HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA

Briefs Focus

Special Supplement for HASC Members

Managing Care for the Acute Mentally Ill in California is Insane

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Introduction

California's emergency rooms are becoming increasingly crowded with mentally ill and often disruptive patients, partly the result of inadequate mental healthcare and sometimes injudiciously written "5150 holds." Acute care facilities lacking psychiatric beds sometimes have to hold these patients for days, at significant expense. Medi-Cal reimbursement for psychiatric patients is inadequate; compensation for uninsured patients is all but non-existent.

The move toward involuntary outpatient treatment shows some promise, but its funding has often been uneven. Chronically understaffed and underfunded rural counties are unlikely, if ever, to implement such comprehensive reforms. Many medical providers consider it a single step in a gradual reform that may never completely occur.

Etiology of the Problem

Just months after he was first elected governor of California in 1966, Ronald Reagan proposed a radical reform of the state's mental healthcare system. Rather than warehouse mental health patients indefinitely in state institutions, they would instead be treated in their local communities. Only the most dangerous patients would remain institutionalized.

"It is our belief that local mental health programs offer the most feasible and enlightened way to achieve the best results for treatment of our mentally ill," Reagan said at the time.[1] However, Reagan seemed just as enthused by the prospect of saving money, primarily by proposing cuts of more than 3,400 jobs within the Department of Mental Hygiene.[2] Nonetheless, a bill encapsulating the reforms – which would be funded 75% from state and 25% from county funds – received bipartisan support.

The bill was not without its critics, led by the California State Employees Association labor union. Reagan called the CSEA critique a "propaganda campaign," and in a televised address vowed, "We will not submit to your blackmail. We are going to continue to do what we know is best for the mental patients, what is best for all the people of California."[3]

Concerns were raised shortly thereafter that Reagan had little intent to use state funds to continue providing care. Initial budget increases did little more than cover inflation and increases in population.[4] "It is clear without more money and incentive to increase local services, patients will be forced back into state hospitals… That would be a serious mistake," the Los Angeles Times warned in 1972.[5]

As it turned out, the newspaper's editorial page was only partially correct. Insufficient funding for mental health concerns has remained the norm in California. However, the operation of publicly-funded hospitals for the mentally ill continued to wind down in the decades after Reagan implemented community-based treatment.

One of the biggest blows was the 1997 closure of Camarillo State Hospital, the largest such institution in Southern California and the only state facility to treat both the mentally ill and the retarded.[6] In operation for more than 60 years, the Ventura County institution had not only pioneered many treatments for schizophrenia, but was a cultural inspiration of sorts as well: Charlie Parker, Frank Zappa and several renowned bands made reference to the hospital in their music.[7]

Instead, the state's acute care hospitals have become the often unwilling custodians for those in the community experiencing psychotic episodes or other bouts of instability. Their emergency rooms have become reluctant waystations for the mentally ill.

The 5150 Conundrum

Some of these deeply troubled patients are put into the category of "5150 holds," the section of the state Welfare and Institutions Code that allows a person believed to be of immediate harm to themselves or others to be held against their will for 72 hours for psychiatric evaluation. However, the code is Byzantine in terms of delegating this decision-making power. A peace officer with a high school education may designate a 5150 hold, but physicians and RNs who lack specific mental health training may not. Partly as a result, children who are having little more than an epic temper tantrum can be designated for a hold.

"It's at least a weekly occurrence. They will punch a wall or engage in some other out-of-control behavior," says Michelle Buckman, a clinical nurse specialist at Loma Linda University Medical Center.[8] Loma Linda averages about 60 5150 holds a month. Some of the holds have been as young as four, according to Buckman. Many are acting out because it gives them a respite from deeply unhappy and deprived family environments, she adds.

Partly as a result, Buckman and other healthcare professionals interviewed for this paper said they believe peace officers often exercise poor judgment in writing 5150 holds. Instead, they believe, it is done primarily to take the patient off the street and shift responsibility for their welfare to the providers.

"Law enforcement holds are notoriously poor. It is not their expertise; they are trained in crowd control and public disturbance management," says Heidi Lennartz, chief executive officer of Mission Community Hospital, which operates a combination acute care and psychiatric facility in the central San Fernando Valley.[9]

Even if a 5150 patient has insurance, a payer is more likely to depend on the psychiatric evaluation to actually authorize payment for care, Lennartz adds.

"The police may administer a 5150, but there are few places to put these patients," says Earlene Tarr, director of patient safety and risk management at Placentia-Linda Hospital.[10] Tarr's facility is one of many in Orange County's that in a difficult fix: it has no inpatient psychiatric beds. The nearest facility that had psychiatric capacity, Brea Community Hospital, closed in March 2005. Not only was Placentia-Linda deprived of this nearby capacity, but its ER traffic increased 60% almost immediately after Brea's closure.[11]

Hospitals without psychiatric beds, or that are not designated as a psychiatric facility, may not hold these patients beyond eight hours as a search is made for a more appropriate facility without being criminally or civilly liable. However, SB 916, signed into law by Gov. Arnold Schwarzenegger last October, increases the hospital's time limit to hold the patient to a maximum of 24 hours.

If the hospital lacks inpatient psychiatric beds, the onus is placed on each county's department of mental health's response team to find a psych bed. However, many providers interviewed for this paper suggest that the teams are often slow or reluctant to respond.

"The (Los Angeles) county (Department of Mental Health) has pulled back on their response teams in a huge way," says Marc Futernick, M.D., medical director of emergency services at California Hospital Medical Center near downtown Los Angeles. "It is their take that it is illegal for them to write a hold without a bed available. If there is no bed available in their system, they won't write a hold."[12]

"The county won't go into hospital ERs anymore," Lennartz says. "They have limited their involvement to board and care and group homes. That has left the burden purely on the private level. And hence the dilemma: hospitals that don't have psychiatric units have no expertise to care for these patients."

Lennartz estimates that her facility receives a half-dozen phone calls a day from general acute care hospitals in the San Fernando Valley area seeking to transfer patients to her facility.

Given that publicly-funded psychiatric beds operate near capacity, that often makes hospital emergency rooms the unwilling custodian of someone who can disrupt operations for hours, if not days.

"We are experiencing a rise in 5150 patients, and we experiencing a significant rise in the time it takes to get them out of ERs," says Julie Puentes, a regional vice president in Orange County for the Hospital Association of Southern California.[13]

Such patients can cram the ERs of urban hospitals in low-income neighborhoods, such as California Hospital Medical Center, located near downtown Los Angeles. According to Futernick, California receives an average of six 5150 patients a day, but on some days there are as many as 10 such patients – in an ER with only 19 beds.

California Hospital Medical Center

The 5150 Conundrum

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is hardly alone in this situation. St. Joseph Medical Center in Orange has two of 57 emergency department beds allocated for psychiatric patients. However, the hospital admits as many as 11 psychiatric patients a day. This requires staff to convert general use beds to psychiatric use, requiring them to be sealed off from other ED patients for obvious reasons.[14]

"Imagine bringing your child into the ER for treatment, and they are sitting next to someone who is grossly psychotic, clearly deranged and abnormal," says Brian Johnston, M.D., an emergency room physician and chief of state at White Memorial Medical Center near downtown Los Angeles. "This creates a very bad environment… It is truly a scandalous situation."[15]

"The patients can be incredibly disruptive. They're yelling, sometimes they're urinating or worse outside of a bathroom, or they're attacking staff," Puentes says.

In such a situation, a specific portion of the emergency room has to be cleared of potentially harmful items to hold the patient. A special "sitter" – often a member of the nursing or security staff – needs to be assigned to observe such a patient around the clock. According to Puentes, such patients often place already crowded ERs in jeopardy of diversion, complicating matters for other facilities nearby.

There is no expectation that this situation will improve anytime soon. Southern California's privately-operated inpatient psychiatric beds are disappearing. When Century City Hospital closed earlier in the decade, it took 41 psychiatric beds with it. Cedars-Sinai has trimmed its unit in recent years by more than 25%. California Hospital Medical Center, San Gabriel Valley Medical Center and St. Mary Medical Center have all closed their voluntary units in recent years.[16]

Orange County, which has nearly 3 million residents, has fewer than 200 general psychiatric inpatient beds. The number will be reduced by 37 if the County approves requests by two hospitals, Huntington Beach Hospital and La Palma Intercommunity, to be de-designated as LPS facilities. There are only 13.5 publicly-funded psychiatric beds, according to county officials.

With capacity stretched to the limit and on-call psychiatrists and psychologists difficult to come by, Tarr says that Placentia-Linda is seeking an agreement with College Hospital, a two-facility psychiatric system based in Cerritos, to transfer their 5150 patients.

California Hospital Medical Center has a transfer agreement with College, but it comes at a steep price for uninsured patients: California pays College a flat rate of $1,000, plus a case rate of $1,000 per day, according to Futernick.

Given the bleak economic realities, Futernick believes few patients are actually receiving appropriate psychiatric care. He cites one patient who was in the ER on 5150 holds three times in a week.

"Each time he returned as the result of a very serious suicide attempt. One time he was found hanging from a tree, another time he had cuts to his head and arms," he says. Futernick has since lost track of the patient, who was both homeless and uninsured – a combination virtually guaranteeing he would not receive appropriate psychiatric care.

"It is very uncomfortable discharging people who are suicidal," Futernick says. "It is really inappropriate."

Johnston notes that White Memorial is often overwhelmed by younger 5150 patients, as the hospital lacks any pediatric beds.

"There are private facilities that will take the children, but if their families don't have any insurance, they are always full," he says.

The Economics of Psychiatric Beds

The reason so many psychiatric beds have gone off line is simple – they are a loss leader of sorts for hospitals, often bringing in far less revenue than are required to operate them. And Medi-Cal patients – those often in the most dire need of comprehensive mental healthcare – are unwittingly assisting in taking these beds offline.

According to Rodney Corker, a vice president with the Adventist Health System and head of its managed care division, private insurers pay anywhere from $800 to $1,000 a day per bed at the two acute care hospitals in Southern California where they operate psychiatric beds – Glendale Adventist Medical Center and White Memorial. These beds cost around $800 a day to operate. That generally means a privately insured patient is at least a break-even proposition to the hospital, with some positive cash flow in the best-case scenario.[17]

However, Medi-Cal pays a mere $475 a day for a psychiatric bed – the same general acute care rate – a figure that hasn't budged in years. That means every Medi-Cal patient housed in an Adventist psychiatric bed costs the system a minimum of $300 a day, per Medi-Cal patient – or more than $100,000 a year – in negative cash flow.

"It's an unconscionable number," says Corker of the Medi-Cal rate, which is negotiated at the county level rather than the state level. It's also one that creates a familiar scenario in Southern California – private operators and county officials pushing back against one another over mental health funding.

Lennartz, who describes the $475 Medi-Cal rate as "abysmal," notes there is no outlier variance. "If you have an intensive care psychiatric patient, you get the same whether they are in seclusion or restraints. A patient who is acutely suicidal needs constant supervision. They need to see a psychiatrist every day. They need an (individual) nurse who is overseen by another nurse. The nursing itself is $400 a day for a single nurse."

Medi-Cal enrollees comprise about a third of Mission's overall patient base. Along with a shrinking DSH allocation, Lennartz says it is becoming increasingly difficult to care for these patients.

Corker says that Adventist will continue to negotiate with county officials about a more appropriate rate of reimbursement. "This is the most underperforming contract in the system, and these beds will not stay on the market at these rates," he says. But Corker adds that many other hospitals in the Los Angeles area have signed onto these contracts, making it more difficult to bargain. And there are days when Adventist management mulls about whether offering this line of service is financially feasible in the long run.

Unfortunately, Southern California is not alone in its predicament. Cuts in mental health funding have become commonplace throughout the United States, with a similarly predictable impact on hospital ERs.

In Austin, Texas, mental health patients are waiting up to two days in local ERs for a transfer to a psychiatric facility.[18] In Atlanta, some patients are waiting three days in ERs before being admitted to psychiatric facilities. In one instance, a 21-year-old man set a fire in a downtown-area ER, forcing an evacuation of the facility.[19]

"Our big concern is that there is no course of treatment in the ER," says Steven Kiner of Emory Healthcare.[20]

Back to the Future?

Recent mental healthcare reforms usually occur in the wake of a tragedy. In Virginia, Gov. Tim Kaine recently proposed an additional $42 million in funding for the state's troubled mental health system. Kaine had been prodded into this reform by the shooting spree at Virginia Tech University in April 2007.[21] The perpetrator, Virginia Tech student Seung-Hui-Cho, had been declared mentally ill by a state court nearly two years before, but received little treatment.[22]

In New York, the January 1999 death of Kendra Webdale – who was killed when she was pushed into an oncoming subway train by a man with a long history of mental illness and inconsistent care – sparked a movement in that state toward "assisted outpatient treatment" (AOT). In essence, AOT mandates that those with incapacitating mental illness receive involuntary treatment, such as the administration of antipsychotic drugs, on an outpatient basis. Such treatment can come at the behest of a

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patient's family.

The rationale behind AOT may be indirectly summed up by Webdale's killer, Andrew Goldstein, who had stated during his first trial that "If I had taken my medication, that whole thing would have never happened."[23] (After a mistrial and a conviction later reversed on constitutional grounds, Goldstein pled guilty to manslaughter in 2006 and admitted he knew what he was doing was wrong when he had pushed Webdale.)[24]

In essence, AOT is a fusion of the pre-Reagan and post-Reagan treatment philosophies. The nearly compulsory involuntary commitment element of mental healthcare is guided by community-based treatment. It has been enacted in some form in 42 states.[25]

AOT has been a qualified success in New York. Six months after its implementation, the incidence of "significant events" – psychotic episodes – had dropped considerably. The incidents of psychiatric hospitalizations, homelessness and arrests dropped dramatically.[26]

In North Carolina, AOT reduced overall hospital admissions by 57%. Among schizophrenics and other major disorders, admissions fell by 72%. Similar drops were reported in Ohio, Iowa and Washington, D.C.[27]

However, the report about New York's experience warned that the quality of services has been uneven, bedeviled by gaps in necessary funding and personnel. "The result is that while treatment plans may look good 'on paper,' they too often do little to help the person other than encouraging medication compliance."[28]

California embraced its own version of AOT, predictably sparked by a gap in care that led to tragedy. Scott Harlan Thorpe – a former janitor who had a long history of schizophrenia with paranoid delusions – went on a shooting rampage in a mental health clinic and restaurant in Nevada City in 2001, killing two people and seriously wounding three others. One of the dead was Laura Wilcox, a 19-year-old high school valedictorian who was working in the clinic during winter break from Haverford College.[29]

In 2003, California enacted "Laura's Law," legislation that is modeled after the New York reforms. The following year, voters approved Proposition 63, which imposed a surtax on high-income Californians to raise $1.5 billion a year to shore up the mental healthcare system. Los Angeles County receives about $200 million a year in Proposition 63 funds.

Yet both initiatives have been unevenly implemented at best, primarily for the same reasons as the New York initiative. Laura's law is not accompanied by state funds, and thus few counties have fully implemented it – a somewhat radical departure from the funding mechanisms for the Reagan-era reforms.

In 2006, the California Department of Mental Health Care issued emergency regulations stating that programs funded by Proposition 63 are to be enacted on a purely voluntary basis.[30] Many rural counties lack not only psychiatric beds, but also psychiatrists – making treating their patients according to the new guidelines all but impossible. Even with an infusion of Proposition 63 funds, Modoc County's mental health budget is 25% smaller than it was in 2004.[31]

In addition, as Gov. Schwarzenegger signed into law a long-overdue state budget last August, he eliminated a $55-million program that assists about 4,700 homeless mentally ill – the same people who have become staples in hospital ERs in recent years. The program, implemented in the late 1990s, had dramatically lowered the rates of homelessness, incarceration and hospitalization among its participants.[32]

Southern California providers say Laura's Law and Proposition 63 would make significant differences in the volume of mentally ill individuals who appear in hospital emergency rooms if they were fully implemented. Others say they are merely a stopgap measure.

"An enormous amount of money could be saved by having greater outreach to psychotic patients," Brian Johnston says. "But one of the problems in enforcing Laura's Law is that (the availability of) outpatient psychiatry is obviously inadequate. And there are problems elsewhere. For instance, Medi-Cal has had for a number of years a six-prescription per month limit."

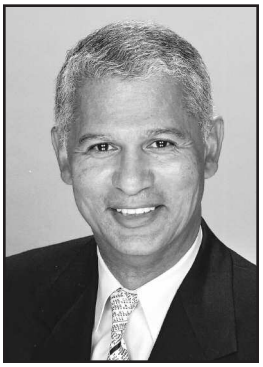
Johnston notes that an AOT program in Massachusetts implemented in the 1990s saved a significant amount of money in hospitalizations, "but it cost far more in terms of (prescription) authorizations.

"It has to come from somewhere," he adds.

Recommendations

The following recommendations are a dynamic work in progress (i.e., they are subject to revision as the result of further study).

1. Increase Medi-Cal payment rates for mental health acute hospitalizations. Every hospital should be paid rates that approximate its cost for treating government-sponsored patients.
2. Fully fund and implement "Laura's Law" (i.e., mandatory assisted outpatient treatment) in every county. Either designate Proposition 63 funds or appropriate/designate other government funds for this purpose.
3. Reinstate the $55 million program eliminated in this year's state budget that provided assistance to about 4,700 homeless mentally ill persons.
4. Direct counties to designate emergency department personnel authorized to release 5150 holds placed by law enforcement officials.
5. Instruct peace officers to not use hospital emergency rooms as dumping grounds for their charges who are disruptive, acting out, or otherwise express disturbing behavior, but have no other physical condition that warrants medical treatment. These charges may instead be incarcerated and evaluated by jail medical personnel.
6. Require county departments of mental health to dispatch response teams to determine if 5150 holds are warranted within eight hours of a request from hospital emergency rooms, whether or not psychiatric beds are available at the time. Confer immunities from liability to the counties and the hospitals in such circumstances.
7. Establish a new licensed sub-acute locked bed category and payment rate schedule for patients on involuntary holds who do not require acute medical care and treatment.
8. Amend Medi-Cal regulations to allow hospitals to expedite the Medi-Cal application process for persons in need of emergency and/or inpatient mental health services.
9. Appropriate funds for the expansion of County and privately run mental health urgent care centers as alternatives to hospital emergency rooms for persons in need of immediate mental health care, but who are not experiencing a life-threatening physical health crisis.
10. Amend the federal law that prohibits free-standing psychiatric hospitals from receiving reimbursement for patients aged 18-64 who need placement in designated Institutes for Mental Disease (IMD) beds.
11. Amend WIC Section 17000 to create parity language that assigns counties the same obligation for indigent mental health patients as they have for indigent physical health patients. (Currently counties have less responsibility to care for indigents suffering from mental health illness than from physical illness.)
12. Amend state law so that the mechanism that determines the Medi-Cal default rate for non-contracted mental health hospitals is the same mechanism that determines the non-contracted default rate for Medi-Cal general medical services.
13. Require urban counties to use MHSA Innovative Program funds to establish Tele Psychiatry programs that would provide screening assessment and treatment in non-designated hospital emergency departments in underserved regions.



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