

*Psychiatric Hospital Beds in California:
Reduced Numbers Create System
Slow-Down and Potential Crisis*

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A Report from the
California Institute for Mental Health

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Acute Psychiatric Services in California

A Preliminary Evaluation with Recommendations for Future Assessment and Immediate Action Prepared for the California Institute for Mental Health

Executive Summary

In 1995, California consolidated the administration of its two mental health Medi-Cal systems into one system to be administered by the local county. The Department of Mental Health (DMH) and other stakeholders, including the California Mental Health Directors Association (CMHDA) developed a Health Care Financing Administration (HCFA) waiver plan that, it was hoped, would lead to lower expenditures on inpatient care and, therefore, more money to provide needed community based care. It was believed that local administration, with flexibility and integration into local systems of care would provide greater efficiency and effectiveness.

Among the factors leading to this conclusion was the belief that “cost-based” reimbursement for psychiatric hospitalization was most likely higher than “market based” reimbursement. In the following years, counties were very effective at negotiating lower rates for inpatient hospital days.

Under financial pressure due to reduced reimbursements from all sources, a saturation of the market, and increased regulatory pressure, there was a major consolidation of hospitals. There was also movement by some hospitals from non-profit to for profit entities. Many of these for profit hospitals also became publicly traded.

The administrators of these larger organizations were increasingly focused on “the bottom line.” From a strictly financial standpoint,

psychiatric inpatient beds looked less attractive. First, reimbursements from counties and managed behavioral healthcare organizations had been consistently declining. Some hospitals, classified as “IMDs” continued to be barred from federal financial participation.¹ Second, the potential liabilities of these units continued increasing (e.g., HCFA audits of billing for Medicare), as did regulatory requirements (HCFA requirements concerning seclusion and restraint and county utilization review systems).

In addition, national and regional economic forces led to a critical shortage of qualified mental health staff for inpatient psychiatric units.

With very little community discussion or planning, many hospital inpatient units, and, indeed, entire psychiatric hospitals, were closed.

Fortunately, counties did reinvest inpatient hospital savings into community-based care, and generally perceive that this reinvestment did result in reductions in inpatient care for traditional community mental health clients, such as those with schizophrenia, bipolar disorder and severe recurrent depression.

Unfortunately, both in California and nationally, there were significant increases in the number of dually diagnosed clients (those with substance abuse), and patients behaviorally disordered due to organic dysfunction who required inpatient hospitalization because alternative services were not available. This shift in the inpatient population may have contributed to an increase in administrative days that further reduced hospital reimbursement.

As a result of these trends, there is now a shortage of inpatient psychiatric beds in California as well as a lack of adequate capacity of the existing mental health system to provide alternative

¹ Under the federal Medicaid program, facilities that are considered “Institutions for Mental Disease” or “IMDs” are currently prohibited from being reimbursed by Medicaid for patients between the ages of 22 and 64. IMDs are defined as licensed acute care facilities, nursing facilities or residential treatment programs with more than 16 beds that have 50 percent or more of their licensed beds designated for the treatment of persons with mental illness or substance abuse disorders. (Refer to page 12 for more information.)

care for those clients with more severe and urgent need for care. Significant licensing and regulatory barriers also contribute to the lack of alternative care capacity. In addition, the overall crisis in lack of affordable housing exacerbates the pressure on placement alternatives.

This shortage appears to be most severe and pervasive for children (ages 1 through 12) and adolescents (ages 13 to 18). Adult shortages vary from region to region. Los Angeles is the exception, with shortages only for sub-specialty care.

There is a general belief among mental health professionals that there are significant opportunities to develop additional community based alternatives to hospitalization. This includes crisis services with a residential component that might prevent hospitalization; community based facilities that could manage some patients currently being treated in skilled nursing facilities; and specialized programs for persons with organic brain syndromes.

This report suggests both short-term and long-term strategies for addressing the situation, as well as areas for further study. Short-term strategies include the following:

1. Develop and strengthen partnerships and regional initiatives at multiple levels:
 - (a) Set up discussions with California hospitals through the California Healthcare Association (CHA) in order to identify steps that could be taken immediately and in the long run in order to improve the availability of hospital beds
 - (b) Set up workgroup(s) with providers of alternative services, such as crisis residential (California Association of Social Rehabilitation Agencies), crisis stabilization (CHA) and special residential treatment programs (children and adolescents, geriatric patients), to identify barriers to expansion of services and to create a statewide action plan to address those barriers

2. Conduct a real-time inventory of beds to assess and monitor acute bed numbers and demand.
3. Conduct an assessment of the use of administrative day beds to determine the types of alternatives needed to resolve placement needs. Identify populations of patients in need of hospital alternative programs that do not currently exist (e.g., sub-acute psychiatric rehabilitation beds for behaviorally disordered adults with brain injuries). Determine state, regional and local responsibilities/solutions.

In addition to sustaining many of these short-term solutions on a long-term basis, the following long-term strategies are proposed:

1. Collaborate with DMH to identify regulatory and legal barriers to developing and implementing alternative programs and create a legislative agenda for change.
2. Open alternative placement programs. Consideration should be given to contracting with providers of existing programs.
3. Form partnerships with national organizations such as the National Association of State Mental Health Program Directors, the National Association of County Behavioral Health Directors, and the National Association of Psychiatric Health Systems, to develop a national legislative strategy to eliminate the Institute for Mental Disease (IMD) federal exclusion.
4. Work with DMH to clarify an appropriate audit mechanism for administrative day determinations that is compatible with standards of practice in psychiatric hospitals and consistent with Health Care Financing Administration (HCFA) regulations.
5. Strengthen the role of regional organizations of mental health plans in meeting the needs of acute psychiatric patients by developing special programs for community-based care.
6. Utilize partnerships to negotiate longer and more uniform contracts with hospitals.

7. Identify ways to reduce the administrative costs of operating hospitals by developing more standard and streamlined ways of accomplishing the goals of utilization review and ensure that the least restrictive and most effective treatment is provided to patients.

One of the clearest findings from this very preliminary analysis is that there needs to be more sustained attention to the analysis of existing data and prediction from that data of future needs in the system.

Since the implementation of the Freedom of Choice waiver in California, the Department of Mental Health has acquired better and better data about service utilization. Unfortunately, as is often the case in public systems, the resources to analyze this data have not kept up with the need to do so.

The costs of not addressing this problem will be measured not just in wasted Medicaid dollars, as individual providers respond to shortages by raising their rates, but also in human suffering due to lack of appropriate care. Some recommendations for further data analysis are identified at the end of this report.

Introduction

Early in 2001, the California Mental Health Directors Association (CMHDA) identified an emerging and potentially very serious problem of a shortage of acute psychiatric beds available in California, with the possible exception of Los Angeles County. This problem appeared to be most acute for beds available for children and youth.

CMHDA requested the California Institute for Mental Health (CIMH) to conduct an analysis of the problem and to provide some initial recommendations of strategies to address the issues. CIMH then subcontracted with Dr. Peter Forster of Gateway Psychiatric Systems to conduct a survey, preliminary data review and provide an initial analysis. Gateway Psychiatric Systems worked with a committee of CIMH and CMHDA representatives to provide a draft, which was then completed by CIMH.

Background

On March 26th of 2001, Gateway Psychiatric Services (GPS) participated in a conference call with an ad hoc committee of experts from CIMH, CMHDA, and DMH to discuss the apparent shortage of acute psychiatric services in California. The discussion proposed preliminary evaluation of this problem that would be useful to CMHDA and other stakeholders for planning purposes.

The committee suggested that GPS conduct phone interviews with key informants in order to:

1. Assess the nature and extent of the shortage, both geographically and in terms of specific age groups (child, adolescent and adult).
2. Assess the nature of the information currently available that could guide immediate and long term planning in order to reduce this shortage.
3. Make proposals for further steps to either: (a) assess the causes of the shortage or (b) address the shortage.

In that call, the recommendation was that GPS conduct “a quick and dirty study to get a grasp on all the issues and see if we are missing anything important.”

GPS agreed to make a proposal by early April that would address this urgent need. On April 10th CIMH authorized the study.

On April 16th GPS hired a part-time project lead to work on the study.

After one month of interviews with various experts and regular consultation with the committee, evolving understanding and focus, the following report and recommendations are offered.

This report is based on Internet and library research, combined with semi-structured interviews with 19 mental health professionals representing public and private hospitals, associations, county agencies and private agencies throughout California. Representatives were interviewed from mental health agencies and/or hospitals throughout California. In addition, representatives of the State Department of Mental Health (DMH), California Healthcare Association (CHA), California Mental Health Directors Association (CMHDA), The California Association of Social Rehabilitation Agencies (CASRA), County Alcohol and Drug Program Administrators Association of California (CADPAAC), a major private managed behavioral healthcare organization, Kaiser and The Lewin Group were interviewed. GPS also hired a data analyst to evaluate information provided by DMH and information available from the behavioral healthcare industry related to trends in inpatient psychiatric utilization.

National Healthcare Trends

A major long-term study of the health care system conducted by the Center for Studying Health System Change (HSC) has identified a national shortage of inpatient medical and psychiatric beds.² The HSC conducts site visits every two years at 12

² Emergency Room Diversions: A Symptom of Hospitals Under Stress, Issue Brief #38, May 2001. Linda R. Brewster, Liza Rudell, Cara S. Lesser. Center for Health System Change.

communities throughout the country to explore how the health system is changing. The HSC found that between 1994 and 1999 inpatient medical beds numbers decreased by 15.6%. Meanwhile, the number of ER visits between 1990 and 1999 increased by 15%.

A nursing shortage is affecting the entire nation, with some regions more affected than others. According to a February 2001 report released by the Health Resources and Services Administration (HRSA), nursing shortages vary region by region. New England has the highest concentration of FTE registered nurses working in health care (1,075 RNs per 100,000 of population), compared to the Pacific area's lower concentration of RNs (596 RNs per 100,000 of population). The report noted that California has a total of 226,352 FTE registered nurses, and one of the lowest nurse-to-patient ratios at 544 RNs per 100,000 of population.

Although nursing shortages tend to be cyclical, hospitals today are more vulnerable to the vicissitudes of nursing supply because of operational changes over the past 10 years. To reduce fixed costs and accommodate lower inpatient utilization expected under managed care, many hospitals downsized nursing staff, retaining a smaller permanent core staff and supplementing with part-time or temporary nurses to cover fluctuations in patient census.

Institutes for Mental Disease

As a result of an outdated provision of the federal Medicaid program, facilities that are considered "Institutions for Mental Disease" or "IMDs" are currently prohibited from being reimbursed by Medicaid for patients between the ages of 22 and 64. IMDs are defined as licensed acute care facilities, nursing facilities or residential treatment programs with more than 16 beds that have 50 percent or more of their licensed beds designated for the treatment of persons with mental illness or substance abuse disorders.

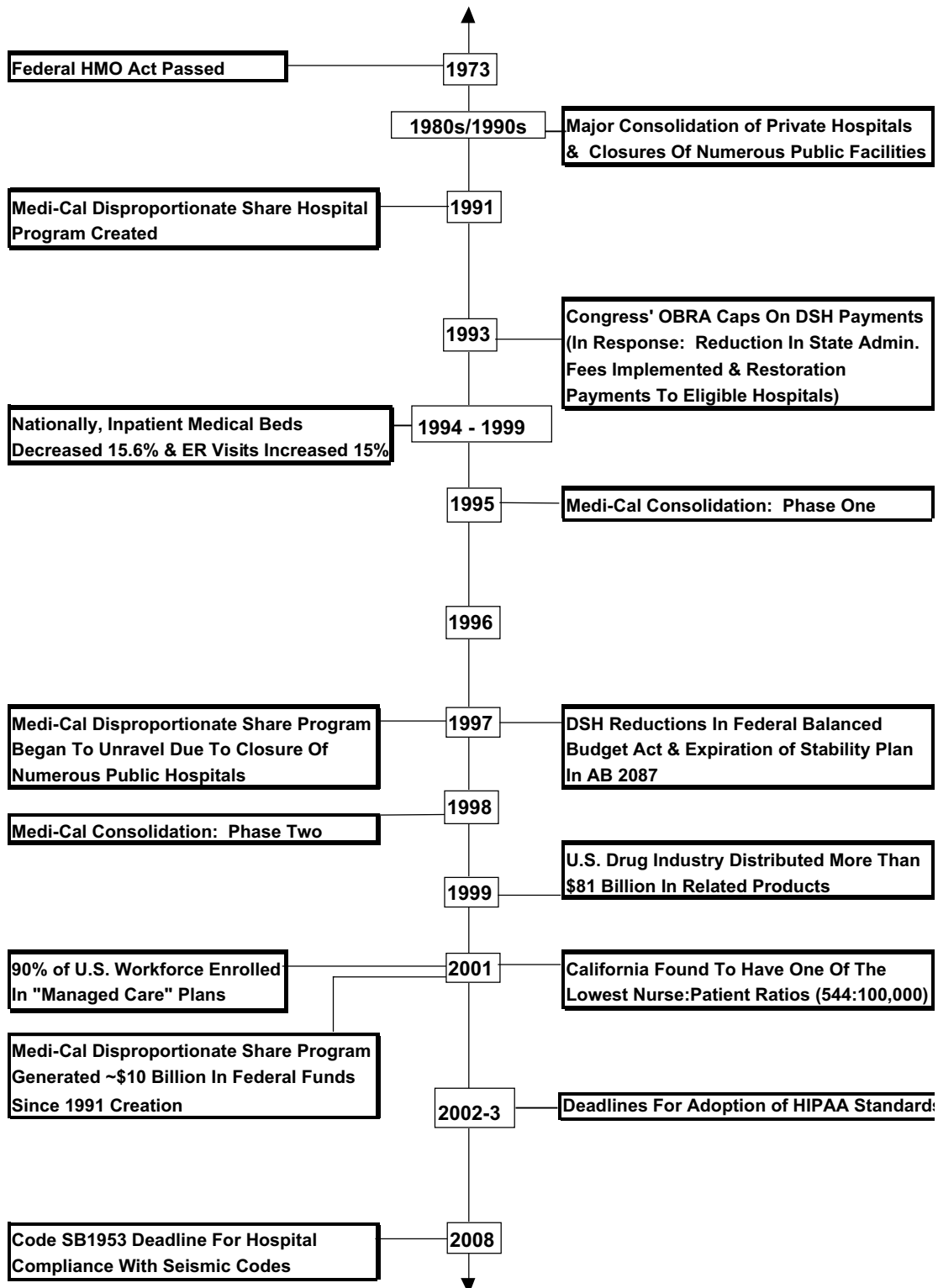
The IMD exclusion was developed in an era in which persons with mental illness typically were institutionalized in state hospitals and other settings, for lack of treatment alternatives. Most of this care was paid for by state dollars, so the exclusion was designed primarily to protect the federal Medicaid program from taking over

the costs of care associated with persons chronically mentally ill. Reimbursement for short-term acute episodes of illness was not the focus of the IMD exclusion. However, as the treatment model for people with serious mental illnesses evolved from a long-term institutional approach to community-based treatment in the least restrictive setting, providers of inpatient psychiatric care shifted from the state hospitals to smaller, community-based acute psychiatric settings. As a result, hospital-based care for seriously mentally ill in California today is designed to meet the need for short-term acute care crisis management.

Currently, there are two categories of facilities used for short-term acute psychiatric care in California: freestanding acute psychiatric hospitals [or psychiatric health facilities (PHFs)], or general acute care hospitals with a psychiatric unit. Both categories meet the hospital conditions of participation for serving Medicaid patients; however, the acute freestanding hospital is prohibited from serving adult Medicaid patients simply because of the IMD exclusion, while general acute care hospitals are allowed to treat the same patient and get reimbursed for their care by the Medicaid program.

As more and more hospital beds close, the IMD exclusion is becoming a serious barrier to counties in finding inpatient beds for their adult Medi-Cal population. For example, in Sacramento there are no general acute care hospitals with psychiatric units. However, there are three freestanding acute psychiatric hospitals and one psychiatric health facility. The Medicaid IMD exclusion not only creates discriminatory barriers to care, but also results in Sacramento County paying for 100 percent of the cost of care for adult Medi-Cal-eligible beneficiaries.

Timeline of Events related to California Psychiatric Services



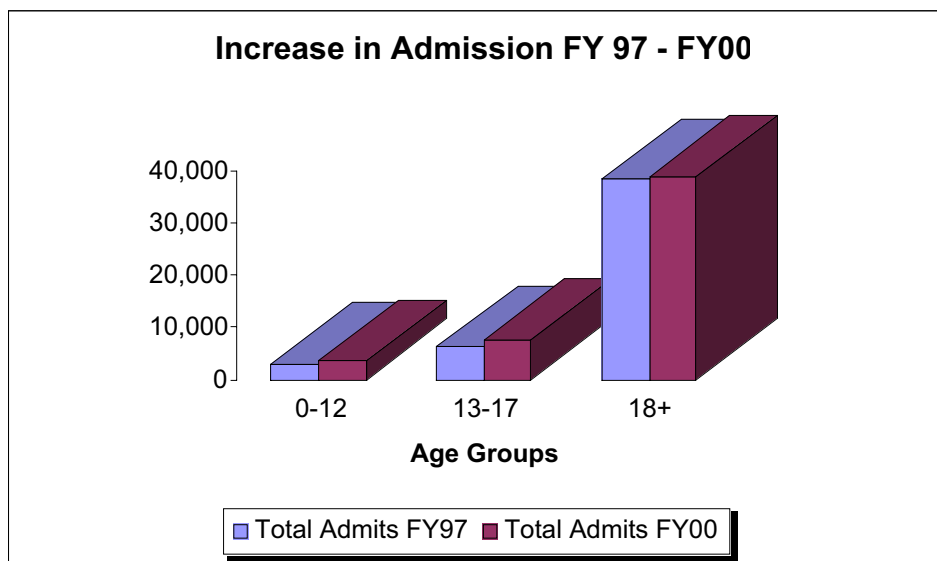
Evidence of a Shortage of California Psychiatric Beds

Of the 19 people interviewed for this report, all expressed concerns and a belief that there is a shortage of inpatient psychiatric beds in California. Most also felt that this shortage is reaching, or has already reached, a crisis situation for some parts of the state. In addition, a 2001 CMHDA survey conducted of county mental health agencies showed that 35 out of 37 counties responding to the survey reported recent difficulty in accessing hospital beds.

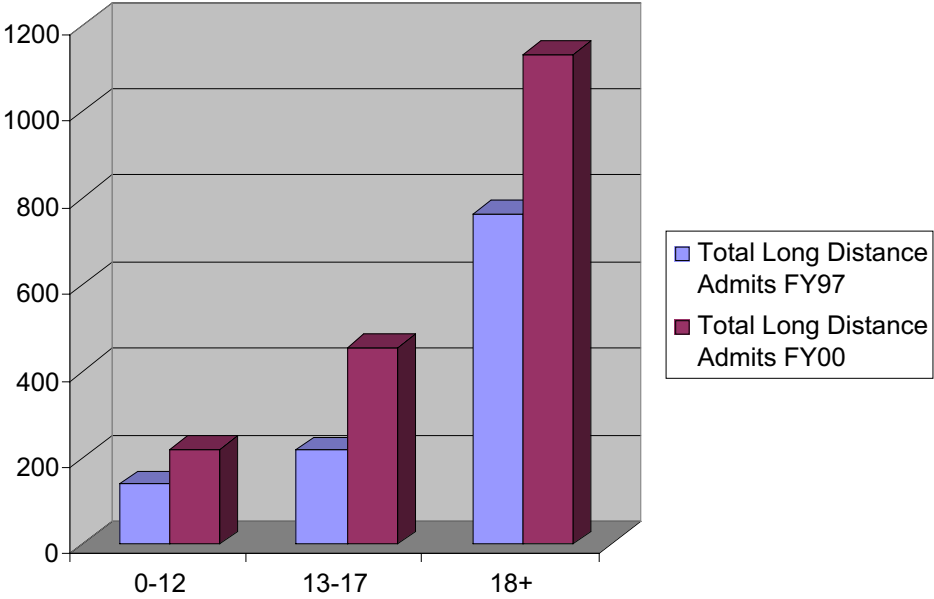
Over half of those who were interviewed felt that children were the most affected. The county survey results indicated that 81% of the participating hospitals reported experiencing shortages in child beds; 81% of the participating hospitals reported experiencing shortages in adolescent beds; and 57% of the participating hospitals reported experiencing shortages in adult beds.

Information was requested from DMH to help quantify the extent of the shortage.

Data from DMH showed that there had been a relatively modest increase in total admissions between FY 97 and FY 00. However this modest increase (5%) was composed of a very small increase in adult admissions (2%) and fairly large increases in adolescent (18%) and child admissions (20%)(see figure below).



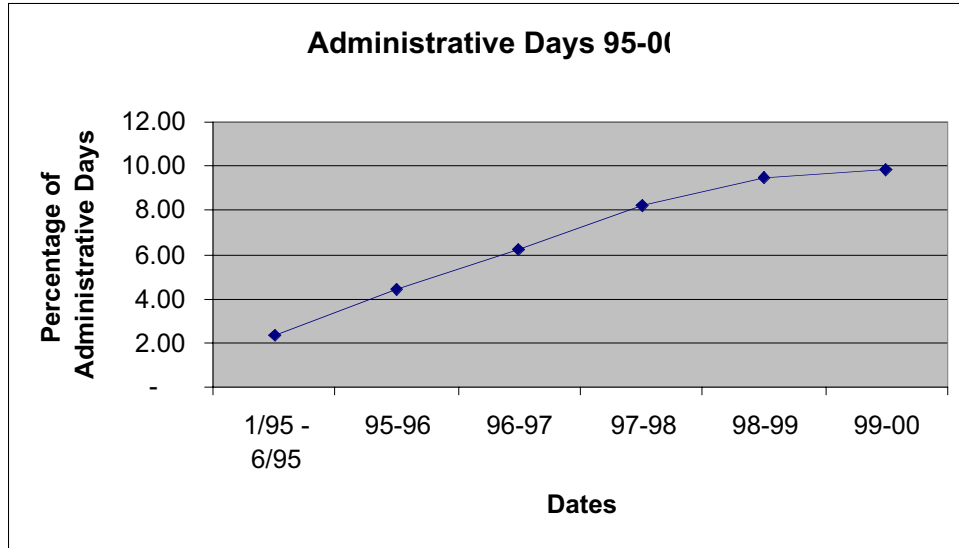
One interviewee suggested an analysis of the number and percentage of child, adolescent and adult patients, by county for each year since consolidation, who were hospitalized at an out-of-county or out-of-region facility. This analysis revealed that there had been a very significant increase in adolescent, adult and child admissions to facilities that were in a different region from the Medi-Cal County (county of beneficiary).



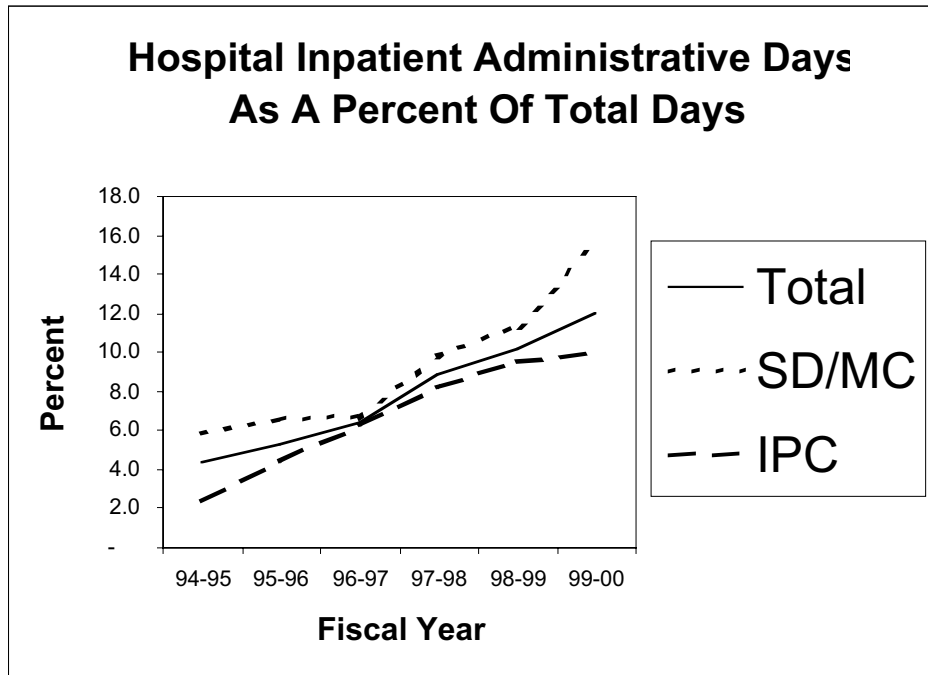
The shortage of beds exists for all ages, but seems to reflect different changes for adults (where there has not been a big increase in admissions), than for children and adolescents (where there has been a significant increase in admissions).

Data on the increases in administrative days suggest that the shortage for adults may reflect a lack of aftercare options. Administrative days for adolescents and children are generally much lower than they are for adults.³

³ Source: Short-Doyle/Medi-Cal Approved Paid Claims File, Fee for Service Paid Claims File and Inpatient Consolidation Paid Claims File – Claims paid through January 2000.



This increase in administrative days reflected a very large increase in administrative days in the Short Doyle (SD) Medi-Cal hospitals (generally county facilities and providers of last resort) and a relatively small increase in the Fee for Service (FFS) hospitals.



Further evaluation of the county-by-county data on administrative days reveals huge variation in the percentage of administrative days by year and by county, which makes it somewhat harder to interpret the increases. In addition, some counties with relatively

rich networks of aftercare services have had consistently high administrative day rates. Nevertheless, the trend data for the state does suggest increased difficulty with patient placement at the appropriate level of care.

There are also significant differences between regions. Further analysis of these differences may suggest strategies focused on regional issues.

In addition to an increase in administrative days, DMH data suggests that there has been an increase in repeat admissions for adults. The implication is, again, that there is a lack of aftercare resources.

Between FY93/94 and FY98/99, there was a decrease in the total number of persons served in inpatient services statewide. During the same time period however, there was a 26% increase in the number of persons who were readmitted to inpatient hospital services within thirty days of their discharge.⁴

One interviewee suggested that it might make sense to perform, during a second phase of this analysis, a phone survey of psychiatric emergency and crisis services in each county, in order to identify times when there are significant delays in finding an inpatient psychiatric bed for a patient in crisis and to further determine the extent of the apparent shortage.

Regional Analysis

We performed phone interviews with multiple informants in selected counties: large and small, urban and rural, bay area, Central Valley, northern and southern California. We also looked at the DMH data regarding total admissions and long distance admissions.

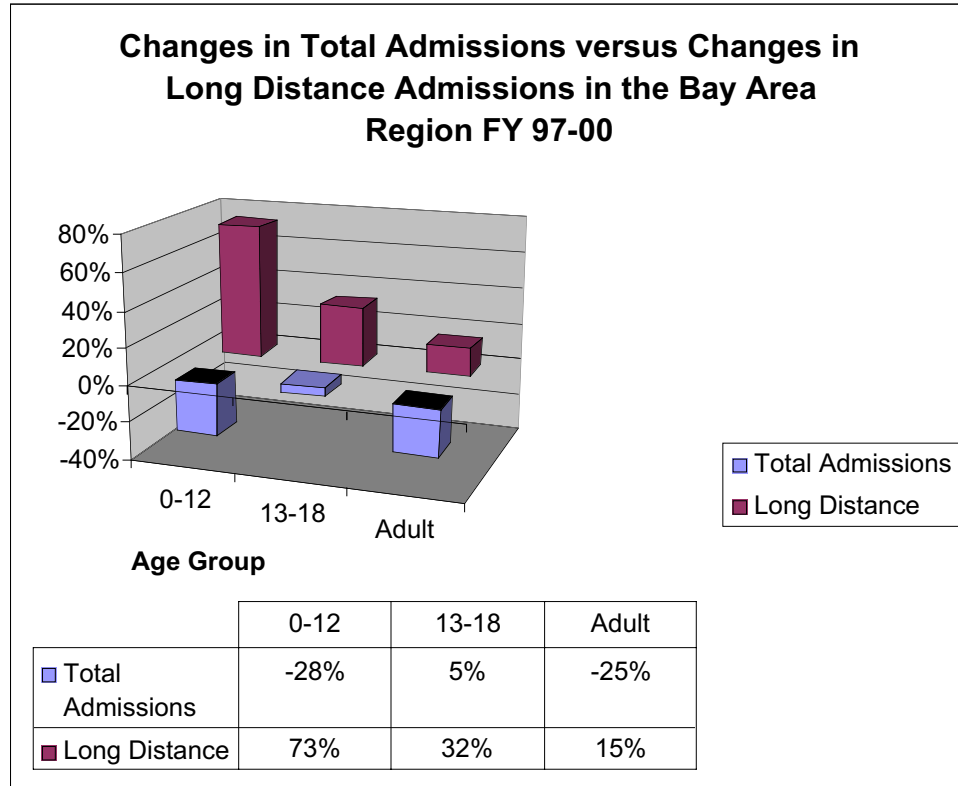
- **Bay Area**

In the Bay Area, we found that:

⁴ Source: Short-Doyle/Medi-Cal Approved Paid Claims File, Fee for Service Paid Claims File and Inpatient Consolidation Paid Claims File – Claims paid through January 2000.

- According to our interviewees, the inpatient bed shortage is the greatest for children.
- The interviewees said that the bed shortage is not as severe for adolescents as for children, but there are still shortages.
- The shortage is the least for adults, but they said that there are increasing periods of time when no adult beds are available.
- The adult shortage seems the most amenable to alternative program development, in that several of those interviewed felt that a number of hospital admissions would more appropriately have received community-based care, but facility siting and other problems have made it very hard to develop these programs.
- A comparison of changes in total admissions between FY 1997 and FY 2000 versus admissions to inpatient facilities outside the Bay Area (a measure of the bed shortage) is instructive. Total admissions for all except adolescent patients dropped significantly, whereas the percentage of admissions to out of the area facilities increased for all groups. There was no correlation between the change in admissions and the change in long distance admissions.
- This suggests that the shortage here is largely driven by facility closings.

There have been a number of recent closings or downsizings in the Bay Area including: Charter Hospital in Santa Clara closed; Walnut Creek Hospital closed; Fremont Hospital may close; Langley Porter in San Francisco has closed its children's units; Ross Hospital closed in Marin; St. Mary's hospital in San Francisco has closed all of its adult beds.



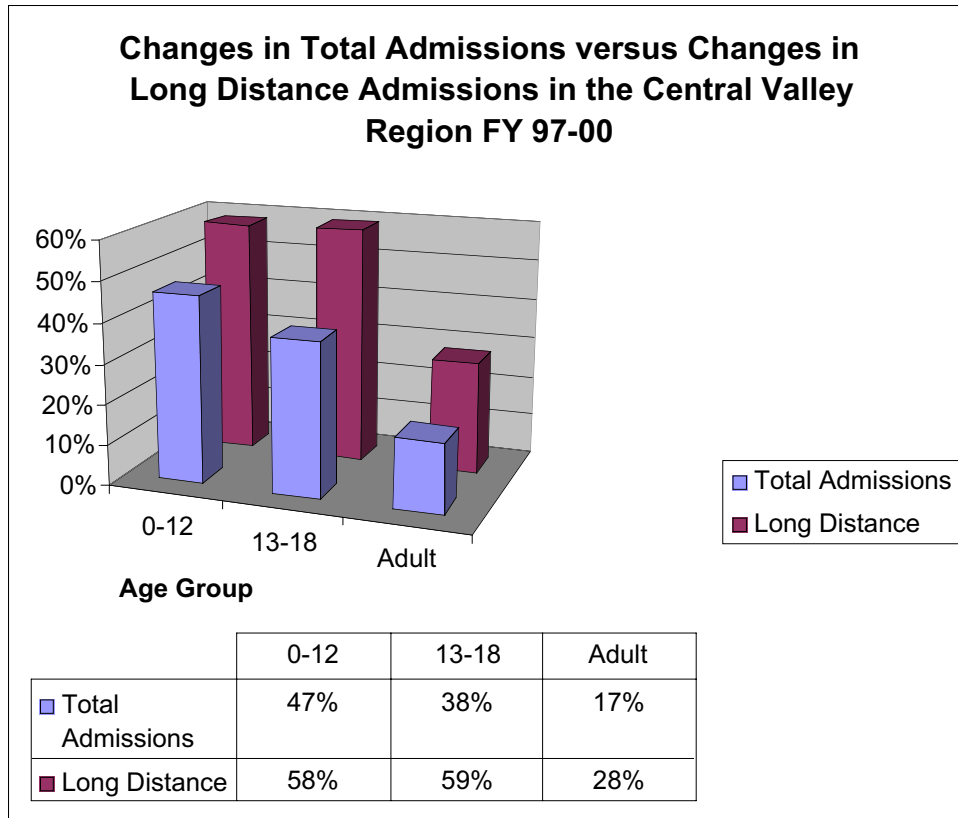
- **Central Valley**

In the Central Valley, we found that:

- According to those we interviewed, the bed shortage is most severe for children.
- Of three counties interviewed, in one there was a moderate shortage of adolescent beds and in a second there was no shortage.
- As with Bay Area counties, our interviewees said that the shortage is the least severe for adults and for adults there are the largest opportunities to reduce use with hospital alternative programs, in that many patients might be appropriate for community-based alternatives.
- One of the counties in this region has seen a very large increase in child hospitalizations.
- Those interviewed also said that the children being treated are increasingly difficult to manage. In one instance, a

county could not find a bed in all of California for a child because of the safety concerns by the hospitals.

- Changes in total admissions and long distance admissions between FY 1997 and FY 2000 in this region mirrored each other, suggesting that in this region the shortage may reflect increased number of clients needing admission. It may also reflect insufficient alternatives.

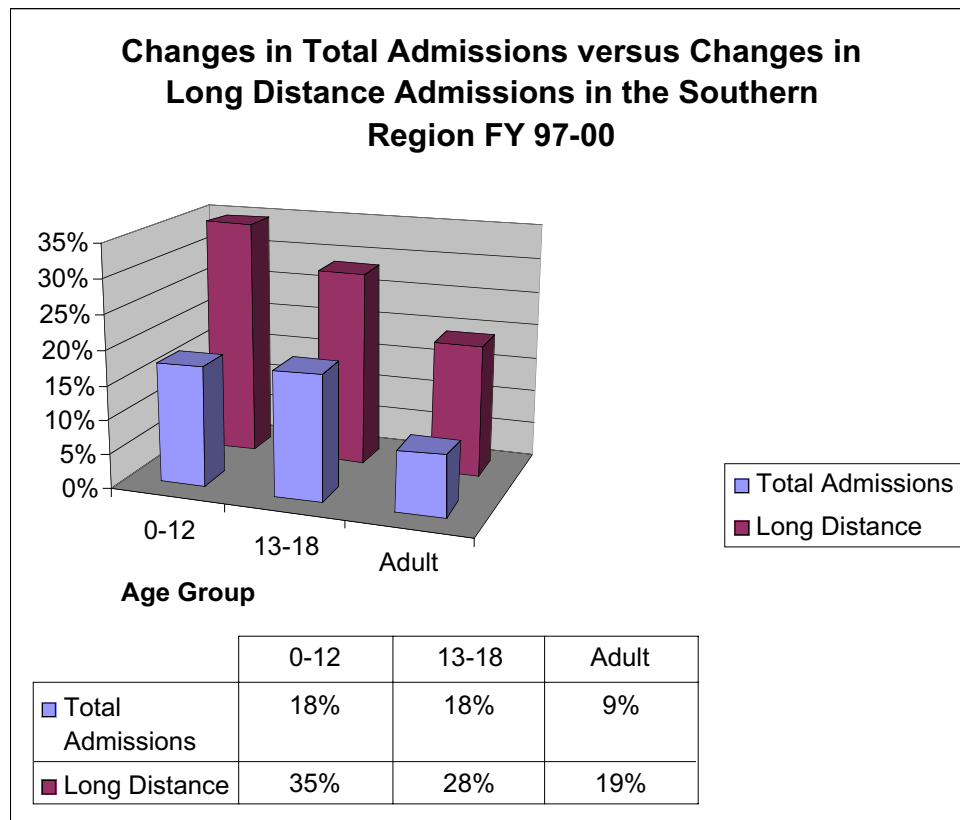


- **Southern California**

In Southern California we found that:

- Those we interviewed said that adolescent bed shortages are the most severe, followed by children’s beds
- As with other regions, adult shortages are the least severe.
- There do not appear to be significant shortages in all parts of Southern California.

- One interviewee suggested that there may be a relationship between shorter lengths of stay (five days in one county) and a higher recidivism rate, suggesting a state of diminishing returns from tight utilization review. This would be an unusual finding, since most studies have found no relationship between the two.
- Total admissions and long distance admissions for all age groups increased from FY 1997 to FY 2000. Except for adult clients the shortage of beds seems to be mostly driven by increases in the number of clients needing admission in this region.



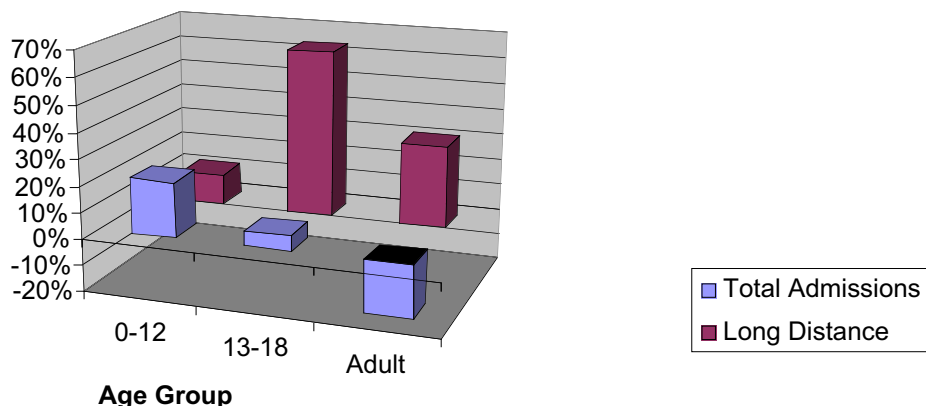
- **Northern Counties**

In the northern counties, we found that:

- Both counties interviewed report a great deal of difficulty in locating hospital beds for children and adolescents.

- The adult bed shortage is not as severe as the child or adolescent shortage in one county. One county is having a great deal of difficulty in locating hospital beds for adults.
- One county has been forced to exceed its maximum census on its inpatient unit, in some cases going as high as 25% over census.
- There appear to be significant opportunities to develop adult crisis services that could reduce hospitalization rates.
- A comparison of the percentage increase (or decrease) in total admissions from fiscal year 1997 to fiscal year 2000 for this region showed that there were increases in admissions for both children and adolescents. The very large increase in out of county admissions for adolescents was not linked to a similar change in the number of admissions. Moreover, total admissions for adults *decreased*, whereas the number of adults hospitalized in out of county facilities increased significantly.

Changes in Total Admissions versus Changes in Long Distance Admissions in the Northern Region FY 97-00



	0-12	13-18	Adult
Total Admissions	21%	6%	-20%
Long Distance	12%	64%	31%

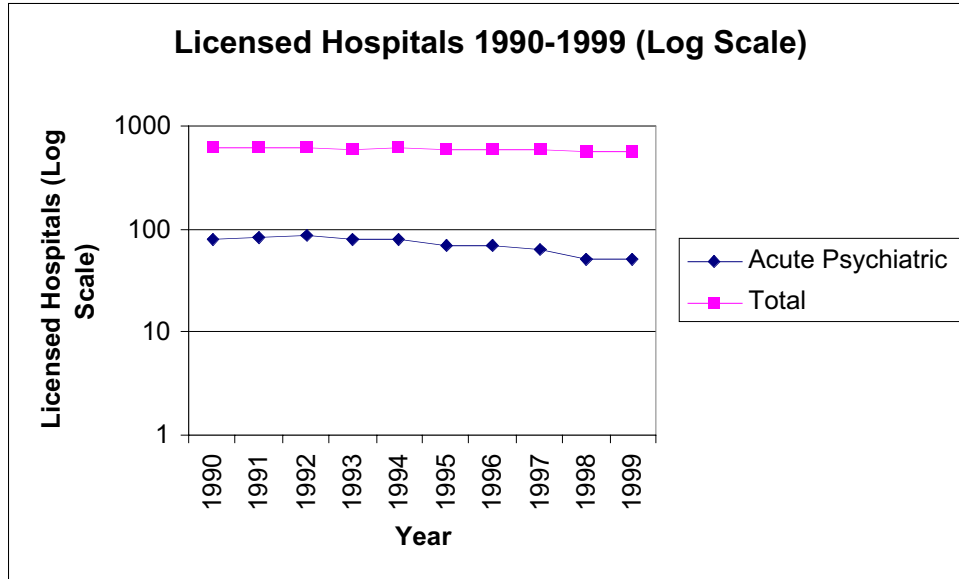
California Hospital Data 1990-1999

During this period⁵ there was a significant reduction in the number of private for profit hospitals and the number of public hospitals.

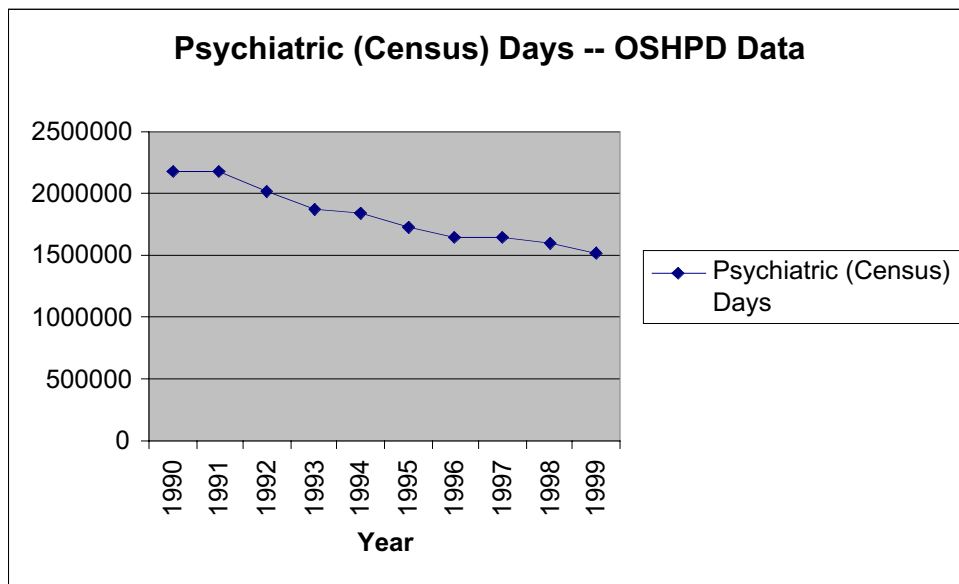
This mirrored changes that were taking place nationally.

The effect of both of these types of closures disproportionately affected psychiatric beds. The for profit hospitals that closed in California included a large number of psychiatric hospitals, due to national bankruptcies or organizations leaving the business, and public hospitals have always provided a large percentage of psychiatric beds.

⁵ data from the Office of State Health Planning and Development (OSHPD) 2001



The inpatient psychiatric census in California fell by nearly 30% during those years.

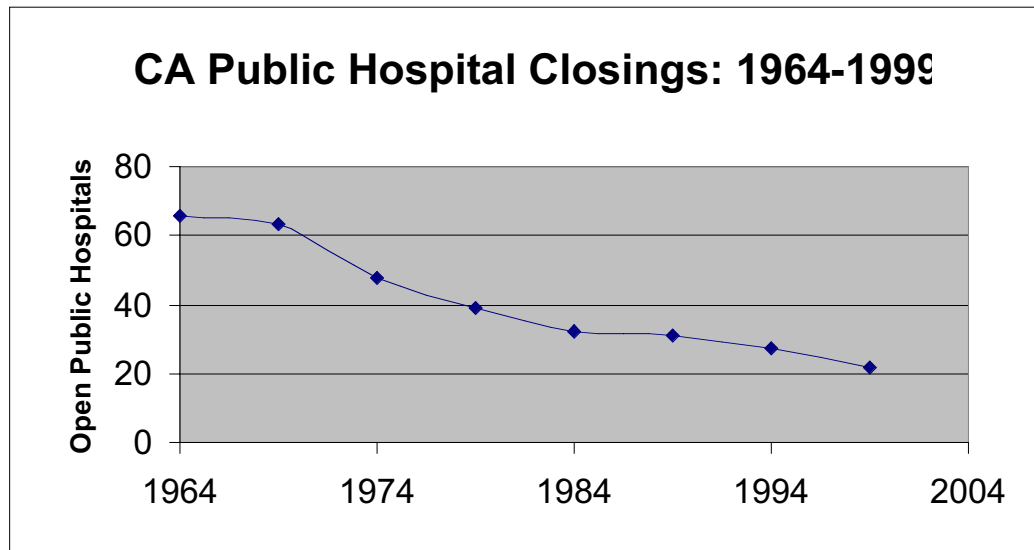


California Public Hospital Closings: 1964-1999

One of the factors that may be related to the shortage of inpatient psychiatric beds is the loss of hospitals with a public health mission.

The California Association of Public Hospitals provided information concerning public hospital closings from 1964 to

1999. The data shows that the number of California public hospitals dropped from 66 in 1964 to 22 in 1999. Of the 44 public hospital closings, nine occurred within the past 10 years (1991 or later), which accounts for approximately 20.5% of total closings.



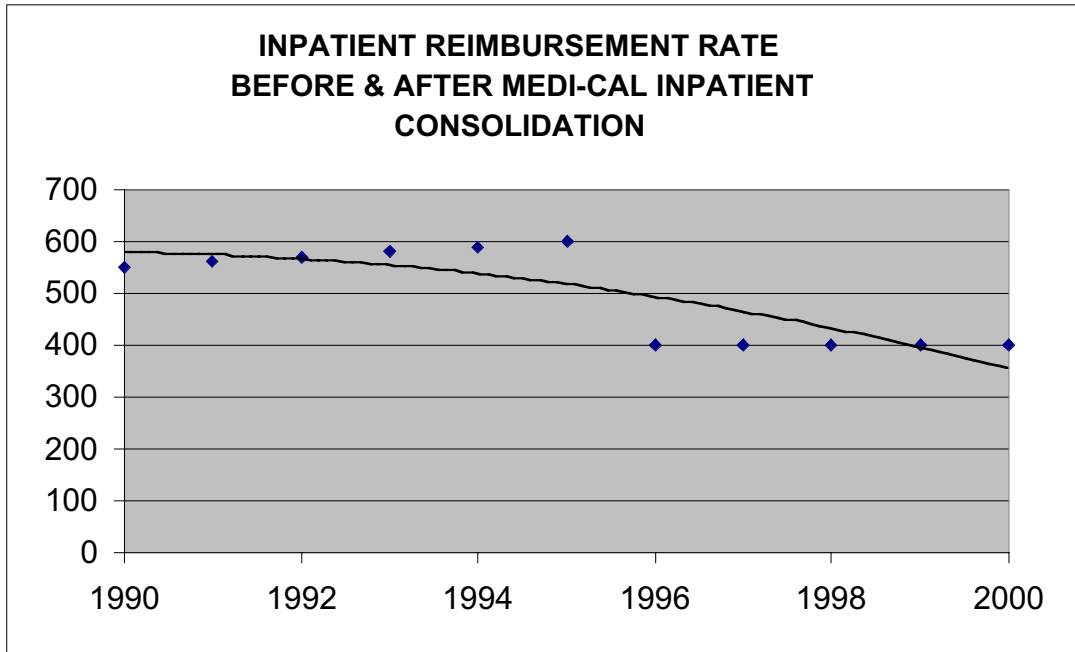
Other Issues Impacting the Availability of Psychiatric Beds

The issues leading to the statewide inpatient psychiatric bed shortage are multi-faceted and cyclical, with each hinging on the other. There are several areas that need to be explored.

Effect of the Mental Health Plans

Since inpatient consolidation in 1995, reimbursement rates for the Fee for Service (FFS) hospitals have significantly decreased. The resulting closure of some hospital beds was not unexpected. Now that California no longer has an excess capacity of inpatient psychiatric beds it is essential to switch from a strategy of careful price negotiation with the hospitals, to one of collaboration. As outlined below, several factors make it likely that the financial pressures that have led to inpatient psychiatric bed closures are likely to continue to exert pressure on hospitals to close beds unless their concerns are addressed⁶.

⁶ CHA Special Report: "California Hospitals Continue to Face Financial Pressures." April 2001



Reductions in acute day rates have been exacerbated by an increase in the number of inpatient beds filled by patients on administrative days. The administrative day rate was based on the highest reimbursement for medical skilled nursing facilities. This rate drastically understates hospital costs for care for these patients, which most of those interviewed (in hospital administration and in the mental health plans) agree is similar to the costs for acute patients. Interviewees felt that an administrative rate of 80-90% of the acute rate would more closely reflect the costs of care. The Department of Mental Health is limited in its ability to adjust this rate based on Health Care Financing Administration (HCFA) regulations. It may be necessary to address this problem from several directions: (1) adjusting the language that defines medical necessity for acute days, (2) adjusting the rate for administrative days and (3) addressing the shortage of aftercare options that is resulting in increased administrative days.

Disproportionate Share Funding

In 1991, the Medi-Cal Disproportionate Share Hospital Program was created to enable hospitals in the public sector to remain economically viable through supplemental federal funding. According to a report by the California Association of Public

Hospitals (CAPH) and Health Systems⁷, the program has brought nearly \$10 billion in federal revenues into California since 1991, which have supported over 130 public and private hospitals in 36 counties.

The program began to unravel in 1997, due to an increase in private hospitals collecting DSH and Congress' Omnibus Budget Reconciliation Act (OBRA) '93 caps on DSH payments.

To prevent a collapse of the entire system, relief from OBRA '93 caps for public hospitals was provided and a reduction in the state administrative fee was implemented. However, there has still been a decrease in DSH payments, which represents a major reduction in overall reimbursement to hospitals for psychiatric patients (since a disproportionately high percentage of psychiatric patients, versus medical patients, are on Medicaid), compounding the effects of rate decreases from the county mental health plans.

Staffing Shortages

In conducting interviews for this report, we repeatedly ran into the issue of staffing shortages, particularly among nurses and child psychiatrists. Inpatient units, as well as residential facilities, are having difficulties in securing qualified staff. This is particularly true for children's programs.

There were fairly consistent reports, from all surveyed, of inpatient psychiatric units that remained below census due to staffing shortages. The most severe shortages appeared to be (in descending order): child psychiatrists, child nursing staff and other nursing staff.

Several factors have exacerbated the shortages: (1) rising costs (particularly the cost of real estate), (2) stagnating salaries, (3) changes in the workplace environment due to managed care and (4) opportunities in other industries. With low unemployment throughout the state, mental health professionals easily opt for more highly paid jobs in other sectors.

⁷ CAPH Policy Focus – “Medi-Cal Disproportionate Share Hospital Payment Program” updated 2000.

Child Inpatient Staffing Issues

Child inpatient units may be the most difficult to staff. In terms of staff-to-patient ratio, children's beds require a lower ratio than adult units. One estimate is that, for the many patients, a one-to-one staffing ratio is required for children 12 and younger. Also, censuses for adult units are usually more stable than censuses for children's units. Therefore, a hospital that is short on staff could make it a priority to staff adult units before children's units based on purely financial reasons.

Access to Hospital Alternatives

Of the 19 people interviewed, 13 were asked about their thoughts on alternative placement and its role in the inpatient psychiatric bed shortage. Of these 13 people, 12 felt that an increase in alternative programs would be a key step in addressing the inpatient psychiatric bed problem. The review committee for this paper strongly agreed with this perspective and emphasized the need for alternatives to be integrated into a system of care that permits flexibility around the individual's specific needs.

Several interviewees felt that hospital beds were often filled with people not necessarily in need of acute services, such as people with other organic brain diseases, developmental disabilities, dually-diagnosed clients, etc.

A review article of hospital alternatives outlines the continuum of care that can reduce hospital use. These services are described in greater detail below.⁸

Crisis Residential

One expert in alternative community based systems felt that the development of community crisis residential programs would be the most effective way to address this problem. Crisis residential alternatives may be more effective at avoiding hospitalization in some cases, and are generally less expensive and do not focus on rehabilitation as much as crisis intervention. Studies have shown much lower costs for crisis residential versus inpatient for voluntary clients.

⁸ Schreter, Robert K. Reorganizing Departments of Psychiatry, Hospitals, and Medical Centers for the 21st Century. Psychiatric Services. Vol 49., No. 11. 1998.

Hawthorne, Green, Lohr, Hough and Smith (1999) conducted a study that compared the demographic and diagnostic characteristics of clients and the outcomes of treatment in five short-term acute residential programs and two acute hospital-based psychiatric programs. Three hundred and sixty-eight clients in the short-term acute residential treatment programs and 186 clients in the psychiatric hospital programs participated in an observational study. Costs of treatment episodes were considerably lower for the short-term residential programs and client satisfaction with the two types of programs was comparable. Short-term acute residential treatment is a less costly yet similarly effective alternative to psychiatric hospitalization for many voluntary adult clients.

Currently there are few organizations providing these types of residential services in California. Ninety-five percent of community residential programs certified through the Medicaid system are California Association of Social Rehabilitation Agencies (CASRA) members. CASRA member organizations provide crisis community residential programs in only nine out of 58 counties. An assessment of these counties could help to ascertain quality and cost-effectiveness of community based programs as alternatives to hospitalization. Ideally, local organizations that want to learn how to implement these programs or organizations that would like to expand into new counties could be targeted to develop new residential programs.

Other Treatment Alternatives

- *Intensive Case Management*

It is generally recognized that there is a need for expansion of intensive case management in the California mental health system. Expanding ICM is likely to be a cost-effective way of reducing the need for hospitalization for the highest cost clients. However, there are two caveats: (1) ICM is not likely to be a good way of reducing overall health costs, and, if given to clients who are not high service users, it is likely to increase overall health costs;⁹ (2) the duration of ICM needs to be carefully considered; several studies

⁹ Hornstra, R. K., V. Bruce-Wolfe, et al. (1993). "The effect of intensive case management on hospitalization of patients with schizophrenia." *Hosp Community Psychiatry* 44(9): 844-7.

suggest that it is not likely to be necessary long term (shorter term treatment might allow more access to other clients who need it).¹⁰

^{11 12} The review committee again emphasized the need for flexibility, with intensity and duration of ICM determined by individual need.

- *Adult Residential*

A recent study of alternatives to hospitalization in one system found that experienced clinicians could identify clients (in this study 29% of the sample) who did not require hospitalization. When asked what service was needed as an alternative the greatest number of answers related to adult residential care.¹³

Supported housing is the model of care that has the largest cost effectiveness evidence.^{14 15}

A recent New York study found that supported housing was equivalent in cost to “usual care” for homeless mentally ill (it is worth noting that this study did not select high cost clients, unlike other studies we have cited previously).¹⁶

- *Alternatives to Hospitalization – Children’s Services*

There is a growing body of research regarding effective interventions for children with Serious Emotional Disturbance (SED). As effective treatment modalities for this population, these interventions have the potential to reduce the need for psychiatric hospitalization, shorten the length of hospitalizations and in some cases serve as alternatives to hospitalizations.

¹⁰ McRae, J., M. Higgins, et al. (1990). “What happens to patients after five years of intensive case management stops? [see comments].” *Hosp Community Psychiatry* **41**(2): 175-9.

¹¹ Salyers, M. P., T. W. Masterton, et al. (1998). “Transferring clients from intensive case management: impact on client functioning.” *Am J Orthopsychiatry* **68**(2): 233-45.

¹² Sherman, P. S. and C. S. Ryan (1998). “Intensity and duration of intensive case management services.” *Psychiatr Serv* **49**(12): 1585-9.

¹³ Beck A, Croudace TJ, Singh S, Harrison G. The Nottingham Acute Bed Study: alternatives to acute psychiatric care. *Br J Psychiatry*. 1997 Mar;170:247-52.

¹⁴ Carling, P. J. (1993). “Housing and supports for persons with mental illness: emerging approaches to research and practice.” *Hosp Community Psychiatry* **44**(5): 439-49.

¹⁵ Goldfinger, S. M., R. K. Schutt, et al. (1999). “Housing placement and subsequent days homeless among formerly homeless adults with mental illness [In Process Citation].” *Psychiatr Serv* **50**(5): 674-9.

¹⁶ Bernstein, N (2001). “Housing Mentally Ill People Is Cost-Effective, Study Finds” *New York Times*. May 2, 2001.

Multisystemic Therapy (MST), an intensive community-based treatment service, has undergone rigorous scientific trials that have established its effectiveness with a variety of populations, and has demonstrated that it can be an effective alternative to hospitalization.¹⁷ A study last year found that access to MST reduced hospital need by more than 40%, improved outcomes and reduced costs.¹⁸ The results support the view that MST was at least as effective, and in some cases more effective, than emergency psychiatric hospitalization at decreasing symptoms. Other models, such as WrapAround¹⁹ and Therapeutic Foster Care²⁰ have also proven to be effective with children with serious emotional disturbance, and may prove to be resources that can prevent hospitalization. And research suggests that other interventions, such as partial hospitalization, and therapies, such as positive behavioral interventions, are promising as well.

Legislation and legal proceedings have created a number of opportunities that can support the creation of services that may prove to be alternatives to hospitalization and/or reduce the overall use of psychiatric hospital services in California. Funding for Children's System of Care²¹ has been available to all California counties. (The FY 01/02 state budget requires a reduction that has not yet been allocated.) Similarly, funding for WrapAround services through Title IV-E waivers and the SB 163 pilot is promoting the expansion of these services throughout the state. In the area of juvenile justice, Challenge Grants and the Crime Prevention Act have made flexible resources available to develop interagency programs for this population. And lastly, the recent conclusion of a lawsuit has made Therapeutic Behavioral Services, an intensive one-to-one treatment service that can be delivered in

¹⁷ Henggler, Scott (1999) "Home-based Multisystemic Therapy as an Alternative to Hospitalization of Youth in Psychiatric Crisis: Clinical Outcomes," Journal of American Academy of Child and Adolescent Psychiatry.

¹⁸ Schoenwald SK, Ward DM, Henggeler SW, Rowland MD. Multisystemic therapy versus hospitalization for crisis stabilization of youth: placement outcomes 4 months postreferral. *Ment Health Serv Res*. 2000 Mar;2(1):3-12.

¹⁹ A family-focused, strengths-based program where intensive and comprehensive social, mental health and health services are "wrapped around" children and their families (biological, adoptive and/or foster families) to reinforce natural family supports.

²⁰ Foster parents as primary interveners who are provided with training, clinician support and consultation, case management, and family therapy

²¹ Children's System of Care is a systemic change to create child and family service systems that support strength-based, family focused, culturally competent treatment planning and service delivery, collaboration between child serving agencies, and tracking of outcome measures

most settings, available to children with full-scope Medi-Cal insurance.

- ***Child Residential***

Several studies have suggested that there are models of care that are quite effective in working with a population of severely disturbed children, such as the population of children that is currently being hospitalized in California.^{22 23}

Unfortunately, a general failure to acknowledge the reality of treating this population by regulatory agencies at the state (e.g., the inevitability of risk taking behavior and acting out, even in the best managed facilities) appears to have made it almost impossible to find providers who are willing to develop these services in California.

Community Treatment Facilities (CTFs), a level of care that is new to California, is a sub-acute mental health treatment facility that is authorized to lock its doors and utilize restraint and seclusions. While the targeted number of 400 beds is not yet available, some CTFs are now in operation and others are in various stages of planning and development. Many are concerned that the design and regulatory requirements may prohibit it from serving many children who may need it and will make this an overly expensive treatment option. Nonetheless this is another alternative to psychiatric hospitalization for children and adolescents.

Dually Diagnosed

Almost all interviewees cited a significant increase in dually diagnosed inpatients over the last five years as a factor in the adult shortage of beds. Dually diagnosed clients are those with both a mental disorder and a substance abuse disorder. This is similar to

²² Henggeler SW, Pickrel SG, Brondino MJ, Crouch JL. Eliminating (almost) treatment dropout of substance abusing or dependent delinquents through home-based multisystemic therapy. *Am J Psychiatry* 1996 Mar;153(3):427-8

²³ Henggeler SW, Pickrel SG, Brondino MJ. Multisystemic treatment of substance-abusing and dependent delinquents: outcomes, treatment fidelity, and transportability. *Ment Health Serv Res.* 1999 Sep;1(3):171-84.

national data. Several unique problems have made it harder to develop hospital alternative programs for this population.

First, state and federal billing regulations make dual diagnosis programs hard to fund. Dual reporting and billing requirements do not recognize the need for treatment of persons with both disorders. Second, there is a lack of providers who are able or willing to provide this service. Finally, substance abuse programs in California are currently preoccupied with developing Proposition 36-related services. Nevertheless, successfully addressing this problem could make a major contribution to addressing the inpatient shortage. Moreover, there is preliminary data from an ongoing study at San Francisco General Hospital, which suggests that programs targeting dual diagnosed users of acute services can be cost-effective (meaning the reductions in health care costs by providing enhanced services more than paid for the services).²⁴

An additional complicating factor is the dearth of substance abuse hospital treatment beds in California. There are limited medical detoxification beds, some limited private but no publicly funded inpatient substance abuse treatment beds and no involuntary beds for substance abuse.

Special Populations: Brain Injured, Organic Brain Disorders, Developmental Disabilities, etc.

There are two populations of clients who are impacting the availability of acute care beds because of inadequate or slow to respond care systems: those with organic brain disorders and clients with developmental disabilities.

Changes in the system providing care to persons with developmental disabilities (DD) have also impacted use of acute beds. Increased pressure to move DD clients out of State Developmental Centers (SDC) into communities has increased the number of clients with very significant challenges in communities (thereby increasing “crisis” service needs) and decreased the

²⁴ Okin RL, Boccellari A, Azocar F, Shumway M, O'Brien K, Gelb A, Kohn M, Harding P, Wachsmuth C. The effects of clinical case management on hospital service use among ED frequent users. *Am J Emerg Med.* 2000 Sep;18(5):603-8.

number of SDC beds available. There are also no locked sub-acute beds for this population.

The problem of inadequate aftercare services for clients with developmental disabilities and severe behavioral problems is not a new one and a number of efforts have been made to address it with modest success. Perhaps because the problem involves two different systems (the Regional Centers for the developmentally disabled and the Mental Health Plans) with different missions it has been very difficult to successfully implement solutions.

The problem of clients who are behaviorally disordered due to organic brain syndromes is also not new. It is a problem that needs to be addressed because of the aging population, which will lead to a major increase in the number of these clients in need of care in the next ten years. Preliminary evidence²⁵ suggests that residential alternatives to sub-acute care may be cost effective, and this may allow a reduction of administrative days and, thus, free up acute hospital beds. In 1996, the legislature authorized the development of locked perimeter residential care facilities for individuals with dementia. An informal survey conducted in May of 2000 suggested that there are still no such facilities in operation.

Future Issues that May Impact Bed Availability

Consolidation of Hospitals May Affect Future Negotiations

The major hospital chains in California are Catholic Healthcare West (CHW), Sutter Health, Adventist Health, Behavioral Healthcare Corporation (BHC), Tenet, and Hospital Corporation of America (HCA). For the most part, these organizations came into existence out of the mergers and acquisitions environment during the 1980s and 90s and in response to the increasingly tight managed care environment.

In addition, there has been a national trend in hospitals forming loose partnerships or alternatives to joining a corporate organization. This partnership provides some of the benefits the

²⁵ Leon J, Moyer D. Potential cost savings in residential care for Alzheimer's disease patients. *Gerontologist*. 1999 Aug;39(4):440-9.

hospital chains are receiving without losing a great deal of control over their individual organization. In California, around 25 hospitals throughout California have signed up with Calnet, a third party administrator located in Paso Robles. Calnet facilitates and negotiates the managed care contracting process on behalf of the hospitals. Calnet represents one point of contact, one main office and is basically the go-between for the hospitals and managed care organizations.

When Calnet negotiates, they represent all 25 hospitals at once. This has resulted in generous, across-the-board rates for all of the facilities. The rates received through Calnet no longer depend upon factors such as the facilities' size and geographical location. In response to an increasingly tighter and more powerful managed care market, Calnet is currently creating a tiered system for rates that will take in to account size and geographic discrepancies between the hospitals, while still allowing the facilities to receive some advantages through partnering.

Earthquake Compliance

SB 1953, which mandates that every hospital evaluate its buildings for compliance with seismic codes by 2008, could have an affect on California's mental health and medical industry. Though SB 1953 has been in effect for several years, many health institutions have not taken action in evaluating the status of their buildings, perhaps feeling that this was too big of an undertaking and hoping that the state would step in before 2008. However, as 2008 draws closer, SB 1953 becomes more of a reality.

SB 1953 has the potential to affect psychiatric units that are a part of a general hospital in particular. (Psychiatric units that are not under the same roof as the general hospital or are not licensed as part of a general hospital are not affected.) One possible reason is that, in general, psychiatric units do not require technological needs to the extent that medical hospitals do. This leads to many psych units being housed in older buildings, which on average will be affected greater by SB1953 and its seismic codes than newer buildings. One mental health professional interviewed felt that medical institutions will take a hard look at SB 1953's economic implications in making decisions about which facilities to rebuild.

As medical institutions search for ways to finance this, the question of whether or not they should rebuild capacity for psychiatry or use this as an opportunity to downsize their inpatient psych wards will continue to be raised.

Aging Population

The United States' population continues to age. According to the U.S. Census Bureau, the most rapid increase in size of any age group in the Bureau's profile was a 49% jump in 45-54 year olds, a total of 37.7 million in 2000. In addition, the median age for the year 2000 was 35.3 years, the highest ever, which is expected to rise until 2050.

Psychiatric hospitals will need to address psychiatric compounded by medical needs of this population as it ages. According to the American Psychiatric Association, 15-25% of elderly people in the United States suffer from a significant mental illness. In addition, severe organic mental disorders afflict one million elderly people in the United States, and another two million suffer from moderate disorders.

Organic brain disorders and other medical ailments that arise as a result of aging will and in some cases have already put strains on psychiatric acute care. This population is more difficult to manage, requiring additional staff attention and in most cases treatment beyond the scope of acute psychiatric. A number of hospitals interviewed expressed difficulty in treating and then placing elderly clients exhibiting both psych and medical problems. In a few cases, these hospitals saw elderly clients with organic brain disorders or other medical ailments with no psychiatric problems who were placed in acute psychiatric.

Energy Crisis

California's energy crisis is another factor that could impact psychiatric hospitals. Escalating energy prices increase the operating cost of hospitals and could affect the closing of acute care beds and other services should a hospital not be able to cover the rising cost. One hospital interviewed noted that its electric bill last year was \$3 million. In addition, the hospital is entering this

year with a \$2 million dollar deficit. Another hospital noted that its large energy bill is financially impacting the hospital overall.

Rising Pharmacy Costs

As the population ages, technology advances, and pharmaceutical marketing initiatives grow, pharmacy demands and costs rise. According to a February 29, 2000 analysis by health policy expert Bob Laszweski,²⁶ spending on prescription drugs more than doubled from \$37.7 billion to \$78.9 billion between 1990 and 1997, with utilization driving much of this growth. The number of prescriptions filled in the United States was up 40% between 1992 and 1998.

The United States' elderly population will both increase the demand for pharmaceuticals and be hit hard by rising costs. The average utilization rate of pharmacy is two to three prescriptions per year for adults aged 25 to 44, while the rate of utilization grows to nine to 12 prescriptions per year for those age 65 and over. Other studies show prescription drug costs rising at a rate of 18%, which will soon outstrip the costs associated with hospitalizing a client.

A number of interviewees pointed to rising pharmaceutical costs as a possible cause of increasing losses from hospitals providing inpatient psychiatric care to Medi-Cal patients.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996 to protect the security and confidentiality of electronic health information. By February 26, 2003, doctors, hospitals and insurance companies must be in compliance with HIPAA requirements.

One concern is that, while HIPPA will enhance confidentiality measures, the overhaul will cost medical and psychiatric facilities heavily to reach compliance and avoid penalty fees. Some speculate that it will affect psychiatric services much harder than medical services. The U.S. government estimates the five-year cost of the privacy regulation alone to be \$3.8 billion.

²⁶ Laszewski B: Pharmacy Costs Rising at Record Rates; drkoop.com, February 2000.

Recommendations

Short-term recommendations:

1. Develop and strengthen partnerships and regional initiatives at multiple levels:
 - a. Establish discussions between DMH, CMHDA, and California hospitals through the California Healthcare Association (CHA) in order to identify steps that could be taken immediately and in the long run in order to improve the availability of hospital beds;

Several of those interviewed felt that there may be opportunities in the short term to open acute psychiatric beds. For instance, a number of licensed beds are closed due to staff shortages. If CMHDA and the members of CHA could agree on an adequate long-term rate of reimbursement for inpatient services and agree on the long-term need for a certain number of beds, this projected stability might allow hospitals to recruit staff more effectively.

One health care system partner that was very enthusiastic about this kind of discussion was Kaiser. Independently, several Kaiser interviewees expressed their wish that a joint meeting with CMHDA be set up as soon as possible.

- b. Establish a workgroup with providers of alternative services, such as crisis residential (California Association of Social Rehabilitation Agencies), crisis stabilization (CHA) and special residential treatment programs (children and adolescents, geriatric clients), to identify barriers to expansion of services and to create a statewide action plan to address those barriers;

It seems to be common knowledge among providers of hospital alternative services, that one of the greatest problems limiting the expansion of these services is a hostile regulatory and legal environment. Licensing standards, community review processes, etcetera, all make it increasingly difficult to provide services where they are

needed the most. The current crisis can also be an opportunity to highlight the need to address these problems in a comprehensive fashion.

2. Conduct a real-time inventory of beds to assess and monitor acute bed numbers and demand.

Although there are many compelling reasons for having mental health service planning take place at a local or county level, the crisis in acute beds in California illustrates the fact that there is also a need to develop statewide monitoring systems that can monitor access and availability of acute services. Development of a central system for tracking the availability of inpatient beds is proposed. The cost of developing and maintaining a web-based database of acute beds would be a small fraction of the multiple FTE's currently spent across all the mental health plans tracking hospital beds. Developing such a system should be a collaborative effort of DMH, CMHDA and CHA.

3. Conduct an assessment of administrative day beds to determine the types of alternatives needed to resolve placement needs.

A quality improvement workgroup should be appointed, involving consumer, family, provider and state and county representatives to identify the best way of describing the needs of clients who are currently on administrative days in California hospitals.

One such system is the Level of Care Utilization System (LOCUS) developed by the American Association for Community Psychiatry. This tool has been shown to have reliability and validity even when used by providers who have not received special training (as it would have to be if it were widely used in California).

4. Identify populations of clients in need of hospital alternative programs that do not currently exist (e.g., sub-acute psychiatric rehabilitation beds for behaviorally disordered adults with brain injuries; Therapeutic Behavioral Services or WrapAround for children).

A consequence of completing the previous recommendation would be the identification of well-defined (by care needs) client

populations that are unable to get their needs met within the existing programs. A few groups have been identified based on interviews, but this identification is somewhat reluctant because of the natural human tendency to overestimate the number of difficult to care for clients in any system. System planning can take place in a much more confident fashion when there is good data.

Alternatives developed must be fully integrated into an overall system of care to ensure that individual client needs are addressed as they change over time.

Long-term recommendations:

1. Open alternative placement programs. Consideration should be given to contracting with providers of existing programs.

Just as there needs to be collaboration with CHA, DMH and CMHDA need to develop collaboration with those organizations (for profit and not for profit) that provide alternatives to hospital care. One of the fastest ways of expanding this network would be to encourage existing providers who have successfully developed programs in one county to develop programs in other counties or regions. Further, there is a clear need for counties to implement a much more efficient process for developing specialized programs that are regional. The state should consider “loans” to MHPs, similar to the up-front funding for EPSDT, to allow counties to shift costs to community-based prevention programs.

2. Collaborate with the Department of Mental Health (DMH) in identifying regulatory and legal barriers to developing and implementing alternative programs and create a legislative agenda for change.

As noted above, there is a clear consensus that the various state and local mechanisms that regulate alternative programs are making it impossible to provide accessible, community-based care for California’s mentally ill. If it is to really address the needs of this population, the legislature needs to address this issue. With a consensus about the need for better care, now is the time to create a legislative agenda for change.

3. Work with DMH to clarify an appropriate audit mechanism for administrative day determinations, that is compatible with standards of practice in psychiatric hospitals and with HCFA regulations.

We consistently heard stories from interviewees about seemingly irrational guidelines for determining whether a day qualified as “acute” or “administrative.” One example is the issue of whether each day should “stand on its own” in a review. For a clinician, it is difficult to understand the logic of a review that ignores the severity of the illness on the preceding day in determining whether a patient should be released the next day. A large study completed by Steve Segal identified severity of illness on presentation to an acute service as the major predictor of early rehospitalization.²⁷

4. Strengthen the role of regional organizations of mental health plans in meeting the needs of acute psychiatric patients by developing special programs for community-based care.

One interviewee summarized this recommendation as follows: “A county driven system that encourages regional planning is what is needed.” Several others who were interviewed commented that there was a need for greater collaboration amongst counties in the existing system. CMHDA needs to carefully evaluate existing multi-county collaborations in order to identify the best ways of developing more such collaborative efforts.

5. Utilize partnerships to negotiate longer and more uniform contracts with hospitals.

In a highly consolidated market with a few very large hospital chains that have administrators who are quite skeptical about the economics of providing psychiatric inpatient services, it seems essential to have greater uniformity in financial arrangements between counties and these large chains. Otherwise, there will be more and more competition between counties to secure needed resources, without necessarily generating any interest in the kind of long term financial investment that is necessary to create new

²⁷ Segal, S. P., P. D. Akutsu, et al. (1998). “Factors associated with involuntary return to a psychiatric emergency service within 12 months.” *Psychiatr Serv* 49(9): 1212-7.

hospital beds. An analogy is the current power crisis in California: a short-term price increase is enhancing the bottom line of energy companies, but it isn't what is necessary to encourage the development of new generators.

6. Identify ways of reducing the administrative costs of operating hospitals by developing more standard and streamlined ways of accomplishing the goals of utilization review and ensuring that the least restrictive and most effective treatment is provided to clients.

One of the inefficiencies of a county-based system is the development of multiple incompatible utilization review systems. As noted above, this makes it difficult to generate useful information that can guide statewide planning. It is also inherently burdensome for providers.

If the workgroup were to select an instrument, such as LOCUS, for determining level of care, this would make it much easier for hospitals to meet the requirements of utilization review. It would also create a common language for describing client care needs that would make matching clients with the appropriate placement more likely in both the short and long term.

Data analysis recommendations:

Attempts to collect the relevant data were made in order to prepare this preliminary report. It quickly became apparent that the relevant statewide and county-specific data had likely never been previously used to perform an analysis of this type. A managed care data consultant noted that the data relevant to long and short term planning and negotiation does not appear to be centrally located.

With a lot of help, the authors were able to locate federal, statewide and county specific data in electronic format from a variety of sources. However, the current analysis of data remains largely incomplete due to time and financial constraints.

The authors recommend that future analysis include:

- Data from each of the 58 counties in California and the state.

- This data should include: utilization review data, cost data from public hospitals, as well as service utilization data.
- Data from each of the 58 counties in California and the state that is consistent in terms of the time periods of information to be reviewed. Several of the analyses that might have been useful could not be performed because the data sample only included some of the relevant years.
- Data for a wide range of levels of care, such as crisis residential and residential treatment, psychiatric rehabilitation and intensive case management. To really respond to a shortage in inpatient beds the next lower level of care needs to be analyzed in terms of availability.
- Data for all contracted and reimbursement rates, actual administrative and clinical costs, and the federal, state and county amounts budgeted for this care from governmental organizations, which would give a more complete fiscal picture.
- Data related to the impact of additional factors that affect acute services, such as staffing shortages, new state regulations (e.g., SB 1953 costs).
- Data related to hospital, unit and bed closings and openings in each of the counties.

In addition, as previously noted, one interviewee suggested that a phone survey of psychiatric emergency and crisis services in each county be conducted in order to identify times when there are significant delays in finding an acute psychiatric bed for a client in crisis. This could serve as an “early warning” system of impending shortages.

In order to use the data outlined above to guide planning, it will need to cover at least 3-5 years.

The collection of additional data will require the partnership of the California Mental Health Directors Association, the Department of Mental Health and the California Healthcare Association. The

authors recommend that these organizations also be involved in defining the scope of the project. By involving a variety of organizations in the beginning, the groundwork can be laid for creating an environment of mutual participation and interest.

Conclusion

In many ways the current report is the natural product of a mental health system in the early phases of adapting to the implementation of a county-based managed care system.

County-based planning has been very successful, but now the system needs to develop a greater capacity for statewide planning and service development.

The next step could not have taken place without the integration of the Short-Doyle and Fee-for-Service systems that preceded it.

Success in addressing the challenges identified in this report will require the same level of commitment, vision and inclusiveness that made Phase I and Phase II Consolidation possible.

Appendix A: Documents and Data Reviewed for This Report

<i>FORMAT</i>	<i>YEARS</i>	<i>MAIN CONTENT</i>	<i>ADDITIONAL CONTENT / NOTES</i>	<i>REFERENCE</i>
TABLE	2000 ONLY	CA HOSPITALS BY LOCATION & TYPE	BEDS BROKEN DOWN BY TYPE (IE PSYCH)	OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT, HEALTHCARE INFORMATION DIVISION, HEALTHCARE INFORMATION RESOURCE CENTER
BAR GRAPH	FY 97/8	LA ADMISSIONS AS % OF CA	LIMITED	FROM KARI YOSHIKAWA AT DMH.Q.STATE EMAIL
TABLES ELECTRONIC	FY 95/96 & 98/99	10 COUNTY SPECIFIC TABLES ON # OF ADMISSIONS & DAYS	BY DIAGNOSIS	CA HEALTH AND HUMAN SERVICES AGENCY, DMH
TABLES	2001	HOSPITAL SEISMIC PERFORMANCE RATINGS	BY COUNTY AND HOSPITAL	CA'S OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
TABLE AND GRAPH	94/5 – 99/00	INPATIENT DAYS STATEWIDE AND COUNTY SPECIFIC	PERCENTAGE OF INPATIENT DAYS BY M/C HOSPITALS AND I/P CONSOLIDATION HOSPITALS	CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY, DEPARTMENT OF MENTAL HEALTH FEBRUARY 2001
TABLE ELECTRONIC	FY 92-93	INPATIENT DAYS STATEWIDE AND COUNTY SPECIFIC	DAYS, TREATMENT DAYS AND ADMINISTRATIVE DAYS	
TABLE	1/95 – 6/95	STATEWIDE AND COUNTY SPECIFIC FOR IPC HOSPITALS	DAYS AND ADMIN DAYS	

TABLE ELECTRONIC	FY 98/9 & 99/00	STATEWIDE MEDICAL ADMISSIONS AND COUNTY SPECIFIC DATA FOR 7 COUNTIES	UNDUPLICATED CLIENTS, PERCENT OF CLIENTS IN INPATIENT, AVG # OF ADMITS, TOTAL INPATIENT DAYS AND AVERAGE INPATIENT DAYS	DMH: SHORT DOYLE MEDICAL APPROVED CLAIMS AND INPATIENT CONSOLIDATION FILES FAXED AND ELECTRONIC
TABLE & GRAPHS ELECTRONIC	FY 97/98 & FY 98/99	STATEWIDE MEDICAL ADMISSIONS AND COUNTY SPECIFIC DATA FOR 7 COUNTIES	READMISSION, AGE, DIAGNOSIS, CATEGORY, RACE, PROVIDER	
TABLE ELECTRONIC	FY 97/98 & FY 98/99	COUNTY SPECIFIC MEDICAL ADMISSIONS	NUMBER OF CLIENTS	
TABLE ELECTRONIC	FY 96/97 & 99/00	MEDICAL ADMISSIONS	BY COUNTY, BENEFICIARY AND AGE	
TABLE ELECTRONIC	FY 97 & 00	MEDI-CAL APPROVED DOLLARS	BY COUNTY AND TYPE OF SERVICE	
TABLE ELECTRONIC	FY 96/97 & 99/00	STATEWIDE MEDICAL DATA FOR SD MEDICAL AND INPATIENT CONSOLIDATION (IPC) BY 24 HOUR OR INPATIENT	AGE AND APPROVED DOLLARS	EMAIL FROM DMHQ
TABLE	1964-1999	STATEWIDE PUBLIC HOSPITAL CLOSINGS		CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS
TABLE	2000	CALIFORNIA HOSPITAL LOCATIONS		OFFICE OF STATE HEALTH PLANNING AND DEVELOPMENT WEBSITE http://www.oshpd.cahwnet.gov/
SURVEY	2001	SURVEY OF MENTAL HEALTH PLANS RE ACUTE SERVICES ACCESS	RESPONSES TO A SURVEY	CALIFORNIA MENTAL HEALTH DIRECTORS ASSOCIATION JUNE 2001

Appendix B: Organizations Contacted

- Department of Mental Health (DMH)
- California Healthcare Association (CHA)
- California Mental Health Directors Association (CMHDA)
- The California Association of Social Rehabilitation Agencies (CASRA)
- California Alcohol & Drug Program Administrators Council (CADPAC)
- A major private managed behavioral healthcare organization
- Kaiser
- Catholic Healthcare West
- The Lewin Group



The California Institute for Mental Health is a non-profit public interest corporation established for the purpose of promoting excellence in mental health. CIMH is dedicated to a vision of “a community and mental health services system which provides recovery and full social integration for persons with psychiatric disabilities; sustains and supports families and children; and promotes mental health wellness.”

Based in Sacramento, CIMH has launched numerous public policy projects to inform and provide policy research and options to both policy makers and providers. CIMH also provides technical assistance, training services, and the Cathie Wright Technical Assistance Center under contract to the California State Department of Mental Health.

Gateway Psychiatric Services consulted on this report. The mission of Gateway Psychiatric Services is to enhance the quality of psychiatric care by providing consultation to organizations delivering psychiatric services, professional education to mental health professionals, as well as support for research and direct patient care

For additional information on this report, contact CIMH at (916) 556-3480 or visit our web site at www.cimh.org.