

**COMMUNITY MEDICAL
DIRECTOR'S ROUNDTABLE**

AGENDA

**Tuesday, July 22, 2014 @ 8:30 a.m.
3031 IH 10 West, CHCS Board Room
San Antonio, Texas 78201**

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|-------|---|--|
| I. | Welcome | Dr. Hnatow |
| II. | Dr. Bill Rago | Mr. Leon Evans |
| | 20 to 30 Minutes to present his findings around our funding and acuity of the patients we serve to our Medical Directors Roundtable. | |
| III. | Bexar County Mental Health Department | Gilbert Gonzales |
| IV. | Crisis / Emergency Services | All Reports; CTU, UHS, CSU, CCC Data, MCOT et al |
| V. | Substance Use Services | All Reports; Detox, Sobering |
| VI. | Adult MH Services | Integrated Care Team, High Utilizers |
| VII. | Children's Services | Melissa Tijerina |
| VIII. | State Mental Health Beds | SASH, CHCS, Nix, SWG |
| IX. | Homeless Services | Haven for Hope / Prospects Courtyard |
| X. | Law Enforcement/ First Responders | SAPD / Bexar County Sheriff's Office / EMS/SAFD |
| XI. | 1115 Waiver Updates | All |
| XII. | New Business | |
| XIII. | Adjournment – Next meeting; August 26, 2014 | |



JUNE 20, 2014

EXPLORING THE FUNDAMENTAL
RELATIONSHIP BETWEEN COMMUNITY
MENTAL HEALTH CENTER FUNDING AND
UNCOMPENSATED CARE COSTS IN TEXAS

THE IMPACT OF THE DSHS PERFORMANCE CONTRACT

BILL RAGO

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Executive Summary

This paper describes the potential impact of the Department of State Health Services (DSHS) standardized performance contract on the Center for Health Care Services' (CHCS) value-driven-access approach to client services. In doing so, the paper also outlines the impact of CHCS's services on the problem of uncompensated care (UC) costs in Texas, illustrating how the contract's conditions can unintentionally incentivize increases in the cost of UC.

An analysis by the Department of State Health Services (DSHS) of adult hospital admissions in Texas from 2006 to 2011 found 1,454,097 hospitalizations to be potentially preventable, generating approximately \$41.4 billion in total charges. During this same time period, potentially preventable admissions in Bexar County hospitals exceeded 88,000 at approximately \$2.6 billion in charges. A disproportionate number of preventable admissions and readmissions to Texas hospitals occur to individuals who have both medical and behavioral health conditions, (approximately 30% of potentially preventable events have a co-morbidity according to some estimates). Both CMS and HHSC have developed funding initiatives to control the growth in hospital costs by reducing the occurrence of these potentially preventable events.

In Bexar County the Center for Healthcare Services provides behavioral healthcare to not only a more complex client population, (i.e., case mix of 1.41) than other centers in the state but also serves a higher number of these complex clients than the other centers relative to the DSHS's targets identified in the performance contract. CHCS, by providing an alternative to hospitalizations that would have occurred without its intervention on such an expanded scale, is bending the Bexar County cost curve. In this way, CHCS is likely substantially reducing UC cost experienced by every hospital in Bexar County but most particularly the cost experienced by the Bexar County Hospital District which is responsible for using local tax revenues to reimburse the private hospitals who participate in the Medicaid supplemental payment programs. Yet, the public benefit of CHCS's approach to access is not limited to reducing UC costs in Bexar County. It is also likely that there is a substantial impact on HHSC's use of GR as state match for the Medicaid DRG payment system.

DSHS's standardized performance contract, as manifested through its sanctions and withhold-based outcome formulas, appears to negatively reinforce community center behavior like that of CHCS as it seeks to serve the most complex of clients who are also those most likely to seek hospitalization without such intervention. In this way, DSHS's approach to the performance contract appears misaligned with, if not contrary to the larger HHSC objectives of bending the healthcare cost curve as it is defined by both Medicaid and UC costs. The performance contract in several ways actually incentivizes centers to serve a minimum number of clients in terms of both its targets and the methodology it formulated to allocate funds to reduce the wait list. In addition, to the degree that what is paid for defines what is done, it is also quite possible that the potential for sanctions also, though unintentionally, directs centers to serve the mildest of those clients fitting the requirements of DSHS's uniform assessment, placing the more difficult on wait lists.

Ultimately, the performance contract for community centers appears to manage GR in ways that are not aligned with the larger objectives of HHSC. If nothing else, center performance such as that of CHCS, should not be penalized for exceeding the expectations with regard to client access and the associated impact on bending the Bexar County healthcare cost curve.

Introduction

This paper describes the potential impact of the Department of State Health Services (DSHS) standardized performance contract on the Center for Health Care Services' (CHCS) value-driven-access approach to client services. In doing so, the paper also outlines the impact of CHCS's services on the problem of uncompensated care (UC) costs in Texas, illustrating how the contract's conditions can unintentionally incentivize increases in the cost of UC.

As implemented, "value-driven-access" refers to CHCS's view that individuals who require services that are necessary for stabilization and recovery should have access to these services. Ultimately, the "value-based-access" philosophy as actualized by CHCS is quite simple, provide services to those in need because supporting fellow Texans is the right thing to do.

The Center for Healthcare Services' DSHS Performance Contract

In line with DSHS's standardized structure CHCS's performance contract addresses the requirements of its authority and provider functions. Specifically, the contract identifies the following requirements for providing services to adults and children:

- Application of the Uniform Assessment,
- UM rules for client placement into standardized Levels of Care (LOC),
- Performance measures and targets and
- Financial sanctions associated with not meeting these measures and targets.

The performance contract also identifies a series of specific outcome measures for which CHCS may earn "bonus" funding. However, the source of these additional funds is the 10% withhold that DSHS places on CHCS's general revenue allocation. Thus, CHCS, contingent upon its outcome performance, has an opportunity to earn back its full funding allocation.

Contract Performance Outcomes

The contract has three categories of outcomes as identified below. The funding methodology for all three of the outcome categories is: *"Adult service outcomes shall be measured 37 calendar days following the close of Quarter 2 (measuring Quarter 1 and Quarter 2) and Quarter 4 (measuring Quarter 3 and Quarter 4). For each outcome target met, Contractor will receive a percentage of withheld general revenue allocation in proportion to the number of outcome targets met. For each individual outcome measures met, Contractor may be eligible for redistribution of general revenue funds that are withheld from Centers that did not meet outcome targets."* (pps.38-39)

Resilience and Recovery Outcomes – Adult Mental Health Services:

- Employment Target. Percent of adults in full LOC who have independent employment.
- Housing Target. Percent of adults living independently or in a group or treatment setting.
- Community Tenure Target. Percent of adults in full LOC that avoid DSHS purchased hospitalization.

- Improvement Target. Percentage of adult population showing reliable improvement in one or more ANSA domains.¹
- Engagement Target. Average percentage of individuals each month receiving at least one encounter.

Resilience and Recovery Crisis Outcomes – Applicable for Adult and Children’s Mental Health Services

- Hospitalization Target. The rate of inpatient psychiatric hospital bed-days in the population of the local service area.
- Jail Diversion Target. Percentage of valid bookings across the adult population with a match in CARE.
- Effective Crisis Response Target. Percentage of adults and children/youth who receive crisis services and avoid psychiatric hospitalization with 30 days of the first day of the crisis episode.
- Frequent Admissions Target. Percent of adults and children/youth in a full LOC admitted 3 or more times to a DSHS purchased psychiatric hospital bed within 180 days.

Resilience and Recover Outcomes – Children’s Services Outcomes

- Juvenile Justice Avoidance Minimum Target. 95% of children/youth enrolled in a full LOC showing no arrests (acceptable) or reduction of arrests (improving) from time of first assessment to time of last assessment within measurement period.
- Community Tenure. Minimum target – In Q1/Q2, the percentage of all children/youth in a full LOC avoiding psychiatric hospitalization in a DSHS purchased bed after authorization into a full LOC.
- Improvement. Minimum target – The percentage of children and youth served in a full LOC in Q1/Q2 showing improvement according to the Reliable Change Index (RCI) in one or more domains on the CANS.²
- Engagement. Minimum target – In Q1/Q2, the average percentage of children/youth each month receiving at least one encounter.

CHCS’s Client Case Mix

As illustrated above, the standardized performance contract methodology for evaluating CHCS’s outcome performance is, for virtually all measures, the percentage of CHCS’s client population. This methodology is equitable when centers provide services to clients with the same degree of service complexity and in the same relative numbers.

The Texas Council of Community Mental Health Centers engaged an actuary to construct a case mix index using center reported cost, encounter and eligibility data for SFY12. The table in Attachment 1 shows this case mix index for the centers participating in the study. The first column in the table (FY12 Monthly) shows the center’s monthly client enrollment for adults. The second column shows each center’s reported average cost per adult client. The third column shows the actuary’s calculated statewide uniform cost based on LOC. The Case-Mix Index Risk Adjustment column (Column 4) shows each center’s calculated case mix, which is the center’s uniform cost divided by the overall statewide uniform cost. For example, the Center for Health Care Services case mix is 367.4 / 260.41 which equals

¹ ANSA is Adult Needs and Strengths Assessment. It is a component of the uniform assessment that identifies the LOC needed by the individual.

² CANS is the Child and Adolescent Needs and Strengths.

Column 4's 1.41. The meaning of the case mix Index is its ability to express the degree to which a center has relatively more or fewer clients in the more costly LOCs. The higher the case mix for a center the greater the proportion of its clients in the higher LOCs.

From the table in Attachment 1, the highest case mix belongs to Emergence Health Network in El Paso which has a value of 1.51. The next highest belongs to the Center for Health Care Services in Bexar County with a value of 1.41 that is followed by 1.29 for Starcare in Lubbock and then Tropical Texas with 1.14. Virtually all other case mix values hover around 1 which is the typical client intensity.

The case mix analysis reveals that the Center for Health Care Services provides services and treatment to a client population that is substantially more complex to work with than all centers except one.

DSHS's Allocation of Wait List Funding

The Texas Council's actuarial analysis revealed that the Center for Health Care Services client population has a substantially higher LOC than virtually all other centers in the state. The table in Attachment 2, which contains DSHS's funding to reduce the wait list for adult mental health services, provides additional insight into the service patterns of the Center for Health Care Services. While its 2013 target (Current 2013 AMH CARE Target) is 3,797, they served an average of 5,016 through 2013 quarters 1 to 3. Essentially, the Center served 1,229 clients over their DSHS target through the first three quarters of 2013.

The tables in both attachments, when considered together, show that CHCS not only serves a more complex client population, as represented by its case mix, but it also serves, relative to its funded DSHS target, many more clients.

Oddly, the table in Attachment 2 also reveals the highly negative impact to CHCS as a result of its value-based efforts to meet community need. That is, the DSHS Proposed AMH 2014 Target of 5,350 clients is only 334 clients above CHCS's actual 2013 served population of 5,016. As a result, DSHS's wait list funding formula greatly reduced CHCS's funding presumably, because of DSHS's assumption that CHCS had already reduced its wait list. As a result, CHCS only received \$281,580 dollars to meet the needs of clients on the wait list. Table 1 shows the statewide cost for each adult LOC as calculated by the actuary.

Table 1
Statewide Level of Care Average Costs

LOC	Statewide Average Cost
1	\$165.75
2	\$460.87
3	\$641.75
4	\$1,334.06

It is not surprising that the standardized cost per LOC calculated across all centers shows that as one goes deeper into LOC the cost of services increases. The reasons for this increase are rather straightforward. More complex clients require not only more services but also more intensive services.

Summary

The Center for Health Care Services' case mix shows that its client population is more severely ill and in need of more intense services which are more costly as the LOC increases. Attachment 2 shows that CHCS provides services to a substantially larger number of clients than the DSHS target reimburses.

Attachment 2 also shows that one impact of CHCS's implementation of its value-based-access approach to client services is that it received considerably less of the wait list funding than it would have received if it had not served the number of clients it did.

In looking at the Performance Contract requirements, the fact that CHCS has the case mix that it does and serves an increased number of clients, increases the possibility that it may not meet its performance requirements and will be financially sanctioned. A particularly odd component of the performance contract is the 10% withhold and its associated outcome methodology. It is much more difficult for a center to meet the outcome requirements identified in its contract when its client population is more severely ill. For example, consider the two outcomes below:

- Employment Target. Percent of adults in full LOC who have independent employment.
- Housing Target. Percent of adults living independently or in a group or treatment setting.

Both of these outcomes are significantly impacted by the client composition of CHCS's population. For the Center for Health Care Services, it is much more difficult to achieve these community center outcomes because of its decision to serve Texans most in need.

UC in Texas and Its Relationship to Community Mental Health Performance Contract

Uncompensated Care Overview

In Texas the responsibility for providing care to indigent and uninsured Texans falls locally to the counties and municipalities. Providing care to the uninsured creates uncompensated care costs for providers who then seek to find payment sources for the care they provided. In many cases these providers are hospitals, both private and public.

Another source of UC that is directly related to the manner in which Texas chooses to fund its Medicaid program is the Medicaid Shortfall. Hospitals participating in the Medicaid program, whether in managed care networks or not, have their inpatient payment amounts directly influenced by the Texas Medicaid All Payer Related Diagnostic Related Groups, (DRGs) prospective payment methodology. DRGs essentially identify the cost associated with over 1,200 diagnoses and pay the hospital provider based on the diagnosis of the Medicaid patient.

The Texas DRG program is funded primarily with general revenue (GR). Historically, the Texas legislature has underfunded the Medicaid DRG program so that the full amount of the DRG payment due the hospital is not fully funded by the state. The difference between the full DRG-based amount of the Medicaid payment and the payment received is the Medicaid Shortfall. The Centers for Medicare and Medicaid (CMS) refer to the shortfall as uncompensated care and allow it to be reimbursed through CMS-approved supplemental payment mechanisms. In Texas there are two of these payment mechanisms for UC; the Disproportionate Share Hospital program (DSH), and under the current Medicaid 1115 waiver, the Uncompensated Care Pool (UC Pool).

The all-funds amount (defined as including both the federal and state share of the Medicaid payment) for DSH in Texas has grown to just over \$1.6 billion per year. However, the Affordable Care Act (ACA), in recognition of potential reductions in UC resulting from the expansion of insurance, forged a time table for the gradual reduction in the federal share of DSH programs throughout the nation. In line with ACA requirements DSH funding in 2014 was to be reduced by \$.5 billion, with this reduction increasing each year to \$4 billion in 2020. Implementation of the federal reduction for DSH has been delayed and as of yet, no reductions have occurred.

Funding in the Medicaid waiver’s UC Pool is presented in the table below. As can be seen, the amount of UC funds available for payment decreases steadily each of the five years of the waiver, moving from a high of \$3.9 billion in FFY 2013 (Federal Fiscal Year 2013) to a low in 2016 of \$3.1 billion. What the table does not show is that as a condition of the waiver, approximately \$440 million in UC Pool funding was prepaid to Texas hospitals when the hospital Upper Payment Limit (UPL) program ended in 2011. This \$440 million will reduce the \$3.1 billion in 2016 that is available for reimbursing hospitals and physicians for their UC costs.

Table 2
Texas Medicaid’s 1115 Waiver UC Pool Funding by Year

FFY 2012	FFY 2013	FFY 2014	FFY 2014	FFY 2016	Total
\$3,700,000,000	\$3,900,000,000	\$3,534,000,000	\$3,348,000,000	\$3,100,000	\$17,582,000,000

The Rate Analysis Department of the Health and Human Services Commission (HHSC) is charged with working with Texas providers of UC to calculate the allowed amount of reimbursable UC costs incurred by each provider and then to allocate available funding to each of the eligible providers. Since both the DSH program and the UC Pool are CMS-based supplemental payment programs, HHSC must adhere to the rules in place for making its allocation. These rules are typically codified in the Texas Administrative Code and govern how the supplemental payments are to be made. The amount of UC cost incurred by Texas hospitals and physician practice groups (the major groups of eligible providers for participation in the two UC programs, with hospital by-and-far the dominate UC provider in the state) substantially exceeds the funding available to reimburse providers through the two programs. This excess of cost over available funding forces HHSC to develop methodologies that essentially “ration” the funding to providers. Simply put, there is more UC cost than funding available to reimburse provider cost.

The following table, based on HHSC data, shows that private hospitals had a total just over \$4 billion in UC costs in FFY2013 (which runs from October 2012 to September 2013). However, these hospitals, after supplemental payments are made for UC costs, still had approximately \$1.5 billion in unreimbursed costs. Public hospitals had approximately \$2.4 billion in UC costs which, after reimbursement from the UC Pool was reduced to just about \$400 million in unreimbursed UC costs.

Table 3
Statewide Estimates of Unreimbursed UC Cost in Hospitals FFY2013

	Private Hospitals	Public Hospitals	Total
Total UC Costs³	\$4.1 billion	\$2.4 billion	\$6.5 billion
Total Unreimbursed UC Costs⁴	\$1.5 billion	\$.4 billion	\$1.9 billion

From Table 3 it is clear that there is a substantial amount of UC costs incurred by providers above the funding available to offset it. There are several issues which make this unreimbursed UC cost even more dramatic than represented in the Table and that is the fact that the funding streams to reimburse UC, (i.e., DSH and UC Pool) are subject to declining federal funding in coming years.

If we move from a statewide view of UC to a local view as illustrated by the data in Table 4 we find that the total amount of unreimbursed UC cost in Bexar County, home of the Center for Health Care Services, (i.e., RHP 6), is approximately \$123 million. For private hospitals in Bexar County approximately 23% of their Total UC Costs (\$78 million) remained unreimbursed, while for public hospitals 14% was unreimbursed (\$45 million).

Table 4
RHP 6 (Bexar County) Estimated Unreimbursed UC Costs in Hospitals in FFY2013

	Private Hospitals	Public Hospitals	Total
Total UC Costs	\$337 million	\$313 million	\$650 million
Total Unreimbursed UC Costs	\$78 million	\$45 million	\$123 million

Community Center's Role in UC

Largely unrecognized in the performance contract requirements of DSHS is the role of the community mental health center in modulating the amount of UC in the state. Community centers are not eligible for UC reimbursement through any of the supplemental payment mechanisms. Yet, the degree to which their client focus is on individuals with severe and persistent mental illness, a population highly at risk of

³ In FFY2013, as shown in Table 2, the waiver's UC Pool had its highest amount of funding at \$3.9 billion. This is the amount that is used in Tables 3 and 4 to estimate the amount of Unreimbursed UC Costs. In later years, the UC Pool amounts decrease substantially which means there is likely to be increasing amounts of UC cost that remains unreimbursed given the current circumstances around insurance and Medicaid expansion. Total UC Cost is an estimate of the amount of UC costs that are incurred by an individual hospital and reimbursable through the UC Pool. It includes the Hospital Specific Limit (CMS's definition of UC costs), allowed physician, pharmacy and clinic costs. It is an estimate of the total amount of UC cost prior to being reduced by supplemental payments from either DSH or the UC Pool.

⁴ Total Unreimbursed UC Costs is a calculation that references the UC costs remaining for a hospital after it has received UC Pool and DSH funding. Since UC Pool funding occurs after DSH funding, total unreimbursed costs represent an estimate of the UC costs that are unreimbursed after both DSH and UC Pool supplemental payments have been made.

multiple hospitalizations, significantly impacts hospital cost and thereby significantly reducing the amount of UC cost incurred by hospitals throughout the state. It is here that the work of Center for Health Care Services with its value-driven philosophy to access is aligned with the larger state goal of reducing the growth, if not the absolute level of UC costs in Texas.

The irony of the situation for CHCS, when viewed from the perspective of their DSHS performance contract, is that the standardized structure of this contract appears to be blind to the impact of CHCS's performance on helping to reduce UC costs in Bexar County. The performance contract's standardized sanctions, and in particular, the allocation methodology for the 10% withhold actually forces CHCS to reduce the individuals served as well as to work with individuals who are less intense in their service needs. The likely impact of this action, if implemented, would be to increase the number of hospitalizations, and since this population will not be insured, to increase the amount of UC cost in Bexar County.

Medical and Behavioral Health: Impact of Co-Morbidity

Of the initiatives undertaken by CMS to control the growth in health care costs many have focused on reducing hospital costs. Of particular interest is the CMS-driven focus on potentially preventable events (PPEs). PPEs refer to several types of hospital events, including potentially preventable admissions, readmissions and emergency department visits. It can also refer to potentially preventable complications, which are events that occur within the hospital and are associated with potentially poor care.

Defining Potentially Preventable Readmissions (PPRs)

HHSC applies a computerized algorithm developed by the 3M Company to DRG claims data for all Medicaid hospitals in Texas to identify PPRs for each hospital. This algorithm identifies plausible clinical relationships to the care provided during or immediately following a prior hospital admission. Of the many ways to define and report readmissions, the simplest approach is to count the number of all readmissions that occur within a given time period. The algorithm used by HHSC is more sophisticated than this simpler approach because it risk adjusts for the severity of illness and counts only readmissions for which there was a plausible clinical connection between the reason for the initial admission and the reason for the readmission.⁵

The 3M algorithm employs such concepts as "PPR chain"⁶, "Actual PPR Rate" and "Expected PPR rate" to calculate a hospital's "PPR Performance Ratio." The end result of this calculation is a risk adjusted PPR ratio for each Medicaid hospital in Texas. The PPR ratio for a hospital is an aggregate calculation that quantifies the frequency of individual diagnosis-specific PPRs which enables a description of the hospital's performance relative to other hospitals with similar case mixes.

⁵ HHSC's *Potentially Preventable Readmissions in the Texas Medicaid Population, State Fiscal Year 2012*, November 2013.

⁶ A readmission chain starts when a PPR occurs within 15 days of the discharge from the initial admission. If there is a second readmission within 15 days of the first readmission, then the chain includes two readmissions. The chain still counts only once in the calculation of the PPR rate.

PPRs and the Performance of Texas Medicaid Hospitals

HHSC's *Potentially Preventable Readmissions in the Texas Medicaid Population, State Fiscal Year 2012* report's key findings include the following:

- Overall, 3.7% of admissions were followed by a readmission chain that started within 15 days of discharge. Rates varied widely by care category: .8% for obstetrics, 4.1% for non-obstetric patients under age 18 and 8.2% for non-obstetric adults.
- Mental health and substance abuse conditions comprised 9.3% of initial admissions but 27.4% of PPRs. Bipolar Disorders, Schizophrenia, Major Depression, Cesarean and Vaginal Delivery and Health Failure represented substantial numbers of PPRs.
- Overall, two-thirds of readmissions were to the same hospital and one-third to a different hospital.
- Of the 20 DRGs with the highest numbers of initial admits, Schizophrenia, Heart Failure and Bipolar were the only ones with PPR rates of 10% or higher. These 3 DRGs were responsible for 20% of the readmission chains in the analysis. [Major Depression had a 9.5% PPR rate.]

Potentially Preventable Hospitalizations in Texas

DSHS's analysis of all adult hospital admissions in Texas (not just those in the Medicaid population) from 2006 to 2011 found 1,454,097 hospitalizations that were potentially preventable that generated approximately \$41.4 billion in total charges. Interestingly, the DSHS analysis only focused on 10 diagnoses in estimating the impact of preventable hospitalizations (these 10 conditions are listed in the table in Attachment 3). Hospital charges for Potentially Preventable Admissions (PPAs), as incurred by different payers, are in the table below.⁷

Table 5
Adult Potentially Preventable Hospitalizations in Texas by Payer
(2006 – 2011)

Payer	PPA Charges
Medicare	\$26.2 billion
Private Insurance	\$7.4 billion
Uninsured	\$4.0 billion
Medicaid	\$2.9 billion
Other	\$1.0 billion

Potentially Preventable Hospitalizations and Behavioral Health Co-Morbidity in Bexar County

The table in Attachment 3 dis-aggregates the statewide data on PPAs discussed above to show the impact of preventable hospitalizations in Bexar County. For the time period covered by DSHS's analysis, there were 88,626 hospitalizations that were evaluated to be potentially preventable for only those 10 conditions listed at the left of the table. These 10 conditions generated over \$2.6 billion in hospital charges, an amount that averaged \$2,134 per Bexar County resident in 2011.

⁷ Mike Gilliam, DSHS: *Adult Potentially Preventable Hospitalizations in Texas*, UT Mentorship Program – Health Careers, November 21, 2013.

The far right hand column in the Attachment 3's table provides additional information descriptive of these 10 conditions. It identifies the impact of behavioral health co-morbidity on the frequency of preventable admissions. As can be seen from this column, while the impact of co-morbidity varies across the conditions, (44% for COPD to 20.3% for Diabetes Long Term), the overall impact appears to be between 30% and 32% of all preventable hospitalizations.

Integration of Medical and Behavioral Healthcare

For many years and certainly recently, healthcare was driven in large part by revenue maximization strategies through which states and other healthcare payers would maximize their revenues in an attempt to keep pace with growing costs. A major example of such a strategy in Texas was the creation of the hospital public UPL program, and within this program, the extension of UPL to private hospitals. Ironically, in many respects, the impetus for the UPL supplemental payment program was contained in the CMS requirement that Medicaid programs not increase their provider payments beyond the amount that Medicare would have paid for a similar client mix. While this rule was intended to control the growth of Medicaid costs, because so many states reimburse below Medicare rates, this Medicare "upper limit" appears to have had the opposite effect, creating instead revenue maximization opportunities.

While the ACA has substantially increased healthcare funding, it is clear that this trend cannot be sustained. With this recognition CMS has created an Innovation Center that is charged with, among other things, developing alternative strategies and methodologies for bending the healthcare cost curve by identifying and testing payment reform models for the delivery of care.

Milliman (2014) in a report to the American Psychiatric Association writes that "Continually escalating healthcare costs have prompted payers to seek ways to improve member health while reducing the growth of healthcare claims expenditures. One such initiative is the integration of medical and behavioral healthcare."⁸ Milliman analyzed claims across three different payers, commercial, Medicare and Medicaid, to look at the impact on cost of treating individuals with behavioral co-morbidities.

The table in Attachment 4 is Milliman's analysis of the Per Member Per Month (PMPM) healthcare costs by population and presence of behavioral conditions.⁹ This analysis analyzed claims from the three types of payers to identify the additional cost associated with behavioral conditions. The table shows that individuals with a treated behavioral condition typically cost 2-3 times as much on average as those without a behavioral condition in all payer markets. For example, individuals for whom Medicaid is the payer and who fall into the MH/SUD¹⁰ group have an average PMPM of \$1,301 compared to the Medicaid individual in the NO MH/SUD grouping whose average PMPM cost is \$381.

Table 6 shows the total cost impact of treating individuals with and without behavioral health co-morbidities. According to Milliman "the total spending in the US across all service categories and the three populations for those with MH/SUD disorders is estimated to be \$525 billion annually, compared

⁸ Milliman, *Economic Impact of Integrated Medicaid-Behavioral Healthcare: Implications for Psychiatry*. April 2014, p.4.

⁹ Milliman's analysis does not focus just on inpatient costs but includes all claims associated with patient treatment. As such, facility costs are a subset of the total cost reported by Milliman.

to \$1.7 trillion for all service categories.... In other words, even though members with treated MH/SUD constitute only 14% of the total insured members across the three markets, they account for over 30% of total healthcare spending.” (p.8)

Table 6
Total Healthcare Spending in the Presence of Behavioral Conditions
2012 Costs in Millions

	Medical	Behavioral	Medical Rx	Behavioral Rx	Total
No MH/SUD	\$1,002,332	\$9,210	\$137,173	\$11,009	\$1,159,724
MH/SUD	\$371,119	\$49,587	\$66,333	\$38,252	\$525,291
Total	\$1,373,451	\$58,797	\$203,507	\$49,261	\$1,685,016

The Milliman analysis of the impact of medical and behavioral health co-morbidity on healthcare costs included the identification of what they referred to as “total value opportunity” which was defined as the difference in PMPM costs between those treated for MH/SUD conditions and those not treated for MH/SUD conditions multiplied by the enrolled member months. Table 7 reveals the results of this analysis. The value opportunity, (i.e., potential for savings) for the commercial market payer is estimated to be \$162.4 billion annually, while for Medicaid the value opportunity is approximately \$100.4 billion.

In Milliman’s work, the value opportunity represents something of an ideal potential for savings. In an attempt to convert from this potential to what may be realizable, Milliman reviewed the literature on integrated medical and behavioral healthcare to estimate the savings in healthcare costs when treatment is integrated. Their research estimated that approximately 5% to 10% of the total MH/SUD cost in Table 6 (i.e., \$525 billion) could be saved through the integration of behavioral and medical care. The far right column of Table 7 (Cost Impact of Medicaid & Behavioral Health Integration) shows this total estimated savings across three different payers.

Table 7
Average Annual Cost Savings and Impact on Cost of Integrated Medical & Behavioral Healthcare
(In Millions)

Payer Type	Member Months	Total Claims	Value Opportunity	Cost Impact of Medicaid & Behavioral Health Integration
Commercial	2,386,000,000	\$1,013,386	\$162,366	\$15,815-\$31,629
Medicare	556,000,000	\$362,793	\$30,803	\$3,347-\$6,693
Medicaid	546,000,000	\$308,836	\$100,374	\$7,103-\$9,945
Total	3,487,000,000	\$1,685,016	\$293,543	\$26,265-\$48,267

SB58 of the 83rd Legislature

SB58 of the 83rd Texas legislature recognized the significant value associated with the integration of medical and behavioral healthcare when they directed HHSC to complete the integration of mental health services into the Texas Medicaid managed care program. While Medicaid card services have historically been part of the managed care mental health benefit, targeted case management and mental health rehabilitation services have been carved out. In September 2014, these remaining two services will be integrated into the funding of Medicaid managed care and the managed care organizations (MCOs) will be responsible for not only the medical care of its members but also their mental healthcare as well.

Summary

The potentially preventable events data in Texas and Milliman's analysis of payer claims arrive at very similar conclusions, that is, approximately 30% of the cost of healthcare is related to the co-morbidity of medical and behavioral healthcare. In Texas a very significant part of this cost is uncompensated and, as such, falls to the local community to pay, either by paying the full cost, (e.g., unreimbursed UC) or funding the state match, (i.e., IGT) required for participation in the two major Medicaid supplemental payment programs. Typically, this IGT is provided by a small number of urban public hospitals which includes the Bexar County Hospital District's University Health System Hospital (UHS).

In Bexar County the Center for Healthcare Services provides behavioral healthcare to not only a more complex client population, (i.e., case mix of 1.41) than other centers do in the state but also serves a higher number of these complex clients than the other centers relative to the DSHS's targets identified in the performance contract.

In implementing its value-based-access philosophy, CHCS's approach to access is working to substantially reduce the UC cost in Bexar County from what it would be otherwise. That is, CHCS, by providing an alternative to hospitalizations that would have occurred without its intervention on such an expanded scale, is bending the Bexar County cost curve. In this way, CHCS's applied philosophy is likely substantially reducing UC cost experienced by every hospital in Bexar County but most particularly the cost experienced by the Bexar County Hospital District who is responsible for using local tax revenues to reimburse the private hospitals who participate in the Medicaid supplemental payment programs. Yet, the public benefit of CHCS's philosophy is not limited to reducing UC costs in Bexar County. It is also likely that there is a substantial impact on HHSC's use of GR as state match for the Medicaid DRG payment system.

DSHS's performance contract, as manifested through its sanctions and withhold-based outcome formulas, appears to negatively reinforce community center behavior like that of CHCS as it seeks to serve the most complex of clients who are also those most likely to seek hospitalization without such intervention. In this way, DSHS's approach to the performance contract appears misaligned with and contrary to the larger HHSC objectives of bending the healthcare cost curve as it is defined by both Medicaid and UC costs. The performance contract in several ways actually incentivizes centers to serve

a minimum number of clients both in terms of its targets and through the methodology it formulated to allocate funds to reduce the wait list. Yet, to the degree that what is paid for defines what is done, it is also quite possible that the potential for sanctions also, though unintentionally, directs centers to serve the mildest of those clients fitting the requirements of DSHS's uniform assessment, placing the more difficult on wait lists.

Ultimately, the performance contract for community centers appears to manage GR in ways that are not aligned with the larger objectives of HHSC. If nothing else, center performance such as that of CHCS, should not be penalized for exceeding the expectations with regard to client access and the associated impact on bending the Bexar County healthcare cost curve.

Attachments

Attachment 1: Case Mix Ratios for Community Centers Adult Clients

Center	FY12 Monthly Enrollment	FY12 Average Cost Center Reported	FY12 Average Cost Uniform State	Case-Mix Index (Risk Adjusted)	Spend Ratio
Anderson/Cherokee	1,001	179.78	223.79	0.86	0.80
Andrews Center	1,726	179.87	210.34	0.81	0.86
Austin Travis Co Integral Care	4,038	257.83	268.52	1.03	0.96
Behavioral Health Center of Nueces	1,469	241.22	275.35	1.06	0.88
Betty Hardwick Center	716	283.01	256.37	0.98	1.10
Bluebonnet Trails	2,190	305.57	279.96	1.08	1.09
Border Region	1,297	267.4	238.92	0.92	1.12
Burke Center	1,895	209.1	209.64	0.81	1.00
Camino Real	1,206	311.36	258.01	0.99	1.21
Center for Life Resources	554	308.51	277.1	1.06	1.11
Central Counties	1,348	227.18	189.32	0.73	1.20
Central Plains	430	244.88	210.68	0.81	1.16
Coastal Plains	2,020	198.68	255.85	0.98	0.78
Community Healthcore	2,375	204.55	246.01	0.94	0.83
Denton County	1,303	263.04	240.38	0.92	1.09
Emergence Health Network	3,269	251.98	392.36	1.51	0.64
Gulf Bend	802	188.02	228.1	0.88	0.82
Heart of Texas	1,062	304.93	258.12	0.99	1.18
Helen Farabee	2,963	159.28	187.89	0.72	0.85
Hill Country	2,560	222.7	211.49	0.81	1.05
Lakes Regional	1,259	192.06	217.33	0.83	0.88
MHMR Auth or Brazos Valley	1,462	192.14	248.97	0.96	0.77
MHMR Auth of Harris Co	8,613	430.58	266.06	1.02	1.62
MHMR of Tarrant Co	5,938	224.6	260.33	1.00	0.86
MHMR Services for the Concho Valley	507	315.07	211.82	0.81	1.49
Pecan Valley	1,922	154.78	215.35	0.83	0.72
Permian Basin	1,637	271.22	233.43	0.90	1.16
Spindletop	1,850	376.36	253.83	0.97	1.48
Starcare Specialty Health System	931	227.1	336.86	1.29	0.67
Texana	2,356	196.9	233.53	0.90	0.84
Texas Panhandle	1,654	232.94	248.09	0.95	0.94
Texoma	725	197.52	270.84	1.04	0.73
The Center for Health Care Services	4,734	322.96	367.4	1.41	0.88
The Gulf Coast Center	2,462	200.76	210.78	0.81	0.95
Tri-County MHMR Services	1,940	262.96	267.94	1.03	0.98
Tropical Texas	4,258	231.53	296.8	1.14	0.78
West Texas	1,414	274.59	197.88	0.76	1.39
Total / Weighted Average	77,886	260.67	260.41	1	1

Table Notes:

FY12 Average Cost Center Reported: The average cost per center using hours per service from the encounter report and cost per hour reported on the CAM reports aggregated by LOC.

FY12 Average Cost Uniform State: The average cost per center using statewide weighted average costs per LOC.

Case-Mix Index Risk Adjusted: This index is the average cost per center using the statewide weighted average cost per LOC divided by the overall average cost.

Spend Ratio: This is the average cost per center using their own cost divided by the same but using statewide weighted average costs per LOC.

Attachment 2: DSHS Allocation of Wait List Funding to Community Centers

August 8, 2013 FY13 Q1-3 Average Baseline AMH	Current 2013 AMH CARE Target	AMH Avg Served (2013 Q1-3)	DSHS Proposed AMH 2014 Target	DSHS Proposed Target Change	Wait List Funds Rec'd	Additional Served over FY2013 Target
Center for Health Care Services	3,787	5,016	5,350	1,563	\$ 281,580	1,229
Helen Farabee	1,929	2,946	2,963	1,034		1,017
Austin Travis Co Integral Care	2,996	3,901	4,068	1,072	\$ 112,632	905
Andrews Center	1,097	1,979	2,071	974	\$ 350,892	882
Pecan Valley	1,335	2,082	2,168	833	\$ 324,900	747
Texana Center	1,592	2,320	2,555	963	\$ 134,292	728
Burke Center	1,285	1,941	2,106	821	\$ 667,128	656
Coastal Plains	1,384	2,007	2,024	640		623
Gulf coast	1,833	2,439	2,550	717	\$ 207,936	606
Hill Country	1,964	2,499	2,564	600		535
Tri County	1,488	2,004	2,220	732	\$ 636,804	516
Tropical Texas	3,790	4,264	4,972	1,182	\$ 2,915,436	474
Community HealthCare	1,887	2,332	2,393	506	\$ 212,268	445
MHMR of Tarrant County	5,777	6,199	7,009	1,232	\$ 3,287,988	422
ACCESS	658	1,077	1,094	436		419
Brazos Valley	1,084	1,449	1,542	458	\$ 363,888	365
Emergence Health Network	3,042	3,399	3,705	663	\$ 1,225,956	357
Boorder Region Behavioral Health	1,120	1,418	1,559	439	\$ 567,492	298
Texas Panhandle	1,464	1,755	1,772	308		291
Camino Real	1,005	1,263	1,284	279	\$ 43,320	258
Gulf Bend	607	798	900	293	\$ 420,204	191
Lakes Regional	1,093	1,279	1,298	205		186
Permian Basin	1,486	1,640	1,658	172		154
Nueces County	1,251	1,388	1,405	154		137
Central Counties	1,362	1,492	1,551	189	\$ 51,984	130
MHMR for Concho Valley	413	526	543	130		113
Denton	1,182	1,259	1,581	399	\$ 1,104,660	77
Texoma	677	745	763	86		68
Center for Life Resources	501	544	562	61		43
Central Plains	404	432	449	45		28
Heart of Texas	1,082	1,108	1,169	87	\$ 220,932	26
Betty Hardwick	697	720	737	40		23
StarCare Specialty Health System	948	933	968	20	\$ 112,632	(15)
Spindletop Center	1,764	1,730	1,747	(17)		(34)
West Texas Centers	1,458	1,380	1,534	76	\$ 641,136	(78)
Bluebonnet Trails	2,375	2,198	2,376	1		(177)
MHMR of Harris County	8,844	8,034	9,781	937	\$ 7,065,492	(810)
Total	66,661	78,496	84,991	18,330	\$ 20,949,552	11,835

Attachment 3: Potentially Preventable Hospitalizations & Impact of Behavioral Health Co-Morbidity in
Bexar County

Potentially Preventable Hospitalizations for Adult Residents of Bexar County		Potentially Preventable Hospitalizations & Associated Charges Bexar County			
	2006 - 2011				
	Total Admissions 2006 – 2011	Average Hospital Charge	Total Hospital Charges	Hospital Charges Divided by 2011 Adult County Population	Percent Mental Illness / Substance Abuse as Secondary Diagnosis ¹
Bacterial Pneumonia	15,496	\$29,496	\$457,033,315	\$374	32.5%
Dehydration	5,423	\$17,376	\$94,229,307	\$77	31.0%
Urinary Tract Infection	11,611	\$19,731	\$229,097,562	\$187	36.1%
Angina	938	\$22,654	\$21,249,604	\$17	31.3%
Congestive Heart Failure	22,716	\$37,887	\$860,630,446	\$704	20.6%
Hypertension	8,848	\$21,791	\$105,642,092	\$86	30.9%
Chronic Obstructive Pulmonary Disease or Asthma	12,607	\$26,428	\$333,182,830	\$273	37.0%
Diabetes Short-Term Complications	4,124	\$21,087	\$86,962,115	\$71	44.4%
Diabetes Long-Term Complications	10,865	\$38,608	\$419,477,843	\$343	29.3%
Total	88,627	\$29,421	\$2,607,505,113	\$2,134	

¹ This percentage has been added to the table and is a state wide percent, not specific to Bexar County. From Mike Gilliam, *Adult Potentially Preventable Hospitalizations in Texas: UT Mentorship Program – Health Careers*. November 21, 2013.

Attachment 4: Healthcare Costs of Beneficiaries with and without Behavioral Disorders

Population	Behavioral Health Diagnosis	Member Months	Costs				
			Medical \$	Behavioral \$	Medical Rx \$	Behavioral Rx \$	Total \$
Commercial	No MH/SUD	2,048,000,000	280	3	53	4	340
	Non-SPMI MH	278,000,000	661	23	145	74	903
	SPMI	47,000,000	759	128	135	175	1,197
	SUD	22,000,000	830	73	102	67	1,072
	Total	2,386,000,000	335	8	66	16	425
Medicare	No MH/SUD	508,000,000	579	3	NA	NA	582
	Non-SPMI MH	23,000,000	1,369	40	NA	NA	1,409
	SPMI	21,000,000	1,222	215	NA	NA	1,437
	SUD	6,000,000	1,291	213	NA	NA	1,504
	Total	556,000,000	640	13	NA	NA	653
Medicaid	No MH/SUD	437,000,000	309	4	63	5	381
	MH/SUD	109,000,000	757	286	172	86	1,301
	Total	546,000,000	398	61	85	21	565
Total	No MH/SUD	2,993,000,000	335	3	55	4	397
	MH/SUD	494,000,000	751	100	148	86	1,085
	Total	3,487,000,000	394	17	69	17	497

Notes:

Costs are average per member per month (PMPM) costs.

Medical Column shows facility and professional costs for non-behavioral services.

Medical Rx Column shows the pharmacy costs for drugs used to treat medical conditions.

Behavioral Column shows facility and professional costs for treating behavioral conditions.

Behavioral Rx Column shows the costs for prescription drugs to treat behavioral conditions.

SUD refers to substance use disorder diagnoses.



Mobile Crisis Outreach Team: A Hospital Guide

WHO IS MCOT?

MCOT is a mobile assessment team with the Center for Health Care Services that provides assessment for least restrictive treatment environment in a variety of community settings from hospitals to an individual's home.

MCOT acts as the Local Mental Health Authority representative (LMHA). They manage the utilization of state funded contract beds for individuals experiencing psychiatric crisis.

WHEN TO CALL:

When an individual presents in your facility with the following criteria met; please call the Crisis Line to make a referral.

- Assessed psychiatric crisis (risk to self/other; acute psychiatric decompensation)
- Your internal assessment team has assessed that the person meets inpatient criteria (assessment must be available in chart)
- Bexar County resident
- Lacking medical insurance
- Not acutely intoxicated (BAC 0.8 or below, no other substances within last 4 hours)
- Medically Cleared
- Not experiencing acute withdrawal symptoms or detox
- Able to provide for own self-care needs (ADLs)
- Your facility does not have capacity to treat individual

Center for Health Care Services
Restoration Center
601 N Frio St.
San Antonio, TX 78207
Office: 210-225-5481

Please call Crisis Line to make referral 24/7:

210-223-7233



Crisis Care Center Summary

6/30/2014

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Total
Crisis Care Center							
Total Served	455	424	449	475	513	488	2,804
Crisis Care Center	Jan	Feb	Mar	Apr	May	Jun	Total
Individuals Placed in Observation	225	225	250	243	271	280	1,494
Average Length in Stay in Hrs	20.26	20.97	18.52	20.28	22.26	22.43	20.79
Times on Diversion	9	2	11	12	1	3	38
Hours on Diversion	107.18	28.08	163.83	133.90	9.33	30.83	473.15
Active Routine Cases	50	52	42	38	49	49	280
Active Urgent/Emergent Cases	117	122	131	119	115	129	733
Total Routine Cases	129	125	120	140	175	149	838
Total Urgent/Emergent Cases	300	266	292	286	294	306	1,744
CCC - ED's & MHW's	Jan	Feb	Mar	Apr	May	Jun	Total
Total Involuntary	103	104	89	115	142	148	701
Emergency Detentions	98	90	76	100	128	129	621
Voluntary to Involuntary > Emergency Detentions	2	6	5	6	5	9	33
Mental Health Warrants	3	8	8	9	9	10	47
Courtesy Rides	8	5	7	6	13	9	48
Brought By EMS	1	0	0	0	0	0	1
Brought By Ambulance	0	0	0	0	0	0	0
Warrant Applications	19	31	36	40	35	28	189
CCC - Dispositions	Jan	Feb	Mar	Apr	May	Jun	Total
Total Hospitalized	82	83	81	83	117	102	548
SASH	0	0	0	0	0	0	0
ER for Medical Clearance	4	3	4	2	3	3	19
Crisis Transitional Unit	24	20	36	44	27	22	173
Detox	28	23	24	37	36	34	182
CHCS Sobering	0	2	1	2	0	1	6
IHRP	7	4	8	4	7	9	39
CHCS Clinics	51	85	58	47	54	68	363
Intake CHCS	62	50	48	36	47	50	293
VA Services	2	4	2	5	10	5	28
Community Services	57	52	69	79	60	56	373
Crisis Line	Jan	Feb	Mar	Apr	May	Jun	Total
Total Calls	2,263	2,228	2,428	2,225	2,365	2,236	13,745
Routine AMH	44	35	36	41	47	48	251
Urgent AMH	110	94	109	94	101	100	608
Resolved by Phone AMH	257	227	277	242	279	286	1,568
Community Referrals AMH	189	213	222	195	197	246	1,262
Emergent AMH	17	13	10	16	14	7	77
Routine CMH	11	10	16	15	16	3	71
Urgent CMH	14	22	32	12	26	6	112
Resolved by Phone CMH	35	30	38	35	29	26	193
Community Referrals CMH	33	55	53	49	46	29	265
Emergent CMH	0	0	1	1	1	2	5
State Bed Authorization	372	306	324	389	388	343	2,122
Non-Assessment/Information Only	1,181	1,223	1,310	1,136	1,221	1,140	7,211

Mobile Crisis Outreach Team Summary

6/30/2014

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014	TOTAL
Total Referrals	377	336	328	382	435	410	2,268
Community (Self/Family) Referrals	64	64	55	42	57	57	339
Magistrate Referrals	0	5	3	5	4	3	20
Haven for Hope/PCY Referrals	0	5	2	2	4	2	15
CHCS Referrals	0	7	5	2	9	11	34
SASH Walk-ins	10	12	17	14	13	14	80
State Bed Authorization Referrals	303	230	225	283	337	292	1,670
Other	0	13	21	34	11	31	110
State Bed Monthly Total - Nix	81	72	75	68	51	54	401
State Bed Monthly Total - SWG	51	39	45	44	41	37	257
Response							
Face to Face	277	256	269	297	339	316	1,754
911 Only	0	0	0	0	0	0	0
Cancelled by Hospitals	63	36	39	54	82	48	322
Negative Contact	29	32	20	27	9	22	139
Community Referral Outcomes							
Arrested	0	0	0	1	0	0	1
Refused Services	0	1	0	0	1	1	3
Resolved on Scene	3	17	27	37	35	20	139
Emergency Detentions	21	34	15	16	27	30	143
ED to Crisis Care Center	7	13	4	8	24	19	75
ED to Hospital	14	12	11	8	2	10	57
Volunteer to Crisis Care Center	18	11	28	12	18	16	103
Volunteer to Detox	0	0	0	0	0	0	0
Volunteer to Other Hospitals	6	0	3	1	0	3	13
Referred to Community Agency	0	0	0	0	0	0	0
Follow Up with CHCS Clinic	0	0	0	0	0	0	0
Magistrate Referral Outcomes							
Sent to Detox	0	0	0	0	0	0	0
Sent to UHS	0	2	1	3	2	2	10
Sent to CCC	0	0	0	0	1	0	1
Sent to Other	0	0	1	1	1	1	4
Sent to ADC	0	0	0	0	0	0	0
Sent to Community Reintegration	0	0	0	0	0	0	0
Released to Self	0	0	0	0	0	0	0
Level of Care 5							
Individuals Served	68	57	41	35	42	43	286

Restoration Center - Sobering

JAN -
JUN 2014

	Jan	Feb	Mar	Apr	May	Jun	Total
Admissions/Discharges							
1 Total PI Admissions	559	536	646	635	568	583	3,527
2 Unduplicated Admissions*	395	383	471	426	396	391	2,462
3 Total Re-Admissions	353	339	383	407	358	372	2,212
4 Multiple Admissions in Month	67	58	64	73	68	68	398
5 Rejections	0	0	0	0	1	0	1
Length of Stay by Hours							
6 Average Hours per Stay	4.10	5.51	4.10	4.36	4.49	6.33	4.82
Magistrate's Office PIs							
7 Total PI's Booked	254	242	275	271	266	285	1,593
8 PI Only	158	175	166	171	163	180	1,013
9 PI w/ Warrant Class C	45	40	41	43	49	54	272
10 PI w/ Warrant Class B	50	27	68	57	55	51	308
11 Homeless PI at Mag	40	43	42	39	42	44	250
12 PI's Diverted from Mag	33	46	32	29	22	12	174
Demographics							
13 Female	62	52	60	72	60	63	369
14 Male	448	424	522	529	469	520	2,912
15 Veterans	14	14	19	20	14	10	91
16 Homeless Females	22	17	18	25	23	25	130
17 Homeless Males	271	266	299	312	304	293	1,745
18 Homeless Veterans	4	9	8	9	8	2	40
Primary Substance							
19 Alcohol	542	521	625	608	553	568	3,417
20 Benzos	4	0	1	1	1	0	7
21 Cocaine	0	0	0	2	1	0	3
22 Heroin/opiates	5	3	6	8	4	4	30
23 Inhalants	1	0	1	0	0	0	2
24 Marijuana	2	2	2	1	3	3	13
25 Methamphetamine	0	0	0	1	1	0	2
26 Unknown	5	10	11	14	5	8	53
Referral Source							
27 Haven for Hope	2	0	2	5	1	5	15
28 LawEnf: University Healthcare System PD	0	0	5	5	1	3	14
29 LawEnf: Airport PD	1	2	3	3	3	3	15
30 LawEnf: Bexar County Sheriff's Office	12	7	31	41	32	33	156
31 LawEnf: San Antonio Park Police	22	37	52	33	39	40	223
32 LawEnf: SAPD	377	352	398	407	393	411	2,338
33 LawEnf: Trinity Campus PD	1	3	2	0	0	0	6
34 LawEnf: VIA Transit Police	10	14	14	19	12	12	81
35 LawEnf: Windcrest PD	1	4	3	5	5	3	21
36 Picked Up from Mag	33	46	32	29	22	12	174
37 Prospect Courtyard	91	58	82	62	50	44	387
38 Walk-in	5	2	7	7	2	10	33
39 Other Sources	3	11	15	19	8	8	64
Referral Destination							
40 ER	7	3	3	8	1	5	27
41 GI Forum	0	0	0	0	0	0	0
42 Detox Unit	32	24	34	45	23	30	188

Restoration Center - Minor Medical Clinic

JAN thru
JUN 2014

	Jan	Feb	Mar	Apr	May	Jun	
Admissions/Discharges							
1 Total Admissions	91	86	103	99	90	83	552
2 Unduplicated Admissions*	90	86	100	98	88	83	545
3 Multiple Admissions in Month	1	0	3	1	1	0	6
Length of Stay by Minutes							
4 Average Minutes per Stay	31	39	40	35	35	36	36
Procedure *							
5 Wound Care	32	45	51	46	52	46	272
6 Taser	12	12	17	11	10	14	76
7 Dermabond	11	3	5	7	5	7	38
8 Sutures/Staples	4	3	2	7	8	6	30
9 Evaluation/No treatment	21	16	21	19	14	12	103
10 Refused Treatment	4	4	3	5	0	3	19
11 Eval/Refer to ER	11	7	7	12	6	9	52
12 X-rays	3	2	3	5	3	6	22
Referral Source							
13 SAPD	81	69	84	80	64	63	441
14 BCSO	4	5	8	9	13	16	55
15 Bexar County Jail	0	0	0	0	0	0	0
16 VIA	2	0	0	0	3	0	5
17 H4H/PCY	0	0	0	0	0	0	0
18 UCPD/ CONSTABLE	0	1	0	0	1	0	2
19 SA Park Police	0	1	0	1	1	0	3
20 PSU/IHRP/Crisis	5	8	7	8	6	4	38
21 LOPD/HPD/DPS	0	2	0	1	0	0	3
22 WCPD/APD/CHPD	0	0	1	1	0	0	2

*Procedure data will not equal Total Admissions due to some clients getting multiple procedures.

Restoration Center - Detox

JAN 2014
JUN 2014

	Jan	Feb	Mar	Apr	May	Jun	Total
Admissions/Discharges							
1 Total Admissions	190	200	242	200	199	197	1,228
2 Total Discharges	185	202	241	200	199	197	1,224
3 Unduplicated Admissions	171	173	184	194	191	192	1,105
4 Successful Completions	110	100	110	130	138	105	693
5 Multiple Admissions in Month	11	7	17	9	8	5	57
Total Bed Day Count							
6 Bed Days	854	803	873	849	953	912	5,244
7 Average Length of Stay	3.99	3.51	3.25	3.72	3.78	3.52	3.63
Demographics							
8 Female	56	51	54	53	61	62	337
9 Male	124	128	149	141	138	135	815
10 Veterans	1	0	0	2	0	2	5
11 Homeless Females	2	3	2	1	1	1	10
12 Homeless Males	21	21	25	22	7	10	106
13 Homeless Veterans	0	0	0	1	0	0	1
Primary Substance							
14 Alcohol	66	63	63	79	69	57	397
15 Benzos	0	0	0	1	0	1	2
16 Cocaine	1	1	1	2	2	3	10
17 Heroin/opiates	114	115	134	120	127	133	743
18 Inhalants	0	0	0	0	0	0	0
19 Marijuana	0	0	0	1	0	1	2
20 Methamphetamine	0	0	3	0	1	1	5
21 Unknown	1	1	3	1	0	1	7
Referral Source							
22 Bluebonnet Trails MHMR	1	1	0	2	2	0	6
23 CHCS Crisis Center	15	12	10	15	10	12	74
24 CHCS Methadone Clinic	0	2	1	0	1	2	6
25 Child Protective Services	0	0	1	3	1	0	5
26 Community Physician	0	0	0	0	5	2	7
27 Drug Courts	1	3	3	1	0	0	8
28 Lifetime Recovery	4	0	3	0	0	0	7
29 Prospect Courtyard	2	0	1	0	2	0	5
30 Sobering	35	27	34	43	24	30	193
31 University Hospital Contract	8	9	6	8	4	2	37
32 Walk-in	113	122	140	127	148	146	796
33 Other Sources	2	4	5	5	2	3	21

Restoration Center - In House Recovery Program

Jan - June
2014

		Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014	Total
Admissions/Discharges								
1	Total Admissions	34	41	43	45	52	44	259
2	Total Discharges	38	49	38	36	40	39	240
3	Unduplicated Admissions FYTD	31	38	43	45	52	44	253
4	Multiple Admissions in Month	0	0	0	0	0	0	0
Total Bed Day Count								
5	Bed Days	2,709	2,066	2,235	2,275	2,720	2,910	14,915
6	Average Length of Stay	79.34	75.72	73.62	61.67	73.81	73.73	72.98
7	Completion Rate	61%	74%	51%	50%	62%	63%	60.00%
Demographics								
8	Female	8	11	5	11	17	24	76
9	Male	26	30	37	34	35	20	182
10	Veteran Female	0	0	1	1	1	0	3
11	Veteran Male	9	4	4	2	7	4	30
12	Total Homeless	34	41	43	45	52	44	259
Primary Substance								
13	Alcohol	60	57	44	48	63	68	340
14	Benzos	1	0	0	0	0	0	1
15	Cocaine	15	13	9	11	14	21	83
16	Heroin/opiates	35	37	42	44	41	34	233
17	Inhalants	0	0	0	0	0	0	0
18	Marijuana	2	2	1	0	0	0	5
19	Methamphetamine	12	13	17	14	14	14	84
20	Unknown	0	1	1	0	1	0	3

Restoration Center

Mar-June 2014

Crisis Transitional Unit

	Mar 2014	Apr 2014	May 2014	Jun 2014	Total
1 Total Admissions	33	57	52	40	182
2 Unduplicated Admissions	27	41	43	40	151
3 Average Length of Stay In Days	11	9	7	10	37
4 Total Bed Days	305	403	223	232	1,163
5 No. of Unfunded Clients	19	20	25	24	88
CTU Referral Sources	Mar 2014	Apr 2014	May 2014		Total
6 BMC	0	5	2	3	10
7 CCC	15	20	22	22	79
8 IOPC	1	4	8	2	15
9 Nix	2	4	1	1	8
10 SASH	1	4	0	1	6
11 SWGH	4	6	6	2	18
12 UHS	3	1	1	6	11
13 Other Sources	2	0	3	3	8
CTU Discharge Disposition	Mar 2014	Apr 2014	May 2014		Total
14 Boarding Home	1	1	2	1	5
15 CCC	0	4	2	1	7
16 Cloudhaven	8	9	2	4	23
17 Hospital	3	1	1	3	8
18 Home	1	11	3	1	16
19 Salvation Army	2	1	0	3	6
20 Self-discharged	13	10	18	8	49
21 Other Dispositions	0	5	4	3	12



Mobile Crisis Outreach Team: A Hospital Guide

WHO IS MCOT?

MCOT is a mobile assessment team with the Center for Health Care Services that provides assessment for least restrictive treatment environment in a variety of community settings from hospitals to an individual's home.

MCOT acts as the Local Mental Health Authority representative (LMHA). They manage the utilization of state funded contract beds for individuals experiencing psychiatric crisis.

WHEN TO CALL:

When an individual presents in your facility with the following criteria met; please call the Crisis Line to make a referral.

- Assessed psychiatric crisis (risk to self/other; acute psychiatric decompensation)
- Your internal assessment team has assessed that the person meets inpatient criteria
(assessment must be available in chart)
- Bexar County resident
- Lacking medical insurance
- Not acutely intoxicated (BAC 0.8 or below, no other substances within last 4 hours)
- Medically Cleared
- Not experiencing acute withdrawal symptoms or detox
- Able to provide for own self-care needs (ADLs)
- Your facility does not have capacity to treat individual

Center for Health Care Services
Restoration Center
601 N Frio St.
San Antonio, TX 78207
Office: 210-225-5481

Please call Crisis Line to make referral 24/7:

210-223-7233



Restoration Center Report

Community Medical Directors

Round Table

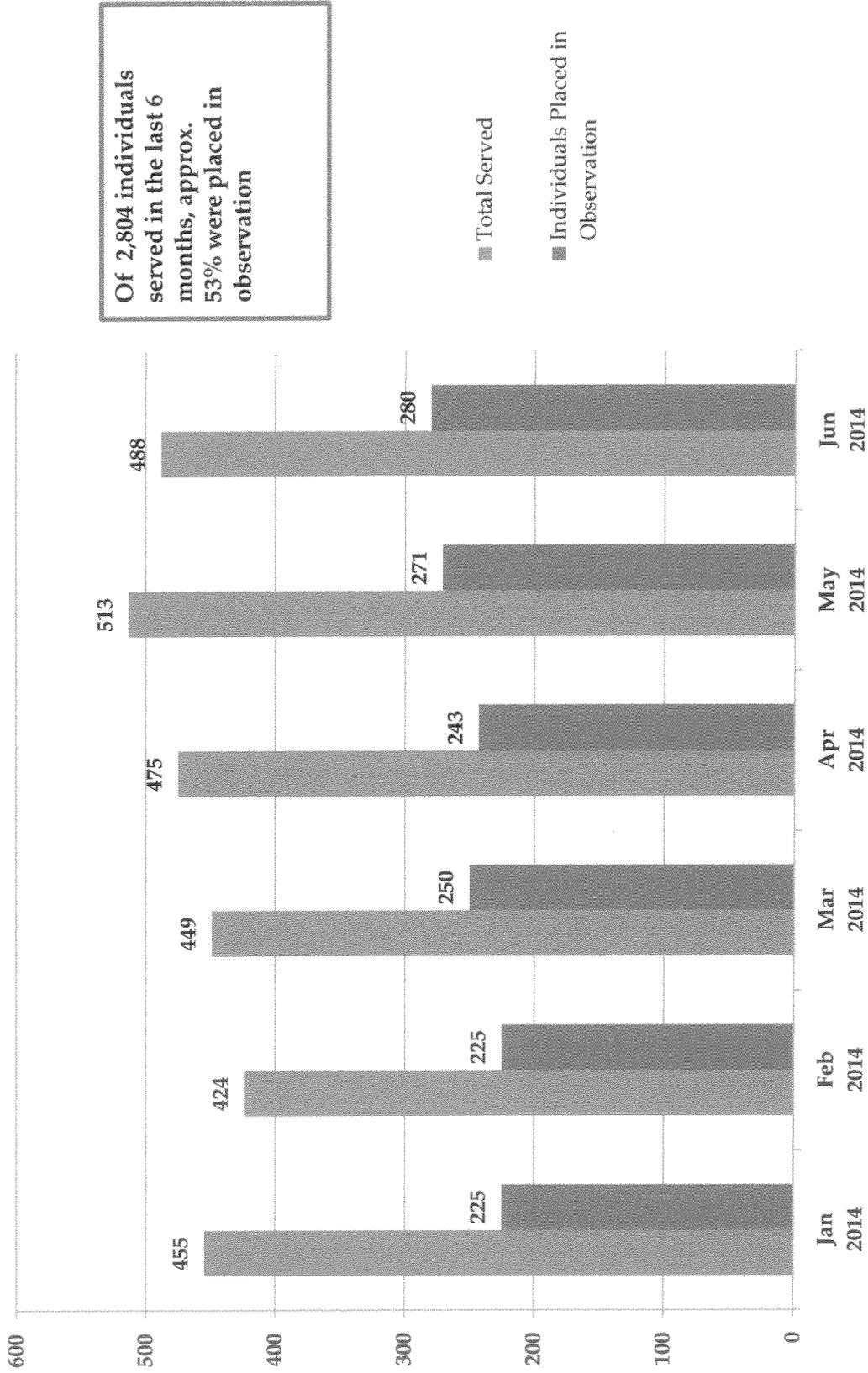
July 22, 2014

Crisis Care Center

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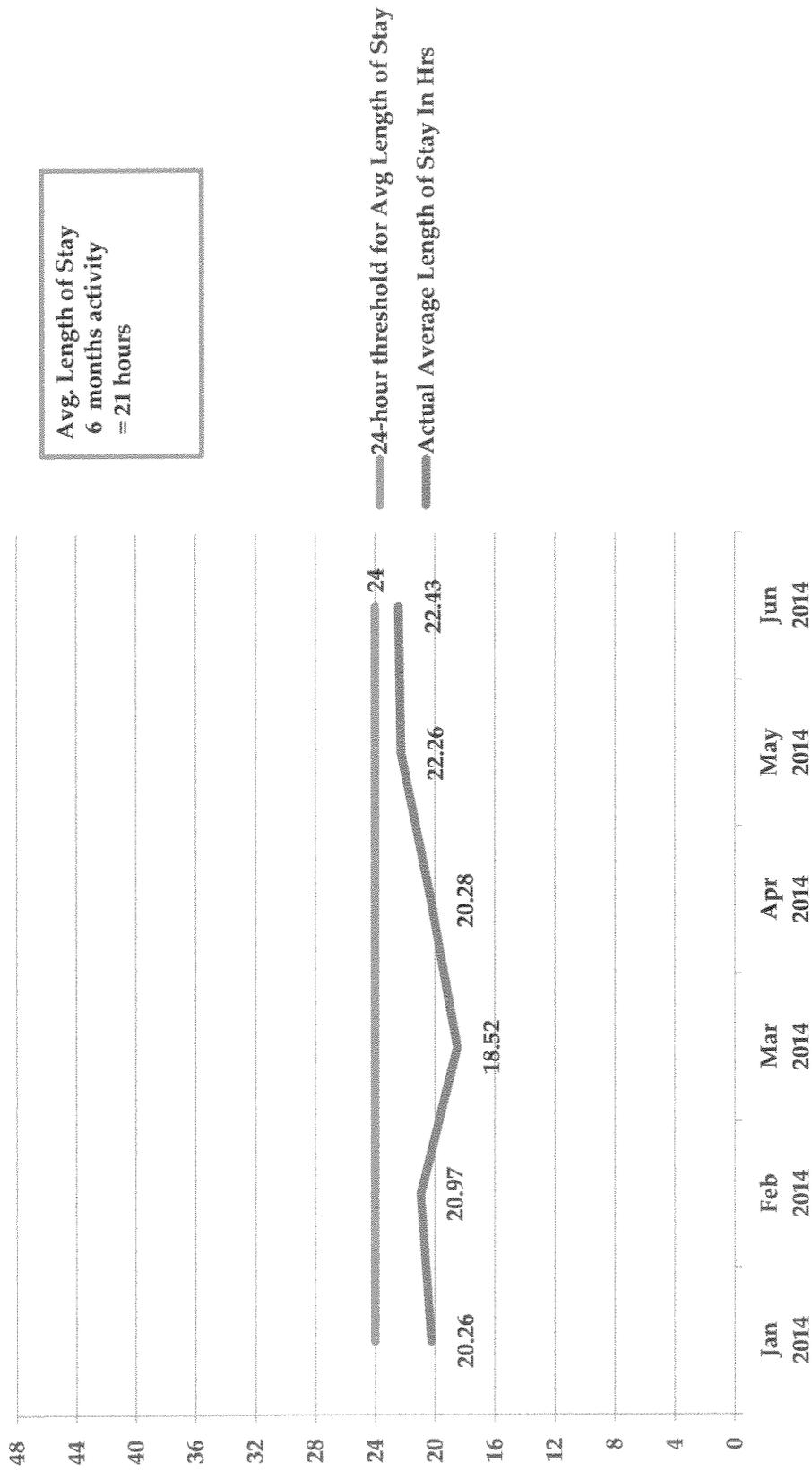
June 2014

- Crisis Care Center - Individuals Placed in Observation -

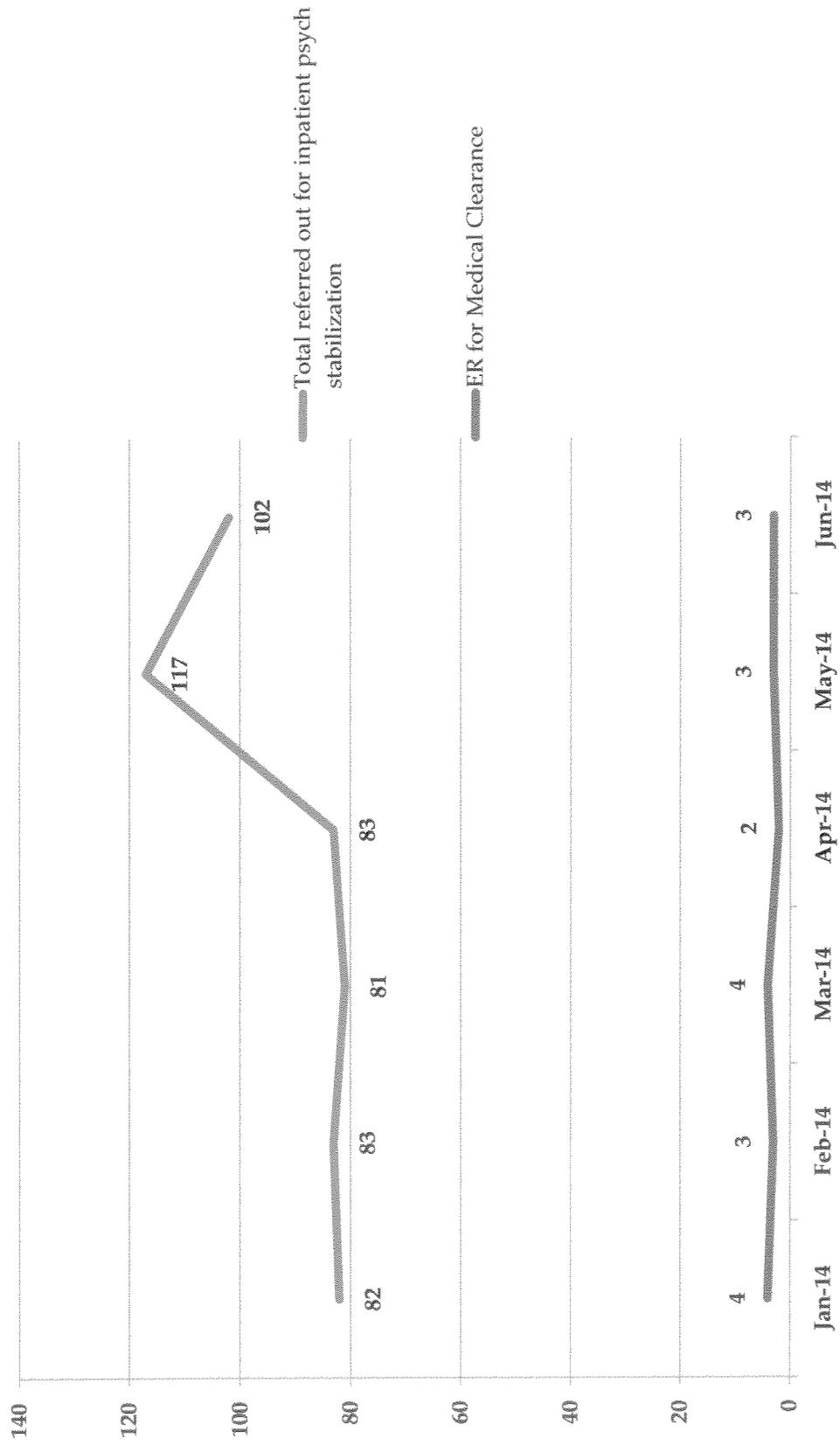


Crisis Care Center * Individuals in Observation

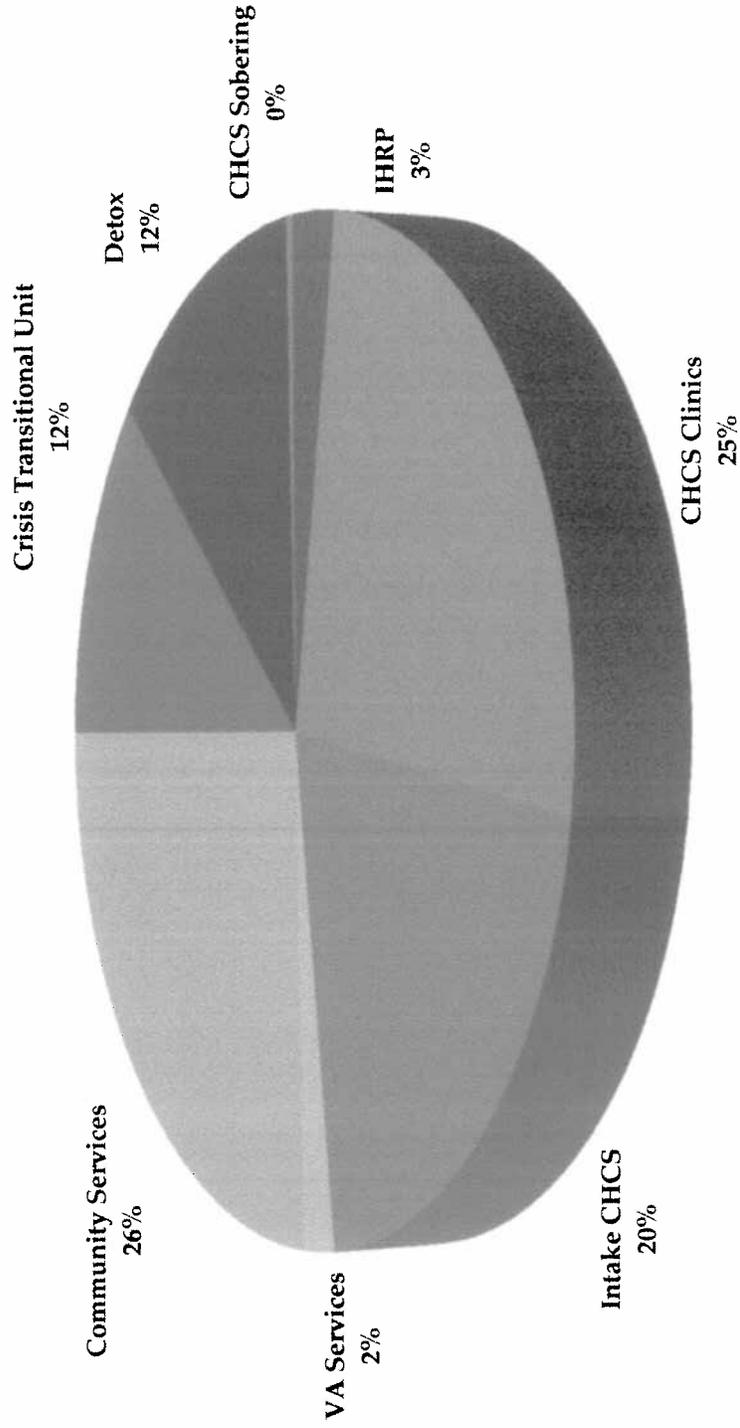
Avg. Length of Stay
6 months activity
= 21 hours



- Crisis Care Center - Hospital Referrals -



Crisis Care Center Disposition/Referrals 6 month activity

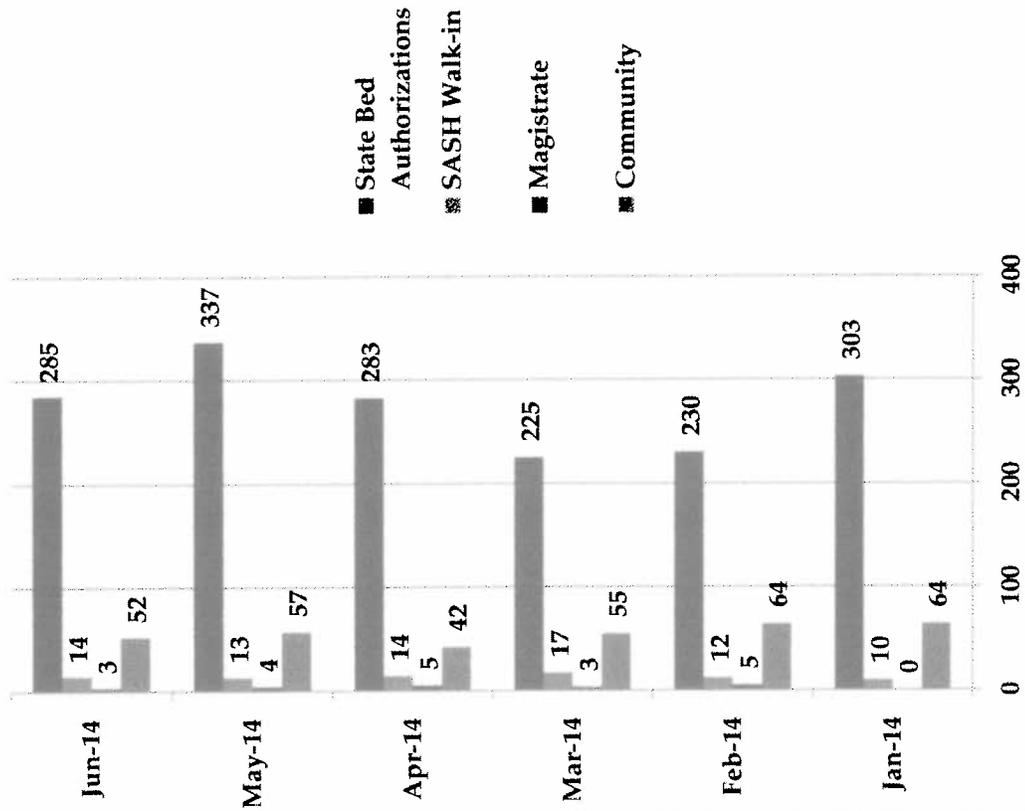


MCOT

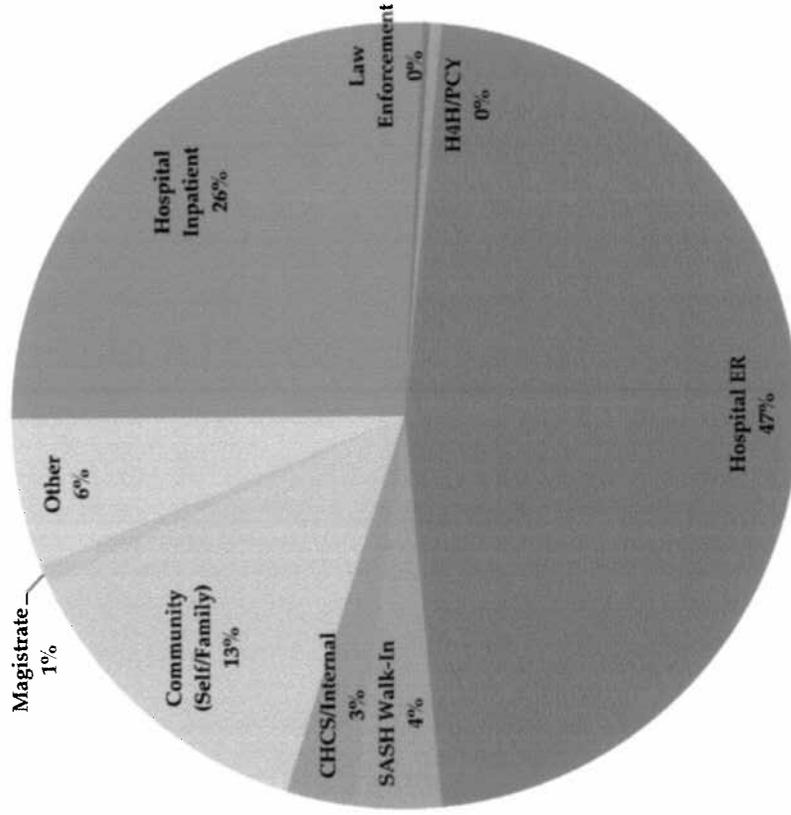
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June 2014

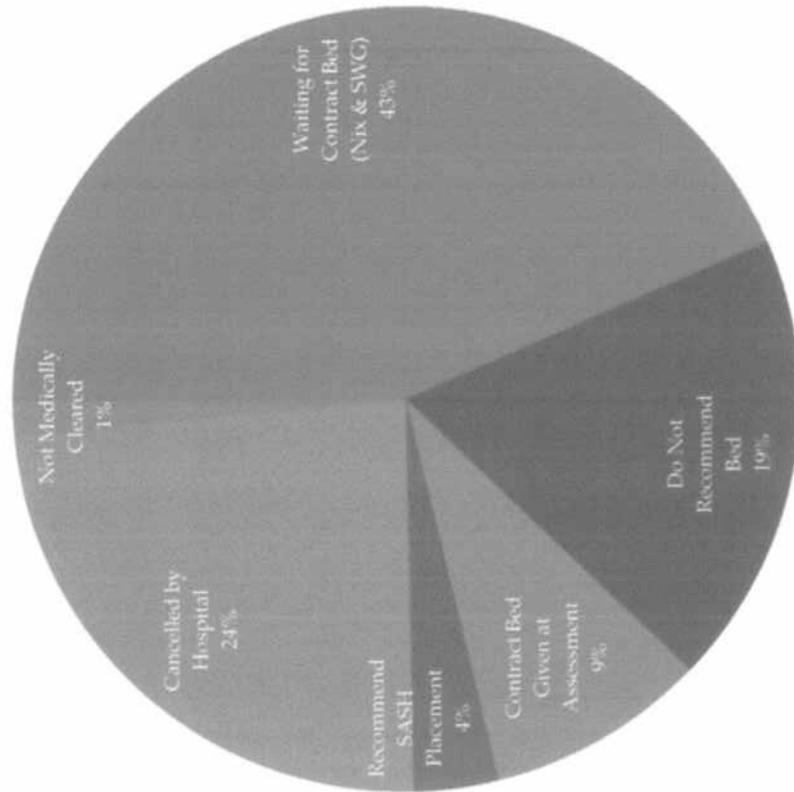
Referrals to MCOT - 6 month activity



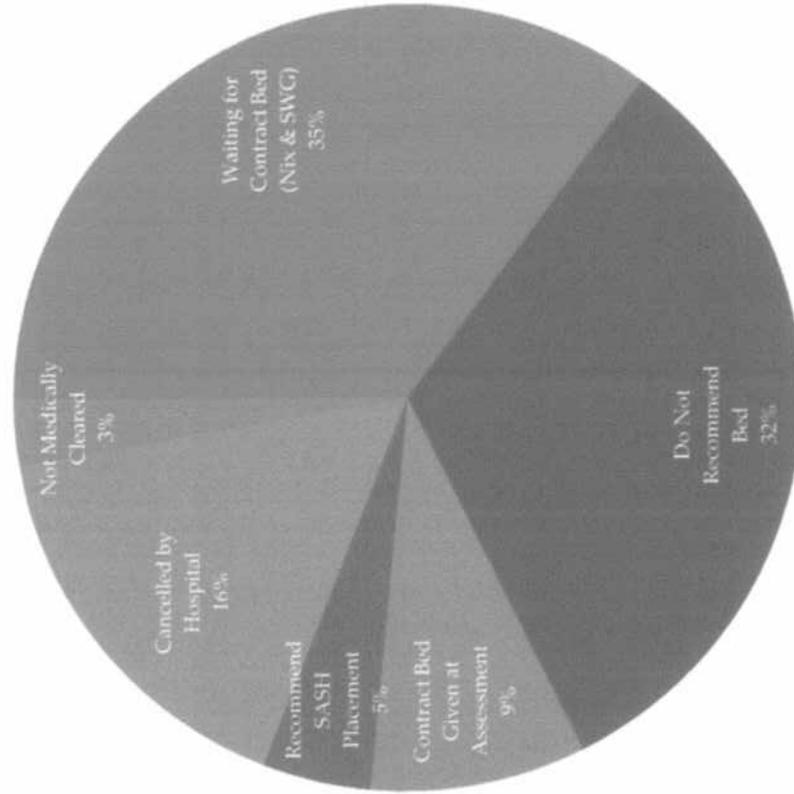
Breakdown of Referrals to MCOT - June 2014



MCOT-Hospital Referral Dispositions - May 2014



MCOT-Hospital Referral Dispositions - June 2014

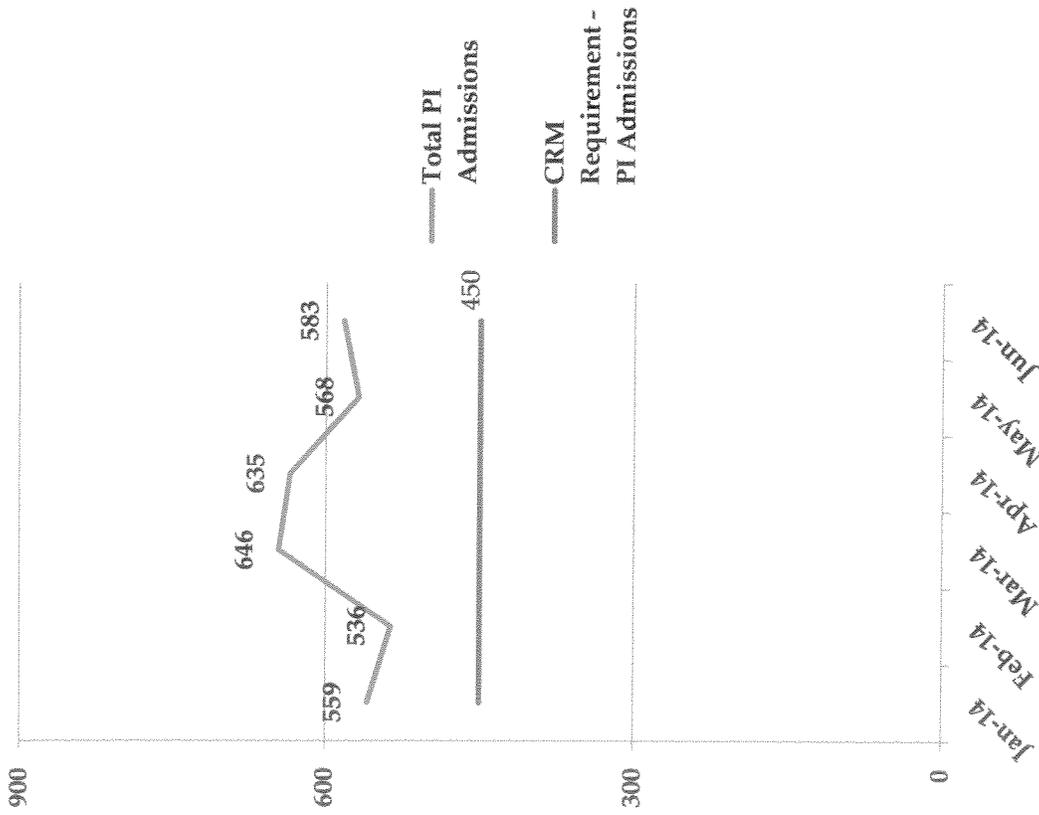


Sobering

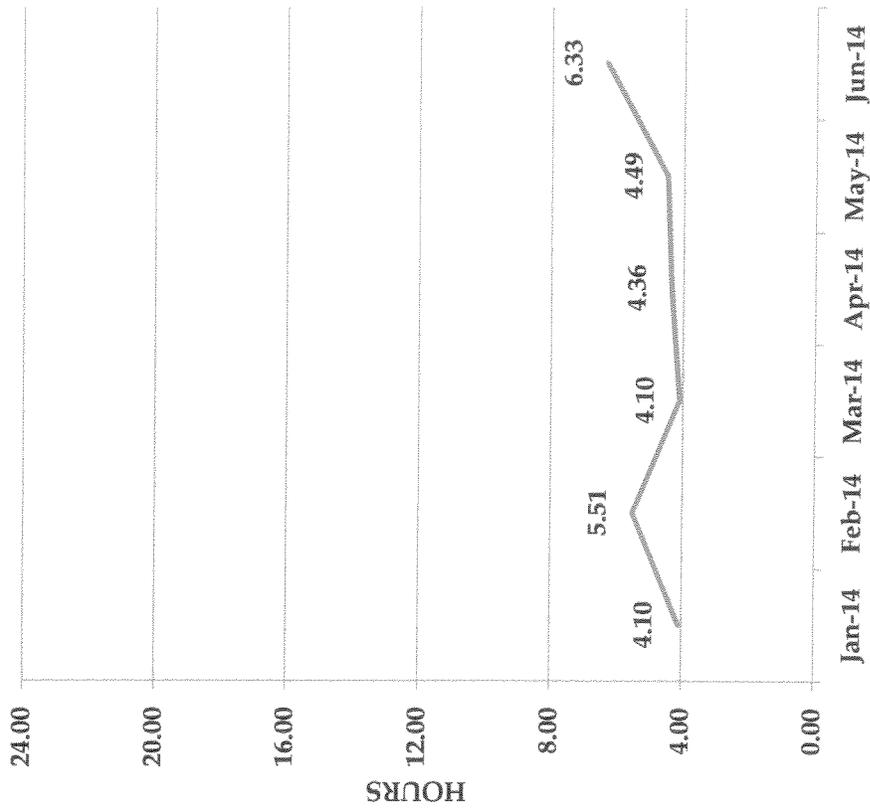
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June 2014

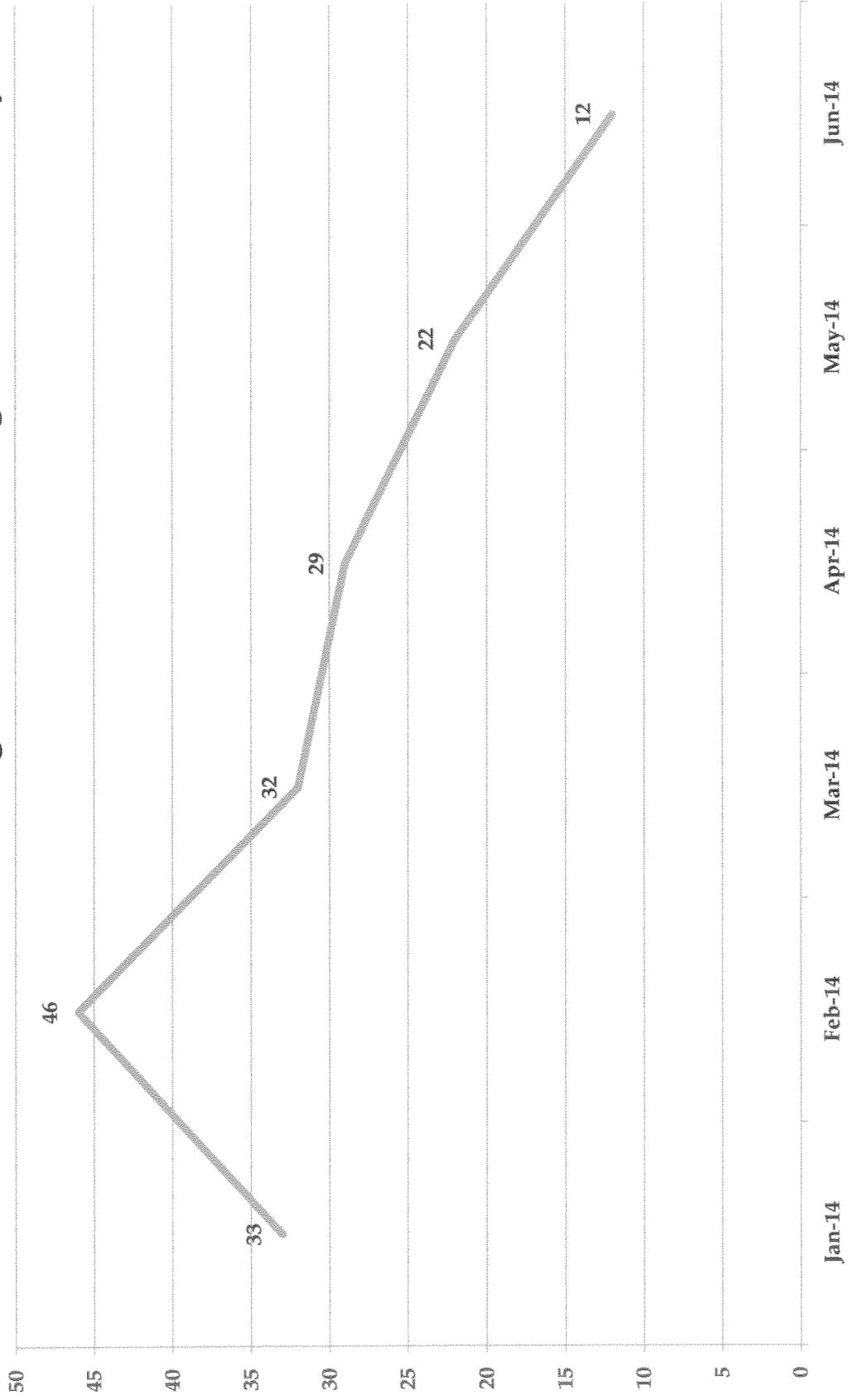
Sobering - PI Admissions



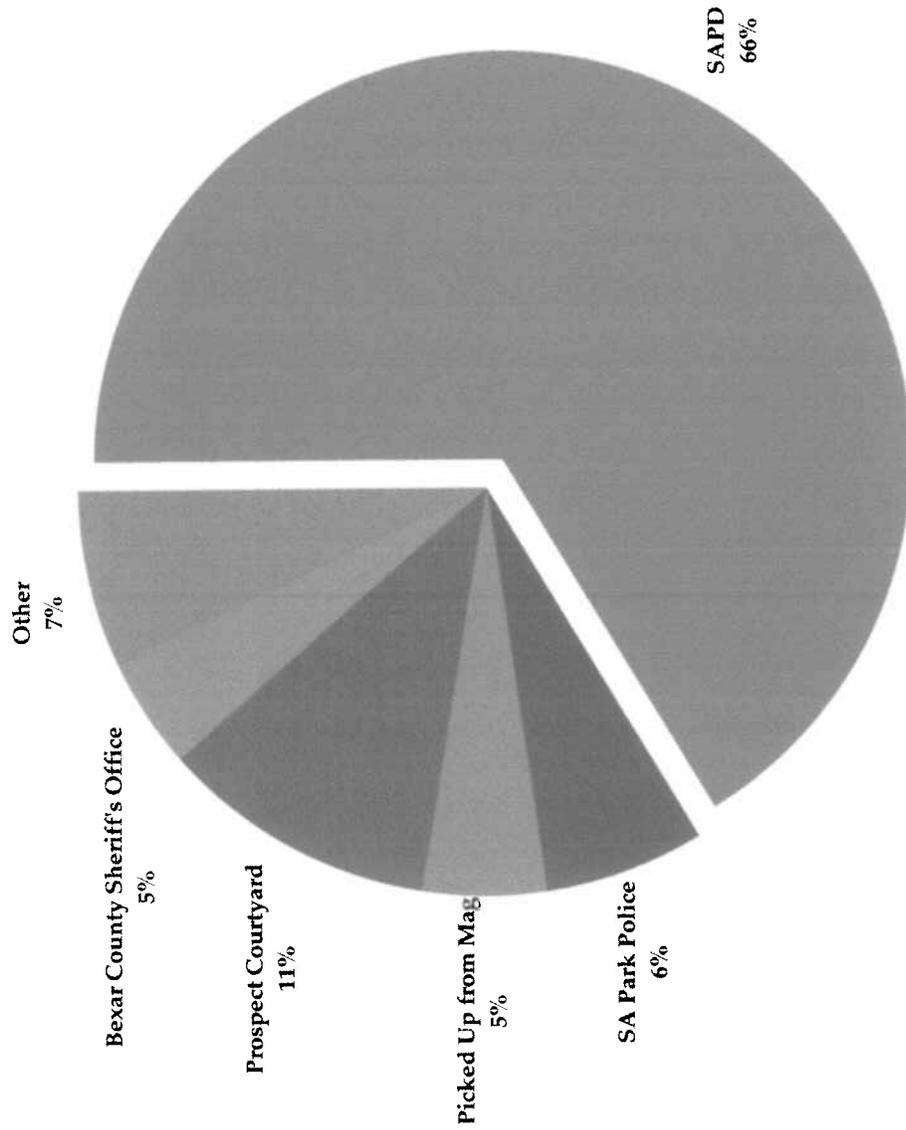
Sobering - Average Hours per Stay



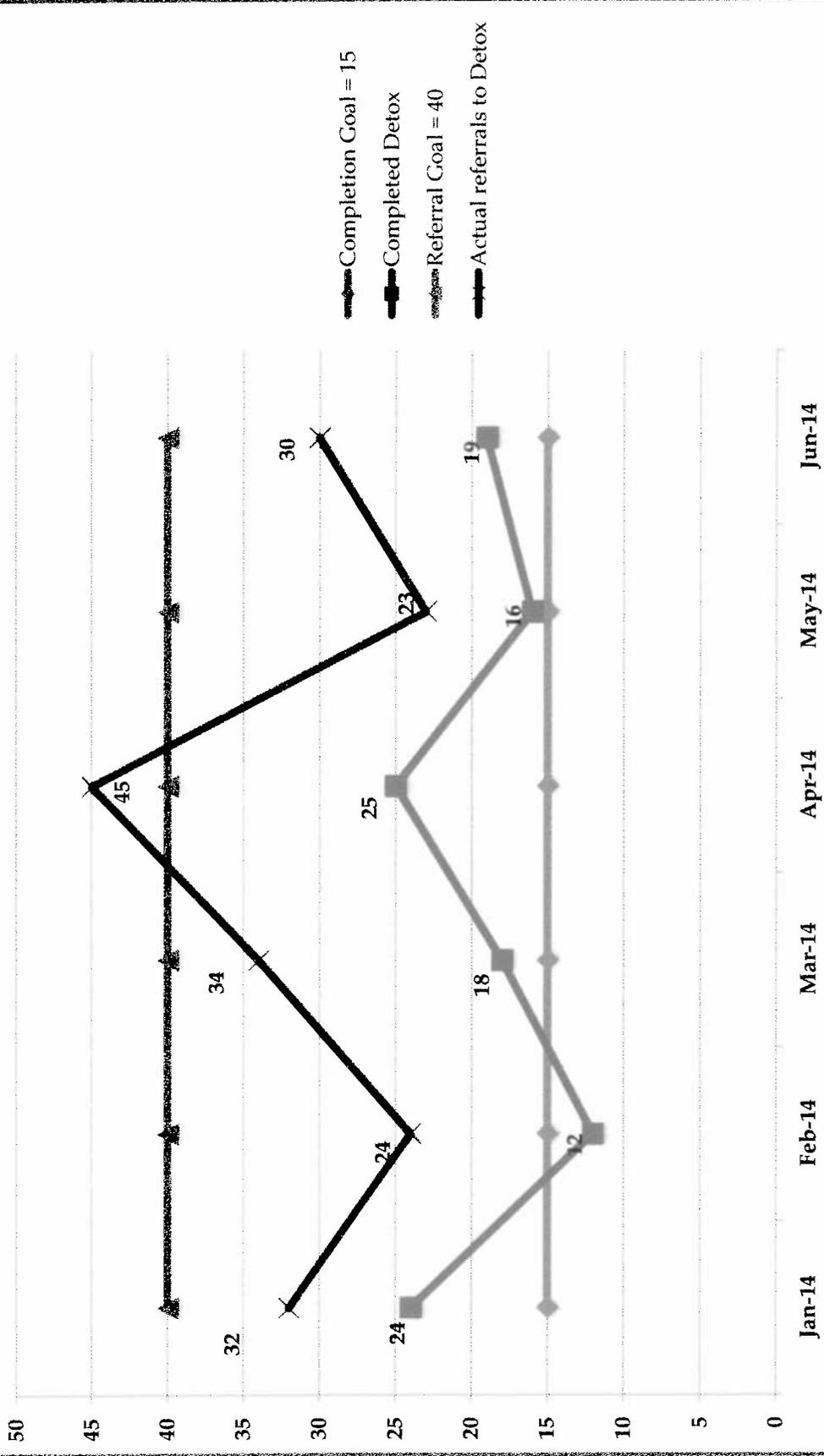
PI's Diverted from Magistrate to Sobering - 6 month activity



Sobering - Referral Sources 6-month activity (Jan-June 2014)



Referrals to Detox from Sobering 6-month activity

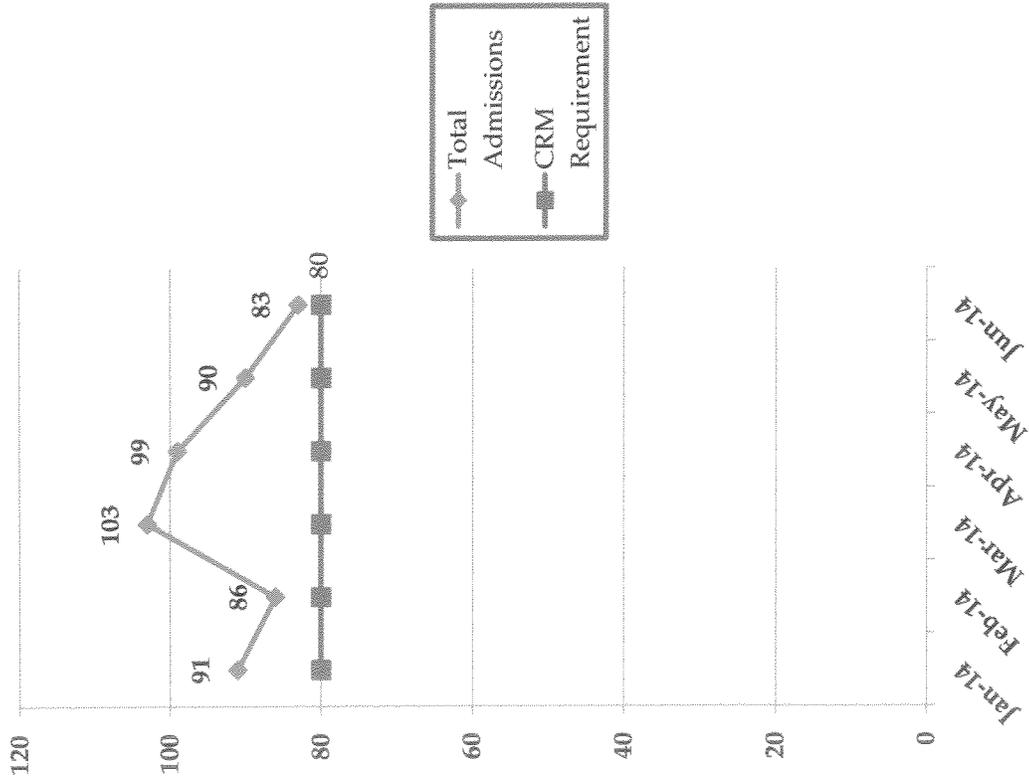


Minor Medical

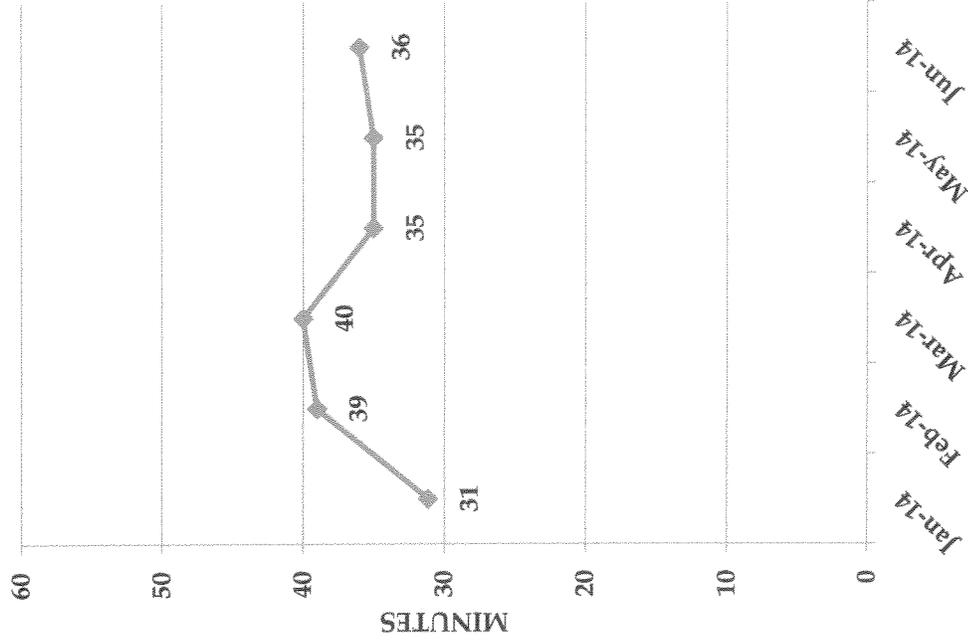
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June 2014

Minor Medical Admissions

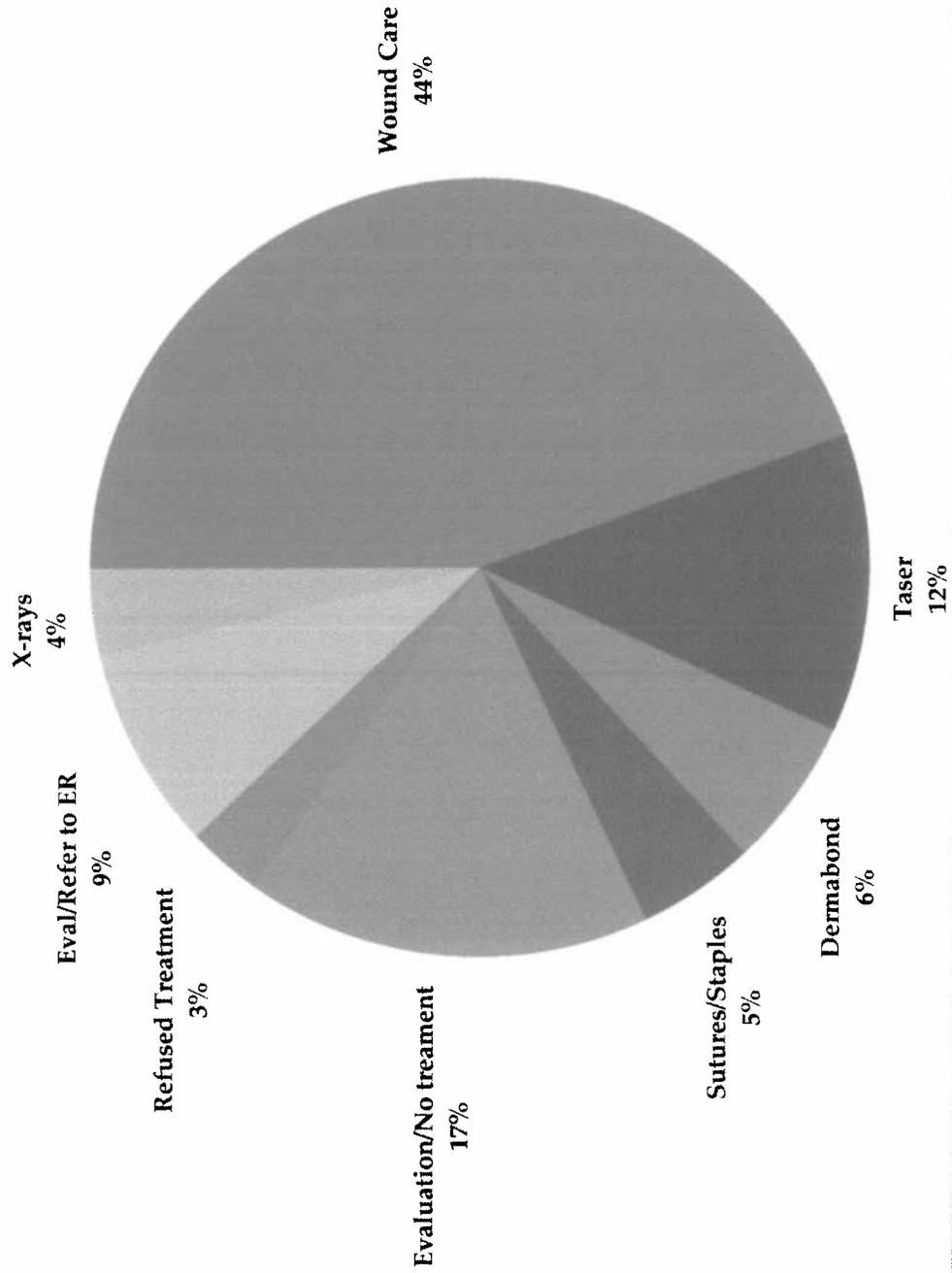


Minor Medical Clinic - Avg. Minutes Per Stay

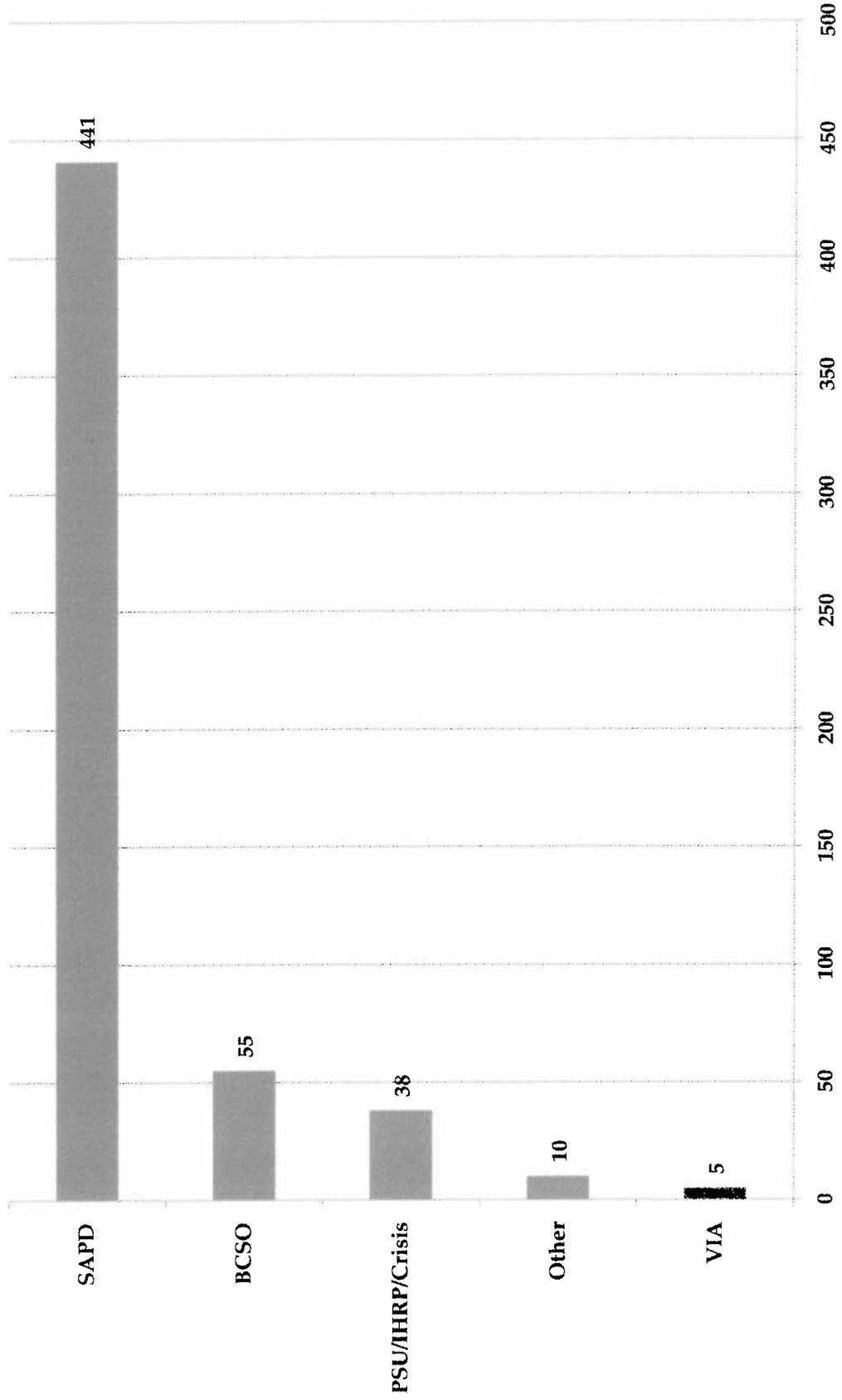


Minor Medical Clinic - Procedures Breakdown

6-month activity



Minor Medical Clinic - Total Referral Sources (Jan - June 2014)

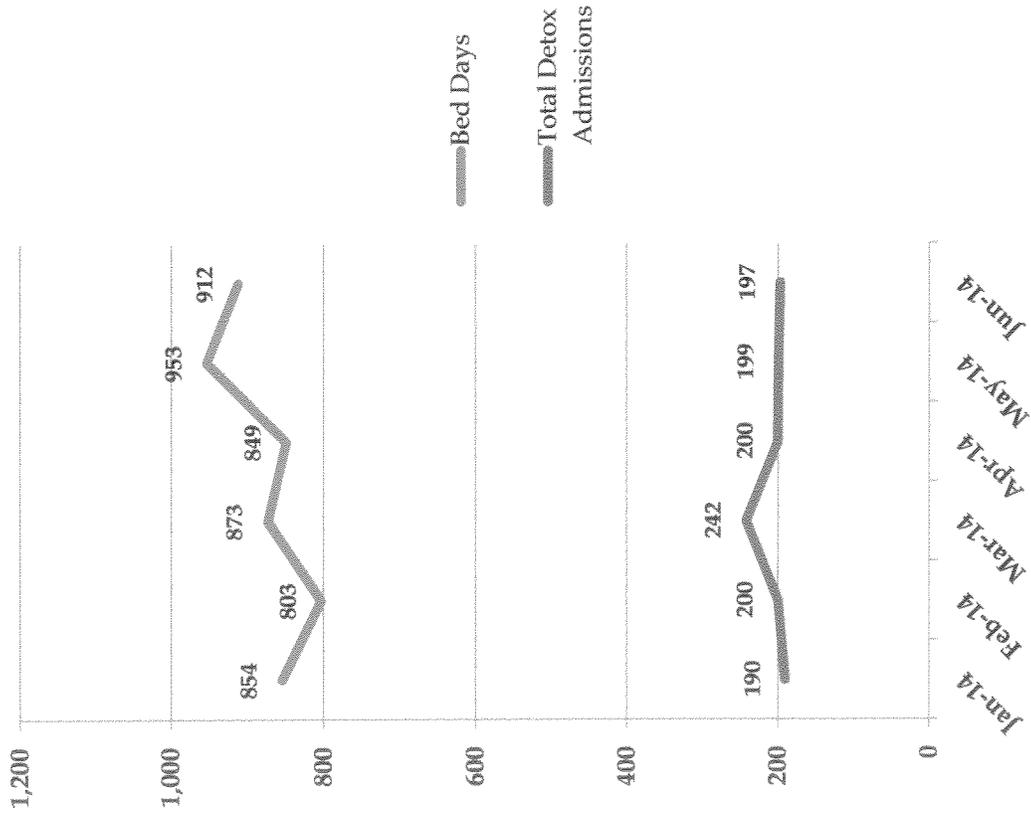


Detox

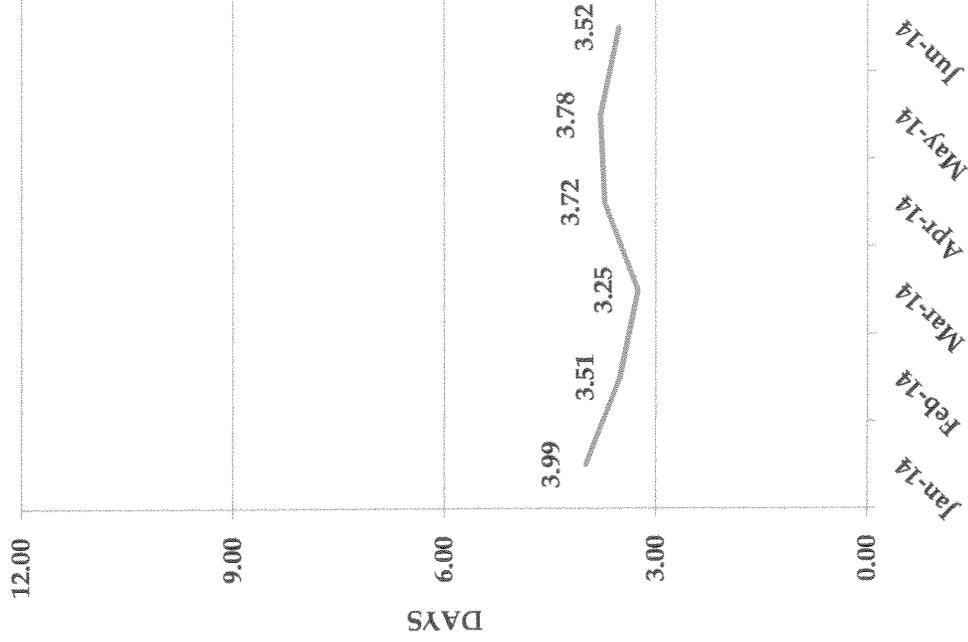
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June 2014

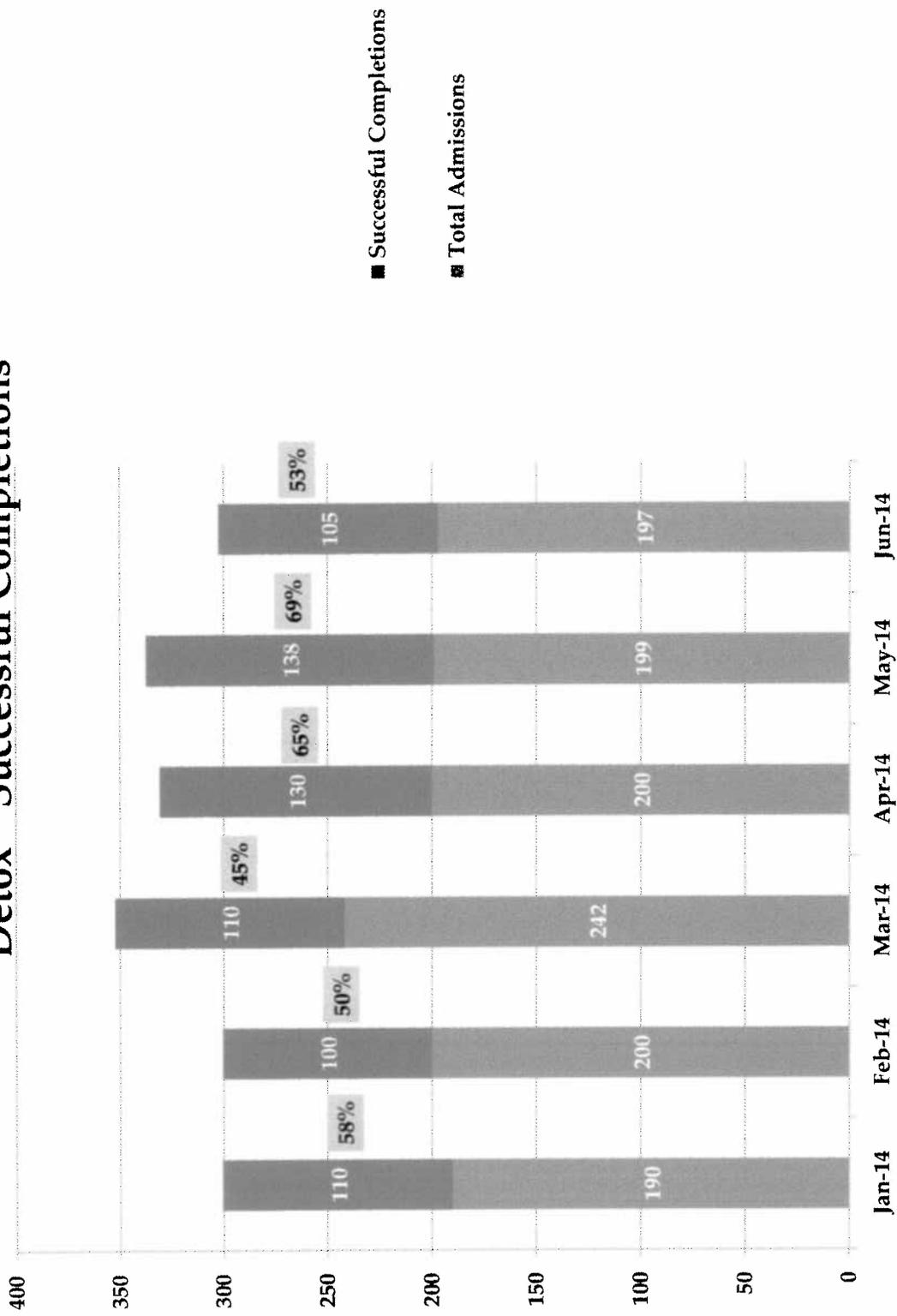
Detox Unit - 6-month activity



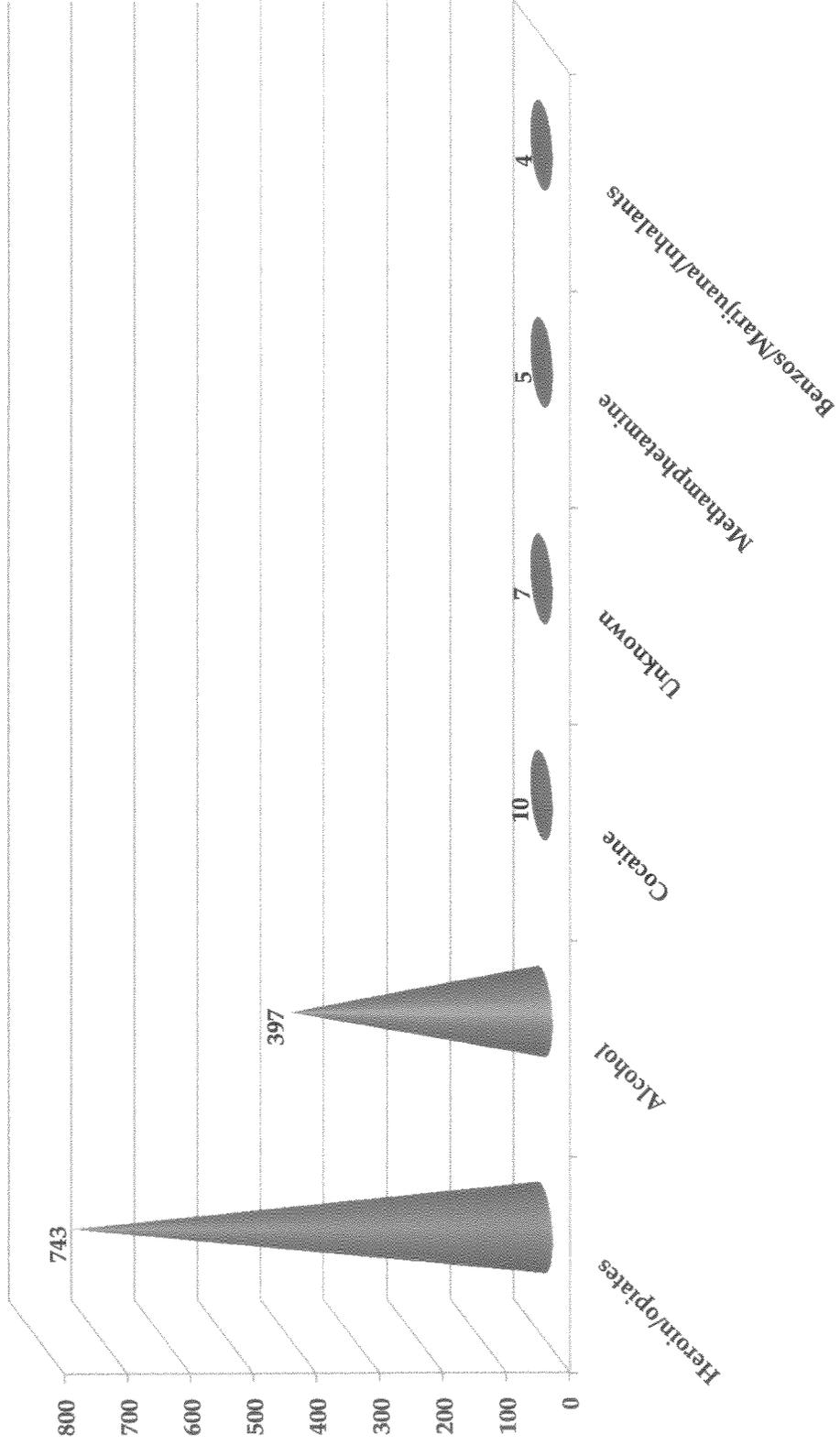
Detox * Average Length of Stay



Detox * Successful Completions



Detox * Primary Substance 6-month activity (Jan - June 2014)

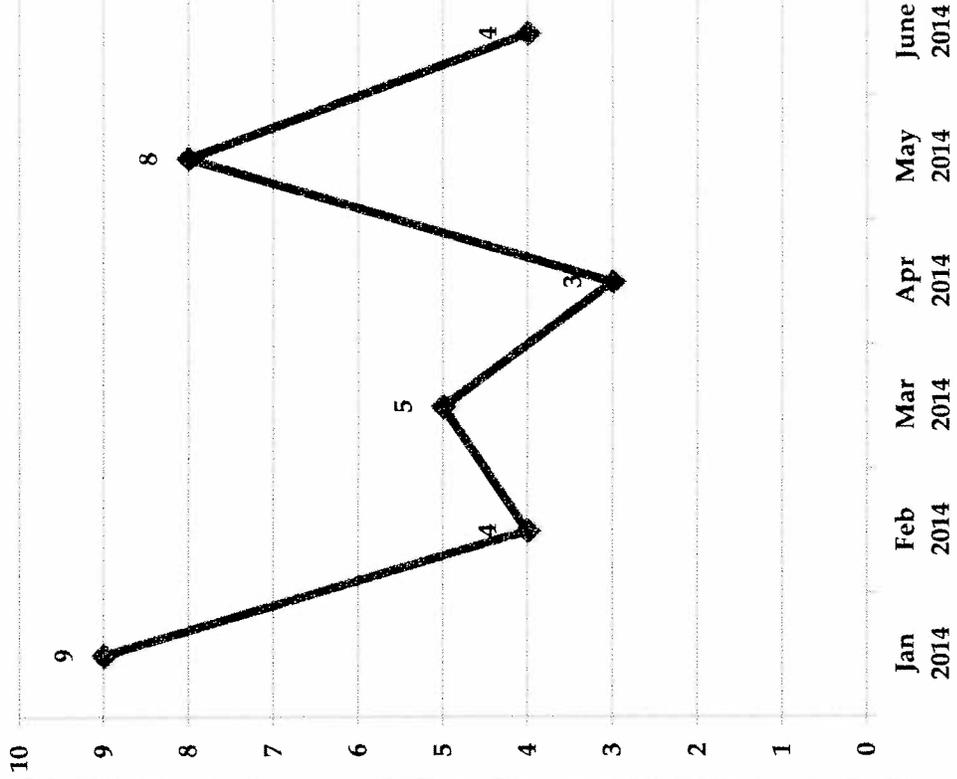


IHRP

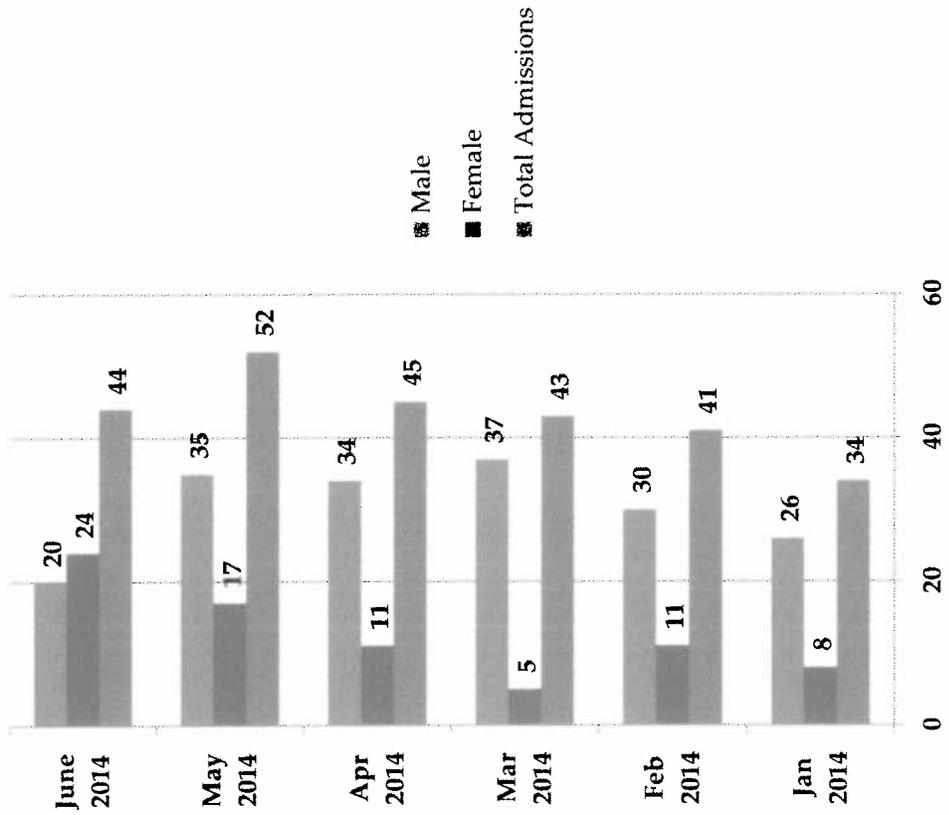
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June 2014

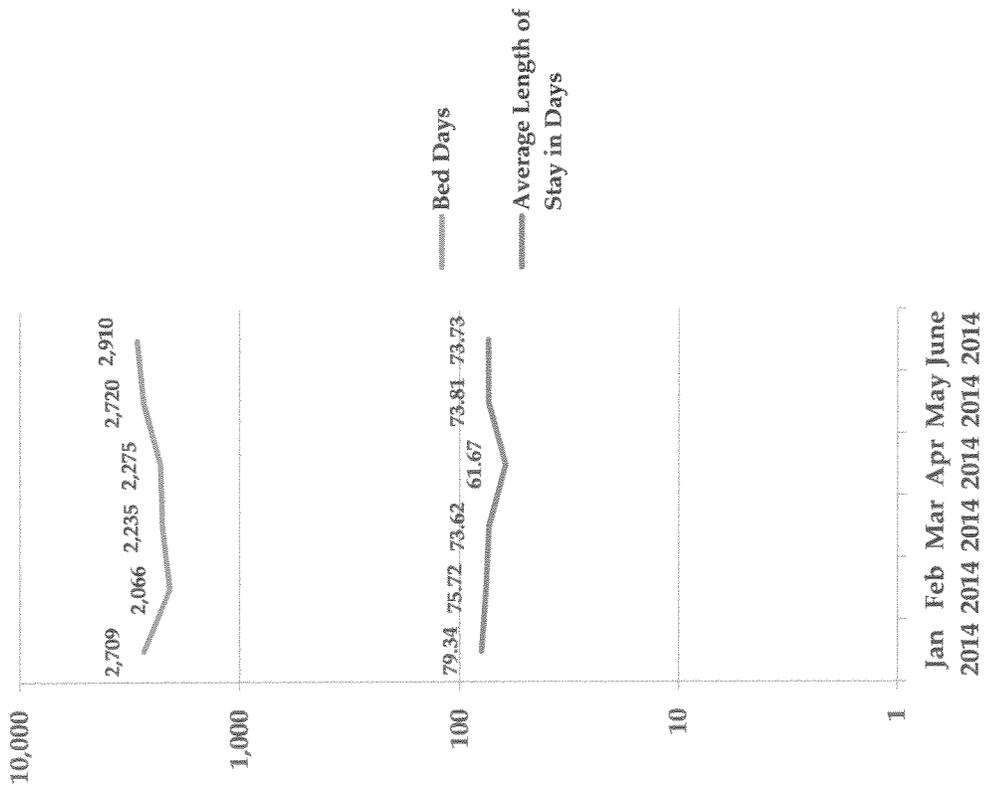
**- IHRP Veterans Served -
6 month activity - 33**



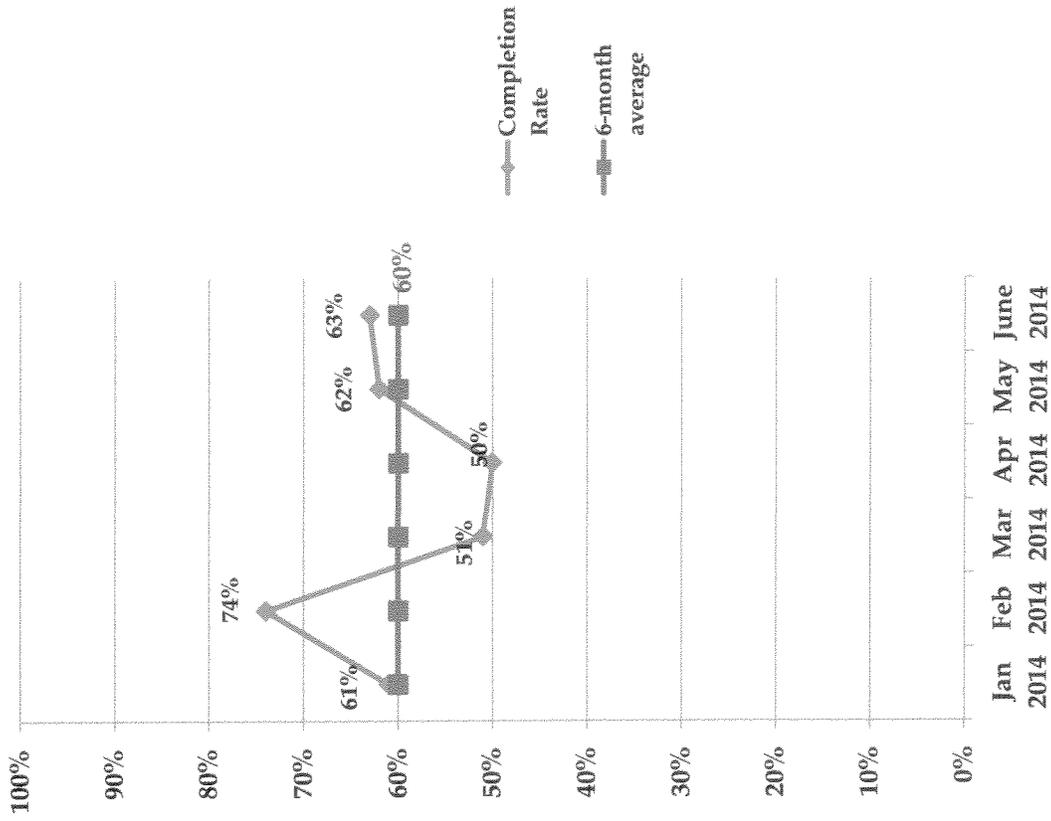
**- IHRP Admissions -
6 month activity - 259**



- IHRP - Bed Day Count -



IHRP Completion Rates

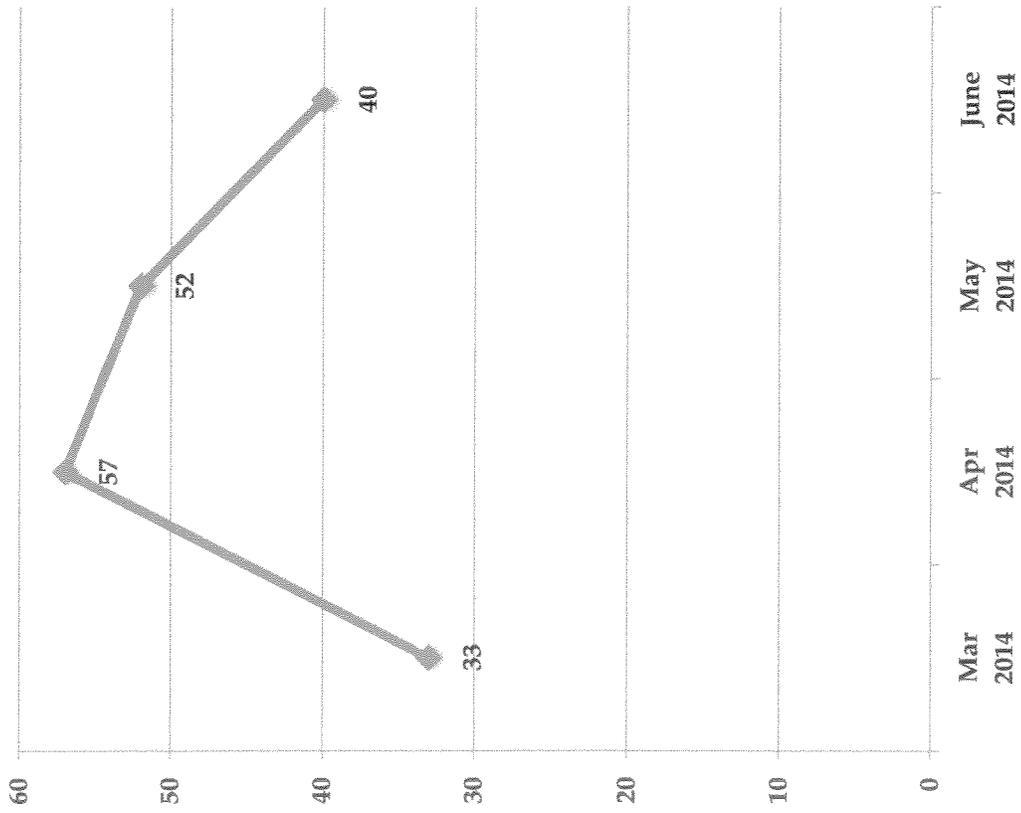


CTU

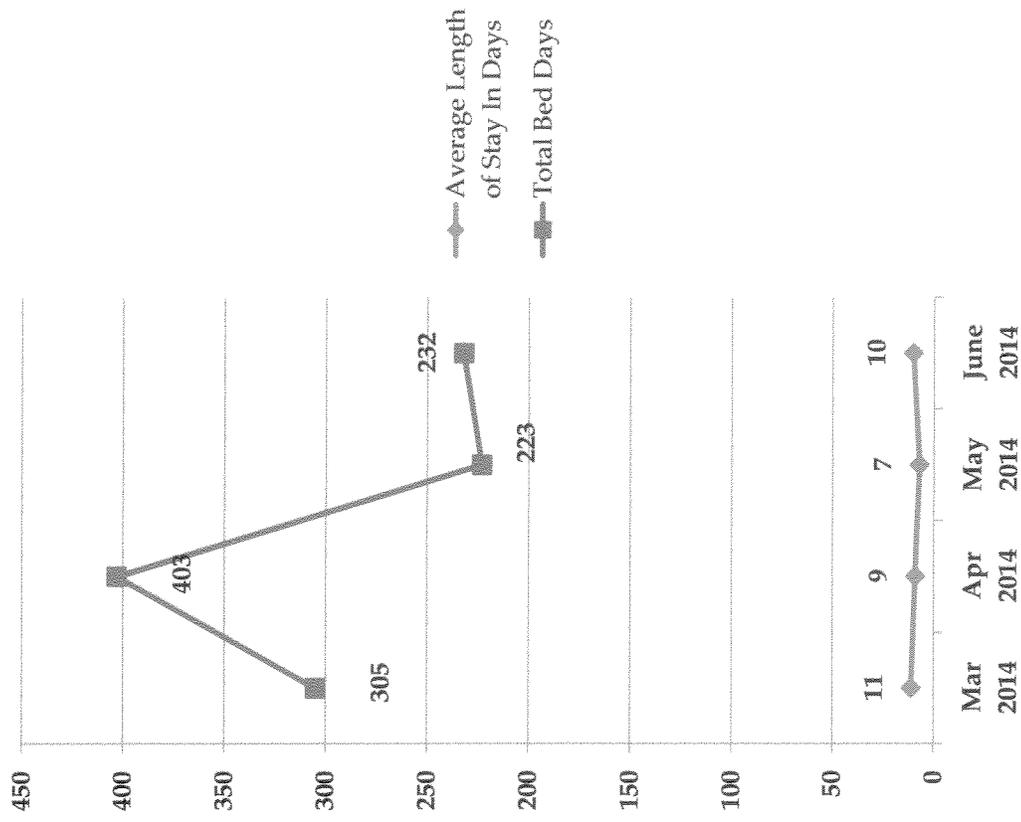
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June 2014

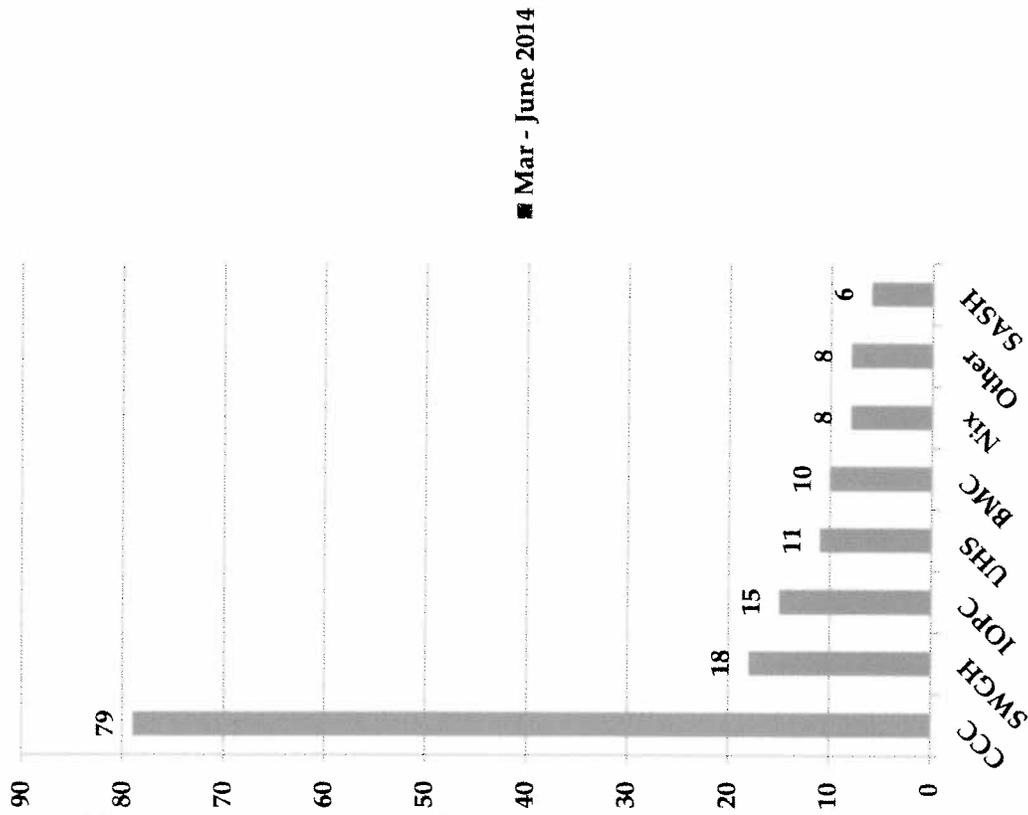
Total CTU Admissions



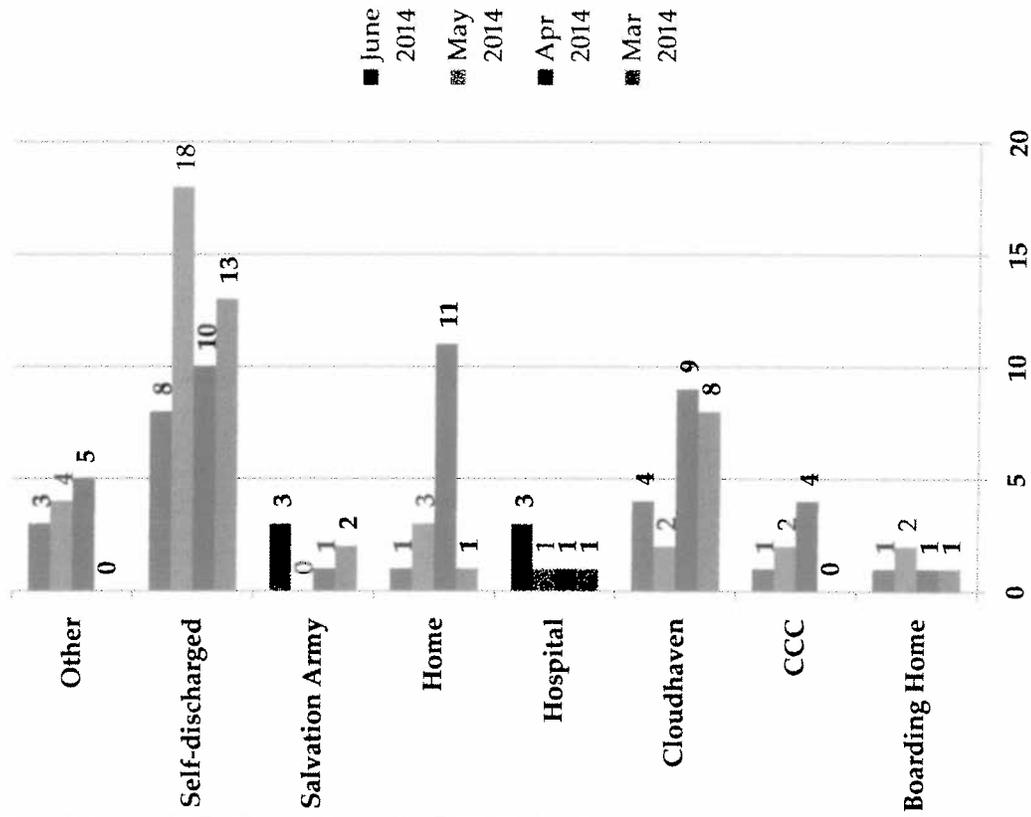
CTU Bed Days



CTU Referral Sources



CTU Discharge Disposition



-Conclusion- Restoration Center Report

Community Medical Directors

Round Table

July 22, 2014