Meadows Mental Health Policy Institute
“What is a Bed?” – Inpatient Needs in a Community Context
February 2015

The Need for “Beds”
In January 2015, two important reports were released attempting to define the need for inpatient “beds” in the state of Texas:

• **Rider 83 State Hospital Long Term Plan**: This Department of State Health Services (DSHS) report draws a great deal from the November 2014 consulting report by CannonDesign. That report was based on an architectural review of selected state hospitals, review of data from DSHS on State Psychiatric Hospital (SPH) utilization, and demographic trends. It recommends development of 570 beds in the near term and an additional 607 beds to keep pace with population growth through 2024.

• **Allocation of Outpatient Mental Health Services and Beds in State Hospitals**: This DSHS report originated from the 83rd Legislature (HB 3793), which required a plan to identify needs for inpatient and outpatient services for both forensic and non-forensic groups. A diverse stakeholder group was identified in the legislation to advise DSHS in determining the need and developing a plan to address it. The Task Force recommended that DSHS request 720 additional inpatient beds in the 2016-2017 biennium and an additional 1260 over subsequent biennia to meet the current and projected population growth.

Using a cost-estimate of approximately $280,000 per inpatient bed, these two reports recommend new expenditures of $160 to $200 million annually.

The Long Term Plan and CannonDesign reports recommended the development of integrated mental health, substance abuse and primary care community-based services, in addition to creating more inpatient beds. They also acknowledged that a more integrated system of community-based services would reduce the demand for inpatient services. However, neither report factored this into their analysis. They instead assumed that community services would remain the same, and they explicitly avoided any attempt to assess the impact of the 1115 Waiver DSRIP projects or the implementation of the pending 1915i State Plan Amendment. The HB 3793 report also addressed the potential impact of community-based services in the narrative, but presented no data to determine its potential for reducing inpatient demand. Nor did any of the reports address the use of crisis alternatives or best practices such as Assertive Community Treatment (ACT), Forensic ACT, or Critical Time Intervention. The primary weakness of both plans was their lack of elaboration and specificity on how development of community capacity to reduce the need for “beds” fits into the equation. Access to crisis supports, outpatient care, and intensive treatment services affect the need. There was also:

• Inadequate attention to the role that best practice jail diversion strategies could play in reducing demand from forensic commitments;
• Absence of data on SPH property values and how those values would figure into the financing of elements of the Long Term Plan;
• Lack of an analysis of the impact of potential income losses from Disproportionate Share Funds (DSH) and Medicaid/Medicare reimbursements financing;
• Lack of analysis of the use of telehealth for areas with workforce shortages; and
• Lack of concrete plans to allow communities to determine the best use of resources to address service needs and manage inpatient demand locally.

What is a “Bed”? Despite these limitations, both reports identify a substantial need for new “beds.” While both reports focus on inpatient beds in state hospital and community settings, the functional need that both reports attempt to address is not just a need for inpatient “beds.” MMHPI recommends reframing the “bed” need to instead be a need for a safe, effective, and efficient treatment option for people with acute needs, particularly those in emergency room, correctional, or other community settings. The focus of this care is on people with the highest, most acute needs (people who are most dangerous to themselves and others or most actively psychotic or otherwise psychiatrically disabled). While an inpatient bed is one way to meet this need, the full range of alternatives includes many options that can be just as safe, but more effective and efficient, if part of a well-functioning local system of care.

A Continuum of Beds. One set of options includes a range of other 24/7 beds in safe treatment facilities. Many people end up in inpatient beds because of a lack of an intermediary alternative option up front or the lack of a lower-level step-down after the immediate risk has stabilized:

• State-purchased Inpatient Beds: The state estimates the annual cost of these beds to be $280,000 or just under $770 a day. There is evidence that this rate may not be competitive, given reports that DSHS efforts to request qualifications from facilities willing to provide capacity at this rate have had limited success. Typical rates for community inpatient beds generally are closer to $1,000 or higher per day.
• Crisis Stabilization Beds: These are very short-term residential treatment programs designed to reduce acute symptoms of mental illness within a secure and protected setting, with 24/7 clinical staff availability (including 16-24 hours a day of nursing), psychiatric supervision, daily psychiatric management, and an active treatment environment. These programs have lower medical and nursing capacity than a hospital inpatient unit and do not have the full spectrum of laboratory and related services that hospital units provide, but they can offer safe medical treatment services for those at the right level of need. Costs per day are typically much lower than inpatient care ($82,000 per year, or $225 per day) and even lower for less intensively staffed options. Longer-term versions (Crisis Residential) are typically less intense and can have longer lengths of stay. These programs are sometimes called Crisis Respite programs, though this term also apply to lower intensity and less costly alternatives.
Continuum of Treatment Alternatives. As noted above, Assertive Community Treatment (ACT), Forensic ACT, Integrated Dual Disorder Treatment, and other best practices such as Critical Time Intervention are specifically designed for use by highutilizers of inpatient and correctional system resources. The cost of a best practice ACT team is approximately $15,000 per year, per treatment slot. In general, cost-effectiveness studies have found ACT teams to cost about the same per person as the inpatient care and other costs averted by their use.

Continuum of Crisis Supports. In addition to bed and treatment alternatives, an array of other crisis supports can reduce the need for inpatient care and divert individuals from both inpatient and forensic settings. These include:

- **Psychiatric Emergency Centers:** The essential functions of a psychiatric emergency center include immediate access to assessment, treatment, and stabilization for individuals with the most severe and emergent psychiatric symptoms in an environment with immediate access to emergency medical care.
- **Observation Beds:** These are very high acuity (and high cost) evaluation beds, time-limited to 23 hours or less where individuals receive evaluation and intervention to determine if their acute situation can be stabilized sufficiently to avoid hospitalization (often discharging to another crisis placement). These settings are usually located within hospitals because of the high acuity situations they manage.
- **Crisis Triage / Assessment Centers and Crisis Urgent Care Centers:** These are walk-in locations in which crisis assessments and the determination of priority needs are determined by medical staff (including prescribers). Crisis urgent care centers provide immediate walk-in crisis services. They may or may not be based in a hospital. Such centers may be peer-run (such as the Recovery Innovations program in Harris County).
- **Mobile Crisis Outreach Team (MCOT):** These are mobile services that provide psychiatric emergency and urgent care, with the capacity to go out into the community (in the person’s natural environment) to begin the process of assessment and treatment outside of a hospital or health care facility. The MCOT has access to a psychiatrist and usually operates 24/7 (though overnight response may be less comprehensive).
- **Crisis Telehealth:** These are crisis assessment or intervention services provided through telehealth systems. They can allow access to higher-level medical (e.g., psychiatrist) capacity within the crisis settings noted above or other settings. It can also include consultation through telehealth systems by a behavioral health specialist to non-psychiatrist medical staff to facilitate the assessment or management of individuals in other non-behavioral settings (e.g., general emergency departments, jails).

MMHPI Recommendations
Based on our ongoing review of the available data on costs and effectiveness, MMHPI recommends that communities be empowered and held accountable for developing comprehensive crisis systems to reduce use of state hospitals and inappropriate use of forensic
and criminal justice settings. This requires more than having the state “purchase or build more beds;” it requires effective procurement of an array of crisis supports, operating in a system for which the local community is accountable and responsible.

MMHIP recommends that states align purchasing of inpatient capacity, crisis services, and intensive treatment capacity in a coordinated effort to help local communities fill gaps, such as those noted above. Furthermore, in Texas multiple payers (DSHS, counties, Medicaid managed care organizations, private insurance payers) have need of crisis services for the people they serve, so the service should be developed as an integrated, multi-payer system.

If willing and able to pass proportionate costs on to third party payers (e.g., Medicaid managed care organizations), local mental health authorities (LMHAs) would be one possible point of responsibility and accountability for such systems. However, not all LMHAs may be willing or able to carry out these requirements, so provisions may be necessary to purchase regional systems through other means. Local match requirements may be necessary to ensure that local governments appropriately participate in costs. Ideally, in alignment with DSHS Sunset Recommendation 2.1, these systems would be part of integrated behavioral health systems that include access to substance abuse treatment and detox services.

If contracted to local service systems, MMHPI projects that the cost of filling the gap could be substantially less than the cost of developing a comparable number of inpatient beds, and the effectiveness would likely be higher. This could be done by:

- Shifting responsibility for the allocation of current beds to LMHAs, per DSHS Sunset Recommendations;
- Allocating the cost of developing additional needed inpatient capacity proportionally, as recommended in the CannonDesign report;
- Instituting cost-sharing requirements, per DSHS Sunset Recommendations, from LMHAs that overuse their allocated capacity to LMHAs that underuse;
- Instituting performance metrics related to emergency response time initially and, over time, emergency department overuse, post-inpatient discharge follow-up, and criminal justice system overuse. Performance metrics should be developed in collaboration with stakeholders, per DSHS Sunset Recommendations.

In order to achieve cost and performance goals, local systems would need to move toward implementing the following features in their crisis systems:

- **Promote universal and early access to help.** Each community should have a clear protocol by which an individual or a family, regardless of insurance status (including uninsured, Medicaid, and commercial insurance), in any kind of mental health or substance abuse crisis, can ask for and receive help quickly and easily and obtain a proactive and timely response, whether through walk-in or mobile services.
Measurement of timeliness of response and access to voluntary help versus help through law enforcement or an emergency department should be key success metrics.

- **Identify and fund local crisis coordination and continuity “leads” in each region or community.** These entities would be responsible for coordinating all care for individuals in crisis and providing oversight and performance improvement activities. Access to crisis intervention, including mobile outreach, for those at high risk of hospitalization, incarceration, or homelessness, should be a priority metric for system success and a priority for system funding by all payers, including Medicaid and private insurers.

- **Develop and fund a full range of diversion services.** Policy makers need to provide definitions for each type of service, with local flexibility and development incentives to fill gaps. Policy makers could also address the current licensing and certification rigidity that interferes with development. All funders would need to certify and adequately reimburse diversion services, just as they are required to reimburse inpatient services.

- **Promote a wide range of locally accessible psychiatric inpatient services (in freestanding and community hospitals) to eliminate reliance on state hospitals for acute care.** In accord with the Long Term Plan and HB 3793 recommendations, state hospitals should be used only for long-term rehabilitative and recovery services for the most severely impaired individuals, as well as for forensic services that cannot be performed in less restrictive settings. The state needs to coordinate all funding, including state, local, Medicaid, Medicare, and private insurance to help local systems and their hospitals develop adequate acute capacity at the local level. State licensing and oversight needs to be supportive of the ability of hospitals to develop successful programs within the rate structure provided. Successful application of this approach could result over time in additional savings through reduced reliance on selected state hospitals in which physical plant challenges are especially costly to repair.

- **Facilitate access to crisis help, including emergency detention, with minimal use of law enforcement and the judicial system.** Many states facilitate access to civil commitment by providing authority to physicians, psychologists, nurse practitioners, and licensed social workers to initiate short-term emergency holds for evaluation without requiring the involvement of justice personnel. The 2012 Texas Appleseed review of the Texas Mental Health Code includes many ideas to help Texas reduce reliance on law enforcement.

- **Maximize access to peer support.** Peer support should be a core feature of diversion programs and acute care. As recommended by the Hogg Foundation, reimbursement models should remove restrictions on use of peer support to include all types of mobile and site-based diversion services, regardless of provider type. Peer-operated crisis services should be developed in all local systems.

- **Maximize access to telehealth.** Telehealth services by licensed practitioners should be made available throughout the full range of crisis diversion services, including mobile crisis, rather than only in licensed health facilities.