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Position Statement on OMH Regional Centers of Excellence Plan

In July 2013, the NYS Office of Mental Health (OMH) issued a plan to reorganize the State's mental health system. The Plan calls for major changes in State-operated inpatient mental health services, representing a shift from inpatient services to community-based services. Under the proposed plan, over the next three years, the state public mental health system will be redesigned into 15 Regional Centers of Excellence (RCEs) including three forensic regional centers of excellence and two research centers of excellence. According to the Plan, RCE's will be "regionally-based networks of inpatient and community-based services, each with a specialized inpatient hospital program located at its center with geographically dispersed community service "hubs" overseeing state-operated community-based services throughout the region." RCE's will be established in Western New York, Central New York, Hudson River, New York City, and Long Island.

NYSPA is concerned that the proposed closure of a number of psychiatric hospitals across the state will create disastrous results for persons requiring acute care services unless we work to establish community-based safety nets to ensure continuity of care.

It is worth noting that the State has an obligation to provide services for people with mental illness. The New York State Constitution states: "The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and
in such manner and by such means, as the legislature may from time to time determine." It is clear that the state is morally and legally compelled to take care of citizens who suffer from mental illness. This obligation is not a question of whether such services and supports must be provided to vulnerable populations – the only question is by what means.

Pre-Investment Not Reinvestment

The state's current proposal to close state hospitals without first establishing appropriate alternate treatment sites and residential and community supports has the potential to be a repeat of past mistakes. In the 1960s, New York State embarked on a program of deinstitutionalization of the state hospital system that was implemented without first developing a community based system of residential, clinic and day program services. Former state hospital patients were dumped into various communities without adequate support or services.

Thirty years later, the state embarked on a second plan for closure of state psychiatric centers, labeled "reinvestment," which was based on rationales similar to the current situation. Reinvestment was intended to avoid the defects of deinstitutionalization by providing that savings from closures of psychiatric centers would be “reinvested” in community-based services. Once again, closures took place, but the promise of reinvestment was not fully realized.

It would be ill-conceived to attempt a similar deconstruction of the state system without first ensuring that a safety net exists for all individuals currently being served by state psychiatric hospitals. It is imperative that the state develop a plan for provision of intermediate and long term care services that will take the place of the hospitals to be closed.

What we need now is a commitment to “pre-investment” in community based services before the current state inpatient hospital system is once again deconstructed.

The state psychiatric hospital system, including those facilities slated for closure, has been in existence for more than 80 years. Ironically, one might ask why these facilities are not *already* considered to be "centers of excellence." It is unclear how the new regionally-based inpatient units will be different from current inpatient facilities and whether they will truly represent best practices. Further work needs to be done to determine the needs of the individuals requiring services in each of the identified regions and to highlight pre-existing “models of excellence” that could be replicated across the state.

The Plan acknowledges that any restructuring of the state-operated inpatient system must take into consideration and integrate all the elements of the state mental health system including the voluntary inpatient acute care system and the outpatient service system. However, the proposal is utterly devoid of any consideration or discussion of the relationship between the state inpatient hospital system and current voluntary inpatient acute psychiatric care system. There is no data on the number of acute care psychiatric beds in the state and their geographical distribution. No discussion of the number of acute care beds required for each region of the state. There is no acknowledgment of the fact that many areas of the state have already lost inpatient acute psychiatric beds over the past five years. While the Plan acknowledges that many state psychiatric hospitals serve as acute care facilities in various localities, there is no discussion of how closures and consolidations will impact access to acute care.

Further, there is no discussion of how the existing voluntary hospital and outpatient services system will be able to assume responsibility for patients who need acute, intermediate and long-term care who will no longer be able to secure such services from state psychiatric hospitals. Conceptually, the “safety

net" could be maintained by community hospitals and outpatient programs run by voluntary agencies, but there is no discussion of how the transfer of the "safety net" function will be accomplished. We need to have the replacement for the state-operated safety net in place and operational before we dismantle the current system.

Prior to taking any further steps in connection with hospital reorganization, NYSPA would first suggest that the State undertake a survey of the services presently available. It is critical that we determine precisely how many private acute beds are available in each of the five regions and there occupancy rate and lengths of stay for both children and adults. We also need to assess the outpatient and community services and determine whether there would be sufficient resources available following the planned closures. The survey could query the specific types of community services that are presently available, e.g. inpatient, ACT, waiver, ICM, day treatment, partial hospital, respite beds, medication clinics with sufficient psychiatric staff, and would permit assessment of where gaps exist. A plan to provide missing or inadequate services must be in place before any hospital is closed.

Concerns Regarding Medicaid Managed Care

We support the proposal to "roll up" inpatient care in state psychiatric centers into Medicaid managed care plans and mandate that such plans cover the cost of inpatient treatment in state psychiatric centers. However, we note two disturbing financial details mentioned in the Plan. On page 7, the current cost of OMH hospital care is reported as $1.3 billion per year while on page 8, the current annual cost of debt services on state hospital facilities is reported as a staggering $1.23 billion per year. If we read these numbers correctly, then 50% of the current annual cost of operating the state psychiatric centers goes to paying principal and interest on the state debt incurred for the capital cost of the state psychiatric centers. This level of expense is unsupportable. If the average per diem cost of care is approximately $800 per day as reported and half that cost is debt service, then there is little way that state psychiatric centers will be able to survive under managed care. No institution – whether public, private, for-profit or not-for-profit - can survive when half its costs are mortgage payments. If the system shrinks even more under the Plan, there will be even fewer facilities with fewer beds to carry this debt burden. The Plan contains no recommendations for handling this crushing debt burden.

In addition, NYSPA is particularly concerned that any roll up of inpatient state services into Medicaid managed care without careful consideration of the circumstances may only create further problems. Individuals with serious and persistent mental illness (SPMI) often require significantly longer inpatient stays then even the typical population enrolled in Medicaid managed care. In our members' experience, managed care companies often seek to move patients out of acute care hospitals very quickly. If Medicaid managed care plans aim to

be effective in servicing the SPMI population, appropriate level of care criteria must be in place in order to avoid potential threats to public health and safety as a result of premature hospital discharges.

Similarly, the state's plan to implement the Health and Recovery Plan (HARP) approach to managed care raises the same concerns. In order for a HARP to provide efficient and effective management of treatment for the SPMI population, appropriate levels of care must be made available and must be provided on a timely basis. Without these necessary safeguards in place, any transfer of vulnerable populations into a managed care environment will fail and will compromise not only the care of these individuals, but public safety as well.

Services for Children and Adolescents

With respect to children and adolescents with mental illness, it is crucial that the state system maintain a full range of services across the continuum of care as not all children can be adequately served in community-based settings and may continue to require acute care services. If children fail to receive necessary services, there will be an increase in school drop outs, homelessness and the number of children and adolescents incarcerated in juvenile detention facilities and ultimately in jails and prisons. The length of time children and adolescents wait in emergency rooms for a permanent bed will only be further extended.

In addition, children in need of inpatient care must be geographically close to their families. It is unreasonable to expect parents to travel long distances to visit with their children. For example, the RCE plan calls for closure of the Sagamore Children's Psychiatric Center, an inpatient and outpatient treatment facility located in Dix Hills, Long Island. If this facility is shuttered, families in Suffolk County may have more than a one and half hour trip to visit their children at the next closest state inpatient facility, which is expected to be located in Queens or the Bronx. Finally, it remains unclear whether the state will be providing transportation assistance to those families who are unable to afford these significant costs associated with travelling long distances to see their children.

Conclusion

Here in New York, if we again embark on another plan to "restructure" the state psychiatric centers to achieve cost savings, we must first plan, implement and adequately fund an alternative state-operated "safety net" to continue to provide crucial services for those children and adults who currently rely on the public hospital system before we dismantle it.

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