

March 12, 2008

Raised H.B. No. 5810
Session Year 2008

I am Dr. Phil Brewer from Cheshire. I am a practicing emergency physician with twenty years experience of providing care to patients in several emergency departments in our state. I represent the Connecticut College of Emergency Physicians which supports HB 5810 AN ACT CONCERNING THE PROVISION OF BEHAVIORAL HEALTH SERVICES IN EMERGENCY ROOMS, with the following recommendations:

First, we would prefer the following wording of the statement as to the bill's intent: "To require the Departments of Mental Health and Addiction Services and Social Services to establish a two-year behavioral health services pilot program in up to five regions of the state that will develop and implement innovative methods for improving **assisting** emergency departments outcomes for **in their assessment and disposition of** adults with behavioral health needs."

Second, we would like the bill to reflect the fact that while Emergency Department Physicians and Nurses work tirelessly to provide timely, life-saving care, our ability to do so is challenged by intolerable conditions that are beyond our control. The two basic dilemmas of the emergency department are as follows:

1. Too many individuals and institutions think of us as the answer to problems that they are unable or unwilling to address by other means. Knowing that we are always open and can't refuse anyone, we become the solution of choice for the individual who can't reach his or her private physician, who has no family doctor, or whose physician cannot or will not accommodate them when they need to be seen urgently. We become the de facto 24/7/365 medical consultant for police departments, nursing homes, group homes, psychiatric hospitals, and residential programs for adolescents and adults. We receive patients sent from detox units for "medical clearance" prior to routine admission. We receive elderly patients who have been admitted to extended care facilities for behavioral problems for emergency evaluation of...behavioral problems. These institutions do not maintain systems whereby advanced practice providers or physicians are available to provide on site evaluation. As a result, what is usually a simple problem that could be dealt with on site becomes a prolonged and expensive process (Just the ambulance ride can cost \$500 and more) that is actually detrimental to the patient.
2. Once the patient has been evaluated in our emergency department and a disposition has been chosen (admission, return to home or the sending facility, transfer to another facility), there is very frequently a very lengthy delay in moving the patient out of our department. Transportation is a constant factor but the problem that destroys our ability to keep things moving so we can take care of new patients is the simple fact many of the patients who arrive at our doorstep clearly cannot be discharged to the community but we are unable to

obtain placement for them in an appropriate facility and their length of stay stretches into hours, days, and sometimes even weeks. This is especially true for psychiatric patients. All of our patients suffer when our harried staff is forced to deal with psychiatric patients whose behavioral problems are made all the worse by a noisy, chaotic environment that is brightly lit 24/7.

We support the creation of innovative laws and programs that will reduce the burden of non-emergency care within our emergency departments. We ask for consideration of the following measures:

1. Referring institutions should be held responsible for inappropriate use of the emergency department. Drug and Alcohol treatment facilities should be required to provide medical clearance exams on site. Extended care facilities should rely more on their medical staff for medical evaluation of their residents. Referrals to the emergency department should only be made when acute conditions requiring immediate attention are present.
2. Holding referring institutions responsible for transfer to other facilities if indicated. The inelegant term of "patient dumping" applies here, and the abusive dumping of "undesirable patients" in the emergency department by institutions must come to an end.
3. Increasing the availability of physical and staff resources to accommodate emergency department patients who require emergency admission. This is a matter of creating additional beds as well as improving the ability to locate them. I have listened to many a psychiatric social worker make multiple telephone calls in an attempt to locate a bed for an emergency department patient. Each time he or she goes through the entire story, answers the same questions, and waits for the call back that always seems to take an hour or more. If the answer is a refusal to accept the patient, the process repeats itself. This is a waste of professional time that is needed elsewhere. An electronic clearinghouse would solve this problem.

We thank the committee for taking up this issue, the resolution of which is a key element to reducing emergency department crowding. We will assist you in any way possible to answer your questions and make further suggestions.

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Chair, Connecticut College of Physicians Government Affairs Committee