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TO: The Honorable Sara Gelser, Chair
Senate Human Services, Mental Health and Recovery Committee

FROM: Sara Walker, MD, Interim Chief Medical Officer
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SUBJECT: SB 686: Relating to mental health care (NO POSITION)

Chair Gelser, Vice-Chair Anderson, and members of the committee, I am Dr. Sara Walker, Interim Chief Medical Officer at Oregon State Hospital.

I am here to talk about the impact this bill, as written, would have on the Oregon Health Authority and outline four areas that would benefit from further clarification. OHA has no position on the bill.

The first point of clarification pertains to which facilities are affected by the bill. It specifies "a hospital licensed under ORS 441.015, a state hospital and a secure intensive community inpatient facility." The latter is not defined, and we are uncertain if this pertains to Secure Residential Treatment Facilities. We are also uncertain if the intent is to include patients receiving psychiatric care in hospital emergency departments or other non-psychiatric hospital beds.

If so, in either case, the bill includes no provisions for the impact of critical psychiatric provider shortages, which disproportionately impact those living in rural and other traditionally underserved areas. In such circumstances, telehealth services currently provide access to psychiatric care which would otherwise be difficult to obtain.

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Requirement for in-person treatment would predictably increase the cost of providing psychiatric care for rural SRTFs like Pendleton Cottages, or render it entirely unavailable. Rural hospitals would similarly need to increase staffing and cost to maintain around-the-clock availability of a psychiatric provider who could respond in person to a patient not already in an inpatient psychiatric bed.

The second point of clarification pertains to Section 1(2)(c), particularly the inclusion of civil commitment proceedings with assessments and evaluations of a defendant's mental capacity or qualifying mental disorder. The term "proceedings" implies the commitment hearing itself is included.

If this is the intent, it raises several points: first, the question of whether the many other types of hearings held for Oregon State Hospital and Pendleton Cottages patients are also meant to be impacted. Second, we do not consider a hearing to be an assessment or evaluation by the testifying psychiatrist. Third, hearings are routinely held by virtual means. Requiring the in-person presence of the patient and/or psychiatric practitioner when the hearing is conducted in a separate location creates substantial logistical, cost and patient care impacts in relation to patient transport and reduced availability of the practitioner to care for their other assigned patients.

The third point of clarification relates to reasonable exceptions. For patients admitted to the state hospital or inpatient acute-care psychiatric beds, the general practice is already in-person assessment for both the initial and ongoing assessments, which are considered entirely separate services. Telehealth provision of these services by hospital psychiatry staff is permissible now only under two separate waivers of CMS rules, due to the COVID-19 pandemic. This bill, however, includes no provisions for circumstances which might foreseeably require telehealth visits to inpatients under such waivers: epidemic disease or other disaster conditions, for example, in addition to critical provider shortages.

Similarly, there are circumstances which might foreseeably require telehealth evaluations of mental capacity, fitness to proceed, or qualifying mental disorder. In addition to those noted above: transportation of a defendant to the Oregon State Hospital for outpatient evaluation by the Forensic Evaluation Service from distant counties in extreme weather or road conditions, or when it is medically unsafe to do so. A requirement for in-person evaluation in such circumstances will delay evaluation and may lead evaluators to decline to provide services.

Another exception pertains to the risk of violence directed at the practitioner. In settings such as an SRTF, the Forensic Evaluation Service's interview area at OSH, an emergency department or a non-psychiatry inpatient floor at an acute care hospital, this risk is far more difficult to mitigate than on an inpatient psychiatric unit. For a small number of patients, an in-person assessment presents an unacceptable risk of harm to the

practitioner; mandating in-person assessment despite this risk would be likely to lead to loss of available practitioner services.

The fourth point of clarification is the intent of the term “other mental health care provider.” This is not defined in the bill, but the content of subsection 2 implies that it would include physicians, nurse practitioners, physician assistants, psychologists, and other qualified mental health professionals. The way in which the bill is written indicates that such providers might be responsible for prescribing medications. Psychiatric prescribing is most appropriately the province of practitioners trained and licensed to assess and provide medical treatment for psychiatric conditions.

In summary, while practitioners in inpatient psychiatric settings expect to see their patients on-site and in-person, there are several circumstances in which telehealth services might be necessary and we recommend those provisions be added. In addition, there are several instances of terminology and organization in the bill which require clarification to better define the intended scope.

Thank you for the opportunity to testify on this matter. I remain available as a resource to the committee, to provide further information or input as needed.