthcare providers; Physicians, Healthcare Organizations etc. to enhance communication and strategize to improve coordination of care.

Recognize that communities may decrease the need for inpatient care, but this will not totally eradicate the need for hospital acute services. The health of these organizations is in jeopardy.

Recognize that cuts in crisis stabilization will result in fewer beds that already cannot meet the need of the communities. This will result in consumers' needs not being met.

In closing, Healthcare should be consistent, and provide the same appropriate level of care for all patients who willingly seek it. Voluntary patients need services just as involuntary patients do. I do not believe it was the intent of the re-investment project to transfer the burden of acute care from the state psychiatric facilities to the communities, now only to abandon their needs.