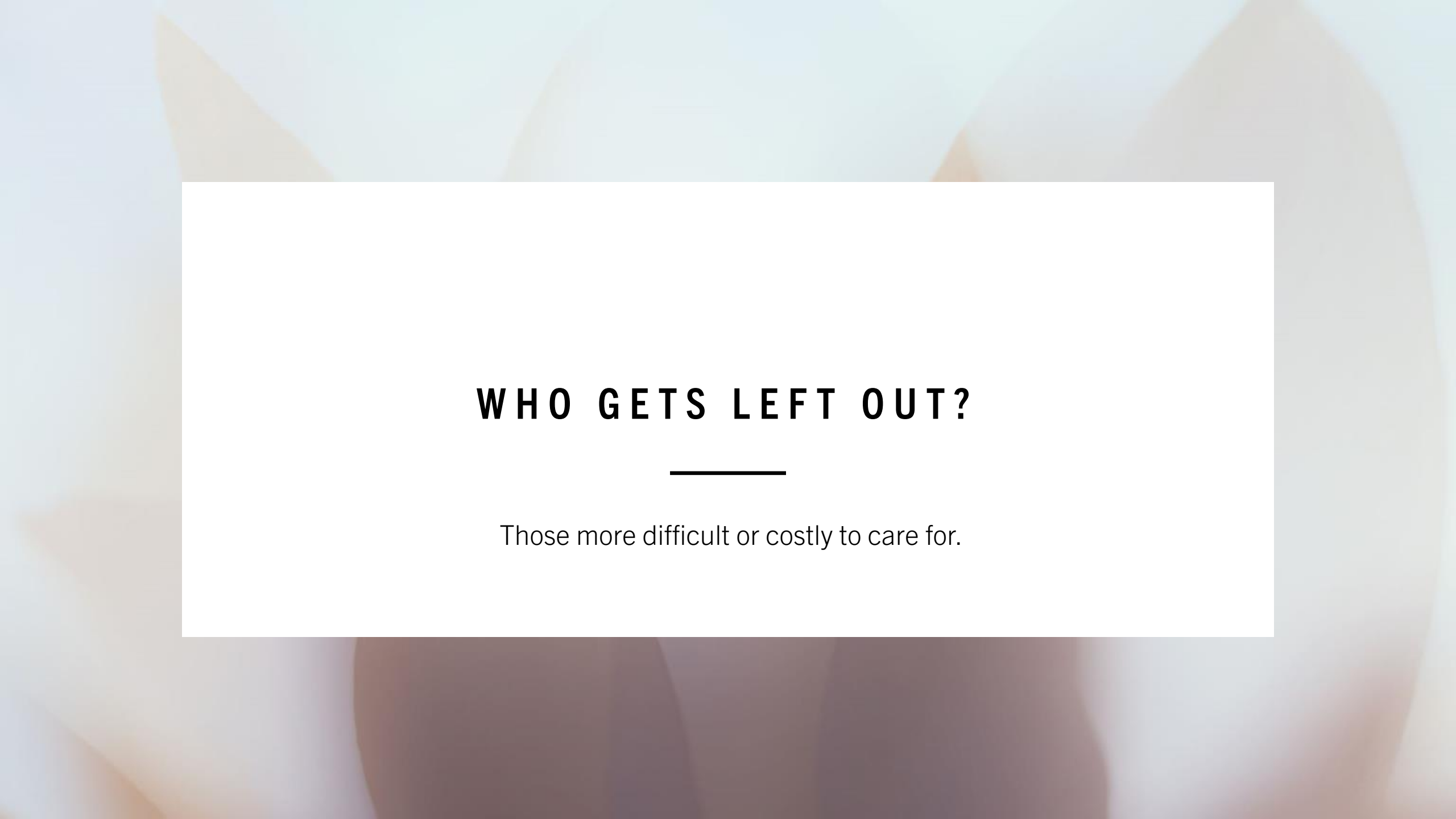

WHO GETS LEFT OUT?

Those more difficult or costly to care for.

PATIENTS WITH MEDICAL CO-MORBIDITIES

- Examples:
- Major Neurocognitive Disorder with Behavioral Disturbance
- Comorbid psychiatric and medical conditions making care costly and often beyond capability of most psychiatric hospitals
- Needing LTC enrollment to place
- Not eligible for LTC yet, but with functional limitations needing some hands-on care
- Stigma and concerns about risk and expense lead to SNFs refusing to take patients with serious mental illness, even when symptoms in good control

CHRONIC SEVERE DANGEROUS TO SELF AND/OR OTHERS BEHAVIORS

- Chronic self-injury (eg, swallowing) requiring repeated medical interventions and long-term 1:1 monitoring
- Self-starvation requiring tube feeding
- Treatment-resistant psychosis (may have ASPD in addition) leading to repeated aggression

NEURODEVELOPMENTAL DISORDERS

- Often need specialized environments and treatment interventions beyond the expertise of most psychiatric hospitals
- May be refused due to concerns they will adversely affect the experience of other patients
- Long delays for placement once discharge ready; hospital concerns about medically unnecessary days leading to lack of payment

POTENTIAL SYSTEM-LEVEL SOLUTIONS:

1) Payors provide higher rate of payment for high acuity/more costly patients

2) State licensing agencies require licensed acute care psychiatric hospitals to be able to treat a broader range of acuity

3) States have similar system and funding mechanism for psychiatric hospitals willing to take the most difficult patients, similar to the system for Level 1 Trauma Centers.

3) Payors required to continue payment at the acute rate if enrollee is discharge ready to a lower level of care, which is covered by the plan, but no contracted facility is willing to accept the patient

SYSTEMS SOLUTIONS, CONTINUED:

4) Expedited enrollment process for Medicaid programs (including LTC) for psychiatric inpatients and those who are homeless.

5) Expedited process for obtaining temporary emergency guardians for patients requiring this for placement from the hospital, and/or change in regulations to allow placement under an outpatient civil commitment order

6) Requirement for parity when SNFs evaluate referrals from psychiatric vs. med/surg hospitals

SYSTEMS SOLUTIONS, CONTINUED:

- DDD to develop step-down options from the hospital, as well as respite care facilities/group homes for individuals who need new placements but don't need a hospital
- AHCCCS to prioritize development of a specialized inpatient unit for adults with developmental disorders and severe behavioral symptoms, similar to the current Aurora Special Needs Unit developed for adolescents.

PRACTICAL STEPS:

- Recommend, if hospitalization is necessary and patient is voluntary and safe to transport, that family take patient to an ED which is part of a hospital with a psychiatric unit
- Understand the functional impairment checklist for ALTCS and help family be prepared with relevant information for this assessment
- Become knowledgeable about treatment options for behavioral disturbances manifested by individuals with dementia or developmental disorders so you can attempt to stabilize before they lose their housing
- Consider clozapine earlier for individuals with severe, repetitive aggressive behaviors.

PRACTICAL STEPS, CONTINUED:

- Understand medical necessity criteria for inpatient hospital care and aggressively appeal attempts to deny continued stay
- Consider referral for an ACT team for individuals who are SMI and require frequent hospitalizations with poor outpatient adherence, but have family willing to provide them housing.