Shaping the Debate
Focusing on Critical Illinois Health Care Issues

May 2011

Illinois Mental Health and Substance Abuse Services in Crisis

Each year, hospitals in Illinois are encountering a steadily increasing number of persons with mental and substance use illnesses—in their emergency departments (EDs), in their medical beds, and in specialty facilities. The Illinois Hospital Association (IHA) and hospital community are deeply concerned and alarmed by the human consequences of delays in treatment, inadequate treatment, or no treatment at all for persons with serious mental illness or substance abuse problems. Families have limited options available for needed services such as substance abuse treatment, medication, community outpatient and psychiatric care. Far too many families are waiting far too long, for far too few services.

The loss of state-operated and private hospital inpatient beds in the past decade, recent community mental health agency funding cuts, and a shortage of psychiatrists and other mental health professionals have combined to diminish, and in some instances deplete, the pool of mental health resources in many communities.

In some parts of our state, mental health services simply do not exist—for anyone. In other parts of the state, services are limited in their nature or scope: outpatient services are available but not acute inpatient psychiatric care; mental health services are available for adults, but not for children; mental health services are available, but there are no substance abuse services. In almost every part of the state, the person who lacks insurance, especially the single adult male without children, faces closed doors.

And, it is this group of persons who are often in our jails and prisons or are homeless. It is this group who does not qualify for Medicaid or Medicare who have been abandoned when the state closes a state-operated psychiatric hospital; cuts non-Medicaid mental health funding, such as the Community Hospital Inpatient Psychiatric Services (CHIPS) program; or closes residential substance abuse treatment facilities.

Facing the Obstacles

When it comes to mental health services, there has never been a time in which resources have been adequate to meet the need. The weakened national and state economy, an unprecedented state budget deficit, and the state's continuing high unemployment rate have all combined to further weaken and tear apart an already fragile and broken behavioral health system in Illinois.

1. **Inpatient capacity is not evenly distributed and acute inpatient capacity has shrunk.**

   - Illinois state-operated hospitals (SOHs) had once more than 35,000 beds in the 1950s and 1960s; by 2009, only 1,400 beds in the nine remaining SOHs.

   - The number of licensed psychiatric beds has decreased from 5,350 in 1991 to 3,869 in 2010—a 28% drop. During the same time period, there has been a 45% drop in

licensed psychiatric and substance abuse beds combined. Unfortunately, the loss of beds has not been evenly distributed, leaving some communities with no psychiatric beds at all.

- There are 53 Illinois counties with hospitals that do not have inpatient psychiatric services. Another 24 Illinois counties do not have hospitals at all.

2. **There is a psychiatrist shortage, particularly for children, especially in rural Illinois.**

- Of the 102 Illinois counties:

  - 50 counties do not have a psychiatrist at all;
  - 14 counties have one psychiatrist;
  - 17 counties have between 2 and 5;
  - 84 counties do not have a child psychiatrist;
  - 6 counties have one child psychiatrist; and
  - 7 counties have between 2 and 5 child psychiatrists.

Source: *Illinois Psychiatric Society*, 2006 data

- According to the Mental Health Work Group of the Illinois Rural Health Association, in 2005, 70% of the 84 medically underserved counties in Illinois did not have a psychiatrist; and 100% of the medically underserved counties without a psychiatrist were in rural counties.

3. **Payment for mental health and substance abuse services is inadequate.**

- Coverage for mental health and substance abuse conditions historically has been less than that for other medical problems. Passage of federal mental health parity legislation and health reform legislation will improve coverage for these conditions. However, federal mental health parity legislation requires equal coverage for mental and other medical conditions only in group policies of 50 people or more, and coverage for behavioral health conditions is still not required. Federal health reform legislation will require benefits for behavioral health conditions in essential benefits packages, but these requirements go into effect in 2014. Medicare only recently began the elimination of discriminatory provisions limiting inpatient care, outpatient visits and life-time limits. Medicaid base rates are far below costs for institutions or professionals.

- Most mental health programs are underfunded. When other self-sustaining programs are no longer able to offset the losses incurred by mental health services, they become targets for elimination, especially in organizations such as hospitals that are not grant-funded.

4. **Hospital EDs are filling in the gaps created by an insufficient number of acute inpatient beds and outpatient services.**

   In calendar year 2009, Illinois hospital EDs treated more than 750,000 people with a behavioral health condition. Of these, more than 190,000 had a principle diagnosis of mental health or substance abuse. Most ED patients with a primary diagnosis of behavioral health are mentally ill (76%), the remainder have a primary diagnosis of substance abuse.

   - Many psychiatric patients must wait extended periods in the ED before being admitted to an inpatient bed. A 2005 IHA survey of hospital ED behavioral health services indicated psychiatric patients waited twice as long as other patients. Recent data from Illinois hospitals indicate that this trend has continued, exacerbated by state budget reductions for community mental health and substance abuse services as well as the elimination of the Division of Mental Health (DMH)-funded CHIPS program on July 1, 2009.

   - SOHs transfers are the most difficult to accomplish in a timely manner. Patients commonly wait many hours, even days, for a bed.

5. **The care of inpatients and outpatients once borne by the state has been shifted to the private sector without a commensurate shift in dollars and resources.**

   - When SOHs closed or downsized, the resources were not redirected to the community, despite the state's representation that such funds would be preserved for those patients who otherwise would have been treated in a SOH.

   - The state's continued emphasis on primarily funding Medicaid programs and minimizing any funding for persons who either lack insurance or do not qualify for state and federal payment programs, not only compromises access to care for those persons for whom the state system was designed but it also shifts to hospitals the burden of caring for a growing number of people for whom other alternatives have become unavailable.

6. **Community mental health and substance abuse systems have incurred deep and disproportionate cuts.**

   - The community mental health system has lost critical services, many of which cannot be replaced due to Illinois' budget shortfalls. While the state's overall FY2011 budget has reflected about a 5% spending cut from the previous year, the Department of Human Services' (DHS) cuts were cut about 8% from the previous year's funding.

   - The DHS budget in FY2011 was cut by $576 million; of that, $515 million has been a reduction in non-Medicaid programs for mental health, developmental disabilities, and rehabilitation services. In the current fiscal year, community mental health

providers lost approximately $35 million in funding, almost all of which is for non-Medicaid services. Almost $50 million was cut from DMH operations, including state hospitals. The FY2011 loss compounds losses incurred in the previous two years: DMH in FY2010 lost almost $43 million; in FY2009 it lost $35.6 million.

- Recent threats to cut DHS's budget by an additional $208 million have been abated, although additional cuts of $57 million are still expected. DMH programs will be cut an additional $4.9 million in this fiscal year. The Governor's FY2012 budget proposes 30% less funding for community mental health programs than was available in 2009.

- The continued threats and actual losses to the mental health system have resulted in staff reductions, program closures, and waiting lists. Two mental health centers have closed their doors, one of which had served downstate Illinois, further straining an already vulnerable rural region.

- The substance abuse community also has experienced large budget cuts over the past several years. The DHS Division of Alcoholism and Substance Abuse (DASA) lost an additional $7.2 million in FY2011 on top of losses of $23 million in FY2010 and $55 million in FY2009. FY2012 could cut 26% of addiction treatment funds and reduce Medicaid reimbursements by 6%. These cuts have caused many substance abuse providers to shrink or close treatment programs. All report long waiting lists.

7. **Rural hospitals are inundated with behavioral health patients for whom they have limited services.**

   - Because there are only a few inpatient units in rural Illinois, patients have difficulty obtaining medical oversight for psychotropic medication and monitoring. Patients must travel great distances to obtain care and with limited transportation means, patients have difficulty reaching those few treatment options that exist. As a result, rural hospitals are seeing patients in their EDs until transportation and a bed are available.

8. **The financing and delivery of behavioral health services is fragmented and uncoordinated—*not patient centered*—and contributes to increased costs and poor outcomes.**

   - Despite the consolidation of human services in 1997, a streamlined system of care has yet to be realized. The failure to integrate substance abuse and mental health services is particularly discouraging since many patients have a co-occurring disorder. Service fragmentation, driven by different funding streams, perpetuates a system that is not patient centered and presents enormous access barriers.

   - Moreover, primary medical care is funded through the Illinois Department of Healthcare and Family Services (HFS). But inpatient psychiatric care and substance abuse services are financed by the Department of Human Services through DMH or DASA, which finances community-based mental health and substance abuse services as well as publically-funded and managed inpatient psychiatric services.

It is very difficult to develop a continuum of care when different state agencies, with funding sources of varying criteria, are not coordinated through a unified plan.

Exploring the Solutions

1. Refine the Care Delivery System

- Organize, fund and provide the regulatory framework for a coordinated, comprehensive continuum of care that is **patient centered**, utilizing best practices, is accessible, cost-effective, culturally competent, and recovery oriented. The present system is organized around funding streams.

- **Integrate primary medical and specialty behavioral health services.**

  The U.S. Surgeon General, the Institute of Medicine and the President's New Freedom Commission on Mental Health concluded that primary medical and specialty psychiatric care need to be integrated. For example, one-fifth of people hospitalized for cardiac conditions have depression. People with serious mental illnesses die at a younger age than the general population because of untreated underlying medical conditions.

  Expand models, such as medical homes, to coordinate primary and specialty services for the Medicaid patient and to the unfunded patient whose services may (or may not) be funded through DMH. Also, consider ways in which Accountable Care Organization models may apply to behavioral health providers. Some Federally-Qualified Health Centers have aligned with behavioral health facilities and hospitals in various areas in Illinois. Explore ways in which the models can be replicated or adapted to other regions.

  House Bill 2982, which establishes Regional Integrated Behavioral Health Networks, would provide a platform for the integration and organization of behavioral health and primary health care services according to community resources and needs. Care integration of care is cost-effective and has shown improved patient outcomes. This collaborative approach is consistent with the models supported under health care reform.

- **We will always need a safety net. Therefore, we need to have sufficient acute inpatient and crisis capacity regardless of whether the state or the private sector delivers it.**

  Acute inpatient and/or acute crisis services must be available for persons with serious mental illness whose conditions require stabilization and treatment in a setting that is designed, staffed and funded appropriately. State-operated hospitals **or their equivalent** must be supported by the state. Private hospitals, as they are currently configured, cannot serve every patient who is served in a SOH.

- **There must be some mechanism to achieve a unified behavioral health system of care. This mechanism could be a strategic plan that incorporates all of the state agencies that have a responsibility for funding, operating or regulating a health or behavioral health service.**

- **Care for people in the right place at the right time.**

  Nursing homes generally are not equipped nor designed to care for the young, mentally-ill resident. Some residents have medical conditions that can be served in a nursing facility; and some residents' mental illnesses are too severe for independent or supportive housing. However, many nursing home residents can live in supportive housing. Illinois is making significant strides to transitioning residents from nursing facilities into the community. Resources are necessary to accomplish this goal.

2. Improve care in the Emergency Department

- The IHA Behavioral Health Steering Committee in 2007 published a report, *Best Practices for the Treatment of Patients with Psychiatric and Substance Use Illnesses in the Hospital Emergency Department.* This report provides practical tips for hospitals that have specialized psychiatric or substance abuse expertise as well as those that do not. This report is available on IHA's website (click here).

- More work needs to be done to bring the resources of the specialty psychiatric and substance abuse communities to the ED. Moreover, new models of care should be explored. Consideration should be given to regional emergency psychiatric triage teams; an emergency continuum of care that connects acute inpatient hospitals, crisis respite beds, and outpatient providers in a network, especially in rural areas, need the support of the specialty and general health care communities.

3. Financing

- Pay for the reasonable costs of delivering services. The Medicaid base rate has not been materially increased since the early 1990s. The only providers who can survive under the Medicaid payment system are those who qualify for payments that are added to their base rates. These payment disparities account for the loss of many of the psychiatric units located in non- or "other" urban areas or our state.

- Pay psychiatrists a reasonable rate. Psychiatrists are paid about $20 per quarter hour or approximately $80 an hour. This rate does not cover their costs. Psychiatrists either cannot afford to serve Medicaid patients, or they are employed by hospitals that already are struggling to maintain a viable inpatient psychiatric unit. This is another factor contributing to the closure of inpatient psychiatric programs.

- Waivers may permit use of Medicaid funds in ways that are important to maintain a person's independence in the community. For patients who are unfunded and have serious and persistent mental illnesses, innovative financing and clinical care

packages are needed. For example, some states have implemented a funding "package" that eliminates the artificial distinctions between Medicaid and non-Medicaid-funded services. These innovative models also provide "disease management" for care coordination and unnecessary readmission. Illinois can not leave out the unfunded person, who, if untreated, will present in EDs or to law enforcement.

- Provide funding through DMH and/or HFS for every indigent mentally-ill patient who meets clinical criteria for an inpatient hospital. Either arrange in advance for community hospital beds for persons who are unfunded or provide a voucher for such persons to access services.

4. **Assist rural hospitals to meet their communities and patients with behavioral health needs.**

   - Bring the expertise of academic and specialty medicine to rural communities in Illinois through telemedicine. It has been used effectively in many other states and a few of our hospitals have begun to use telemedicine for psychiatric patients in partnership with the SIU School of Medicine and the University of Illinois at Chicago. Funding and technology are needed to expand the ability of telemedicine for psychiatric services to rural hospitals.

   - Develop a strategy to improve transportation funding for people with mental illness.

5. **Use technology such as the electronic medical record to improve quality and coordination.**

Mental illness can touch anyone, regardless of age, gender, ethnicity or socio-economic status. It is serious and can be life threatening. It is also treatable. Unfortunately, it remains misunderstood and too often goes untreated until there is a crisis. It may be masked by homelessness, drug abuse, and absenteeism from work or school. But these sometimes invisible and often times misunderstood diseases must be treated as fully as other chronic health conditions such as heart disease, diabetes, high blood or cancer. Reducing mental health resources places a greater burden not only on hospitals, but also on many other social service providers and diminishes the quality of life for Illinoisans.

We ask the Illinois General Assembly to work with the hospital community and other key partners to solve the issue of access to behavioral health services in Illinois.