Faust

Testimony
Judicial Process Committee
Representative Shirley Meyer, Chairman
December 14, 2009

Chairman Meyer and members of the Judicial Process Committee, I am Dr. Elizabeth Faust, Chair of the Department of Psychiatry for the MeritCare division of Sanford Health MeritCare. I was previously co-medical director for Southeast Human Service Center from 1993-2005. I appear before you to provide information regarding the challenges we face in North Dakota with behavioral healthcare resource management and utilization. I have the opportunity to stand here because I am a representative of MeritCare Health System, but my purpose is to speak from the knowledge that I hold as a physician and citizen of the state of North Dakota. I am here to talk about stewardship of resources rather than presenting a partisan point of view. I believe there are two problems we must deal with:

1) the lack of sufficient resources to deal with the burden of treating mental illness and chemical dependency for the citizens of our state, and
2) fragmented utilization of the private and public resources we are currently devoting to the treatment of mental illness and chemical dependency.

Over the past decade, general hospitals in North Dakota and other states have taken an increasingly larger role of responsibility for behavioral healthcare, particularly in the area of emergency services and as a backstop to other agencies and organizations. However, as financial margins for healthcare reimbursement have gotten narrower and stability of healthcare organizations more tenuous, there has been declining ability of those hospitals to cross-subsidize services which historically are "mission-driven". Psychiatric programs at private facilities across the state have cut programming and faced increasing pressures to reduce financial losses. We have seen downsizing and closure of several behavioral health units in our region in response to these pressures. In my own facility, we have struggled with loss of psychiatric providers and pressure to increase efficiencies in our effort to stabilize financial losses.

Most recently, this has resulted in the temporary reduction of our bed capacity.
For MeritCare Health System, the cost of uncompensated behavioral health care has risen steadily over the past several years:
2005: $1,257,456
2006: $13,51,819
2007: $1,698,932
2008: $3,284,862
2009: $3,531,114

At this point you might anticipate that I am going to start referencing Century Code and the obligation of the state and asking for resources so that my organization isn't under so much pressure. And you might be thinking that the Cass County law enforcement officials who talk to you next will be lobbying to get MeritCare to re-open inpatient beds so they have someplace to send psychiatric emergencies.

But those are really the wrong questions. Arguing about whose responsibility it is to absorb the cost of mental health care in North Dakota diverts energy from the real issues. The real questions are about how we can collectively better manage our resources and get the most from the dollars we spend on mental health care in our state. Because one way or the other, we *will* spend dollars on mental health and chemical dependency. We can continue to be reactive and spend our dollars on emergency services and crisis intervention and law enforcement overtime and meetings to try to get other agencies to take care of the problem, but the patients will continue to flow in crisis to emergency rooms and jails and the human service centers. We collectively spend millions of dollars to deliver unintelligent care.

When I look at MeritCare's figures for uncompensated care, the frustrating thing for me isn't the number, it is that in spite of that staggering figure, we deliver poor care. I am a hospitalist, which means that I provide inpatient care and work in the emergency interface between community and hospital. Of course, *I* don't deliver poor care, but I do.... Patients get admitted to me who wouldn't really require hospitalization, but are a little too sick for the limited community resources available. Or when I have ill patients stabilized, I can't access the necessary step-down services and they fall through the cracks, get sick and come back in the hospital.

A continuum of care is critically important in managing difficult chronic populations effectively. Our services are only as strong as our weakest links. Without adequate supervised residential housing options, community case management, access to medications and outpatient psychiatric care, we are caught in a revolving door cycle of squandering expensive inpatient resources because that is the only thing available in an emergency that often evolves out of the lack of community resources. It is like a relay; no matter how well I run my leg in the hospital, if there is no one to hand off the baton to, we are still going to lose the race.

Facilities like MeritCare want to be responsible. We know that we need to be partners in planning and providing resources. We know that reduced community hospital availability only serves to put more pressure on the public sector, which is already straining to care for this population. We know that if community hospitals stop providing formal psychiatric care, it will not alleviate the flow of psychiatrically ill and chemically dependent individuals into emergency rooms and into contact with law enforcement. That is not the answer. But the private sector cannot continue to be the default front door and backstop in the absence of comprehensive community and crisis services.

The current system consumes limited public and private resources in inefficient ways and perpetuates the myth that caring for mental illness and chemical dependency is a bottomless black hole that cannot be managed. We wrangle endlessly about who should be stuck with it. That is the wrong problem to solve. We *all* own this dilemma, public and private alike.

The right problems to solve are:

1) lack of sufficient resource and
2) fragmentation of resource utilization.

1) Our community-based resources are inadequate to meet the need. A great deal of what presents to our emergency rooms are social crises which result from the lack of housing options, transportation availability, job placement support and case management support. The Human Service Centers are understaffed and overwhelmed by the numbers of these individuals.

They desperately need more case management staff and more community residential options with which to work. There is no amount of institution-based care that is going to solve that part of the crisis. Remember, a continuum of care is essential in managing difficult chronic populations effectively.

2) Our consumption of both private and public resource is fragmented and inefficient. Even without the need for additional resources, we could be doing so much better than we are with what we have. It is time for the development of a new model in which the public and private sectors work collaboratively and integrate the resources we are currently consuming inefficiently. We need to bring together community agencies, DHS, state and local government authorities, the private sector and law enforcement to develop a broad continuum of services and ensure that our citizens are treated in the most appropriate settings. Imagine what we could accomplish if we were investing our money in preventive care rather than crisis management!

My organization is eager and willing to participate in the work necessary to partner and develop such a collaborative model in our state. I hope that this committee and the larger legislative body can assist us by drawing attention to the real problems to be solved and discouraging us all from focusing on the distraction of competing for resources.

I have attached a written description of three general populations of mental illness for the purpose of general information regarding how their severity impacts the consumption of resources. In the interest of time, I will not review that.

This concludes my written testimony. I am happy to answer any questions.

Mental Illness Populations

I have described three general mental illness population groups according to severity, most severe to least severe:

I. Severe and persistent chronic mental illness--this population is very ill, has been very ill for a long time and has demonstrated this beyond any doubt. People with schizophrenia or severe mood disorders which incapacitate them often fall into this grouping. These are individuals who have very limited ability to work and often are unable to maintain day-to-day function without supports. They often have had many hospitalizations and are on Social Security and have Medical Assistance benefits. They typically have health benefits and if case management services are available, this is a population likely to be seen as a high priority because they cannot function without assistance. Many of these individuals would have improved stability with supportive or sheltered employment options if those were available as they are for the developmentally disabled population.

II. Moderate mental illness--this population is the most likely to represent those we see cycling in and out of emergency rooms, inpatient psychiatry facilities and falling through the cracks of our public/private systems of care. They typically have significant mental illness, but have not come to the attention of the system as eligible for funding or services for a variety of reasons related to the presentation of their illnesses. Many of them are able to gain employment sporadically but unable to maintain it consistently.

Examples:

1) Individuals who have had onset of a severe mental illness but haven't been ill long enough to "prove" that and have either not yet applied or are in the protracted multiple denial process of Social Security. This can take years and they are ineligible for SS services or MA care until "proven" longitudinally to be unable to function.

2) Individuals who have severe mental illness and are simply too ill to navigate the complexities of application for Social Security, so fall through the cracks. Many homeless and transient individuals fall into this category.

3) Individuals with severe chronic addiction. These are ineligible for Social Security and represent a huge burden for both the public and private sectors. Of the three populations being described, they are by far the most likely to lack medical insurance because of their level of impairment and lack of stable employability. Almost half of the addicted population has co-occurring mental illness which is rarely recognized.
This group represents a high proportion of the individuals who consume highly expensive hospital resources inefficiently. Residential addiction services, case management, community detox spectrum of care and hospitalization for medical and psychiatric crises are necessary to reduce the excessive dependency on inpatient resources.

4) Individuals who have moderate mental illness which chronically interferes with their functioning to the extent that they are marginally employed, sporadically employed or unemployed. They aren't sick enough to be easily recognized as mentally ill and are often labeled "lazy" or unmotivated, etc. These workers typically do not have or maintain health insurance because they are not consistent in employment or because they are able to access only day labor or entry level positions. They are actually worse off, in a sense, because they are not ill enough to obviously need supports but sick enough to fail to reach their potential. Complicating the picture, 15-40% of this population has co-occurring addiction, which worsens their chances of being recognized as appropriate for Social Security or other supports.

III. Functional mild mental illness--this population has mental illness or addiction that is relatively less severe and has been amenable to treatment with remission and return to normal function. Some of these are individuals who have stable employment or have families who are employed and have third party payment. This represents the "worried well" population and may include you or someone you work with.
The other part of this population are the working poor who have mild mental illness but do not have access to third party payment and stay away from services until symptoms or circumstances are so severe that they are forced to seek services, at which time they are likely to consume expensive emergency resources. This is a subset of the population who utilize emergency rooms for primary medical care, cannot afford follow-up care and cannot pay for medications.