EXECUTIVE SUMMARY

Purpose

In November 2004, the State of Idaho - Department of Health & Welfare (DHW) engaged Myers-Anderson Architects in association with The Estimé Group, Inc. (MA-TEG) to conduct a study to determine the future infrastructure needs to support the ongoing operations of the Mental Health program within the State of Idaho. Based on national trends for mental health services delivery and population demographics, the consultant team was asked to provide recommendations as to the future direction of mental health services and identify necessary improvements to existing infrastructure to meet projected needs. It is anticipated that DHW will use information in this report to guide key decisions relating to future resource allocation and funding requests for mental health services.

The primary focus of this study was to evaluate current and projected demand for community based residential beds, crisis intervention and inpatient psychiatric hospital beds. The study does not address strategies or resource requirements to support outpatient mental health services.

Methodology

Three strategies were used to collect data for this study. First, DHW provided copies of previous studies and reports to the consultant team for review and analysis. Second, a planning questionnaire was developed and distributed to all administrators and department heads at State Hospital North (SHN), State Hospital South (SHS), and Idaho State School & Hospital (ISSH). Finally, a series of interviews were conducted with over 50 key stakeholders throughout the State to discuss demand for mental health services, prioritize needs, and identify opportunities for improvements in the continuum of care. Participants included members of the state legislature, a representative from the Governor's office, heads of the state medical and hospital associations, hospital administrators, program managers and regional directors, policy makers, and representatives from the Department of Corrections.

Ten-year population projections were developed using a trend analysis based on annual population estimates developed by the Idaho Department of Commerce, and the U.S. Census Bureau. Mental health service utilization projections were developed using various statistical methods including utilization trends on a region-by-region basis.

Due to the lack of a centralized database to track utilization of mental health services throughout the State, the consultant team had to rely on data collected and managed by individual providers, agencies and institutions. As a consequence, the level of consistency of the data used to generate the analyses in this report differs by source.

Observations

Previous studies of the State of Idaho's mental health system conducted over the past decade concur on the conclusion that significant systemic problems persist. One of the most reliable indicators of the adequacy of mental health services within a state is the suicide rate per 100,000 residents. The State of Idaho has consistently been ranked among the 10 states with the highest suicide rates in the nation. The four primary impediments to access to quality mental health services in the State includes inadequate funding, shortage of mental health professionals, insufficient number of community based treatment beds, and fragmentation of the mental health services delivery system.

Over the past five years, it is estimated that the State's population increased by 13.6% from 1,293,953 to 1,469,545 people. Over the next ten years, Idaho's population is projected to increase by approximately 25,000 people annually. Assuming that the incidence rates for mental illness will remain relatively stable over the next decade, the population of adults with serious mental illness will increase from approximately 58,000 in 2005 to 68,800 by 2015. The projected number of children with serious emotional disturbance will increase from 13,900 in 2005 to 15,700 by 2015. Should the methamphetamine abuse crisis continue to escalate over the next few years, the incidence rates for serious mental illness will increase dramatically. Therefore, demand for State funded mental health services will increase accordingly.

Inadequate Funding:

In 2001, the State of Idaho's expenditures on mental health services on a per capita basis was $46.01. Idaho ranked 46th among the 50 states and the District of Columbia. Due to decreased funding in 2002, Idaho was ranked 48th with an expenditure of $39.99 per capita. During the same period, the national average expenditure for mental health services was $87.65 per capita. Based on preliminary 2003 & 2004 data from the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI), Idaho's expenditures on mental health services has continued to deteriorate. In fiscal year 2004, the number of adults with serious mental illness receiving services in any mental health program in the state was 9,466 (approximately 17.5% of adults population with serious mental illness).

Shortage of Mental Health Professionals:

Due to the physician shortage in the state, Idaho has been designated an "underserved" area by the U.S. Department of Health and Human Services, Division of Shortage Designation. In Idaho, the number of physicians per 100,000 population is 190 as compared to the national average of 295 physicians. The shortage of psychiatrists in the State is more severe. Based on 2003 figures, Idaho has 4.7 psychiatrists per 100,000 population as compared to the national average 13.0 psychiatrists per 100,000 population. Conservatively, the number of psychiatrists working in the State needs to increase by 30% (20 physicians) to improve access in key areas in the state. The proposed 30% increase would bring Idaho's rate to 6.1 psychiatrists per 100,000 population, approximately 47% of the national average.

Insufficient Community Based Crisis Intervention & Acute Care Beds:

Currently, the State operates an eight-bed crisis facility (Franklin House) in Boise through a contract with St. Alphonsus Regional Medical Center. The State relies heavily on 215 community hospital beds to accommodate mental health emergencies and crisis needs. The majority of community hospitals in the State do not have appropriate facilities or the trained mental health professionals to adequately treat mental health patients during crisis situations. At any given moment, there are between 25 to 35 people on a waiting list for an inpatient psychiatric hospital bed due to the lack of community-based facilities. Based on data from the Substance Abuse & Mental Health Services Administration, the State of Idaho has less than 40% of the number of psychiatric beds to support its population as compared to the national average. The lack of community based short-term crisis facilities and transition beds are forcing an increase in the utilization of more expensive acute care settings. Given the State's large geographic area and low population densities in most counties, the one location in Boise is woefully inadequate.

Fragmentation of Mental Health Services:

The challenges in the mental health service delivery are further exacerbated by the lack of service coordination and communication between local providers, counties and the State. For various reasons, including lack of resources, some counties have used creative mechanisms to shift responsibility for serving people with mental illness to DHW. Coordination of services between the Department of Corrections and DHW is marginal at best. The lack of investment in a dedicated and well-managed information management system is another factor contributing to the lack of coordination among service providers. Consequently, there is no reliable method to track and measure performance, and outcome on a statewide basis. The lack of reliable and accessible information limits providers' ability to share resources to serve common populations.

The following section provides a brief summary of major issues at the three state operated mental health hospitals.

1. State Hospital North

- Based on our discussions with the clinical staff and administrators, the hospital appears to be providing a good quality service. The key challenge remains the hospital's inability to recruit a psychiatrist. Inadequate physician staffing level is the primary reason that the hospital is not operating its full capacity of 50 beds. We believe the State's inadequate compensation structure for these professionals is the primary reason for the lack of progress. Idaho's starting base salary of $150,000 and two weeks of paid vacation is not competitive in the northwest market. Other institutions in the northwest offering $190,000, four weeks paid vacation and assistance with educational loans are having difficulty filling available positions.
- The facility was originally designed to accommodate 30 psychiatric and 30 chemical dependency treatment beds. The design of the chemical dependency unit differed from that of the psychiatric unit because the clients in the chemical dependency unit were voluntary

patients and had significantly more freedom of movement throughout the hospital campus and neighboring community. When the chemical dependency unit was converted to an inpatient psychiatric unit, the physical modifications were relatively minor and focused primarily on securing the unit. Consequently, the bed capacity on the unit was reduced to 20 to create required additional treatment support spaces.

- Although the hospital facility in Orofino is less than 10 years old, there are several building systems that will require upgrading or replacement over the next five years. Controls for the HVAC system will need upgraded to help resolve pressurization problems in the building. The hot water system is in constant need of repairs because there are 38 separate units in operation. There are also 38 separate cooling units on the roof that need to be replaced. Power distribution in the building is inadequate. Additional electrical panels are required. There are numerous leaks in the roofing system adjacent the skylights. All 38 patient shower room floors will need to be replaced to remedy the mold problem in the building. Rough-order-of-magnitude construction costs estimates for these upgrades may exceed $1.1 million.
- There is a perception that the quality of service at SHN is below standards because the facility lacks accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). It appears that the main reason for not seeking JCAHO accreditation is due to the fact that it would result in an increase in annual operating costs without any significant financial benefits. It is estimated that accreditation would cost the State approximately $200,000 to $300,000 the first year, and $50,000 per year for labor costs thereafter.

2. State Hospital South

- Given existing financial constraints, the overall quality of care at SHS is very good. The major challenge at the hospital is inadequate staffing. At any given time, there are six to eight registered nurse positions open at the Hospital. The compensation structure for nurses and other mental health professionals is compromising the hospital's ability to recruit and retain qualified personnel. Currently, other hospitals in the community are offering nurses $3 to $5 more per hour than what the State will allow SHS to pay.
- The Patient Treatment Facility was completed in 1988 with a capacity to accommodate 110 psychiatric treatment beds on three separate units. The main deficiencies on the units are inadequate and unsafe patient toilets, inadequate support spaces, and lack of wheelchair accessible patient rooms and exam rooms.
- Due to constant problems with temperature control during the winter and summer months, large temperature variations between adjacent spaces and lack of pressurization controls, the HVAC system and controls in the Patient Treatment Facility should be upgraded.
- The 26-bed nursing facility is housed on three levels of a multi-story building on campus. This configuration creates numerous patient management challenges and staffing inefficiencies. Many of the elderly patients on this unit require wheelchairs for transportation within

the facility. At the time of our site visit, one of the two elevators in the building was not operational. The elevators in the building are not reliable. Ideally, this unit should be accommodated in a one-story building.

- From a risk management perspective, there are two multi-story buildings on campus that should be demolished. The F and G buildings have major structural, mechanical, electrical and life safety problems. These buildings no longer serve any functional or useful purpose.

- State Hospital South has an open campus with no fencing around its perimeter to limit or control access to its facilities. If a patient manages to exit a building, there are no security barriers in place to prevent an individual from leaving the campus. Overall, security for the site and buildings need significant improvements.

3. Idaho State School & Hospital

- The Idaho State School & Hospital is situated on an 85 acres campus with 18 buildings. Five of these buildings were constructed approximately three years ago. The paint shop and grounds building were constructed in the late 1990s. The remaining buildings were constructed between 1916 and 1964. Several of the older buildings are used primarily for storage because the heating and ventilation systems are no longer operational.
- The medical building has five wings; only two wings are used to accommodate clients/patients.
- There are three boilers in operation in central plant building; only one is required to support the load during the winter months.
- The facility was originally designed to accommodate approximately 1,100 patients. Currently, ISSH is providing care for 92 clients. The site and facilities are well beyond what is required to support the current patient volume.
- During the March 2005 survey, ISSH was cited for inadequate staffing by hospital reviewers. Other recent citations included client-to-client assaults and high levels of staff injury that are most likely caused by inadequate staffing.
- Due to an aging population, total patient volume at ISSH is expected to continue to decline.

Recommendations

Previous reports have identified numerous problems with the mental health services delivery system in the State of Idaho. These reports have outlined numerous strategies to address existing deficiencies, expand services, and develop new programs. With the exception of the report titled, "Mental Health Task Force Priority Needs for Access to Mental Health Care" dated March 7, 2005, little coordinated effort has been made to prioritize identified needs, develop cost estimates for proposed program changes, and development of a clearly defined implementation plan.

The intent of the following list is to present our recommendations in a prioritized format with associated cost impacts, and in a manner that will allow for implementation in an incremental fashion. It should be noted that although the beds deficiency problem represents a major impediment to access to care, we believe that without adequate numbers of experienced mental health professionals, the State will not be in a position to successfully operate existing beds in a clinically effective manner.

The number one issue with regards to the delivery of mental health services in Idaho is inadequate funding to support existing and proposed new programs. The following recommendations are made based on the assumption that the legislature will appropriate additional funds for mental health services to improve staffing ratios, and reduce waiting days by increasing the number of beds available in the system.

1. **Improve Recruitment & Retention of Professional Staff**

   In this period of severe shortage of medical personnel in key disciplines, the State of Idaho needs to modify its hiring policies to become more competitive with other northwest states and the private sector medical providers. We recommend that DHW develop a new compensation structure for the following groups of professionals:

   - Physicians: Increase the base pay for psychiatrists by 30%. Provide increase in vacation time, allowance for continuing medical education, and access. Potential annual additional cost impact - $288,000.
   - Nurses & Other Clinical Staff: Increase the maximum hourly wage rate by 25%. Potential annual additional cost impact - $1.5 million.

2. **Develop Crisis Respite Facilities In Four Regions**

   We recommend that the State of Idaho allocate the required funding to develop 72-hour crisis facilities with eight beds each (similar to Franklin House in Boise) in the following regions:

- Regions-I: located in or near Coeur D'Alene. Construction Cost- $1.2 mil.; Potential annual additional cost impact - $1.46 mil.
- Region-III: located in or near Nampa. . Construction Cost- $1.2 mil.; Potential annual additional cost impact - $1.46 mil.
- Region-VI: located in or near Pocatello. . Construction Cost- $1.2 mil.; Potential annual additional cost impact - $1.46 mil.
- Region-VII: located in or near Idaho Falls. . Construction Cost- $1.2 mil.; Potential annual additional cost impact - $1.46 mil.

Building these facilities now will delay for a decade the need to construct a new state hospital that would likely costs more than $50 million.

3. Construct a Forensic Facility in Region IV

The State Legislature should allocate the required funds for the Department of Corrections to construct a forensic facility in or near Boise. A rough-order-of-magnitude project costs range for a 200-bed medium and high secure facility (approx. 170,000 square feet) is $46.0 to $55.3 million. It would be more cost efficient to develop only one facility however, development of two separate facilities may be more appropriate.

Given their geographic locations with respect to the major population centers within the state, inadequate security and staffing limitations; SHN and SHS should not be considered as potential sites for a new forensic facility.

4. Develop Public-Private Partnerships to Develop & Operate New Facilities

We strongly recommend that the State of Idaho allocate the required funding immediately and address the following needs:

- Detoxification facility: 21-Day program. Private sector investment.
- Transitional Housing: This requires a combination of private sector and State funded developments. Potential costs are dependent on the number and size of these facilities, and the operational model implemented.

Summary Statement

As stated in the "Priority Needs for Access to Mental Health Care" report by the Mental Health Task Force dated March 7, 2005; mental health care is "considered by many to be the weakest link in Idaho's healthcare delivery system." By all standards, Idaho does not appropriate adequate funding to support mental health services. As a result, State programs are operated with inadequate staffing in key clinical areas. Both the public and private sectors throughout the northwest provide significantly higher compensation to new and existing employees than that of Idaho. Consequently, the State will continue to have great difficulty filling clinical positions until the compensation issue is resolved.

Idaho's current approach for providing crisis care is not a cost effective model for the long-term. The State can no longer afford to avoid building an effective community based mental health services delivery system. Due to inadequate construction budget for State Hospital North, several building systems were modified to reduce construction costs. Both the mechanical and electrical systems were negatively impacted. Recently, The State spent approximately $500,000 to upgrade the HVAC system. The need for further upgrades for both mechanical and electrical systems should be anticipated. State Hospital South have benefited from recent upgrades. However, more upgrades will be necessary to keep the facility operational. Similarly, five new buildings were developed at ISSH. Most of the existing buildings are antiquated and have outlived their useful life. Major upgrades to these buildings would not be cost effective. If the State intends to continue to use these buildings, funding should be allocated to improve life safety.

Ideally, the State of Idaho should have constructed a State Hospital in close proximity to Boise. Given current financial limitations, Idaho does not need to build a new hospital at this point in time if the State is willing to invest in the development of more cost effective community based treatment facilities as outlined above under recommendation #2. Finally, the need for a forensic unit in Idaho has reached critical mass.

APPENDIX A

TABLE 2.3 ESTIMATED NUMBER OF PERSONS WITH SERIOUS MENTAL ILLNESS BY REGION FOR 2015

Region/County	Weighted 2015 Pop. Project.	Children & Adolescents	Adults
Region I:	220,207	2,004	8,799
Region II:	110,991	1,010	4,435
Region III:	300,601	2,735	12,012
Region IV:	487,768	4,439	19,491
Region V:	198,878	1,810	7,947
Region VI:	188,530	1,716	7,534
Region VII:	214,475	1,952	8,570
State Total	**1,721,450**	**15,665**	**68,789**

APPENDIX B

TABLE 4.3 NUMBER OF MENTAL HEALTH HOSPITAL BEDS REQUIRED BY REGION FOR 2015

Region/County	Weighted 2015 Pop. Project.	Number of Total Beds	Number of State Beds	Available Private Beds	State of Idaho Beds
Region I:	220,207	169	47	20	0
Region II:	110,991	85	24	18	50
Region III:	300,601	231	64	11	0
Region IV:	487,768	375	103	77	0
Region V:	198,878	153	42	25	0
Region VI:	188,530	145	40	21	136
Region VII:	214,475	165	45	22	0
State Total	**1,721,450**	**1,322**	**365**	**194**	**186**
Rate per 100,000 population		76.80 (All organizations)	21.20 (State Rate)	11.24 (Idaho Rate)	10.80 (Idaho Rate)

APPENDIX C

TABLE 8.3 ESTIMATED NUMBER OF INMATES WITH SERIOUS MENTAL ILLNESS & FORENSIC BED REQUIREMENTS

Region/County	Weighted 2015 Pop. Project.	Estimated No. of Inmates	Number with Mental Illness	Level I: # with Severe Illness
Region I:	220,207	936	293	38
Region II:	110,991	472	148	19
Region III:	300,601	1,278	401	52
Region IV:	487,768	2,073	650	84
Region V:	198,878	845	265	34
Region VI:	188,530	801	251	32
Region VII:	214,475	912	286	37
State Total	**1,721,450**	**7,316**	**2,294**	**295**
			31.4%	4.0%
Rate per 100,000 population		425.00		
		Incarceration Rate		

APPENDIX D

PSYCHIATRISTS COMPENSATION STRUCTURE ANALYSIS

Current Structure:

Physician Average Base Pay	$144,000
Fringe Benefits at 30%	$43,200
Total Compensation	$187,200

Approach A: Use Locum Tenens for Unfilled Position

Physician Cost per hour	$130
Total hours per year	2,080
Total Cost	$270,400

Approach B: Increase Base Pay & Fringe Benefits

Physician Average Base Pay	$200,000
Fringe Benefits at 40%	$80,000
Total Compensation	$280,000

Annual Net Difference Between Approach A & B:

Existing Physisians (3)	$278,400
New Physician	$9,600
Total	**$288,000**

APPENDIX E

DEVELOP REGIONAL 72-HOUR CRISIS BEDS

Base Assumptions:

Average cost per bed per day	$500	
Average cost per bed per year	$182,500	
Annual Operating Cost for 8 Beds	$1,460,000	
Gross building area per bed	750	
Construction cost per square foot	$200	(includes project soft costs)
Cost for an 8-Bed facility	**$1,200,000**	

APPENDIX F

CRISIS BEDS REQUIRED BY REGION THROUGH 2015

Region	No. of Beds	Building Costs	Annual Costs
Region I	5	$750,000	$912,500
Region II	2	$300,000	$365,000
Region III	6	$900,000	$1,095,000
Region IV	10	$1,500,000	$1,825,000
Region V	4	$600,000	$730,000
Region VI	4	$600,000	$730,000
Region VII	5	$750,000	$912,500
Total	**36**	**$5,400,000**	**$6,570,000**