

MANAGING ACCESS TO INPATIENT CARE

Southern States Psychiatric Hospital Association (SSPHA) Conference Call.

December 12, 2006

3:00 p.m. – 5:00 p.m. EST

David Sofferin, GA, welcomed everyone and served as the moderator.

States participating: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, & West Virginia.

Defining the issues – short & long term implications of inpatient census crisis some states are facing

W. Russell Hughes, SC

Within the SSPHA, only Tennessee is under census system-wide; All but 7 states in US identified a need for more beds.

ISSUES:

- Bed need is related to availability of comm. services.
- Explosive growth in Forensics & encroachment into MH beds is big factor.
- States are contracting with private providers for care; due to lack of space in state facilities @ \$500/day versus state rate of significantly less.
- Older beds/facilities being closed and newer beds being opened
- Planning task forces are underway in several states to look at future needs (“crystal ball”); increasingly political situation – question: do we need more beds or more comm. svcs and how much of each.
- Reduction in numbers of private psych beds availability.

South Carolina’s Status:

- Closed all state hospitals but this has put pressure on acute care psych hospitals, especially with the longer-stay patients. This results in clogging in the acute care hospitals and leads to seeking ‘political’ solutions. The acute care hospitals are closing psych beds due to financial stresses.
- Adding 100 mostly forensic beds this year
- Safety issues due to overcrowding... so have turned to EMTALA to say “we don’t have ability to care for this person because we are too full.” Hope to expand residential facilities in community this year.
- South Carolina Hospital Association lobbied on our behalf in last legislative session

Kentucky’s Diverts Program

Steve Wiggins, KY

Data regarding KY:

- 4 state hospitals, 500 patients per day, with 65 hospitalized longer than a year; 160 admissions per month.
- Approximately 60% increase in admissions in past 6 years...
- Hospital budget went up only 5%...

- 2007: got \$2 Million increase because we couldn't continue to run 2600 admissions thru the existing program.
- 12.4% 30 day re-admit rate; 54% re-admit over time; 60% of admissions are d/c in six days

Diverts Planning Program

- NAMI, CMH Centers & state began planning effort re decreasing admissions
- Divide up the \$2M among 4 CMHCs to divert...?
- Set goal of no more than 180 admissions/month. CMHCs began planning how they could use the money to make that occur.
- They didn't agree to do same approach – just to divert people from state hospital.
- There is screening in KY prior to admission, and all CMHCs have crisis centers. There were gaps in psychiatry, follow-up care at discharge.
- Video tele-health network that included the CMHCs and hospital to make most of psychiatry
- Basic components of the effort were:
 - Step downs into CSUs
 - Divert
 - Follow-up after discharge
- In 5 months, have reduced admissions by 11%

Tenn. Use of telemedicine for prescreening hospital admissions

Richard Lee Thomas, TN

We aren't the experts on telemedicine but have experienced some success with it.

Telemedicine

- Reduced the number who arrive at hospital who didn't need to be admitted
- Five uses
 - When person is in emergency and we can assess from a distance
 - CMHCs clinics in rural areas
 - CMHCs working with emergency rooms for initial assessments
 - Predischarge screening from back at the CMHC
 - To get private hospitals to take emergency admissions, could use telemedicine to conduct court hearings

TN reduction in census issues is due to private hospitals taking more patients.

Texas Forensic Clearinghouse – an approach to managing demand for forensic services

James E. Smith

“Clearinghouse” list is a term used for the list of persons waiting for admission to a non-maximum security forensic state hospital bed and the Clearinghouse function is that of helping facilities and jurisdictions holding persons awaiting admission arrange hospital admission....

Texas MH system has been historically under funded...

- As the result, the number of staff doing centralized management of hospital system has decreased over the years.
 - For example, no central office staff are devoted exclusively to forensics
- Therefore, we use Executive Committee of the Governing Body and its committee structure to perform lots of functions that larger state offices do elsewhere.

We've been heroic in our work and as the result of our hospitals' effectiveness have garnered greater support of the legislature than the Comm. system has gotten in recent times. Nevertheless, we hope that any new resources that become available are used to support community services.

In past: per capita allocation of resources to MH Authorities. No cash changed hands, but set up "trust funds" for each regional area to "pay" for bed days. But certain areas were 'excused' – i.e., maximum security forensic services. More recently all inpatient forensic services have been excused or "exempted" from trust fund charges.

Forensic challenges

- Co-occurring disorders
- Use of non-forensic beds in order to meet forensic beds
- Early 1990s – 6% of beds were occupied by forensic pts.
- Now – 31% are forensic
- Don't have much comm.-based competency restoration happening.
- Had big waiting list for forensics even though we had capped forensic beds at 30%
- Forensic waiting list = 120 people on Clearinghouse list within a year of opening new beds. Max Security waiting list remains at approximately 125..
- Made a stand: defining what forensic capacity will be... but then the waiting list for non-maximum security forensic beds kept growing
- Have recently had to again make civil beds available for forensic admissions.

Clearinghouse is a function, not a place. How it works:

- Court calls The Clearinghouse, gives basic info and the person goes on the List.
- Track how many in queue waiting for admission.
- How many will be moving out of a bed? Each forensic unit prospectively identifies anticipated vacancies.
- Book the beds in advance based upon anticipated availability.
- Cluster admissions so that travel is minimized due to the largeness of the state.

Results: the waiting list came down, but then went back up again, so opened civil beds for non-max security forensics AGAIN and, guess what, they filled up.

But, real improvements have happened:

- Consistent assessment of dangerousness have been instituted
- Consistency in restoration to competency – same model of services/curriculum
- Use of tele-video to offset the need for jurisdictions to travel for some court proceedings.
- System of forensic services is underpinning guiding principles.

West Virginia's Use of private hospitals in managing demand for public services
Jack Clohan

History in WVA: In 1995 had mostly deinstitutionalized in this state and good community services.

NOW:

- Census is up
- Waiting list for forensics but by court order can only keep them in jail for 30 days.
- Demand for Forensics has limited civil beds
- 60/69 months have been above census

So – State reached out to private psychiatric community...

- Partnering with 13 private psych hospitals around the state, to serve diverted patients who are involuntary civil commitments.
- If no state hospital bed open, then the local CMHC contacts one of the local private hospitals and state pays as payer of last resort.
- 30% of these admissions have Medicaid or other 3rd party payer.
- 78 diverted patients as of today; more admissions to diverted private psych hospitals than state hospitals
- Currently paying \$580 to \$1200 /day depending on patient and hospital. \$580 is a bit under their state hospital cost per day and will be their new contracted rate except in certain cases.
- This isn't a SOLUTION – just a response to the need.
- Private hospitals have been expanding their beds to address the 'opportunity' to treat this population.

15 Beds per 100,000 population is a formula he quoted for estimating the proper number of beds for the state.

Other strategies WVA is currently using:

- Community Care Coordinators = to reduce re-admissions and keep people in the community.
- Using Crisis Unit for step-down into community

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David Sofferin mentioned the following:

- **New website: www.sspha.com. Please be sure to check the web site on a regular basis for updates.**
- **Invoices have been mailed to each member hospital. If you are not certain if you have paid your dues please check the web site.**

Jim Smith asked for ideas/suggestions for future "Meet-Me-Calls." Please give your ideas to the board member representing your state.