

TESTIMONY
Alternatives to Incarceration
9 December 2013
By: Greg LaFrancois, CEO Prairie St. John's
701-476-7270

Chairman Carlisle and members of the Commission on Alternatives to Incarceration, I am Greg LaFrancois. I am the chief executive officer of Prairie St. John's Hospital in Fargo ND. We are a 91 bed acute care psychiatric hospital serving children, adolescents, and adults. We also provide partial hospitalization services to this population and residential services to adults suffering from chemical dependency and addiction. Today, I will discuss challenges we face in caring for our community and state; actions we've taken to overcome those challenges; and opportunities, we see, to improve the behavioral health of our state as a whole. While our work is essential for the health of our citizens, we also assist in the effort to reduce the number of persons entering our prison and corrections systems.

CHALLENGE 1: IMD Exclusion- Stand-alone psychiatric facilities often called Institutions for Mental Disease (IMD) do not receive reimbursement through the Medicaid program for services provided to those ages 21-64. This policy has been in place since 1965, when Medicaid was enacted. In 1965 state and local psychiatric hospitals housed large numbers of persons with severe mental illness, at the state's expense. The Congress did not want the new Medicaid dollars to fund this expense of the individual states. This means there are only two public funded options for those suffering from acute psychiatric conditions. They can be treated in hospitals that operate a psychiatric unit, within a larger medical hospital, or be treated at the State

Hospital. In North Dakota, there is insufficient capacity in those two options to care for our citizens in crisis. Prairie St. John's, and others, fill that void but are not guaranteed payment. This is an imperfect system that leaves large numbers of citizens at risk, as many cannot afford care.

ACTIONS: Prairie St. John's worked closely with the Department of Human Services to create a public/private partnership to address the immediate stabilization of patients in crisis. The ND Legislature funded this initiative in the two most recent sessions and the DHS has been an incredible partner in supporting the acute needs of patients.

Additionally, DHS works closely with their hospital partners to provide access to less costly alternatives. This is a solid solution for our at-risk citizens and I believe it should become permanent.

OPPORTUNITY: In 2010 Congress authorized states to request participation in demonstration projects to test the theory that treating persons subject to the IMD Exclusion would reduce overall public costs. In July of 2013 eleven states were approved to participate in a demonstration project to eliminate the IMD exclusion. North Dakota choose not to participate in the demonstration project. I believe North Dakota should request authority to join the cohort of states in the demonstration project. This would add permanence to a large portion of those being served under the public/private partnership.

CHALLENGE 2: Addiction Counselor Capacity- States that have implemented early forms of Medicaid Expansion are experiencing a greater-than-expected use of behavioral health services (see attachment). The most significant growth is in the area

of chemical dependency and addiction services. We experience great difficulty recruiting Licensed Addiction Counselors (LAC) because there are limitations to the number of candidates that can be trained annually and practitioners from other states face many obstacles in gaining a North Dakota License. Chemical dependency treatment in lieu of jail is proving to be a very successful strategy but additional resources are required.

ACTIONS: Prairie St. John's entered into a contract with the ND Department of Human Services to offer Intensive Outpatient Services to non-violent offenders whose major problems stem from substance abuse. This treatment is one component of the overall Drug Court initiative. Initiatives such as Drug Court substantially reduce the rates of rearrests among participants and represent a viable alternative to incarceration.

Expansion of this program is only possible with sufficient LAC capacity.

OPPORTUNITY: I believe North Dakota should create increased capacity to treat those suffering from chemical dependency and addiction by incentivizing candidates in training programs and removing disincentives for out of state professionals who wish to practice in North Dakota. We do this in other areas of medicine and veterinary care so the methods are already in place.

CHALLENGE 3: Sub-acute Capacity- Once a patient is stabilized from an emergent psychiatric event, we attempt to transition them to a safe, less costly, level of care. The State of North Dakota has insufficient capacity in these less acute alternatives. Psychiatrists cannot discharge patients unless they are certain of that patient's, and the community's, safety. The result is prolonged hospital stays. Nowhere is this need as

obvious as with children and adolescents in need of residential care. In 1999 North Dakota established a moratorium on the addition of residential treatment beds. By 2003, occupancy rates exceeded 85% in those facilities. Today young patients remain in hospitals waiting for either a North Dakota residential bed or the approval to be placed out of state. Average waits for these options exceed 4 weeks. Of course, this issue is not exclusive to the child population. Group homes, for adults with mental health issues, in North Dakota are extremely limited. Often these individuals remain in acute care hospitals while on the waiting list for one of the very limited openings. If these patients demand to be discharged, we must oblige. In those instances, patients often end up in homeless shelters, hospital emergency rooms, or jail.

ACTIONS: The 2013 ND legislature changed the law to permit transfer of beds between psychiatric and residential care. This provides some flexibility and was a positive step but those changes have not yet been made. Even when made they are within the context of a continuing moratorium on beds.

OPPORTUNITY: I believe North Dakota should create incentives for providers to open additional child and adolescent residential capacity. If additional capacity is not possible, the timeline for processing the Interstate Compact on Placement of Children (ICPC) must be improved. There are significant resources in other states but children remain in North Dakota acute hospitals while requests are processed through the ICPC. The ICPC is under the supervision of the Department of Human Services, Children and Family Division. Additionally, consider options such as providing additional funding for respite care for parents. Many times a few days to allow "cooler heads to prevail" is all that families need. While the child is in respite, intensive in-home family therapy could

provide the family parenting skills designed specifically for parents managing the behaviors of their children. For the adults, I believe there should be incentives to operate group homes. An expansion of this capacity provides a viable living arrangement for at-risk adults and will absolutely impact the rates of incarceration. Finally, I believe all these sub-acute resources should be connected by an online application to streamline the placement process. All facilities could be tied into a statewide system. A single application would be uploaded to the system and it would be transmitted to all facilities in the State. Those who have a bed available could review the profile, make a determination, and either accept or reject the patient.

CHALLENGE 4: Medications- Patients often decompensate and return to acute hospitalization when they do not take their prescribed medications. The most significant barrier to adherence is affordability of medications.

ACTIONS: We, at Prairie St. John's, developed an internal resource for our physicians to review the cost of the medications they prescribe. We indicate generic alternatives, and identify any medications where the manufacturer offers cost supports for patients. We continually look for opportunities to remove the cost barrier for our discharged patients.

OPPORTUNITY: I believe the State should increase efforts to make medications more affordable. I believe the Medicaid Provider Drug Utilization Review Board, under the Department of Human Services, is involved with such a task. I continue to be amazed at the improvement in the quality of life of those who adhere to their medication regimens. A significant number of patients that cycle through our services, on a

continuing basis, could avoid hospitalization if only they had taken their medications as prescribed. This factor alone would positively impact rearrests rates as well. I strongly recommend the DUR Board or similar group of professionals be charged with developing a strategy to improve access and adherence to medications.

Attached, I've included information about Medicaid Expansion, referenced earlier, and a brief overview of Prairie St. John's. We thank you for this opportunity to testify and look forward to working with your Commission. I welcome this committee, or any of its members, to tour our facility at your convenience. We are extremely proud of the work we do.

Again, I thank you

New Medicaid Enrollees Come with Mental Health Needs, Uncertain Costs

BY: Chris Kardish | December 2, 2013

The experiences of the six states that expanded Medicaid in the years just before the 2014 start of the Affordable Care Act show that costs are hard to predict and new beneficiaries likely suffer from untreated mental health or substance abuse issues, according to a new report.

Since the passage of President Obama's health care overhaul in 2010, five states and Washington, D.C., have expanded coverage to some or all of the low-income population that the federal government will cover completely before phasing down support to 90 percent. All of them—California, Connecticut, Minnesota, New Jersey and Washington state—cover childless adults at varying levels, from 23 percent of the federal poverty line in New Jersey to 200 percent in some California counties. The federal government will cut off expansion coverage at 138 percent of the federal poverty line under the latest eligibility system starting 2014.

Interviews with Medicaid officials in those states formed the basis of the study from the Urban Institute and the Harvard School of Public Health. The report was recently published in the *Medicare and Medicaid Research Review*, a publication of the Centers for Medicare and Medicaid Services.

The officials, who were protected with anonymity, most mentioned the challenge of predicting expansion enrollment or costs and other planning or administrative issues—a total of more than 30 times in all six states. Coming up second, with 27 mentions in five states, was the high demand for mental health and substance abuse services among expansion populations.

While some of the six states accurately projected how many would sign up, in one unnamed state enrollment doubled initial expectations, prompting calls among legislators to cut back the expansion. That state is Connecticut, where high enrollment fueled a \$224 million Medicaid deficit. Even wealthier communities such as Greenwich saw enrollment spikes that officials attributed to the down economy, according to a 2012 Associated Press report. Enrollment in another two states was 20 to 40 percent higher than anticipated, but officials there handled the load with less difficulty, according to the study.

All these states had the advantage of being able to predict enrollment by looking at existing programs that were covering some of the new populations, but some found that they underestimated what they would need to pay the managed-care plans running their Medicaid programs. In one case, it was by more than 12 percent per beneficiary, per month.

The study also found that the behavioral health and substance abuse needs of the newly eligible population, which had gone untreated, have overwhelmed the available services in the states. Previously they didn't qualify under the disability portion of Medicaid because substance abuse was their main condition, which wasn't enough for eligibility, noted one official. Two states reported that 9 to 13 percent of the early expansion population suffers from substance abuse disorders. Some 60 percent of those with mental illness also had a concurrent substance abuse problem, according to one official's estimate.

The study's authors and other policy analysts have recommended states find ways to expand mental health services and integrate them with primary care to improve access.

The full study can be found here.

This article was printed from: <http://www.governing.com/topics/health-human-services/Report-New-Medicaid-Enrollees-Come-With-Mental-Health-Needs-Uncertain-Costs.html>

Our Community

Prairie St. John's is located in Fargo, North Dakota with a clinic in its neighboring community of Moorhead, Minnesota. Our primary service area has a population of approximately 250,000. We are the largest, most comprehensive provider of psychiatric and addictions services in the state of North Dakota. We serve some unique populations to include Native American Reservations, Air Force installations, National Guard members, and transient residents working in the oil industry.

Mission, Values, Vision

At Prairie St. John's we offer hope and healing to those suffering from psychiatric conditions and addictions. This mission derives from our collective values of compassion, integrity, and respect and moves us toward our vision of being a leader in psychiatric and addictions treatment.

Organizational Structure

Prairie St. John's serves the region through acute inpatient psychiatric care with chemical dependency, dual diagnosis, and mental illness tracks for adults and adolescents. We also offer a mental illness track for children. We offer residential treatment for adults suffering from chemical dependency. Prairie St. John's offers child, adolescent, and adult partial hospital programs and intensive outpatient programming for chemically dependent adults and adolescents.

| | |
|---------------------------------|--|
| Acute Inpatient – 91 Beds | Child/Adolescent Partial Hospitalization Program – 30 Patients |
| Residential Treatment – 48 Beds | Adult Partial Hospitalization Program – 60 Patients |

Management Structure

| | |
|--|---|
| Chief Executive officer – Greg LaFrancois | Medical Director – Eduardo Meza, MD |
| Chief Financial Officer – Tom Eide | Chief Operating Officer - Jennifer Faul |
| Dir of Nursing – Jacki Toppen | Dir of Social Services – Greg Clark |
| Dir of Needs Assessment – Elysia Neubert | Dir of Chemical Dependency Services – Tonya Sorenson |
| Dir of Human Resources – Michelle Parkinson | |

Staff Composition (361 Employees)

| | | |
|------------------------|-------------------------------|------------------------------------|
| Registered Nurses – 70 | Licensed Practical Nurse – 20 | Psychiatry Techs – 86 |
| Therapists – 13 | Psychologists – 3 | Licensed Addiction Counselors – 18 |
| Psychiatrists – 9 | All Other – 151 | |

For more information on Prairie St. John's, please contact Greg LaFrancois at 701-476-7270