September 15, 1988
0157F/DS:lt

INTRODUCED BY: Audrey Gruger, Ron Sims, Lois North

PROPOSED NO.: 88-696

MOTION NO. 7316

A MOTION supporting a request to the state to provide for significant improvements in the mental health system in return for county assumption of responsibility for administering all public funds for the mentally ill.

WHEREAS, the State Senate Health Care and Corrections Committee staff have provided the committee a background report on mental health which projects that Washington State would need 10,080 state hospital beds to provide the same level of care in relation to population provided before deinstitutionalization in 1960, and

WHEREAS, the same State Senate Committee staff report documents that currently only 6,000-6,500 beds are available to mentally ill persons state-wide in institutions and all types of community care settings, and

WHEREAS, State Mental Health Division bed need standards based on experience in other states indicate a total state need for 11,351 beds of all types, and

WHEREAS, King County currently lacks a total of 1,656 community residential care beds according to State Mental Health Division standards, and

WHEREAS, a provision in the federal Omnibus Reconciliation Act (OBRA) of 1987 disallows the use of nursing homes by a large portion of the mentally ill persons now living in such facilities thus further increasing the need for state supported residential beds in King County by as many as 300 to 500 beds, and

WHEREAS, a new federal statutory definition of an "institution for mental diseases" (IMD) defines a facility of more than 16 beds as ones for which the use of federal supplemental security income and medicaid funds is precluded affecting all but 12 of King County's 460 existing Congregate Care and Adult Residential Treatment beds, and

WHEREAS, utilization of intensive involuntary inpatient treatment for acute psychiatric problems continues to grow steadily at 6% per year in King County and at similar rates statewide, which is considerably above the level warranted by overall population growth, and

WHEREAS, the need to fund growth in mandatory involuntary treatment investigation, detention and legal services has eliminated crisis outreach services which helped to resolve some psychiatric crises without resort to involuntary treatment, and

WHEREAS, pilot case management projects have demonstrated effectiveness in reducing psychiatric emergencies and stabilizing life for chronically mentally ill persons within their communities, and

WHEREAS, continuous case management is not systematically available to the majority of chronically mentally ill persons, and

WHEREAS, Western State Hospital and local inpatient units have trouble finding placements and determining who is responsible for after-care, and

WHEREAS, the excess growth in involuntary treatment is an apparent result of the lack of an adequate longer-term care and emergency response services, and

WHEREAS, the actual total biennial state budget for mental health has grown by an average of 30% per biennium over each of the last three biennia, and

WHEREAS, growth for each biennium was originally budgeted at about half of the 30% level, and

WHEREAS, the differences between budgeted and actual biennial expenditures are almost all due to overruns in involuntary treatment in the community and at the state hospitals, and

WHEREAS, budgeting for the historic actual growth level but applying half of the additional amount to filling the documented service gaps could supply enough funds to fill 75% of the gap within 4 years, and

WHEREAS, experience in a number of other states indicates that the most cost/effective systems are ones where responsibility for clientele and authority over all public funds is vested in a single local authority with the flexibility to provide whatever services are needed and the responsibility to pay for use of state institution services, and

WHEREAS, under state statutes King County is required to provide involuntary treatment services and is given responsibility for planning and administering a system of care for mentally ill persons but does not administer inpatient and some residential facility services funds, and

WHEREAS, about $49 million per year are currently spent on mental health services for King County residents from the state mental health budget of which 57% are spent on inpatient services, mostly short term involuntary treatment and on 12% on longer term residential support, and

WHEREAS, the five counties in Region 3 of DSHS (Snohomish, Skagit, Whatcom, Island and San Juan) have presented a plan to fill 75% of the gap in residential services and develop and manage services in the region, and

WHEREAS, the Senate Health Care and Corrections Committee, with involvement of the Senate Ways and Means Committee and the House Human Services Committee is holding a hearing on September 22, 1988 to hear proposals from other regions;

NOW, THEREFORE BE IT MOVED by the Council of King County:

King County shall seek support from the 1989 State Legislature for a phased-in, six year plan as outlined in Attachment A to stabilize the lives of mentally ill adults and the costs of acute involuntary care by:

A) filling 75% of the gap in residential care services based on King County needs assessments and State Mental Health Division standards and covering the impact of new federal OBRA requirements and IMD definitions;

B) restoring and enhancing emergency response options;

C) reorganizing existing community mental health treatment services around core, case management systems within the county;

D) phasing in full responsibility at the county level for providing services and administering all public funding for mentally ill adult residents including appropriate authority and flexibility to move funding between program components and ultimate responsibility to pay for or limit the use of state institutions.

PASSED this 19th day of September, 1988.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

Gary Grant
Chair

ATTEST:

Dorothy M. Owens
Clerk of the Council

ATTACHMENT A

7316

THE KING COUNTY PLAN FOR A SYSTEM OF CARE FOR ADULTS WHO ARE MENTALLY ILL

A THREE-BIENNIUM PLAN

Corrected 9/16/88
MH.07(RES2.5)

KING COUNTY MENTAL HEALTH SYSTEM DEVELOPMENT OUTLINE

1989 - 1991 Biennium

I. Reorganize and enhance existing community mental health services into Community Support Programming (CSP) in two sub-regions covering about half of the County. CSP programming includes crisis intervention, case management services and crisis beds.

II. Assume authority and responsiblity for all existing residential care programs now under contract with the State (Congregate Care/Mental Health and Adult Residential Treatment Facilities). Evaluate utilization of existing residential programs and develop some additional small facilities. Develop supported living programs in normal housing. Implement coordinated discharge planning/placement function.

III. Begin implementing County "Managed Care System" functions including administration of federal medicaid and medicare funds and state grant-in-aid for the CSP sub-regions and assure quality assurance/utilization review for the two CSP sub-regions and residential care. This assures cost effective use of public funds.

Biennium Results:

° Reduction of growth in in-patient admissions begins in part of the County due to the new CSP programs. Reduction of in-patient length of stay begins due to coordinated discharge planning/residential placement. The goal is to avoid traditional ITA related overruns at Western State Hospital (WSH). (Note: Harper decision may adversely affect average length of stay.)

° King County use of WSH extended care beds is reduced by moving 90 long term patients to new community residential settings.

° Half of the residential needs of the clients affected by the Omnibus Budget Reconciliation Act (OBRA) and about 35% of the general unmet residential care needs are covered by new residential care development.

° The state and County are no longer both contracting directly with community mental health providers in the two CSP sub-regions. The County is the sole "authority".

1991-1993 Biennium

I. Complete implementation of CSP in remaining sub-regions of King County. All sub-regions have crisis intervention, case management and crisis beds.

II. Complete expansion of residential programming, emphasizing supported living options located in the community.

III. Complete implementation of County managed care functions for all out-patient and residential services countywide.

Biennium Results:

° All of the residential needs of the clients affected by OBRA and 75% of the unmet residential care needs are covered.

° The full effect of the residential care enhancements and CSP implementation begins to be seen in better maintenance of clients in the community and further reductions in inpatient admissions and length of stay. ITA overruns are avoided and savings begin to accrue to the system.

° The number of WSH extended care beds used by King County remains at the lower level established in the previous biennium.

1993-1995 Biennium

I. Complete full implementation of County managed care functions by taking on administration of all public funds including inpatient funding.

II. The County retains authority but delegates responsibility for continuity of client care to one agency in each sub-region. This agency is accountable for all services for each client including inpatient care (voluntary and involuntary).

Biennium Results:

° County replaces emphasis on involuntary treatment and in-patient hospitalization as the "driver of the system" with case management services and community options. Savings are redirected to case management and other services as needed.

° County replaces reliance on WSH for overflow of acute/emergency involuntary detentions and long term care with residential programming located in the community.

° The County maintains authority for establishing criteria for enrollment and for evaluating program quality. The County through one agency in each sub-region purchases in-patient and out-patient psychiatric care, both voluntary and involuntary treatment.

HISTORIC FUNDING PATTERNS

Total Mental Health Budget

Actual 1981-83	Actual 1983-85	Actual 1985-87	Gov's Proposed 1987-89
$175,505,719	$230,790,020	$294,953,955	$326,233,831

Percent of Growth Over Previous Biennium

29.2%	31.5%	27.8%	11%

Averages 30%

Potential Growth In 1989-91

30%	=	$97,870,151
15%	=	$48,935,075
20%	=	$65,246,766

KING COUNTY RESIDENTIAL NEED

(Based on state total unmet need figures, but with a different mix of beds needed)

Acute Crisis	LTC Adaptive	LTC Rehabilitation	Supervised Living	Supported Living
96.5	462 366(4)	(2) x (3) 296	248	850(1) + WSH + WSH + OBRA

1. Supported Living Bed need increase based on King County needs data. Need shifted fro Supervised Living which King County believe are high.

2. 90 people moved from WSH into the community; 65 into LTC Rehabilitation, 25 into comm Full state funding of present King County 110 ARTF beds affected by IMD.

3. Based on King County 1988 survey of eight nursing homes; will conduct statistically s

4. These are people in nursing homes who should be there because of physical care needs is not a "bed" need.

I. Residential Care

A. Supported Living:
(King County needs data)

638 (75% of 850) at $17.5/day x 365 =	$ 4,075,225
25 x 17.5 x 365 =	$ 159,688

1. 25 moved from WSH who are ready for community living (PALS/LINK Program)

   OFFSET Rationale:

   $135/day = rate for WSH extended care beds. Not all funds can be used as offset since some staff and overhead will remain at WSH regardless of the people moving out.

   25 x $90.45 (67% of $135) x 365 = [$ 825,356]

2. 130 people moved from CCF/MH's into community
3. 75 people moved from regular rate CCF's (150 estimated in King County CCF's)
4. 433 new people (See King County's Department of Planning and Community Development: "Bridging the Housing Gap" 1987)

B. Supervised Living
(King County needs data)

186 (75% of 248) at $25.32/day x 365 =	$ 1,718,975
25 moved from WSH	
25 x $90.45 x 365 [WSH Offset] =	[$ 825,356]
161 new people	

C. Community Long Term Rehabilitation
(King County needs data)

296 - OBRA: 296 x $50.72 x 365 =	$ 5,479,789
Medicaid savings: 296 x $23.64 x 365 =	[$ 2,554,066]
65 (LTC Rehabilitation) x $75 x 365 =	$ 1,779,375
WSH Offset: 65 x $90.45 x 365 =	[$ 2,145,926]
110 x $27.72 x 365 =	$ 1,112,958

(Present King County ARTF's - IMD)
fully State-funded $75 - 47.28 = $27.72

D. Community Long Term Adaptive Care

347 (75% of 462)
347 x $50.72 x 365 = $ 6,423,942

366 (100% OBRA) treatment need
$532/mo. = $17.16/day
366 x $17.16 x 365 $ 2,292,404

E. Acute Crisis Beds

72 (75% of 97) crisis beds at $75/day x 365 = $ 1,971,000

II. Crisis Intervention $ 1,800,000

TOTAL $20,462,652

III. Managed Care For Residential Resources and Implementation of the Regionalized Model
5% of $20,462,652 = $ 1,023,133

Managed care will include:

A. 10 FTE's* (Residential) = $402,283
DSHS Offset:
5 caseworkers @ $28,000 + 24% = $34,720 [$ 173,600]

Training for providers of Supported Living Programs = $10,000

B. 9 FTE's (Regionalized Model Implementation)
Utilization Review/Quality Assurance = $356,850

1.4 FTE/500 clients
3230 total client/500 = (6.46) x 1.4 = 9FTE

9 FTE's x $25,000 = $225,000 + 22% (benefits) =
$274,500 + 30% (overhead) = $82,350

C. Expansion of basic contracting, fiscal management and clerical support.

GRAND TOTAL $21,312,185

* 1 Residential Coordinator
1 Housing Developer
3 Client Care Coordinators
4 Placement Persons
1 Fiscal Technician (SSPS)