

# Mental Health System of Care

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# Key Issues

- Emergency Departments statewide continue to experience overwhelming demand for psychiatric crisis services
- Length of stay at ALL levels of care is a critical factor not being addressed. Bottlenecks experienced by all at the next level of care:
  - ED > Diversion Beds > Inpatient > Crisis Step-down > Transitional Housing > Supported Living
- Secure Residential is needed to improve care and free up capacity
- Wide regional disparities in service availability across the State need to be addressed



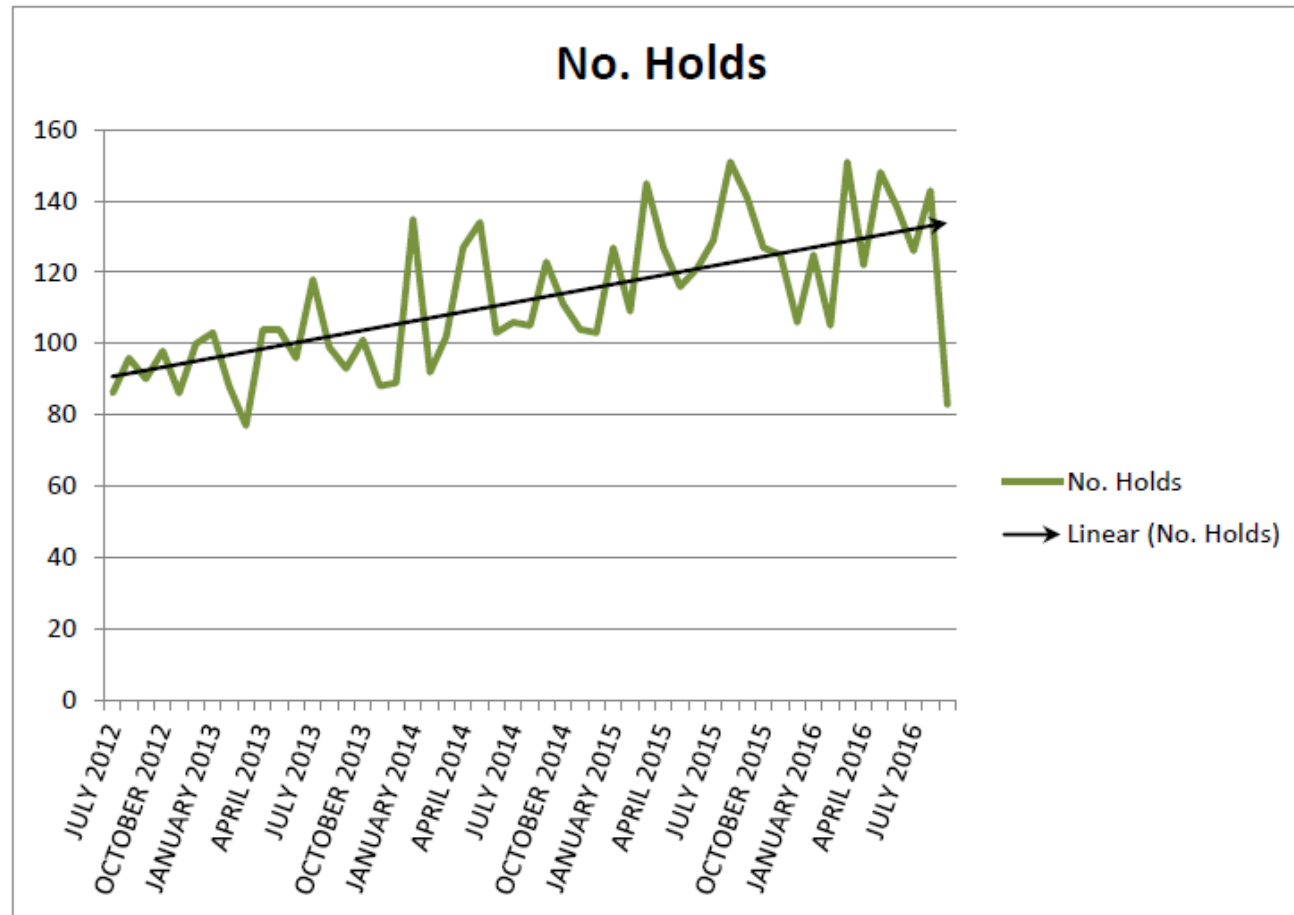
# RRMC Emergency Dept. Psychiatric Crisis Services

## RRMC ED PSYCHIATRIC PATIENT CENSUS/ LOS (thru SEPT 2016)

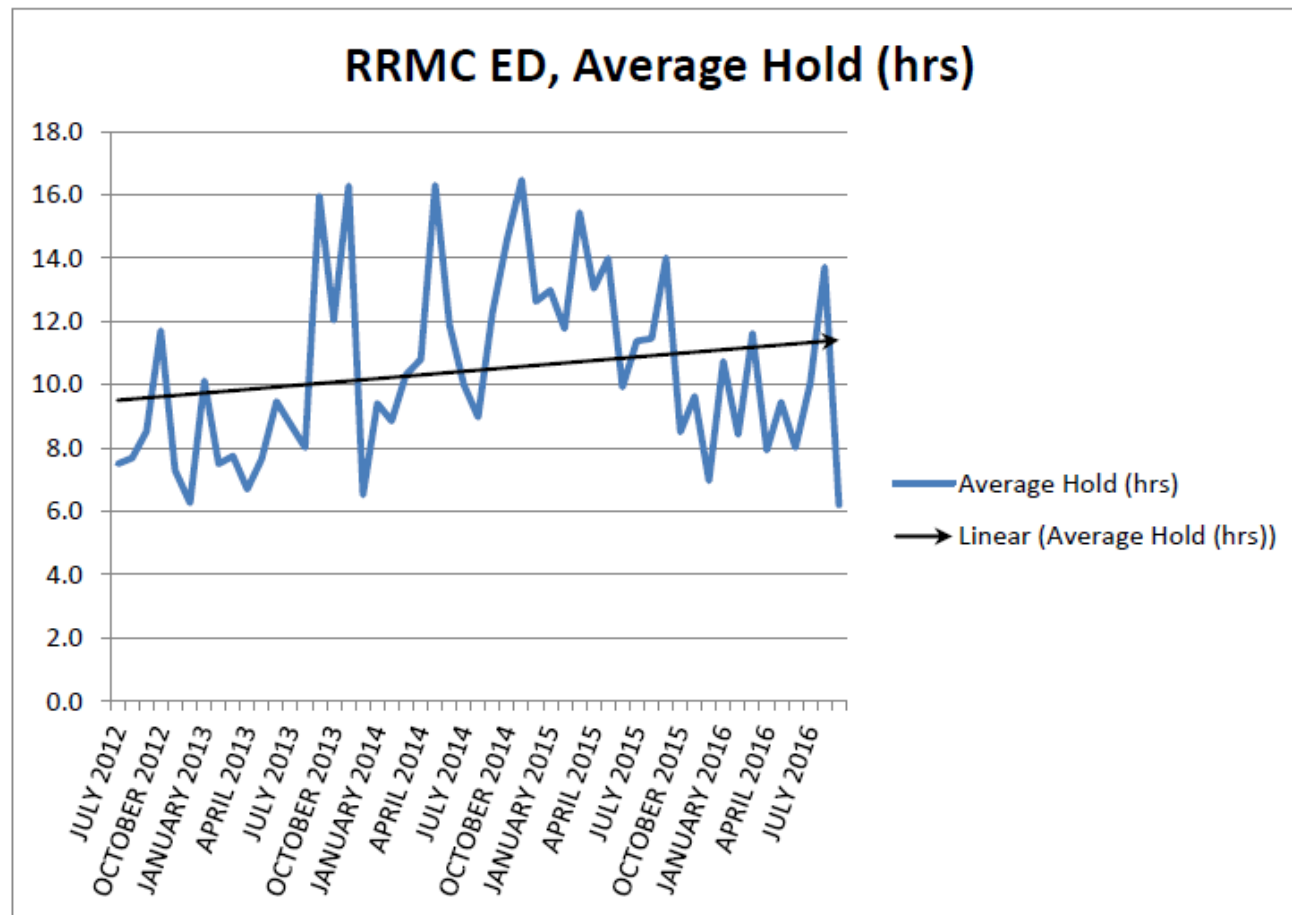
	FY 2013	FY2014	FY2015	FY2016	%Change (2013-2014)	%Change (2014-2015)	%Change (2015-2016)	%Change (2013-2016)
<b>Census</b>	35343	34739	35126	34614				
<b>No. Holds</b>	1166	1305	1484	1499	12%	14%	1%	29%
<b>Average Holds/Day</b>	3.19	3.57	4.05	4.10	12%	14%	1%	29%
<b>Total Time (hours)</b>	10863	14850	19399	19192	37%	31%	-1%	77%
<b>Total Time (days)</b>	453	619	808	800	37%	31%	-1%	77%
<b>Average Hold (hrs)</b>	8.9	11.14	13.1	9.3	25%	17%	-29%	4%
<b>No. Holds/ 1000 patients</b>	33	38	42	43	14%	12%	3%	31%
<b>Hold hours/ 1000 patients</b>	307	427	552	554	39%	29%	0%	80%
<b>Avg. No. Holds &gt;8 hours</b>	35	43	54	61	23%	25%	14%	75%
<b>Months Included</b>	12	12	12	12				



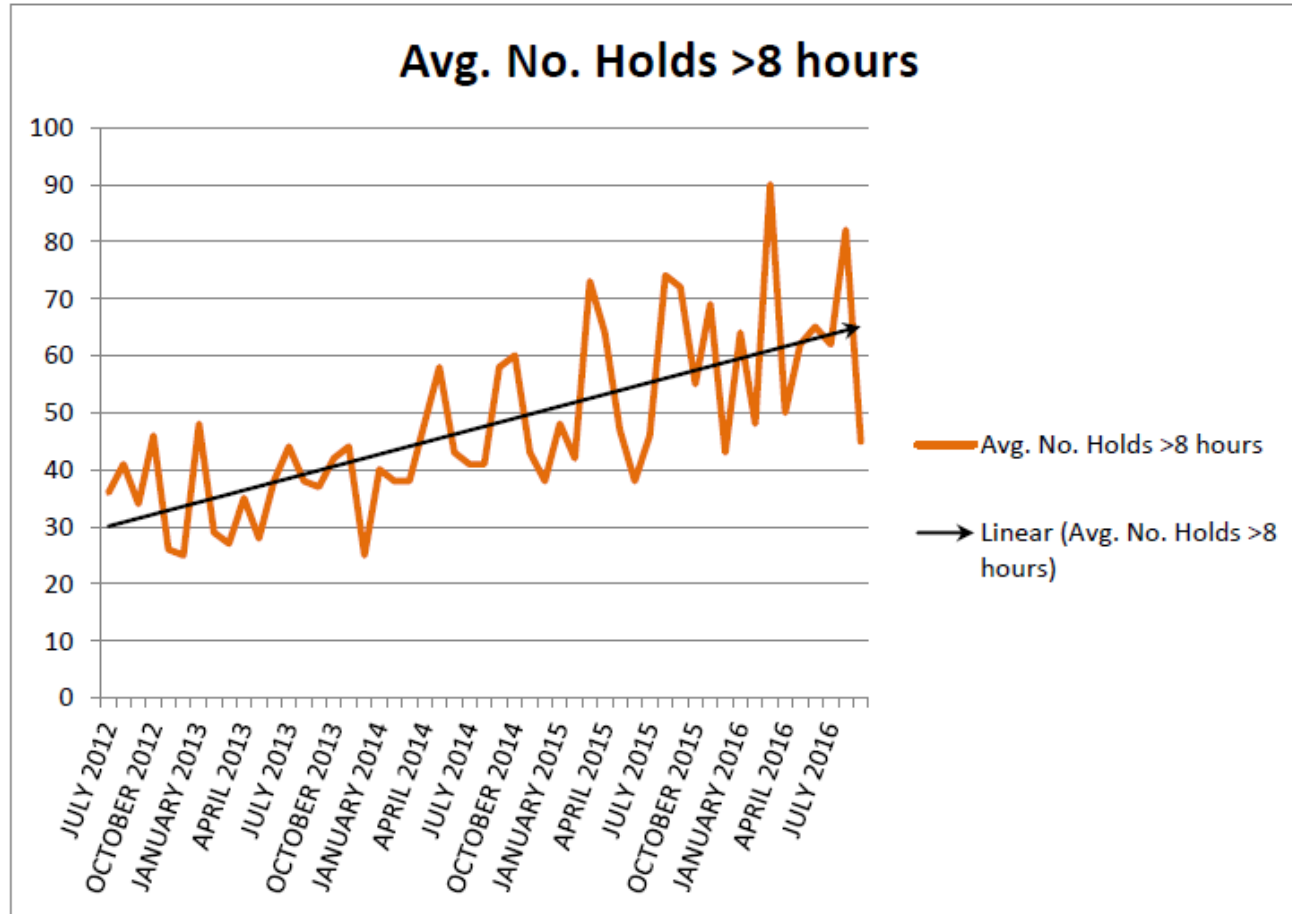
# RRMC Emergency Dept. Psychiatric Crisis Services: Volume



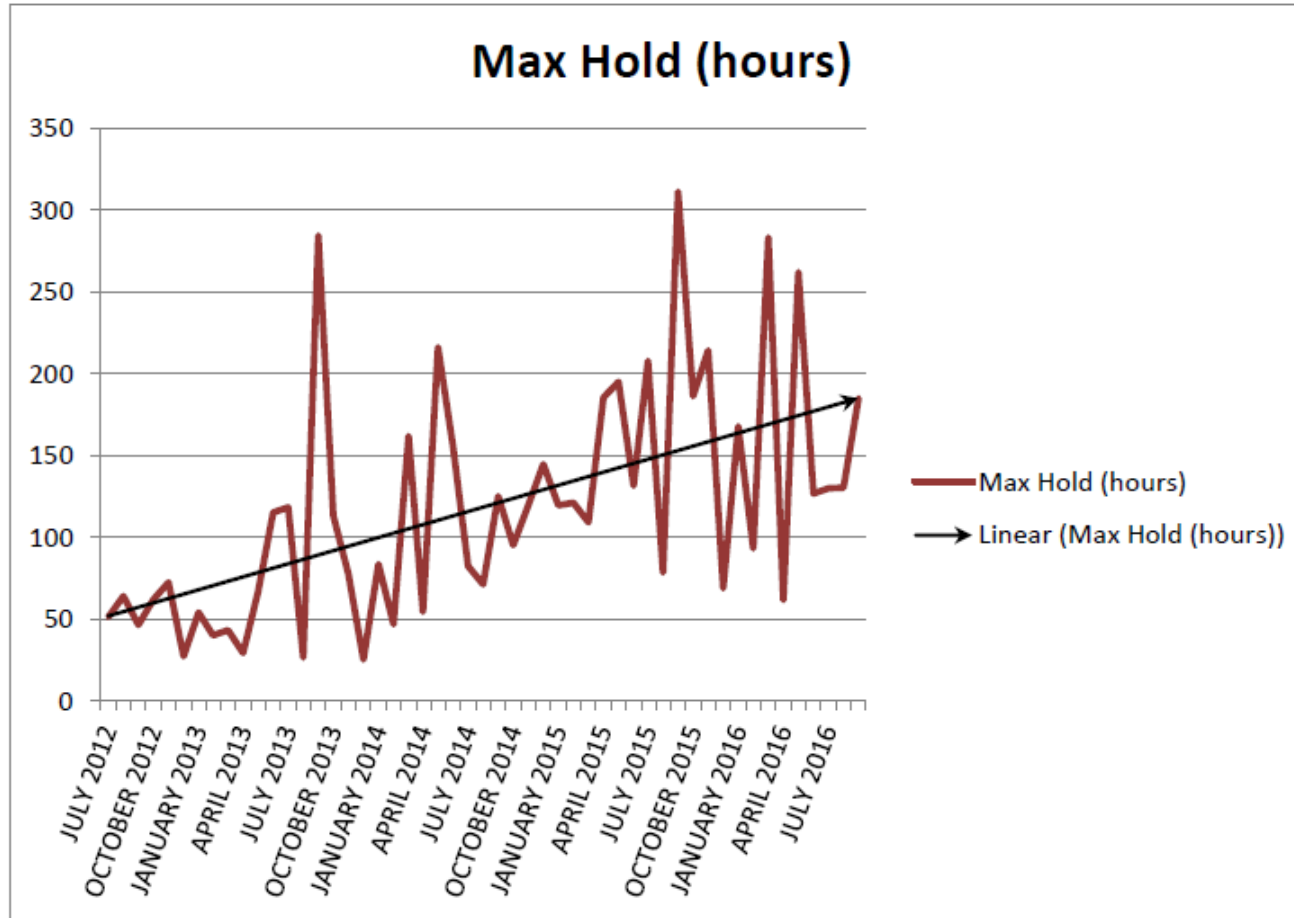
# RRMC Emergency Dept. Psychiatric Crisis Services: Wait Time



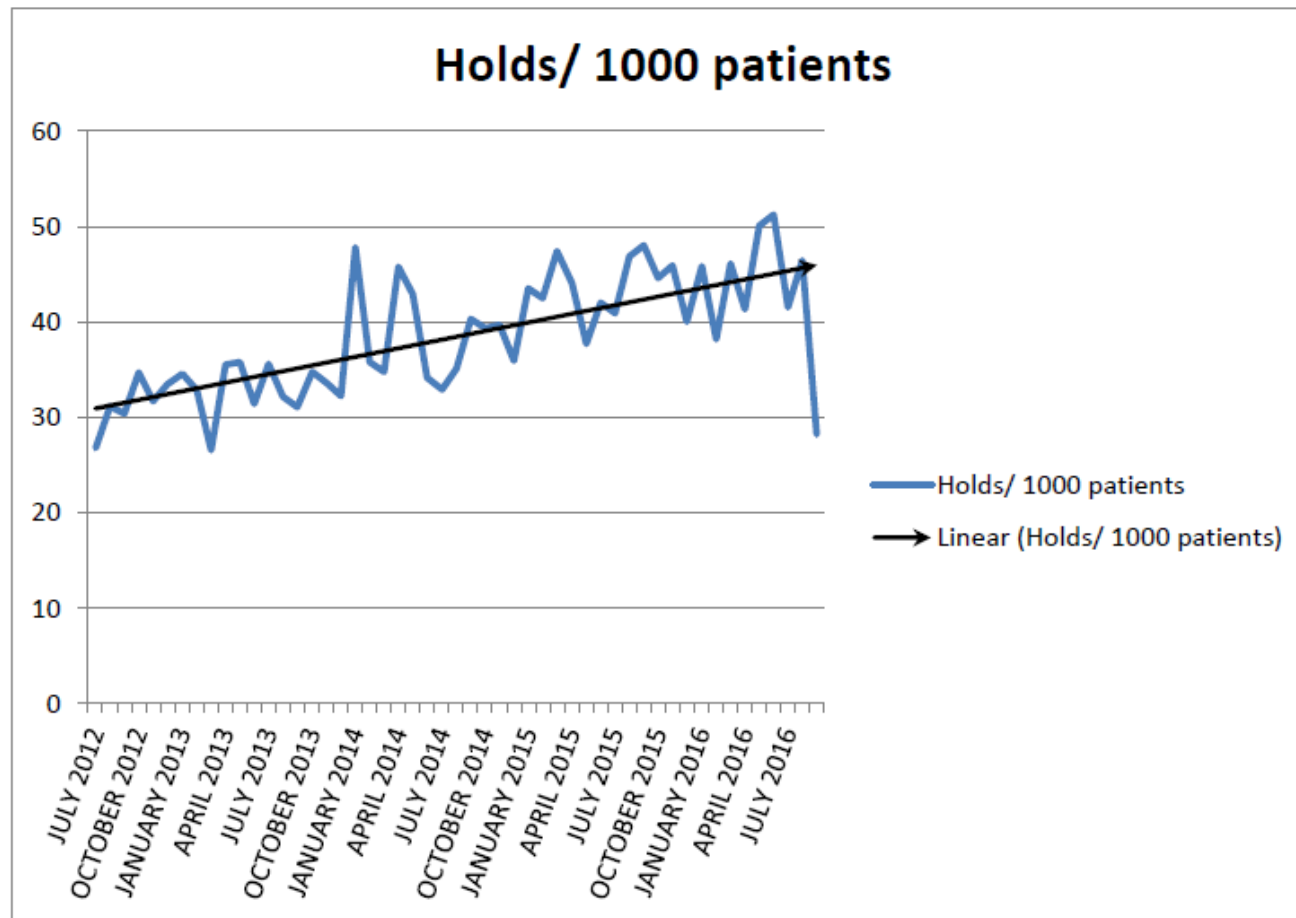
# RRMC Emergency Dept. Psychiatric Crisis Services: Wait Times over 8 Hrs



# RRMC Emergency Dept. Psychiatric Crisis Services: Maximum Wait Time

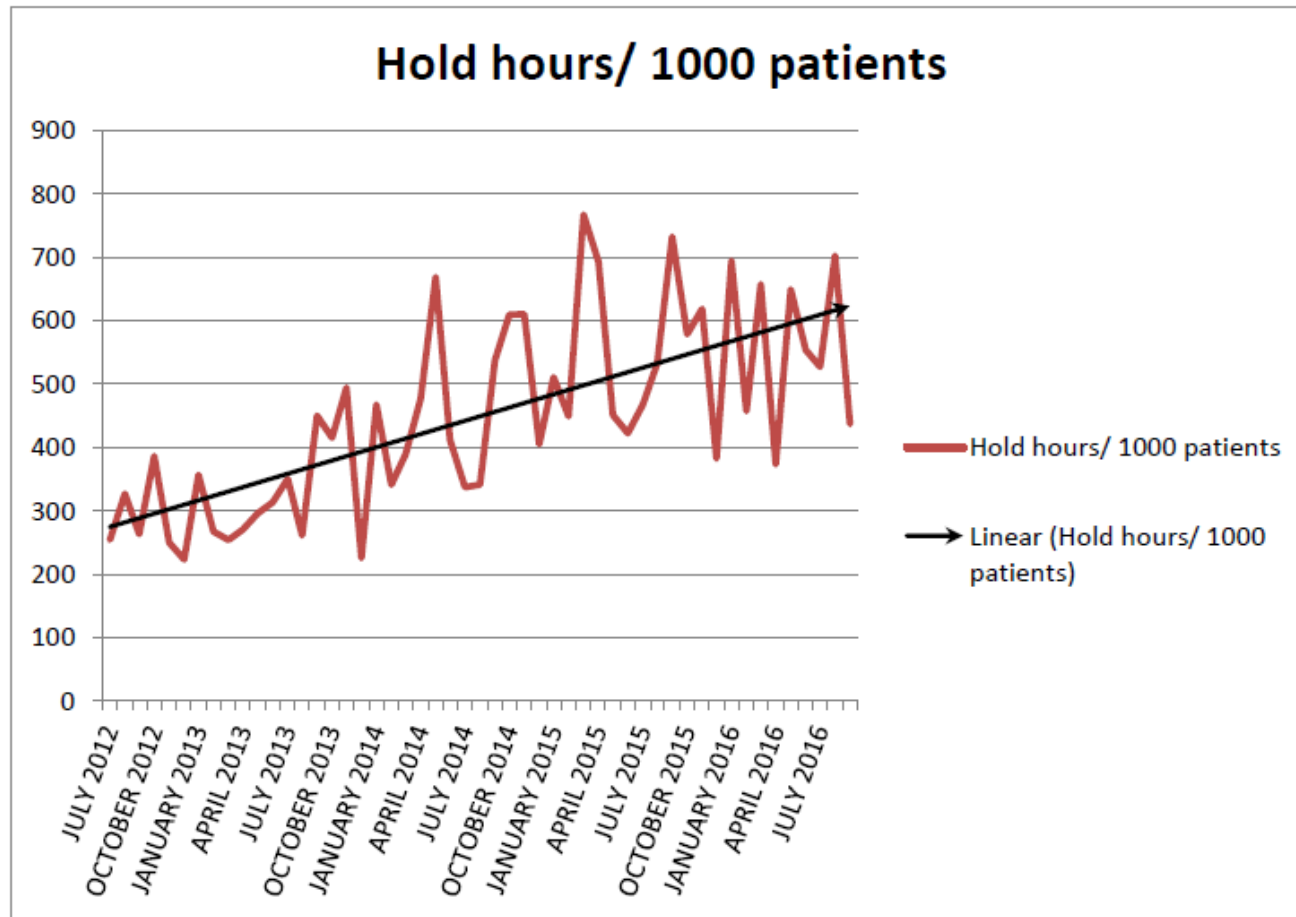


# RRMC Emergency Dept. Psychiatric Crisis Services: Volume Adjusted for ED Volume





# RRMC Emergency Dept. Psychiatric Crisis Services: Wait Time Adjusted for Volume



# Inpatient Psychiatry Length of Stay (LOS)

## ● General Unit

- FY '16 ALOS was over 8 days for the first time ever
- 51 (8%) fewer patients served
- FY '17 LOS trending over 8 days

General Unit							
FY	Total Adm.	Avg. LOS	LOS Over 45 days	% Over 45 days	LOS Over 100 days	% Over 100 days	Max LOS
2014	557	7.83	14	3%	-	0%	83
2015	627	7.55	10	2%	3	0%	133
2016	576	8.43	8	1%	1	0%	166

## ● Level 1

- ALOS improved in 2016
- 14 (25%) more patients served
- FY '17 ALOS trending over 53 days

South Wing							
FY	Total Adm.	Avg. LOS	LOS Over 45 days	% Over 45 days	LOS Over 100 days	% Over 100 days	Max LOS
2014	72	48.79	26	36%	8	11%	293
2015	56	52.12	24	43%	11	20%	238
2016	70	43.49	22	31%	6	9%	327



# Key Strategies

- Key Strategies:
  - Improved metrics to measure patient flow at ALL levels is needed (i.e., inpatient, residential, crisis beds, Transitional Housing, etc.)
  - Increased Secure Residential Capacity
  - Designated Agency Investment and Accountability
  - Emphasis on Integrated Behavioral Health Services



# Strategy: Include focus on metrics related to Patient Flow

- Statewide Capacity is Dependent on LOS
- Small changes in LOS can result in significant capacity increases
- Utilization (% of beds occupied) and is not a measure of capacity
- Current DMH focus creates full beds - Expanded focus will help ensure beds remain available

General Beds				
Current Beds #	ALOS	Admission Capacity	Increase In # of Pts Served	Increase In % of Pts Served
<b>143</b>	<b>10</b>	<b>5,220</b>		
	9.5	5,494	275	5%
	9.0	5,799	580	11%
	8.5	6,141	921	18%
	8.0	6,524	1,305	25%
	7.5	6,959	1,740	33%

Level 1 Beds				
Current Beds #	ALOS	Admission Capacity	Increase In # of Pts Served	Increase In % of Pts Served
<b>45</b>	<b>50</b>	<b>329</b>		
	45	365	37	11%
	40	411	82	25%
	35	469	141	43%
	30	548	219	67%



## Strategy: Secure Residential Beds

- We estimate that at any given time there are at least 2 patients who could step down from the hospital to a secure residential level of care
  - 1 patient = 365 bed days = 45 admits at 8 day LOS
- Patients would benefit clinically from:
  - Ability to practice self-management skills in a safe environment
  - Increased autonomy
  - More gradual transitions back to the community
  - Initiation of community integration



## Strategy: CHMC Investment and Accountability

- DAs are very willing to create new programming, but require financial investment to do so
  - Recruitment, retention, and training of staff remain critical funding issues
- Wide disparities in the local systems of care need to be addressed
  - Access to services remains highly variable across the State
- DAs need to share in accountability for admissions and LOS of patients from their catchment area



# Strategy: Integrated Behavioral Health Services

- Behavioral health needs to be fully integrated in primary care, specialty care, care management and emergency services.
  - SBIRT
  - Women's Health Initiative
  - Community health teams
  - BAMBI
- Focus on maintaining wellness and early identification / intervention
- Shared care plans for all high risk patients
- Care management



# Summary

- Patients are backed up at each level of care with Emergency Departments experiencing the greatest burden
- Focus should be on improved management and expansion of community resources to provide increased functional capacity
- State focus needs to be expanded to include patient flow (LOS) not just utilization in order to increase bed availability
- Investment in community resources needs to be targeted at critical needs and address regional disparities
- Shared accountability by DHs, DAs, and DMH to ensure continued availability of beds
- Continued investment in integrated health services will help reduce demand

