

Barriers for Service

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During the last year, I have had the privilege of working on the Community Paramedicine Team in Lexington, Ky. The purpose of the Community Paramedicine Team is to investigate referrals for complex cases, familiar faces, vulnerable individuals, medically fragile and at risk individuals. Many of our clients suffer from serious mental illness, addiction, dual diagnosis, intellectual or developmental disabilities. A common issue we find is a reduction in critical thinking, problem solving and dispute resolution skills. These compounding issues many times increase the risk of homelessness for this demographic.

The Community Paramedicine Unit is composed of Paramedics, Social Workers and Police Officers. We begin with in-depth assessments of our clients to identify the root causes of their situation. We develop comprehensive, collaborative solutions and action plans to address root causes for each individual's situation in order to get them access to the level of assistance they require. We mostly rely on community partners and agencies such as Adult Protective Services and State Guardianship in order to assist these clients.

Having been part of this team afforded me the unique opportunity to identify the barriers for assistance to the clients I have served. Many of these barriers are systems issues created by policies and/or legislation or a lack of policies and legislation. Some of these barriers could be removed at no cost to our tax payers with simple policy or legislative changes. In the following pages I have identified barriers for service, how or why they are barriers and possible ways to overcome these barriers.

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Access to Medicaid

Barrier:

Medicaid is suspended for an individual when they are incarcerated. **Medicaid is not automatically reinstated when the person is released from the jail.** The experience in jail can cause a person to re-evaluate their situation and/or addiction issues. We often encounter individuals at jail who want to enter a rehabilitation program when they are released from jail. Once released from jail, they find their insurance is not active and no facility will accept them. Many times we miss this temporary opportunity before additional social factors come into play and the individual relapses.

Possible Solution:

The Kentucky Department for Medicaid Services currently offers training and certification to reinstate Medicaid insurance for individuals to Medicaid Partners on their Medicaid Partner Portal. Jails already employ inmate services staff which could be certified free of cost by Medicaid to reinstate an individual's Medicaid insurance upon release from the jail. **This barrier could be overcome with legislation requiring jails to have staff certified to reinstate Medicaid upon an individual's release.** This would be a no-cost solution which could save Medicaid on the backend by reducing future emergency room transports and admissions for individuals in addiction.

Access to Adult Protective Services

Barrier:

When Adult Protective Services receives a self-abuse or self-neglect report for an individual who is homeless and has no phone number the case is closed without follow-up. The reason the case is closed is because we cannot justify looking for someone who we don't know how to find. This leaves individuals which are entitled to services without access to services because of their homeless status. This can prolong their homeless status and exposes them to factors which will worsen their overall condition.

Possible Solution:

Many times the primary agencies homeless individuals interact with are Shelters, Police Departments, Jails and EMS/Fire Departments. Establishing partnerships and information sharing between Adult Protective Services, Shelters, Police Departments, Jails and EMS/Fire Departments is a no cost solution which would aid Adult Protective Services in the location of their clients. This is something that has already been resolved in Fayette County with Adult Protective Services but it has not been resolved at the state level. **Legislation requiring Adult Protective Services to contact Shelters, Police Departments, Jails and EMS/Fire Departments prior to closing a case due to a lack of an address is a possible no-cost solution to the situation.**

Subjectivity in Treatment for Mental Illness

Barrier:

There is a discrepancy in interpretation of the language for involuntary hospitalization which creates a gap of service. KRS.202A.041 sets two criteria for Emergency Detention; reasonable grounds to believe the person is mentally ill and presents a danger or threat of danger to self, family or others if not restrained. KRS.202A.026 sets an additional two criteria for involuntary hospitalization; the person can reasonably benefit from treatment and for whom hospitalization is the least restrictive mode of treatment. **The criteria requiring a person can reasonably benefit from treatment is very subjective in interpretation as there are no clearly identified predictors for if and when a person will benefit from treatment.**

I have had a documented case were the same individual has been seen by two facilities. One facility refused to admit the individual on the grounds that he would not benefit from treatment. On the same day, the other facility conducted the involuntary hospitalization. After the 72 hour was completed the facility noted that the individual had benefited from treatment in their discharge paperwork.

Possible Solution:

Removing the language from KRS.202A.026 which requires the belief that someone will benefit from treatment is a possible no-cost solution. This would remove the subjective interpretation of the law which often leaves individuals without care.

Lack of Treatment Alternatives for Mental Illness

Barrier:

We have the ability to conduct Involuntary Hospitalization but this is only as long as they continue to meet criteria. This leaves many mentally ill individuals, which are in crisis, on the street because they no longer meet criteria for danger to self and others but still in crisis and require care to be stabilized. **There is no step down form involuntary hospitalization to involuntary crisis stabilization or to a 60 day court ordered outpatient treatment for mental illness.**

Possible Solution:

There needs to be a step down option for involuntary hospitalization to involuntary placement in a locked Crisis Stabilization Units or involuntary 60 day outpatient treatment. There needs to be legislation allowing such facilities or petitions in Kentucky. There will be costs that need to be assess on this but there will be savings on the back-end with reduced arrests and re-admittance for involuntary hospitalizations.

Lack of Locked Nursing Facilities

Barrier:

There is a demand for placement at locked nursing facilities in Kentucky for mental illness but the state does not have legislation to allow for such facilities. Kentucky State Psychiatric Facilities refer approximately 40 people a year to locked nursing facilities out of state in order to circumvent the lack of appropriate placement in Kentucky.

Possible Solutions:

Change legislation to allow for locked nursing facilities for patients with mental illness in the state and offer incentives for such programs. Locked nursing facilities for individuals with mental illness are a recognized need by behavioral health specialists. We currently have locked nursing facilities for individuals who often face similar limitations but are diagnosed with dementia or autism.

No Available State Operated Juvenile Behavioral Health Units

Barrier:

When juveniles are involuntarily detained and taken for a psychiatric evaluation the only options are privately owned and operated facilities. The problem is whether or not the facility is then willing to accept their insurance or if they are willing to manage their behavior. Many times, when a juvenile is involuntarily detained, they are transported to several facilities in order to find one which will accept them.

Possible Solutions:

There is a high demand for a state operated juvenile behavioral health facility but there are none in Kentucky. **There needs to be a state run juvenile behavioral health facility.**

Medicating Mental Illness

Barrier:

Many times we encounter individuals who are on medication for their mental illness that needed their dosage adjusted and are now in a delusional state. That delusional state is frequently one in which they believe their medications are being poisoned and they are no longer willing to take their medication. Often times, the individual's mental state is such that they have no insight into their condition and they do not have the legal capacity to consent. Mental Health Professionals are still required to get consent from a person they have determined does not have the ability, in order to medicate them. **The inability to medically treat an individual who has no insight into their condition and is presenting as a danger to self or others may leave that individual suffering due to a lack of treatment with medication.**

Possible Solution:

When a patient enters a hospital in an altered mental state, due to a physical illness, and they are determined to require medical assistance to return them to baseline, the physician may assume there is implied consent for medical treatment in order to return them to baseline. This can only be done if the person has not revoked consent to treatment with medication while able to consent. The implied consent principal has been in practice for medical treatment for a long time. **The same standard for implied consent should be applied to mental illness as it is applied to physical illness. Legislation should allow a Mental Health Professional to medicate a patient based on the following combined criteria: a person has no insight into their condition, they do not have the capacity to consent, they are a danger to self or others and they have not placed an order refusing medical treatment while having the capacity to consent.**

Access to Specialized Personal Care Homes

Barrier:

There is a lack of appropriate housing options for individuals with mental illness which are reliant on Medicaid. Personal Care Homes are only governed by regulations from the Office of the Inspector General. Specialized Care Homes are governed by regulations from the Department for Behavioral Health, Developmental and Intellectual Disabilities and the Office of the Inspector General. As a result of these higher standards, Specialized Care Homes are very well run and are great placement for their clients. Unfortunately, there are not enough placements available at Specialized Care Homes to address the needs of the community forcing many into Personal Care Homes.

Possible Solutions:

Either Personal Care Homes need to be held to the same standards as Specialized Care Homes and provided with incentives to do so or there has to be an increase in availability at Specialized Care Homes. There are costs implied with this solution which need to be assessed. There are also costs which would be saved by housing this demographic instead of them being continually cycled through hospitals, psychiatric facilities and the legal justice system.

Appropriate housing options could also be increased by the creation of Medicaid waivers for mentally ill. There are similar waivers for individuals facing similar difficulties but that are diagnosed with Developmental Disabilities, Intellectual Disabilities or physical disabilities such as Traumatic Brain Injuries.

No Legislation to Protect a Person in Addiction

Barrier:

When a person is in a drug induced psychosis and presenting as a danger to self or others there is no legislation in place to take the person in to custody for their protection. Drug induced psychosis is often mistaken for mental illness and people are often Emergency Detained in error. Once the person is evaluated by a QMHP and found to be in substance induced psychosis, they are released. The person might still be a danger to self and others but since the cause is substance abuse instead of mental illness; we do not have any legislation protecting them or others.

Possible Solutions:

Legislation similar to KRS.202A.041 with the criteria of having reasonable grounds to believe the person has a substance abuse disorders is a possible solution. This would require facilities willing and able to treat for co-occurring and substance abuse disorders. The National Institute of Health recognizes about 50% of all people suffering from substance use disorder also suffer from a mental illness.

Legislation strengthening Casey's Law to include emergency detention and funding for treatment is another possible solution.

Access to Addiction Rehabilitation Services

Barrier:

If a person with Medicaid insurance starts an inpatient rehabilitation program and they leave the program for any reason, they cannot apply to another 28 day inpatient program until 31 days have passed from the beginning of the initial program. We often encounter individuals which have left a program for a legitimate reason, such as a death in the family, which prevents them from re-entering a program because the placement was taken. What compounds the situation is that Medicaid will not allow for entry into another program till the 31 days have passed.

Possible Solution:

There has to be access to addiction rehabilitation services in order to assist individuals out of addiction. There are costs which need to be assessed for this. I am unclear on the actual cause of the issue but it was explained as a billing issue. Rehabilitation facilities are billing for the whole 28 day program at one time regardless if the patient stays for the entire 28 day program. **If that is the case, it might be possible to cover costs if the billing model is changed so Medicaid only pays for the days clients are serviced.** If it is not the case, we have to find a way to change Medicaid regulations so we can assist people out of addition when they have the desire to do so.

Access to Continuation of Addiction Rehabilitation Services

Barrier:

Once a person with Medicaid insurance has completed a 28 day rehabilitation program there are no additional rehabilitation, step down or support services paid for by some MCO's. This is a crucial time in a person's transition from addiction when they will likely require additional support to succeed.

It is often the case that a homeless individual completes a 28 day substance rehabilitation program and their biggest fear is returning to the environment they were in. We often have people plea with us to help find them some form of transitional care so they can begin to get their life back on track.

Possible Solution:

There has to be access to transitional services after a 28 day program such as sober living facilities. This is a crucial time when these individuals need support to succeed in their rehabilitation.

Medicare / Medicaid Debate

Barrier:

When an individual has both Medicaid and Medicare insurance and they want to enter a substance abuse rehabilitation facility Medicare takes precedence over Medicaid. **The issue is Medicare will often not cover costs for the rehabilitation facility. Medicaid would normally cover the costs for treatment at the facility for an individual but because the person has Medicare, Medicaid will state Medicare has to cover the cost.** Medicare has come to the determination they will not cover the cost and Medicaid has come to the determination they will not cover the cost while Medicare is also in place. Meanwhile the individual which was seeking help for their substance abuse disorder has been left with no options for treatment.

Possible Solution:

There has to be a clear cut policy or decision on who will cover the costs for substance abuse rehabilitation services for individuals covered by both Medicare and Medicaid. The alternative is these individuals not get help and they continually cycle through hospitals, jails and the legal justice system costing communities much more on the backend.

Incidental Homeless Occurrence

Barrier:

When an individual is Emergency Detained they are taken to a psychiatric facility to be evaluated for Involuntary Hospitalization. Per KRS.202A.028, if they are not admitted or if they are released from the involuntary hospitalization they shall be transported to the person's county of discharge by a sheriff or other peace officer, by an ambulance service designated by the cabinet, or by other appropriate means of transportation which is consistent with the treatment plan of that person. The reality of the situation is people who cannot think logically due to their mental illness are asked at time of discharge for an address they want to return to. Some cannot recall an exact address and some people don't recognize they have a supportive home they can return to. These individuals are often released to shelters or released to hotels if no placement is available in a shelter. **The person then becomes homeless as a consequence of flaws in discharge policies or interpretation of privacy laws by psychiatric facilities.**

Possible Solution:

Community partnerships to assist in continuum of care are crucial. Law enforcement agencies and The Cabinet for Health and Family Services have access to data and information which might be able to return the person to their home instead of transitioning them in to homelessness.

Guardianship Powers

Barrier:

State Guardianship is limited to their abilities by KRS 387.660 and lack of funding. **State Guardians are limited to case management and do not have funding to provide for basic needs when the ward does not have the funds.** State Guardians have caseloads which cannot be effectively managed. Surprisingly State Guardians are held to a much lower standard than a Private Guardian. State Guardians cannot provide food, shelter or housing for an individual if the individual does not have the funds to do so. This lack of powers often leaves homeless mentally ill individuals under state guardianship in the same undesirable conditions they were in prior to receiving Guardianship for prolonged periods. It is possible to argue a Private Guardian would be neglecting their client if they were unable to provide food, shelter or housing for their ward if the ward does not have the funds to pay for it.

Possible Solution:

State Guardianship has to be awarded the powers, funding and staffing to effectively function as a guardian in order to care for their clients.

Limitations on Emergency Guardianship

Barrier:

If a person is in a hospital or psychiatric hospital and they are evaluated and found in need of Emergency Guardianship, Emergency Guardianship cannot be applied for because a hospital is recognized as a “safe place” therefore there is no emergency. The issue is the person could be discharged at any moment for either not meeting criteria or for no longer needing that level of care. The person is then discharged to the street in a state which requires Emergency Guardianship. This makes it exponentially harder for APS to contact and investigate the situation.

Possible Solution:

Changing the language of KRS 209.100 to allow for Emergency Guardianship to be filed for someone when they are temporarily in a safe place is a possible solution. Another option is clarifying language that a hospital, psychiatric hospital is not a safe long term placement for an individual.

Lack of Mobile Crisis Units

Barrier:

Mobile Crisis Units have been utilized across the US in various municipalities. Mobile Crisis Units are typically composed of a Police Officer, a Paramedic for medical assessment and a Qualified Mental Health Professional or equivalent. They have been proven to produce major cost savings for communities by reducing emergency detentions, involuntary hospitalizations and arrests. In the County of Yavapai, Arizona, which is comparable in population to Fayette County, a Mobile Crisis Team was able to produce an estimated \$31M savings to the community in a three-year-period. In those 3 years, they avoided over 1,100 arrests and over 2,000 Emergency Department visits. **The barrier for the creation of Mobile Crisis units in Kentucky is the lack of billing ability by Qualified Mental Health Professionals which make this position economically unfeasible.**

Possible Solution:

Opening Medicaid billing to include billing for clinical care and case management for people in crisis or in transitional care would make this position economically feasible. A Mobile Crisis Unit would have costs associated which would have to be assessed but these units have demonstrated cost savings on the back end.