

Access and Alternatives Work Group Executive Summary

Senate Joint Resolution No. 94 directs the Joint Commission on Behavioral Health Care, in conjunction with the Joint Commission on Health Care, to study and recommend long-term solutions to the shortage of inpatient psychiatric beds and the adequacy and access to outpatient mental health treatment. In order to fulfill this request, the Department of Legislative Services partnered with the department of Mental Health, Mental Retardation and Substance Abuse Services and other public and private-sector entities to further define the problems associated with psychiatric inpatient access and to develop systemic remedies to ameliorate the problems. The Access and Alternatives Workgroup, which included a broad range of stakeholders from the public and private sectors, held four meetings over a six-month period, to review data relative to the problem, evaluate options for improving the services system, and to develop short-term and long-term recommendations to inform the Joint Commission on Behavioral Health Care and the Restructuring Workgroup.

The Access and Alternatives workgroup concluded that the Commonwealth is experiencing a significant problem across the system of mental health services to the extent that there is insufficient care capacity for Virginians in need of acute and long-term psychiatric services. Across the state, providers are experiencing increased demand for services, public hospitals are operating at capacity, and the resources necessary for hospital and community staff to discharge individuals into the community are in short supply, thereby significantly delaying patient discharges and thus further limiting access to beds. The problem is systemic, encompassing acute care hospitals, state psychiatric facilities and community services boards, and may be described as a statewide access problem that has less to do with a shortage of actual beds than with the availability and distribution of inpatient and outpatient resources.

The Workgroup further concluded that public hospitals, community providers and acute care hospitals must work together to address this challenge. There can no longer be a clear delineation of public and private sector services but an interdependent system that provides stations in the continuum of care that will enable a better fit between an individual's severity of illness and his intensity of service needs. To achieve this, collaboration, coordination, and communication between various services providers must be enhanced at all points along the service continuum, and all parties must work together and direct available resources towards the resolution of the problems and the achievement of a system that is integrated rather than polarized. Specifically, the Access and Alternatives Workgroup offers the following recommendations:

Short Term Strategies to Address Bed Access and Community Services Availability:

- Decentralize the state hospital forensic review process to expedite the review of forensic patients ready for release.
- Establish, within the Department's Division of Health and Quality Care, a centrally organized and supervised utilization management function for state facilities.
- Develop a standardized level of care determination tool for use by all CSB emergency services pre-admission screeners to assess the severity of the patient's illness; determine the intensity of care needs; and identify the most appropriate placement.

- Develop an acute care model of treatment for patients who require a short-term stay in public sector hospitals.
- Retain and further develop programs with proven records of effectiveness in reducing inpatient bed utilization, e.g. crisis stabilization, 23-hour psychiatric holding, residential beds, and social detoxification.
- Expand the availability of consultative, educational and treatment services that are provided by facility staff to supplement community services board expertise in such areas as psychopharmacology, child and adolescent services, and geropsychiatry
- Explore the impact of new Departmental regulations on hospital admission practices and resource allocation strategies and evaluate the risk and benefit to clients.

Long-term Strategies to Address Bed Access and Community Services Availability

- The Department, CSBs, acute care hospitals, and the Department of Medical Assistance Services should work together to reassess community treatment needs and identify alternative services for treating acute psychiatric episodes in a community setting.
- Evaluate the feasibility of structuring funding streams to offer incentives for the development of alternative services, such as:
 - o Assignment of inpatient care budgets to each community services board;
 - o Establishment of a system whereby community services boards and facilities share penalties for non-certified bed day use; and
 - o Evaluating options to improve Medicaid reimbursement for services.
- Develop mechanisms to routinely and objectively evaluate needs; identify options to address the need; and ensure that funding for new service options provides for infrastructure development, as well as direct service costs.
- Create regional structures with representatives from state hospitals, acute care community hospitals and CSBs to develop alternatives to state hospital placement; identify local and regional needs; and develop strategies to break down among providers.
- Reconfigure resources from a bed focus to a community focus.
- Utilize protocols from evidence-based practices that are known to be effective in working with individuals with serious mental illness in community settings.

Establish a centralized triage center that will operate 24 hour, 7 days a week basis to assist in locating available beds throughout the Commonwealth.

Report of the Access and Alternatives Work Group

Introduction

The Commonwealth is experiencing a serious and urgent problem in its system of mental health services. Providers are experiencing increased demand for services across the system of care, as well as mounting difficulties in accessing psychiatric inpatient beds and arranging for community based alternatives to inpatient care. Public sector community service providers, community hospitals, and other services providers' concerns about the increasing demand for these services and the shrinking supply of beds available for persons with a serious mental illness who are served by the public sector is escalating to the extent that many consider the present situation a crisis.

The system is confronted with multiple factors that influence inpatient resource utilization and management. Rising health care costs, an increase in the number of uninsured, a community services system that must respond to terrorism, a general economic downturn, licensing and regulatory requirements, and a shortage of qualified personnel are all integrally related to the issue of public and private hospital access and the availability of community alternatives to hospitalization. Clinically, all segments of the service system must address the needs of a more psychiatrically and medically complex client population. State facilities are experiencing an increase in their geriatric and forensic populations while private hospitals and community providers are asked to address the needs of people with serious psychiatric impairments and multiple community needs and individuals with violent behaviors. All of these factors, as well as others are integrally related to the issue of public and private hospital access and the availability of community alternatives to hospitalization.

A range of factors influences both the availability and access to state inpatient services. While admission to a DMHMRSAS psychiatric facility is largely driven by the individual's service needs, the multiple requirements imposed on state facilities have increased the cost of care, created barriers to the development of short-term (e.g., three to five day) acute stabilization services, offset efforts to reduce hospital lengths of stay, and contributed to an overall decrease in the availability of beds. The availability of acute care inpatient beds cannot be fully understood or problems with access addressed unless the issue of community resources is also included. The ability for hospital and community staff to discharge individuals from acute care beds into the community is predicated on the availability of adequate community resources. Those resources range from adequate levels of case management, housing, employment or adequately structured day activities, education/ training, and general healthcare. If those resources are in short supply, then discharging individuals from acute and long-term hospital stays is significantly delayed, thus further limiting access to beds.

As with the public sector, there are additional factors that influence access to acute care hospital beds in the community. Increasing numbers of individuals with serious mental illness are accessing services through acute care hospital emergency departments. The federal Emergency Medical Treatment and Active Labor Act (EMTALA), requires hospitals with emergency departments to provide medical screening and stabilization services to any person who comes to the emergency department requesting services for an emergency medical condition.

However, not all private psychiatric hospitals have the programs or specialized staff to treat individuals with complex psychiatric conditions, e.g., dually diagnosed with mental illness and a coexisting mental disability and those who are aggressive and violent. And, while acute care hospitals in the community provide a considerable amount of charity care, (Table 1) the rising demand for service by individuals who are uninsured or underinsured is creating a serious financial burden on these hospitals.

Table 1
Payers and Charges for Private Psychiatric Hospitals
Calendar Year 2001

Payer	Volume	Average LOS	Average Charge
Indigent/Charity	491	4.17	\$4,290.84
Self Pay	3737	3.88	\$4,550.69
Medicare	14137	8.63	\$9,468.40
Medicaid	7682	8.04	\$6,951.88

The pressures to respond to these new and growing demands have been intensified by recent state budget reductions. Community services boards face a 10% reduction in their budgets, which will affect inpatient utilization. The issues of shrinking resources, multiple external requirements, the increasingly complex treatment needs of clients, and a shortage of qualified personnel have created a sense of urgency to find strategies that will provide some immediate relief for a services system that is attempting to cope with multiple external pressures and shrinking internal resources. Long-term solutions also are needed to prevent the erosion of service quality and provide the stability that the citizens of the Commonwealth have come to expect from their public service system.

Problem Definition

Legislative interest in this issue prompted the enactment of Senate Joint Resolution No. 94 directing the Joint Commission on Behavioral Health Care, in conjunction with the Joint Commission on Health Care, to study and recommend long-term solutions to the shortage of inpatient psychiatric beds and the adequacy of access to outpatient mental health treatment. In order to fulfill this request, the Department of Legislative Services partnered with the Department of Mental Health, Mental Retardation and Substance Abuse Services and other public and private-sector entities to further define the problems associated with psychiatric inpatient access and to develop recommendations to address the problems. Participants in the meetings included representatives from MCV, Virginia Hospital and Healthcare Association (VHHA), DMAS, VDH, Tucker Pavilion, Sentara, Bon Secours Maryview, DMHMRSAS, and several CSBs. The group met on four occasions: April 11,2002, June 27,2002, September 17, 2002, and October 25, 2002. The following report summarizes the deliberations and recommendations of the Access and Alternatives Work Group.

Problem Evaluation

Source of Data: The workgroup's approach to problem evaluation included a review of previous study reports of the issues, available data, and qualitative information obtained from both the service provider and advocacy community. Data on private psychiatric inpatient services was obtained from Virginia Health Information and is based on the calendar year. Acute care community hospitals data for 2001 was estimated, using data from the first three quarters of 2001. Public inpatient and Community based data were provided by the DMHMRSAS, which utilizes the fiscal year (July through June) for reporting purposes. DMHMRSAS data for 2002 was derived using data from the first eleven (11) months of that fiscal year.

Previous Studies: A profile of the bed needs of the Commonwealth, conducted by the Virginia Health and Hospital Association's Needs Assessment Task Force provided support for the concerns expressed by service providers by showing a decrease in community hospital acute inpatient psychiatric bed availability. Similarly, an October, 2001 report prepared by a task force of the Virginia Association of Community Services Boards summarizes the problem as follows: "All communities are experiencing a critical shortage of psychiatric beds for adults, children and adolescents, and special populations (e.g., dually diagnosed MH/MR and MH/SA). This shortage is severely impairing community capacity to support the treatment needs of residents. Reduction in numbers of acute care community hospital psychiatric beds is intensifying this problem, as is action by the Commonwealth to downsize state facilities."

Bed Availability: While it is the case that public sector inpatient psychiatric beds are essentially operating at capacity, overall, it is important to note that there is considerable variation across the Commonwealth with regard to bed availability and occupancy rates. The data for bed availability and occupancy rates in Table 2 show that, during the past two years, 478 public and acute care hospital psychiatric beds were closed. One hundred and sixty one (161) acute care hospital psychiatric beds were closed between 2000 and 2001 and 312 state psychiatric beds were closed in the first three quarters of 2002.

Bed Occupancy: A low bed occupancy rate means that beds are readily available when an emergency requires hospitalization. However, low occupancy also means that funds are not being managed efficiently because physical plant and staffing cost accrue so long as these beds are open. By contrast, a high occupancy rate means that individuals who require inpatient care often are unable to access beds. A high occupancy rate is desirable, from a cost perspective, because it improves the efficiency of staff utilization and physical plant resources, which are the hospital's highest costs. However, the role of the public sector is to provide services to individuals who are in need and unable to locate appropriate services in acute care community hospitals. Therefore, from a public sector perspective, occupancy rates should allow people who require services to access an inpatient bed, when needed.

The data in Table 2 show that for the public sector, bed occupancy is high but this occupancy rate is only apparent in 2002 data, suggesting that it is the result of a significant change rather than a growing trend. Private bed occupancy shows some increase between 2000 and 2001 but it is not sufficiently high to suggest a shortage of beds. Although no data are available, many

Work group members suggested that one explanation for the high occupancy rate in state hospitals is that there is a shortage of staff, particularly registered nurses, in the current marketplace. Without adequate staff, hospitals will be unable to expand their complement of beds, even if the increase in demand that is evident in 2001 and 2002 continues.

The change that produced the sharp increase in state hospital bed occupancy is evident in the data. Between 2001 and 2002, the Department closed 312 staffed beds. The combined occupancy rate for Central State Hospital and Piedmont Geriatric Hospital between FY 2001 and 2002 increased by 14% after a reduction of 130 psychiatric beds in that region. Similarly, Eastern State Hospital's occupancy rate increased by almost 11% between 2000 and 2002, after 56 of the hospital's beds were closed. Acute care hospital occupancy in the Eastern region also increased from 54% to 87% between 2000 and 2001, after 78 psychiatric beds in acute care hospitals were closed. In Southwest Virginia, state facility staffed bed occupancy increased by a full 27% between 2001 and 2002, when the number of beds dropped by 165. Several workgroup members expressed concerns about the lack of 2002 occupancy data for acute care community hospital occupancy rates because they believe the existing data does not demonstrate the full effect of these closings on regional occupancy rates.

Bed Utilization: One possible explanation for the perceived shortage of psychiatric beds in the Commonwealth may be found in bed utilization data. These data are not available for acute care community hospital; however, the public sector data suggests that long-term populations such as geriatric patients and forensic patients are utilizing an increasing number of psychiatric beds. In FY2002, forensic patients accounted for 28% of all patient days and geriatric patients accounted for 24% of all patient days. This means that only 48% of all bed days were available for acute and long-term patients. Further analysis of the data shows that, in FY2002 there were 1,557 non-forensic, adult bed days but only 147, approximately 10% were devoted to acute patient care.

In summary, it appears then that the perceived shortage of beds in the state may be due, in part, to the limited number of acute care beds in state psychiatric hospitals. Although acute beds are available in the acute care community hospitals, workgroup members suggested the available complement of inpatient beds often does not fit the cohort of individuals who are seeking admission, e.g., patients with complex psychiatric problems, patients who are violent and aggressive, and those with complex discharge needs. The workgroup further suggested that additional community resources will allow community services boards to treat long-term patients who are discharge ready, thus freeing up additional beds for patients who require short-term stays.

Table 2
Occupancy Rates for Public and Private Psychiatric Hospitals
1998 - 2002

Virginia Regions	Acute Care Hospital		Public Sector Hospitals	
	Staffed Beds	Staffed Bed Occupancy	Staffed Beds	Staffed Bed Occupancy
Central				
1998	379	67.23%	581	86.9%
1999	525	72.42%	581	85.3%
2000	525	79.35%	516	83.4%
2001	441*	81.24%	516	79.9%
2002*	-		455	94.3%
Eastern				
1998	373	58.25%	581	86.9%
1999	373	59.68%	581	85/3%
2000	373	54.23%	581	83.7%
2001	296*	87.39%	581	84.8%
2002	-		530	94.5%
Northern				
1998	290	56.45%	148	72.3%
1999	290	53.88%	148	84.8%
2000	290	57.29%	137	88.3%
2001	290*	57.87%	137	86.7%
2002	-		127	93.9%
Northwestern				
1998	179	49.69%	424	88.7%
1999	179	50.69%	369	89.3%
2000	179	57.30%	312	88.5%
2001	179*	64.30%	312	82.7%
2002	-		287	88.6%
Southwestern				
1998	217	64.43%	529	86.2%
1999	217	64.51%	529	74.9%
2000	217	62.81%	523	65.7%
2001	217*	83.75%	523	61.8%
2002	-		358	89.1%
Children/Adol	NA	NA		
1998			48	75.7%
1999			48	76.8%
2000			48	77.5%
2001			48	76.3%
2002			48	74.5%
State Totals				
1998	1,438	60.12%	2,394	87.2%
1999	1,484	62.49%	2,336	81.9%
2000	1,584	64.64%	2,117	80.0%
2001	1,423*	76.01%	2,117	77.5%
2002	-	-	1,805	91.9%

* Data based on first three quarters of the reporting year.

Actions Taken to Address Bed Access

The Department has undertaken a variety of strategic interventions, clinical, administrative and budgetary, to help manage and control the utilization of inpatient resources. Administrative interventions over the years have included modification of facility catchment area and back-up responsibilities, clarification of priority target populations, promulgation of a standardized discharge planning protocol thereby strengthening role of CSBs, implementation of uniform preadmission screening processes, and development of the a CSB preadmission screener certification process thereby establishing minimum education and raining standards for staff assessing the need for hospitalization. Budget actions have included the establishment of several census management initiatives around the Commonwealth involving any of several strategies, including purchases of local inpatient services and awarding fiscal incentives to CSBs for reduced state hospital utilization. Several ongoing strategies are as follows:

Virginia PACT

Programs of Assertive of Community Treatment or PACT are self-contained clinical teams that assume responsibility for directly providing needed treatment, rehabilitation, and support services to identified clients with severe and persistent mental illness. Caseloads are small with no more than 10 clients to one clinical staff person. Services are provided on a long-term basis and 75% or more of the services are provided outside program offices. Virginia has 15 PACT teams that served over 1,000 clients in FY 01. The average cost per consumer served was between \$15,000 and \$18,000 per year. The savings from this program are realized through reduced bed utilization and reduced bed day use. DMHMRSAS data show that, since 1999, a sample of PACT consumers showed a 71% reduction in bed utilization and 87% reduction in the number of bed days used when compared with matched consumers who were not served by a PACT team. Actual savings to the Department occur when the number of State hospital beds is reduced. These results are similar to those found by the Veterans Administration Hospital and other hospital systems that have implemented the PACT treatment model.

Sentara's Life Coach Program

Sentara Health initiated the Life Coach program to assist discharged patients in accessing needed services in the community. Under this model, discharged psychiatric clients are assigned a life coach who assists in applying for benefits, keeping appointments, and accessing other needed community services. Data collected by Sentara during the first year of the pilot program show that 88% of individuals who were assigned a life coach kept their appointments with outpatient psychiatric service providers. Further, there were 56% fewer emergency room presentations for this cohort and their readmission rate was 37% lower than that of clients without life coaches. These preliminary data show a savings of \$73 per member per month for clients with Life Coaches. Life Coaches are generally professionals, such as licensed clinical social workers and masters prepared nurses. Sentara will begin testing the effectiveness of volunteer Life Coaches in the near future to determine if similar results can be achieved with greater savings.

Evidence-based Practice

Research funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and by the Robert Wood Johnson Foundation has identified at least six evidence-based-practices that make a difference in improving the lives of people with serious mental illness. These practices include: (i) integrated treatment of people with severe mental illness and substance use disorders; (ii) supported employment; (iii) medication prescribing for specific illness; (iv) case management based on the principles of assertive community treatment; (v) illness self-management; and (iv) family psycho-education. Many of these evidence-based-practices require the implementation of clinical practice guidelines and a well-structured support system to ensure that clinicians adhere to guidelines. Implementation typically requires a sophisticated information management system, extensive training, and an administrative system to monitor compliance and evaluate outcomes. However, some of the practices recommended by SAMHSA, such as family psycho-education, can be implemented without formal guidelines or an extensive support system.

Public Sector Census Reduction Projects

- Region IV Acute Care Project

The goal of this project is to provide a local alternative to acute care in a state facility. Comparing the mean and median length of stays in the project population and the state facility, the project population has a median length of stay 26 days shorter than the state facility and an average length of stay 105 days shorter than the state facility. Recidivism to acute hospitalization was reduced to 8.3%. Recidivism rates for similar populations range from 15% to 21.2%.

- Discharge Assistance and Diversion Project (DAD) - Region II.

This project is managed through an Agreement with the Community Service Boards, the Northern Virginia Mental Health Institute (NVMHI) and the Department of Mental Health, Mental Retardation and Substance Abuse Services. This project has been in practice since its inception in 1993. The project has evolved through experience into the current agreement for purchase of beds at local community hospitals when the Northern Virginia Mental Health Institute is full. Through regional management, DAD is able to provide an alternative to state hospitalization when acute inpatient care is identified as a need. In 2002, this project admitted 333 consumers for a total of 2049 bed days, for a cost of \$854,836. Through the regional management approach, this current fiscal year, the average length of stay has been reduced to 5.7 days, thereby increasing the availability of inpatient beds.

- Discharge Assistance Program (DAP) DMHMRSAS

This program was developed as a means to support client centered discharge planning and currently has 329 consumers enrolled. All clients all have experienced prior state hospital admissions, with an average of 6 admissions. Program data indicate that DAP. Client use of state hospital admissions was reduced by 81%, translating into a reduction in bed days by 93%. Using a matched comparison with state hospital patients, the state

hospital group had 1.7 times as many admissions as the DAP group. Further, the state hospital group used 3.6 times as many bed days.

Conclusions

- The occupancy rate for the Commonwealth's acute care hospitals, as reported by Virginia Health Information, is 76.01%, in calendar year 2001, with considerable variability between regions.
- Public sector beds are essentially at capacity.
- The pressure on the public sector will increase if Northern Virginia's proposal to close 120 beds in Fairfax County is implemented. Northern Virginia has a large number of uninsured individuals and those who are ineligible for Medicaid; these patient groups only have access to public sector beds.
- Length of stay in acute beds within the DMHMRSAS system often exceeds what is generally considered to be an acceptable acute care length of stay. This phenomenon prevents other acute care patients from accessing these beds.
- Virginia needs a new vision for its system of services for individuals with mental illness. Both public and acute care community hospitals are facing problems of fewer resources, lower reimbursement rates for clinicians, and outpatient systems that are unable to keep pace with demand. The public and acute care community s must work together to address this challenge.
- Collaboration, coordination, and communication between public and private providers and between hospital and community-based providers, must be enhanced at all points along the service continuum. A related imperative is the need for public and private sector participation and involvement in all statewide, regional, and local mental health planning initiatives.
- Regulatory requirements should be reviewed and, as appropriate, modified, to minimize apparent redundancies, unintended administrative burdens and fiscal disincentives.

Recommendations

Short Term Strategies to Address Bed Access and Community Services Availability:

- Establish, within the Department's Division of Health and Quality Care, a centrally organized and supervised utilization management function for state facilities. A centralized function will ensure the use of commonly accepted acute care review criteria across all facilities; objectify the process; and provide for a more rigorous and consistent utilization review process.
- Decentralize the state hospital forensic review process to expedite the review of forensic patients ready for release.
- Develop a standardized level of care determination tool, such as the LOCUS, for use by all CSB emergency services pre-admission screeners whereby specific and uniform indices are available to assess the severity of the patient's illness; determine the intensity of care needs; and identify the most appropriate placement.

- Develop an acute care model of treatment for patients who require a short-term stay in public sector hospitals. Similar to the model used in the acute care community hospitals, this model would focus on both stabilization in the hospital and the maintenance and further development of the patient's community support system. In other words, maximize CSB active involvement in acute stabilization and discharge planning during an acute treatment episode.
- Explore the impact of new Departmental regulations on hospital admission practices and resource allocation strategies; identify those requirements that pose the greatest regulatory burden and evaluate the risk and benefit to clients.
- Programs with proven records of effectiveness in reducing inpatient bed utilization, e.g. crisis stabilization, 23-hour psychiatric holding, residential beds, and social detoxification, should be retained where currently existing and further developed to provide stations in the continuum of care that will enable a better fit between the severity of illness and the intensity of service requirements than a polarized inpatient versus outpatient only option.
- Expand the availability of consultative, educational and treatment services that are provided by facility staff to supplement CSB expertise in such areas as psychopharmacology, child and adolescent services, and geropsychiatry. Specific actions may include collaboration by facility and community staff to develop new models of service delivery for special populations in the community; facility staff providing consultation, education, and intensive on-site training in community treatment settings; and sharing costly or scarce treatment personnel and resources.

Long-term Strategies to Address Bed Access and Community Services Availability

- The Department must work with community services boards, the acute care community hospitals, and the Department of Medical Assistance Services to reassess community treatment needs and identify alternative service models for treating acute psychiatric episodes in a community setting.
- Funding streams must be structured to offer incentives for the development of alternative services. Options include the following:
 - o Assign inpatient care budgets to each community services board, based on inpatient bed use for the past two years;
 - o Establish a system whereby community services boards and facilities share penalties for non-certified bed day use. While any fiscal penalties would be nominal, such action would establish a structure long envisioned by the Department of fiscal accountability in which "funds follow the client." It is envisioned that the funds would be assigned to a risk pool which would be used to fund or otherwise support the development of public and/or private sector community-based services; and
 - o Evaluate the feasibility of establishing a Home and Community-Based Waiver for individuals with serious mental illness.
- The mental health system must shift from a resource-based model to a needs-based model. Mechanisms must be put in place to routinely and objectively evaluate needs; to identify the most appropriate options to address the need; and to ensure that funding for new service options provides for infrastructure development, as well as direct service costs.
- Reconfigure resources from a bed focus to a community focus.

- Create a regional review structure that includes representatives from state hospitals, CSBs and acute care community hospitals. Guided by a centralized goal-setting process, these regional groups would develop appropriate alternatives to state hospital placement; identify local and regional needs; and develop strategies to break down barriers in service coordination, communication, and consultation among providers.
- Utilize protocols from evidence-based practices that are known to be effective in working with individuals with serious mental illness in community settings.
- Establish a centralized triage center that will operate 24 hour, 7 days a week basis to assist in locating available beds throughout the Commonwealth.

Access and Alternatives Work Group
Addendum to report: Child and Adolescent Beds

The issue of the availability and access to inpatient psychiatric beds has a great impact on children and adolescents as well as adults. Over the last ten years, the number of public inpatient psychiatric beds for children and adolescents has decreased from 172 to 64. The remaining public beds are located at the Commonwealth Center for Children and Adolescents in Staunton (48 beds) – meant to be a statewide facility – and Southwestern Virginia Mental Health Institute in Marion. The latter has 16 beds for adolescents only, mainly to be used by those in the southwestern part of the state, but also for overflow from CCCA.

State facilities for children are not distributed in a geographically equitable way: the two facilities are located in the western part of the state, while the population density is in the northern and eastern part of the state. The distance makes it extremely difficult for many children, particularly those in Tidewater, to utilize state facilities. There is a growing use of these state beds for court-ordered 10-day evaluations, meaning an increasing number of beds are being used to assess children who may or may not even have a mental health problem. This limits the availability of state beds for children with serious mental health needs who are not involved with the court system.

Concurrently, the number of private psychiatric beds has decreased markedly in the past several years, mostly because private facilities lose money on their child beds. Private insurance and Medicaid reimbursement rates are inadequate for covering costs of treating children and adolescents. Many private facilities have closed their children's units altogether or converted them to residential (non-acute) beds that are reimbursed through the Comprehensive Services Act. Estimating the number of acute care psychiatric beds in the private sector is difficult since the industry has been in a state of flux. Two recent attempts have been made to count the available beds. In May 2002, the DMHMRSAS licensing office contacted twenty private facilities that are licensed with acute beds for children and adults to get a count of the staffed beds. Not all facilities responded, and this data may be outdated already.

While the Access and Alternatives Work Group originally planned to address child and adolescent issues along with adult issues, this has not happened. The complexity of children's issues, as well as the difference between the adult and child systems, has made it difficult for the Work Group to discuss the needs of both populations effectively during this time frame. Several members of the Work Group recommended that the issue of access to children's beds needs to be addressed thoroughly in the near future. To help inform this process, this analysis should include information currently being collected by other entities:

- 1) DMHMRSAS is in the process of collecting data about children and adolescents who need acute care psychiatric hospitalization but are unable to find it within a day. (The original time frame was 24 hours, but it has since been adjusted to 8 hours.) This effort also includes data collection on the number of children needing residential treatment and not able to access it within a reasonable period of time and is a result of House Bill 887 and Senate Bill 446.

- 2) The Inspector General has recently completed a report on the underutilization of state beds for children.

The study of bed accessibility for children and adolescents should be coordinated with two other larger planning processes that are in place. First, the Secretary of Health and Human Resources' ongoing study of the Comprehensive Services Act could provide additional information about ongoing challenges and policy changes in the system of care for children and adolescents. Second, any plan for restructuring the mental health system needs to take into account the needs of children and adolescents – both for inpatient psychiatric care and for community-based alternatives.

Access and Alternatives Work Group
Addendum to report: EMTALA

Recommendations addressing the placement of behavioral health patients in public and private hospitals must take into account hospitals' screening, stabilization and transfer responsibilities under EMTALA. Any hospital with an "emergency department," defined in federal regulations as one offering services for emergency medical conditions within its capability, is required under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) to provide an appropriate medical screening examination to any individual who comes to the emergency department requesting treatment for an emergency medical condition. The hospital also must stabilize any identified medical condition or transfer an unstable individual to another medical facility if the patient so requests or to obtain stabilization that the screening hospital is unable to provide. EMTALA sets rules for "appropriate" transfers. Hospitals capable of specialized care must accept transfers of patients who require their services; even if a hospital has reached its occupancy limit, if it customarily accommodates any additional patients in excess of this limit, it also must do so for a transferred patient under EMTALA. CMS' interpretive guidelines of its EMTALA regulations state that even if a hospital, including a psychiatric hospital, has no established ED, if it offers emergency services for medical, psychiatric or substance abuse emergency conditions, it is required to comply with EMTALA. The law's applicability to state mental health hospitals is currently being analyzed. In practice, implementation of EMTALA is guided by a complex web of regulations, guidelines and case law; the interaction of EMTALA and state law as they apply to psychiatric patients further complicates compliance. The law's impact on psychiatric placements is significant.