Memorial Hospital
OF SWEETWATER COUNTY

June 12, 2015

Joint Subcommittee on Title 25
Wyoming Legislative Service Office
213 State Capitol
Cheyenne, Wyoming 82002

Dear Members of the Joint Subcommittee:

My name is Dr. Charles A. Bongiorno, and I am privileged to be a newly hired psychiatrist working for Memorial Hospital of Sweetwater County (MHSC). I am originally from the Philadelphia, Pennsylvania area. I have recently completed my training in General/Adult Psychiatry as well as Child and Adolescent Psychiatry at Jefferson University Hospital in Philadelphia. My family and I moved to Rock Springs, Wyoming in July of 2014 to begin my career as a psychiatrist at Memorial. I am serving as the Medical Director of the Department of Behavioral Health at our hospital.

As some background to this letter, I would like to first say that I am very excited about the direction that mental healthcare is going across the country, but I'd also like to note that we still face many serious challenges: For example, equal access to care (aka "equal parity") for mental health and medical problems, perceived "stigma" towards folks with psychiatric conditions, and access to enough appropriately trained providers to render proper diagnosis and treatment, remain an enormous and often dividing issues for our entire country. Indeed, nationwide, there are only approximately 40,000 psychiatrists for a country with over 250 million people. This is just staggering when compared with the hundreds of thousands of physicians in other specialties. The shortage with regard to child and adolescent psychiatrists is even more critical, with only about 7,000 of these providers currently available for our country's children and teenagers. The expected need for services in the coming decades is expected to grow while the availability of specialists is expected to continue to plateau. Many states such as New York or San Francisco have more reasonable numbers of providers but the shortages are hardest felt in the Midwest and the West.

I was vaguely aware of this before, but when I moved to Wyoming I realized that this shortage is a tremendous issue, particularly on the Western side of the state where MHSC is located. In many counties, there are neither psychiatrists nor mental health providers of any level, and patients have few to no options for care in some of these communities. The suicide rate is historically alarmingly high in this part of the country, and Wyoming has also felt this sting, often leading the nation in the adjusted rate suicide deaths per hundred thousand people. Some counties, like Sweetwater, for example, do have LCSW level-providers who can provide some counseling and some Title 25 work. While these folks are not physician-level providers, they do offer a much needed service to these patients.

I am very proud to be living in Sweetwater County and very proud to represent MHSC. The administration here, led by Jerry Klein, our CEO, and Deborah Gaspar, our CNO, is extremely forward thinking, extremely compassionate, and has made mental healthcare a priority. Not only has it been a pleasure to work with them, but I can always count on their commitment to make things better and head in the direction of progress. As of today, we do not have a "psychiatric hospital" or an "inpatient

unit" but we do have a wonderful ED staff of physicians who are well trained from the University of Utah, multiple detainment rooms for our "titled" patients, an outpatient psychiatric clinic, and a collaboration with LCSW providers from Southwest Counseling, who assist the ED, hospitalists, and myself with Title 25 work. We are recruiting additional psychiatrists and therapists to the hospital and together with the administration we are building a true "Department of Behavioral Health."

Since I started working here in July of 2014, I have noticed a large swelling of our patients detained on title 25. While some days we have 2-4 patients, we often have 5-6 and we have had as many as 9 patients detained on a single day at least once this year. I believe this is due to the convergence of several factors: Our reputation as a leader in mental healthcare is growing; Folks are coming to Sweetwater County to get help for themselves or for their friends or family; We also have an absolutely enormous number of transient patients traveling across I-80 from other states such as Florida, NY, Utah, California, etc., who are typically on their way to another state and who frequently get into "trouble" at local rest stops. Some of these patients have been out of psychiatric treatment for months and off of their medications and wind up in automobile accidents. Some of them are suicidal. Some are "psychotic" (meaning out of touch with reality) at gas stations and wind up scaring the public and/or engaging with local law enforcement. In addition to this, we have a huge amount of "spillover" patients coming to our county (or sent to our county) from surrounding counties who lack psychiatric services. Mr. Klein has taken the stand that we will not abandon people who come to us in need and I believe that not only is this the honorable and right thing to do, but it would be inhuman not to provide care when we can do so in a state that often leads the nation in suicide deaths. I have reviewed county coroner deaths for Sweetwater County going back a large number of years and seeing these names…. the names of our parents, our brothers, and our children, in black and white, along with the age and cause of death (most often "self-inflicted gunshot wound"), truly leaves an lasting impression. It's hard to even look at that list without having some emotions and a lump in one's throat.

Here is the rub: While we are taking this stand, several things tend to occur. Hiring psychiatrists means we are hiring people trained in medical school, residency, and fellowship to stamp out depression, to curb other mental health problems (like schizophrenia and bipolar), and to cut down on suicide. The training is extensive and grueling, but it's necessary to create doctors that know what they are doing and how to uphold "the standard of care" for these patients. While our LCSW colleagues are doing some great work, we occasionally have differences of opinion as to what this standard is. For example, it is not adequate (from a physician's perspective) for a patient to "say" they are "not suicidal any more" after having ingested 37 tablets of Tylenol which has injured their liver and after having written an extensive suicide note with stains on the page from their tears. Some non-psychiatrists might recommend discharging them, because "the moment has passed and we need to respect their "civil rights," but for a physician, this is not considered acceptable or safe behavior. This is not a civil rights issue in my opinion. The language of the law (meaning the language of who is and should be "detainable" on Title 25 is reasonable consistent with the corresponding mental health laws in other states. To simplify it down to a concept, the person must exhibit an unacceptable *probability* of coming into, or causing a dangerous harm as a product of mental illness. I would argue that those who are *most qualified* to measure this probability are physician-level (psychiatrist) providers. Most of the time, we are fortunate, however, to be in agreement with our non-psychiatrist (LCSW) colleagues. Differences of opinion are not necessarily a bad thing, but it's what to do when these disagreements occur that merits further discussion. I would argue that it would be helpful if perhaps the law could more strongly state a hierarchy of providers or measures to take for when legitimate differences of opinion occur.

For psychiatrists across the nation, the standard is to:

1) Do no harm. We learned this in medical school. It's harmful not to practice at the highest extent of one's training.
2) Gather a huge amount of "collateral" information needed to render a decision based on the "*probability of harm*" that a patient could do to themselves or others. It's like punching in variables into a computer. If you don't know a variable (or you don't ask) you can miss something quite important and necessary to make the best decision possible.
3) Ultimately, to *safely* decide whether to hold a patient or let them go.
4) Decide what medications or other services, if any, are needed.
5) Err on the side of *conservative, compassionate care*. IE, it's better to hospitalize someone when a number of alarming factors present, then to let them go home. There are no second chances for suicide. *Pleasing* the patient is not the focus. The primary focus is safety.

There are some other considerations to think about here. It's quite frankly expensive work to hospitalize mental health patients, not just in Wyoming, but everywhere. No one wants to run up a huge bill, but we run up large bills for aortic aneurism repairs (that can also lead to death). Death is an unacceptable and painful outcome for any specialty in every community. It's also expensive to lose folks to suicide, more than on just an *emotional* level. On a numbers basis, we are losing a person from our economy forever. The likelihood of suicide in that person's dependents or his or her relatives statistically skyrockets after their death and this has ripples into the economic productivity of many individuals over many years. Many patients wind up on SSI disability income and others wind up utilizing hospital services at an alarming rate after they lose someone to a suicide.

It's not correct, in my opinion, to say that the "answer" lies in mainly or only beefing up the state's outpatient services and placing the "emphasis" for the expensive or so-called "over hospitalization" of these folks on the outpatient side of things. It's not correct to say that "if outpatient care was stronger folks wouldn't wind up on Title 25." It's true that outpatient services are incredibly important, (and should be improved everywhere) but arguably, the inpatient side is equally important. (As a side note, traditionally the business margins for inpatient work are actually better than for outpatient clinics.) Psychiatric patients, simply put, end up hospitalized at times, with or without outpatient care as a natural course of their illness, and having adequate inpatient services (and adequate and appropriate staffing) often saves their lives. Sometimes the medications aren't enough and sometimes outpatient therapy isn't enough. When things are "dicey", we need the hospital to serve as a final common safety net. This is considered a standard component to almost every large hospital system in almost every state as far as I am aware. We truly need both types of services to be intact and working in counties across the state. I realize that this is a large undertaking and cannot occur "overnight."

One challenge we face here is that many folks feel as though our psychiatric hospital system in WY is a bit strained. This isn't a negative commentary and we are very grateful for the relationships we have with the existing hospitals and physicians, but this is coming both from our patients' and from our own observations. We frequently have huge delays that transpire from the time our judge orders a hospitalization and the time the patient leaves our facility. This can range from 5 to 30 days and costs the entire system a huge amount of money in terms of process-inefficiency. (Yes it is true that patients may, at times, stabilize during the post-court period and we have petitioned the court for release. The court is very reasonable and has worked with us nicely on this.) That said many patients still need to go to the full-fledged psychiatric hospitals. We are often told that WY State Hospital has "no beds" and that transfer to Wyoming Behavioral Institute or Pine Ridge is impossible for a number of days as well.

This is typically due to the number of beds or to the weather, but a number of reasons can combine to cause significant delays. We have gotten to the point at MHSC that we have had to have discussions about what to do when we have so many mental health patients here that we may not have room for our critical ICU patients or post-op surgery folks. We also face the scenario of folks re-presenting to our ED only minutes or days after being discharged from Wyoming facilities. This re-hospitalization burden has been felt throughout this year by our entire facility.

Today is the 12th of June and we currently have 6 titled patients. Three of them are suicidal and 2 of them are acutely psychotic. Currently, they are not considered fit to be driving vehicles, caring for their families, working or walking around our community. These folks truly, truly, need our help. The last thing any of their families need is a tragedy to break their hearts. We can't, as a community, allow these folks to (God forbid) crash into a school bus, make impulsive decisions with firearms, or be responsible for the safety of their own children or other people's children. So we will continue to take a stand and do whatever we can for them.

To that end, I'd like to close by discussing our fantastic and exciting partnership with the University of Utah, which is truly a ray of sunshine that we are fortunate to have. Every community hospital could benefit from a "big brother" for access to more extensive or "University Level" services. I would like to add that Memorial Hospital of Sweetwater County, being a 99-bed local community hospital, certainly offers a tremendous array of sophisticated, state-of-the-art services, all delivered in a beautiful and modern building. We have a brand-new medical office building which houses a variety of medical specialties, as well as a beautiful and impressive Cancer Center, just to name a few of the things that we have and we can do. I am incredibly proud to work here, and I feel that our community is well cared for by this facility. That said, sometimes we need to turn to the University of Utah for a little bit of assistance. For example, if we need to Life Flight someone from the emergency room for cardiac catheterization services, or complications of pregnancy, the "U of U" is always there for us.

With regard to mental health patients, there are occasionally some folks who we will send to Utah. Typically this involves "voluntary" cases that are perhaps a bit more stable than some of our more concerning patients. For example if someone has had a serious overdose, and is still contemplating suicide very frequently, it's probably not a good medicine to send them across the interstate to Utah on any kind of voluntary basis. Typically those folks will enter our court system and will end up in the Wyoming hospital system. In some cases we have sent children or other patients with less "lethal" presenting problems on a voluntary basis to our psychiatric colleagues in Utah. Some parents are telling us their preference is for their children to go to Utah whenever possible. Some of them have expressed a greater level of trust in the Utah system, and at the end of the day, we have to try and honor their requests when we can as good stewards of the folks in our community. Again, this is not a negative commentary on the Wyoming psychiatric hospital system on our part, but it's what parents may at times request because they are already familiar with Utah from their own interactions or from medical visits they or their children have had.

At the University of Utah, there are over 70 psychiatrists with a multiple sub-specialization areas including: adults, pediatrics, geriatrics, addictions, and co-occurring disorder patients, to name a few. There have also been patients who have been extremely critical in terms of both medical and mental health conditions that we have needed to transfer. For example, a typical scenario might involve someone with all of the following co-presenting conditions: depression with suicidal thoughts, advanced dementia, hallucinations /metabolically-induced delirium, renal failure. We have sent patients similar to

this to the "5 West" unit at the University of Utah Neuropsychiatric Institute (UNI). This is a specialized unit that delivers a high level of acute comorbid medical and mental health care for patients with such complicated and intermingled problems. Now, often times we can take care of these patients right here at Memorial, but if they require advanced medical care, if their situation begins to deteriorate too quickly despite medical care, or if they start to refuse medications, refuse food, and/or place themselves in further jeopardy, we cannot, as a local community hospital, care for them. We can't "force feed" or "force medicate" them, according to our standards and bylaws. In these situations, our colleagues have been absolutely wonderful and have taken over the care of these folks. Frankly, the process has gone seamlessly and we have a friendly, collaborative, productive, relationship. I have sent my patients directly from my clinic to UNI when they have needed electroconvulsive therapy because they have failed a myriad of psychiatric medications that we have tried, and I have also sent patients directly from my clinic for admission to the hospital at UNI as well. So far, things have gone quite well.

Earlier this year, the administration and I thought about the possibility of having *titled, involuntary patients* sent to Utah for care subsequent to being court ordered into inpatient hospitalization. The University of Utah almost always has open beds and they are geographically extremely close to us. As I alluded to, they offer a sophisticated level of psychiatric care, and procedures such as ECT and transcranial magnetic stimulation, which we do not offer. They have safe protocols for force feeding and force medicating that we do not have here. So far this has just been an idea, and I can imagine that some people would not like the idea of the state of Wyoming paying for the care of patients entering in an *outside state*. I would imagine, however, that cutting down on the 5-20 days of post 72-hour hospitalization here, would save hundreds of thousands of dollars, if not more than this in the long run. Of course there would be legislative and legal implications to making such an arrangement work, but I believe that our partners at Utah would be willing to consider serving as a receiving facility for Title 25 should this be something we are prepared to consider.

Ultimately, if this is not palatable to the legislature, then we can still send folks to this institution on a voluntary basis, but we are left with how to go about caring for our involuntary patients psychiatrically and economically in an efficient and streamlined way. I can tell you that from the perspective of a physician, making recommendations that someone be released from title, when they are not stable enough and when they continue to merit hospitalization, is malpractice. There is not a psychiatrist that I can think of who I have trained with that would be comfortable with this. No one has suggested this of course, but I would imagine that bringing more psychiatrists into the state will lead to more hospitalization, not less. This will be expensive, but it's what most other states do out of necessity. The suicide rate is telling us that this is probably necessary and that a larger solution, at the legislative and state level is required. Perhaps we need to expand the budget for psychiatric hospitalization. Perhaps we need another psychiatric hospital. Perhaps the existing psychiatric hospitals need additional wings or additional beds or services to make them more attractive to Wyoming residents (and to concerned parents). Perhaps we need to look at strengthening community partnerships with University level hospitals on the borders of our state or even incorporating them into the Title 25 arrangements. Perhaps we need to consider adding in a *voluntary* provision into title 25 as many other states have legislation that covers this. Certainly, we need to improve uniformity of services throughout the state so every county shares in the burdens and benefits of this important task equally. This issue is bound to have strong opinions on many sides and just getting this conversation going again is certain to lead to good things.

Although this is the Cowboy State, and although the attitude of "cowboy up" is certainly a wonderful and fun part of the local heritage and culture, we have to be careful when applying it to the issue of

gravely depressed or seriously mentally ill individuals. These folks require sophisticated interventions including appropriate, standard of care-driven screening by physicians, appropriate medications, psychotherapy, and hospitalization at state-of-the-art facilities that can offer such things as a positive milieu, art therapy, occupational therapy, social work, and inpatient medical care. I do not believe that I'm wise enough or experienced enough already to understand all of the legal, financial, and political implications of all of these things, but I am humbly and foremost a young psychiatrist, trying to do whatever I can here to do my part to make things better. I am extremely grateful for the relationship that I have with Jerry and Deb, for the support that they have given me, and for the direction that we are heading together. Whatever transpires, I know that there are good things in store for Sweetwater County and for Wyoming at large. I certainly know that the government in Wyoming is wise and is aware of these issues, and that many, many people care about mental health. It really is an honor to be able to write such a letter to the legislation in this great state.

Sincerely,

Charles A. Bongiorno, MD, Medical Director
Department of Behavioral Health
Direct: 307-352-8161
Answering Service: 307-352-1540
cbongiorno@sweetwatermemorial.com

Main 307-362-3711, Fax 307-212-7788
1200 College Drive, Rock Springs, Wyoming 82901
www.sweetwatermemorial.com