

**Utah State Hospital Funding
Study Group Report**

**Social Services Appropriations
Committee**

January 11, 2011

TABLE OF CONTENTS

Executive Summary	Page 3
Appendix 1 Study Group Membership and Meeting Dates	Page 10
Appendix 2 State Law	Page 11
Appendix 3 USH Admission, Treatment and Discharge Process	Page 12
Appendix 4 Options Considered	Page 14
Appendix 5 USH Statistics for Patients Served	Page 18
Appendix 6 USH General Fund Distribution Chart	Page 22

EXECUTIVE SUMMARY

The mission of the Utah State Hospital (USH) is to provide inpatient psychiatric treatment for adult patients, age 18 and older (UCA 62A-15-610)(2)(a); treatment for children ages 6 – 18 (UCA 62A-15-610)(2)(b); and adult forensic treatment for patients admitted through the district court (UCA 62A15-902)(2). The adult and pediatric beds are allocated to the 13 Local Mental Health Authorities (LMHA's) per statute (UCA 62A-15-611).

In 2010, the Legislative Fiscal Analyst for the Department of Human Services (DHS), conducted an in-depth budget review of DHS and presented the findings to the Health and Human Services Interim Committee on November 18, 2010 in the document titled "Human Services In-depth Budget Review Recommendations and Follow Up." One of the recommendations of the Analyst was:

3. The Analyst recommends the department realign priorities and decision making by moving USH funding to local governments since they are responsible for hospital placements. The department and county authorities should provide two or more options to the Analyst by November 1, 2011.

The department passes state and federal funding through to local county authorities, who then manage mental health services. However, county authorities manage USH placements, but not the funding. While the state does not manage the placements, it does pay for the costs. This creates a disincentive for local authorities to consider costs when making USH placements.

As a result of the recommendation by the Legislative Fiscal Analyst and the Social Services Appropriations Committee, the Legislature passed the following intent language:

Intent Language

The Legislature intends that DHS report back during the 2012 General Session, its progress regarding the following items found in the document titled Human Services In-depth Budget Review Recommendations and Follow Up affecting the department's FY 2012 appropriated budget as reported to the Social Services Appropriations Subcommittee on February 3, 2011; item numbers 1, 2, 3, 6, 7, 9, 10, 11, 13, 14 and 15 of the Selected Major Recommendations and numbers 1, 2, 4, 5, 8, 9, 10, 11, 12, 13 and 14 of the Remaining Recommendations (SB2).

Background

The DHS convened a Study Group comprised of Department staff, senior leadership staff of LMHAs with representatives from diverse parts of the state, county commissioners, and other stakeholders to analyze funding strategies for the USH (See Appendix 1 for a list of Study Group

members and meeting dates). The legislative mandate was to determine if and where disincentives exist, and to determine how funding and placements should be aligned to meet the needs of the individuals served by the USH and to utilize available resources in the most cost effective manner possible.

In order to determine if the basic premise of the study that “a disincentive for local authorities to consider costs when making USH placements” exists, the current process of admission and discharge to the USH was evaluated. The assumption that financial incentives are not aligned properly and that the LMHAs might utilize the USH for inpatient services in order to avoid costs in other private acute care settings is false. There are currently system controls in place to ensure integrity in the utilization of state hospital beds as demonstrated in Table I below:

Table 1

USH ADMISSION AND DISCHARGE PROCESS							
FY2011							
LMHA	STATUTE/COMMITMENT	REFERRALS	ADMISSIONS	UTILIZATION REVIEW	DECERTIFICATION	DISCHARGES	ARBITRATION
Bear River (Box Elder, Cache, & Rich counties)		5	5		1	9	
Weber (Weber County)		19 (1 malingering-deemed not appropriate & 1 patient did not meet criteria for admission)	17			20	1
Davis (Davis County)		10	10		1	15	
Wasatch (Utah County)		11	11		2	13	1
Central (Juab, Millard, Sanpete, Sevier, Piute, & Wayne counties)		1	1			4	
Southwest (Beaver, Iron, Washington, Garfield, & Kane counties)		14 (1 patient on dialysis- not medically cleared)	13			14	
Northeastern (Duchesne, Uintah & Daggett counties)		5	5		1	4	
Four Corners (Carbon, Emery, & Grand counties)		4	4			4	
San Juan (San Juan County)		0	0			1	
Heber Valley (Wasatch County)		1	1			2	
Valley (Salt Lake, Summit & Tooele counties)		73 (1 DSPD candidate and 1 did not require this level of care)	71		2	91	

Statutes have been written establishing these controls throughout the continuum of the Admission and Discharge process for the USH. UCA 62A-15-602(8) defines mental illness and UCA 62A-15-631(10) outlines the civil commitment criteria, both of which address pertinent requirements for admission. UCA 62A-15-610 specifically defines the admission criteria for the USH. Rarely do the LMHA's refer an individual to the USH who does not meet these criteria. The USH is certified by the Center for Medicaid and Medicare Services which also requires a utilization review process to ensure that a person needs inpatient services and that active treatment is being provided. Patients not meeting these requirements are de-certified and discharge processes are implemented. The LMHAs and the USH work collaboratively to discharge patients to the appropriate community treatment setting.

Whenever disagreements arise in regards to discharge readiness or placement, Arbitration Guidelines are established that direct levels of negotiation to resolve the conflict. The Director of the Division of Substance Abuse and Mental Health (DSAMH) has final authority to make disposition decisions. Arbitration occurs infrequently in that the system currently works very efficiently. The system controls keep patients moving through the continuum of care as well as ensures appropriate placement at the USH.

There would be a disincentive for the LMHAs to leave patients at the USH for financial gain because the acute inpatient psychiatric beds in their communities are more costly compared to USH bed day rates, and it is more beneficial for the LMHAs to keep patients who need inpatient care moving through their allocated beds as opposed to creating a back-log of patients waiting for USH beds. Since the time that this recommendation was made by the Legislative Fiscal Analyst in the In-Depth Review, the appropriation to the USH was reduced by the Legislature in an amount that required closing 30 adult civil beds.

LMHAs have adjusted their bed usage not through increased hospitalization in private facilities, but by adopting a philosophy focused on keeping consumers in an independent setting (often their own or a shared residence) and using hospitalization only for those extreme cases which require 24-hour supervision. In many cases, the LMHAs involve less extreme, need-specific resources and acts as a case manager in the community with the goal of avoiding hospitalization. Seven (7) Adult Residential Support Units operate throughout the State to help people coming out of USH/acute inpatient and to divert them from the hospital by providing services in the least restrictive setting possible.

Process

The Study Group began its work with a basic set of assumptions, which include the following:

- All possible options, including the status quo, would be carefully and objectively evaluated;
- Utilization of the intermediate inpatient beds for adults and pediatrics at the USH is a scarce resource which should be used only when absolutely necessary;
- Whenever possible, adults and children should be treated in their communities. Utilization data, based on population, was obtained for both adults and pediatrics to determine if Utah's utilization of the USH is lower or higher than other states around the country;

- Existing resources to develop the infrastructure for alternative community resources such as ACT team and Mobile Crisis Services are inadequate, particularly for patients who are not funded by Medicaid;
- All decisions would be based on verifiable data sources, including local and national data; and
- External expertise and resources would be sought as needed to inform the Study Group.

During the initial phase of the discussions, the following four options were identified as possible recommendations from the Study Group. They were:

- Option 1: Decentralize General Fund to LMHAs and Maintain Current Bed Allocation;
- Option 2: Decentralize General Fund to LMHAs and Discontinue Bed Allocation Formula;
- Option 3: Change Civil Commitment Back to the State; and
- Option 4: Leave Current System of Funding in Place.

Each of the four options was explored in great detail with both the positives and the negatives of each option highlighted. Data, including potential financial implications, was collected for each of the options. The detailed analysis of each option is available in Appendix 4.

In order to determine whether or not there is a fiscal incentive for LMHAs to inappropriately admit or delay discharge of a patient at the USH, the process involved in an admission was reviewed and is detailed in Appendix 3.

The Study Group also invited representatives from NAMI-Utah to present NAMI's position to the Study Group in order to obtain concerns from the broader advocacy community.

Findings Influencing Study Group Recommendations

- Utah has the fourth lowest utilization of adult civil beds in the country;
- Utah successfully treated 29,489 adults in 2011 in the community, and only 219 adults were admitted to the USH;
- The average cost for an adult bed at the USH in 2011 was \$409 compared to \$900-\$1200 in one of Utah's community acute care psychiatric unit;
- Utah successfully treats more than 15,500 children annually in the community. Only 109 children have been hospitalized at the USH for both of the last two fiscal years. Also, the lengths of stay for pediatrics on all three units at the USH have dropped dramatically over the past four years;
- Utah has the 13th lowest utilization of pediatric beds in the country. All 12 states with admission rates lower than Utah have coverage in their State Medical Plans for psychiatric residential treatment facilities (PRTFs), while Utah does not. A PRTF is any non-hospital facility with a provider agreement with the State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21 (psych under 21 benefit). The criteria for admission is equivalent to the inpatient criteria at a state hospital and PRTFs must meet the requirements in §441.151 through 441.182 of the CFR; and

- LMHAs have aggressively developed responses and service delivery options that have led to a decrease in bed usage over time and have enabled their communities to weather reductions in funding for the USH without negative social impacts.

Bed Utilization Efficiencies Department of Human Services

The USH has implemented best practice models and operational efficiencies to promote decreased lengths of stay and improve bed utilization. Since Utah has less state hospital beds per capita than most states, the LMHAs understand the importance of the limited resource. Patients referred to the USH are the most seriously ill and the USH programming is designed to address the needs of this higher acuity patient. Decreased length of stays and improved bed utilization efficiencies have been accomplished through the following:

- Best practice treatment modalities including specialized treatment tracks and Treatment Mall programming;
- Bed over-utilization programming to accommodate LMHA bed needs and prevent waiting lists;
- Implementation of the 2007 Legislative Audit recommendations;
- Improved coordination with Court systems to decrease waiting list time with forensic patients;
- Enhanced monitoring of outplacement monies from DSAMH; and
- High-level staffing processes to streamline communication with other agencies and maximize discharge options for patients.

Bed Utilization Efficiencies Local Mental Health Authorities

Bed usage over time demonstrates an increasing use of community based treatments and an effort to avoid hospitalizations. LMHAs have developed six (6) teams based on the Assertive Community Treatment (ACT) model. For example the “Bridge Team” operated by Wasatch Mental Health in Provo consists of a Psychiatrist with experience in ACT services, a nurse, case manager and therapist who is also the team lead. The team currently serves thirty (30) individuals and was first created in August 2009. The Bridge Team is focused on serving clients who have accessed local and state psychiatric hospital services at least twice in the last year. Many of the clients are also under an order of civil commitment or have been released from jail within the last year. The majority of the clients have diagnoses of Schizophrenia, Schizoaffective Disorder or Bi-Polar Disorder with psychotic features. The goal of the program is to decrease the frequency and duration of the USH, acute-care inpatient hospitalization and aid the client to transition off of civil commitment. It is expected that the Bridge Team will serve people for a minimum of one (1) year. Individuals will be transitioned back into standard outpatient services when the client and the team feel they have maximum benefit from the program.

For children, Family Resource Facilitation with Wraparound to Fidelity, brings families and community partners together to work on behalf of children whose mental health needs impact education, juvenile justice, child welfare and other community partners to help families find or develop skills, services and resources necessary for intervening early to prevent or ameliorate

symptoms and out of home placements. This has been an effective way to help children and youth transition back into the community and divert others from inpatient care.

NAMI Input

Sherri Wittwer, Public Policy Consultant and Legislative Liaison and Rebecca Glather, Executive Director of NAMI provided the following feedback to the Study Group:

- Recognized the need for and appreciates what the USH does;
- Indicated they actively lobbied for funding for the beds at the USH in the 2012 Legislative session;
- Challenged the committee to demonstrate that we can reinvent the system and that we can look for innovative cost-saving models in these austere times;
- Supports LMHAs control of state general fund dollars with appropriate oversight, reporting requirements and a list of specific treatment alternatives to hospitalization such as ACT, wraparound to fidelity, and mobile crisis teams;
- Supports the maximization of Medicaid by allowing LMHAs to use the USH state general fund dollars to fund alternative services to hospitalization at the local level;
- Supports the exploration of options with the Department of Health for Home and Community Based services waivers;
- Noted that providing treatment in the community is a more cost effective and less traumatic alternative to hospitalization for adults and children;
- Stated that the LMHAs have the perverse incentive of “free beds” at USH; and
- Encouraged LMHAs to develop partnerships with their local jails and prisons because legislators are receptive to reducing the costs of incarceration.

Recommendations

After careful consideration, the Study Group recommends:

- Continue to appropriate funding directly to the USH at the current level;
- Fund the DSAMH requested building block (Mental Health Early Intervention in the Governor’s Budget) for the expansion of early intervention and prevention home and community-based services for children and youth;
- Increase funding for mental health services overall in order to support the development of infrastructure to support community based services;
- Increase funding for community support services, specifically Assertive Community Treatment Teams (ACT) or ACT-like teams in Utah in order to support individuals with serious mental illness in the community while maintaining funding for the state hospital at the current level; and
- If the Legislature chooses not to accept the Study Group recommendations, a funding transfer should only be considered after careful review and study of the possible negative consequences on patients and the mental health service delivery system in Utah. Some of the areas of study would include:
 - Assurance that funding for inpatient services “will follow the patient” and will result in the development of appropriate diversionary services in communities across the State;

- Statutory changes necessary to ensure appropriate oversight of the inpatient resources;
- Identify and plan for the diverse alternatives to hospitalization treatment and funding needs across the state; and
- Identify the appropriate State resources necessary to build infrastructure in the local communities where specialized diversion services are needed, but the existing allocation of USH resources would not be sufficient to meet the need.

Summary

DHS convened a Study Group comprised of senior leadership staff of the LMHAs, County Commissioners, Department staff, Consumer Advocacy Organizations and other stakeholders to analyze the assumption that a disincentive for local authorities to consider costs when making USH placements exists, and to study various funding strategies for the USH. The Study Group concluded that the initial assumption that financial incentives are not aligned properly and that the LMHAs might utilize the USH for inpatient services in order to avoid costs in other private acute care settings is false.

Four options were carefully reviewed, and the recommendations of the Study Group are detailed above. The Study Group noted that current funding for the mental health service delivery system, particularly for adults and children who are not eligible for Medicaid, is inadequate to build the necessary infrastructure for more community-based services. The lack of infrastructure is particularly apparent in the rural and frontier areas of the State. The following quote from a 2011 National Alliance on Mental Illness report highlights many of the concerns raised by the Study Group.

“History illustrates that eliminating hospital beds without appropriate community alternatives is cruel, irresponsible public policy and leads to shifting of costs to criminal justice systems and emergency departments rather than true cost savings. The development of a strong infrastructure of community-based services will decrease the need for inpatient beds in some cases, but this infrastructure is today inadequate in most places. A range of options for responding to youth and adults in crisis is needed, including mobile crisis teams, 24-hour crisis stabilization programs, and inpatient beds in community hospitals. It is also important to preserve beds in state hospitals, particularly for those individuals requiring intermediate or long-term care.” *NAMI State Mental Health Cuts: A National Crisis, A Report by the National Alliance on Mental Illness March 2011.*

Appendix 1 Study Group Membership and Meeting Dates:

Adam Trupp, Utah Association of Counties-Legal Counsel and UBHC Director
Randy Bates, Chair – Utah Behavioral Healthcare Committee (UBHC) Finance Directors
Kyle Snow – Executive Director/CFO – Northeastern Counseling Center
Bill Cox – County Commissioner – Rich County
P. Bret Millburn – County Commissioner – Davis County
Mike Deal – Executive Director/CFO – Southwest Behavioral Health Center
Bruce and Ruth Smith – Utah County NAMI members/Utah State Hospital Governing Body
Gail Rapp – Assistant Director – Division of Medicaid & Health Financing – Utah Department of Health
Lori Cerar – Executive Director – Allies with Families/Utah Family Coalition
Tim Whalen, Deputy Director – Salt Lake County Behavioral Health
Kevin Eastman, Executive Director – Weber Human Services
Mark E. Ward, Deputy Director - Department of Human Services
Lana Stohl, Director, Division of Substance Abuse and Mental Health (DSAMH)
Dallas Earnshaw, Superintendent, Utah State Hospital
Doug Thomas, Assistant Director – Mental Health, DSAMH
Paul Korth, Administrative Services Director, DSAMH

Meeting Dates:

May 17, 2011
June 27, 2011
July 11, 2011
August 11, 2011
September 8, 2011 (Rescheduled)
November 10, 2011
January 11, 2012

Appendix 2 State Law

62A-15-603. Administration of state hospital -- Division -- Authority.

(1) The administration of the state hospital is vested in the division where it shall function and be administered as a part of the state's comprehensive mental health program and, to the fullest extent possible, shall be coordinated with local mental health authority programs. When it becomes feasible the board may direct that the hospital be decentralized and administered at the local level by being integrated with, and becoming a part of, the community mental health services.

(2) The division shall succeed to all the powers, discharge all the duties, and perform all the functions, duties, rights, and responsibilities pertaining to the state hospital which by law are conferred upon it or required to be discharged or performed. However, the functions, powers, duties, rights, and responsibilities of the division and of the board otherwise provided by law and by this part apply.

(3) Supervision and administration of security responsibilities for the state hospital is vested in the division. The executive director shall designate, as special function officers, individuals to perform special security functions for the state hospital that require peace officer authority. These special function officers may not become or be designated as members of the Public Safety Retirement System.

(4) Directors of mental health facilities that house involuntary detainees or detainees committed pursuant to judicial order may establish secure areas, as prescribed in Section **76-8-311.1**, within the mental health facility for the detainees.

Appendix 3 Utah State Hospital Inpatient Psychiatric Treatment Admission, Treatment and Discharge Process

- The mission of the USH is to provide inpatient psychiatric treatment for adult patients, age 18 and older (UCA 62A-15-610)(2)(a); treatment for children ages 6 – 18 (UCA 62A-15-610)(2)(b); and adult forensic treatment for patients admitted through the district court (UCA 62A15-902)(2);
- The adult and pediatric Beds are allocated to the 13 LMHAs per statute (UCA 62A-15-611);
- All adult USH patients are treated at the USH under a civil commitment status (UCA 62A-15-628/637). The actual commitment is to the LMHA (UCA 62A-15-631). More importantly, the individual is reviewed by the civil court on a regular basis to determine if they continue to meet the commitment criteria (UCA 62A-15-638). The maximum time period a person may go before their next review is six months. This process also ensures that any person at the USH is not being held involuntarily in a restrictive setting without meeting the legal commitment criteria defined in statute. Patients who do not meet commitment criteria are released by the civil court and discharged from USH;
- Each LMHA assigns a liaison who works directly with USH to make referrals for admission and assists with discharge planning;
- Adult admissions are coordinated through the USH Admissions Office which screens all referrals to ensure appropriateness for admission according to specific criteria outlined by Statute and required by Center for Medicare and Medicaid Services (CMS);
- Children and youth referrals are made to the Pediatric Service Management Team to ensure appropriateness for admission through a similar screening process;
- Medicaid requires that all patients (certified Medicaid and non-Medicaid eligible patients) receive the same level of care and requires active treatment that demonstrates progress towards discharge. Inpatient psychiatric hospitals are required to demonstrate an effective utilization review program to assess for appropriateness of ongoing inpatient services and certification of stay for each patient. A Utilization Review (UR) Program has been developed at the USH that is nationally recognized as one of the leading UR programs in the country. The UR process ensures appropriateness of admission, quality of care and active progress towards discharge for each patient. Patients who do not meet the standards reflecting active levels of treatment are decertified (their commitment is dropped and the patient is discharged) and Medicaid can no longer be billed. LMHA's and the USH work closely together to ensure appropriate treatment and discharge plans are identified for all patients;
- The liaisons from each LMHA and representatives from USH meet in a monthly "Continuity of Care" meeting to address the needs of patients who are placed on a discharge list and who have special or unique treatment needs to be considered in order to be placed in the community;
- A Readiness Evaluation and Discharge Implementation (REDI) program has been developed by DSAMH to track progress towards discharge for USH patients and identify barriers to discharge. These barriers are addressed at monthly Continuity of Care meetings with the LMHAs and the USH Staff; and

- When a disagreement exists between the USH and the LMHAs in regards to a patient’s “readiness for discharge or disposition for placement” an arbitration process is utilized that was developed by the Continuity of Care Committee and approved by the DSAMH and the LMHA Directors. Levels of negotiation include discussions with the treatment staff from the agencies responsible for the patient’s treatment and discharge. If the treatment teams are unable to resolve the issue, the Director of the DSAMH assigns a committee of clinicians and administrators from the responsible agencies to address the concerns. If the committee is unsuccessful, the case is referred to the Clinical Directors of the Hospital and the LMHAs to discuss the case and attempt a resolution. If this is unsuccessful, the case is referred to the Director of the DSAMH who has authority for final disposition.

Appendix 4

OPTION #1 – Decentralize General Fund to LMHAs and Maintain Current Bed Allocation				
PROS	CONS	DATA	IMPLICATIONS	OVERCOMING BARRIERS
<p>Realigns incentives.</p> <p>Potential to leverage Medicaid funding for adults.</p> <p>Allows more flexibility in programming for the LMHA's.</p> <p>Provides the possibility for development of new programs by the LMHA.</p> <p>Counties have more control of funding from the State General Fund.</p>	<p>Increased financial risk to the state and the LMHA.</p> <p>USH bed rates will increase to cover costs of operation and loss of economy of scale.</p> <p>Each area of the State presents unique challenges in developing programs.</p> <p>The Pediatric units are funded by institutional Medicaid, very limited GF dollars would be moved to the community.</p> <p>Current statute does not ensure that commensurate community-based resources will be developed or available to clients throughout the State.</p> <p>No incentive to treat clients unless dollars are required to "follow the person".</p> <p>Creates a more complex system for the clients.</p> <p>Smaller counties will not receive enough General Fund to provide appropriate community-based services.</p> <p>Potential for new programs is offset by potential increase in community inpatient/residential facility costs.</p> <p>Significant probability (based on historical data) that the counties could lose funding through the legislature in future years jeopardizing mental health programming.</p>	<p>Incentives are aligned in Iowa where counties use property taxes to pay 80% of the cost of inpatient state hospital days for adults. However in 2010, seven counties in Iowa have had to adopt waiting lists for mental health services due to "shrinking budgets"</p> <p>Pennsylvania requires the counties to manage their utilization of bed days at their state hospitals—very similar to Utah's bed allocation. To incentivize the counties to use fewer state hospital bed days, money accompanies the patient discharged from the state hospital so that services can be provided in the community, resulting in the closure of three state hospitals and a decrease in access to inpatient specialty care.</p> <p>Texas decentralized on a regional basis. Yearly bed allocation contracts were pre-negotiated to ensure fixed overhead costs were covered at the Hospital. One region used their allocated money for community services which resulted in the closure of 40 beds at their regional state hospital. (Texas has 2484 state hospital beds.) The region later realized the need for the 40 beds still existed along with the community programming but were unsuccessful in obtaining funding to restore the hospital beds.</p> <p>Ohio has decentralized to align incentives with 7 State Hospitals and 61% more beds than Utah. The Associated Press reported in October 2010 that Ohio's mental health system, once a national model, was now on the verge of collapse.</p>	<p>Funding and authority are aligned.</p> <p>Closure of additional state hospital beds OR increased cost per bed day at USH.</p> <p>Counties have to match General Fund money up to 20%.</p> <p>Need additional funding sources for rural counties to fund inpatient care.</p> <p>Need for increased workforce development in rural areas.</p> <p>Restructuring of USH to include fiscal operations and staffing.</p> <p>Rewrite statutes in Utah Code Annotated.</p> <p>DSAMH would have to revise Area Plans to address quality of services delivered with the new money from the bed allocations.</p>	<p>Develop contracts between USH and LMHA's for base operations of USH.</p> <p>Increase DSAMH staff and oversight to monitor LMHA development of crisis services for accessibility and outcomes.</p> <p>Consider restructure of rural MHA's to consolidate resources and funding.</p> <p>Collaborate closely with Higher Education and Federal programs such as WICHE and NHSC to provide incentives for professionals to work in rural areas.</p> <p>Consider funding formula revision to address disadvantage of rural centers in providing high cost care.</p> <p>"Managed care systems established primarily to cut costs but not improve services can be particularly risky for vulnerable children and adults living with serious mental illness. Thus, if these systems are to be adopted, they must be designed and implemented carefully, with particular focus on ensuring that vital inpatient and community services for people living with serious mental illness are accessible and adequately funded." <i>NAMI State Mental Health Cuts: A National Crisis A report by the National Alliance on Mental Illness March 2011.</i></p>

OPTION #2 – Decentralize General Fund to LMHAs and Discontinue Bed Allocation Formula

PROS	CONS	DATA	IMPLICATIONS	OVERCOMING BARRIERS
<p>Incentives would be aligned with the money.</p> <p>Potential to leverage Medicaid funding for adults in the community.</p> <p>LMHA's have additional control of funding from the State General Fund which provides the possibility for development of new programs.</p> <p>Eliminates inefficiency of allocation system.</p>	<p>Each area of the State presents unique challenges in developing programs.</p> <p>Smaller counties would not receive enough resources from the General Fund to develop new programs.</p> <p>Decreased accessibility to USH inpatient beds for entire State if some LMHA's choose not to purchase beds at USH.</p> <p>Increased cost for USH inpatient services due to loss of economy of scale.</p> <p>No assurance that appropriate resources will be available to clients.</p> <p>No incentive to treat clients without attached funding.</p> <p>Minimal General Fund dollars move to LMHA's for pediatrics.</p> <p>Pediatrics would lose USH inpatient Medicaid eligibility.</p>	<p>The State of Ohio in 1988 passed the Ohio Mental Health Act which, over a period of a few years, reconfigured the mental health budget system into an "incentive based" program and shifted the budget to the Local Mental Health Boards from the State Hospitals. What was once considered a "Model Program" for De-centralization has now resulted in the following:</p> <ul style="list-style-type: none"> i. The Ohio system closed multiple state hospital beds due to de-centralization resulting in increased homelessness and incarceration of people with mentally illness. ii. Ohio hospitalizes individuals at a higher rate (30% higher) per capita than Utah. iii. In 2010 the Associated Press reported the Ohio System is on the "Verge of Collapse". <p>ACT teams started in Wisconsin in 1972. Stats comparing Wisconsin with Utah in 2006 and 2008 show no difference in use of state hospital beds or in funding:</p> <ul style="list-style-type: none"> • 22% of adults receive services in both states. • 28% of state budget goes to state hospital in both states • Major difference is in cost of housing - 71% of SSI in Wisconsin and 86% of SSI in Utah. <p>In 2004, 500 of 1500 Connecticut children were receiving services in out-of-state facilities which cost \$30,000/year more than in-state services because of a lack of pediatric beds in Connecticut.</p> <p>Texas partially decentralized their state hospital budget by assigning all fixed administrative costs to the 9 state hospitals and decentralizing the clinical costs to the mental health centers or regions. All the regions or mental health centers meet yearly to contract the number of beds to be purchased at the state hospitals. The larger centers used their money for community services leading to a closure of 40 state hospital beds (Texas has 2484 state hospital beds). Later they needed the hospital beds and went to the legislature for the money to purchase state hospital beds and were turned down. During FY 2010, the system was on diversion (meaning at least one of the State Hospitals was unable to accept admissions) 40 percent of the time and had approximately 400 clients waiting in jail for a state hospital bed.</p> <p>Colorado's mental health system requires the regional behavioral health organization to contract with the state for provision of services. The BHO's have a bed allocation at the state hospitals for the uninsured but must pay for admission of Medicaid individuals to state hospitals.</p>	<p>Funding and authority are aligned.</p> <p>Closure of additional state hospital beds or increased cost per bed day at USH.</p> <p>Counties would have to match the increase in General Fund money at 20%.</p> <p>Need additional funding sources for rural counties to fund inpatient care.</p> <p>Need for increased workforce development in rural areas.</p> <p>Recruitment and retention plans change to match operational changes at USH.</p> <p>Rewrite statutes in Utah Code Annotated.</p> <p>DSAMH would have to revise Area Plans to address quality of services delivered.</p>	<p>Develop contracts between USH and LMHA's for base operations of USH.</p> <p>Restructuring of USH to include fiscal operations and staffing.</p> <p>Increase DSAMH staff and oversight to monitor LMHA development of crisis services for accessibility and outcomes.</p> <p>Consider restructure of rural MHA's to consolidate resources and funding.</p> <p>Collaborate closely with Higher Education and Federal programs such as WICHE and NHSC to provide incentives for professionals to work in rural areas.</p> <p>Consider funding formula revision to address disadvantage of rural centers in providing high cost care.</p>

OPTION #3 – Change Civil Commitment Back to the State

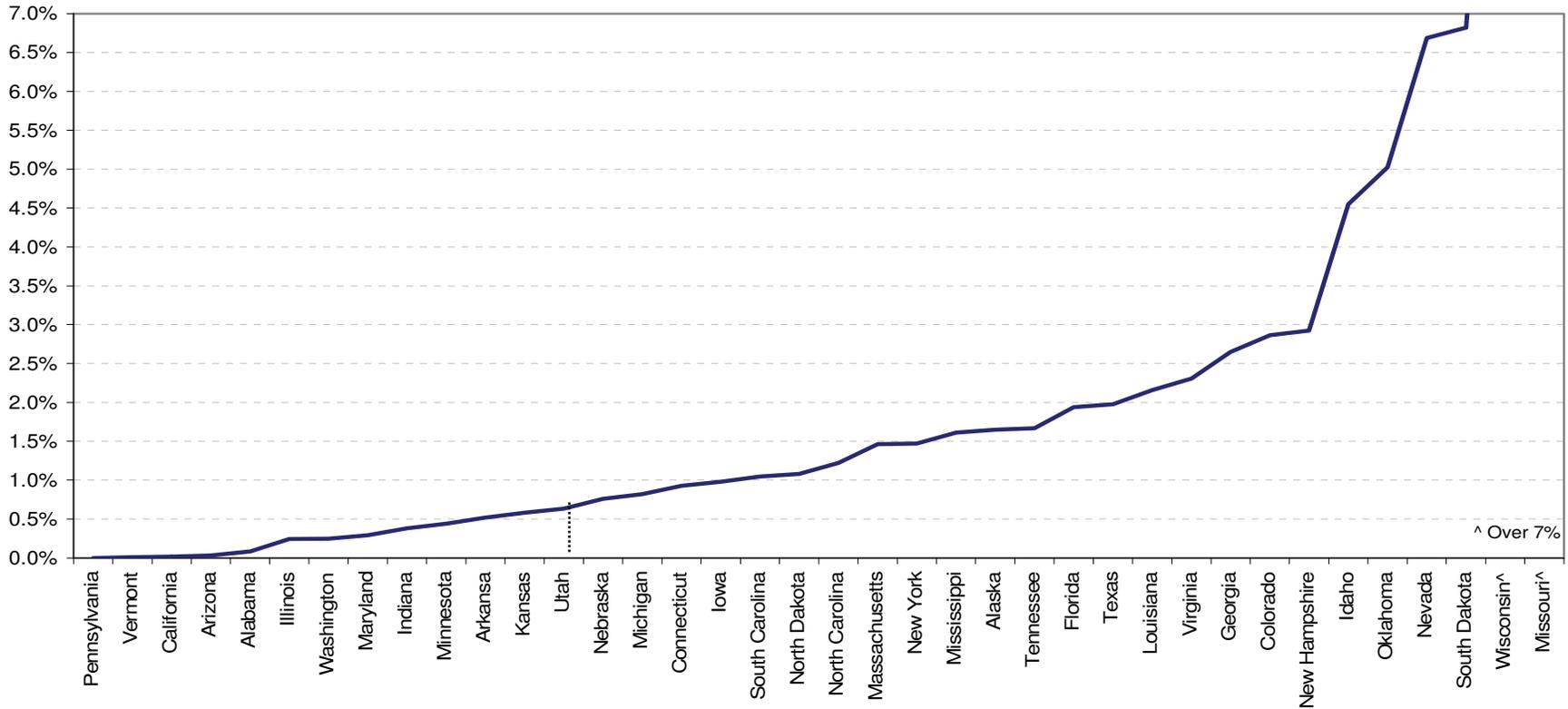
PROS	CONS	DATA	IMPLICATIONS	OVERCOMING BARRIERS
<p>Incentives would be aligned with the money.</p> <p>DSAMH would have authority to implement state wide programs.</p> <p>Additional layer of checks and balances for civil commitment principles.</p>	<p>Creates an increased administrative burden, fiscal responsibility and treatment oversight on the State to manage the care of those that are civilly committed statewide.</p> <p>More incentive for the LMHA to file for civil commitment which could increase hospitalization rates as it would make the State responsible for payment of treatment.</p> <p>No incentive for LMHA's to provide inpatient care for the greatest number of clients.</p> <p>No incentive for the LMHA to discharge people from USH or inpatient care back to their community of origin.</p> <p>Would require additional money for DSAMH to oversee patients committed in community hospitals and community outpatient treatment.</p> <p>Duplication of check and balance system.</p>	<p>For SFY2010-2011 data shows a Statewide average of 1,953 initial filings for civil commitment. During that time an average of 423 new people were civilly committed through that process resulting in 1,376 people under an order of civil commitment at any one time throughout the State.</p> <p>In Utah County alone there were an average of 720 civil commitment hearings (this includes both initial and review hearings)</p>	<p>DSAMH would have to provide utilization review for all clients under an order of commitment throughout the entire State in all levels of care.</p> <p>LMHA no longer fiscally responsible for people who are under civil commitment.</p> <p>DSAMH would need to place expectations in Area Plans for LMHAs to participate in statewide programs.</p> <p>DSAMH would have to monitor LMHA's for participation in state wide programming.</p> <p>Would require changes in protocols for civil commitment process and increase need for resources and checks and balances to avoid perverse incentives</p> <p>Increased number of state contracts to provide services.</p> <p>Rewrite statutes in Utah Code Annotated.</p> <p>Changes in funding, payment and personnel responding to the court system for civil commitment processes</p>	<p>Increased need for DSAMH staff to provide utilization review for all clients under an order of commitment, monitoring of state wide programming and for the court process for civil commitments.</p> <p>Restructure commitment process.</p>

OPTION #4 – Leave Current System of Funding in Place

PROS	CONS	DATA	IMPLICATIONS	OVERCOMING BARRIERS
<p>Minimizes overhead through “Economy of Scale” and reduces duplication of services.</p> <p>Provides quality comprehensive services in one location: Recreation Therapy, Occupational Therapy, Vocational Rehabilitation (most inpatient and most PRTF’s do not provide these services).</p> <p>Allows greater accessibility to inpatient beds including for non-Medicaid eligible citizens.</p> <p>Allows for most efficient cost per bed day.</p> <p>Provides Medicaid eligible treatment for pediatrics, reducing need for General Fund.</p> <p>Inpatient treatment less costly at USH than community inpatient beds</p>	<p>No fiscal incentives for community-based service development</p> <p>Distance to resources for some areas of the state.</p> <p>Adults lose Medicaid eligibility while at USH</p> <p>Inability to leverage resources to develop other community programs</p>	<p>2010 USH Utilization (beds per 1,000 population): Utah -- 0.25; National -- 0.51</p> <p>2010 Admissions Comparative Stat: Utah – 0.00013; National – 0.004</p> <p>Conclusion: Utah is using USH beds more efficiently than the national average.</p> <p>2011 Penetration rates (rate per 1000 population) for children ages 0-17 years: Utah -- 0.1; National -- 0.2.</p> <p>2011 Penetration rate for adults ages 21-64 years: Utah -- 0.4; National -- 0.7.</p> <p>Conclusion: Fewer people with mental illness in Utah are being hospitalized per capita by nearly ½ of the national average.</p> <p>There are no studies that show a state has closed all state hospital beds and in lieu of those beds developed community based programs to address needs.</p> <p>FY2009 State Hospital cost per bed day in sample states: Texas - \$401; Ohio - \$525; Eastern Washington State - \$524; Western Washington State - \$499; Vermont - \$1260; Louisiana - \$390; Alabama - \$384; Minnesota - \$982; Kansas - \$428; Montana - \$474; Virginia - \$440; Utah - \$473. In 2011 USH cost per bed day was \$409.</p> <p>Several states have found ways to modify their “bed allocation” system and provide incentives for mental health treatment in the community. All of those states have more than one state hospital and their state hospitals continue to receive the greater portion of their budget directly from State General Fund dollars.</p> <ul style="list-style-type: none"> • California’s 5 state hospitals • Colorado’s 2 state hospitals • Washington State’s 2 state hospitals and their Children’s Center. <p>Pennsylvania’s 6 state hospitals continue to be funded directly by state General Fund dollars for 82% of their total budget.</p>	<p>Funding out of alignment with the individual committed to the Local Mental Health Authority (LMHA).</p> <p>Encourages collaboration between USH and the LMHA’s to determine most efficient use of resources with regard to use of USH beds.</p> <p>Most efficient mechanism to keep cost low for daily bed rate.</p>	<p>2007 Legislative Study of USH revealed an under utilization of beds. This resulted in a collaborative effort between USH and the MHC’s to develop the Bed Utilization Program and utilize resources to minimize the misalignment of funding and authority:</p> <ul style="list-style-type: none"> • Adult Occupancy rate at USH in 2007 – 90% • Adult Occupancy rate at USH in 2010 – 95.6% • 2010 -LMHA’s were able to access almost 2000 additional Bed days of service. • 2010 - System-wide cost Savings of over \$2 million dollars. • Anecdotal information reports there are fewer accessibility issues in the community with no clients having to be placed out of state in the last 18 months.

Appendix 5

**Percent of Children Served
in State Hospitals
by State 2009**



2009 SAMHSA NOMS: CMHS Uniform Reporting System

*Not reported: Montana, Hawaii, Delaware, Wyoming, Rhode Island, Maine, New Mexico, West Virginia, Oregon, New Jersey, Kentucky, and Ohio.

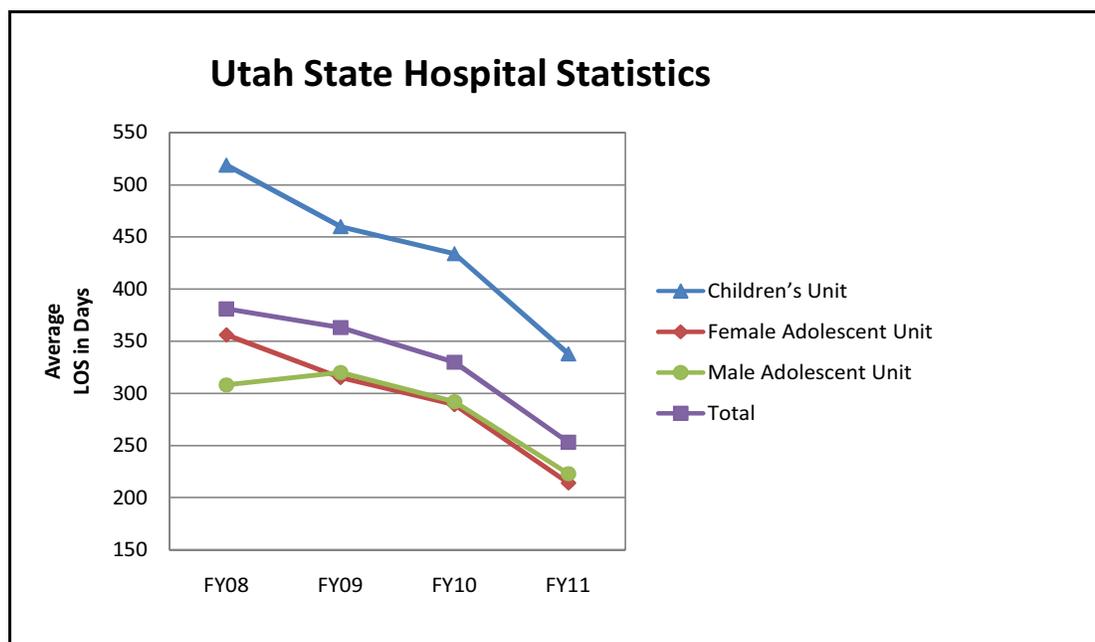
All 12 states with admission rates lower than Utah have coverage in their State Medical Plans for psychiatric residential treatment facilities (PRTF), Utah does not. A PRTF is any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21 (psych under 21 benefit). The criteria for admission is equivalent to an inpatient criteria at a state hospital and PRTFs must meet the requirements in §441.151 through 441.182 of the CFR.

Utah State Hospital Statistics

Average Length of Stay Trends FY2008 – FY2011

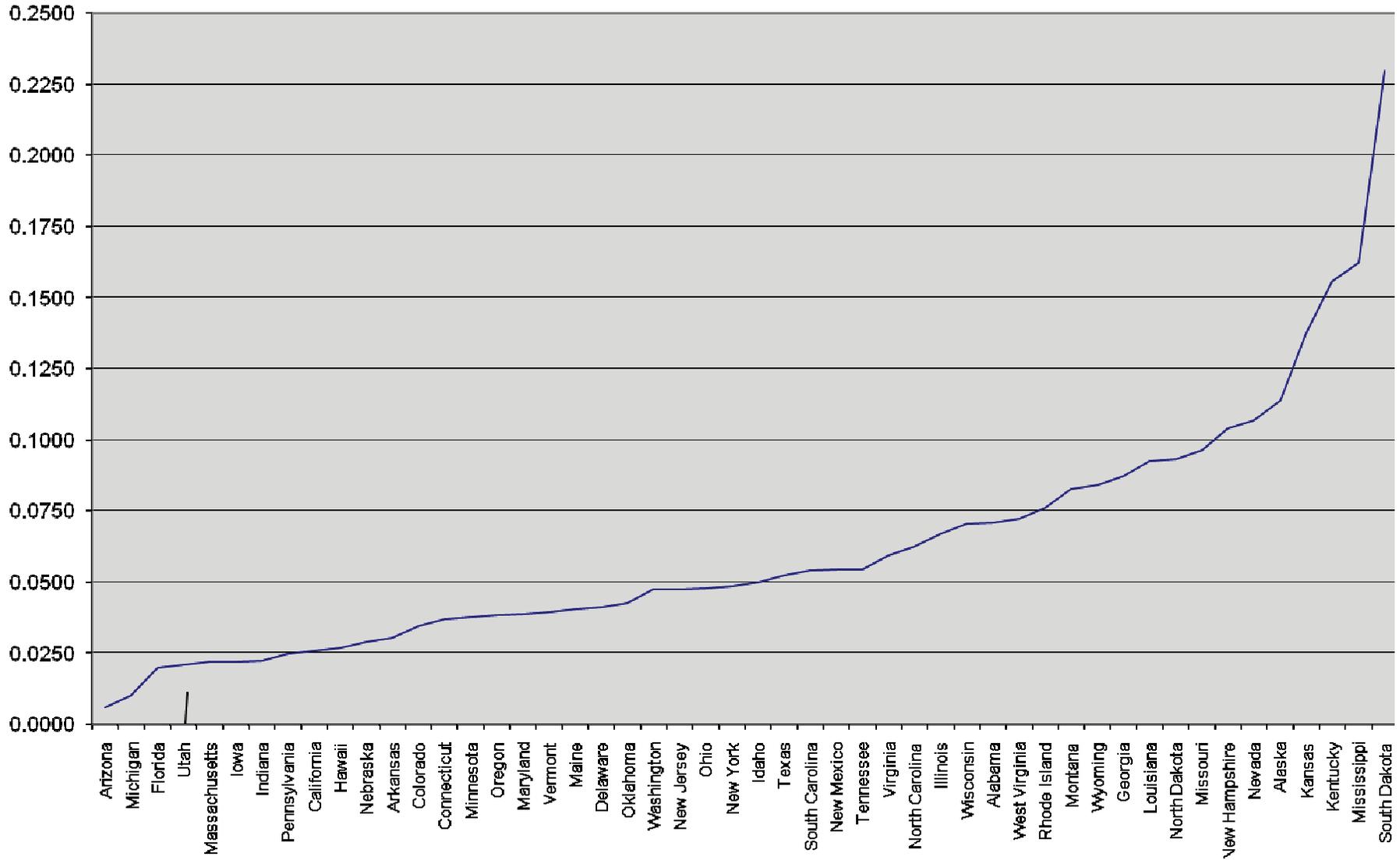
Utah State Hospital	Total Children & Youth on Units During Year			
	FY08	FY09	FY10	FY11
Children's Unit	32	31	30	31
Female Adolescent Unit	36	28	36	29
Male Adolescent Unit	48	38	43	49
Total	116	97	109	109

Utah State Hospital	Average LOS (In Days) During Hospitalization				Change FY08-FY11
	FY08	FY09	FY10*	FY11*	
Children's Unit	519	460	434	338	↓ 181
Female Adolescent Unit	356	315	289	214	↓ 142
Male Adolescent Unit	308	320	292	223	↓ 85
Total	381	363	330	253	↓ 128



Please Note: 1. For this report, transfers between units are not counted as two separated stays, but will be tracked as one stay in order to facilitate accurate calculation of length of stay (LOS) by a child/youth. 2. When a child/youth has been on two different units, the unit on which the child/youth remained the longest will carry the full LOS. 3. *Hospitalization LOS will change to reflect discharges that take place after this report was first published.

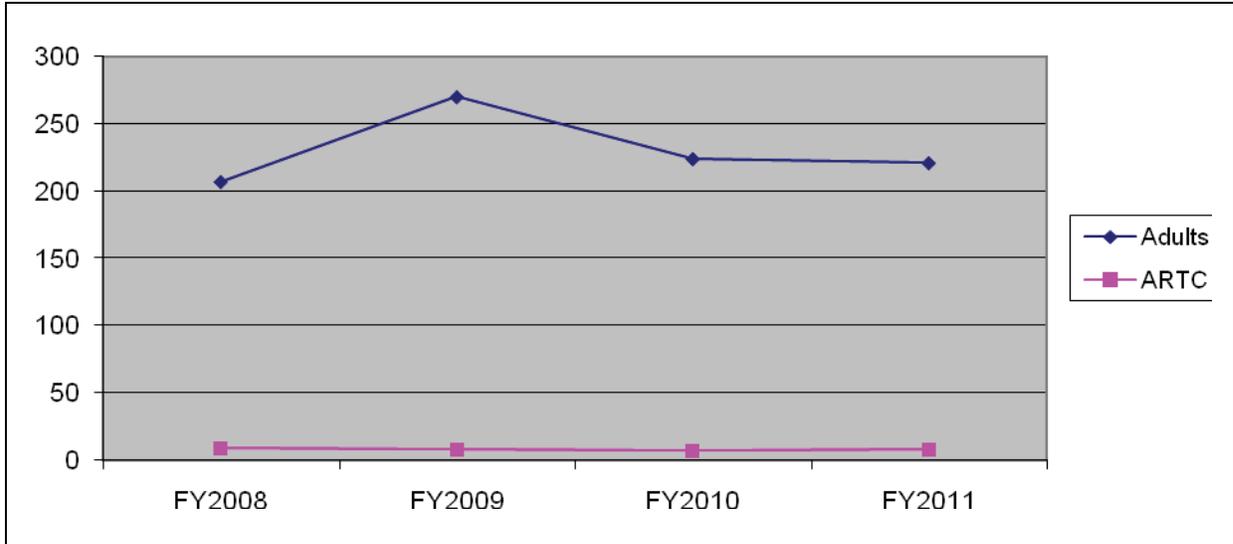
Percent of Adults Served in State Psychiatric Hospitals by State
2009



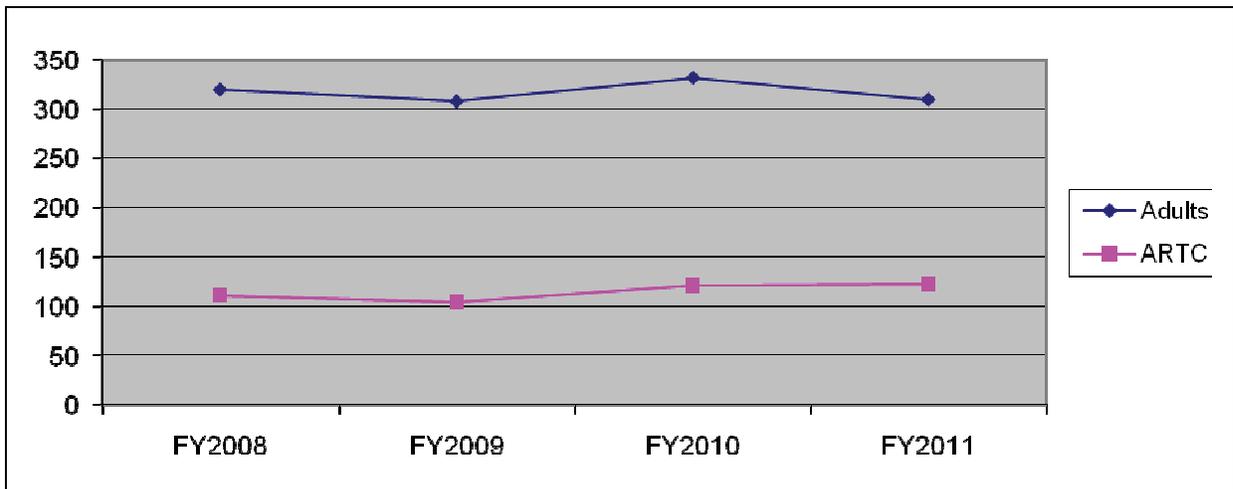
Utah State Hospital Statistics

Average Length of Stay Trends FY2008 – FY2011

MEDIAN LOS OF DISCHARGED PATIENTS				
	FY2008	FY2009	FY2010	FY2011
Adults	207	270	224	221
ARTC	9	8	7	8



TOTAL CLIENTS SERVED				
	FY2008	FY2009	FY2010	FY2011
Adults	320	308	332	310
ARTC	112	105	122	123



Division of Substance Abuse and Mental Health				
Utah State Hospital - Pediatric Beds - General Fund Allocation Per Center				
FY2012 Projected Full Occupancy				
	Total	GF Per Patient	Days	Projected Allocation
Center	Allocation	Per Day		Per Center
Bear River	4	11	365	15,843
Four Corners	1	11	365	3,961
Central Utah	2	11	365	7,921
Davis County	8	11	365	31,685
Salt Lake County	25	11	365	99,015
San Juan County	1	11	365	3,961
Southwest	5	11	365	19,803
Summit County	1	11	365	3,961
Tooele County	2	11	365	7,921
Uintah Basin Tri County	1	11	365	3,961
Utah County	15	11	365	59,410
Wasatch County	1	11	365	3,961
Weber County	6	11	365	23,764
Total	72			285,166
Division of Substance Abuse and Mental Health				
Utah State Hospital - Adult Beds - General Fund Allocation Per Center				
FY2012 Projected Full Occupancy				
	Total	GF Per Patient	Days	Projected Allocation
Center	Allocation	Per Day		Per Center
Bear River	8	356	365	1,039,559
Four Corners	2	356	365	259,890
Central Utah	4	356	365	519,779
Davis County	17	356	365	2,209,062
Salt Lake County	57	356	365	7,406,856
San Juan County	1	356	365	129,945
Southwest	12	356	365	1,559,338
Summit County	2	356	365	259,890
Tooele County	3	356	365	389,834
Uintah Basin Tri County	3	356	365	389,834
Utah County	29	356	365	3,768,400
Wasatch County	1	356	365	129,945
Weber County	13	356	365	1,689,283
Total	152			19,751,613