

**WEST VIRGINIA BEHAVIORAL HEALTH PROVIDERS ASSOCIATION RESPONSE TO THE JANUARY 10, 2011
REPORT OF THE SPECIAL ASSISTANT TO THE OFFICE OF THE COURT MONITOR REGARDING THE HIGH
RATE OF INVOLUNTARY COMMITMENTS RESULTING IN THE OVER-BEDDING OF STATE PSYCHIATRIC
HOSPITALS**

FEBRUARY 10, 2011

The West Virginia Behavioral Health Providers Association (WVBHPA) sees four main issues currently intersecting as problems/solutions to this phenomena: the decay of community services in the West Virginia Behavioral Health System over the past decade leading to the increase in involuntary commitments; the slow but steady growth in forensics patients housed in our State Psychiatric Hospitals; Judge Bloom's Court Order demanding that certain community support services be funded to re-established, restore and develop a more effective Behavioral Health System of care for all West Virginians in need of services; and last but not least, funding such an effort. This WVBHPA response attempts to build on the recommendations of the Special Assistant and make suggestions to develop such a system of care.

West Virginia was a national leader in the de-institutionalization movement for person with psychiatric and intellectual disabilities in the 60s and 70s. Prior to that West Virginia State Institutions warehoused as many as 6000 of its citizens. By the 80s a remarkable and nationally acknowledged effort successfully transitioned nearly all of those patients into our communities. The combined efforts of the West Virginia Department of Human Resources (Office of Behavioral Health Services) and 14 Comprehensive Community Mental Health Centers from across the state accomplished this achievement utilizing case management services, group homes, day treatment programs, and community support services. Patient census was low in our State Hospitals during this time and a considerably smaller new replacement State hospital (Sharpe) was built in Weston in the 90's. Throughout the 90's excess capacity existed at both Sharpe and Bateman Hospitals.

It is well documented that the Involuntary Commitment rate in our State increased by nearly 400% from 2000 – 2004 and has continued to increase since then. The unprecedented increase of Involuntary Commitments which led to the over-bedding problem is correlated with the reduction of service utilization as a result of the 2000 initiation of West Virginia's first version of Medicaid Managed Care administratively provided by American Psychological Services (APS) Healthcare. Part and parcel to the effects of APS, simultaneously other significant funding reductions to community services occurred in the West Virginia Behavioral Health System. While operating expenses continued to increase, Medicaid reimbursement rates were frozen for nearly a quarter of a century. Vital services such as group homes, day treatment programs and community support programs (in-home care for persons with psychiatric disabilities) were no longer paid for and were subsequently closed. This was the result of Medicaid's determination that these services were not medically necessary, thus not eligible for reimbursement and the lack of a reintroduction of State dollars to continue these services. This combination of factors resulted in many Comprehensive Mental Health Centers managing their operations differently focusing

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on crisis psychiatric emergencies rather than providing the traditional psychiatric and clinical treatment paired with critical stabilizing and supportive community based array of services. Subsequently, when assessing and meeting patient needs primarily during a psychiatric crisis, to a great extent, the option of utilizing the Involuntary Commitment process became the only avenue available, and hence resulted in the “over-bedding” problem in our State Psychiatric Hospitals (see the WVBHPA 2010 Crossroads Report).

THE RESTORATION OF COMMUNITY SERVICES

The WVBHPA opposes any regression or movement toward the continuation of re-institutionalization or warehousing of patients with psychiatric and intellectual disabilities in an attempt to solve the “over-bedding” problem primarily caused by increased Involuntary Commitments resulting from a decade of reductions in community options. The WVBHPA continues to support the development of an accessible, integrated, Behavioral Health System that provides a full continuum of behavioral health care within one hour of any resident. Providers support Evidenced-Based community programs such as Assertive Community Treatment (ACT), Crisis Stabilization Units and Intensive Outpatient Programs in combination with Residential Supportive Housing, Transitional Housing, Group Homes and Day Treatment Programming for West Virginians suffering from persistent psychiatric, addictive and intellectual disabilities including the forensic patients clinically ready for discharge from our two State Hospitals. These vital community based services are consistent with what Judge Bloom, BHHF and the Petitioners have agreed to as a step in the right direction to reverse the historical effects of the last decade with regard to the “over-bedding” issue.

One of the first positive steps DHHR took in response to Judge Bloom’s court order was a review of and eventual increase to many Behavioral Health Medicaid rates. Given the financial realities of professional salaries, adequate benefits and risk management issues, never again should a behavioral health service provider have to wait 25 years for a rate increase. We support legislative movement to require annual reviews and recommendations for such rates. Additionally, the WVBHPA appreciates that, though initially delayed, the BHHF has moved to implement the court ordered group homes, residential supportive living programs and dual diagnosis programs. We are now near the end of the second year of Judge Bloom’s Court Order requiring specific improvements to community behavioral health services. Decisions for funding pertaining to these projects were made a year ago and year-one funds for group homes and residential supports have now been distributed for the development of these vital community support services that both the court, BHHF and petitioners have identified as essential to rebuilding our Behavioral Health System. Year-two funds for the same types of services, in different

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geographical regions, have recently been sent to mental health centers in the form of “change orders” to initiate the same types of community based programs. Providers identified for year-three funding have recently submitted proposals for strengthening their community based services and it is anticipated that year-three funding will be available on time in July 2011. These very positive changes will allow for the initiation of the reconstruction of our community services which will strengthen the regional continuums of care throughout our state.

Providers disagree with the Special Assistant’s Report that the pressing issue regarding the “over-bedding” problem is the increase of the forensic patients in our State hospitals. The “over-bedding” problem is a result of a short sighted response to the forced decay of community services as previously described. Prior to 2000 there were no diversions. In 2004 the State paid \$4,000,000 to divert patients to community hospitals. The State, in its “diversion process” now annually spends over \$14,000,000 to deal with this self inflicted wound. West Virginia’s Involuntary Commitment rate as tracked over 10 years has increased by 400%, some provider service areas commit over 700 residents per 100,000 residents as compared to a national average of 80. The WVBHPA believes that this cost could be significantly reduced by competent utilization management at both the State hospitals as well as diversion hospitals. As reported in the Special Assistant’s data (Appendix B) lengths of stay in our two State Hospitals for “non-forensic” patients were 138.89 days at Sharpe and 379 days at Bateman. These are unacceptable and staggering statistics that far outweigh our forensic problem. Conversely, only 34% of Community Hospital diversions had lengths of stay longer than 20 days. While most diversion hospitals contract with BHHF to treat Involuntarily Committed patients for \$700/day, recently released data from BHHF reveals that several hospitals receive on average over \$1,000/day and some as much as \$1,300/day. Certainly these costs are more controllable with proper utilization management and reimbursing hospitals at such extreme differences leads to the very manipulation that the Special Assistant states is not occurring.

Providers also disagree that that current Crisis Stabilization Units, as stated by the Special Assistant, “do not appear to be accepting patients who are legitimately in crisis that would otherwise require inpatient acute care”. Further, providers strongly disagree with the Special Assistant’s belief that “the current incarnation of CSUs is an appropriate placement for individuals who recognize their need to take a break from stressful situations in order to regroup, and gain some perspective”. In fact admissions to CSUs are clinically reviewed and pre-authorized by APS, the very administrative managed care entity that is correlated with reducing community service utilization and resulting increased costs to the State due to the resulting in increased involuntary commitments and diversions. Patients admitted to CSUs are determined to be in a crisis and are clinically differentiated from patients appropriate for inpatient psychiatric units or State hospitals. To explain in terms of a continuum of care, the State hospital patient has actively been a behavioral threat to harm himself or someone else, i.e. actively homicidal or suicidal. The community hospital patient is suicidal with a plan. The CSU patient is in crisis but not to these extremes. However, to dispute an inaccurate conclusion of the Special Assistant, the CSU facility,

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unlocked but with a staff- secure environment could provide a higher level of care, given proper reimbursement to account for the risk management concerns, for some diversions or “step-down” patients from State hospitals, inpatient units or even other types of disenfranchised patients (such as persons with addictive disorders in need of detoxification, the psychiatric homeless or psychiatric patients needing transitional care) if reasonably paid.

Funding for such a system is challenging. DHHR has already earmarked a sizeable portion for community supports over the next three years in the form of Group Homes, Residential Supports, Day Treatment Programming and Dual Diagnosis Treatment which should go a long way toward addressing the “over-bedding” problem. Transfer of diversion funds under the budgeted amount of \$9M is another potential source although last year and this year the actual amount is \$14M and this funding source cannot be creatively utilized until the costs are contained at \$9M. A third source of funding is uncompensated care dollars and a work group is currently studying alternative distribution methods such as “fee for service” and “infra-structure” supports to determine their best utilization for outcomes. Lastly, there is savings in utilization management of diversion monies in both our State Hospitals and Diversion Hospitals.

To summarize, we believe given Judge Bloom’s Order, and BHHF’s implementation of community services demanded by the Order, that our vision of a newly developed and functional West Virginia Behavioral Health System is in the beginning stages of recovery. Establishing regionally integrated behavioral health continuums of care; improving utilization management in State and Diversion Hospitals, including structured and secure discharge planning for forensic patients; and creative, coordinated utilization of Crisis Stabilization Units including the development of a more responsive addiction recovery network, should be the second step in the evolution of the system.