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State of Washington
Department of Social and Health Services
Mental Health Division

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Capacity and Demand Study for Inpatient Psychiatric Hospital and Community Residential Beds - Adults and Children

FINAL REPORT
October 2004

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Purpose

- Update and expand 2002 Report "Projecting the Need for Inpatient and Residential Behavioral Health Services for Adults Served by the Mental Health Division"
- Focus on civil – not forensic – beds
- Further defined residential and inpatient services
- Compatible with 2002 service definitions
- Located needed services by Regional Support Networks (RSNs) or region
- Added review of Children's Long Term Inpatient Program (CLIP)
- Recommended new children's program model

Approach

- Reviewed 2002 – 2004 MHD documents and data
- Data request to 14 RSNs, multiple follow-up data clarifications and conversations
- Site visits and record reviews of CLIP facilities
- Peer state and literature review of children's inpatient services
- Interviews with key stakeholders from the state hospitals, community hospitals, and CLIP facilities
- Meetings with senior staff of Western and Eastern State Hospitals
- Meetings and data review with the Washington Behavioral Health Inpatient Association

Scope

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- The following areas were covered by the study:
  - Provider System Overview
  - Stakeholder Interviews
  - Adult Services Data Analysis
    - State Psychiatric Hospitals
    - Inpatient Community Hospitals
    - Evaluation & Treatment Centers (E&Ts)
    - Residential Services
    - Adult Peer State Comparison Update
  - Children Services Data Analysis
    - CLIP Facilities
    - Inpatient Community Hospitals
    - Children's Peer State Comparison Study
    - Medical Record Review of CLIP Facilities

Recommendations

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- **A-1: State spending for adult mental health residential and inpatient services remains significantly below peer state investment for comparable services.** ***We estimate the gap in spending to be a minimum of $20 million to meet the spending level of peer states for residential services only.***
  - Residential services under the auspices of RSNs do not include community hospital inpatient services
  - The gap is not service specific
  - Does not factor in new CMS interpretations of Washington waiver
  - Assumes a 3.5% annual inflation in peer state spending since 2002

Recommendations

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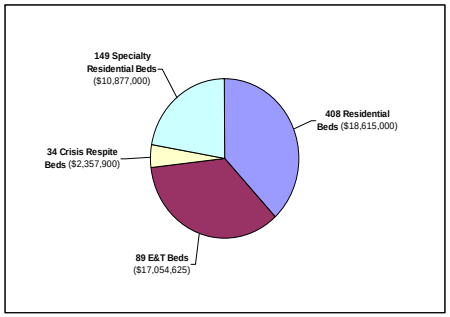
- **A-2: Spending for community-based residential and inpatient services should increase by 680 beds to meet the identified gaps in specific community-based residential and inpatient services detailed in this study.**
  - $48.9 million
  - Will increase the capacity of the community system by more than one-third
  - Does not take into account case management and other outpatient services



Recommendations

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- **A-3: The lack of community-based residential and alternative community-based inpatient capacity is particularly apparent with specialty patient populations currently served by the state hospitals. It is estimated that up to 144 patients at Western State Hospital and 5 patients at Eastern State Hospital could be served in the community if specialty community-based programs were developed. These services would cost an estimated $10,877,000 per year.**
  - Psychiatric nursing care/adult family homes
    (up to 30 beds at WSH)
  - Specialty residences for persons with developmental disabilities
    (up to 34 beds at WSH)
  - Medical facilities for persons with traumatic brain injury
    (up to 30 beds at WSH)
  - Other residential programs for populations with special or rehabilitative needs
    (up to 50 beds at WSH and up to 5 beds at ESH)

Recommendations

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- **A-4: During the past two years there has not been enough progress to create sufficient capacity to divert admissions from state hospitals or other psychiatric inpatient settings. We recommend (a) expansion of Evaluation and Treatment (E&T) centers to add at least 89 beds to the system, divided between the Eastern Region (33 beds) and the Western Region (56 beds) at a cost of $17,054,625 per year, and (b) increased access to 34 additional hospital diversion beds, at an annual cost of $2,357,900, focused solely on those areas with limited access to hospital diversion care.**

  E&T Beds
  - Currently, no E&T beds in Eastern region; 78 beds in Western region
  - Move to statewide standard of 3.3 beds per 100,000 population
  - Recommended beds based on regional allocation, not RSN allocation

  Crisis Beds
  - 3 RSNs have no crisis beds
  - 6 RSNs are at 100% occupancy
  - Move to 3.8 beds per 100,000 population with RSN access

Recommendations

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- **A-5: There has not been adequate progress made in developing and locating sufficient community residential beds in most RSNs. Analysis of the supply and utilization data suggests that the state may be in need of 408 new community residential beds, at an annual cost of $18,615,000 to create sufficient local residential resources.**
  - One RSN has no community residential beds
  - Nine RSNs are over 90% occupancy; five of these nine RSNs are at 100%
  - Bring all RSNs up to the statewide average of 35.4 beds per 100,000 adult general population

Recommendations

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- **A-6: The state hospital bed capacity has been reduced to 834 staffed beds (as of the July 1, 2004 RSN allocation). Further reductions should be made as MHD is able shift hospital resources and make investments to expand community residential alternatives. MHD should consider a state hospital target of approximately 575 beds, the median range of its peer states.**
  - State hospital bed capacity has been reduced from 981 to 834 beds, a reduction of 15% in the past two years
  - Continued bed reduction will require a combination of new funds and continued re-allocation of state hospital resources
  - It is most likely that the state will continue to incrementally build community capacity and reduce state hospital beds as resources are available

Recommendations

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- **A-7: The existing community psychiatric hospital bed capacity has eroded by 95 beds since the 2002 study. The capacity should be preserved, with opportunities to expand, to meet the increasing demand of the states population growth and decreasing reliance on state hospital beds. This requires a rate structure that fully reflects the cost of providing services to the consumers referred by the public system who are eligible for Medicaid, other third party coverage, or who have no coverage.**
  - It is estimated that 32% of community hospital admissions are publicly funded; 23% are Medicaid eligible
  - State-only payments to community hospitals is currently 30% of actual cost, a shortfall of approximately $550 per day
  - Access to community inpatient beds in Washington is less than half the availability of beds per 100,000 in the peer states

Recommendations

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- **A-8: Adult community support services should be reviewed for further expansion to include the development of PACT teams and the expansion of additional support services and treatment for co-occurring disorders. These services are needed in addition to the residential and impatient care recommended in this report.**
  - Non-residential services, designed specifically to meet the needs of adults with serious and long-term mental illness, can cost effectively supplement or replace residential programs.
    - additional support services (such as Clubhouse, Supported Employment, High Intensity Teams),
    - specialized treatment (in the areas of substance abuse, neurological / cognitive impairment, forensic involvement and medical issues),
    - community program enhancements that integrate the treatment of co-occurring disorders (substance abuse / mental illness) through a combination of supported housing, PACT / ACT teams and flexible support services
  - Examples of evidence-based practice services include PACT teams and specialized services for those with dual diagnoses.

Recommendations

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- **A-9: A continuous, statewide MHD planning function should be fully developed to oversee the implementation and management of the recommendations of this report.**
  - MHD should establish a function to monitor the residential capacity of the system
  - A reporting capacity should be established to document the availability and utilization of all residential services delivered by RSNs
  - These requirements should be built into the contracts with RSNs

Recommendations

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- **C-1: A new therapeutic foster care community model to serve high risk children and adolescents should be developed. We recommend a minimum of three new therapeutic foster care models, two in western Washington and one in eastern Washington.**
  - Three clusters of 10 beds each
  - Therapeutic foster care, where services are available to "wrap around" and support home environments, is an emerging and cost-effective best practice
  - New therapeutic foster care models should be aligned with specific CLIP programs to facilitate transition and avoid excessively long CLIP stays

Recommendations

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- **C-2: The Children's Long Term Inpatient Programs (CLIP) plays a critical "safety net" role and should remain in place until the new service is deployed and evaluated. CLIPs should be strengthened by the better alignment of payment levels to service delivery costs.**
  - CLIP programs provide an appropriate level of care for children with severe mental illness and behavioral disorders
  - Once the therapeutic foster care model is widely deployed, a reassessment of these two forms of care should be conducted to ensure that the right blend of services, as measured by outcomes and costs, is available statewide

Recommendations

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- **C-3: Community outpatient services should be expanded to support children and adolescents at risk of placement and especially to support reintegration of families when children return home from CLIPs.**
  - Expansion of community-based services is essential to minimize the need for foster care, residential, or inpatient services
  - Promotes effective integration back into the community once an individual has left any of these treatment alternatives
  - These services minimize disruptions and corresponding risks that may occur with inpatient and residential treatment options while also offering effective outcomes and comparatively lower cost of care

Recommendations

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- **C-4: Funding and access to specialized children's services, including CLIPs and new therapeutic foster care, should be planned and managed by Washington MHD to ensure effective model implementation reduce waiting time and ensure appropriate access to care.**
  - New models are best developed by a central entity that will design and implement them in line with proven and evidence-based practices and will administer access based on need
  - MHD should ensure that there is improvement in the flow of patients through the system and a process for system-wide oversight of extended lengths of stay or clinical review of "stuck cases" should be implemented