Behavioral Health Care Policy Update

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California Hospital Association
Forward Motion: Driving the Future of Post-Acute Care

Behavioral Health Care Policy Update

Post-Acute Care Conference
January 30, 2015
Huntington Beach, CA
What is Behavioral Health?

- **Mental Health (MH)**
  - Schizophrenia
  - Schizoaffective disorder
  - Major depressive disorders
  - Obsessive-compulsive disorder
  - Bipolar disorder
  - Anorexia nervosa and bulimia nervosa
  - Panic disorder and anxiety disorder
  - Pervasive development disorder
  - Certain serious emotional disturbances of a child

- **Substance Use Disorders (SUD)**
  - Alcohol
  - Drug – illicit and prescription
What is Not Behavioral Health?

- Organic Brain Syndrome (OBS)
- Dementia
- Alzheimer’s
- Developmental Disability (a.k.a. intellectual disabilities/retardation)
- Traumatic Brain Injury (TBI)
Prevalence of Mental Health Disorders

• 1 in 4 adults – approximately 61.5 million Americans – experiences mental illness in a given year. 1 in 17 adults – about 13.6 million – live with a serious mental illness such as schizophrenia, major depression or bipolar disorder. Approximately 30% seek treatment (National Institutes of Health, National Institute of Mental Health).

• Approximately 20% of youth ages 13 – 18 experience severe mental disorders in a given year. For ages 8 to 15, the estimate is 13% (National Institutes of Health, National Institute of Mental Health).
Prevalence of Substance Use Disorders

• More than 8 million Americans are dependent on alcohol, or twice the number dependent on illicit drugs.
• Approximately 10% seek treatment.
• Alcohol is associated with 85,000 deaths in the United States annually and additionally with accidents, suicide, and abuse.
• The combined cost of alcohol abuse in the United States is $200 billion.
• 40% of all ED patients have alcohol in their system.

“Alcohol Withdrawal Syndrome,” by Richard W. Carlson, MD, PhD
Years Lived with Disability

Four of the six leading causes:
1. Depression
2. Alcohol use disorders
3. Schizophrenia
4. Bipolar disorder

Others:
• Cancer
• Cardiovascular disease

Individuals with serious mental illness (SMI) have a life expectancy up to 25 years shorter than those without SMI.
Causes of the Treatment Gap

- Stigma and discrimination
- Lack of health care coverage
- Insufficient services
- Inadequate linkages among services
- Inadequate behavioral health workforce: size and preparation
- Inability to communicate among and between provider types: hospitals and community providers
440 Hospitals in California

- **Inpatient Psychiatric Bed Data**
  - 2012 OSHPD Data
  - www.calhospital.org/PsychBedData
  - 6500 beds for 38 million people
    - 2300 beds in 26 Acute Psychiatric Hospitals (APH) – no physical health medical services
    - 3800 beds in 100 dedicated psych units in General Acute Care Hospitals (GACH)
    - 400 beds in 23 Psychiatric Health Facilities (PHF) – no physical health medical services
    - Does not include approximately 2000 beds in State Hospitals
Psychiatric Bed Loss

Between 1995 and 2012:

• Decrease of 24.3% in facilities
• Decrease of 30.1% in beds
• Increase of 19.9% in population
# County Breakdown

## Acute Care Inpatient Psychiatric Bed Distribution

Not all beds are available to individuals on LPS involuntary holds. Does not include data from state-operated hospitals.

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TOTALS

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County Breakdown

- 27 Counties have 0 Adult beds (54% of state)
- 47 Counties have 0 Child/Adolescent beds (81%)
- 56 Counties have 0 Gero-Psych beds (97%)
- 52 Counties have 0 Psych Intensive Care beds (90%)
- 50 Counties have 0 Chemical Dependency beds (86%)
- **27 Counties have NO inpatient psych services (54% of state)**
Bed Type Breakdown –
Adult Beds

132 facilities
5522 beds
27 counties without beds

Note: “Adult” beds are for those aged 18 and older. These beds are found in general acute hospitals (GACH), freestanding acute psychiatric hospitals (APH), and psychiatric health facilities (PHF).
Bed Type Breakdown – Child/Adolescent Beds

- **648 beds statewide**
- **70 for children under 12**

**Note:** Child beds and adolescent beds are not inter-changeable. A hospital may have a dozen adolescent beds, but zero child beds. There is no state definition regarding age ranges for child vs. adolescent beds. The definitions are hospital-specific, i.e., one facility may consider “adolescent” to mean ages 11 to 17, while another may consider it to be 12 to 17. However, because child and adolescent together are a single license category, OSHPD data does not reflect the difference between them. There are only 5 providers of child psychiatric services in the state and 28 adolescent providers, with 33% of the adolescent inpatient services providers also provide child services. No facility offers inpatient child services without adolescent services. An informal survey has revealed that there are less than 100 beds for children aged 11 and under requiring inpatient psychiatric services.

**Table:**
- **Total Facilities:** 28
- **Total Beds:** 648
- **Total Counties With Child/Adol:** 11
- **Total Counties Without Child/Adol:** 47
Bed Type Breakdown – Chemical Dependency Beds

24 facilities
860 beds
50 counties without beds

Total Facilities: 24
Total Beds: 860
Total Counties With CD: 8
Total Counties Without CD: 50
Additional Services – Hospital-Based – Medical Model

- PHP – Partial Hospital Programs – 5x/week
- IOP – Intensive Outpatient Program – 3x/week, Medicare/commercial insurance only
- Specialty Outpatient Programs
  - Vets
  - Eating Disorders
  - Addiction Services
  - Older Adult Transition Services
  - Suicide Prevention
  - Depression Screening
  - Mentors on Discharge
  - Teen Anxiety Management

The list is endless. Many are community benefit programs.
Community-Based Behavioral Health
Non-Hospital Based – Social Model

- Crisis Response Teams
- Crisis Residential
- Crisis Stabilization
- ACT – Assertive Community Treatment
- Respite
- Transport
- Supportive Housing
- Assisted Outpatient Treatment (AOT – Laura’s Law)
- Integrated Service Agencies
  - Medication Management
  - Risk Assessments
  - Counseling
  - Group Therapy
  - Employment Assistance
  - Home Visits
Percentage of Inmates with Mental Health Problems

Federal Prisons: 44.8%
State Prisons: 56.2%
Local Jails: 64.2%

Where Did All the Mental Health Services Go?

- Lack of public funding – federal & state level
- Provider abuse of publicly-funded systems
- 1991: California realignment of community-based mental health (VLF and sales tax)
- 1995: California consolidated Medi-Cal inpatient and community mental health
- 2004: Proposition 63 “Millionaire tax” – currently $2 billion/year
- 2005-2009: economy tanks – county-based services close for behavioral health and physical health, resulting in ever-increasing dependence on hospital EDs
- 2011: realignment again – currently $6 billion/year to counties
- 2012 – 2015: heightened focus on prison, jail, state hospital population reductions
- Voluntary, community-based services
Why Did All the Hospital Behavioral Health Services Close?

- Hospitals not being viewed as recovery-based
- Involuntary care not desirable, even though necessary
- Community model preferred over medical model
- Nurse-to-patient ratio mandates
- Seismic retrofit mandate – typically only revenue centers were built out
- Administrative burden working with 58 different county delivery systems – requires hospitals to have two systems
  - Separate coders and billers
  - Separate electronic health records
  - No electronic TAR
  - Workforce that has to compete with prisons, counties, and state hospitals – only 400 psychiatrists graduate annually in the U.S. and child psychiatrists require an additional year of residency
Additional Barriers

• Federal law – 190-day lifetime cap on inpatient psychiatric care and IMD exclusion rule (age 21-64, no federal matching funds) if patients are in a behavioral health facility of more than 16 beds or with 51% or more patients with psychiatric diagnosis
• Funding silos – state and county governments – trifecta of physical, mental, and substance use
• Care coordination and integration hindered by special protections of health information for mental health and SUD
• Four-quadrant treatment responsibility model – Medi-Cal patients – county mental health or physical health managed care
• Inadequate infrastructure – levels of care across the continuum – who is responsible?
New or Newer Opportunities

- Behavioral health now considered an essential health benefit (EHB) – Covered CA
- State and Federal Parity rules
- HMO and soon PPO access regulations
- Department of Mental Health (DMH) and Department of Alcohol and Drug abolished – duties assumed by Department of Health Care Services
- SBIRT (alcohol screening) now a covered benefit in primary care settings
- New voluntary inpatient detox as a covered benefit for Medi-Cal
- Efficacy of the community-based social rehabilitation model is being questioned and scrutinized
- New partners emerging – police, sheriff, highway patrol, EMS transport entities, schools, judges/courts, veteran services
Heads-Up – Action Needed

• IMPACT ACT – mandates (by Oct. 2016) the development of a standardized post-acute care assessment tool and the establishment of payment rates (2020) according to the characteristics of the patient.
  • Assessment tool, as described, DOES NOT adequately consider the socio-economic, psychosocial status, living situation, or lifestyle of the beneficiary
  • ACTION – Consider developing a risk assessment tool/process that works for your individual hospital to optimize positive outcomes for your patients
• PASARR – Preadmission Screening and Resident Review – major change to federally mandated screening process. New, automated IT system (web-based), implemented by DHCS Jan. 1, 2015. Goal is to discontinue paper-based process no later than June 30, 2015
Challenges for Post-Acute Care

- Patients are sicker and have multiple co-morbid conditions
- Increasing numbers being served with no social support system
- Emergence of unregulated community placement agencies
- More entities in the delivery system, learning as they go – don’t be enablers
- Most risk assessment tools lack in appropriate psychosocial areas
- Patients ready for discharge
  - Determining who’s responsible – hospital, health plan, county, conservator/guardian, regional system
  - Is the necessary level of care even available?
  - Crossing county lines to obtain services (seen one county/seen one county)
  - Social determinants for success
- Most outside of the hospital world don’t know what you do – interacting with new players
- Many think hospitals have excess resources and can augment the social needs of patients and communities

A WORD OF CAUTION – Fact-check hearsay before documenting – especially around disruptive behavior
Considerations for Tomorrow

- Community case workers – Are there any? Should there be?
- Mentors on Discharge – Have you considered engaging previous patients?
- Medi-Cal only patients – Are they eligible for Medicare? Are there resources to get them enrolled?
- Have you met your County Behavioral Health Director?
- Do you know what community services and supports are available for MH/SUD?
- Have you met the leadership team of your closest psychiatric inpatient hospital?
- What patient advocacy resources are you aware of?
- Get to know your political officials – City Council and Board of Supervisors and state legislative representatives

DEVELOP RELATIONSHIPS OUTSIDE THE WALLS OF THE HOSPITAL NOW – DON’T WAIT UNTIL THERE IS A PROBLEM
Behavioral Health Web-Based Resources Moving Forward

- Working with challenging behaviors – CHA ED Tool Kit
  www.calhospital.org/emergency-department-toolkit
- CA Department of Health Care Services
  - Mental Health www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx
  - SUD www.dhcs.ca.gov/services/Pages/DMCD-TreatmentProgram-Svcs.aspx
- NAMI California – find your local NAMI www.namicalifornia.org
- California Network of Care –
  california.networkofcare.org/splash.aspx?state=california
- County Department Behavioral Health – every county has one
- Disability Rights California – www.disabilityrightsca.org/
- SOAR - SAMHSA's SSI/SSDI Outreach, Access, and Recovery Technical Assistance (SOAR TA) – soarworks.prainc.com/
  - National project designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are homeless or at risk of homelessness and have a mental illness and/or a co-occurring substance use disorder.
  - PDF on Collaborating with hospitals
    www.ncceh.org/media/files/page/Hospital_Primer.pdf
Questions
Thank you

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