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Green Mountain Care Board Psychiatric Inpatient Capacity Planning Update February 20, 2019

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THE University of Vermont HEALTH NETWORK

UVM Health Network
Psychiatric Inpatient Capacity (PIC)
Aim Statement

"Provide the analysis, engagement, and planning necessary to design and create a UVM Health Network inpatient psychiatric facility/unit that will substantially improve access to inpatient mental health care as part of an integrated system of care in Vermont."

THE University of Vermont HEALTH NETWORK

Psychiatric Inpatient Facility Planning

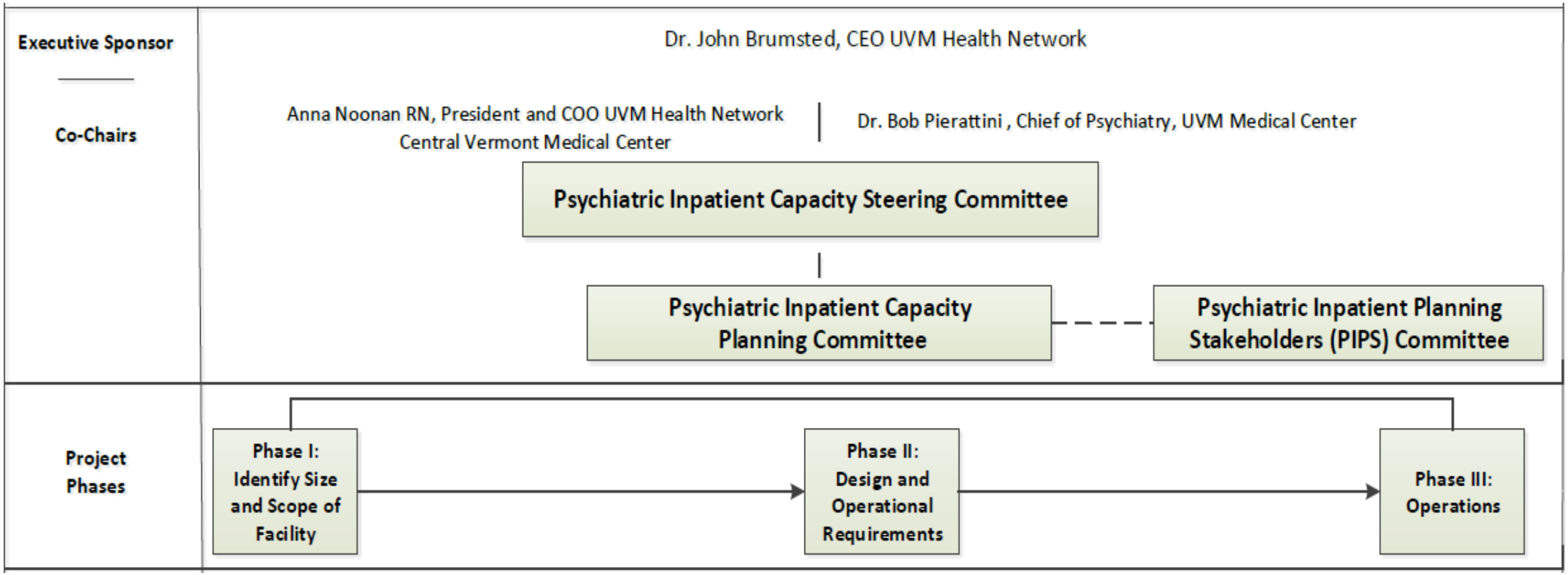
- Design and create a UVM Health Network inpatient psychiatric facility/unit on the Central Vermont Medical Center Campus that will “substantially improve access to inpatient mental health care as part of an integrated system of care in Vermont.”

- Anchor planning in data-driven, evidence-based process.

- Provide a forum for interested stakeholder input to inform the planning process: Psychiatric Inpatient Planning Stakeholders (PIPS) Committee created. Quarterly meetings scheduled through planning process.

- Create other opportunities to share information publicly, including community forums, legislative briefings, media relations, public reporting, etc.

Planning Process
Supporting Structure



Inpatient Psychiatric Bed Capacity

Eve Hoar MBA,
UVM Health Network
Director, Strategic and Business Planning

Adult Inpatient (IP) Psychiatric Capacity: Current State
200 Adult Beds in Vermont

Location	Type	Age	Subject to IMD Waiver	Capacity
Brattleboro Retreat Osgood 2 (LGBT)	In-Patient	Adults 18+	✓	15
Brattleboro Retreat Osgood 3 (Emerging Adult)	In-Patient	Adults 18+	✓	14
Brattleboro Retreat Tyler 1 (Co-Occurring)	In-Patient	Adults 18+	✓	22
Veterans Affairs – White River Jct	In-Patient	Adults 18+		12
Brattleboro Retreat Tyler 2 (Acute Adult)	In-Patient	Adults 18+	✓	24
Brattleboro Retreat Tyler 4 (Level 1 Adult)	In-Patient-Level1	Adults 18+	✓	14
Central Vermont Medical Center	In-Patient	Adults 18+		15
Rutland Regional Medical Center PSIU (acute care)	In-Patient	Adults 18+		17
Rutland Regional Medical Center PSIU South Wing (Level 1 acuity)	In-Patient-Level1	Adults 18+		6
University of VT Medical Center Shep 3	In-Patient	Adults 18+		12
University of VT Medical Center Shep 6	In-Patient	Adults 18+		16
Windham Center (Springfield)	In-Patient	Adults 18+		10
Vermont Psychiatric Care Hospital	In-Patient-Level1	Adults 18+	✓	25
TOTAL				200

63 Focused Beds

Brattleboro Retreat: 65% VT

137 General Beds

45 Level One
92 General IP Psych

63 beds under IMD Waiver

Estimate of Additional Bed Need

Vermont Emergency Department (ED) Patients with Mental Health Needs

IP Psych Unmet Need:

100% >28 hr ED Stay
1 of 5 pts 12-28 hr ED Stay

617 patients

OP Mental Health Need:

100% <12 hr ED Stay
4 of 5 pts 12-28 hr ED Stay

871 visits 12-28 hr

+

9,045 visits <12 hr

ED patient visits with primary psychiatric diagnosis or secondary diagnosis = suicide ideation or suicide attempt, with or without a psychiatric assessment

Simulation Results: +26 inpatient (IP) beds >55% reduction in patient hours* in EDs

Combined Outpatient ED Change - Brattleboro, CVMC, Rutland, Springfield, Southwest, and UVMMC

Excludes impact of patients admitted to same hospital

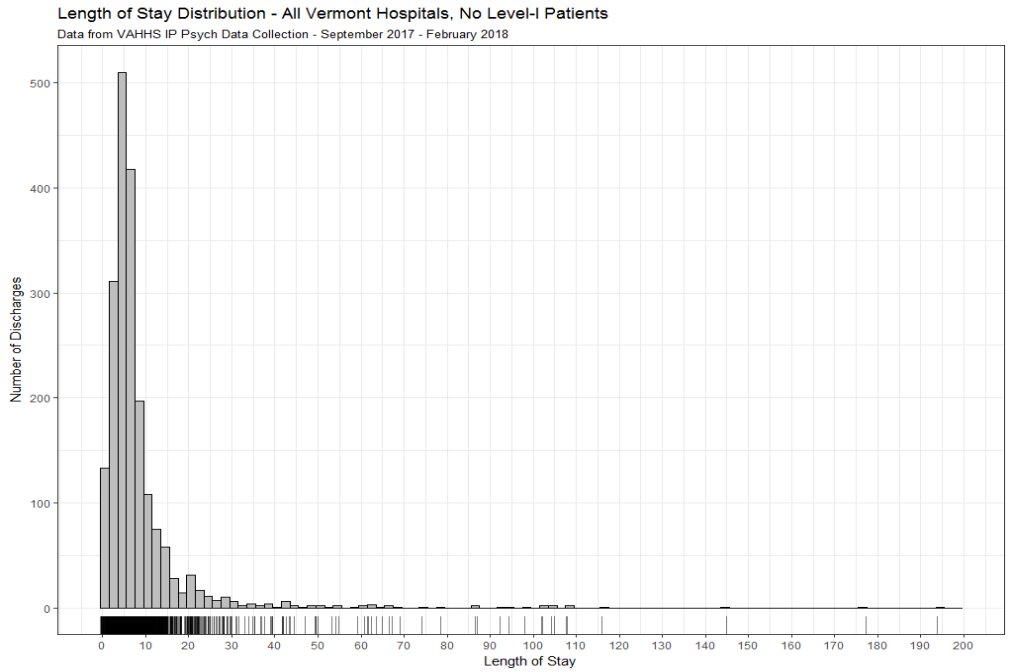
		Patient Hours in ED		
Patient Disposition	**Patients Affected**	Current State	26 Additional Beds	**Change**
Admitted: New Bed	478		2,268	
Admitted: Transfer	810	31,410	6,480	-79%
OP ED	4,865	59,973	32,335	-46%
Grand Total	**6,153**	**91,382**	**41,083**	**-55%**

* Does not include reduction in wait time for patients admitted to IP bed in same facility due to data availability.

Sensitivity Analysis: What if we could shorten the length of stay (LOS) for the "Unmet Needs" group of patients?

How long would these additional patients have stayed in an IP Psych bed?

- Assumed length of stay
  - VAHHS IP Psych data for non- Level 1 patients
  - LOS range: 0 -194 days
  - ALOS = 8.4 days
- Simulations randomly select from this distribution rather than using ALOS to better imitate reality



Reduce LOS by 1 day for all patients (ALOS ~ 7.4 days)

-1.5 beds

17-19 Beds for unmet need

18-20 Beds for unmet need

Institution for Mental Disease (IMD) Considerations

Eric Miller
UVM Health Network SVP and General Counsel

Institution for Mental Disease (IMD)

- The Rule: Federal funding under Medicaid is generally not available for any services provided to a Medicaid-eligible adult while the adult is an inpatient at an "Institution for Mental Disease" (IMD):
  - Promotes parity
  - Shifts funding burden for IMD care to states

- The Definition: An IMD is defined as a hospital or nursing home of more than 16 beds that is "primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases"

Institution for Mental Disease (IMD)

- The Test: In order to determine whether a facility is "primarily engaged" in providing mental health care, CMS looks at the "overall character" of the facility, asking:
  - Is it licensed as a psychiatric facility
  - Is it accredited as a psychiatric facility
  - Is it under the jurisdiction of the state's mental health authority
  - Does it specialize in psychiatric/psychological care and treatment
  - Are more than 50% of the patients in the facility admitted for the treatment of mental illness?
    - Measured on the day the determination is made

- The Implications: A hospital designated as an IMD loses federal Medicaid funding for all of the care it delivers, not only mental health care.

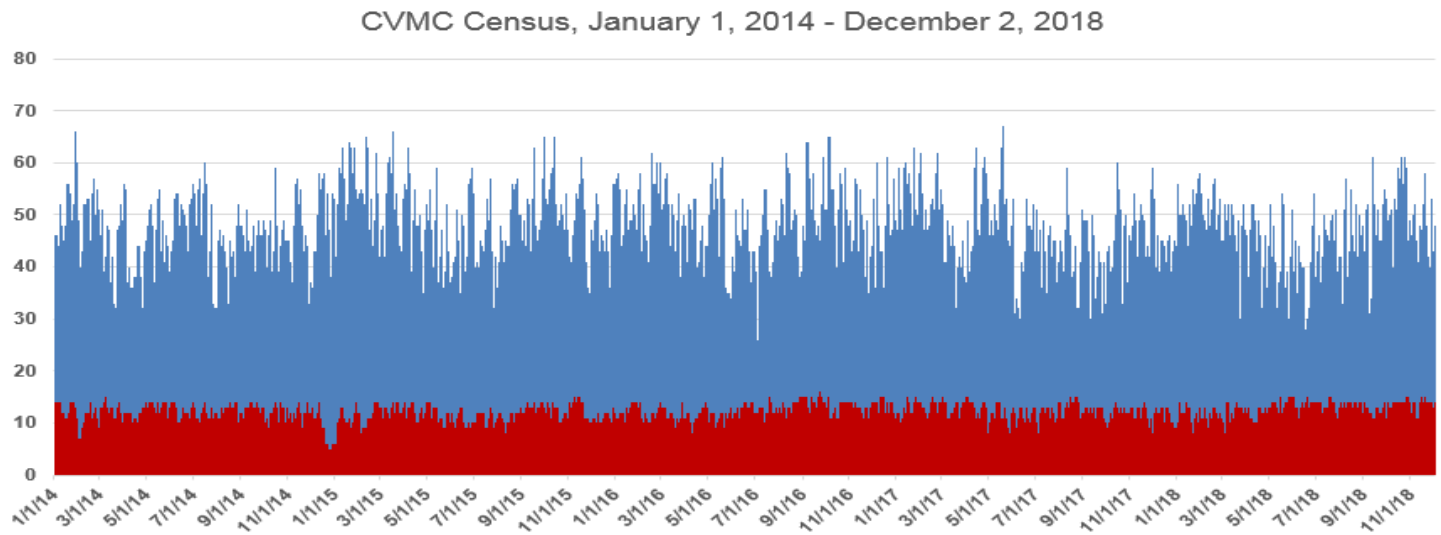
Institution for Mental Disease (IMD)

- The Question: How many inpatient psychiatric beds, when added to 15 existing beds, would place CVMC at risk of being designated an IMD?

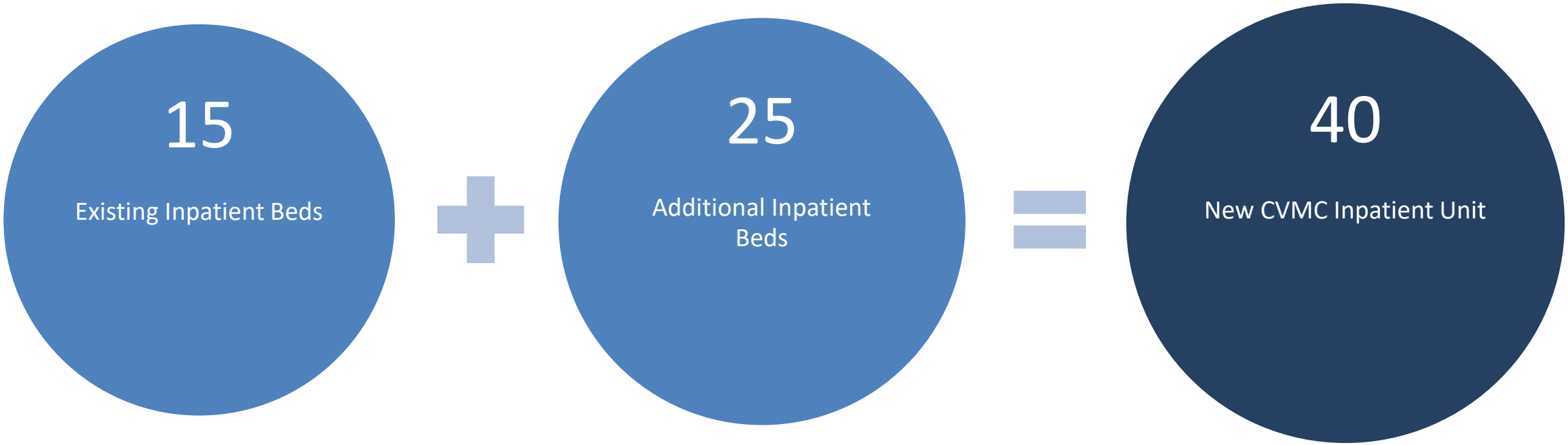
- The Answer Depends On Many Things, Including:
  - Historical analysis of medical/surgical patient census and psychiatric patient census
  - Projections of future medical/surgical patient census
    - UVMHN Care Delivery Optimization
  - Projections of future psychiatric patient census and occupancy rate
    - Number of beds in the entire system
  - Flexibility to bring psychiatric beds online and offline based on medical/surgical census
  - Staffing considerations point to 8-bed increments

Institution for Mental Disease (IMD)

- CVMC Capacity
  - Licensed for 122 beds
  - Staffed for average daily census of 57+/-
    - Including 15 inpatient psychiatry beds with average daily census of 12-13
    - Average daily medical surgical census of 44-45



Institution for Mental Disease (IMD)



Bed Programming

Bob Pierattini, MD
Chief of Psychiatry

Goal

"Maximize community access to inpatient psychiatric care after a thorough clinical evaluation concludes that inpatient treatment is medically necessary"

Design Goals:

- Minimize the number of people who wait >4 hrs in the ED for admission, once the determination that inpatient care is necessary
- Maximize the capability to manage any psychiatric or medical presentation
- Ensure efficient and cost-effective operation
- Minimize risk of harm to other patients and staff

Process

1. Stratify patient need by behavioral control and risk of aggression
2. Clinical programming correlates with measures of behavioral control
3. Design units to ensure safe management while maximizing personal independence and freedom from restraint
4. Identify the number of beds needed for each behavioral category, without compromising availability of beds for challenging presentations

1. Identify the behavioral categories of patients to be served

- The existing stratification (Shepardson 3, Shepardson 6, and VPCH) is essentially duplicated at other community hospitals. (CVMC is a mix of Shepardson 3 and 6).
- For planning purposes, these are designated Tier 3, Tier 2, and Tier 1
- Literature review did not find other stratification models.
- Forego subspecialized care to preserve access to any patient in need

Tier 1

Tends to treat psychotic disorders, mania, and brain injury (with or without associated substance use disorders or medical problems)

Patients tend to have the following characteristics:

- Poor behavioral control
- Threatening and violent, posing significant risk to other patients and staff
- Potential sexual aggression or very limited personal boundaries
- Social interaction is very distorted or frightening
- Not necessarily engaged in treatment, including voluntary status
- Bigger focus on restoring locus of control to the patient
- Bigger focus on ensuring safety of other patients, staff, and the public
- More staff attention required during phase of inpatient treatment

Tier 2

Tends to treat psychotic disorders, mania, and brain injury (with or without associated substance use disorders or medical problems)

Patients tend to have the following characteristics:

- Less behavioral regulation (may be loud, mildly threatening, agitated)
- Less social interaction (may be intrusive, belligerent, loud). Group therapy interventions and activities modified to accommodate verbal interest and tolerance of group
- Not necessarily engaged in treatment, including voluntary status
- Bigger focus on restoring locus of control to the patient

Tier 3

Tends to treat suicidality, depression, personality disorders, and anxiety disorders (with or without associated substance use disorders or medical problems)

Patients tend to have the following characteristics:

- Good behavioral regulation
- Ability to interact socially and interact in verbal group therapeutic interventions
- Engagement in treatment
- Interest in psychotherapy, reflection, mindfulness, anxiety management techniques

2. Identify the security level the beds will be configured to

- The physical and architectural features of each unit map onto overt behavior characteristics.
- For example, a Tier 3 unit does not require a seclusion room
- All units will meet regulatory requirements for environment of care.
- Tier 1 and Tier 2 beds should have a mechanism to separate aggressive patients.

3. Identify the number of beds allocated for each Tier

- There is no convenient measure of needed Tier for patients who recovered in the ED without admission.

- The allocation of beds to each Tier will be vetted during phase II facility planning work.

Phase II

- Facilities Planning
  - Programming plan and space allocation: three workgroups convened
  - Integration with CVMC Master Facilities Plan

- Financial Impact
  - Capital Needs
  - Operating Plan and financials

Questions & Discussion