SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: SB 1154
AUTHOR: Eggman
VERSION: February 16, 2022
HEARING DATE: March 30, 2022
CONSULTANT: Reyes Diaz

SUBJECT: Facilities for mental health or substance use disorder crisis: database

SUMMARY: Requires the California Department of Public Health, by January 1, 2024, to develop a real-time, Internet-based database to collect, aggregate, and display information about available beds to treat those in mental health or substance use disorder crisis, as specified.

Existing law:
1) Requires the California Department of Public Health (CDPH) to license and regulate hospitals, including a general acute care hospital and an acute psychiatric hospital. [HSC §1250, et. seq.]

2) Requires the Department of Health Care Services (DHCS) to license and regulate residential alcoholism or drug abuse recovery or treatment facilities (RTFs). [HSC §11834.02, et seq.]

3) Requires DHCS and counties to provide specialty mental health services for Medi-Cal beneficiaries through a county mental health plan, as specified, which may include crisis stabilization services and inpatient psychiatric care. [WIC §14705 and 14712]

4) Requires the Department of Social Services (DSS) to license community care facilities, including any facility, place, or building that is maintained and operated to provide nonmedical residential care, day treatment, adult day care, or foster family agency services for children, adults, or children and adults, including, but not limited to, the physically handicapped, mentally impaired, incompetent persons, and abused or neglected children, and may include crisis residential services. [HSC §1501, et seq.]

5) Establishes psychiatric health facilities, licensed by DHCS, which provide 24-hour inpatient care for people with mental health disorders that includes, but is not limited to, the following basic services: psychiatry; clinical psychology; psychiatric nursing; social work; rehabilitation drug administration; and, appropriate food services for those persons whose physical health needs can be met in an affiliated hospital or in outpatient settings. [HSC §1250.2 and WIC §4080]

6) Establishes the Lanterman-Petris-Short (LPS) Act, which authorizes a person to be involuntarily detained for a period of up to 72 hours for assessment, evaluation, and crisis intervention (known as a "5150" hold), when as a result of a mental disorder the person is a danger to self or others, or is "gravely disabled,". Defines "gravely disabled" as a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter. [WIC §5008 and 5150]

7) Requires facilities, for the purposes of detaining a person for up to 72-hour treatment and evaluation, to be designated by a county and approved by DHCS, which may be a licensed psychiatric hospital, a licensed psychiatric health facility (PHF), and a certified crisis stabilization unit (CSU). [WIC §5008]

This bill:

1) Requires CDPH, in consultation with DHCS and DSS, to develop a real-time, Internet-based database to collect, aggregate, and display information about beds in inpatient psychiatric facilities, CSUs, residential community mental health facilities, and licensed RTFs in order to facilitate the identification and designation of facilities for the temporary treatment of individuals in mental health or substance use disorder (SUD) crisis. Requires the database to be operational by January 1, 2024.

2) Requires the database to include, at a minimum, all of the following:

   a) The contact information for the facility's designated employee;
   b) The facility's license type;
   c) Whether the facility provides SUD, mental health, or medical treatment;
   d) Whether the bed is secure for the treatment of a person placed on a 5150 hold;
   e) The types of diagnoses for which the bed is appropriate;
   f) The age ranges for which the bed is appropriate; and,
   g) Whether the bed is available.

3) Prohibits the database from including information relating to hospitals under the jurisdiction of the Department of State Hospitals.

4) Requires the database to have the capacity to both collect data and enable searches to identify beds that are appropriate for those in mental health or SUD crisis.

5) Requires CDPH to confer with stakeholders to inform the development of the database, including, but not be limited to, DHCS, DSS, the County Behavioral Directors Association (CBHDA), and organizations that have experience providing inpatient psychiatric care, psychiatric crisis stabilization, residential community mental health, and RTF services.

6) Requires CDPH and stakeholders to consider strategies for facility use of the database.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, while California has seen a small increase in the number of psychiatric beds since 2012, we are still falling well below nationally established standards of 40-60 beds per 100,000 adults and have 30% fewer beds than we had in 1995. Finding beds in this environment is hard. Hospital emergency departments (EDs) continue to be frontline responders in behavioral health crises, and often board patients until an open bed in an appropriate facility is found. The backdrop here is that 16% of California adults live with serious mental illness, and 60% of those individuals do not receive any treatment whatsoever. Identifying open beds so that timely transfers can take place expedites the connection to critical and badly needed treatment. It decreases adverse incidents and improves outcomes. Mental illness or SUDs, like many other health conditions, when treated early and with appropriate supports and services is less disabling with fewer serious

consequences. Bed registries are an essential tool to speed access to care and provide timely coordination between service settings. The online registry in this bill fits perfectly with current behavioral health infrastructure building initiatives, helping to map and connect patients and facilities and, as such, contributes to a badly needed transformation of our mental health system.

2) *Treatment beds in California.* According to a 2021 RAND report, California requires 50.5 inpatient psychiatric beds per 100,000 adults: 26.0 per 100,000 at the acute level and 24.6 per 100,000 at the subacute level, or 7,945 and 7,518 beds, respectively. At the community residential level, the estimated need is 22.3 beds per 100,000 adults. RAND estimated that California has a total of 5,975 beds at the acute level (19.5 per 100,000 adults) and 4,724 at the subacute level (15.4 per 100,000 adults), excluding state hospital beds. If state hospital beds are included, these figures increase to 7,679 (25.1 per 100,000 adults) and 9,168 beds (29.9 per 100,000 adults), respectively. RAND also observed large regional variation. For example, excluding state hospitals, acute bed capacity ranged from 9.1 beds per 100,000 adults in the Northern San Joaquin Valley to 27.9 beds per 100,000 adults in the Superior region. For subacute bed capacity, regional estimates ranged from 7.4 to 31.8 beds per 100,000 adults. At the community residential level, RAND estimated that California has a total of 3,872 beds (12.7 per 100,000 adults). California has a shortfall of approximately 1,971 beds at the acute level (6.4 additional beds required per 100,000 adults) and a shortage of 2,796 beds at the subacute level (9.1 additional beds required per 100,000 adults), or 4,767 subacute and acute beds combined, excluding state hospital beds. If state hospitals were included in this estimate, the shortage of acute inpatient beds would shrink to 267, and there would be no observable shortage in beds at the subacute level. Separately, RAND estimated a shortage of 2,963 community residential beds.

3) *Crisis residential programs and crisis stabilization.* According to a 2010 report by the California Mental Health Planning Council, crisis residential programs are a lower-cost, community-based treatment option in home-like settings that help reduce ED visits and divert hospitalization and incarcerations. These programs include peer-run programs, such as crisis respites that offer safer, trauma-informed alternatives to psychiatric emergency units or other locked facilities. Crisis residential programs help reduce unnecessary stays in psychiatric hospitals, reduce the number and expense of ED visits, and divert inappropriate incarcerations while producing the same or superior outcomes to those of institutionalized care. Crisis stabilization services are those lasting less than 24 hours for individuals who are in psychiatric crisis whose needs cannot be accommodated safely in a residential setting. Crisis stabilization must be provided onsite at a 24-hour health facility, hospital-based outpatient program, or at other certified provider sites. The goal of crisis stabilization is to stabilize individuals and reintegrate them back into the community quickly. According to various reports, costs of providing care in a crisis stabilization unit are significantly lower than inpatient hospitalization. Beds for both of these types of facilities are typically decided upon licensure, and there is no entity that currently tracks real-time availability of beds in these facilities.

4) *Licensed RTFs.* Licensed RTFs provide nonmedical care and specialize in providing services to adults with SUDs who do not require treatment in an acute care medical facility on an inpatient, intensive outpatient, outpatient, or partial hospitalization basis. These facilities range in size from six-bed facilities in residential neighborhoods to facilities that accommodate hundreds of beds. The services typically include group, individual, and educational sessions and alcoholism or drug abuse recovery or treatment planning.

Detoxification services are also provided and are defined by DHCS as services to support and assist an individual in the withdrawal process and to explore plans for continued treatment. RTFs also are licensed as per-bed facilities, and DHCS does not track the number of available times in real time. Some counties, however, may require reporting by licensed facilities of bed availability in real-time as part of their contracts through the Drug Medi-Cal Organized Delivery System program.

5) *State of Virginia registry*. The State of Virginia launched the Virginia Acute Psychiatric and Community Services Board Bed Registry, a mandatory web-based registry, in March of 2014, which was developed through a multi-year partnership between the Virginia Department of Behavioral Health and Developmental Services (DBHDS), the Virginia Hospital and Healthcare Association, the Community Services Boards (CSBs)/Behavioral Health Authorities in Virginia (which are similar to California's county mental health programs/departments), and the Virginia Health Information. According to the DBHDS website, the registry is a web-based program which enables CSBs and psychiatric hospitals to search for acute psychiatric bed availability at participating psychiatric hospitals (including state facilities) and CSUs on a 24/7 hour basis. It serves as a tool for emergency services staff to identify potential bed availability at various hospitals, maximizing precious time during a crisis situation. It does not, however, eliminate the need to call facilities to discuss the appropriateness of the admission. The registry includes contact information for the facilities and aids mental health professionals in obtaining current information about participating psychiatric hospitals and CSUs. It is designed to enable CSBs and hospital users to more efficiently determine the availability of appropriate psychiatric beds in Virginia facilities using various search parameters within the registry data base. Queries can be tailored to specific needs (e.g., region, patient type, level of security, etc.).

   However, a January 2016 report published by the Virginia Office of the State Inspector General (OSIG report) examined the utility of the registry as a tool for emergency services staff to facilitate the identification and designation of facilities for the temporary detention and treatment of individuals including the registry's successes, challenges, and efficiencies, and the impact of the current registry-related operations on various health facilities and stakeholders. A survey of registry users indicated that for 55% of respondents, it was taking more time to locate a willing facility compared to prior to the implementation of the registry. Additionally, 36% of respondents indicated that the registry did not improve the time that it took to identify an available bed, and only 9% reported that the amount of time it took to identify an available bed decreased. The OSIG report further stated that facilities, CSBs, and/or providers did not uniformly update the registry when there was a change in bed availability, and in addition to requiring duplicative efforts by staff, the registry resulted in diverting limited staff time and resources, preventing individuals from placement in an appropriate bed in the most efficient manner, and preventing emergency services staff from proceeding to other emergencies. The OSIG report recommended that DBHDS ensure that all providers are in full compliance with the registry requirements by developing a system for monitoring providers' procedures for updating it whenever a change in bed availability occurs, and to develop a process for addressing noncompliance.

6) *Related legislation.* SB 929 (Eggman) expands DHCS's responsibility in current law to collect and publish information about involuntary detentions to include additional information, such as clinical outcomes, services provided, and availability of treatment beds. *SB 929 was heard in this Committee on March 23, 2022, and passed out by a vote of 11-0.*

7) *Prior legislation.* AB 682 (Eggman of 2019), AB 1136 (Eggman of 2018), and AB 2743 (Eggman of 2016) were substantially similar to this bill. *AB 682 was held on the Assembly Appropriations Committee suspense file. AB 1136 was held on the Senate Appropriations Committee suspense file. AB 2743 was held on the Assembly Appropriations Committee suspense file*.

8) *Support.* The Psychiatric and Physicians Alliance of California, sponsor of this bill, states that this database will map and connect patients and open beds, facilitating access to acute psychiatric inpatient, crisis stabilization, and residential mental health and residential SUD treatment beds. This is a critical function since patients in crisis may need emergency care or the intensive services provided in residential care, and delays in finding an open bed willing to take the patient can exacerbate crises. For instance, in the approximately 138 current facilities containing 6,680 acute psychiatric inpatient beds, information in the registry would identify critical information about whether the facility with an available bed is a secure facility, offers concomitant health or SUD treatment, is appropriate for the diagnosis or the age of the patient, and whether there are other restrictions on those beds. The Big City Mayors Coalition states that they have seen firsthand how our communities have struggled to provide appropriate and timely care to those experiencing severe mental illness. A sometimes-incapacitating challenge in our fragmented behavioral health continuum is a lack of care coordination between various provider types and a lack of information about which resources are accessible and available in the community. This bill will address both issues by establishing a database of behavioral health placements with the ability to collect important data to help assess the capacity of our system. Alcohol Justice states that alcohol-related mortality remains a major driver of preventable death in California, accounting for over 11,000 deaths in the state annually. Alcohol use is a frequent comorbidity alongside chronic mental illness. Currently, only 37% of California residents with mental illness are engaged with treatment service. This makes access to medical, recovery, and shelter services a critical resource to reduce the burden of alcohol harm in California. This bill reduces the time and burden on behavioral health infrastructure from connecting people in need of shelter and services with locations able to provide it. This increases the odds that individuals in need of immediate shelter or care can receive it. The Steinberg Institute argues that behavioral health bed databases are a proven tool to help ensure people in need can be quickly referred to the most appropriate facility to gain the treatment they urgently need. A critical component to addressing the needs of people living with mental illness or SUD and supporting their recovery is to assure that critically important, safe, and intensive care in the least-restrictive setting is accessible when needed.

9) *Letter of concern.* The County Behavioral Health Directors Association (CBHDA) states that reviews of other states' efforts to create real-time bed registries have raised concerns regarding the viability and utility of these efforts, similar to those found with the Virginia registry. According to one evaluation, very few states reported having registries that were updated 24/7 with real-time information despite requirements to provide real-time updates. This evaluation also identified various barriers to real-time registries including potential cherry picking by hospitals, which was the most common issue identified as limiting the usefulness of registries. In many states, compliance with the Emergency Medical Treatment and Labor Act impacts inpatient provider willingness to participate in a real-time bed registry, hampering its effectiveness. CBHDA argues this has been an elusive goal in other states that have invested significant resources to create statewide bed registries. CBHDA does believe our state would benefit from an annual or periodic inventory of existing beds and an evaluation of need based on this capacity. However, CBHDA recognizes the

importance of sharing data regarding bed utilization and would like to continue conversations on how to make this information more accessible.

SUPPORT AND OPPOSITION:

Support: Psychiatric and Physicians Alliance of California (sponsor)
Alcohol Justice
Big City Mayors Coalition
California State Sheriffs' Association
Inland Empire Coalition of Mayors
Steinberg Institute

Oppose: None received

-- END --