Kansas Department of

Social and Rehabilitation Services

Gary Daniels, Acting Secretary

Legislative Budget Committee
October 10, 2005

Mental Health Hospital Admission Increases

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Chairman Neufeld, Vice-Chairman Umbarger, and Committee Members, I am Acting Secretary Gary Daniels, Kansas Department of Social and Rehabilitation Services. Thank you for the opportunity to discuss with you the increasing need for access to public inpatient psychiatric services. I will provide some overview information about this issue, and how SRS and our business partners are managing it.

Context
Let me begin by stating that SRS is committed to providing this level of services to Kansas citizens who require them in order to become more stable to live, work and function in our communities. SRS has no intention of ceasing hospital admissions or closing any current facilities. Our data indicates that either of these approaches would leave a segment of our population more vulnerable, including jeopardizing the safety of our patients and our communities.

It is important to see the increase in the number of Kansas receiving services in the public mental health system. The number of Kansans turning to the public mental health service system for mental health supports has increased by over 21% during the past five years. The following chart outlines the increased number of citizens in our state seeking public mental health services.

State Fiscal Year	Number of Kansas Served	Percent Increase
2000	81,030	
2001	82,985	2.40%
2002	88,400	6.50%
2003	90,391	2.20%
2004	98,133	8.60%

With that context set, we all know that admissions at our state mental health hospitals have experienced a significant increase in the past five years as well. It is important to note that admission rates to state mental health hospitals in Kansas during state fiscal year 2004 were very similar to that of admission rates across the United States, based upon the number of people per 1,000 that were admitted for such services:

	Number Admitted Per 1,000 Persons	
	Kansas	United States
Children	1.07	1.02
Adults	1.07	1.08

In addition, to the rising increase, SRS faces increased challenges in meeting budget allocations for hospitals as the needs for these services rises. The chart below shows the total number of admissions for both children, adolescents and adults for the months beginning in March 2005 until September 2005. The chart indicates median length of stay for patients, average daily census with the budgeted capacity in parenthesis.

Month (in calendar year 2005)	Number of Psychiatric Admissions			Median Length of Stay			Average Daily Census (vs. Average Budgeted Capacity)		
	OSH	RMHF	LSH	OSH	RMHF	LSH	OSH	RMHF	LSH
March	188	71	83	13	15	13	152 (160)	43 (45)	76 (99)
April	165	40	88	14	21	13	172 (160)	41 (45)	78 (99)
May	184	32	95	10	18	10	169 (160)	31 (45)	82 (99)
June	175	26	90	16	24	14	178 (160)	24 (45)	70 (99)
July	179	59	96	14	14	11	172 (165)	37 (45)	81 (99)
August	163	69	107	14	18	10	186 (165)	41 (45)	77 (99)
September	179	52	91	10	21	14	183 (165)	50 (45)	86 (99)

As we continue to monitor this situation, we would like to share with you steps we have taken during this past summer that SRS believes will result in admissions numbers that will be more manageable.

Kansas Hospital Experience

Contributing Factors

We could point to several contributing factors to the rising admissions at our hospitals. One factor in particular relates to the number of private psychiatric hospital beds in Kansas. Information about private psychiatric hospital beds throughout Kansas indicates that from 2002 to 2004, there was a loss of 111 beds in those settings, due to closures or reductions in bed capacity. And according to a recent survey conducted as part of the Governor's Mental Health Services Planning Council – Service Delivery System Subcommittee service review, only 13 private hospitals in Kansas continue to provide inpatient care for people with acute psychiatric service needs. The combined total bed capacity of those 13 hospitals is 279 beds, and only 168 of those beds are available for people who are involuntarily committed for mental health care – people who are acutely mentally ill, represent a present danger to themselves or others, and are unable to voluntarily seek and obtain mental health services.

Some other contributing factors include:

- For approximately 50% of the people admitted, it is their first experience with mental health services (they are unknown to our community public mental health system).
- From FY 1990 to FY 2003 the average daily census of Kansas' mental health hospitals decreased from 1,283 to 293, a 77% reduction.
- Meanwhile, the number of people with the most significant mental illness accessing community-based services continues to increase, up by 60% for youth (15,811 in FY 2003) and up by 14% for adults with serious and persistent mental illness (15,699 in FY 2003) in the last four years.

Treatment Challenges

Between 60-70% of state mental health hospital patients have a co-occurring diagnosis. Mental health disorders are accompanied by substance use disorders as well as behavioral and cognitive functioning issues or serious physical conditions.. These factors not only require more complex and intensive hospital-based treatment, but render effective discharge planning – and therefore durable recovery supports – far more challenging and time-consuming to develop.

In addition, there are significant numbers of patients admitted from correctional facilities, primarily local jails. State hospitals experience a 7-8% admission rate of patients from these facilities. Those admissions frequently bring with them complicating factors of behavioral disorders, medication access limitations, and security risks.

Effects on hospital and agency budget

In the past several years Kansas' State mental health hospitals have experienced budget challenges, especially with other operating expenses (OOE). Most of the increased costs in OOE are due to higher drug costs, utility bills, and outside medical expenses. SRS and the state hospitals have taken steps in the last several years to fund OOE expenditures within their combined approved budgets.

In FY 2005, state hospitals intentionally forced staff vacancies to help cover OOE budget shortfalls. These savings, however, were not enough, even after Larned State Hospital received additional funding for the cost of extraordinary outside health care. In response, SRS arranged additional savings of its own so $1,147,106 could be shifted to the state hospitals to cover their remaining OOE shortfall.

State hospitals have no choice but to pay the higher costs of drugs, utilities, and food must be paid. But since OOE in total makes up only about 17 percent of the state hospitals' budgets, when OOE is underfunded, the only remaining place to find significant savings is salaries. Salary savings can only be achieved by artificially holding positions vacant.

Covering the OOE shortfall by intentionally creating salary savings at the hospitals is no longer feasible. Staff, especially direct care and clinical staff, are the key to quality service delivery at the state hospitals. Fewer staff means compromising care, support, and treatment. Employing fewer staff reduces the quality and quantity of state hospital services. Particularly during times of high census, all staff positions need to be filled to minimally meet the needs of the additional people at the hospital. Intentionally leaving positions vacant, especially during times of high census, could result in longer lengths of stay, inadequate care, and potentially endangering the safety of the staff and patients.

Rainbow Mental Health Facility has experienced some of these difficulties in serving adolescents and children. As a result they are requesting a supplemental appropriation of $288,434 and an enhancement request of $576,868 to increase direct contact staff in its youth service unit.

Another consequence of intentionally forcing staff vacancies at the state hospitals has been the accumulation of unpaid compensation time for staff. Since staff can not be given time off because that would just exacerbate staff shortages, "comp. time" is accumulated and unpaid.

The costs of drugs, utilities, outside medical care, and other expenses continue to rise faster than the budgeted OOE growth rate. For example, it has been estimated that drug costs will increase by more than 7 percent in FY 2006. Natural gas and other utilities prices have risen by as much as 30 percent in the last twelve months.

As a result of the growing service pressures, the state hospitals have budgeted to fill all of their positions within their available allocation. This leaves too little in the allocation to cover all OOE costs. As a result the state mental health hospitals are requesting a supplemental appropriation of about $2 million and an enhancement request of $1.9 million for drugs and utilities.

SRS Actions and Solutions

SRS has engaged in heightened concentration on building a higher level of collaboration and cooperation between our public mental health systems. This heightened partnership involves hospital leadership and staff, community partners and leadership and staff from Community Mental Health Centers.

This partnership is committed to constantly monitoring, exploring, implementing, re-evaluating, adjusting, and following through with aggressive problem solving and management of the state hospital resources. The concentration on solutions has provided an agreed upon protocol (attached) that will assist in managing the admissions at state hospitals more effectively.

Census Management Protocol

Building on stakeholder planning begun last year, hospital staff and community partners developed an agreed "Protocol for Managing SMHH Census Increases." Key elements of the protocol are:

- Regular communication to community partners about census levels so all involved partners are aware of the resource picture and can address upward fluctuations quickly.
- Extraordinary mutual planning and discharge effort when census crises loom.
- Hospitals reaching out to each other, using feasible admission diversion and transfer options.
- Reaching out to other treatment resources for people with intense or unique service needs, including aging and disability services.
- Continuing effort to explore and build alternative service options which will allow people to access inpatient psychiatric services, or other appropriate services to meet their needs, rather than admission to a state psychiatric facility.

Current Initiatives

Ongoing study from the census management work group, as well as other initiatives from state hospital leadership/staff, includes multiple options being actively assessed or implemented, such as:

- Transitional housing or "step down" services on state hospital grounds, for community services to people who are clinically prepared for discharge but working on one or more functional issues before returning to their home community to live.
- Exploring public/private partnerships, focusing initially on youth services or other pilot project arrangements so that experience can build success and teach lessons. These planning discussions are actively underway with several private inpatient psychiatric service providers.
- Ramping up communication connections between hospital and community staff, to ease the transition of patients and treatments back and forth, supporting durable and prompt discharge planning.

- Treatment program enhancements, to help ensure that patients are getting treatment that is efficient, effective, consumer/family focused, supportive of community care, and contributes to durable recovery.
- One recent and promising practice implemented at Osawatomie State Hospital is the prompt identification of a planned discharge date shortly after admission. Each patient's situation is assessed, and in consultation with the patient and community partners, a target discharge date is established and communicated to the patient and all treatment team members. The setting of a specific date – subject to revision if the patient's needs so require – has helped to solidify treatment decisions and discharge planning, to support sound discharge and aftercare decisions. This practice was implemented in response to a very recent census crisis, and was instrumental in abating that crisis. Of course, the long-term effects of these and similar measures can only serve to compress a very tight system resource.
- Similar focus on sound discharge planning, including a Discharge Planning Work Sheet initiated as part of an improvement initiative at Larned, has been critical to successful discharges for patients who had been at the hospital for longer than one year.
- Vigorous triage assessments on admission, with the shortest effective treatment track assigned to each patient. The consistent use of a triage system has been an essential element of success at OSH, and has led to the development of two crisis stabilization units which specialize in short-term treatment and community return with eligible patients.
- Assessing the feasibility of providing outpatient observation treatment with a psychiatric hospital. Generally such patients have a combination of non-SPMI diagnoses; historical success in community functioning; intoxication; or presence of a "social" rather than purely psychiatric crisis. The outpatient status allows for more rapid service response without extensive assessment/evaluation requirements associated with inpatient care.
- Another related advisory group has been focusing on enhancement of services at, and building alternative service options for, RMHF. A key feature of this effort is the efficient and effective joining of Rainbow resources with OSH resources, so that every available opportunity is taken to infuse those resources at the direct care level. The longer term focus of this group is to build successful diversion strategies and the related community-based care patients will need.

Care must be taken to ensure that approved resources are sufficient to meet the existing census levels at state hospitals, and are in reality sufficient to meet the needs of each patient admitted. SRS will continue to monitor care of patients, capacity of facilities and budget and make adjustments in partnership with stakeholders to address this continuing concern.

Update on Larned State Hospital

Some Department of Corrections (DoC) inmates experience symptoms of mental illness. Many of these inmates are effectively served while remaining in the general population of inmates.

Others experience symptoms that are so severe or persistent that specialized inpatient mental health services are needed. Typically these persons would be referred to the Larned State Hospital State Security Program (LSH/SSP). However, the current LSH/SSP capacity is insufficient to serve all of the DoC inmates who need such services. In response to those unmet needs the LSH/SSP was provided an additional $1.1 million and 70 full time equivalent staff to serve up to 90 additional DoC inmates for the last 3 months of FY 2006. As a result, the LSH/SSP will be ready to take additional DoC inmates beginning in April 2006. However, it should be noted that an additional $3.65 million will be needed to serve these inmates for a full year in FY 2007.

This new expanded program will provide these inmates with a full array of specialized inpatient mental health services. LSH/SSP will continue to provide intensive hospital level of care for those experiencing the most severe symptoms of mental illness. However, the new expanded program also will serve inmates who need longer term mental health support and treatment to remain stable which may not be achievable if they return to the general inmate population. The individualized mental health services provided to these persons would include individual therapy, group therapy, psycho-social education, medication management, vocational assistance and activities, training toward a general education diploma, and life skills training.

This concludes my testimony. I will be happy to answer questions from the committee.

ATTACHMENT

GARY J. DANIELS, ACTING SECRETARY

K A N S A S

KATHLEEN SEBELIUS, GOVERNOR

SOCIAL AND REHABILITATION SERVICES

Protocol for Managing SMHH Census Increases
September 2005

Background & Values

The state mental health hospitals (SMHH) in Kansas have experienced significant growth in admissions during the past several years. Already increasing at 10% and more per year, in state fiscal year 2003 there were 3,115 admissions. That growth rate surged over 27% in two years, with 3,964 admissions at the three state mental health hospitals in state fiscal year 2005.

The hospitals continue to address growing admissions by increasing the intensity and effectiveness of hospital treatment, resulting in reduction in lengths of stay and stabilizing their census. OSH, in particular, changed its service delivery to include extensive crisis stabilization services for those who would benefit from a short-term, intensive hospital stay.

SRS will continue to actively explore and implement strategies to meet the increasing demand for state mental health hospital services. We have not implemented any suspension of admissions, and no one seeking admission has been denied access to state hospital services. The option of suspending admissions has been eliminated at this time.

Ultimately, it is the obligation of the state to meet the needs of patients with acute psychiatric inpatient treatment needs that cannot be met in their communities.

State mental health hospital staff, SRS Mental Health Services program staff, and Community Mental Health Centers (CMHCs) must work together on a continuous basis to prevent, identify and respond to census and capacity difficulties.

The very best use of existing resources will not accommodate extensive or prolonged additional treatment demand, and if the admission surge continues new resources will be required to meet the continued and growing demand for these critical safety net services.

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Management Protocol

SMHH administration will provide total census numbers through daily email updates to SRS, Health Care Policy staff and CMHCs. Weekly updates will be provided of total daily census by CMHC, and these weekly updates will be supplied to each CMHC.

Census status and concerns, as well as issues which may be contributing to census concerns, will be regularly discussed between each SMHH and the CMHCs in their service area. This subject should be a topic of discussion at periodic business meetings between the SMHH and CMHCs, and specific census issues should be communicated electronically to each involved CMHC. Each CMHC will inform the SMHHs how they want such notices to be sent – i.e., who should receive what type of notifications related to census issues, based upon the business practices of the CMHC involved.

Each SMHH will define its operational capacity (based upon such factors as budget status, staffing situation, and other contributing factors), and will communicate that operational capacity to CMHCs and Health Care Policy staff. Likewise, as changes develop in the operational capacity, those changes will be communicated. Included in the definition of operational capacity will be a description of what threshold issues, events or status will trigger a notice that the SMHH is "approaching capacity" and needs assistance from CMHCs and others.

When a SMHH's census increases to the point of approaching capacity, CMHC staff, SMHH staff and SRS Mental Health Services staff will work together to attempt to decrease admissions, increase discharges, and explore other measures to avoid exceeding capacity. Responses could include any one, or any combination of, the following:

1. The SMHH Superintendent (or the State Mental Health Program staff) shall notify CMHCs that census status has triggered a notice of approaching capacity, providing whatever context information will be helpful in problem solving. The notice will go to each CMHC according to their identified preference for such notices. While the practice goal will be to avoid the sending of such notice, including through ongoing communication with all CMHCs about census and other business issues, we all recognize that on occasion such a notice will be necessary. All persons communicating about these issues will keep in mind that rushed and pressured communication inherently carries the increased risk of alarming its recipient and prompting a defensive reaction. Extraordinary effort should be made by all involved to be available for dialogue and open to hearing both creative solutions and frustrating realities during these discussions. If there are particular communication protocols available during these situations (such as the availability of 24/7 phone access to a management staff at the SMHH), they should be included in the notice.

2. The SMHH Superintendent shall conduct a review of all patients who are at or nearing completion of treatment/stabilization, and who are prepared or preparing for discharge. In this regard, the following information shall be provided to the SRS Director of Mental Health Services and the applicable CMHCs :

    A. Summary information about individuals who are clinically prepared for discharge, including name, county of residence and CMHC; why discharge is not occurring; and a brief description of the anticipated discharge plan.

    B. Summary information about individuals who appear to need developmental disability services including name, county of residence and CMHC; if already being served

through a CDDO, which one; if not already being served, whether a CDDO referral has been made (and which CDDO, date of referral and status or results of referral).

C. Summary information about individuals who appear to need substance abuse services including name, county of residence and CMHC; whether a RADAC referral has been made (and which RADAC, date of referral and status or results of referral).

D. Summary information about individuals who appear to need aging-related services including name, county of residence and CMHC; whether an aging services (AAA or nursing facility) referral has been made (and which service system, date of referral and status or results of referral).

E. Other current issues that individuals at the SMHH are experiencing which present challenges for discharge.

3. The State Mental Health Director will notify Mental Health Field Staff of census issues generally. Only if specifically requested, Mental Health Field Staff will make themselves available to assist with problem solving a particular issue associated with census management. Involvement of field staff will be on a case- or issue-specific and as-requested basis only.

4. When census continues to approach SMHH capacity, the SMHH Superintendent, CMHC staff as designated by each CMHC, and State Mental Health Director should consider and decide upon pursuit of the following options:

A. The SMHH Superintendent may contact other state hospitals, including State Mental Retardation Hospitals, to consider possible patient transfers or to refer patient admissions (with referral of new admissions being considered first). SMHH staff will continue to work with applicable CMHCs to assess best options for such transfers or referrals. If new admissions need to be diverted to another state hospital, it will be done in active consultation with any CMHC involved and the other state hospital involved, and with geographic and volume variables taken into consideration.

B. Admission and/or discharge problems related to a specific state hospital will be identified. Resolution could include accessing or providing technical assistance related to contributing treatment issues, exploring alternative community service options or arrangements, sharing of resources from other hospitals, and/or contracting with other CMHCs or private providers for short-term solutions.

C. Partnerships will be explored with community inpatient facilities, to determine the feasibility of those facilities providing treatment through contracting arrangements under specified census conditions.

5. If it appears that new resources will be essential to meet the demand for SMHH services, the SMHH Superintendents and Director of Mental Health should develop specific recommendations about such resources and present them to the Deputy Secretary for review and decision.