

Michigan Inpatient Psychiatric Beds Report

(FY2022 Appropriation Act - Public Act 87 of 2021)

July 1, 2022

Sec. 1062. By July 1 of the current fiscal year, the department shall provide a 5-year plan to address the need for adult and children's inpatient psychiatric beds to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office. The report shall include recommendations for utilizing both public and public private partnership beds.



The background features a blurred image of a person lying in a hospital bed, overlaid with a semi-transparent green layer. This layer contains various medical icons: a syringe, a pill, a stethoscope, a microscope, a group of people, and a large white cross. A dark grey diagonal band runs from the top right to the bottom left, containing the title and subtitle text.

Michigan Department of Health and Human Services

Framework for Development of a Five-Year Strategic Plan for Inpatient Psychiatric Beds

May 24, 2022



**MYERS AND
STAUFFER** LLC
CERTIFIED PUBLIC ACCOUNTANTS



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Executive Summary

In recent years, there has been growing concern regarding the national shortage of inpatient psychiatric beds within states.¹ This concern has only heightened in recent years by the COVID-19 Public Health Epidemic (PHE), which spotlighted shortages within State's delivery system. In the State of Michigan, discussions regarding inpatient psychiatric bed capacity have been ongoing, and in 2017, culminated in the formation of the Michigan Inpatient Psychiatric Admissions Discussion (MIPAD) workgroup, which investigated challenges and gaps within the State's system and provided a series of recommendations for improvement.² These recommendations included:

1. Expanding the number of psychiatric beds that are available through the Certificate of Need (CON) program.
2. Approving funds to pursue the building of a new facility to replace the existing Caro facility.
3. Expanding units available at existing facilities, for example, at the Center for Forensic Psychiatry.
4. Collecting and examining data on the causes of denials for inpatient services.
5. Facilitating transitions of care through the Children's Transition Support Team Pilot.

However, even with these recommendations, Michigan still continues to experience operational and administrative challenges due to the lack of inpatient psychiatric beds. Individuals who require these services are often left without access to necessary treatments, which are critical to their health and wellbeing.³

Engagement with Myers and Stauffer

The Michigan Department of Health and Human Services (MDHHS) is charged with developing a five-year plan to address the need for adult and children's inpatient psychiatric beds, pursuant to the Michigan Public Act 87 of 2021. This five-year plan, due to the Legislature on July 1, 2022, is due to the House and Senate Fiscal Agencies, Policy Offices, the Appropriations Subcommittees on the Department Budget, and the State Budget Office. To support the work required under this Act, MDHHS engaged Myers and Stauffer LC a certified public accounting firm with extensive experience in assisting state Medicaid agencies with effectively designing, reimbursing, and overseeing behavioral health services

¹ "Inpatient Bed Tracking: State Responses to Need for Inpatient Care." ASPE, aspe.hhs.gov/reports/inpatient-bed-tracking-state-responses-need-inpatient-care-0. Accessed 28 Apr. 2022.

² MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, MIPAD FINAL WORKGROUP PAPER REPORT (Feb. 13, 2018), https://www.michigan.gov/documents/mdhhs/MIPAD_WorkgroupReport_613570_7.pdf

³ "Kids 'Stack Up' in Michigan ERs as Hospitals Resist Adding 100+ Needed Psychiatric Beds." WXYZ, 14 June 2021, www.wxyz.com/news/local-news/investigations/kids-stack-up-in-michigan-ers-as-hospitals-resist-adding-100-needed-psychiatric-beds. Accessed 28 Apr. 2022.



and supports. Myers and Stauffer was engaged to conduct this work in early February 2022. Given the time permitted, Myers and Stauffer and MDHHS agreed on an alternative approach to the development of the five-year plan, as follows:

- Conduct an “as-is” assessment of statewide children and adult inpatient psychiatric beds (i.e., the existing system capacity to serve patients).
- Conduct research of up to three peer states to determine how those states addressed capacity issues and/or the need to expand capacity for child and adult inpatient psychiatric beds.
- Develop an “options analysis” based on the as-is assessment and initial research (i.e., options for consideration, advantages, and potential constraints or barriers).
- Provide initial recommendations based on the “as-is” assessment and peer state research.

This report provides an overview of the current Michigan in-patient psychiatric hospital landscape, a view into how other states are handling similar challenges, domains that should be considered during strategic plan development, and recommended next steps.

Methodology

For the “as-is” assessment, we reviewed data from MDHHS for state hospitals and private facilities for the calendar years (CY) of 2018 to 2020. We received aggregated state hospital data directly from MDHHS and relied on the CON annual survey for information on private facilities. For this assessment, we reviewed available beds based on three variables:

1. Type of bed (i.e., public or private facilities).
2. Location of beds (i.e., geographic region of the state as defined by the state’s catchment areas. For the purposes of this evaluation, we defined catchment area based on state hospital catchment: Caro, Kalamazoo, and Walter P. Reuther catchment areas).
3. Patient population served (i.e., adults or children/adolescents).

For the peer-state research, we worked with MDHHS to identify three peer states in close geographic proximity to Michigan. The three states selected for this assessment includes: Illinois, Minnesota, and Ohio. We conducted an environmental scan of publicly available information from national agencies or organizations and state websites to gather information on lessons learned and best practices identified by these states regarding bed capacity. In recognition of the widespread challenges of inpatient psychiatric bed shortages, we expanded our best practice research to include findings from national research.

Summary of Findings

Based on our review of MDHHS data and our peer research, we found:



- 1. The need to develop a long-term solution to address inpatient psychiatric bed need.** Peer and national research suggest that Michigan should consider inpatient psychiatric services as part of a broader mental health strategy. Improvements must be made along every entry point in the continuum to realize long-term benefits in managing inpatient psychiatric bed shortages.
- 2. The importance of determining psychiatric bed capacity and managing available psychiatric beds.** State hospitals in Michigan had higher lengths of stays and on average, higher occupancy rates for adults and children across the State. These differences suggest there may be opportunity for the State to conduct additional analysis to determine potential factors that would help strengthen the public-private delivery network in Michigan. Additionally, peer and national research yielded potential tools and processes that can be implemented, such as psychiatric bed registries that would help Michigan timely and accurately identify bed availabilities across the state.
- 3. The need to maximize community-based resources.** While inpatient psychiatric bed capacity is an important element of the mental health continuum, there are other variables that Michigan must consider including enhancements in community-based supports.
- 4. Additional needed supports in behavioral health options for safe discharge.** One element that may be indirectly impact inpatient psychiatric hospitalizations is the lack of safe discharge processes. Namely, individuals need to have a viable and realistic discharge plan that transitions that allows for the transition of individuals from institutions back into the community.

Recommendations and Next Steps

MDHHS is tasked with developing a five-year plan for improving psychiatric bed capacity. The State will need to consider the full continuum of care, with a goal to use resources efficiently while not institutionalizing people when they do not need to be or for longer than necessary. When systems of care focus on one side of the service system at the expense of the other the distribution or availability of supports can lead to a system out of balance with the needs of the community. We suggest MDHHS consider the following strategic options:

Table 1 Summary of Options

Increase Bed Capacity	Increase the number of beds	Assess licensing restrictions or CON requirements.
		Monitor usage of beds by geographic area.
	Increase the efficient use of current beds.	Assess the current options for adding to or repurposing existing facilities.
		Assess transportation and access to existing beds.
		Assess licensing limitations that prohibit the use of existing institutional beds for psychiatric care (e.g. Nursing Facilities).



	Monitor the number of beds against community need.	Assess the current distribution by population and need (children, adults, youth, forensic population, LTC population, other specialty needs).
Decreasing Bed Need	Establish diversion programs to prevent in-patient placements.	Assess the use of crisis response systems by population or setting (e.g. Adult, Children, Community based mobile crisis, Short Term Stabilization Units). Assess the use of jail based restoration or other programs that support the forensic BH system of care.
	Increase safe discharge placements to shorten length of stay.	Assess availability and licensing of community housing options. Consider waiver options for supported housing or tenancy support services.
	Establish programs to reduce readmissions.	Examine hospital management processes that reduce readmissions. Examine community based supports such as Psych APRN home health visits.

To determine which proposed options may best align with the goals of the State, we suggest the following:

1. Develop a Stakeholder Engagement Strategy to Consider Stakeholder Perspectives and Priorities.
2. Prioritize Options Presented in this Report to Determine Potential Next Steps.
3. Conduct an In-Depth Assessment of Existing Community and Outpatient Based Alternatives in the State.
4. Evaluate the Impact of COVID-19 on State and Private Hospitals.
5. Conduct A Needs Assessment of the Population Using Inpatient Psychiatric Services.
6. Consider Implementation and Development of a Statewide Strategy to Monitor and Manage Psychiatric Beds.



Introduction

As attention on mental health and substance abuse prevention and treatment heightens, the role and availability of inpatient care is increasing as topics of interest. The National Association of State Mental Health Program Directors (NASMHPD) notes in their September 2021 report titled *Ready to Respond: Mental Health Beyond Crisis and COVID-19* that “It is clear that psychiatric inpatient services, although necessary, are not sufficient as a single solution to the mental health needs of the population.”⁴ The report further states:

“The [Centers for Disease Control and Prevention] CDC’s Monthly Morbidity and Mortality Weekly Report showed that in June 2020, the U.S. adult population reported experiencing increased levels of mental health symptoms including anxiety, depression, trauma-related symptoms, increased substance use and increased reports of serious suicidal ideation compared to earlier pre-pandemic data. These findings were heightened for specific populations, including Black and Hispanic populations, essential workers and younger respondents.”⁵

Similar conversations with legislators and stakeholders have been occurring in Michigan, garnering a significant amount of interest relative to the inpatient psychiatric bed capacity in the State. As a result of growing conversations regarding the State’s ability to provide appropriate supports to individuals in need of in-patient psychiatric care, the Michigan Department of Health and Human Services (MDHHS) is charged with developing a five-year plan to address the need for adult and children’s inpatient psychiatric beds, pursuant to the Michigan Public Act 87 of 2021. By July 1, 2022, the five-year plan is due to the House and Senate Fiscal Agencies, Policy Offices, the Appropriations Subcommittees on the Department Budget, and the State Budget Office. The five-year plan is to be inclusive of recommendations for using public and public private partnership beds.

Background

There has been ongoing attention in Michigan to calculating and making available the right number of inpatient psychiatric beds to accommodate the needs of the State’s population. Over the years, researchers have worked to project accurate inpatient psychiatric bed needs based on utilization of

⁴ Pinals, D.A. (2021). *Ready to Respond: Mental Health Beyond Crisis and COVID-19*. Technical Assistance Collaborative Paper No. 1. Alexandria, VA: National Association of State Mental Health Program Directors. <https://www.nasmhpd.org/sites/default/files/ready-to-respond-compendium.pdf>. Accessed 28 April, 2022. Page 16.

⁵ Ibid, 2.



services across the State.⁶ The State of Michigan and Michigan Legislature have responded by implementing a series of strategies that expand access to inpatient psychiatric beds and improve quality of care for individuals needing this level of service.⁷ These strategies include:

1. Expanding the number of psychiatric beds that are available through the CON program.
2. Approving funds to pursue the building of a new facility to replace the existing Caro facility.
3. Expanding units available at existing facilities, for example, at the Center for Forensic Psychiatry.
4. Collecting and examining data on the causes of denials for inpatient services.
5. Facilitating transitions of care through the Children's Transition Support Team Pilot.

In July 2017, MDHHS launched the Michigan Inpatient Psychiatric Admissions Discussion (MIPAD) to investigate the ongoing challenges surrounding expanding access and quality of care for individuals needing inpatient psychiatric services and produce recommendations to help address existing barriers in the State. The resulting MIPAD recommendations emphasized the importance of addressing inpatient psychiatric bed shortages as indicative of a broader, systemic issue.

The findings from MIPAD are reflective of the challenges that states face when addressing inpatient psychiatric bed capacity issues. While having the right number of beds is a key variable in addressing service needs, solutions to address inpatient psychiatric bed capacity should not be viewed singularly. Simultaneous to addressing bed shortages, states are leveraging community-based and outpatient alternatives so that individuals are receiving the right types of care in the appropriate settings.⁸ States are also factoring in other policy, operational, and financial considerations such as the availability of the workforce to sufficiently cover beds, clinical and administrative processes that promote quality of care, as well as financing and reimbursement methodologies for care delivery.⁹

In addition, in recent years, states have had to address unprecedented demands resulting from the COVID-19 public health epidemic (PHE) on their delivery system, including inpatient psychiatric

⁶ PAUL L. DELAMATER, PSYCHIATRIC BED NEED METHODOLOGY OVERVIEW (Oct. 8, 2018), https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder3/Folder53/Folder2/Folder153/Folder1/Folder253/10_17_18_Materials.pdf?rev=18fe7f37b47c429987cb2b023cd1d55c Shaun A. Landley et al., *A methodology for projecting hospital bed need: a Michigan case study*, 5 SOURCE CODE FOR BIOLOGY & MED. (2010) <https://scfbm.biomedcentral.com/articles/10.1186/1751-0473-5-4>

⁷ MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, MIPAD FINAL WORKGROUP PAPER REPORT (Feb. 13, 2018), https://www.michigan.gov/documents/mdhhs/MIPAD_WorkgroupReport_613570_7.pdf

⁸ Ted Lutterman et al., TRENDS IN TOTAL PSYCHIATRIC INPATIENT AND OTHER 24-HOUR MENTAL HEALTH RESIDENTIAL TREATMENT CAPACITY 1970 TO 2014, NASMHPD Commissioners Meeting (July 31, 2017), https://www.nasmhpd.org/sites/default/files/2%20NRI-2017%20NRI%20Meeting--Distribution%20of%20Psychiatric%20Inpatient%20Capacity%2C%20United%20States_0.pdf

⁹ Jenna Bernson, MD et al., *Examining Access to Psychiatric Care in Michigan's Upper Peninsula*, 5 PRIMER 44 (Dec. 17, 2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8842812/>



hospitals. States have reported the impact of the PHE on the supply of available beds and the steadily increasing demand for beds from their State population.¹⁰ While the impacts of COVID-19 on inpatient psychiatric hospitals is not a focus of this evaluation, this issue may need to be part of the ongoing dialogue in Michigan as policymakers consider future assessments of inpatient psychiatric services.

Engagement with Myers and Stauffer

In February 2022, MDHHS engaged Myers and Stauffer, LC a certified public accounting firm with extensive experience in assisting state Medicaid agencies with effectively designing, reimbursing, and overseeing behavioral health services and supports, to support the work required to fulfill requirements under the Michigan Public Act 87 of 2021. Given the time permitted for the Myers and Stauffer study, Myers and Stauffer and MDHHS agreed on an alternative approach to the development of the five-year plan, as follows:

- Conduct an “as-is” assessment of statewide children and adult inpatient psychiatric beds (i.e., the existing system capacity to serve patients).
- Conduct research of up to three peer states to determine how those states addressed capacity issues and/or the need to expand capacity for child and adult inpatient psychiatric beds.
- Develop an “options analysis” based on the as-is assessment and initial research (i.e., options for consideration, advantages, and potential constraints or barriers).
- Provide initial recommendations based on the “as-is” assessment and peer state research.
- Provide proposed activities that need to be conducted by MDHHS, after July 1, 2022, to move from this report to a detailed five-year plan.

Overview of the Report

This report is organized into several sections as delineated in the table of contents, and includes two appendices used to illustrate research findings and provide information on references incorporated into this report.

- **Current State:** This section provides an overview of information received and analyzed from MDHHS and public resources to describe the “as-is” assessment of Michigan’s children and adult inpatient psychiatric bed capacity.
- **Peer State and Best Practice Research:** Research from Illinois, Minnesota, and Ohio is included to inform MDHHS on peer state demographics, inpatient psychiatric services, and community-based options. Peer state and national best practices are included in this section to present

¹⁰ Alan B. McGuire et al., *Inpatient Mental healthcare before and during the COVID-19 Pandemic*, HEALTHCARE 1613 (Nov. 23, 2021) <https://www.mdpi.com/2227-9032/9/12/1613/pdf>



opportunities and suggestions to MDHHS on pathways forward to further expand psychiatric services in Michigan.

- **Strategic Options:** The Strategic Options section presents information relative to how MDHHS can prioritize initiatives for inclusion in the five-year plan required by the Michigan Public Act 87 of 2021. Strategic Options include exploring approaches to expand psychiatric treatment capacity and community-based supports to provide a more robust array of services across the mental health care continuum for individual.
- **Conclusions and Next Steps:** This section summarizes the findings and recommendations included within the report and provides suggested next steps for MDHHS to consider with regards to the development of the detailed five-year plan.
- **Appendix A: Peer State Profiles:** Appendix A provides a visual summary of the peer state information for Illinois, Minnesota, and Ohio.
- **Appendix B: Reference List:** References used throughout this report are included in Appendix B, for ease of use by MDHHS.

Information included herein provides MDHHS an overview of inpatient psychiatric bed capacity in Michigan; how other states have reacted to similar trends in their states; and options, strategies, and recommendations.



Current State

MDHHS requested a high-level “as-is” assessment of the current state of inpatient psychiatric facilities in the State. The objective of this “as-is” assessment is to get a better understanding of current availability of inpatient psychiatric beds across the State and how this availability varies across factors such as geography and population (e.g., adults versus children and adolescents). The State of Michigan and its Legislature have implemented several strategies to help expand access to inpatient psychiatric beds and improve quality of care delivered in these facilities. While these strategies have been critical in enhancing and strengthening Michigan’s care continuum for individuals requiring inpatient psychiatric services, the State has recognized the need for additional analysis to determine how best to address gaps in inpatient psychiatric service needs.

As a result, in response to MDHHS’ request for a clearer understanding of inpatient psychiatric bed availability in the State and part of a strategy to address the growing need, Myers and Stauffer conducted an overview of private and state beds using data provided by the State. This assessment provides a general census of currently available beds, where these beds are located, and if beds are available to adults and/or children and adolescents.

Overview of Methodology

We conducted a retrospective analysis of inpatient psychiatric beds across state hospitals for state fiscal years (SFY) 2018 through FY 2021. We worked with MDHHS to request and receive data to support a review of inpatient psychiatric beds in the state. For our analysis, we relied solely on publicly available data or data provided by MDHHS, which included the following:

- **State Psychiatric Hospital Data:** We received aggregate data from MDHHS regarding patient days, number of patients, number of discharges, and average length of stay for each facility between 2018 and 2020.
- **State’s Certificate of Need (CON) Data:** We relied on publicly available CON data and data received from MDHHS from the CON survey, issued annually to facilities as part the State’s licensing process. We received data regarding patient days, number of patients, and length of stay for psychiatric facilities within the state for adults and children between 2018 and 2020.
- **U.S Census Bureau Data:** We relied on the U.S. Census Bureau population data for each county in the State between 2018 and 2020.

To obtain a general understanding of the number of inpatient psychiatric hospital beds available in the state, we first conducted an inventory of licensed beds in the state. We evaluated available beds based on three variables:



1. Type of bed (i.e., public or private facilities).
2. Location of beds (i.e., geographic region of the state as defined by the state's catchment areas).
3. Patient population served (i.e., adults or children/adolescents).

For the purpose of this assessment, and in alignment with definitions used by Michigan's Annual CON survey, we define adults as any individual over 18 years of age and children and adolescents as any individual under 18 years of age.

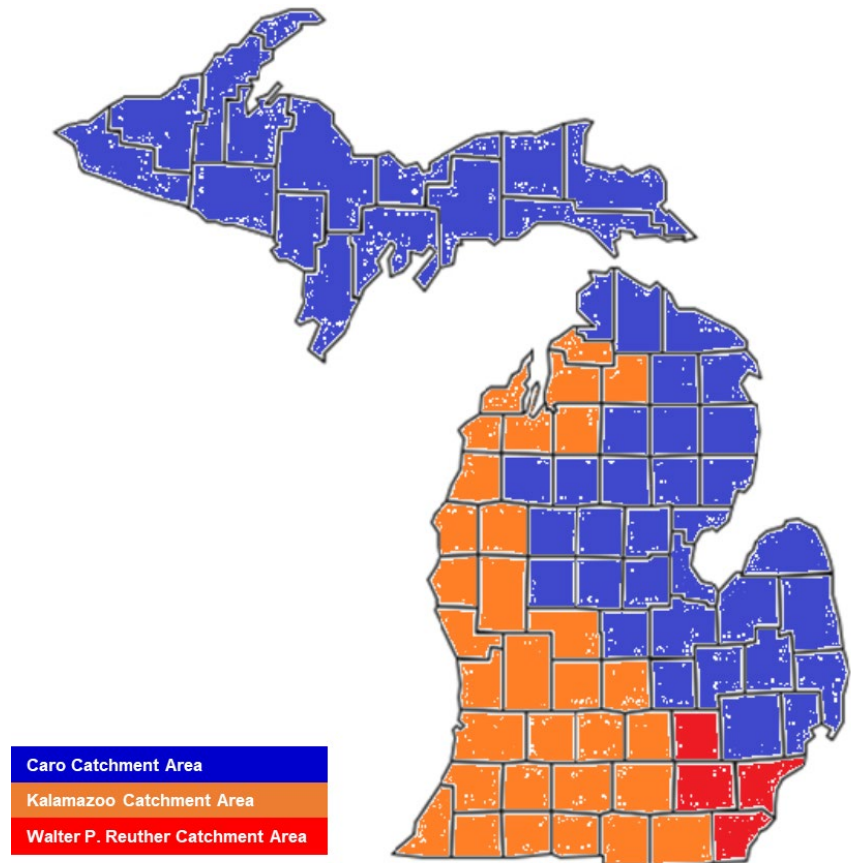
We then used this inventory to conduct a high-level analysis of the availability of beds in the state by total population. This analysis helped us determine how Michigan compared in terms of bed-to-population ratios to other states or to data reported by national resources.

We also identified patterns of changes in the number of beds, patients, patient days, and length of stay across the three-year period of SFY 2018 to 2020. While we initially proposed conducting this analysis across the four-year period of SFY 2018 to 2021, MDHHS indicated that data for private facilities in 2021 would not be available at the time of this report. Using the available data, we calculated occupation rate based on patient days to identify potential capacity changes across the state.

For the analysis, we reported findings based on the State's catchment areas defined by the State's three inpatient hospitals for adults. We determined the county of operation for each state or private facility based on its city of operation. We cross walked counties to the three catchment areas within the State. We understand from conversations with MDHHS that Oakland County is in the Caro catchment area, but some individuals are closer to the Walter P. Reuther catchment area and may go to a different facility as a result of geographic proximity. However, for the purposes of this analysis, we considered facilities within Oakland County as being part of the Caro catchment area. Since inpatient psychiatric hospitals are not available in all counties of the State, and after conversations MDHHS, it appeared that aggregating findings based on catchment areas would provide a more accurate review of service gaps. The following figure provides a review of the State's catchment areas.



Figure 1: Michigan Catchment Areas



Limitations of the Current System Assessment

Again, Myers and Stauffer relied primarily on publicly available data and data provided to us by MDHHS. Data from private facilities were provided by the state’s CON survey issued by MDHHS annually per State Code 333.222, while state hospital data was summarized and compiled by MDHHS. Since the CON survey data served as the primary source of information for private facilities, we were limited to data on licensed beds pursuant to State Code 330.1137. For State Hospital data, we used data directly provided by the state hospitals.

We did not receive or evaluate patient-level data or utilization patterns for state or private facilities. Therefore, our findings are limited to aggregate level analysis across the three-year period of interest (SFY 2018 to 2020). We propose to conduct additional analysis in the future on utilization patterns based on findings from this assessment in order to get a better understanding of Michigan’s ability to respond to patient needs for inpatient psychiatric hospitals. Given the timeframe for completion of our work, we were also unable to engage stakeholders, and conduct extensive financial and operational planning.



We also did not conduct any analysis on the impact of COVID-19 during the assessment period. In conversations with MDHHS, we determined that while there were direct impacts to bed availability due to some units or beds being converted for use to treat COVID-19 patients, this impact would be short-term. Private facilities and state hospitals would ultimately revert back to using identified beds for inpatient psychiatric patients. While we recognize that COVID-19 may impact other touchpoints along the care continuum for individuals, we determined the long-term impact on beds to be minimal or too preliminary for this analysis (for example, hospital closures due to the COVID-19 pandemic would need to be assessed post 2021).

Finally, we relied on a variety of publicly available data to help conduct this assessment. Examples of this data include U.S. Census Bureau for Michigan population data as well as Medicaid and Healthy Michigan enrollment reported by MDHHS. We made several assumptions in using this data. First, the U.S. Census Bureau reported population data for Michigan by county in April 2019, upon completion of the 2020 Census. To get an accurate overview of the State's population in non-Census collecting years of 2018 and 2020, we calculated a percent change between the projected total populations reported by the U.S. Census Bureau during these years and applied this percent change to the county-level data reported in April 2019. Additionally, the U.S. Census Bureau data reports aggregate population data, including children and adolescents. As a result, we did not project bed ratios separately for adults or children and adolescents. MDHHS will likely want to consider this additional delineation between adults and children and adolescents in the future.

Current System Assessment

This section summarizes our findings of the current state of available inpatient psychiatric hospital beds, based on data made available to us for the purposes of this analysis. For this assessment, we report on:

- Number of private inpatient psychiatric hospitals and state hospitals in the State
- Changes in the availability of inpatient psychiatric hospital beds between 2018 and 2021 for state or private facilities by catchment area.
- Changes in the number of patients accessing Inpatient Psychiatric Hospital beds between 2018 and 2021 for state or private facilities by catchment area.
- Changes in the occupancy rate between 2018 and 2020 for state or private facilities by catchment area.
- Total bed to population ratio in 2018 – 2020 by catchment area and for the state.

Number of Private Inpatient Psychiatric Hospitals and State Hospitals

We reviewed available data from state and private facilities to provide an overview of the maximum availability of Michigan's inpatient psychiatric hospital beds. We compiled information specific to each of the State's facilities, as well as general population data.



There are currently five state psychiatric hospitals in Michigan. The following table provides additional detail on these facilities.

Table 2: State Hospitals

State Hospitals			
Name of Facility	Location	Population Served	No. of Beds
Caro Center	Caro Catchment	Adults	100
Kalamazoo Psychiatric Hospital	Kalamazoo Catchment	Adults	170
Walter P. Reuther Psychiatric Hospital	Walter P. Reuther Catchment	Adults	160
Center for Forensic Psychiatry	Statewide	Adults – Forensic Process Patients	240
Hawthorn Center	Statewide	Children and Adolescents	55

MDHHS reports that the number of beds available at state hospitals remained consistent from 2018 to 2020, with the exception of Caro Center, which decreased their beds from 150 to 100 due to staffing shortages. While some of the beds in state hospitals may have been repurposed to help address the State’s response to COVID-19, these changes have been transient and do not change long-term commitments to state hospital bed availability. As evidenced in Table 2, the only state hospital in Michigan serving children and adolescents is the Hawthorn Center. With regard to private facilities, we reviewed data from the facilities shown in Table 3 below.

Table 3: Review of Private Facilities

Review of Private Facilities			
Facility	Number of Facilities Reviewed		
	2018	2019	2020
Caro Catchment			
Private Facilities – Adults	27	27	27
Private Facilities – Children and Adolescents	6	6	6
Total	33	33	33
Kalamazoo Catchment			
Private Facilities – Adults	19	19	20
Private Facilities – Children and Adolescents	4	4	4
Total	23	23	24
Walter P. Reuther Catchment			
Private Facilities – Adults	12	12	12
Private Facilities – Children and Adolescents	2	2	2
Total	14	14	14
STATE TOTAL	58	58	59



Between 2018 and 2020, the number of beds in private facilities for adults increased from 58 to 59, one additional facility created in the Kalamazoo catchment area in 2020. For children and adolescents, facilities have remained constant at 12.

Availability of Inpatient Psychiatric Hospital Beds

The number of available beds in private psychiatric facilities increased by six percent between 2018 and 2020. The total number of private psychiatric beds between 2018 and 2020 for adults increased six percent, and for the pediatric population, seven percent. *Table 4* provides a more detailed analysis of trends in the availability of inpatient psychiatric beds.

Table 4: Total Number of Beds by Catchment Area for Private Facilities

Total Number of Beds by Catchment Area for Private Facilities								
Catchment Area	Adults				Child/Adolescent			
	2018	2019	2020	% Change between 2018 and 2020	2018	2019	2020	% Change between 2018 and 2020
Caro	1,093	1,130	1,152	5%	161	165	171	6%
Kalamazoo	656	666	689	5%	89	99	99	11%
Walter P. Reuther	449	477	497	11%	32	32	32	0%
Total	2,198	2,273	2,338	6%	282	296	302	7%

In contrast, the number of total available beds in state psychiatric facilities decreased by 50 between 2018 and 2020, per *Table 5*. Per discussions with MDHHS, the Caro Center reduced the number of beds in 2019 from 150 to 100 to address patient and staff safety issues due to staffing limitation.

Table 5: Total Number of Beds by Facility for State Hospitals

Total Number of Beds by Facility for State Hospitals						
Facility Name	Adults			Child/Adolescent		
	2018	2019	2020	2018	2019	2020
Caro Center	150	100	100	N/A	N/A	N/A
Kalamazoo Psychiatric Hospital	170	170	170	N/A	N/A	N/A
Walter P. Reuther Psychiatric Hospital	160	160	160	N/A	N/A	N/A
Center for Forensic Psychiatry	240	240	240	N/A	N/A	N/A
Hawthorn Center	N/A	N/A	N/A	55	55	55
Total	720	670	670	55	55	55

Several private facilities in the Caro and Kalamazoo catchment area provide flex beds, which are adult psychiatric beds that can be converted to a child/adolescent psychiatric bed in an existing child and adolescent psychiatric hospital during peak periods in order to meet patient demand. The number of



flex beds did not change between 2018 and 2020. *Table 6* highlights the number of flex beds available by catchment area in the state.

Table 6: Total Flex Beds by Catchment Area for Private Facilities

Total Flex Beds by Catchment Area for Private Facilities			
Catchment	2018	2019	2020
Caro Catchment	18	18	18
Kalamazoo Catchment	26	26	26
Total	44	44	44

Strategies to increase bed capacity in the community by private facilities, such as the use of flex beds, do not always translate to increased capacity for state hospitals. Bed capacity is controlled by availability as well as admissions criteria and staffing. Based on data provided by MDHHS, there has been no correlation between increased bed capacity in private facilities and reduced waitlists for state hospitals.

Patient Days at Inpatient Psychiatric Hospital Beds

There have been inconsistent trends in inpatient days for both state hospitals and private facilities for both adults and children and adolescents between 2018 and 2020. Overall, MDHHS 2020 data shows decreases in patient days for state hospitals and private facilities from 2018. This decrease is greater for the adult population than for children and adolescents, regardless of the facility type (e.g., state hospitals or private facilities). *Table 7* provides a high-level overview of general trends in patient days.

Table 7: Total Patient Days by Facility Type between 2018 and 2020

Total Patient Days by Facility Type between 2018 and 2020					
Facility Type	Population Type	2018	2019	2020	% Change Between 2018 and 2020
State Hospitals	Adults	257,884	240,498	236,379	-8%
State Hospitals	Children and Adolescents	19,173	17,765	18,911	-1%
Private Facilities	Adults	568,416	574,173	531,652	-6%
Private Facilities	Children and Adolescents	77,419	72,668	75,237	-3%

There were slight variation in trends in patient days across catchment areas. The data indicates a general decrease in patient days across the State. We found that in state hospitals, there was an overall increase in patient days between 2018 and 2020 for the adult population in Kalamazoo Psychiatric Hospital. For private facilities, there was a slight increase in patient days between 2018 and 2020 for children and adolescents in Kalamazoo Psychiatric Hospital and for adults in Walter P. Reuther Psychiatric Hospital. The tables below provide a more in-depth review of trends in patient days by facility or State catchment area for adults and children and adolescents.



Table 8: Adult Patient Days by State Hospital Facility or Private Facility Catchment Area

Adult Patient Days by Facility or Catchment Area							
Year	State Hospital Facilities				Private Facilities		
	Caro	Kalamazoo	Walter P. Reuther	Center for Forensic Psychiatry	Caro Catchment	Kalamazoo Catchment	Walter P. Reuther Catchment
2018	52,778	51,206	59,669	94,231	279,486	164,011	124,919
2019	32,711	54,708	60,242	92,837	278,513	160,577	135,083
2020	36,031	58,326	56,555	85,467	259,249	142,990	129,413
% Change between 2018 and 2020	-32%	14%	-5%	-9%	-7%	-13%	4%

Table 9: Child and Adolescent Patient Days by State Hospital Facility or Catchment Area

Child and Adolescent Patient Days by Facility or Catchment Area				
Year	State Hospital Facility	Private Facilities		
	Hawthorn Center	Caro Catchment	Kalamazoo Catchment	Walter P. Reuther Catchment
2018	19,173	39,770	27,821	9,828
2019	17,765	35,454	27,329	9,885
2020	18,911	31,437	34,258	9,542
% Change between 2018 and 2020	-1%	-21%	23%	-3%

In general, we found that Walter P. Reuther Psychiatric Hospital experienced the least amount of fluctuation in patient days for both state hospitals and private facilities compared to the other two catchment areas.

Inpatient Psychiatric Hospital Bed Occupancy Rates

We found higher occupancy rates for adults, and children and adolescents in state hospitals based on patient days than for private facilities. *Table 10* shows overall occupancy rates for adults and children and adolescents by facility type between 2018 and 2020.



Table 10: Occupancy Rates by Facility Type between 2018 and 2020

Occupancy Rates by Facility Type between 2018 and 2020					
Facility Type	Population Type	2018	2019	2020	Percent Change between 2018 and 2020
State Hospitals	Adults	98%	98%	97%	-1%
State Hospitals	Children and Adolescents	96%	88%	94%	-2%
Private Facilities	Adults	71%	69%	62%	-13%
Private Facilities	Children and Adolescents	75%	67%	68%	-9%

This table demonstrates that occupancy rates decreased between 2018 and 2020 for both adults, and children and adolescents for all facility types. One potential explanation is the reduction of occupied beds in all facilities in 2020 to support isolation and quarantine wards needed because of the COVID-19 pandemic. In addition, workforce shortages in recent years have potentially posed more of an issue, limiting the number of patients that could be enrolled in both community and private facilities and state hospitals. Such staffing shortages could indirectly impact the total occupancy rates in 2019 and 2020. For state hospitals, we also note that the Caro Center reduced their bed census starting in 2019, which may have indirectly impacted average occupancy rates in 2019 and 2020.

In discussions with MDHHS, we determined that while the number of patients accessing state hospitals increased between 2018 and 2020, occupancy rates based on patient days decreased for both adults and children/adolescents in the state. This decrease in occupancy rates may be attributed to improvements in throughput, as the State has begun working closely with Community Mental Health Services (CMH) to increase the availability of community supports and a decrease in reliance on state psychiatric facilities.

When assessing occupancy rates by catchment areas for the adult population, we found differences between state hospitals and private facilities. For state hospitals, the occupancy rate was highest for the Center for Forensic Psychiatry, which provides services statewide. Correspondingly, the range for occupancy rate across private facilities was smaller than for state hospitals, with Kalamazoo having the highest average occupancy between 2018 and 2020. *Table 11* demonstrates our results in greater detail.



Table 11: Occupancy Rate for Adults by State Hospital Facility or Catchment Area

Occupancy Rate for Adults by Facility or Catchment Area							
Year	State Hospital Facilities				Private Facilities		
	Caro	Kalamazoo	Walter P. Reuther	Center for Forensic Psychiatry	Caro Catchment	Kalamazoo Catchment	Walter P. Reuther Catchment
2018	96%	83%	102%	108%	70%	68%	62%
2019	90%	88%	103%	106%	68%	66%	57%
2020	99%	94%	97%	98%	62%	78%	71%
Average	95%	88%	100%	104%	67%	71%	63%

MDHHS has only one facility serving children and adolescents in the State, where occupancy ranged from 88 percent to 96 percent. For private facilities, occupancy rates for private facilities were, on average, lower in all three catchment areas when compared to state hospitals.

Table 12: Occupancy Rate for Children and Adolescents by State Hospital Facility or Catchment Area

Occupancy Rate for Children and Adolescents by Facility or Catchment Area				
Year	State Hospital	Private Facilities		
	Hawthorn Center	Caro Catchment	Kalamazoo Catchment	Walter P. Reuther Catchment
2018	96%	68%	86%	84%
2019	88%	59%	76%	85%
2020	94%	50%	95%	82%
Average	93%	59%	86%	84%

With regards to available flex beds, MDHHS data shows that these beds are more likely to be occupied by children and adolescents, as shown in Table 13.

Table 13: Average Occupancy Rate for Flex Beds by Catchment Area

Average Occupancy Rate for Flex Beds by Catchment Area						
Population Type	Caro Catchment			Kalamazoo Catchment		
	2018	2019	2020	2018	2019	2020
Adults	47%	22%	8%	37%	33%	20%
Children and Adolescents	39%	49%	33%	34%	36%	48%

Length of Stay

The average length of stay was significantly higher in state hospitals for both adults and children and adolescents as compared to private facilities. Per conversations with MDHHS, private hospitals may structure their admissions criteria differently resulting in these differences in length of stay. This is an area that warrants further analysis. We also evidenced that for private facilities, the average length of



stay did not change between 2018 and 2020 for both adults and children and adolescents. Table 14 identifies the average length of stay by facility type from 2018 through 2020.

Table 14: Average Length of Stay by Facility Type and Population in Days

Average Length of Stay by Facility Type and Population in Days				
Facility Type	Population Type	2018	2019	2020
State Hospitals	Adults	1,017	953	870
State Hospitals	Children and Adolescents	193	180	143
Private Facilities	Adults	9	9	9
Private Facilities	Children and Adolescents	7	7	7

For adults and children and adolescents in State Hospitals, the average length of stay decreased between 2018 and 2020.

When assessing length of stay by catchment area, we found the longest length of stay for adults in state hospitals at the Center for Forensic Psychiatry, which serves patients statewide. For private facilities, the longest length of stay was in Walter P. Reuther catchment area, however the range between the three catchment areas was not significant. Table 15 provides additional detail on the average length of stay for adults between 2018 and 2020.

Table 15: Average Length of Stay for Adults by State Hospital Facility or Catchment Area

Year	Average Length of Stay for Adults by Facility or Catchment Area						
	State Hospital Facilities				Private Facilities		
	Caro	Kalamazoo	Walter P. Reuther	Center for Forensic Psychiatry	Caro Catchment	Kalamazoo Catchment	Walter P. Reuther Catchment
2018	884	883	933	1,366	9.10	8.87	8.94
2019	890	908	885	1,129	9.03	8.70	9.63
2020	725	865	904	985	8.88	8.30	10.22
Average	833	885	907	1,160	9.00	8.62	9.60

For children and adolescents, the average length of stay for children in state hospitals was significantly greater than for private facilities in all three catchment areas. For private facilities, children and adolescents in the Walter P. Reuther catchment area had the highest average length of stay, per Table 16, with an average length of stay between 2018 and 2020 of around 11 days.



Table 16: Average Length of Stay for Children and Adolescents by State Hospital Facility or Catchment Area

Average Length of Stay for Children and Adolescents by Facility or Catchment Area				
Year	State Hospital	Private Facilities		
	Hawthorn Center	Caro Catchment	Kalamazoo Catchment	Walter P. Reuther Catchment
2018	193	5.33	8.48	10.50
2019	180	5.18	7.98	10.50
2020	143	5.45	8.10	11.66
Average	172	5.32	8.19	10.89

Trends in Bed Ratio

Using data provided by MDHHS and U.S. Census population estimates, we also conducted a high-level review of bed ratio per capita of 100,000 in Michigan between 2018 and 2020. To conduct this analysis, we calculated the total number of available licensed beds and total population statewide for state and private facilities. Table 17 shows our findings from this analysis.

Table 17: Inpatient Psychiatric Beds per 100,000 Population

Inpatient Psychiatric Beds per 100,000 Population								
2018			2019			2020		
# of Beds	Pop.	Bed Ratio	# of Beds	Pop.	Bed Ratio	# of Beds	Pop.	Bed Ratio
3,255	9,984,072	32.6	3,294	9,986,857	33.0	3,365	10,067,664	33.4

We found that the average bed ratio in 2018, 2019, and 2020 across all state and private facilities was 33.0 per 100,000. Notably, other studies have examined bed to population ratios and recently, in 2020, one study suggested a national inpatient psychiatric bed ratio of 34.9 per 100,000. Our findings indicate that bed ratios in Michigan were slightly lower than suggested by national standards.¹¹

Summary of Findings

The analysis of available data identifies several key trends that appear relevant for MDHHS to consider as it develops its five-year plan, as follows:

1. The number of private facility beds increased across 2018 to 2020, while the number of total state hospital beds decreased due to reductions in beds at the Caro Center in 2019. There was a six percent increase in the number of available beds for adults and a seven percent increase in available beds of children/adolescents for private facilities. For state hospitals, the number of

¹¹ Hudson, Christopher G. "Benchmarks for Needed Psychiatric Beds for the United States: A Test of a Predictive Analytics Model." International journal of environmental research and public health vol. 18,22 12205. 20 Nov. 2021, doi:10.3390/ijerph182212205



beds for children and adolescents remained the same in state hospitals across the three years, while the number of beds adults decreased by 7%. Moreover, State leadership indicated that the number of beds available in state hospitals were less in 2020 as the State repurposed some of the facilities to support State COVID-related care.¹²

2. Patient days decreased slightly between 2018 and 2020 for adults and children/adolescents in both state hospitals and private facilities). However, this decrease was more pronounced for adult patient days. In 2020, there was an eight percent and six percent decrease in adult patient days in State Hospitals and private facilities, respectively. Discussions with MDHHS indicate that COVID-19 and the use of facilities to provide frontline support in battling the pandemic may have contributed to this decrease. Additionally, since 2018, there has been a push for a greater reliance on community networks within the State.¹³ As a result, this may lead to a slight decrease in utilization for both state hospital and private facilities. As the State continues to examine trends in inpatient psychiatric hospital utilization, consideration should be given to the growth in community supports and increases in options for more home-based care delivery models within the State.
3. Occupancy rates were greater in State Hospitals than in private facilities. For private facilities, occupancy rates were highest in the Walter P. Reuther catchment area. For state hospitals, average occupancy rates were highest at the Center for Forensic Psychiatry, which serves patients statewide. On average, occupancy rates were lower for children than adults in both state hospitals and private facilities. One of the mitigating factors in occupancy rates across adults and children/adolescents for private facilities compared to State Hospitals is the availability of flex beds. A few private facilities had flex bed availability, which are adult beds that can be transitioned to accommodate children. This provides some flexibility in meeting surges in demand for adults and children and adolescents. State Hospitals are limited in caring for children/adolescents as there is only one facility that provides targeted care for this population. MDHHS should consider conducting additional quantitative and qualitative analysis of specific needs for adults versus children and adolescents. For instance, the MIPAD recommended requiring all community short-term acute care hospitals with children's inpatient specialties to implement and maintain psychiatric programs for this population. This recommendation indicates a need for the State to reevaluate targeted services for children and adolescents requiring psychiatric services.
4. There is a wide difference between the lengths of stay in a state hospital and a private facility. One potential explanation is that private hospitals are thought to sometimes turn away prospective patients due to their acuity, which may indirectly lead to lower lengths of stay.¹⁴

¹² Mellos, Dr. George. Email to Venesa Day. 31 March 2022

¹³ Ibid, 12

¹⁴ <https://www.wxyz.com/news/local-news/investigations/whitmer-calls-for-significant-increase-in-state-psych-beds-for-children>



The State should conduct additional analysis to determine potential factors that may contribute to such differences. Other variables should also be assessed, such as readmission rates and discharge processes to determine if there are any policy or operational changes that may be needed to help mitigate this gap in length of state between facility types. Potential solutions proposed by the MIPAD include evaluating if individuals can be served at therapeutic foster care homes or other residential treatment facilities.

5. There has been ongoing national dialogue on the number of inpatient psychiatric beds that provide optimal support for their population.^{15,16,17} While target bed ratios offer some guidance to states in planning bed capacity, there are other variables that states need to be considered, including policies within the state that may impact admissions to or discharge from an inpatient psychiatric facility. For example, states may need to consider admissions criteria to validate an individual's need for inpatient psychiatric facilities. Respectively, there may be an absence of a discharge location for individuals, which prevent them from leaving inpatient psychiatric facilities. As a result, MDHHS should review bed ratio as just one factor of the care continuum in the State.

In addition to the Michigan-specific findings noted above, the following section details research from peer states which may be relevant for further consideration as MDHHS develops the five-year plan.

¹⁵ Ibid, 11

¹⁶ McBain RK, Cantor JH, Eberhart NK. Estimating Psychiatric Bed Shortages in the US. *JAMA Psychiatry*. 2022;79(4):279–280. doi:10.1001/jamapsychiatry.2021.4462

¹⁷ Lutterman, T., Shaw, R., Fisher, W. and Manderscheid, R., 2022. Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014. [online] Nri-inc.org. Available at: <<https://www.nri-inc.org/media/1319/tac-paper-10-psychiatric-inpatient-capacity-final-09-05-2017.pdf>> [Accessed 28 April 2022].



Peer State and Best Practices Research

Introduction

As part of our study, Myers and Stauffer researched select peer states and conducted a national review of best practices across states. This information will provide further context to MDHHS policymakers regarding options the State may consider as it develops its five-year strategic plan for determining the need for inpatient psychiatric beds and services. Taking into account information and existing service delivery options from across the nation will allow MDHHS to consider current practices while tailoring best practices to meet the needs of Michiganders.

Selection of Peer States

Myers and Stauffer worked with MDHHS to review and select peer states, based on factors such as geographic proximity, size of the Medicaid population, urban versus rural distribution of the population, and Medicaid expansion status. For this peer research, we conducted an environmental scan of publicly available information from national agencies or organizations and state websites. The following table highlights several key variables to illustrate similarities across Michigan and the selected three states. We also detail specific findings from our research in the sections below.

Table 18 Selected Michigan and Peer State Metrics

Metrics for Consideration	Michigan	Minnesota	Illinois	Ohio
Total State Population ¹⁸	9.98 M	5.7 M	12.5	11.69 M
% of Population in Urban Areas ¹⁹	82.1%	78%	88.8%	80.1%
% Enrolled in Medicaid ²⁰	22.1%	16.9%	18.2%	20%
Medicaid Expansion (Y/N) ²¹	Y	Y	Y	Y
% Enrolled in Medicare ²²	13.1%	14.7%	14.1%	15.9%

¹⁸ United States Census Bureau, *Quick Facts* (last visited Apr. 28, 2021), <https://www.census.gov/quickfacts>

¹⁹ USDA Economic Research Service, *State Fact Sheets* (last updated Feb. 4, 2022) <https://data.ers.usda.gov/reports.aspx?ID=17854>

²⁰ KFF, *Health Insurance Coverage of the Total Population* (2019) <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

²¹ KFF, *Status of State Medicaid Expansion Decisions: Interactive Map* (Apr. 26, 2022)

<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

²² KFF, *Health Insurance Coverage of the Total Population* (2019) <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>



Metrics for Consideration	Michigan	Minnesota	Illinois	Ohio
% Receiving Military Health Benefits ²³	0.5%	0.7%	0.7%	0.8%
% Uninsured ²⁴	3.0%	4.8%	7.3%	6.7%
Number of State Hospitals	5	15 ²⁵	7 ²⁶	6 ²⁷

Peer State and Best Practices Research

There has been national attention on assessing the adequacy of inpatient psychiatric beds, which has translated to states working to identify gaps and potential solutions to help mitigate issues and provide a pathway for individuals to receive such intensive supports. This same topic has received attention in the peer states. State monitoring activities vary based on whether the hospitals are state run, or privately owned. We reviewed peer state and national best practices research and focused our findings in the following categories:

1. Developing a long-term solution to address inpatient psychiatric bed need
2. Determining psychiatric bed capacity and managing available psychiatric beds
3. Maximizing community-based resources
4. Support behavioral health options for safe discharge

As available, for each of these categories, we provide additional insight and findings from our peer state and national best practice research.

²³ KFF, *Health Insurance Coverage of the Total Population* (2019) <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

²⁴ Ibid, 22

²⁵ Department of Health and Human Services, *Community Behavioral Health Hospitals* (last updated Feb. 4, 2022) <https://mn.gov/dhs/people-we-serve/adults/services/direct-care-treatment/programs-services/community-behavioral-health-hospitals/>

²⁶ Illinois Department of Human Services, *Inpatient Services* (last visited Apr. 28, 2022) <https://www.dhs.state.il.us/page.aspx?item=30433>

²⁷ Ohio Mental Health and Addiction Services, *Regional Psychiatric Hospitals* (last visited Apr. 28, 2022) <https://mha.ohio.gov/about-us/regional-psychiatric-hospitals>.



Developing a Long Term Solution: Supporting the Full Continuum of Behavioral Health Services

Peer states and states across the nation are moving away from developing a single solution to the issue of supporting in-patient care, i.e., increasing bed capacity, to a solution that considers the full continuum of psychiatric services in determining bed need. For example, Minnesota has begun to evaluate their mental health continuum of care based on the intensity of the modality of service delivery.²⁸ Many states, including the peer states, have also begun to focus attention on initiatives that are intended to bolster community-based supports that may enhance, expand, or strengthen the care continuum for behavioral health services. As a result, initiatives may be more focused on increasing community resources than building new beds. The following table provides a description of the activities and programs prioritized by the peer state to help develop activities outside of inpatient services.

Table 19 Peer State Research Summary: Development of Community Resources

State	Initiatives
Ohio	Development of Programs that Provide Targeted Services: Ohio has several programs that helps individuals transition to and stay in the community. The Funds Recovery provides housing, targeted for individuals recovering from substance use disorders. The PATH program supports people with serious mental illness who are experiencing homeless or at risk of becoming homeless. ²⁹
Ohio	Assessment of Outpatient Needs Post Discharge from Psychiatric Hospitals: In select counties in the State, Ohio has awarded grants to support increased reliance on outpatient services. The Mental Health and Recovery Board (MHRB) reviews utilization reports biweekly to support a more proactive approach to facilitating transition from inpatient treatment to outpatient care for those individuals being discharged from State Regional Psychiatric Hospitals. Currently, there is sufficient capacity and resources in Warren and Clinton counties to address the treatment needs of those individuals being discharged as community -based outpatient services are readily available. ³⁰
Illinois	Investments in Community-Based Programs: There has been a continued shift from hospital inpatient care towards community-based clinic outpatient treatment that has taken place in the State, as is exemplified by the budget trends of state mental health agencies. On average, approximately 72% of their budgets is now spent on community-based programs, compared to 33% in the early 1980s. Compared to the U.S. average,

²⁸ *Understanding the Adult Mental health Service Continuum* (June 10, 2015)

https://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs16_195685.pdf

²⁹ *2021 Annual Report* (last visited April 28, 2022) <https://mha.ohio.gov/about-us/media-center/annual-reports/2021-annual-report#Treatment>

³⁰ *Mental Health Recover Board Serving Warren and Clinton Counties* (last visited April 28, 2022)

<https://mha.ohio.gov/static/SupportingProviders/ApplyforFunding/ForCurrentAwardees/2021/Warren-Clinton.pdf>



State	Initiatives
	the Illinois Department of Mental Health spends a very low amount per capita on community-based programs. ³¹
Illinois	Recognizes the Importance of Each Entry Point in the Care Continuum: Illinois offers a continuum of services from intensive inpatient hospitalization to outpatient care backed by supportive housing and employment programs. The State recognizes the interconnectedness of community-based supports with inpatient psychiatric service needs.
Minnesota	Supporting a More Diverse Workforce in Alignment with Specific Needs in the State: During the 2021 Legislative Session, Minnesota made significant changes to help address the capacity and diversity of the State’s mental health workforce. The goals of these states were to support the development of a more robust workforce that may encourage earlier intervention of needed services. ³²
Minnesota	Relying on Community Behavioral Health Hospitals to Meet Short-term Needs. Minnesota supports six Community Behavioral Health Hospitals (CBHHs) to provide short-term inpatient care. The goal is to keep individuals as close to the community as possible to encourage faster treatment and recovery, while individuals receive the necessary intensive inpatient services. ³³

National Best Practices

In a collaboration between the National Association of State Mental Health Program Directors (NASMHPD) and the Treatment Advocacy Center (TAC), a national study and policy analysis was conducted to inform and strengthen the vital system of behavioral health services. The analysis, titled *Beyond Beds*, included a comprehensive review of:

- *Overall inpatient capacity*
- *Forensic bed capacity and number of beds*
- *Health integration and co-occurring substance use disorders*
- *Populations with intellectual and developmental disorders and other special needs*
- *Crisis intervention capacity*

³¹ MARVIN LINDSEY ET AL., BEHAVIORAL HEALTH WORKFORCE EDUCATION CENTER TASK FORCE REPORT TO THE ILLINOIS GENERAL ASSEMBLY (Dec. 27, 2019), <https://www.ilga.gov/reports/ReportsSubmitted/693RSGAEmail1488RSGAAttachBH%20Workforce%20Task%20For ce%20Report%2027DEC2019%20FINAL.pdf>

³² NATIONAL ALLIANCE ON MENTAL ILLNESS MINNESOTA, MENTAL HEALTH WORKFORCE CRISIS (Feb. 22, 2022) <https://www.house.leg.state.mn.us/comm/docs/iifYmJzb10uPOF4OungF3w.pdf>

³³ Department of Health and Human Services, *Community Behavioral Health Hospitals* (last updated Feb. 4, 2022) <https://mn.gov/dhs/people-we-serve/adults/services/direct-care-treatment/programs-services/community-behavioral-health-hospitals/>



- Homelessness
- Trauma-informed care
- Peer services
- Health disparities and cultural competence³⁴

Resulting from the analysis of the population characteristics and reported capacity, the authors developed a series of 10 recommendations. These recommendations were structured to provide a mechanism for laying the foundation of a strong system rather than making specific programmatic recommendations. Rather, by using the recommendations to assess and determine the needs of each specific system, policy makers and stakeholders would be positioned to make choices more likely to support people with serious mental illness need and by removing barriers or obstacles to treatment they already commonly experience.

While many of the recommendations are structured to create common terminology or other foundational systems, the first study recommendation was to create a comprehensive continuum of care. This recommendation was placed first in the list as it represent a core foundational consideration. The premise of Beyond Beds is to look at the whole system of care rather than seek to solve one portion of the system that seems inadequate to meet the current needs. Rather viewing the system of care as an interdependent system allows policy makers to look at multiple program decisions both in how they impact the immediate need and how they have flow-on impacts to other parts of the system in both positive and negative ways. It is through this more interconnected analysis that stakeholders can create a system that serves the myriad needs of the population.

Determining Psychiatric Bed Capacity

States have been evaluating the optimal bed capacity for inpatient psychiatric hospitals as a way to combat gaps in care delivery and support access to necessary services.³⁵³⁶ The following table summarizes how the peer states are monitoring and regulating bed capacity in state and private facilities.

Table 20 Peer State Research Summary: State Approaches to Monitoring Beds

Metrics	MN	IL	OH
State-Operated CON Program (Y/N)	No	Yes	Yes

³⁴ Debra A. Pinals, MD & Doris A. Fuller, MFA, Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care, NASMHPD (Oct. 2017), https://www.nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf

³⁵ Hanke Heun-Johnson et al., *The Cost of mental Illness: Minnesota Facts and Figures*, USC Schaeffer (July 2019), <https://healthpolicy.usc.edu/wp-content/uploads/2019/11/MN-Chartbook-v1-2019.pdf>

³⁶ Ibid, 11



Metrics	MN	IL	OH
	MN terminated its CON program in 1984 and is currently operating under a hospital bed moratorium. This moratorium is a way of limiting investments in excess hospital capacity. Per MN Statute 144.551, the State is prohibiting establishment of new hospital licenses and expansion of existing hospital licensed beds. ³⁷	The Health Facilities Planning Act (Act) (20 ILCS 3960), established Illinois' certificate of need (CON) program. The Act established the Health Facilities Planning Board (since renamed the Health Facilities and Services Review Board (Board)) which issues permits for construction or modification projects proposed by or on behalf of healthcare facilities, and for the acquisition of major medical equipment.	The CON Program is operated by the Ohio Department of Health (ODH); processes are set forth in sections 3702.51 to 3702.62 of the Ohio Revised Code (ORC) and Chapter 3701-12 of the Ohio Administrative Code (OAC). ³⁸
Other State Regulations on Licensing of Psych Hospital Beds	MN Chapter 9520 identifies additional requirements related to licensing of facilities.	All licensed facilities must follow requirements listed in Illinois Administrative Code, Title 77	OAC 4122-14-03 identifies licensing requirements for providers wishing to establish inpatient services for persons with mental disorders.
Recent Policy Changes to Add/Decrease Hospital Beds (3-5 Years)	Currently operating under a hospital bed moratorium. This moratorium is a way of limiting investments in excess hospital capacity. Per MN Statute 144.551, the State is prohibiting establishment of new hospital licenses and expansion of existing hospital licensed beds. ³⁹	None Identified	None Identified
Activities Taken by the State to Monitor and Track State Hospital Beds, including Legislative	In 2016, DHS formed a Task Force, at the behest of the Governor, to discuss potential strategies for addressing inpatient psychiatric bed capacity. The Task Force acknowledged	No specific actions taken.	OHMHAS releases state owned psychiatric hospital capacity in their annual reports. The 2021 report provides a summary of the efforts taken to limit bed capacity to prevent the spread of COVID-19. OHMHAS temporarily

³⁷ Stefan Gildemeister, *Regulating Hospital Bed Capacity in Minnesota*, (Jan. 27, 2021) https://www.house.leg.state.mn.us/comm/docs/radytZw7G0eLVa6Qe_SiGA.pdf

³⁸ Ohio Department of Health, Certificate of Need (last visited Apr. 28, 2022), <https://odh.ohio.gov/know-our-programs/certificate-of-need/welcome-to>

³⁹ Ibid, 37



Metrics	MN	IL	OH
Reports, Programs, etc.	the need for considering bed shortages in light of the complicated continuum of care for these populations. ⁴⁰		funded local mental health boards to pay for inpatient stays in private and general hospitals, when necessary. Most beds in state run hospitals were occupied by forensic patients ⁴¹
Targeted Activities Implemented to Support the Forensic Population	In February 2021, the Community Competency Restoration Task Force submitted a legislative report highlighting potential recommendations to support individuals found incompetent to stand trial. Some of these recommendations include access to a continuum of competency restoration programs, including inpatient settings. ⁴²	One facility in the State, the Chester Mental Health Center, provides maximum-security treatment only for individuals sent by the criminal courts or who are in need more intensive behavior modification services. ⁴³	In addition to Ohio joining the PSYPACT, SB 2 also aims to improve access to regional psychiatric hospitals by diverting appropriate individuals to community-based competency restoration. New funding will help support a statewide network of outpatient providers serving the forensic population referred to outpatient restoration ⁴⁴
Description of Access or Quality Reporting Requirements From MCOs, if any	Hospitals must report annually psychiatric hospitalization rates and readmission rates. However, there are no additional managed care specific requirements	The Department of Human Services and Department of Children and Family Services work together to create a coordinated single point of entry, allowing the tracking of screening and assessment for children and adolescents to an inpatient psychiatric facility.	Ohio’s Medicaid Managed Care Delivery System can be categorized into those individuals enrolled in a traditional Medicaid Managed Care Plan (MMC) or those individuals enrolled in the demonstration program known as MyCare Ohio (MCOP). As of 2018, all plans, regardless if they were only providing services in the MCOP provided inpatient treatment. ⁴⁵

⁴⁰ GOVERNOR’S TASK FORCE ON MENTAL HEALTH, IMMEDIATE IMPROVEMENTS IN INPATIENT BED CAPACITY AND LEVELS OF CARE TRANSITIONS: PROPOSED SOLUTIONS (Sept. 9, 2016) https://mn.gov/dhs/assets/draft-solutions-9-9-16_tcm1053-255346.pdf

⁴¹ 2021 OHIO MENTAL HEALTH & ADDICTION SERVICES ANNUAL REPORT, at 13 <https://mha.ohio.gov/about-us/media-center/annual-reports/2021-annual-report>.

⁴² COMMUNITY COMPETENCY RESTORATION TASK FORCE, FINAL LEGISLATIVE REPORT (Feb. 2021) https://mn.gov/sentencing-guidelines/assets/9-CCRTF-FinalReport_tcm30-470615.pdf

⁴³ State of Illinois Department of Human Services, *The Expectation is Recovery: Services Offered by The Illinois Department of Human Services’ Division of Mental Health* (last visited Apr. 28, 2022) <https://www.dhs.state.il.us/OneNetLibrary/27897/documents/Brochures/4658.pdf>

⁴⁴ Ibid, 41

⁴⁵ Ohio Department of Medicaid, *MHPAEA Final Report* (July 1, 2018) <https://medicaid.ohio.gov/static/Stakeholders%2C+Partners/ReportsandResearch/OH-MHPAEA-Final-Report.pdf>



Metrics	MN	IL	OH
			Managed care plans are required to provide average length of stay and number of admissions for inpatient psychiatric facilities.

One tangible example of managing bed capacity from our peer states is from Ohio, which has developed a bed registry tool in one part of the state to facilitate timely transfer of individuals. This tool, which targets residents in the northeastern part of the state diagnosed with serious mental illness, was developed with funding from SAMHSA, which provided up to \$150,000 to establish or expand a comprehensive psychiatric crisis bed registry system. The Behavioral Health Connection, or B-CON, is an online psychiatric bed registry intended to facilitate timely admission to an inpatient psychiatric unit. This tool is part of a larger effort in Ohio to meet people with serious mental illness where they are and to ensure they receive the care they need in the most appropriate setting.

National Best Practices

The Office of the Assistant Secretary for Planning and Evaluation (APSE) contracted with RTI International, an independent, nonprofit research institute, to conduct research on publicly accessible inpatient psychiatric bed tracking systems or registries.⁴⁶ In their 2019 report titled *Inpatient Bed Tracking: State Responses to Need for Inpatient Care*, the researchers note that “providing information on openings in mental health and SUD treatment programs could be helpful to patients, their families and providers who are seeking treatment.” They further cite a national survey conducted by SAMHSA that one in five adults who self-determined the need for treatment, did not receive treatment due to lack of knowledge regarding how or where to seek services.⁴⁷ Of the national and U.S. territory environmental scan conducted, RTI found 16 states had psychiatric inpatient bed tracking, and eight were developing systems. Most of the states tracked state owned psychiatric beds, and five of the 16 states, also tracked substance use residential beds. Only five states provided direct public access to bed tracking information. Though the researchers did not locate formal evaluations of bed tracking systems, and they acknowledge challenges with existing bed tracking systems, they recommended public facing registries as a method to enhance awareness of bed capacity throughout the state. They also recommended:

- Adding more levels of care to tracking registries, including community-based care and supports;
- Leveraging financial and legislative levers to improve timeliness of data entry; and

⁴⁶ Office of the Assistance Secretary for Planning and Evaluation. *Inpatient Bed Tracking: State Responses to Need for Patient Care*. 5 August, 2019. <https://aspe.hhs.gov/reports/inpatient-bed-tracking-state-responses-need-inpatient-care>. Accessed 22 April, 2022.

⁴⁷ Ibid, 43



■ *Allowing providers to reserve beds through the system.*⁴⁸

Another national example is from North Carolina, which has created a standardized facilities plan that creates a standardized method for analyzing capacity and population over time. Because the report is standardized and produced on a schedule, data is tracked and compared over longer time periods. This allows them to see the changing need or the result of other systems changes that occur over longer spans of time. A lack of historical data and consistent measurement over time makes it challenging to project future need or to measure potential changes.⁴⁹

Maximizing Community-Based Resources

Community based resources is a general description for the array of services that may be offered primarily in a non-institutional setting at different points along the continuum of services. In earlier sections of the report, we have described several activities implemented by peer states to help strengthen community-based programs to keep people out of institutions and in less restrictive institutions of care. We know this is also an area of focus for Michigan. For example, twenty-eight counties in Michigan are already participating in Stepping Up. The Stepping Up initiative was launched in 2015 as a partnership between The Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation. Since then, Stepping Up has provided counties with resources and tools to effect comprehensive, cross-systems change that can address the prevalence of mental illness and co-occurring substance use disorders in local justice systems.⁵⁰ Participating in these locally targeted diversion initiatives can help to reduce the need for greater overall beds.

Ohio implemented a 1915(i) State Plan Amendment for Specialized Recovery Services. In addition to regular Medicaid services, participants are given access to recovery management and assistance developing a plan of care specific to an individual's needs, individualized placement and support for employment, and peer recovery support. In 2020, Ohio reported serving more than 12,000 individuals.

National Best Practices

Medicaid Waiver programs targeted to Individuals with Mental Illness

With growing frequency states are considering the impact of Medicaid coverage and the ability of existing Medicaid Waiver authorities to develop structured supports for individuals with serious mental illness that mirror, to some degree, complimentary programs already serving seniors, adults, and children with physical or intellectual disabilities. Through the different waiver authorities, states can structure population eligibility rules as well as supportive services such as supported living, supported

⁴⁸ Ibid, 46

⁴⁹ NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF HEALTH SERVICE REGULATION, STATE MEDICAL FACILITIES PLAN (2021) <https://info.ncdhhs.gov/dhsr/ncsmfp/2021/2021-F-SMFP-assembled-num-bookmarks.pdf>

⁵⁰ Step Up Together (last visited Apr. 28, 2022) <https://stepuptogether.org/#/>



employment, peer supports, respite, and nutritional supports, with a goal of reducing the need for inpatient care.

Medicaid provides administrative structure as well as a more sustainable funding mechanism for programs that provide both medical and social supports for individuals. In general, like other areas of behavioral health, these programs are tailored to either adults or children. Adult programs focus more on the development of housing and employment supports and stability along with coordinating treatment and health care. Child-focused programs typically involve wrap around style supports that factor in the individual and their family. All of the waiver programs are structured to provide greater community based supports so that the individual can remain in the community and out of inpatient hospital settings.

CMS has indicated that there are a number of current waiver and state plan flexibilities available to provide greater community based supports for individuals.⁵¹ Which option is the best for each state depends on the services included in the state plan, type of programs already in existence (e.g., a risk-based managed vs. fee-for-service system), and population characteristics.

Table 21 Potential Waiver Authorities and Services

Potential Authorities	Potential Covered Services
<ul style="list-style-type: none">• Section 1905(a) State Plan Authority• Section 1915(i) State Plan Benefit• Section 1915(j) Optional Self-Directed Personal Assistance Services• Section 1915(k) Community First Choice Optional State Plan Benefit• Section 1915(c) HCBS Waiver Program• Section 1115 Demonstrations• Section 1945 Health Homes• Managed Care Programs• PACE programs• EPSDT	<ul style="list-style-type: none">• Home Accessibility Modifications• One-Time Community Transition Costs• Housing and Tenancy Supports• Non-Medical Transportation• Home-Delivered Meals Home-Delivered Meals• Educational Services• Employment• Community Integration and Social Supports• Case Management

⁵¹ Centers for Medicare & Medicaid Services, *SHO# 21-001 RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health* (Jan. 7, 2021) <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>



Ten states have been approved for 1915c waivers and eight states have been approved for 1915i waivers targeted for individuals with behavioral health needs. A few notable examples include:

- *The North Dakota Medicaid 1915(i) State Plan Amendment allows North Dakota Medicaid to pay for additional home and community-based services to support individuals with behavioral health conditions.⁵² Services include training and supports for unpaid caregivers, community transitional services, benefits planning, non-medical transportation, respite, prevocational training, supported education, supported employment, supported housing, family peer support, and peer support.*
- *The Texas Youth Empowerment Services (YES) waiver provides wraparound services which build on family and community support and use YES services to help build the family's natural support network and connection with their community. Services include specialized therapy services (e.g., animal therapy or art therapy), community living supports, family supports, supported employment, adaptive aids and minor home modification, transition services, and respite.⁵³*

Community Supports for Forensic Population

Other methods for bolstering community based services include population-specific programs such as Forensic Assertive Community Treatment (FACT). Providing “hospitalization without walls,” the FACT model serves people with serious mental illness who are involved in the criminal justice system. FACT is client-focused, community-based, time-unlimited, and is delivered by a multidisciplinary team. In Minnesota, the Department of Human Services partnered with Hennepin County’s Department of Community Corrections and Rehabilitation and the state departments of Corrections and Human Services to develop a FACT team serving Hennepin County.⁵⁴

FACT builds on the evidence-based assertive community treatment (ACT) model by making adaptations based on criminal justice issues—in particular, addressing criminogenic risks and needs.⁵⁵ In this sense, FACT is an intervention that bridges the behavioral health and criminal justice systems. So far, FACT has proven to keep individuals in the community, instead of in institutions, and provide a person-centered time-unlimited approach to improving individuals’ mental health outcomes and reducing recidivism.

Other community based supports include jail based restoration. Jail based restoration provides stabilization services in the jail rather than requiring a transfer and admittance to a forensic psychiatric

⁵² North Dakota Medicaid 1915(i) State Plan Amendment (last visited Apr. 28, 2022)
<https://www.behavioralhealth.nd.gov/1915>

⁵³ Texas Health and Human Services YES Waiver (last visited Apr. 28, 2022)
<https://www.hhs.texas.gov/services/mental-health-substance-use/childrens-mental-health/yes-waiver>

⁵⁴ Roth, Alisa. “‘FACT’ Teams Aim to Keep People with Mental Illness out of Jail.” MPR News, 18 Sept. 2019, www.mprnews.org/story/2019/09/18/fact-teams-aim-to-keep-people-with-mental-illness-out-of-jail.

⁵⁵ Substance Abuse and Mental Health Services Administration, *Forensic Assertive Community Treatment (FACT)*
<https://store.samhsa.gov/sites/default/files/d7/priv/pep19-fact-br.pdf>



hospital.⁵⁶ One of the advantages of a jail-based unit is that restoration services can begin before the court issues an order finding the defendant incompetent to stand trial and transferring him to the hospital. It can reduce the length of time a defendant is pending adjudication and reduce the reliance on transportation to state psychiatric facilities which may be a significant distance away.

Diversion Programs

One of the ways in which other states have begun to assess the need for community-based supports, is by evaluating early intervention points of entry. For example, access to care can often begin at the point of a crisis and result in immediate placement into an inpatient setting. However, crisis intervention helps to divert the individual from a hospital admission to a community based service. Studies by The Substance Abuse and Mental Health Services Administration (SAMSHA) have demonstrated that this diversion has a significant financial impact. Mobile crisis for example, has demonstrated a 79 percent reduction in costs for inpatient hospital care over a six month time period. Short term stabilization has a return of \$2.16 for every one dollar invested.⁵⁷ In its toolkit, SAMSHA finds that overall crisis mental health care in the United States is inconsistent and inadequate when it falls short of aligning with the best practice. SAMSHA indicates that good crisis care is widely recognized as:

- *An effective strategy for suicide prevention*
- *An approach that better aligns care to the unique needs of the individual*
- *A preferred strategy for the person in distress that offers services focused on resolving mental health and substance use crisis*
- *A key element to reduce psychiatric hospital bed overuse*
- *An essential resource to eliminate psychiatric boarding in emergency departments*
- *A viable solution to the drains on law enforcement resources in the community and*
- *Crucial to reducing the fragmentation of mental health care.*

SAMHSA found that communities across the United States have limited or no access to true “no wrong door” crisis services. Rather these communities were defaulting to law enforcement operating as community-based mental health crisis response teams with few options to connect individuals experiencing a mental health crisis to care in real time. Without comprehensive crisis intervention services the available alternatives represented systemic failures in responding to those in need and

⁵⁶ Peter Ash, Victoria C. Roberts, Glenn J. Egan, Kelly L. Coffman, Tomina J. Schwenke, Karen Bailey
Journal of the American Academy of Psychiatry and the Law Online Nov 2019, JAAPL.003893-20; DOI:
10.29158/JAAPL.003893-20

⁵⁷ National Guidelines for Behavioral Health Crisis Care -A Best Practice Toolkit Knowledge Informing Transformation National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit National Guidelines for Behavioral Health Crisis Care -A Best Practice Toolkit Knowledge Informing Transformation. 2020.



including incarceration for misdemeanor offences. Another result of insufficient crisis intervention services included increased use of hospital emergency department that far too often report being ill-equipped to address a person in mental health crisis. The results of the inadequate responses appeared in the data as high rates of incarceration for individuals with mental health challenges, crowding of emergency departments that experience lost opportunity costs with their beds and higher rates of referral to expensive and restrictive inpatient care with extended lengths of stay because lower levels of intervention that better align with person's needs were not available.⁵⁸

Behavioral Health Options for Hospital Management and Safe Discharge

Discharge planning is a federal licensing requirement, which underscores its importance when in considering inpatient hospitalization. Specifically, 42 CFR § 482.43 requires:

The hospital must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions.

This federal regulation creates a legal requirement for hospitals to maintain an individual in their care until they have identified a safe discharge plan and location. Without appropriate community based services, individuals can experience extended lengths of stay. Ohio, for example, has awarded grants to support a proactive approach to facilitating transition from inpatient treatment to outpatient care for those individuals being discharged from State Regional Psychiatric Hospitals.

National Best Practices

Hospital management is a key area where best practices can greatly impact the efficient use of inpatient psychiatric beds. Research into the causes of readmissions in particular can be helpful when considering best practices for management of inpatient services. The Agency for Health Care Research and Quality published research on Management Strategies to Reduce Readmissions. They found that key factors in decreasing the likelihood of subsequent psychiatric admissions include:

- *Rendering sufficient inpatient care to address adequately the acute presenting problem and stabilize the patient's psychiatric status;*
- *Ensuring an adequate discharge plan and delivery of sufficient support services to transition psychiatric care successfully from an inpatient to an outpatient setting (e.g., discharge services, follow-up calls, short-term case management, bridge visits, and psychoeducation); and*

⁵⁸ Ibid, 54



- *Continuing adequate outpatient services to allow the individual to remain in the community.*⁵⁹

The research examined the four core components of interventions (management strategies) for patients with psychiatric hospitalizations:

1. Length of Stay for inpatient care (i.e., adjusting for appropriate lengths of time on an individual patient basis)
2. Transition support services (i.e., care provided as the individual moves from inpatient to outpatient care)
3. Short-term alternatives to psychiatric re-hospitalization (i.e., short-term outpatient care provided in place of psychiatric re-hospitalization for those not at significant risk of harm to self or others, usually on the order of weeks)
4. Long-term approaches for reducing readmissions (outpatient care generally of a longer duration, usually on the order of months or years)

The goal of these interventions is to develop management strategies that provide for appropriate care for individuals while in the hospital for an appropriate duration, and then provide for transition to less intensive services and long term support to prevent further need of inpatient care.⁶⁰ Engaging in this type of management requires the hospital to institute policies, training, communication, and other procedures that support care based around transition planning and safe discharge. It also positions the hospital as a partner in the development and support of community based settings that reflect the needs of the individuals and can provide better long term support in the same way that acute hospitals transition patients with ongoing medical conditions to housing and medical support systems.

Building on the best practices available from peer states and nationally, MDHHS can look to consider options that may inform their future efforts at strategic planning. In the next section, we will discuss what some of those options might look like and how they can fit into future planning.

⁵⁹ Bradley N. Gaynes, MD et al., *Management Strategies To Reduce Psychiatric, Technical Briefs, No. 21 Readmissions* (May 2015) <https://www.ncbi.nlm.nih.gov/books/NBK299415/>

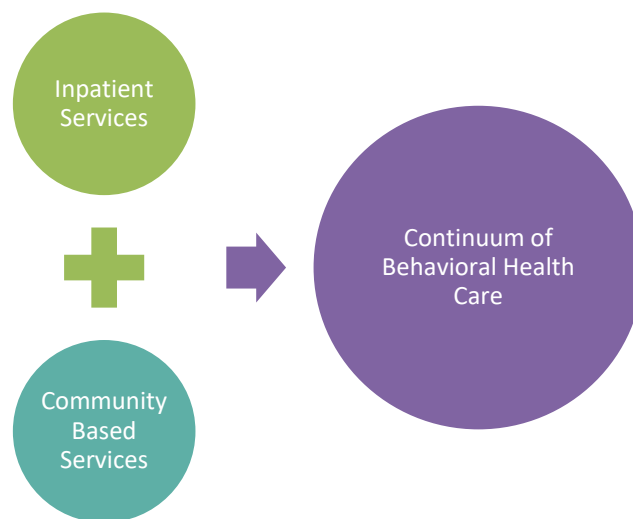
⁶⁰ Ibid, 56



Strategic Options

MDHHS is tasked with developing a five-year plan for improving psychiatric bed capacity. As evidenced by our findings from peer and national research, in planning for future delivery of behavioral health services, including bed capacity, the State will need to consider the full continuum of care, with a goal to use resources efficiently while not institutionalizing people when they do not need to be or for longer than necessary. Improving behavioral health capacity occurs primarily through two pathways: increasing bed capacity or decreasing the need for inpatient beds. However, policymakers are not facing binary choices, as they should not focus solely on increasing the number of beds without also examining community-based programs that can divert individuals away from inpatient placements and provide supportive services support and care outside the hospital setting. These two components work in conjunction; both are necessary for the creation of a system that provides a comprehensive continuum of care for individuals in need of more intensive behavioral health supports.

Figure 2 Continuum of Care



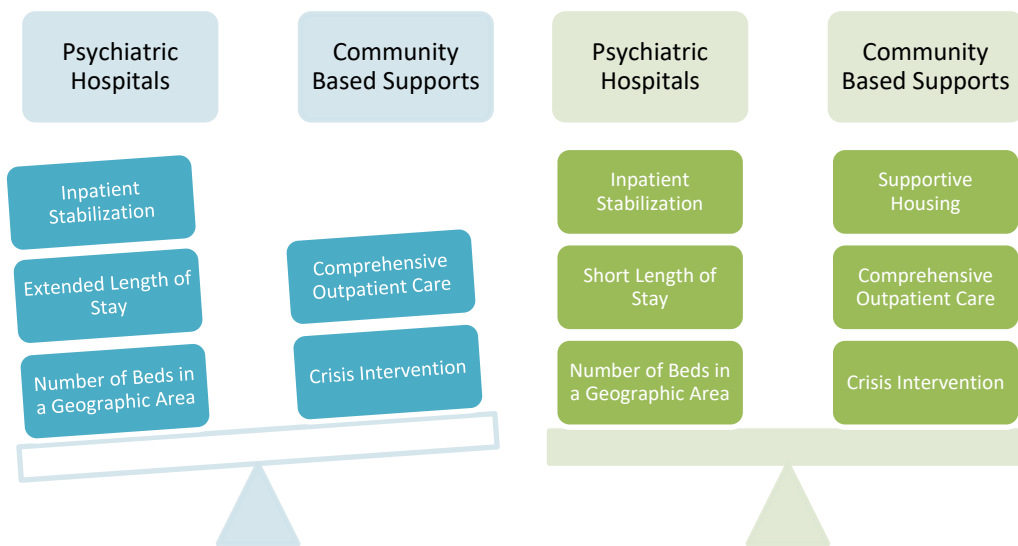
The continuum of care for behavioral health services includes options ranging from the most intensive inpatient options to the full array of community based options that include crisis intervention, intense community based supports such as supported housing, outpatient care, peer support programs and others. When systems of care focus on one side of the service system at the expense of the other the distribution or availability of supports can lead to a system out of balance with the needs of the community. Research and state experience has demonstrated that beds alone are insufficient to provide comprehensive supports to a community.⁶¹ At the same time, there are acute conditions that respond

⁶¹ Debra A. Pinals, MD & Doris A. Fuller, MFA, *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*, NASMHPD (Oct. 2017), https://www.nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf



best within a high structured inpatient setting.⁶² The presence of these complicated conditions creates the complex task of evaluating the whole system of care to ensure that it can respond to the full array of needs. For example, if the focus is availability of beds, then potential solutions tend to focus on creating more beds. A more balanced approach examines the number of beds, and considers how other sources of care, including community-based options, can supplement access to needed services. For example, where options for safe discharge are a primary system barrier that increases the average length of stay in inpatient settings, increasing access to supportive housing may be an alternative. (Figure 3 below)

Figure 3 System Balancing



With the addition of services that are designed to meet the needs of the specific community and reduce barriers to services the system can be rebalanced to reflect both the need for intensive inpatient support (bed capacity) while also providing a continuum of community-based supports.

Options Analysis

Based on the assessment of the current system, peer state examples, and best practices research we have identified in the table below some options and considerations for MDHHS in developing its five-year plan. As a framework for presenting options, we are using two domains for MDHHS consideration in developing strategic options that take into account the development of a balanced system. Domains are a way to refer to an area of control or knowledge in a system. Within the continuum of behavioral health care there are two domains which represent the areas of control:

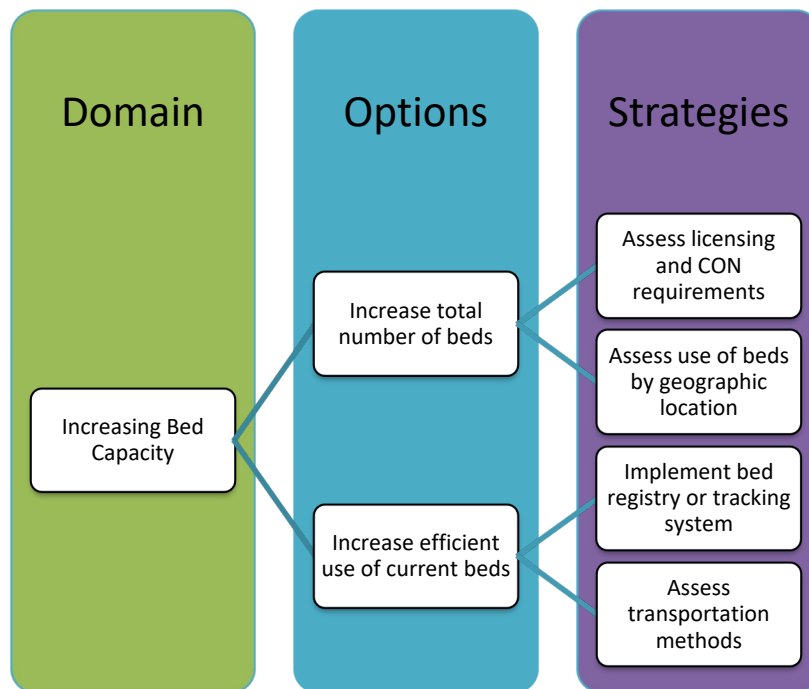
⁶² THE VITAL ROLE OF STATE PSYCHIATRIC HOSPITALS (Joe Parks, MD & Alan Q. Radke, MD eds. 2014) https://www.nasmhpd.org/sites/default/files/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014.pdf



- *Increasing Bed Capacity (Psychiatric Hospitals): Increasing the raw number of beds, or through efficient use of resources, make better utilization of the current bed supply.*
- *Decreasing Bed Need (Community Based Supports): Increasing community-based or complimentary programs that reduce the need for inpatient care or that reduce the length of stay such that the existing inventory of beds is better able to meet the need.*

The options under each domain are decision points or choices that can result in a change for that domain. For example, increasing the number of raw beds or increasing efficient use of current beds are two options under the domain of Increasing Bed Capacity. Under each option are specific strategies. These are distinct actions that can be taken under each option to implement that option. Figure 4 below is an example of how the structure functions.

Figure 4 Example of Options Analysis Structure



Finally, for each option there are a number of variables to consider in assessing the development of the feasibility of implementation. MDHHS will want to examine these considerations as it develops the five-year plan. These variables are key when evaluating the appropriateness and adequacy of a proposed solution. Michigan should evaluate any options and strategies under the careful lens of these factors so that any path forward is operationally and financially reasonable and most importantly, in alignment with their long-term strategy.



Below is a list of considerations that MDHHS should be making as it is developing its strategies and 5-year plan:

- *Alignment with program goals*
- *Consistency with MDHHS objectives*
- *Timeframe for implementation*
- *Interdependence of implementation tasks*
- *Stakeholder and other provider support*
- *Workforce challenges*
- *Change management*
- *Development of rules, policies, procedures*
- *New technologies required*
- *Impact on HIT*
- *Financial investments and ongoing program financing*

The table on the following page outlines the options MDHHS could consider in the development of the five-year plan, using the current as-is assessment, peer state review, and best practices research.



Table 22 Options and Considerations

Domains	Option	Strategy	Considerations
<p>Increasing Bed Capacity</p>	<p>Increase the number of beds.</p>	<p>Assess licensing restrictions or CON requirements.</p>	<p>The number of beds available is a function of both the physical plant and the licensing restrictions and CON requirements that enable or prevent the creation of additional beds.</p> <p>Currently, Michigan allows for flex beds in rural areas. This is a strategy that could be further explored which would allow for short-term stabilization in a larger variety of available settings without requiring the addition of new licensing standards or CON requirements.</p> <p>MDHHS could evaluate the current system that allows for flex beds and any potential outcomes from the current arrangement, and then consider additional less rural areas of the state where this could provide an important increase in raw bed capacity.</p>
		<p>Monitor usage of beds by geographic area.</p>	<p>As beds require fixed physical locations the ability to measure adequate capacity is somewhat constrained by the geographic area and need. MDHHS could look at tracking specific metrics by zip code that would indicate bed usage and bed need. Metrics such as admissions to ED, number of re-admissions to inpatient care, length of stay, distance between hospital and home.</p>
		<p>Assess the current options for adding to or</p>	<p>The development and construction of new physical plants is expensive and time-consuming. As needs change, it may be possible to repurpose existing</p>



STRATEGIC OPTIONS

Domains	Option	Strategy	Considerations
		<p>repurposing existing facilities.</p>	<p>facilities or portions of facilities to serve different populations or programs. Examples can include relicensing a portion of a psychiatric hospital to provide nursing facility level of care for individuals with complex mental health needs who also have age-related health care conditions. It also includes transitioning an adult focused hospital to a youth or child focused hospital; or using vacant buildings that had been historically used for Intermediate Care Facilities or other types of services that may be rehabilitated to meet the requirements of a psychiatric hospital or a short term stabilization unit.</p> <p>MDHHS could survey state owned institutions and determine if any of them could be altered or repurposed to better meet the needs of the community.</p>
	<p>Increase the efficient use of current beds.</p>	<p>Assess transportation and access to existing beds.</p>	<p>Mental health transportation often relies upon law enforcement or Emergency Medical Services (EMS). However, there are alternative options that use non-emergency medical transportation or provide an array of transportation options that best suit the individual and circumstance. For example, Australia is considered an international best practice with their process for providing transportation that is appropriate to the needs of the individual while respecting their rights and dignity. Their programs provide an array of transportation that includes an individual using ridesharing to mental health transportation that is essentially a form of non-emergency medical</p>



Domains	Option	Strategy	Considerations
			<p>transportation with a trained staff member as an escort.⁶³</p> <p>MDHHS should consider the current options for transportation that respect the rights of the individual but also provide for safe transportation without an overreliance on law enforcement or EMS.</p>
		<p>Assess licensing limitations that prohibit the use of existing institutional beds for psychiatric care (e.g. Nursing Facilities).</p>	<p>Facility licensing requirements are often developed over time to comply with state and CMS standards. As a result the requirements often vary significantly between facility type making it difficult to provide behavioral health services in nursing facilities or other licensed institutional settings.</p> <p>MDHHS could conduct a review of licensing limitations and requirements for institutional settings and identify any restrictions that could be refined or revised to permit more comprehensive services without requiring individuals to move settings.</p>
		<p>Assess the current distribution by population and need (children, adults, youth, forensic population, LTC population, other specialty needs).</p>	<p>Populations can shift geographically in response to economic or other changes. This can result in shifts that place individuals far from the original location of facilities and into communities without the necessary infrastructure to support them.</p> <p>MDHHS can monitor population based metrics along with the distribution of services, providers, provider shortages and other similar metrics to gauge whether</p>

⁶³ Victoria Department of Health, *Transport Protocols for People With a Mental Illness* (last visited Apr. 28, 2022) <https://www.health.vic.gov.au/practice-and-service-quality/transport-protocols-for-people-with-a-mental-illness>



Domains	Option	Strategy	Considerations
			<p>resources are adapting as the population shifts. MDHHS will need to consider what databases they have available to them as well other state databases that can monitor population changes such as DMV records.</p>
<p>Decreasing Bed Need</p>	<p>Establish diversion programs to prevent in-patient placements.</p>	<p>Assess the use of crisis response systems by population or setting (e.g. Adult, Children, Community based mobile crisis, Short Term Stabilization Units).</p>	<p>Crisis response systems provide on-the-spot assessment and placement into the most suitable location for individuals experiencing a behavioral health crisis. There are a number of different models that can be tailored to population and community. Most states employ more than one form of crisis response in order to meet the needs of each community dependent upon what other types of services may be available or needed in the community.</p> <p>MDHHS could evaluate the availability of crisis systems by community and population to determine if there are any significant gaps that could provide more support and reduce the inappropriate use of acute or psychiatric hospital placements.</p>
		<p>Assess the use of jail based restoration or other programs that support the forensic BH system of care.</p>	<p>Use of state hospitals to provide competency restoration presents logistical issues with transportation and facility management. Often the length of stay can be very short, but the individual may remain in the setting awaiting transportation back to jail after restoration. Shifting competency restoration to facilities located in the jail system can reduce the need for short term placements and transportation.</p>



Domains	Option	Strategy	Considerations
			<p>MDHHS could partner with partner in the criminal justice system to examine which jails could or should sustain jail based restoration programs.</p> <p>MDHHS could also examine other outpatient programs such as FACT that could provide for better support for individuals with behavioral health needs who are involved in the criminal justice process.</p>
	<p>Increase safe discharge placements to shorten length of stay.</p>	<p>Assess availability and licensing of community housing options.</p>	<p>Length of stay can be greatly impacted by the availability of safe discharge options. There are models of licensing used for other vulnerable populations such as seniors or persons with developmental disabilities that may be helpful with looking at community housing options.</p> <p>MDHHS could examine existing facility types and licenses for community housing and determine if any can be extended to include individuals with serious mental illness.</p>
		<p>Consider waiver options for supported housing or tenancy support services.</p>	<p>CMS has indicated there are a number of options that can be used to support qualifying individuals. North Dakota has recently implemented a 1915(i) waiver that provides comprehensive support for individuals with mental illness including supported housing. Tenancy support services are also an intensive form of case management that can provide assistance attaining and remaining in a housing situation.</p> <p>MDHHS can examine all of the Medicaid options currently available to support community based</p>



Domains	Option	Strategy	Considerations
			<p>services for individuals with serious mental illness to determine which options may best meet their needs.</p> <p>MDHHS could determine the population scope and investment needed to develop and implement a waiver as well as the necessary provider network. Development of a waiver and supporting provider network is typically a multi-year endeavor.</p>
	<p>Establish programs to reduce readmissions.</p>	<p>Examine hospital management processes that reduce readmissions.</p>	<p>There are a number of identified best practices that can reduce readmissions. These include changes to discharge planning, medication coordination, transition services, and in-home supports for recently discharged individuals.⁶⁴</p> <p>MDHHS could consider which practices, policies, or procedures are currently in use and determine if there are additional ways to communicate or collaborate with community based partners and health care providers to reduce readmissions where possible.</p>
		<p>Examine community based supports such as Psych APRN home health visits.</p>	<p>In home support for individuals with serious mental illness can provide the medical support and assistance individuals may need in order to maintain compliance with their treatment plan.⁶⁵</p> <p>MDHHS could examine current capacity for providing similar in home supports tailored to meet the needs of</p>

⁶⁴ Gaynes BN, Brown C, Lux LJ, et al. Management Strategies To Reduce Psychiatric Readmissions [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2015 May. (Technical Briefs, No. 21.) Background. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK299415/>

⁶⁵ Nath, S. B. (2013). Best practices for improving the health of persons with serious mental illness and comorbid physical health conditions. In V. L. Vandiver (Ed.), Best practices in community mental health: A pocket guide (pp. 47–64). Lyceum Books.



STRATEGIC OPTIONS

Domains	Option	Strategy	Considerations
			individuals with serious mental illness. This may require workforce investments or collaborations with nursing programs, professional licensure boards, and coverage providers to determine the best way to implement these types of models in a sustainable way.



Recommendations and Next Steps

State policy makers recognize that increasing bed capacity does not address the greater needs of the population requiring these services. There are other mitigating factors, such as staffing shortages, workforce retention challenges, and resource disparities across the states that may impact their ability to appropriately respond to the state's inpatient psychiatric needs. One of the ways this has manifested is by states recognizing and acknowledging a continuum of services that lead to state hospitalization. For example, there are several less restrictive alternatives, such as residential treatment facilities, or short-term stabilization centers that may offer intensive services that better align with an individual's needs.

In light of this, we have presented various options and strategies for MDHHS to consider in developing their strategic plan. These options and strategies reflect two domains at disparate ends of the spectrum. However, peer and national research demonstrate the need for states to seek balance between these two strategies in order to identify an optimal bed capacity that is a reflection of community and outpatient-based alternatives in the State.

Within each of the options presented, we provided additional insight and considerations into potential responses to inpatient psychiatric bed shortages in the State. These activities help to enhance, expand, and strengthen the mental health continuum at various entry points to decrease the pressure on institutionalization as being the only viable option in the State. As previously discussed, there are various factors that may impact the feasibility or viability of these options within the State. To assist the State in the development of a realistic and appropriate five-year plan, we recommend the following:

- 1. Develop a stakeholder strategy to consider stakeholder perspectives and priorities.** The options presented in this report seek to balance the overall behavioral health system and create appropriate care options for individuals' in-need of more intensive behavioral health services. However, these options need to be considered along with stakeholder perspectives of their communities' needs and their priorities. Michigan can use this opportunity to further delve into the specific needs of specialized populations (e.g., forensic, IDD, substance abuse) to determine the availability and appropriateness of existing programs and infrastructure in the State.
- 2. Prioritize Options Presented in this Report To Determine Potential Next Steps.** The options and strategies we present in this report offer a range of options across two different domains. We recommend MDHHS conduct a more in-depth analysis of each option based on each of the identified variables (e.g., implementation timeline, administrative ease, IT system investment, etc.). MDHHS can do this by weighing the impact of these various factors, which will result in the identification of options categorized by priority for the State. This list can serve as the agenda for the State and help frame an operational work plan of activities for the State.



- 3. Conduct an In-Depth Assessment of Existing Community and Outpatient Based Alternatives in the State.** We have seen from peer and national research an acknowledgement from states of the lack of a “one-size fits all” solution to address the shortages of inpatient psychiatric beds. We also recognize the importance of leveraging existing activities within the State to determine if activities can be expanded or strengthened to better fit the needs of community. We recommend updating the needs assessment provided in this report with feedback from stakeholders across the State.
- 4. Evaluate the Impact of COVID-19 on State and Private Hospitals.** The COVID-19 PHE has heightened awareness of gaps in the care continuum. States have experienced operational and administrative constraints that have negatively impacted psychiatric bed access. Such bed shortages have disrupted access to and quality of treatment, as testified by Minnesotans in 2021 to their House of Representatives.⁶⁶ In its 2021 Annual Report, Ohio’s Mental Health and Addiction Services Department (OMHAS) recognized activity to halt hospital admissions to the State Regional Psychiatric Hospitals, diverting care to private beds. While it is too early to evaluate the impact of COVID-19 on Michigan, there may be lessons learned and strategies implemented nationally that can be leveraged by the State. We encourage MDHHS to conduct a more in-depth review of any lasting impacts of COVID-19 in efforts to factor these findings into decision making and future planning. This includes additional analysis of utilization patterns in both community and inpatient settings pre-and-post PHE.
- 5. Conduct A Needs Assessment of the Population Using Inpatient Psychiatric Services.** Our review of the peer states has also illustrated the diversity of needs of individuals being admitted to inpatient psychiatric facilities. For example, there has been increased focus on the intersection between individuals diagnosed with intellectual disabilities (ID) and need for inpatient psychiatric services.⁶⁷ We reviewed results from the National Core Indicator Survey, which requested information on the severity of an individual’s ID diagnosis as well as the mental health needs of the population.⁶⁸ We found:

 - *Respondents in Michigan were more likely to report an ID diagnosis of severe or profound than the peer states*
 - *People with ID in Michigan reported a higher rate of psychotic disorder or mentally illness or psychiatric diagnosis illness than their peer states.*

⁶⁶ <https://www.house.leg.state.mn.us/SessionDaily/Story/15511>

⁶⁷ <https://www.nasmhpd.org/sites/default/files/TAC-Emerging%20Best%20Practices%20for%20People%20with%20an%20Intellectual%20or%20Developmental%20Disability%20Co-Occurring%20with%20Mental%20Illness.pdf>

⁶⁸ “Michigan | National Core Indicators.” www.nationalcoreindicators.org, www.nationalcoreindicators.org/states/MI/report/2017-18/. Accessed 28 Apr. 2022.



While we did not conduct any patient or utilization-level analysis for this evaluation, we recommend that MDHHS conduct additional analysis of the types of patient population served, and whether there are differences between the populations served by state hospitals or private facilities. This analysis will assist MDHHS in determining specialized needs of populations served in inpatient beds, but also provide a better understanding of the types of community support that may be needed allowing for more targeted interventions prior to hospitalization.

- 6. Consider Implementation and Development of a Statewide Strategy to Monitor and Manage Psychiatric Beds.** Michigan relies on information from the CON annual survey to obtain a year-after-year perspective on availability of private facilities. However, there is no way to track real-time bed availability. Similarly, for state hospitals, there are no formal channels to obtain information on bed availability. Michigan should consider strategies to help monitor and manage beds across the State. These strategies could include streamlining and standardizing data collected from state hospitals and private facilities so that information is shared across public and private organizations to obtain a more holistic picture of inpatient psychiatric bed utilization in the State.

We also recommend Michigan evaluate the pros and cons of implementing technologies, such as a statewide bed registry system. This is a long-term strategy, which provides public access to bed information and will simultaneously create a mechanism for State staff and policymakers to obtain real time information about inpatient psychiatric bed capacity. Furthermore, lessons learned from other state experiences will help Michigan policymakers implement a system and potentially avoid challenges experienced in states with operational registries. Implementing a statewide inpatient bed registry will prove useful to the management of available psychiatric beds. If registry data demonstrates a shortage in bed capacity, further analysis can be conducted to determine the root cause of the shortage (i.e., are there not enough beds or are there other issues causing the lack of capacity). In addition to implementing a bed registry, another strategy for consideration is the creation and institution of a State Medical Facilities Plan that helps project psychiatric bed need and planning for specific health care facilities and services.



Appendix A: Peer State Profiles

State: Michigan	
General State Characteristics	
Total Population	9.98 million people
% of Population in Urban Areas	82.1%
Population by Payer Type	50.9%- employer 22.1%- Medicaid 13.1%- Medicare .5%- Military 3.0- Uninsured
Health Outcomes: Poor or Fair Health	18
Health Outcomes: Poor Physical Health Days	4.3
Health Outcomes: Poor Mental Health Days	4.7
Number of State Hospitals ⁶⁹	5
States Approach to Monitoring Private Inpatient Psychiatric Beds	
State-Operated CON Program (Y/N)	Yes
Description of State CON legislation, if applicable to inpatient psych beds	Part 222 of MI Public Health Code⁷⁰ Part 201 of MI Public Health Code⁷¹
Use of nursing homes to serve individuals with mental illness	State Plan on Aging⁷²
Other State Regulations on Licensing of Psych Hospital Beds	Chapter 330 Mental Health Code⁷³

⁶⁹ <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NMHSS-2018.pdf>

⁷⁰ [http://www.legislature.mi.gov/\(S\(x5zl2mwgdvemplu3oqscktsc\)\)/documents/mcl/pdf/mcl-368-1978-17-201.pdf](http://www.legislature.mi.gov/(S(x5zl2mwgdvemplu3oqscktsc))/documents/mcl/pdf/mcl-368-1978-17-201.pdf)

⁷¹ [http://www.legislature.mi.gov/\(S\(e3xvy12be2mnlx4c1kfy2rd\)\)/documents/mcl/pdf/mcl-368-1978-17-222.pdf](http://www.legislature.mi.gov/(S(e3xvy12be2mnlx4c1kfy2rd))/documents/mcl/pdf/mcl-368-1978-17-222.pdf)

⁷² https://www.michigan.gov/documents/osa/Michigan_State_Plan_on_Aging_FINALOct12020_703804_7.pdf

⁷³ [https://www.westlaw.com/Browse/Home/StatutesCourtRules/MichiganStatutesCourtRules?guid=NE097A5D0314911DBA6A3AFB4DB39BD01&transitionType=Default&contextData=\(sc.Default\)&VR=3.0&RS=cb1t1.0](https://www.westlaw.com/Browse/Home/StatutesCourtRules/MichiganStatutesCourtRules?guid=NE097A5D0314911DBA6A3AFB4DB39BD01&transitionType=Default&contextData=(sc.Default)&VR=3.0&RS=cb1t1.0)



State: Michigan	
	<p>Mich. Comp. Laws Ann. § 330.1137 (West)</p> <p>licensure of psychiatric hospital or psychiatric unit; requirement; disclosures; duration; application procedure; annual report by director</p> <p>Inpatient psych specific licensure requirements/ process⁷⁴</p>
Other State Regulations on Monitoring of Psych Hospital Beds	<p>Mich. Comp. Laws Ann. § 330.1151 (West)</p> <p>The department shall establish and administer and electronic inpatient psychiatric bed registry. The registry must be a web-based resource to identify available psychiatric beds in this state categorized by patient gender, acuity, age, and diagnosis. The registry must be accessible through the department’s website.⁷⁵</p>
Description of Access or Quality Reporting Requirements From MCOs, if any	<p>PIHP Reports⁷⁶</p> <p>MI uses Pre-Paid Inpatient Health Plans (PIHPs). PIHPs are required to provide information and data on topics such as costs, services, consumer demographics, and administrative activities.</p>
Any reports about lack of sufficient beds, lack of beds to treat a specific population; how many beds closed, how many added, etc.	<p>Michigan Psychiatric Care Improvement Project⁷⁷</p> <p>MI SAMHSA Report⁷⁸ from 2020 including MI specific data and US average data</p>
States Approach to Monitoring State Hospitals	
Agency Responsible for Oversight and Management of State Hospitals	Michigan Department of Health and Human Services
Types of Services Delivered in State Hospitals (e.g., acute, long-	State psychiatric hospital applied behavioral treatment manual ⁷⁹

⁷⁴ <https://www.michigan.gov/lara/bureau-list/bchs/providers/psych>

⁷⁵ NOTE: This statute was effective March 30, 2022

⁷⁶ <https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting>

⁷⁷ <https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mi-psychiatric-care-improvement-project>

⁷⁸ <https://www.samhsa.gov/data/sites/default/files/reports/rpt35301/Michigan.pdf>

⁷⁹ https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder50/Folder17/SHA_Applied_Behavior_Treatment_for_IDD-



State: Michigan	
term, etc.; is any outpatient available or associated)	
State Policies Governing Admissions to State Hospitals	<p>Mich. Comp. Laws Ann. § 700.5304 (West)</p> <p>Physical or mental health examination; court-ordered or independent; written report, contents; confidentiality; rights of individual; determination of incapacity</p>
State Policies Governing Discharge from State Hospitals	<p>Mich. Comp. Laws Ann. § 330.1409 (West)</p> <p>The hospital director may at any time discharge a voluntarily or judicially hospitalized patient whom the hospital director considers clinically suitable for discharge. The hospital director must discharge a patient by court order when the patient’s mental condition no longer meets the criteria for hospitalization. If a person is hospitalized by court order, the court and the prosecutor must be notified about the discharge and the patient must undergo a competency examination no less than 30 days prior to discharge.</p> <p>Mich. Comp. Laws Ann. § 330.1476 (West)</p>
Activities Taken by the State to Monitor and Track State Hospital Beds, including Legislative Reports, Programs, etc.	<p>CON Workgroup⁸⁰</p> <p>MIPAD Initiative⁸¹</p>
Activities Taken by the State to Address State Hospital Bed Shortages, if any	<p>Michigan Psychiatric Care Improvement Project⁸²</p> <p>The State of Michigan and Michigan Legislature have pursued several strategies over the last few years to expand access to inpatient psychiatric services. These strategies include: (1) expanding the number of psychiatric beds that are available through the Certificate of Need program, (2) approving funds to pursue the building of a new facility to replace the existing Caro Center, (3) establishing a new unit at the Center for Forensic Psychiatry, (4) collecting and examining data on the</p>

[ASD Manual Version Two.pdf?rev=39e902acd28d442cb26045e46fca432f&hash=F84804D8A341F0B92A8CE60AE755C4FE](#)

⁸⁰ <https://www.michigan.gov/mdhhs/doing-business/providers/certificateofneed/commission/informal-workgroups>

⁸¹ <https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mi-psychiatric-care-improvement-project/history-of-the-mipad-initiative>

⁸² <https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mi-psychiatric-care-improvement-project/history-of-the-mipad-initiative>



State: Michigan	
	causes of denials for inpatient services, and (5) facilitating transitions of care through the Children’s Transition Support Team pilot. Despite these various efforts, the crisis in access has continued unabated.
Recent (3-5 years) policy changes to add/decrease state hospital beds	In 2017 MDHHS opened a new unit at The Center for Forensic Psychiatry which created 34 new beds. ⁸³ Replaced the existing Caro Center with new center.
Additional Considerations Implemented for the Forensic Population	Patient handbook for forensic psychiatry ⁸⁴
Recidivism Rates for Forensic Population Any policies implemented to improve rates	Forensic readmission to hospitals data in SAMHSA report ⁸⁵
Description of Available Community Supports	
Number of Community Mental Health Centers	46 across 10 regions ⁸⁶
Number of Veterans Affairs Medical Center	VA Health Centers ⁸⁷ 5 medical centers 10 outpatient clinics 22 community based outpatient clinics
Description of Services and Supports Available for Individuals with Mental Health Issues	Michigan evidence-based practice individual placement reports from the last three years ⁸⁸
Availability of Congregate Housing for Individuals with Mental Illness	MI Supportive Housing Program ⁸⁹

⁸³ https://www.michigan.gov/documents/mdhhs/MIPAD_WorkgroupReport_613570_7.pdf

⁸⁴ https://www.michigan.gov/documents/mdhhs/Patient_Handbook_01-09-2017_549229_7.pdf

⁸⁵ <https://www.samhsa.gov/data/sites/default/files/reports/rpt35301/Michigan.pdf>

⁸⁶ <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder1/Folder26/PIHPDIRECTOR.pdf?rev=f69ec5090c274eea8ae849a227482db6>

⁸⁷ <https://www.va.gov/directory/guide/state.asp?STATE=MI&dnum=ALL>

⁸⁸ <https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth>

⁸⁹ <https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/cmhsp/communityresources/supportive-housing>



State: Michigan	
	300 units of supportive housing in Allegan, Kent, Genesee and Wahtenaw counties
Types of Community Supports Provided to Individuals Released from State Hospitals	<u>Resources for community living⁹⁰</u> <ul style="list-style-type: none"> • Path projects (homelessness transitional program) • Training resources • Shelter plus care • Supportive housing • Residential leases and program contracts
Community Programs Made Available for Individuals Leaving Psychiatric Facilities (State or Private), if any	See above

State: Illinois	
General State Characteristics	
Total Population	12.5 million people
% of Population in Urban Areas	88.76%
Population by Payer Type	54.6%- employer 18.2%- Medicaid 14.1%- Medicare .7%- Military 7.3%- Uninsured
Health Outcomes: Poor or Fair Health	16%
Health Outcomes: Poor Physical Health Days	3.6
Health Outcomes: Poor Mental Health Days	3.8

⁹⁰ <https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/cmhsp/communityresources/supportive-housing>



State: Illinois	
Number of State Hospitals	7 ⁹¹
Inpatient Psychiatric Beds to Population Ratio	5.28 beds per 100,000 people
States Approach to Monitoring Private Inpatient Psychiatric Beds	
State-Operated CON Program (Y/N)	Yes - Certificate of Need Program - Certificate of Need Program (illinois.gov) ⁹² Law-III. Rev. Stat. ch. 20, § 3960/1 et. Seq (20 ILCS 3960/) Illinois Health Facilities Planning Act ⁹³ Regulated by: Health Facilities & Services Review Board SB 1739 (Enacted 2019) requires CON approval for closing a health care facility. ⁹⁴ Illinois' CON law is scheduled to be repealed December 2029. ⁹⁵
Description of State CON legislation, if applicable to inpatient psych beds	Section 1110.20 Classification of Projects ⁹⁶ <ul style="list-style-type: none"> • Facilities regulated under CON: Hospitals, Long-Term Care facilities, Dialysis centers, ASCs, Alternative health care delivery modals, Free-standing emergency centers, and Birthing centers. • 15 Healthcare services that require CON – ASCs, Cardiac Catheterization, Hospital Beds (Acute, General Licensed, Med-Surg, etc.), ICFs for Individuals with Intellectual Disabilities, Long-Term Acute Care, Neonatal Intensive Care, New Hospitals or Hospital Sized Investments, Nursing Home Beds/Long-Term Care Beds, Obstetrics Services, Open-Heart Surgery, Organ Transplants, Psychiatric Services, Rehabilitation, Renal Failure/Dialysis, and Subacute Services • Activities regulated: Constructing or modifying by or on behalf of a health care facility that exceeds the capital expenditure minimum; Acquiring and housing major medical equipment; adding a new category of services; Substantially increasing a facility's bed capacity;

⁹¹ Note: Chester Mental health Center is forensic only and not open to civil commitments

⁹² <https://www2.illinois.gov/sites/hfsrb/CONProgram/Pages/default.aspx?msclkid=16158ecfc18111ecafb5973739516ee8>

⁹³ <https://ilga.gov/legislation/ILCS/ilcs3.asp?ActID=407&ChapterID=5>

⁹⁴ <https://ilga.gov/legislation/publicacts/fulltext.asp?Name=101-0083>

⁹⁵ <https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

⁹⁶ <https://www.ilga.gov/commission/jcar/admincode/077/077011100A00200R.html>



State: Illinois	
	<p>Substantially changing the scope of function of a health care facility⁹⁷</p> <ul style="list-style-type: none">○ A new or replacement facility located on a new site; or○ A replacement facility located on the same site as the original facility and the cost of the replacement facility exceeds the capital expenditure minimum, which shall be reviewed by the Board within 120 days;○ Projects that involve more than 20 beds, or more than 10% of total bed capacity, as defined by HFSRB, whichever is less, over a 2-year period, and propose a change in the bed capacity of a health care facility by:<ul style="list-style-type: none">○ An increase in the total number of beds;○ A redistribution of beds among various categories of service; or○ A relocation of beds from one physical facility or site to another. [20 ILCS 3960/12(8)]⁹⁸● Projects proposing a change in the bed capacity of a SMHRF by an increase in the total number of beds or by a redistribution of beds among various categories of service or by a relocation of beds from one facility to another by more than 20 beds or more than 10% of total bed capacity, as defined by HFSRB, whichever is less, over a 2 year period. [20 ILCS 3960/12]
<p>Use of nursing homes to serve individuals with mental illness</p>	<p>Public Act 098-0063: provides a very broad definition of “Mental Health Facility”⁹⁹</p> <ul style="list-style-type: none">● The definition of “Mental health facility”: means any licensed private hospital or hospital affiliate, institution, or facility, or part thereof, and any facility, or part thereof, operated by the State or a political subdivision thereof which provide treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, mental health centers, colleges, universities, long-term care facilities, and <i>nursing homes</i>, or parts thereof, which provide treatment of persons with mental illness whether or not the primary purpose is to provide

⁹⁷ https://www.mercatus.org/system/files/illinois_constateprofile_2020.pdf

⁹⁸ <https://www.ilga.gov/commission/jcar/admincode/077/077011260A01300R.htm>

⁹⁹ <https://www.ilga.gov/legislation/publicacts/98/098-0063.htm>



State: Illinois	
	<p>treatment of person with mental illness. (FOID Act, Sec 1.1)</p> <ul style="list-style-type: none"> Inpatient mental health treatment facilities include hospitals with inpatient psychiatric programs, nursing homes identified as Institutions for Mental Disease (IMDs) , and specialized mental health rehabilitation facilities (SMHRF) all of these programs are licensed by the Department of Public Health.
Other State Regulations on Licensing of Psych Hospital Beds	<p>Illinois Summary -- State Residential Treatment for Behavioral Health Conditions: Regulation and Policy (hhs.gov)¹⁰⁰</p> <ul style="list-style-type: none"> Illinois regulates Specialized Mental Health Rehabilitation Facilities (SMHRFs) that provide at least one of four services, three of which are residential (CSUs, RRSs, and TLUs for 3+ pp). Illinois regulates Substance Use Disorder (SUD) level 3.1, 3.2, 3.5, 3.7 and 4, all of which may be provided in a residential setting with corresponding ASAM levels, including hours of service per week. Unregulated Facilities: There are no unregulated residential treatment facilities in Illinois. We exclude MH Community Integrated Living and SUD Recovery Homes because they do not incorporate clinical services within the scope of this summary.
Other State Regulations on Monitoring of Psych Hospital Beds	<p>TITLE 77: PUBLIC HEALTH¹⁰¹ Section 1110.210 Acute Mental Illness and Chronic Mental Illness¹⁰² Section 1100.440 Requirements for Authorized Hospital Beds¹⁰³ Section 1100.75 Annual Bed Report¹⁰⁴</p>
Description of Access or Quality Reporting Requirements From MCOs, if any	<ul style="list-style-type: none"> If you are a healthcare facility or individual physician, clinical psychologist or qualified examiner in Illinois you may have responsibilities for reporting mental health information to the DHS. The Illinois DHS FOID Mental Health Reporting System website provides qualified examiners and facilities with 24-hour and immediate access to report an individual that is receiving mental health treatment or is determined to be a clear and

¹⁰⁰ <https://aspe.hhs.gov/sites/default/files/2021-08/StateBHCond-Illinois.pdf>
¹⁰¹ <https://www.ilga.gov/commission/icar/admincode/077/07701110sections.html>
¹⁰² <https://www.ilga.gov/commission/icar/admincode/077/077011100C02100R.html>
¹⁰³ <https://www.ilga.gov/commission/icar/admincode/077/077011000C04400R.html>
¹⁰⁴ <https://www.ilga.gov/commission/icar/admincode/077/077011000A00750R.html>



State: Illinois															
	<p>present danger, developmentally disabled or intellectually disabled– What to Report¹⁰⁵ Both Inpatient and Outpatient mental health treatment facilities may report on behalf of the physicians, licensed clinical psychologists, and Qualified Examiners</p> <ul style="list-style-type: none"> Facilities which provide inpatient mental health treatment programs must register and report to the Illinois FOID Mental Health Reporting System on a regular basis.¹⁰⁶ Illinois' Managed Care Programs HFS¹⁰⁷ 														
<p>Any reports about lack of sufficient beds, lack of beds to treat a specific population; how many beds closed, how many added, etc.</p>	<p>Inventory of Health Care Facilities and Services and Need Determinations 10/26/2021¹⁰⁸</p> <p>Illinois - Treatment Advocacy Center¹⁰⁹</p> <p>A minimum of 50 beds per 100,000 people is considered necessary to provide minimally adequate treatment for individuals with severe mental illness. Like every state, Illinois fails to meet this minimum standard.</p> <table border="1"> <thead> <tr> <th>Beds in 2016</th> <th>Beds in 2010</th> <th>Beds lost or gained</th> <th>Beds per 100,000 people</th> <th>Census of forensic patients</th> <th>% of all beds occupied forensic</th> <th>State ranking in beds per capita</th> </tr> </thead> <tbody> <tr> <td>1,200</td> <td>1,429</td> <td>-229</td> <td>9.3</td> <td>700</td> <td>58.3</td> <td>36-37</td> </tr> </tbody> </table> <p><small>(SOURCE: GOING, GOING, GONE: TRENDS AND CONSEQUENCES OF ELIMINATING STATE PSYCHIATRIC BEDS, Treatment Advocacy Center, 2016)</small></p> <p>ILLINOIS DEPARTMENT OF PUBLIC HEALTH - REVISED BED NEED DETERMINATIONS 6/5/2019¹¹⁰</p> <p>Hospital Utilization HHS Protect Public Data Hub¹¹¹ going-going-gone.pdf (treatmentadvocacycenter.org)</p> <p>Re CON: Illinois should suspend, repeal hospital bed limit law to address COVID-19 crisis (illinoispolicy.org)¹¹²</p>	Beds in 2016	Beds in 2010	Beds lost or gained	Beds per 100,000 people	Census of forensic patients	% of all beds occupied forensic	State ranking in beds per capita	1,200	1,429	-229	9.3	700	58.3	36-37
Beds in 2016	Beds in 2010	Beds lost or gained	Beds per 100,000 people	Census of forensic patients	% of all beds occupied forensic	State ranking in beds per capita									
1,200	1,429	-229	9.3	700	58.3	36-37									
States Approach to Monitoring State Hospitals															

¹⁰⁵ <http://www.dhs.state.il.us/OneNetLibrary/27897/documents/FOID%20Documents/What-FacilityWithINPMHSvsc.pdf>

¹⁰⁶ <https://foid2.dhs.illinois.gov/foidpublic/foid/#:~:text=The%20Illinois%20DHS%20FOID%20Mental%20Health%20Reporting%20System%20website%20provides,developmentally%20disabled%20or%20intellectually%20disabled.>

¹⁰⁷ <https://www2.illinois.gov/hfs/MedicalClients/ManagedCare/Pages/default.aspx>

¹⁰⁸ <https://www2.illinois.gov/sites/hfsrb/InventoriesData/HealthCareFacilities/Documents/Hospital%20Inventory%202021.pdf>

¹⁰⁹ <https://www.treatmentadvocacycenter.org/browse-by-state/illinois>

¹¹⁰ <https://www2.illinois.gov/sites/hfsrb/InventoriesData/MonthlyHCFInventory/Documents/HOSPITAL%20INVENTORY%20UPDATE%20June%205%202019.pdf>

¹¹¹ <https://protect-public.hhs.gov/pages/hospital-utilization>

¹¹² <https://www.illinoispolicy.org/illinois-should-suspend-repeal-hospital-bed-limit-law-to-address-covid-19-crisis/>



State: Illinois	
Agency Responsible for Oversight and Management of State Hospitals	<p>Illinois Department of Public Health¹¹³ HEALTH FACILITIES AND REGULATION (210 ILCS 85/) Hospital Licensing Act.¹¹⁴</p> <p>To add additional beds and or services to the hospital’s licensed bed inventory - the hospital must contact the Health Facilities Services Review Board¹¹⁵.</p>
Types of Services Delivered in State Hospitals (e.g., acute, long-term, etc.; is any outpatient available or associated)	<p>Chapter H-200 Policy and Procedures For Hospital Services (2014)¹¹⁶</p> <p>H-230 Covered Services A covered service is a service for which payment can be made by the department. Refer to Chapter 100, Topic 103, for a general list of covered services.</p> <p>Handbook for Providers of Medical Services Chapter 100 (2017)¹¹⁷</p>
State Policies Governing Admissions to State Hospitals	<p>Long-Term Care Admissions -Provider Notice 8/23/2021 Re LTC, NF, ICF for ICF/IID, SLP, MC/DD, SMHRF: Provider Notice Issued 08/23/2021 HFS (illinois.gov)¹¹⁸</p> <p>HEALTH FACILITIES AND REGULATION (210 ILCS 85/) Hospital Licensing Act.¹¹⁹</p> <p>The complexity of complete care, assessment on patient admission, volume of patient admissions, discharges and transfers, evaluation of the progress of a patient's problems, ongoing physical assessments, planning for a patient's discharge, assessment after a change in patient condition, and assessment of the need for patient referrals.</p>
State Policies Governing Discharge from State Hospitals	<p>Provider Notice Issued 08/23/2021 HFS (illinois.gov)¹²⁰</p> <p>Illinois General Assembly - Full Text of Public Act 099-0857 (ilga.gov)¹²¹</p>
Activities Taken by the State to Monitor and Track State Hospital	<p>Health Facilities Inventories and Data¹²²</p>

¹¹³ <https://dph.illinois.gov/topics-services/health-care-regulation/hospitals.html>

¹¹⁴ <https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1234&ChapAct=210%20ILCS%2085/&ChapterID=21&ChapterName=HEALTH%20FACILITIES&ActName=Hospital%20Licensing%20Act>

¹¹⁵ <https://www2.illinois.gov/sites/hfsrb/Pages/default.aspx>

¹¹⁶ <https://www2.illinois.gov/hfs/SiteCollectionDocuments/h200.pdf?msclkid=bb1f5cc2c1a811ec94e16a13d4e2ba65>

¹¹⁷ <https://www2.illinois.gov/hfs/SiteCollectionDocuments/82319Chapter100PolicyCopyTitle19ChangesFinal.pdf>

¹¹⁸ <https://www2.illinois.gov/hfs/MedicalProviders/notices/Pages/prn210823a.aspx?msclkid=c1f32f1ac1aa11ec8040d529d6dd2623>

¹¹⁹ <https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1234&ChapterID=21>

¹²⁰ <https://www2.illinois.gov/hfs/MedicalProviders/notices/Pages/prn210823a.aspx?msclkid=c1f32f1ac1aa11ec8040d529d6dd2623>

¹²¹ <https://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=099-0857>

¹²² <https://www2.illinois.gov/sites/hfsrb/InventoriesData/Pages/default.aspx>



State: Illinois	
Beds, including Legislative Reports, Programs, etc.	Annual Facilities Questionnaires¹²³ Facility Profiles and Summary Sheets¹²⁴ Inventory of Health Care Facilities and Services and Need Determinations¹²⁵ Monthly Updates to the Inventory of Health Care Facilities and Services¹²⁶ Other Review Board Reports¹²⁷ Population Projections¹²⁸ Revenue and Expenses¹²⁹ Settlement Agreements¹³⁰
Activities Taken by the State to Address State Hospital Bed Shortages, if any	Bed Capacity Talking Points Illinois Health and Hospital Association (team-iha.org)¹³¹
Additional Considerations Implemented for the Forensic Population	forensicServicesProgramOverview.pdf (state.il.us)¹³² ForensicHandbook111513.doc (live.com)¹³³
Recidivism Rates for Forensic Population Any policies implemented to improve rates	<p>Governor Bruce Rauner created a task force in 2015, the Illinois State Commission of Criminal Justice and Sentencing Reform, to promulgate policies to achieve a 25 percent reduction in the state’s prison population by 2025. Recent data already show positive results.^{134, 135}</p> <ul style="list-style-type: none"> • Raise the felony theft threshold to \$2,000 from \$500, reduce minimum felony sentences, review all state occupational licenses and remove unnecessary licensing restrictions for ex-offenders, review all state occupational licenses and remove unnecessary licensing restrictions for

¹²³ <https://www2.illinois.gov/sites/hfsrb/InventoriesData/Pages/QuestionnaireForms.aspx>

¹²⁴ <https://www2.illinois.gov/sites/hfsrb/InventoriesData/FacilityProfiles/Pages/default.aspx>

¹²⁵ <https://www2.illinois.gov/sites/hfsrb/InventoriesData/HealthCareFacilities/Pages/default.aspx>

¹²⁶ <https://www2.illinois.gov/sites/hfsrb/InventoriesData/MonthlyHCFInventory/Pages/default.aspx>

¹²⁷ <https://www2.illinois.gov/sites/hfsrb/InventoriesData/Other/Pages/default.aspx>

¹²⁸ <https://www2.illinois.gov/sites/hfsrb/InventoriesData/Pages/Population-Projections.aspx>

¹²⁹ <https://www2.illinois.gov/sites/hfsrb/InventoriesData/Revenue/Pages/default.aspx>

¹³⁰ <https://www2.illinois.gov/sites/hfsrb/InventoriesData/SettlementAgreements/Pages/default.aspx>

¹³¹ <https://www.team-ih.org/advocacy-policy/regulatory-policy-issues/hospital-operations/certificate-of-need/suggested-talking-points-on-bed-capacity>

¹³² <https://www.dhs.state.il.us/OneNetLibrary/27894/documents/mental%20health/Forensic/forensicServicesProgramOverview.pdf>

¹³³ <https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dhs.state.il.us%2FOneNetLibrary%2F27897%2Fdocuments%2FMental%2520Health%2FMentalHealth2014%2FsharonCcoleman%2FForensicHandbook111513.doc&wdOrigin=BROWSELINK>

¹³⁴ <https://www.prisonlegalnews.org/news/2019/feb/5/illinois-calculates-high-costs-recidivism/>

¹³⁵ <https://www.illinoispolicy.org/6-highlights-from-illinois-criminal-justice-commissions-final-report/>



State: Illinois																										
	<p>ex-offenders, improve and expand the use of electronic monitoring technology, expand evidence-based programs that target the root causes of crime, such as substance abuse.</p> <p>The Division is facilitating the development of statewide programs to provide community-based alternatives to incarceration. It works to facilitate statewide expansion of the Mental Health Courts in Illinois and statewide expansion of the Datalink Program, which improves continuity of care for persons with mental illnesses making the transition from jails to the community.¹³⁶</p>																									
Challenges Reported by State in Operating or Monitoring State Hospitals, including any ongoing litigation	<p>There are not recent activities, however, previous reports have indicated several challenges:</p> <ul style="list-style-type: none"> • Evanston/Highland Park (Illinois) merger—led to an FTC administrative challenge determining that the acquisition had violated the antitrust laws.¹³⁷ • PCDOC#429173 CON - 975h02!.DOC (ilga.gov)¹³⁸ 																									
Description of Available Community Supports																										
Number of Community Mental Health Centers	<p>IDHS: Services Offered by The IDHS' Division of Mental Health - DHS 4658 (state.il.us)¹³⁹ - Mental health care is available throughout Illinois. The state is divided into five regions, with mental health services available through 162 community mental health centers and agencies, more than 30 community hospitals with psychiatric units, and nine state-operated hospitals.</p>																									
Number of Veterans Affairs Medical Center	<p>4 Medical Centers:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="5">VA Medical Center</th> </tr> </thead> <tbody> <tr> <td>556</td> <td>Captain James A. Lovell Federal Health Care Center</td> <td>3001 Green Bay Road</td> <td>North Chicago, IL 60064</td> <td>IL</td> </tr> <tr> <td>578</td> <td>Edward Hines Jr. VA Hospital</td> <td>5000 South 5th Ave</td> <td>Hines, IL 60141</td> <td>IL</td> </tr> <tr> <td>537</td> <td>Jesse Brown VA Medical Center</td> <td>820 South Damen Avenue</td> <td>Chicago, IL 60612</td> <td>IL</td> </tr> <tr> <td>550</td> <td>VA Illiana Health Care System</td> <td>1900 East Main Street</td> <td>Danville, IL 61832-5198</td> <td>IL</td> </tr> </tbody> </table> <p>Facility Listing - Locations (va.gov)¹⁴⁰</p>	VA Medical Center					556	Captain James A. Lovell Federal Health Care Center	3001 Green Bay Road	North Chicago, IL 60064	IL	578	Edward Hines Jr. VA Hospital	5000 South 5th Ave	Hines, IL 60141	IL	537	Jesse Brown VA Medical Center	820 South Damen Avenue	Chicago, IL 60612	IL	550	VA Illiana Health Care System	1900 East Main Street	Danville, IL 61832-5198	IL
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¹³⁶ <https://www.dhs.state.il.us/page.aspx?item=33007>

¹³⁷ <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf>

¹³⁸ <https://cgfa.ilga.gov/Upload/LewinGroupEvalCertOfNeed.pdf>

¹³⁹ <https://www.dhs.state.il.us/page.aspx?item=33007#:~:text=Mental%20health%20care%20is%20available,and%20nine%20state%20operated%20hospitals.>

¹⁴⁰ https://www.va.gov/directory/guide/rpt_fac_list.cfm



State: Illinois	
Description of Services and Supports Available for Individuals with Mental Health Issues	<p>IDHS: Services Offered by The IDHS' Division of Mental Health - DHS 4658 (state.il.us)¹⁴¹</p> <p>IDHS: Mental Health (state.il.us)¹⁴²</p> <p>Services-Forensic, Child & Adolescent- school based mental health resources, deaf hard of hearing, deafblind and late-deafened services, housing.</p> <p>Support- Mental Health Services & Treatments, Recovery Support, and Consumer Operated Services & Programs</p> <p>Mental Health Resources in Illinois Resources to Recover (rtor.org)¹⁴³</p>
Availability of Congregate Housing for Individuals with Mental Illness	<p>Microsoft Word - Study of Supportive Housing in Illinois FINAL.doc (shnny.org)¹⁴⁴</p> <p>Supportive housing is effective with the most expensive users of public services, such as those with a mental illness or substance users. While these groups used high-cost services before entry into supportive housing, they benefited from being housed and produced a dramatic cost savings after the supportive housing intervention.</p>
Types of Community Supports Provided to Individuals Released from State Hospitals	<p>Mental Health Resources in Illinois Resources to Recover (rtor.org)¹⁴⁵</p> <p>IDHS: 8/3/20 - IDHS Launches Three New Mental Health Programs in Illinois (state.il.us)¹⁴⁶ – Living Room Program, Transitional Living Centers, and Transitional Community Care and Support Programs</p>
Community Programs Made Available for Individuals Leaving Psychiatric Facilities (State or Private), if any	<p>Illinois Mental Health Collaborative for Access and Choice¹⁴⁷</p>

State: Minnesota

General State Characteristics

¹⁴¹ <https://www.dhs.state.il.us/page.aspx?item=33007>

¹⁴² <https://www.dhs.state.il.us/page.aspx?item=29735>

¹⁴³ <https://www.rtor.org/directory/mental-health-illinois/>

¹⁴⁴ https://shnny.org/uploads/Supportive_Housing_in_Illinois.pdf

¹⁴⁵ <https://www.rtor.org/directory/mental-health-illinois/>

¹⁴⁶ <https://www.dhs.state.il.us/page.aspx?item=125817>

¹⁴⁷ <https://www.illinoismentalhealthcollaborative.com/>



State: Minnesota	
Total Population	5.7 million
% of Population in Urban Areas	78% of population
Population by Payer Type	57.8%- employer 16.9%- Medicaid 14.7%- Medicare .7%- Military 4.8- Uninsured
Health Outcomes: Poor or Fair Health	13%
Health Outcomes: Poor Physical Health Days	3.1
Health Outcomes: Poor Mental Health Days¹⁴⁸	3.5
Number of State Hospitals¹⁴⁹	15
Inpatient Psychiatric Beds to Population Ratio	6.6 beds per 100,000
States Approach to Monitoring Private Inpatient Psychiatric Beds	
<i>State-Operated CON Program¹⁵⁰ (Y/N)</i>	No; Minnesota, along with Arizona and Wisconsin, do not officially operate a CON program, but they maintain several approval processes that function similarly to CON.
<i>Description of State CON legislation, if applicable to inpatient psych beds</i>	N/A
<i>Use of nursing homes to serve individuals with mental illness¹⁵¹</i>	Services for persons committed as Mentally Ill and Dangerous. Direct Care and Treatment operates the Minnesota Security Hospital (MSH) in St. Peter, a secure

¹⁴⁸ All health outcome data was sourced from:

<https://www.countyhealthrankings.org/app/michigan/2021/overview>

¹⁴⁹ All state hospital data was sourced from: <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NMHSS-2018.pdf>

¹⁵⁰ <https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

¹⁵¹ <https://www.house.leg.state.mn.us/hrd/pubs/ss/ssdctreat.pdf>



State: Minnesota	
	<p>treatment facility that provides treatment for adults and adolescents admitted under court orders for assessment and treatment of major mental disorders. MSH also operates transition services, and a forensic nursing home for persons in need of nursing home care and who are committed as mentally ill and dangerous, sexually dangerous persons, or as having a sexual psychopathic personality, or who are on medical release from the Department of Corrections.</p>
<p>Other State Regulations on Licensing of Psych Hospital Beds¹⁵²</p>	<p><u>9520.0520 - MN Rules Part - LICENSING PROCESS.</u></p> <p>Subpart 1. License required. No mental health residential program shall operate in Minnesota unless it has a current and valid license or provisional license as required by Minnesota Statutes, chapter 245A.</p>
<p>Other State Regulations on Monitoring of Psych Hospital Beds¹⁵³</p>	<p><u>9520.0660 ADDITIONAL REQUIREMENTS FOR CATEGORY I PROGRAMS</u></p> <p><u>9520.0670 ADDITIONAL REQUIREMENTS FOR CATEGORY II PROGRAMS</u></p>
<p>Description of Access or Quality Reporting Requirements From MCOs, if any¹⁵⁴</p>	<p>Minnesota Medicaid Managed Care Comprehensive Quality Strategy – June 2021</p> <p>DHS Goal 6: Integrate Mental Health and Increase Recovery from Substance Use Disorders – Pg. 32</p> <p>1. Providers will provide the full scope of CCBHC services. a) CCBHCs will provide services from the nine required service categories (outpatient mental health and substance use disorder, crisis services, screening, assessment and diagnosis, treatment planning, targeted case management, peer family supports, psychiatric rehabilitative, community-based services for veterans and outpatient primary care screening and monitoring) serving as a “one-stop-shop” to meet the needs of the population served. b) CCBHCs ensures all nine service categories, if not available directly through the</p>

¹⁵² <https://www.revisor.mn.gov/rules/9520.0520/>

¹⁵³ <https://www.revisor.mn.gov/rules/9520.0660/>

¹⁵⁴ <https://edocs.dhs.state.mn.us/lfs/Server/Public/DHS-4538E-ENG>



State: Minnesota	
	<p>CCBHC, are provided through a Designated Collaborating Organization (DCO). c) Individuals will receive CCBHC services in a person- centered and family-centered manner. d) Providers will consider the client’s choice in care services provided, as well as the physical, behavioral health, and social service needs of each individual as these factors influence the well- being of the whole person.</p> <p>2. Coordinated, integrated care provided by CCBHCs is cost effective since a client will receive an array of services at one location, potentially on the same day instead of accessing care at multiple locations and times.</p> <p>3. CCBHCs will provide care coordination. a) Care coordinators will coordinate care across settings and providers to ensure seamless transitions for clients across the full spectrum of health services, including acute, chronic, and behavioral health needs. Care coordination activities are carried out in keeping with the client’s preferences and needs for care and, to the extent possible and in accordance with the client’s expressed preferences.</p>
<p>Any reports about lack of sufficient beds, lack of beds to treat a specific population; how many beds closed, how many added, etc.</p>	<p>“The total capacity of inpatient beds in Minnesota is inadequate, and the distribution of those beds across geography and systems is inequitable,” said <u>Rep. Peter Fischer</u> (DFL-Maplewood), the division chair.¹⁵⁵</p> <p>See the chart of beds in this link.¹⁵⁶</p> <p>For patients in crisis seeking help, there are about 1,000 beds in Minnesota available — just over 600 for adults, and 200 to 300 or more for children.¹⁵⁷</p> <p>Even then, those beds may not be available. Just because a licensed bed is open doesn’t mean a facility has the staff to operate it.</p>

¹⁵⁵ <https://www.house.leg.state.mn.us/SessionDaily/Story/15511>

¹⁵⁶ https://www.mankatofreepress.com/news/local_news/psychiatric-bed-access-worsens-in-pandemic/article_38a62ea6-27a5-11ec-a81d-bf0489c81126.html

¹⁵⁷ https://mn.gov/dhs/assets/draft-solutions-9-9-16_tcm1053-255346.pdf



State: Minnesota

A recently-released study from Wilder Research on behalf of the Minnesota Hospital Association shows nearly 20 percent of inpatient psychiatric bed days in 20 community hospitals were potentially avoidable. In other words, a person on an inpatient mental or behavioral health unit who reached stability and no longer needed treatment in a hospital was not able to be discharged from the hospital because of a lack of appropriate treatment capacity. According to this pilot study, 14 percent of these potentially avoidable days were due to a patient waiting for transfer to a state-operated Community Behavioral Health Hospital. 11 percent were waiting for substance use disorder treatment. Ten percent awaited Intensive Residential Treatment Services. 11 The inpatient psychiatric bed capacity issue thus has several facets:

- Inadequate community-based services and recovery supports such that a person does not receive the support they need when mental health symptoms first arise and they thus get sicker until they are in a mental health crisis.
- Inadequate coordination of services to support individuals toward recovery.
- Inadequate crisis-response services that could help divert some individuals from needing inpatient psychiatric care.
- Problems with discharge planning, which should start at admission, resulting in people being ready for discharge but not having a destination in their home community (with whatever level of supports required) to go to.
- Inefficient administrative processes (especially in the commitment process, funding eligibility determinations, and community placements) that delay both treatment and recovery in community settings.¹²
- The long waiting times for admission to community psychiatric inpatient beds and especially for state-operated psychiatric beds for people who are under commitment.
- The “cycling” of some patients through Emergency Departments, inpatient hospital stays, and discharge back to the community without adequate supports.
- The “trickle down” effects of these psychiatric patient flow problems on other people and services, including friends and families, community hospitals and their other



State: Minnesota	
	<p>patients, lower intensity psychiatric services, law enforcement, courts, etc. “These patient flow problems reverberate throughout the service system, creating backups at community hospitals and preventing people from receiving the ‘right time, right place’ care they need to successfully pursue recovery.”¹³</p> <ul style="list-style-type: none"> • Questions about what the appropriate number of inpatient psychiatric hospital beds in Minnesota should be and about where policymakers should best invest in order to ensure that people receive “right place, right time” care.
States Approach to Monitoring State Hospitals	
Agency Responsible for Oversight and Management of State Hospitals	Minnesota Department of Human Services ¹⁵⁸
Types of Services Delivered in State Hospitals (e.g., acute, long-term, etc.; is any outpatient available or associated)	Psychiatric Residential Treatment Facility: An Overview ¹⁵⁹
State Policies Governing Admissions to State Hospitals	<p>Child Admission¹⁶⁰</p> <p>To be eligible for PRTF admission, Minnesota Health Care Programs (MCHP) members must meet all of the following criteria:</p> <ul style="list-style-type: none"> • Be under age 21 at time of admission <ul style="list-style-type: none"> ○ Services may continue until individual meets discharge criteria or reaches 22 years of age, whichever occurs first • Has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM), as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others • Has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for

¹⁵⁸ <https://www.health.state.mn.us/facilities/regulation/prtf/index.html>

¹⁵⁹ <https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mental-health/prtf/>

¹⁶⁰ https://mn.gov/dhs/assets/crf-prtf-med-necessity-memo_tcm1053-356859.pdf



State: Minnesota	
	<p>one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs</p> <ul style="list-style-type: none"> • Requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed • Utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed • Was referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional <p>Adult Admission¹⁶¹</p> <ul style="list-style-type: none"> • Individuals are typically admitted based on physician referral
State Policies Governing Discharge from State Hospitals	PRTF provider must notify AFMC within 48 hours of discharge by emailing discharge summary and updated plan of care through AFMC's secure email portal to mnprtf@afmc.org . ¹⁶²
Activities Taken by the State to Monitor and Track State Hospital Beds, including Legislative Reports, Programs, etc.	Regulating Hospital Bed Capacity in Minnesota ¹⁶³
Activities Taken by the State to Address State Hospital Bed Shortages, if any	It seems like the moratorium makes it difficult to add beds but there are exceptions. They just recently added some beds for children. ¹⁶⁴
Recent (3-5 years) policy changes to add/decrease state hospital beds ¹⁶⁵	Currently, MN operates under a hospital bed moratorium with a process for requesting exceptions (public interest review)

¹⁶¹ <https://mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/adult-mental-health/programs-services/>

¹⁶² https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-305532
https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-305532

¹⁶³ https://www.house.leg.state.mn.us/comm/docs/radytZw7G0eLVa6Qe_SiGA.pdf

¹⁶⁴ https://mn.gov/dhs/assets/crf-prtf-med-necessity-memo_tcm1053-356859.pdf

¹⁶⁵ https://www.house.leg.state.mn.us/comm/docs/radytZw7G0eLVa6Qe_SiGA.pdf



State: Minnesota	
	<p>Leading up to establishing the hospital bed moratorium, the MN Legislature was concerned about:</p> <ul style="list-style-type: none"> • Overcapacity in hospital licensed beds; and • The cost associated with potentially excessive inpatient capacity. • Prior to that “Certificate of Need” laws existed – they did not appear to control growth in medical facilities and health care investments • Moratorium was seen as a more effective way of limiting investments in excess hospital capacity. <p>MN Statutes 144.551 prohibit the:</p> <ul style="list-style-type: none"> • Establishment of new hospital licenses; and • The expansion of existing hospital licensed beds • In 2004, it established a process to inform the Legislature’s deliberations as it considers granting exceptions to the moratorium <p>Related sections establish:</p> <ul style="list-style-type: none"> • A process for reviewing proposals for exception to the moratorium (MN Stat 144.552); • A process for conducting reviews if competing proposals exist (MN Stat 144.553); and Responsibilities for MDH to monitor implementation after an exception has been granted [MN Stat 144.552 (g)].
Additional Considerations Implemented for the Forensic Population	<p>Forensic Services Available¹⁶⁶</p> <ul style="list-style-type: none"> • <u>Minnesota Security Hospital</u> • <u>Competency restoration program</u> • <u>Forensic network</u> • <u>Forensic transition services</u> • <u>Forensic nursing home</u>
Recidivism Rates for Forensic Population Any policies implemented to improve rates¹⁶⁷	<p>Community Competency Restoration Task Force – 2/2021</p>
Challenges Reported by State in Operating or Monitoring State	<p>Moratorium promotes a proposal/site-specific, one-off approach, rather than systematic consideration for how</p>

¹⁶⁶ <https://mn.gov/dhs/people-we-serve/adults/services/forensic-services/>

¹⁶⁷ https://mn.gov/sentencing-guidelines/assets/9-CCRTF-FinalReport_tcm30-470615.pdf



State: Minnesota	
<p>Hospitals, including any ongoing litigation¹⁶⁸</p>	<p>capacity aligns with inpatient needs and public policy goals By fixing in place historic capacity, the moratorium:</p> <ul style="list-style-type: none"> • Effectively freezes in place market share & geographic distribution • Gives competitive advantage to large systems with “spare” licensed bed capacity • For all reviews, there is a tension between: <ul style="list-style-type: none"> • The business case for adding beds • The public policy interest in adding beds • 40 hospitals have a hold 1,376 dedicated mental health beds and 3 of those have an additional dedicated 96 SUD beds across the state • 90 percent of hospitals with mental health beds and all hospitals with SUD beds are in urban areas or large rural cities • In 2019 there were 35,089 MH admissions and 11,166 SUD admissions across the state • These 40 hospitals made up 95.5 percent of MH admissions and 83.1% of SUD admissions • Some patients with principal diagnosis related to mental health are admitted to med/surg beds • Anticipated hospital and bed closures in the Twin Cities Metro area will lead to a reduction of 52 MH beds and 32 SUD beds
Description of Available Community Supports	
<p>Olmstead Goals related to inpatient psych beds, and progress toward the goals., e.g., number of community placements, development of community resources,¹⁶⁹</p>	<p>Goal 1: More people with disabilities in Minnesota will move from living in a segregated place to an integrated place. People with disabilities who live in segregated places should be given the opportunity to move to a more integrated place. They should be able to choose whether to stay somewhere segregated or get help to move somewhere more integrated.</p> <p>Goal 2: People who are ready to leave the Anoka Metro Regional Treatment Center move out faster. After getting the care they need, people get to leave the Anoka Metro Regional Treatment Center and move somewhere more integrated.</p>

¹⁶⁸ https://www.house.leg.state.mn.us/comm/docs/radytZw7G0eLVa6Qe_SiGA.pdf

¹⁶⁹ https://mn.gov/olmstead/assets/2022-02-quarterly-report-olmstead-plan-measurable-goals_tcm1143-523879.pdf



State: Minnesota	
	<p>Goal 3: More people will move out of the Minnesota Security Hospital every month. After getting the care they need, some people who live at the Minnesota Security Hospital are ready to move somewhere more integrated. They should get to leave the Minnesota Security Hospital if they are ready.</p> <p>Goal 4: Anyone with a disability who moves gets to use person-centered planning. If you’re deciding to move, you get to use person-centered planning.</p>
Number of Community Mental Health Centers¹⁷⁰	<p>0 – came up on the database search.</p> <p>6 Community Behavioral Health Hospitals were found.¹⁷¹</p>
Number of Veterans Affairs Medical Center	<p>Medical Center – 1¹⁷²</p> <p>It has 309 beds. The medical center provides primary, specialty, mental and behavioral health, and extended care and rehabilitative care to over 80,000 veteran patients.</p> <p>In-state clinics (WI locations were omitted even though listed on website) – 11</p> <p>Vet Centers - 3</p>
Alignment in Agency Monitoring Oversight and Management of State Hospitals and Community Mental Health Services in the State (Y/N)¹⁷³	<p>Minnesota’s Uniform Service Standards Current status:</p> <p>In 2021 the Minnesota Legislature passed the first phase of the USS project. The first phase created a common “core” of standards that will apply to all mental health care services and established the framework for a unified licensing structure. These changes are expected to go into effect July 1, 2022.</p> <p>Subsequent phases of the USS project will incorporate the remaining mental health care services into the new licensing structure.</p>

¹⁷⁰ <https://www.health.state.mn.us/facilities/regulation/directory/providerselect.html>

¹⁷¹ <https://mn.gov/dhs/people-we-serve/adults/services/direct-care-treatment/programs-services/community-behavioral-health-hospitals/>

¹⁷² <https://www.va.gov/minneapolis-health-care/locations/>

¹⁷³ <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/uniform-service-standards/>



State: Minnesota	
<p>Description of Services and Supports Available for Individuals with Mental Health Issues</p>	<p>Continuum of Care for Children and Adults in the links in comment.¹⁷⁴</p> <p>Community, residential, and vocational services for individuals with developmental disabilities and mental illness.¹⁷⁵</p> <p>The Minnesota Life Bridge Program supports adults who have developmental disabilities and exhibit severe behaviors that present a risk to public safety. Minnesota Life Bridge Program provides short-term treatment in residential settings. Individuals served by the program often have co-occurring mental health or chemical dependency diagnoses. Minnesota Life Bridge is the successor to the Minnesota Specialty Health System-Cambridge. More information about the transition of Minnesota Specialty Health System Cambridge to Minnesota Life Bridge, admission and discharge processes, transition planning, and community mobile support services is available in <u>DHS Bulletin #16-76-02</u>.¹⁷⁶</p> <p>Minnesota State Operated Community Services (MSOCS) provides <u>residential (PDF)</u> and <u>vocational (PDF)</u> support services for people with disabilities. Vocational services include day training and habilitation (DT & H) as well as evaluation, training and supported employment. Clients are integrated into the daily flow of the community. A state-of-the-art and highly specialized program called FACES (Friends and Community Experiencing Success) is used to plan individual support services that include community-based residential services typically provided in four-bed group homes.¹⁷⁷</p>

¹⁷⁴ <https://mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/adult-mental-health/programs-services/>

https://mn.gov/dhs/assets/prtf-general-overview_tcm1053-328795.pdf

¹⁷⁵ <https://mn.gov/dhs/people-we-serve/adults/services/direct-care-treatment/programs-services/#:~:text=Community%2C%20residential%20and%20vocational%20services%20for%20individuals%20with%20developmental%20disabilities%20and/or%20mental%20illness>

¹⁷⁶ http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Renderition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs-291254

¹⁷⁷ <https://edocs.dhs.state.mn.us/lfs/lfserver/public/DHS-5539-ENG> ; <http://edocs.dhs.state.mn.us/lfs/lfserver/Legacy/DHS-4070-ENG>



State: Minnesota	
	<p><u>Day Training and Habilitation vocational programs locations¹⁷⁸</u> around the state provide a wide range of individualized vocational training and support, including:</p> <ul style="list-style-type: none"> • Job placement • Supported employment • Mobile work crews • Competitive employment • Volunteer opportunities • Self-advocacy training • Community inclusion • Life skills training.
Availability of Congregate Housing for Individuals with Mental Illness	See comment for Mental Health Initiatives. Mental health shortage information. ¹⁷⁹

State: Ohio	
General State Characteristics	
Total Population	11.69 million people
% of Population in Urban Areas	80.1%
Population by Payer Type	52.6%- employer 20%- Medicaid 15.9%- Medicare .8%- Military 6.7%- Uninsured
Health Outcomes: Poor or Fair Health	18%
Health Outcomes: Poor Physical Health Days	4.1
Health Outcomes: Poor Mental Health Days	4.8

¹⁷⁸ <https://mn.gov/dhs/people-we-serve/adults/services/direct-care-treatment/contact-us/vocational-services.jsp>

¹⁷⁹ <https://www.startribune.com/minnesota-faces-escalating-demand-for-mental-health-services/600150943/>



State: Ohio	
Number of State Hospitals	6
Inpatient Psychiatric Beds to Population Ratio	9.06 beds per 100,000
States Approach to Monitoring Private Inpatient Psychiatric Beds	
State-Operated CON Program (Y/N)¹⁸⁰	Yes-The Certificate of Need Program is operated by the Ohio Department of Health (ODH); processes are set forth in sections 3702.51 to 3702.62 of the Ohio Revised Code (ORC) and Chapter 3701-12 of the Ohio Administrative Code (OAC).
Description of State CON legislation, if applicable to inpatient psych beds	<p>N/A: <u>ORC 3702.51</u>: Certificate of need definitions does not include inpatient psychiatric beds within the definition of long-term care facility, subject to CONs. ORC 3702.51 defines a “Long-term care facility,” except as provided in section <u>3702.594</u> of the ORC, as any of the following:</p> <ol style="list-style-type: none"> 1. A nursing home licensed under section <u>3721.02</u> of the Revised Code or by a political subdivision certified under section 3721.09 of the Revised Code; 2. The portion of any facility, including a county home or county nursing home, that is certified as a skilled nursing facility or a nursing facility under Title XVIII or XIX of the “Social Security Act”; <p>The portion of any hospital that contains beds registered under section <u>3701.07</u> of the Revised Code as skilled nursing beds or long-term care beds.¹⁸¹</p>
Use of nursing homes to serve individuals with mental illness	The Long-Term Care Consumer Guide, published by the Ohio Office of the State Long-Term Care Ombudsman, found approximately 70 nursing homes, throughout the state, who specifically indicate they offer “behavioral health care, non-dementia related” services. (Search conducted on April 21, 2022). ¹⁸²

¹⁸⁰ <https://odh.ohio.gov/know-our-programs/certificate-of-need/welcome-to>

¹⁸¹ <https://codes.ohio.gov/ohio-revised-code/section-3702.51>

¹⁸² <https://prod.ltc.ago.ohio.gov/FacilitySearch>



State: Ohio	
Other State Regulations on Licensing of Psych Hospital Beds¹⁸³	Licensure procedures for private and state psychiatric hospitals are enumerated in OAC 5122-14-03. ¹⁸⁴
Description of Access or Quality Reporting Requirements From MCOs, if any	<p>The Ohio Medicaid Managed Care Delivery System can be categorized into those individuals enrolled in a traditional Medicaid Managed Care Plan (MMC) or those individuals enrolled in the demonstration program known as MyCare Ohio (MCOP). As of 2018, all plans, regardless if they were only providing services in the MCOP provided inpatient treatment. ¹⁸⁵</p> <p>Information released by the Ohio Department of Medicaid (ODM) for Quarter 2, 2021 illustrates average length of stay and number of admissions, by MMC Plan. Data indicates CareSource, Molina, and Paramount had the highest average lengths of stays for children (CareSource and Molina, both at 23.3 days) and Adults (Paramount, 27.7 days). ¹⁸⁶</p>
Any reports about lack of sufficient beds, lack of beds to treat a specific population; how many beds closed, how many added, etc.	<p>Concerns dating back to at least 2015 have been reported regarding the lack of access to inpatient psychiatric beds. Below is a listing of such reports:</p> <ol style="list-style-type: none"> 1. "Ohio has 'critical' shortage of psychiatric hospital beds." ¹⁸⁷ 2. "Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014." ¹⁸⁸ 3. "Gov. Mike DeWine signs legislation to free up psychiatric hospital beds, allow out-of-state teletherapy." ¹⁸⁹
States Approach to Monitoring State Hospitals	

¹⁸³ <https://codes.ohio.gov/ohio-administrative-code/rule-5122-14-03>

¹⁸⁴ <https://codes.ohio.gov/ohio-administrative-code/rule-5122-14-03>

¹⁸⁵ <https://medicaid.ohio.gov/static/Stakeholders%2C+Partners/ReportsandResearch/OH-MHPAEA-Final-Report.pdf>

¹⁸⁶ <https://medicaid.ohio.gov/static/About+Us/Dashboard/2021/Q2+2021+MMC+Inpatient+Psych+DB.pdf>

¹⁸⁷ <https://www.journal-news.com/news/ohio-has-critical-shortage-psychiatric-hospital-beds/MJVEik3ZCkQP81oS60epWI/>

¹⁸⁸ https://nasmhpd.org/sites/default/files/TAC.Paper_.10.Psychiatric%20Inpatient%20Capacity_Final.pdf

¹⁸⁹ <https://www.cleveland.com/open/2021/04/gov-mike-dewine-signs-legislation-to-free-up-psychiatric-hospital-beds-allow-out-of-state-teletherapy.html>



State: Ohio	
Agency Responsible for Oversight and Management of State Hospitals	Ohio Mental Health and Addiction Services (OHMHAS)
Types of Services Delivered in State Hospitals (e.g., acute, long-term, etc.; is any outpatient available or associated)	<p>All six regional facilities provide short-term, intensive treatment to patients in both inpatient and community-supported environments. They also deliver comprehensive care to patients committed by criminal courts. The following-breakdown includes specific information for regarding delivered services.¹⁹⁰</p> <ul style="list-style-type: none"> • Evaluations • Intensive psychiatric care • Recovery • Psychiatry and psychology • Social Services • Patient Education • Occupational and recreational therapy • Work evaluation <p>Twin Valley (Columbus) Behavioral Healthcare includes a civil hospital, Kosar, has four general acute psychiatric units with 104 CMS-certified beds and three extended-care forensic units with 72 CMS-certified beds. The maximum-security facility, the Timothy B. Moritz Forensic Unit, has four units with 52 beds and serves all of Ohio’s 88 counties.¹⁹¹</p> <p>Summit Behavioral Healthcare (Cincinnati) provides recovery-based inpatient services to civil and forensic mentally ill adults.¹⁹²</p> <p>Community support network programs provide services to clients and their families residing in the community.</p>
State Policies Governing Admissions to State Hospitals	<p>Ohio Administrative Code (OAC) 5122-14-12¹⁹³:</p> <p>(C) Criteria for admission shall:</p> <ol style="list-style-type: none"> 1. Limit admissions to those persons whose principal diagnosis and focus of treatment upon admission is a mental disorder according to the latest edition of the American

¹⁹⁰ <https://mha.ohio.gov/about-us/regional-psychiatric-hospitals>

¹⁹¹ <https://mha.ohio.gov/about-us/regional-psychiatric-hospitals/healthcare-facilities/twin-valley/twin-valley>

¹⁹² <https://mha.ohio.gov/about-us/regional-psychiatric-hospitals/healthcare-facilities/summit/summit>

¹⁹³ <https://codes.ohio.gov/ohio-administrative-code/rule-5122-14-12>



State: Ohio	
	<p>psychiatric association's diagnostic and statistical manual of mental disorders (DSM), but excluding admissions to those persons whose principal diagnosis and focus of treatment is a substance abuse disorder, detoxification for substance abuse, a chronic dementing organic mental disorder, or mental retardation. This does not preclude admissions for which the above named excluded diagnoses may be a secondary diagnosis;</p> <ol style="list-style-type: none">2. Include any applicable age limits, diagnostic categories, and other criteria necessary to ensure that each admission is the least restrictive alternative available and consistent with each patient's treatment needs;3. Specify procedures and timelines for responding to an application for voluntary admission; and4. Assure that the inpatient psychiatric service provider will accept patients on a civil commitment and that it has the clinical competence to treat these patients:<ol style="list-style-type: none">a. Utilizing the same criteria applied to voluntary patients, andb. According to admission criteria applied to voluntary patients. <p>Also refer to Section 5122.02 and 5122.05 of the Ohio Revised Code for further information regarding application for voluntary admissions, and involuntary admissions, respectively.¹⁹⁴</p>
State Policies Governing Discharge from State Hospitals	<p>See Ohio Administrative Code (OAC) 5122-14-12¹⁹⁵:</p> <p>(D) Discharge criteria shall include but not be limited to achievement of treatment goals, or that the patient must be transferred to a more appropriate treatment facility. A civilly committed patient shall be discharged when the patient no longer meets the criteria for civil commitment, however such patients shall have the right to apply for voluntary admission status at any time pursuant to division (G) of section 5122.15 of the Revised Code.</p>

¹⁹⁴ <https://codes.ohio.gov/ohio-revised-code/section-5122.02>; <https://codes.ohio.gov/ohio-revised-code/section-5122.05>

¹⁹⁵ <https://codes.ohio.gov/ohio-administrative-code/rule-5122-14-12>



State: Ohio	
Activities Taken by the State to Monitor and Track State Hospital Beds, including Legislative Reports, Programs, etc.	OHHMAS releases state owned psychiatric hospital capacity in their annual reports. The 2021 report provides a summary of the efforts taken to limit bed capacity to prevent the spread of COVID-19. OHHMAS temporarily funded local mental health boards to pay for in-patient stays in private and general hospitals, when necessary. Most beds in state run hospitals were occupied by forensic patients. ¹⁹⁶
Activities Taken by the State to Address State Hospital Bed Shortages, if any	Senate Bill (SB) 2, passed by Ohio's 134 th General Assembly, and signed by Governor Mike Dewine in April 2021, became effective on August 3, 2021. ¹⁹⁷ SB 2 entered Ohio into a psychology interjurisdictional compact (PSYPACT), allowing for the practice of telepsychology by psychologist across state boundaries. Additionally, the bill require criminal courts to consider treatment outside of a hospital for individuals charged with low-level, non-violent crimes. ¹⁹⁸ Instead of receiving treatment at a psychiatric hospital, they instead will be treated at outpatient facilities. The intention of this statute change is create access to capacity in Ohio's regional psychiatric hospitals.
Recent (3-5 years) policy changes to add/decrease state hospital beds	OHHMAS releases state owned psychiatric hospital capacity in their annual reports. The 2021 report provides a summary of the efforts taken to limit bed capacity to prevent the spread of COVID-19. OHHMAS temporarily funded local mental health boards to pay for in-patient stays in private and general hospitals, when necessary. ¹⁹⁹
Additional Considerations Implemented for the Forensic Population	In addition to Ohio joining the PSYPACT, SB 2 also aims to improve access to regional psychiatric hospitals by diverting appropriate individuals to community-based competency restoration. New funding will help support a statewide

¹⁹⁶ <https://mha.ohio.gov/about-us/media-center/annual-reports/2021-annual-report>

¹⁹⁷ <https://www.cleveland.com/open/2021/04/gov-mike-dewine-signs-legislation-to-free-up-psychiatric-hospital-beds-allow-out-of-state-teletherapy.html>

¹⁹⁸ https://search-prod.lis.state.oh.us/solarapi/v1/general_assembly_134/bills/sb2/EN/05/sb2_05_EN?format=pdf;
<https://mha.ohio.gov/know-our-programs-and-services/forensic-services-sitearea/sb2/sb2>

¹⁹⁹ OHHMAS releases state owned psychiatric hospital capacity in their annual reports. The 2021 report provides a summary of the efforts taken to limit bed capacity to prevent the spread of COVID-19. OHHMAS temporarily funded local mental health boards to pay for in-patient stays in private and general hospitals, when necessary.



State: Ohio	
	network of outpatient providers serving the forensic population referred to outpatient restoration. ²⁰⁰
Recidivism Rates for Forensic Population Any policies implemented to improve rates	The Community Transition Program (CTP) provides treatment, transitional recovery supports, and housing to those leaving the Ohio prison system who have participated in recovery services. From its inception in 2017, 1,076 housing placements were made, though April 1, 2021. The recidivism rate for those participating was 4%. ²⁰¹
Description of Available Community Supports	
Number of Community Mental Health Centers²⁰²	87
Description of Services and Supports Available for Individuals with Mental Health Issues	<p>Forensic Services: Facilitate admissions, treatment, and discharge of people who are ordered to undergo psychiatric hospitalization by the criminal court system.²⁰³</p> <p>Coordinated Specialty Care for First Episode Psychosis: A treatment approach offered by a team of mental health professionals that can include medication, counseling, family education and support, supported employment/education services, case management, etc.²⁰⁴</p> <p>Telehealth Services²⁰⁵</p> <p>Behavioral Health Services Offered Under the Medicaid Program including but not limited to:</p> <ul style="list-style-type: none"> • Assertive Community Treatment for Adults; • Community Psychiatric Supportive Treatment; • Counseling; • Crisis Intervention; • Intensive Home-Based Treatment for Youth.²⁰⁶

²⁰⁰ <https://mha.ohio.gov/about-us/media-center/annual-reports/2021-annual-report>

²⁰¹ <https://mha.ohio.gov/about-us/media-center/annual-reports/2021-annual-report>

²⁰² <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NMHSS-2018.pdf>

²⁰³ <https://mha.ohio.gov/know-our-programs-and-services/forensic-services-sitearea/forensic-services>

²⁰⁴ <https://mha.ohio.gov/get-help/treatment-services/get-help-early>

²⁰⁵ <https://mha.ohio.gov/get-help/treatment-services/telehealth>

²⁰⁶ <https://bh.medicaid.ohio.gov/Individuals>



State: Ohio	
	<p>Specialized Recovery Services (SRS): Offered through a Medicaid 1915(i) program, SRS is available, in part, to individuals diagnosed with a serious persistent mental illness. In addition to state plan covered Medicaid benefits, individuals are also eligible to receive SRS covered services including Recovery Management, Individual Placement and Support-Supported Employment, and Peer Support. ²⁰⁷</p> <p>Crisis Intervention Team (CIT) programs are intended to aid first responders with making appropriate treatment referrals for individuals experiencing a mental health crisis to ultimately divert them from the criminal justice system. In 2017, approximately 1714 individuals were trained in CIT and 59 locations throughout the state provided CIT. ²⁰⁸</p> <p>The Criminal Justice and Behavioral Health Linkage initiative encourages communities to create relationships between the behavioral health and criminal justice systems to support individuals' ability to receive needed care. 57 counties were awarded funding from OHMHAS in FY 20-21. ²⁰⁹</p>
Availability of Congregate Housing for Individuals with Mental Illness	<p>Congregate housing is available in various settings throughout the state. The following settings include configuration for congregate housing:</p> <ul style="list-style-type: none"> • Recovery Housing • Residential Care • Traditional/Time-Limited Housing • Residential Treatment <p>Residential Care Settings are Licensed by OHMHAS as Residential Facility Class 3, (room and board only). OHMHAS certifies and licenses Residential Treatment Settings (Substance Use Disorder (SUD) certification; Residential Facility License)²¹⁰</p> <p>In 2021, Governor DeWine signed Sub. SB 57 which clarifies and affirms long-standing real property tax exemptions for permanent housing in Ohio. This is specific to 501(c)(3)</p>

²⁰⁷ <https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/specialized-recovery-services/specialized-recovery-services>

²⁰⁸ <http://files.constantcontact.com/bc3b3589001/77773a43-d2d2-4994-b482-51d84115fa3f.pdf>

²⁰⁹ <https://mha.ohio.gov/about-us/media-center/annual-reports/2021-annual-report>.

²¹⁰ <https://mha.ohio.gov/static/Portals/0/assets/SchoolsAndCommunities/CommunityAndHousing/PolicyOverview/res%20environments%20-%20combined.pdf?ver=2020-09-11-104641-853>



State: Ohio	
	organizations, limited liability companies, and limited partnerships who acquire, develop, lease or otherwise provide suitable supportive housing to individuals diagnosed with mental illness or substance use disorders. ²¹¹
Types of Community Supports Provided to Individuals Released from State Hospitals	Community Forensic Monitoring: Forensic monitors ensure individuals with mental illness have a successful transition from the hospital to the community. They also ensure effective risk management procedures are implemented by community providers. ²¹²
Community Programs Made Available for Individuals Leaving Psychiatric Facilities (State or Private), if any	Community Forensic Monitoring: Forensic monitors ensure individuals with mental illness have a successful transition from the hospital to the community. They also ensure effective risk management procedures are implemented by community providers. ²¹³

²¹¹ <https://mha.ohio.gov/about-us/media-center/annual-reports/2021-annual-report>

²¹² <https://mha.ohio.gov/know-our-programs-and-services/forensic-services-sitearea/community-forensic-monitoring/community-forensic-monitoring>

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