National Association of State Mental Health Program Directors
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Assessment #4

The Role of Permanent Supportive Housing in Determining Psychiatric Inpatient Bed Capacity

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Alexandria, Virginia

Second in a Series of Ten Briefs Addressing: *What Is the Inpatient Bed Need if You Have a Best Practice Continuum of Care?*

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The Role of Permanent Supportive Housing in Determining Psychiatric Inpatient Bed Capacity

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Executive Summary

One obligation of public mental health systems is to ensure sufficient capacity in the range of services that persons with serious mental illness may need. Historically, states relied heavily on psychiatric inpatient beds as the primary method of care. With the expansion of community-based services over the past forty years, the utilization of hospital-based inpatient beds has decreased significantly. Years of experience delivering community-based behavioral health care have proven that most people with a diagnosed mental illness never require hospitalization, and many with the most serious conditions can be successfully treated in the community. There is now a general consensus that a stronger continuum of community-based services results in less demand for psychiatric inpatient beds.

Despite the success of community-based services for people with serious mental illness, public mental health systems often experience pressure to increase psychiatric inpatient capacity in response to real or perceived unmet need. Such pressure often actually stems from an underfunded community mental health system, exemplified by emergency department overcrowding and boarding, visible chronic homelessness, increased police encounters and jail census, stigma, or a high-profile incident.

However, effective management of capacity across the range of services must be data-driven, while taking into consideration the needs of the population, the evidence base for each service or program, individual civil rights, and costs. Changes to capacity in any one type of service or program will impact other services across the system. When determining psychiatric inpatient capacity, system leaders should first assess the capacity of evidence-based community programs and services to reduce the need for inpatient care. This paper discusses the importance of one such model, permanent supportive housing (PSH), in serving people with serious mental illness in the community, and the role PSH can play in determining an area's psychiatric inpatient bed capacity.

Background

The Good and Modern Mental Health System

As articulated by the Substance Abuse and Mental Health Services Administration (SAMHSA), the vision for a "good" and "modern" mental health and addiction system is grounded in a public health model that addresses the determinants of health system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience, and recovery support to promote social integration and optimal

health and productivity.[1] The goal is to provide a full range of high-quality services to meet the full range of age, gender, cultural, and other needs presented. A good system uses interventions that reflect the knowledge and technology available in modern medicine, and that include evidence-informed practice. The system should recognize both the critical connection between primary and specialty care and the key role of community supports with links to housing and employment. A good system also acknowledges that behavioral health disorders are preventable, and promotes healthy behaviors and lifestyles as primary drivers of health outcomes.

A full spectrum of treatment and recovery supports should be available to individuals with mental health and substance use disorders, including inpatient psychiatric care, crisis intervention services, PSH, Assertive Community Treatment (ACT) teams, outpatient behavioral health treatment, psychosocial rehabilitation programs, supported education and employment services, medication-assisted treatment, integrated primary care, and recovery and peer supports. Each of these services has a role to play, but, when community-based behavioral health systems lack the full continuum with a defined role for each service, delivery can become inefficient and ineffective, resulting in poor outcomes.

Generally, stronger and more accessible community-based services and supports and a well-developed psychiatric emergency response system will reduce both reliance on costly inpatient care and overutilization of police intervention. Services such as ACT can decrease the need for inpatient care even among individuals with the most challenging behavioral health disorders.[2] The challenge in developing a "good and modern" behavioral health system is that of achieving the proper balance between a strong, accessible, high-quality community-based system capable of meeting the diverse needs of individuals, and an adequate number of inpatient beds and crisis intervention capacity to form an adequate safety net.

The Role of Psychiatric Inpatient Care Today

With advances in psychiatry and pharmacology and the development of evidence-based community services — including PSH, ACT, and peer-delivered supports — states have been able to reduce their need for inpatient care. Today, psychiatric inpatient care is geared toward providing intensive treatment during periods of crisis and then helping individuals transition back to a less restrictive setting. Average length of stay is now measured in days, not months or years as was the case in the past.

In most states, acute psychiatric inpatient care is provided in general hospitals or private hospitals rather than in publicly operated beds, though this does vary by state. The

[1] *Description of a Good and Modern Addictions and Mental Health Service System*, Substance Abuse and Mental Health Services Administration (SAMHSA), . Rockville, MD (2011).

[2] La E.M., Lich K.H., Wells R., Ellis A.R., Swartz M.S., Zhu R., & Morrissey, J.P., Increasing access to state psychiatric hospital beds: Exploring supply-side solutions, *Psychiatric Services*, 67, 523–528. (2015)

remaining public beds, provided in state or county hospitals and with some variation among states, generally provide forensic services (i.e. evaluation, restoration to competency, long-term commitment for people found not guilty by reason of insanity) and longer-term treatment for people not ready for discharge to the community after a short-term acute hospitalization. In 1955, there were an estimated 559,000 state and county psychiatric beds in the United States, or nearly 340 beds per 100,000 people. Individuals admitted to psychiatric institutions stayed for extended periods of time and had little to no access to community services. By early 2016, state hospital psychiatric capacity had dropped by more than 96 percent, to 37,679 beds, or 11.7 beds per 100,000 people.[3]

Although there is often public outcry when psychiatric inpatient beds are eliminated, several studies have shown that reductions in the number of publicly funded/operated acute and long-term inpatient beds have not resulted in increased negative outcomes such as suicide, incarceration, police interactions, decreased level of functioning, or homelessness.[4] Studies have shown that the demand for acute inpatient care appears to be "elastic,"[5] in that inpatient capacity was fully used when it was available, but other options were found to meet individuals' basic needs when inpatient capacity was no longer available.[6]

Adding further support to community-based services, the 1999 U.S. Supreme Court decision in *Olmstead v. L.C.* affirmed the right of people with disabilities under Title II of the Americans with Disabilities Act to live in the least restrictive setting appropriate to their abilities. The case highlighted that in several states, many of the individuals who occupy inpatient beds do not need that level of care and are only there due to a lack of a community-based supportive housing options. Under *Olmstead*, states have an affirmative obligation to ensure that people with disabilities who choose to live in integrated community settings have maximum opportunities to do so. In 2011 the federal Department of Justice issued a policy brief defining the characteristics of such settings:

> *Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies, and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered site housing*

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[3] Fuller D.A., Sinclair E., Geller J., Quanbeck C., & Snook J., *Going, going, gone: Trends and consequences of eliminating state psychiatric beds,* Treatment Advocacy Center, . Arlington, VA: (2016).
[4] Shumway Martha *et al*. Impact of Capacity Reductions in Acute Public-Sector Inpatient Psychiatric Services, *Psychiatric Services*, Vol. 63 No. 2 (February 2012).
[5] *Ibid.*
[6] *Analysis of Adult Bed Capacity for Milwaukee County Behavioral Health System*, Human Services Research Institute, Technical Assistance Collaborative and the Public Policy Forum (2014). http://media.jrn.com/documents/mentalreport09162014.pdf.

> *with supportive services are examples of integrated settings. By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.*[7]

However, states have experienced various challenges in downsizing inpatient capacity in favor of offering integrated, community-based care, with many states experiencing pressures on the acute care end of the system such as:

- increased emergency department volume and boarding;
- backups in local psychiatric inpatient units due to admissions and barriers to transitioning discharge-ready individuals;
- census problems in state psychiatric hospitals due to community-based capacity; and
- efforts by the criminal justice system to divert consumers to the mental health acute care system.

These pressures on the acute care end of the system are often attributable to nonexistent or underfunded community-based services. Too often, psychiatric inpatient care inappropriately functions as a remedy for homelessness or for "nuisance crimes" such as loitering and panhandling. Access to evidence-based services in many states is limited and therefore prioritized for those with the most complex conditions. In addition, many systems lack adequate crisis response systems that can divert inpatient admissions. In response to such real or perceived gaps in the community-based system of care, public mental health systems are frequently confronted by demands to increase psychiatric inpatient capacity.

Permanent Supportive Housing

Permanent supportive housing has demonstrated its effectiveness in decreasing admissions to emergency departments and inpatient care, and its role in helping to produce other positive outcomes. PSH *is* a combination of affordable, lease-based housing and services designed for people with serious mental illnesses or other

[7] Questions and Answers on the ADA's Integration Mandate and *Olmstead* Enforcement, Civil Rights Division, U.S. Department of Justice, https://www.ada.gov/olmstead/q&a_olmstead.htm.

disabilities who need support to live stably in their communities. These services can include case management, tenancy support services, substance use disorder or mental health counseling, advocacy, and assistance in finding and maintaining employment.[8]

Investing in PSH increases community capacity that can serve as a diversion from inpatient admissions and other institutional settings such as jails and prisons. Furthermore the investment facilitates timely discharges from inpatient care, creating "through-put" for existing beds. The identification of a need for more inpatient beds can be reframed as a need for additional community-based services and affordable housing. In fact, the primary remedy included in all of the more well-known *Olmstead* settlement agreements with the Department of Justice is permanent supportive housing.

A number of studies correlate the importance of PSH in reducing inpatient bed days and costs. Over the 20-month duration of *A Place to Start*, a PSH program of Virginia Supportive Housing, client emergency room visits declined by 61 percent, inpatient psychiatric hospitalizations decreased by 62 percent, and emergency room costs were reduced by 66 percent.[9] An evaluation in San Francisco demonstrated that PSH significantly reduced the likelihood of hospitalization.[10] An evaluation *of New York/New York III*, a major supportive housing initiative, demonstrated a 41 percent decrease in the likelihood of being admitted to a psychiatric inpatient unit, once placedin PSH.[11] *Moore Place*, a PSH program in Charlotte, NC, demonstrated a 79 percent reduction in inpatient bed days for individuals housed.[12]

In Massachusetts' *Home and Healthy for Good* program, 932 participants accumulated 2,472 emergency department visits, 4,044 overnight hospital stays, 1,157 ambulance rides, and 3,049 detoxification stays in the six months prior to housing. The estimated total cost per person for measured services — including medical ($30,513), shelter ($5,436) and incarceration ($1,441) — amounted to $37,390 per year. After one year in the program, the total per person cost for these same services had fallen to $10,112.[13]

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[8] *Implementing Housing First in Permanent Supportive Housing: A Fact Sheet from USICH with Assistance from the Substance Abuse and Mental Health Services Administration,* United State Interagency Council on Homelessness (2014), https://www.usich.gov/resources/uploads/asset_library/Implementing_Housing_First_in_Permanent_Supportive_Housing.pdf

[9] *Additional Facts and Figures on Permanent Supportive Housing*, Virginia Housing Alliance (2017), http://vahousingalliance.org/wp-content/uploads/2017/02/2017-PSH-fact-sheet-addendum.pdf.

[10] Martinez T.E., & Burt M.R., Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults, *Psychiatric Services* 57 (7), pp. 992-99 (2006)..

[11]. *New York/New York III Supportive Housing Evaluation: Interim Utilization and Cost Analysis*, New York City Department of Health and Mental Hygiene (2013).

[12] Thomas L.M., Shears J.K., Pate M.C., & Priester M.A., *Moore Place Permanent Supportive Housing Evaluation Study: Year 1 Report*, UNC Charlotte College of Health and Human Services (2014).

[13]. *Home and Healthy for Good June 2016 Progress Report,* Massachusetts Housing and Shelter Alliance (2016), http://www.mhsa.net/sites/default/files/June%202016%20HHG%20Report.pdf.

A review of the literature was conducted by the Center on Budget and Policy Priorities (CBPP), a non-partisan policy and research institute that focuses on budgetary, program, and policy analysis in order to drive more effective policy outcomes. In 2016, CBPP issued a report on the impact of PSH on vulnerable populations.[14] Here are a few highlights:

- A broad body of research shows that supportive housing effectively helps people with disabilities maintain stable housing. People in supportive housing use costly systems like emergency health services less frequently and are less likely to be incarcerated. Supportive housing also can aid people with disabilities in getting better health care and help seniors trying to stay in the community as they age and families trying to keep their children out of foster care.
- A large body of research shows that the vast majority of people who live in supportive housing are able to stay stably housed in the community. Most of this research focuses on people with severe disabilities experiencing homelessness, especially people with mental illness or substance use disorders.
- A 2012 study by the Urban Institute tracked 121 participants who lived in supportive housing after release from incarceration and a similar-sized cohort who did not. Those in supportive housing were 43 percent less likely to be rearrested on misdemeanor charges and were 61 percent less likely to be re-incarcerated one year later.

Another study, published by the Center for Outcomes Research and Education, was one of the first to assess directly the impact of affordable housing on health care costs for low-income individuals. The study included 145 housing properties of three different types: family housing, PSH, and housing for seniors and people with disabilities. The study found that costs to health care systems were lower for all groups after people moved into affordable housing: 8 percent lower for families,14 percent lower for residents of PSH, and 16 percent lower for seniors and persons with disabilities, for an overall health care cost reduction of 12 percent. In addition, one year after moving into affordable housing, residents reported that outpatient primary care utilization had increased by 20 percent, emergency department use had fallen by 18 percent, access to care had improved by 40 percent, and the quality of care they received had improved by 38 percent.[15]

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14 Dobler E., Bailey P., Rice D., & Katch H.. *Supportive Housing Helps Vulnerable People Live and Thrive in the Community. Center on Budget and Policy Priorities* (2016), http://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community.

[15] Saul A., *Health in Housing: Exploring the Intersection between Housing and Health Care*, Enterprise Community Partners, Inc., Center for Outcomes Research and Education (2016).

Studies of community-based programs for persons with severe mental illness identify an acute care episode resulting in hospitalization as "the single largest cost element in the array of services needed to provide community care."[16] PSH costs far less than other settings in which individuals with mental health disorders may be found who are not successfully integrated into the community: The cost of serving a person in supportive housing is one-half the cost of a shelter, one quarter the cost of being in prison, and one-tenth the cost of a state psychiatric hospital bed.[17]

In addition, costs associated with supportive housing can be offset through a combination of existing funding sources, including Medicaid and federal housing and rental assistance programs. Inpatient care in a state psychiatric hospital, which is typically unable to bill Medicaid because of being classified as an" institution for mental disease,"[18] could cost well over $300,000 per year, while evidence-based alternatives like ACT and PSH cost less than $20,000 per year and can be partially offset by federal participation through Medicaid.[19] [20] An average cost to treat someone with schizophrenia in an inpatient setting has been reported to range from $850 to $1,187 per day ($310,250 to $433,255 annually) versus $61 per day ($22,265 annually) to serve someone in PSH (including case management and rental assistance).[21] [22]

What State Mental Health Authorities Should Be Doing

Data has never been more relevant to planning for and evaluating the behavioral health care delivery system. Research indicates that a disproportionate number of intensive, high-cost services are utilized by a small percentage of the total population served.[23] This

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[16] Fenton W.S., Hoch J.S., Herrell J.M., Mosher L., & Dixon L., Cost and cost-effectiveness of hospital vs residential crisis care for patients who have serious mental illness. *Archives of General Psychiatry* 59 (4), pp. 357–364 (2002)..

[17] The Bazelon Center for Mental Health Law, http://www.bazelon.org/supportive-housing/.

[18] Section 1905(a) of the Social Security Act "prohibits the federal government from reimbursing states under the Medicaid program for services rendered to a Medicaid beneficiary who is a patient in an institution for mental disease (IMD)." The Centers for Medicare and Medicaid Services has defined an IMD as "a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care for people with mental disease."

[19] The FY2012 daily rate for Adult Treatment Services in Oregon State Hospital is $945/day, or $345,000/year, Oregon Health Authority, Oregon State Government, http://www.oregon.gov/oha/amh/osh/Pages/cost-of-care.aspx.

[20] FY2013 New York State Budget for ACT, https://www.omh.ny.gov/omhweb/spguidelines/case_mngmt_models/2013_Upstate_Downstate_Models.pdf.

[21] Stensland M., Watson P., Grazier K., An Examination of Costs, Charges, and Payments for Inpatient Psychiatric Treatment in Community Hospitals*, Psychiatric Services* 63(7), pp. 666-671 (2012).

[22]*. Supportive Housing: Cost Effective with Better Outcomes Fact Sheet*, Partnership for Strong Communities (2015), http://www.pschousing.org/files/PSHCostEffective_FactSheet_Updated2015.pdf.

[23] *Medicaid: A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures,* GAO-15-460, GAO Report to Congressional Requesters (May 2015) https://www.gao.gov/assets/680/670112.pdf .

means that fewer resources are available to support community-based services designed to lessen the demand for psychiatric inpatient care. Targeting individualized services like PSH to the high utilizers of inpatient services has proven an effective way to rebalance service utilization and costs.

Prioritizing and Promoting PSH Policy

State mental health authorities (SMHAs) have an important role in exercising leadership on mental health policy and the services that exist in a good and modern system.[24] The pressures on emergency departments, state and local psychiatric inpatient units, and law enforcement agencies are real, and the solutions must be informed by data, evidence-based practices, and outcomes as budget allocations are made and programs developed. In most states, demand for PSH exceeds capacity and will need to be brought to scale in order to have meaningful impact on more costly acute care services.

Some who advocate for increasing psychiatric inpatient capacity and/or supervised group residential facilities question the outcomes and cost effectiveness of PSH. State mental health authorities are in a strong position to educate stakeholders —consumers, family members, providers, and legislators — on the benefits of PSH to people with mental illness, as well as on the effect it can have on psychiatric inpatient capacity. SMHAs must make access to affordable housing and services a policy priority, given the data on the effectiveness of PSH in reducing inpatient bed and emergency department use, as well as unnecessary stays in inpatient settings, jails, and homeless shelters.

Managing Your System through Planning, Funding, and Partnerships that Support PSH

Increasing PSH capacity and thereby reducing reliance on inpatient capacity requires strategic planning. PSH has the evidence base to assist SMHAs in making the business case to invest in community-based alternatives rather than more costly models of care. New inpatient beds tend to get filled, but states should not necessarily interpret that as justification for the need. Rather, states should consider the possibility that this pattern results from underfunded community-based capacity, and that the expansion of services such as PSH would alleviate pressure on acute care systems and bring about a sustained reduction in the need for inpatient beds.

SMHAs must also ensure that services and supports align with housing resources in PSH. The key is to recognize the importance of flexible, individualized services such as patient

[24] Miller J., *Too Significant To Fail: The Importance of State Behavioral Health Agencies in the Daily Lives of Americans with Mental Illness, for Their Families, and for Their Communities*. National Association of State Mental Health Program Directors (2012).

engagement, evidence-based outpatient treatment, skill-building, and peer specialist and recovery support. Given most states' increased reliance on Medicaid to fund services and supports, partnerships with state Medicaid agencies (SMAs) are important to maximizing the financing of services through new and expanded Medicaid authorities. Several states are implementing § 1915(i) Medicaid state plan amendments and pursuing § 1115 Medicaid waivers to fund PSH-related services and supports that promote community integration for individuals with chronic behavioral health conditions. Some have successfully advocated for Medicaid managed care cost savings to fund housing-related services and supports that promote community integration.

In addition, SMHAs must commit to new or reallocated use of existing resources to improve access to PSH and other community-based services targeted to reduce over-reliance on high-cost Medicaid services such as emergency departments and inpatient services. A robust array of services, such as mobile crisis response, ACT, peer supports, and outpatient services will augment the effectiveness of PSH.

State mental health authorities have historically shouldered the development of the traditional group home model. While SMHAs should take a leadership role in elevating PSH as a policy priority, they cannot and should not assume all of the responsibility. The development of affordable housing is better suited to those with expertise in affordable housing. Successful expansion of PSH requires cross-agency collaboration and partnerships with state housing finance agencies (SHFAs), public housing authorities, and state Medicaid agencies. Few states have sufficient affordable housing stock necessary to meet the need for PSH. Creating a pipeline of housing units requires system planning at the state and, in many cases, local levels. Partnerships are essential to developing strategies that avoid competition among agencies vying for affordable housing to meet the needs of their target populations.

State mental health authorities must establish working relationships with their SHFAs in order to:

- Partner with state housing agencies to develop and align PSH policies and priorities;
- Coordinate access to federal, state, and local affordable housing resources to their target population(s); and
- Coordinate housing and services budget planning with other state and local agencies.

Conclusions and Recommendations: Strategies to Consider When Using PSH to Inform Psychiatric Inpatient Bed Capacity

Capacity should be determined systemically, and not in a vacuum. Reactionary planning typically does not produce desired outcomes and can be costly. Increases or reductions in capacity in specific parts of the system will impact others. There is general consensus that a more robust array of community-based services results in less burden on emergency and inpatient capacity.

However, there is no standard, universally applicable formula for "right-sizing" the components of a behavioral health system. Nor is there a standard formula to apply when seeking to project or estimate the number of inpatient beds that should exist in a system; the unique circumstances within each system should be taken into account when determining what this capacity should be.[25] Precisely how the balance of inpatient versus community-based capacity is to be achieved is difficult to standardize, due to variability in the types, capacity, and effectiveness of available outpatient services and safe, affordable housing in each state. Additionally, population characteristics (including the prevalence of mental disorders, availability or lack of social supports, and barriers of race and poverty) vary by locale.

Rather than rely on an arbitrary ratio of beds per capita, each state can benefit from a data-based analysis of inpatient bed utilization in the context of its community-based capacity. Such an assessment should include a "root-cause analysis" of inpatient utilization which identifies high-utilizer populations, patterns of utilization, and gaps in care, including geographic disparities in capacity and access. A concomitant cost analysis can identify the costs associated with trends in inpatient utilization, anticipated costs to develop alternative capacity, and the impact on various funding sources (e.g. state Medicaid match versus state general funds). This level of analysis will allow for informed decision-making regarding inpatient capacity, as well as related policies and procedures.

A broad range of individuals can benefit from PSH, including those with serious mental illness. Individuals who are chronically homeless, those who are forensically involved, and transition-age youth are also populations for which PSH has proven effective.[26] Whether assessing the need for community-based services or for psychiatric inpatient

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[25] Parks J. & Radke A., eds., *The Vital Role of State Psychiatric Hospitals,* National Association of State Mental Health Program Directors Medical Directors Council (2014), http://www.nasmhpd.org/Publications/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014.pdf.

[26] Dohler, E., Bailey, P., Rice, D. & Katch, H. (2016). Supportive Housing Helps Vulnerable People Live and Thrive in the Community. Center on Budget and Policy Priorities. http://www.cbpp.org/sites/default/files/atoms/files/5-31-16hous.pdf

beds, SMHAs should determine the existing capacity of PSH in the system, the need for PSH, and the potential impact that adding PSH opportunities might have on inpatient utilization.

States should consider the following steps to inform psychiatric inpatient capacity:

- Determine what the existing capacity of PSH is in your system.
- Use available data for individuals currently in PSH to project the decreased utilization of inpatient, emergency department, and other crisis services before and after becoming housed in PSH.
- Estimate how many people with serious mental illness and those in other target populations need PSH.
- Use available data to assess utilization by people with serious mental illness of emergency-based services, including emergency department visits, inpatient admissions, and inpatient bed days consumed. Data sources may include Medicaid claims, National Outcomes Measures, and the Homeless Management Information System (HMIS).
- Compare what the projected penetration of inpatient beds (i.e. number of admissions, length of stay) will be for people who will access PSH against current utilization data and what research suggests for people in need of PSH.
- Determine the new or repurposed resources necessary to expand access to PSH (e.g. case management services funded by Medicaid or non-Medicaid resources; rental assistance).

Other factors will also be important in determining psychiatric inpatient bed capacity, such as the capacity of other community-based services, mobile crisis, jail diversion, crisis intervention teams, and ACT. However, quantifying the current and potential impact of PSH on inpatient utilization will inform your capacity assessment and planning for inpatient bed capacity, support the business case for PSH as a primary intervention within the system, and serve as useful information to educate key stakeholders about a balanced good and modern mental health system.