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NY State Senate and Assembly Joint FY2022 Budget Hearing: Mental Hygiene

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The New York State Nurses Association (NYSNA) represents more than 40,000 registered nurses across New York State for collective bargaining. We are the state's largest RN union and are on the forefront of the fight to expand health care to all New Yorkers, to protect the rights of nurses and other healthcare workers, and to maintain safe, high quality care for all New Yorkers.

Review of FY22 Executive Budget Provisions

The Executive Budget proposals around mental hygiene are consistent with the budget cuts and austerity that are evident throughout the budget.

In the face of an ongoing pandemic and the attendant health care, economic and fiscal crisis that it has triggered, the budget proposes cost cutting austerity measures that are ill-advised fiscally and will seriously affect mental health, drug and substance use, and psychiatric healthcare services.

NYSNA opposes the following measures:

- **Closure of 100 state acute psychiatric in-patient beds:** 100 psychiatric beds in the state facility in Rockland County will be closed, with advance notice requirements for this and additional closures suspended. This continues the ongoing trend of reductions of acute care psychiatric capacity at a time that mental health needs are increasing across the state (Health and Mental Hygiene, Article VII, Parts W and X).
- **An additional 1% reduction in Medicaid reimbursement rates** (on top of a 1.5% cut in 2020): This reduction will disproportionately affect safety-net hospitals and clinics that play an increasingly important role in providing acute and out-patient psychiatric and substance use services.
- **Ongoing implementation of MRT II cuts in Medicaid funding:** These proposals will further weaken the state Medicaid program and restrict access to care across a range of services, at the same time that Medicaid enrollment has increased by 700,000 due to the economic fallout of the pandemic.
- **Cuts in Office of Mental Health (OMH) and Office of People with Developmental Disabilities (OPWDD) totaling $91 million.**

NYSNA supports the following positive proposals in the Executive Budget:

- **Creation of Crisis Stabilization Centers to be operated jointly by OMH and OASAS:** This program would establish local centers to allow people in psychiatric or substance use crisis to be directly dropped off by police and first responders as appropriate. The crisis centers would be staffed by teams including a physician or psychiatric nurse and other appropriate professional support staff. The aim is to provide appropriate alternatives to emergency room admission or unnecessary incarceration. It remains unclear, however, whether there is sufficient funding to operate these Centers at the needed scale (Health and Mental Hygiene, Article VII, Part AA).
- **Extension of the authority of OMH and OPWDD to appoint temporary operators:** This provision allows the state to take over facilities and continue operations in the event that the owners are in violation of standards of care or engaging in fraudulent activity (Health and Mental Hygiene, Article VII, Part U).
- **Increased penalties and sanctions for operators that violate legal requirements:** The proposal would authorize the Commissioner to formulate a more stringent schedule of fines or penalties for violations of patient care requirements. It would also increase the fees for processing applications for operating certificate. These proposals will penalize abusive owners and operators and protect patient care (Health and Mental Hygiene, Article VII, Part Z).
- **Increased OASAS funding for substance use treatment programs:**

Additional proposals that raise concerns for NYSNA:

- **Merger of OMH and OASAS:** This proposal would create a new Office of Addiction and Mental Health Services (OAMHS) by placing the currently separately structured OHM and OASAS. The intent is to create better coordination of mental health and substance use services, and presumably to save administrative costs. NYSNA supports this proposal conceptually, as it offers an opportunity to improve the availability of integrated services. We are concerned, however, that it might become a cost cutting exercise. Accordingly, NYSNA will be monitoring the proposed merger to ensure that it does not impact the availability and quality of mental health and substance use services (Health and Mental Hygiene, Article VII, Part CC).
- **Authorization of licensure of integrated, comprehensive out-patient services:** Under current law, operators of primary care and ambulatory out-patient health clinics are not allowed to co-operate or co-locate their services with operators of mental health or substance use services, which are licensed and supervised by different agencies. Health clinics are under DOH jurisdiction and mental/substance use services are under OMH or OASAS jurisdiction. This proposal would codify certain executive orders suspending these restrictions during the COVID crisis. NYSNA is not opposed to this proposal in principle, but is concerned that it might result in a loosening of standards of care or allow unscrupulous operators to engage in abusive financial or clinical practices. NYSNA will be closely monitoring this proposal to protect the health and safety of patients (Health and Mental Hygiene, Article VII, Part DD).

Addressing the crisis in psychiatric and substance use in-patient capacity

NYSNA is particularly concerned about and opposes proposals in the Executive Budget that will severely impact the scope and availability of acute psychiatric in-patient capacity and the availability of out-patient mental health and substance use services.

The Executive Budget proposal to close the 100 pediatric acute care beds currently located in the Rockland Children's Psychiatric Center continues a worrying trend of substantially reduced in-patient psychiatric and substance use bed capacity.

New York has been steadily eroding in-patient psychiatric and substance use bed capacity for decades. This trend has been driven by the following factors:

- Closure of state psychiatric hospital facilities to reduce spending;
- Private hospitals shedding beds and converting to more lucrative, higher reimbursed services;
- Underpayment for psychiatric and substance use services by public and private insurers;
- Increasing burden to provide services on under-resourced public and private safety net providers;
- Increasing racial and socio-economic disparities in the availability of services and the quality of care;
- The COVID crisis has allowed hospitals to "temporarily" close in-patient psychiatric and substance use units and convert them to COVID units – we fear that many of these temporary closures will become permanent.

NYSNA strongly opposes the closure of in-patient bed capacity and proposes the following measures to address the crisis in in-patient psychiatric and substance use services:

- Enact a moratorium on closures of psychiatric in-patient services for the duration of the COVID crisis;
- Direct hospitals to re-open all in-patient beds that were temporarily converted to COVID care units;
- Adopt a robust and centralized plan to supervise the provision of acute care psychiatric services on a state-wide basis, incorporating a thorough assessment of state-wide and local needs;
- Equalize reimbursement rates for psychiatric services and medical services;
- Establish uniform and enforceable minimum staffing standards for in-patient care to ensure that all patients have access to quality care;
- Establish transparent and fair procedures for oversight and approval of provider requests to reduce, close or restructure services through an enhanced Certificate of Need (CON) process with a robust public participation process; and,
- Address racial and socio-economic inequality within the broader mental health care system by providing fair funding for the safety-net providers that provide the bulk of psychiatric care.

A more detailed analysis of NYSNA's position on the crisis in in-patient psychiatric and substance use bed capacity is attached as an Appendix below.

APPENDIX: Addressing the Crisis of In-patient Psychiatric and Substance Use Bed Capacity
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1. Inpatient Psychiatric Services and COVID: Background

The impact of COVID on New Yorkers and the dire circumstances that we faced during the height of the pandemic in our hospitals and nursing homes have been well documented and are widely known.

Hospitals and nursing homes were inundated with extremely sick patients, with more than 43,000 deaths to date.

The Attorney General's Nursing Home report, issued on January 26th, documents the high toll among nursing home residents and the role that poor staffing, inadequate infection control measures, insufficient PPE and an emphasis on maximizing revenues and profits played in contributing to thousands of avoidable deaths.

A similar pattern was evident in our hospitals, where the lack of minimum staffing regulations left the broader hospital system unprepared to meet COVID patient surges. Already understaffed before the COVID pandemic, many hospitals faced a catastrophic situation, and nurses in critical care units and COVID floors were assigned too many patients and were unable to provide the levels of care that patients needed.

Insufficient staffing and a lack of PPE in hospitals was worsened by the increasingly two-tiered nature of the broader hospital system. Some well-resourced (and profitable hospitals) were better positioned to obtain additional staff and PPE. In contrast, many public and private safety-net hospitals serving the highest numbers of Medicaid, uninsured and low-income patients did not have the ability to get more staff and equipment. The results for patients were catastrophic, with higher mortality rates and thousands of avoidable deaths.

The two-tiered hospital system was particularly pronounced in the high death toll among Black and Latino patients, whose COVID mortality rates have been twice the rate of that of White patients.

The COVID pandemic has also severely affected the mental health of New Yorkers. Before the onset of the pandemic, it was estimated that more than 1.6 million suffered from mental illness or psychiatric or substance use disorders of various types.

The effects of the ongoing COVID health crisis, widespread economic distress over rising unemployment and loss of income, the isolating effects of social distancing and quarantine measures, and other aspects of the pandemic have seriously exacerbated the psychological well-being of millions more.

According to a study conducted by the Kaiser Family Foundation, the percentage of adults reporting that their mental health was negatively affected by the coronavirus pandemic and the economic fallout increased from 32% in March to 53% in July.

The impact of the pandemic, coupled with the effects of the economic crisis on state and local

budgets, has accelerated an ongoing but less visible crisis in psychiatric, mental health and alcohol/substance use health services.

In many hospitals, in-patient psychiatric units were converted to COVID treatment units (ostensibly on a temporary emergency basis), psychiatric patients were discharged or transferred to make room for COVID patient, and new admissions were curtailed. At the same time, in person out-patient psychiatric services were reduced or replaced by remote telephone or tele-health consultations.

These emergency COVID measures were used as cover by many of the wealthier, private sector hospitals to pursue long held initiatives to shrink in-patient psychiatric capacity (which is poorly reimbursed by Medicaid) and convert these units to more profitable service lines (such as spinal, cardiac, cancer, and orthopedic specialty units, all which are paid at much higher rates than psychiatric and substance use services).

New Yorkers facing mental illness, acute psychiatric disorder and substance use diagnoses rely on an integrated spectrum of primary care, out-patient, and acute in-patient services to treat their illnesses.

Unlike other types of health diagnoses, which may be more episodic in nature and amenable to definitive treatment and cure, mental illness and substance use disorders are overwhelmingly chronic in nature and require ongoing treatment. In-patient hospitalization and treatment is a key component of the spectrum of services needed to treat these types of patients, particularly those who suffer from severe forms of mental illness (bi-polar disorders, schizophrenia, etc.).

Notwithstanding the vital role of acute inpatient psychiatric and substance use services, the state of New York faces an intensifying shortage of in-patient psychiatric and detox/rehab beds, a crisis state of affairs that has been worsened by the COVID pandemic.

2. Inpatient psychiatric and substance use capacity was shrinking pre-COVID

In the last 20-30 years there has been a substantial reduction in inpatient psychiatric and substance use bed capacity in New York. Reducing the rate of institutionalization of patients with serious psychiatric diagnoses is a positive development. The problem is that the trend has been accelerated by the state interest in cutting costs and the private sector interest in maximizing revenues and surpluses. The result has been a reduction in capacity that threatens the ability of remaining providers to give patients the care they need.

The long-term trend of reduced in-patient capacity is attributable to the following factors:

- De-institutionalization of people with severe mental health and developmental disabilities. Historically, many such patients were warehoused in large facilities (asylums), often for life and regardless of their particular diagnoses or ability to live independently and, with proper support, in their homes and communities.
- Substantial reductions in the number of state-operated psychiatric hospitals.
- Shift of acute and in-patient care to a systemic reliance on outpatient services and medications to control chronic mental illness (moving away from “brick and mortar”).
- Shift from state and private specialty psychiatric hospitals to acute care Article 28 general hospitals to provide for acute care in-patient needs.

3. **Loss of in-patient psychiatric bed capacity**
The impact of these long term trends is reflected in a substantial decrease in the availability of acute in-patient psychiatric beds in most regions of the state:

- The number of staffed psychiatric beds operated by the State has decreased by 19% since 2013;
- The number of licensed psychiatric beds in acute care Article 28 hospitals has declined from 6,061 in 2000 to 5,419 in 2018 (pre-COVID) – a loss of 636 beds, or more than 10.5% of capacity.

The loss of acute in-patient psychiatric beds in Article 28 hospitals since 2000 has not been uniform geographically or across hospital systems:

- The decline in hospital psych beds has been most pronounced in the downstate area (New York City and Long Island), as well as in Western NY, which together accounted for 621 of the total net loss of 636 beds.
- The Capital, Mohawk Valley, Southern Tier and Central NY regions experienced only a slight loss of in-patient psychiatric beds.
- Certified beds increased significantly in the Mid-Hudson Valley (from 440 to 570, or 24%), largely reflecting regional population growth;
- The New York City area lost the most beds (419 out of 3,240 certified bed since 2000, or more than 14%).
- The highest percentage decline was in Western NY (99 out of 365 beds were closed, reflecting a 27% decline in bed capacity).

4. **Shift of psychiatric bed capacity from state facilities to Article 28 hospitals**
The substantial decline in hospital psych bed capacity throughout the state and particularly in New York City was to a significant extent driven by an increasing emphasis on revenue maximization by individual hospital systems rather than public policy goals.

As the State reduced the capacity of its psychiatric hospital system, an increasing share of acute psychiatric inpatient services shifted to the acute care hospital system, with the share of total hospital capacity operated by Article 28 hospitals becoming more predominant. By 2018, private hospitals accounted for more 68% of total psychiatric bed capacity state-wide.

5. **In-Patient hospital admissions have increased**
Despite the reduction in bed capacity, however, in-patient psychiatric admissions have increased since 2000, reflecting increased demand for services despite the increasing role of outpatient services.

In-patient psychiatric discharges increased from 111,000 in 2000 to 124,000 in 2012, peaked in 2015 and have since declined slightly to 116,000 in 2018.

6. **Private hospitals continue to shed inpatient psychiatric beds in pursuit of higher profits**
Why are hospitals continuing to reduce their psychiatric bed capacity, even though patient demand and admissions remains significantly above 2000 levels?

Hospitals, particularly private hospitals in the large networks in the downstate area, are getting rid of their psychiatric beds because they lose money on them. They are driven by profit considerations to close those units and use the space for more lucrative types of patients and procedures.

Reimbursement rates for mental health services, including acute psychiatric disorders and alcohol/substance use treatment are significantly lower than reimbursements for other types of acute care. Base Medicare reimbursement rates for mental health diagnoses are among the lowest of all diagnosis related groups (DRGs).

Each CMS Medicare DRG group is generally reimbursed on a lump sum basis for each patient discharge. These payments are based on the expected length of stay of the patient for each DRG and are further based on the level of severity. Each DRG is rated as either "without complications", "with complications" or "with serious complications." The reimbursement rate is higher if the patient has complications or serious complications.

Almost every psychiatric DRG is reimbursed by Medicare at a per-case or per discharge rate of less than $10,000. By way of comparison, the rates of reimbursement for many other types of DRGs are much higher. For example, reimbursements for spinal DRGs range from $16,000 to $90,000; for common cardiac care DRGs from $28,000 to $86,000 and for hip/knee surgeries from $14,000-$43,000. In each case the reimbursement rates for these DRGs are significantly higher than those for psychiatric/mental health DRGs.

The differences in reimbursement rates are even more pronounced when these procedures are paid for by private insurers. Generally, private insurance pays anywhere from 125% to 180% or more of the Medicare reimbursement rates, depending on the market power and leverage of the particular hospital system to negotiate reimbursement rates with its insurance carriers.

The economic incentives to close in-patient mental health services are further intensified when the low reimbursement rates for these services are analyzed in conjunction with the expected lengths of stay and other factors that magnify revenues and costs on a per bed basis.

Inpatient mental health services are not only poorly reimbursed, but are also relatively more costly to provide because average length of stay (the number of expected hospital days) is higher for psychiatric/mental health DRGs.

According to the standards used by NY State, the length of stay (LOS) for a hip or knee replacement is 3 days, 2 to 6 days for spinal surgeries, and 2 to 12 days for various cardiac procedures. For mental health DRGs the LOS ranges from 2 days to 22 days,

The net impact of lower per case payments for psychiatric DRGs and higher length of stay is illustrated by the below comparison between the money a hospital is paid for providing in-patient treatment for a psychosis patient DRG as compared with an orthopedic, spinal or cardiology patient DRG:

DRG (Diagnostic Related Group)	Ave. Medicare Reimbursement Rate in NY State	Average Length of Stay (days)	Revenue per Bed Per Patient Day	Revenue Per Bed per year (assuming 100% occupancy)
Psychosis	$8,106	6	$ 1,351.00	$493,115.00
Revision of Hip/Knee Replacement (w/o complications)	$27,253	3	$ 9,084.33	$ 3,315,781.67
Cervical Spinal Fusion (w/o complications)	$16,604	2	$ 8,302.00	$ 3,030,230.00
Cardiac pacemaker replacement (w/o complications)	$42,941	4	$10,735.25	$ 3,918,366.25

As indicated in the above samples, a hospital that closes a psychiatric in-patient unit and replaces it with an orthopedic, spinal or cardiac units can increase revenues by almost 800% or by as much as $3.5 million per bed.

The revenue dynamic is also evident in an analysis of actual hospital reporting data. According to hospital Institutional Cost Reports (ICR) filed by hospitals with the state DOH, the inflation-adjusted net patient revenue per bed for psychiatric in-patient care dropped from about $100,000 per bed in 2000 to about $88,000 per bed in 2018. The average net patient revenue per bed for all in-patient beds (including psychiatric beds) in 2018, by way of contrast was about $1.6 million.

The revenues to be earned by hospitals from converting psychiatric beds to other types of care are further magnified by the prospect of reduced penalties for readmissions, reduced length of stay and more direct control of revenues and expenses. For example, a patient who is released after treatment for psychosis could have another incident, regardless of the quality of care given during the admission and to be readmitted (that is the nature of mental illness). If, on the other hand, the quality of care given to a cardiac pacemaker patient is good, there will be less likelihood of an unreimbursed or penalized readmission.

The motivation of hospitals to close psych beds and replace them with other services is readily apparent - shutting down psychiatric beds and replacing them with other services offers hospital management an avenue to substantially increase hospital revenues and net profits/surpluses.

7. COVID has accelerated the loss of psychiatric inpatient beds

As noted above, State DOH policy during the pandemic required hospitals to increase their capacity (ICU and acute Medical/Surgical beds) to handle the flood of patients during the height of the pandemic. Hospitals by and large did this by cancelling elective procedures to free up space in their hospitals and by converting existing units into COVID overflow units. Often the first units to be converted and repurposed were in-patient psychiatric and substance use units.

The closure or reduction of psych beds to allow for greater COVID hospital capacity was consistent with pre-COVID trends discussed above. This was something that hospitals were

already doing, and COVID accelerated those existing trends.

Moreover, because of the urgent nature of the pandemic emergency, the State suspended normal Certificate of Need and other oversight regulations, allowing (indeed, encouraging) psychiatric beds to be "temporarily closed" without any formal oversight or review by the DOH.

Many hospitals have used the ongoing crisis as cover or an "opportunity" to attain longstanding goals to rid themselves of unprofitable psychiatric beds under the guise of responding to the COVID crisis.

This dynamic has resulted in the "temporary" and unregulated closure of hundreds of psychiatric beds, including the following examples:

a. New York Presbyterian – Allen Campus psych unit in Manhattan
b. New York Presbyterian – Methodist psych units in Brooklyn
c. Northwell Health – Syosset psych units in Long Island
d. NYC Health + Hospitals – NCB psych units in the Bronx and Metropolitan psych unit in Manhattan
e. Westchester Medical Center System – Health Alliance psych units in Kingston

Though these bed closures are ostensibly temporary and are technically an emergency response to the need to increase COVID capacity, there is a serious likelihood that these units will never be reopened and the closures will become permanent, further accelerating the trend in loss of psychiatric beds.

8. New York does not have enough beds to meet inpatient acute care psychiatric needs

The ongoing hospital industry impetus to close psychiatric beds and replace them with more lucrative inpatient service lines has reduced capacity in New York State to unacceptable levels that impede population needs.

A study by the Treatment Advocacy Center estimates that health systems should maintain a psych bed capacity of at least 40 to 60 beds per 100,000 population. The average psychiatric bed capacity among the 34 advanced economies of the Organization for Economic Cooperation and Development (OECD) in 2014 was 68 beds per 100,000 population.

According to the 2019 Report of the Office of Performance Measurement and Evaluation of the NYS Office of Mental Health (covering 2017-2018), New York State had 7,465 licensed adult beds and 1,602 pediatric beds. The OMH report included all Article 28 hospitals, Article 31 psychiatric specialty hospitals, and state operated facilities. It should be further noted that OMH acknowledges that the licensed capacity in the report is an over count because OMH did not measure unused or unstaffed licensed beds.

The OMH survey showed a licensed bed count of 9,067 for a population of 19.8 million or 45.8 per 100,000 population (47.8/100,000 for adults and 38.2/100,000 for children).

This data shows that New York is significantly below the OECD average of 68 beds/100,000 and near the low end of the minimum recommended range of 40-60 beds/100,000.

Given the long term trends, the additional “temporary” closures during the COVID crisis, and the increased prevalence of psychiatric (and substance use) disorders due to COVID related effects, it is clear that NYS does not have sufficient inpatient bed capacity to meet resident need.

9. Increasing role of the prison/carceral system in providing psychiatric patient care

As NY State has continued to see a substantial and sustained loss of needed in-patient psychiatric bed capacity, we have also witnessed an increasing shift of acute psychiatric care from our hospitals to state and local prison systems.

Even as public policy seeks to decrease incarceration rates and to limit pre-trial detention and sentencing for minor non-violent offences, the number and percentage of incarcerated New Yorkers with serious mental health diagnoses continues to increase.

From 2005 to 2014, the number of prisoners in the State prison system hospitalized in forensic care beds increased from 995 per day to 1,269 per day (a 28% increase), according to data analyzed by the National Association of State Mental Health Program Directors (NASMHPD). By way of comparison, the state prison population decreased by 19% between 2006 and 2016 (from 63,756 to 52,245).

In the City of New York, the jail population has decreased from a daily census of 12,790 in 2011 to 7,938 in 2019. But, despite the decline in total prison population, the percentage of prisoners with a diagnosed mental illness has increase from 32% in 2011 to 45% in 2019. The percentage with a serious mental illness (SMI) has increased to 17% of detainees.

The increased prevalence of mental illness in the state and city carceral systems has corresponded with the statewide decrease in acute in-patient psychiatric bed capacity and the reductions in the availability of state psychiatric beds. The prisons are increasingly becoming warehouses for the mentally ill.

Any efforts to break this negative cycle will require an expansion of available non-carceral in-patient and out-patient psychiatric services.

10. Disparate racial impact of reduced inpatient psychiatric bed capacity

Black and Latino/Latinx people generally have lower rates of mental health diagnosis, which may reflect a systemic racial bias in mental health services. Numerous studies suggest that white patients are more likely to be assessed and receive needed mental health services than people of color.

According to a data analyzed by the Substance Abuse and Mental Health Services Administration (SAMHSA), an arm of the federal Department of Health and Human Services, 46% of whites

diagnosed with mental illness receive treatment, while only 29.8% of Blacks and 27.3% of Latinos/Latinx are treated.

Similar racial disparities were found in the prescription of medications and the use of out-patient service to treat diagnosed illness. 41% of white patients were treated with medication, compared to only 23.4% of Black patients and 22.4% of Latino/Latinx patients. With respect to out-patient treatment, 25.7% of whites received care, compared to 18.7% of Blacks and 16.6% of Latinos/Latinx.

In the case of psychiatric in-patient services, however, this pattern is reversed. Among Blacks with psychiatric/mental health diagnoses, 5.1% receive in-patient treatment in hospitals, while the hospitalization rate for Latino/Latinx is 3.2% and for whites 2.9%. Black patients are thus almost 76% more likely to be treated on an in-patient basis than whites.

The reliance of Black patient on in-patient services for their psychiatric care is reflected in an analysis of SPARCS data reported by the New York State DOH. According to the most recently available data for hospitals in the New York City area, Black patients comprise about 27% of all hospital in-patient admissions, but they constitute 39% of all in-patient admissions for mental diseases and disorders. Black patients with psychiatric diagnoses thus have a 44% higher use of inpatient services than their overall hospitalization rate.

The reductions of in-patient capacity will disproportionately impact the availability and access to care for communities of color, particularly Black patients with mental health diagnoses.

By closing in-patient psychiatric and mental health units, private hospitals are in effect shedding services that are more likely to be used by Black patients and thus further shifting their care to the carceral system or leaving that community with less access to care of any kind.

11. The closure of inpatient psychiatric beds disproportionately affects safety net providers

The loss of psychiatric inpatient capacity discussed above has not been uniform throughout the broader hospital industry.

A disproportionate percentage of the lost psychiatric beds were closed by the large, non-profit hospital systems. The New York Presbyterian, Northwell and Mount Sinai hospital systems are prime examples of this private sector trend. These large networks are increasingly operated more like for-profit corporations and they relentlessly seek to increase their revenues and net profits/surpluses.

As has been noted, psychiatric services are much less profitable than other kinds of inpatient services, so the correlation of profit maximizing behavior and the closure of these beds is fairly obvious. The shedding of poorly reimbursed psychiatric services and their replacement with more lucrative services contributes to the increasing concentration in revenues and net revenues or surpluses in these large hospital systems.

In pursuing this profit maximizing strategy, the large medical center systems have increasingly shifted the burden for providing in-patient psychiatric care to public and private safety net providers.

In New York City, this dynamic has led to an increasing concentration of costly and low or no margin acute psychiatric in the public NYC Health + Hospitals system and independent (non-network affiliated) private safety net hospitals.

The NYC Health + Hospitals system accounts for about 18% of total City-wide hospital bed capacity. But according to State SPARCS data for 2014, it provided almost 60% of admissions for schizophrenia, 47% of admissions for bi-polar disorder and 44% of admissions for major depressive disorders.

The shift of in-patient psychiatric care from the large private networks to the public and private safety net hospitals has contributed to the increasing profitability of the large networks and at the same time has increased the financial pressure on the safety net institutions, creating a two-tiered system of well-off hospitals in operating side-by-side with financially precarious safety net providers that are barely able to maintain operations.

This tendency also overlaps the previously discussed racial disparities in the availability of care. Black patients not only use in-patient psychiatric services at higher rates than white patients, but they also increasingly find themselves using these services at under-resourced public and private safety net hospitals.

According to the SPARCS data, 46% of in-patient psychiatric patients at NYC Health + Hospitals and 45% of patients at independent safety net hospitals were Black, compared with only 22% of patients at large network hospital networks.

As private non-profit hospitals shed psychiatric beds and patients, the burden is being picked up by public hospitals. The NYC Independent Budget Office found a 20% increase in mental health discharges at NYC Health and Hospitals from 2009-2014, while the non-profit systems showed a 5% decrease in discharges in the same period.

The stratification of psychiatric bed capacity has driven Black patients needing in-patient psychiatric services to rely increasingly on under-resourced safety systems, all to the financial benefit of the profitable private hospital networks.

12. Need for uniform minimum staffing standards in psychiatric units

The shift of psychiatric in-patient bed capacity from the profitable network hospital systems to financially precarious safety net hospitals, coupled with the low reimbursement rates for in-patient psychiatric care has also increased pressures to reduce expenses to maintain psychiatric services.

The nature of psychiatric care inherently necessitates a cost structure with a higher labor component than is the case with other specialty categories of care. Cardiac, orthopedic, cancer and other specialty units use a proportionally higher amount of technology, equipment, imaging devices and laboratory testing than psychiatric services. In psychiatric care, there is less reliance on such high cost technological factors and more direct care and observation by nurses and other staff. Psychiatric in-patient care is inherently labor intensive.

Because this care is not adequately compensated, there is a tendency to either cut costs by understaffing or to properly staff and operate at a loss. In the case of financially precarious safety net hospitals, this pressure is particularly acute.

To ensure that all psychiatric patients receive the level of care that they need, and to alleviate the pressure to eliminate this "loss leader" or in the alternative to reduce staffing costs to a bare bones minimum, we must (a) implement minimum mandatory staffing standards in psychiatric in-patient units (including nurse to patient and care giver to patient ratios), and (b) substantially increase in-patient psychiatric reimbursement rates to properly compensate hospital providers and reduce the racial inequalities that are increasingly apparent in the distribution of funding and resources for this vital service.