Testimony on S.133 - An act relating to examining mental health care and care coordination

House Committee on Health Care

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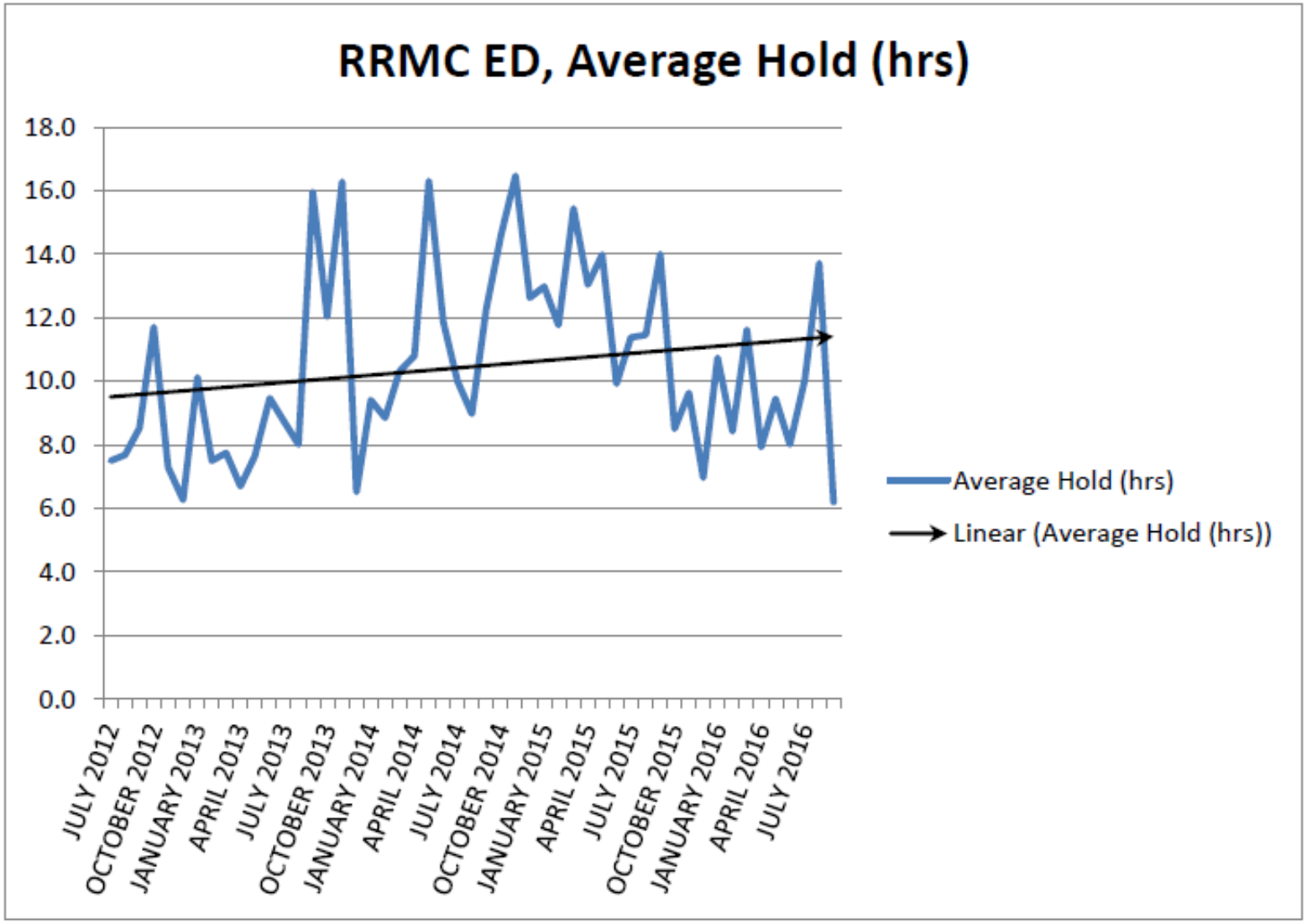
What has been working well

- Quality of care related to:
  - Construction of new updated, modern facilities
  - Co-location of general and Level 1 Units
  - More timely access to involuntary medication
- Cooperative relationship with the State (DMH and ADAP)
- Statewide support for best practices related to reduction of EIP rates
- Inpatient referrals management (front door)

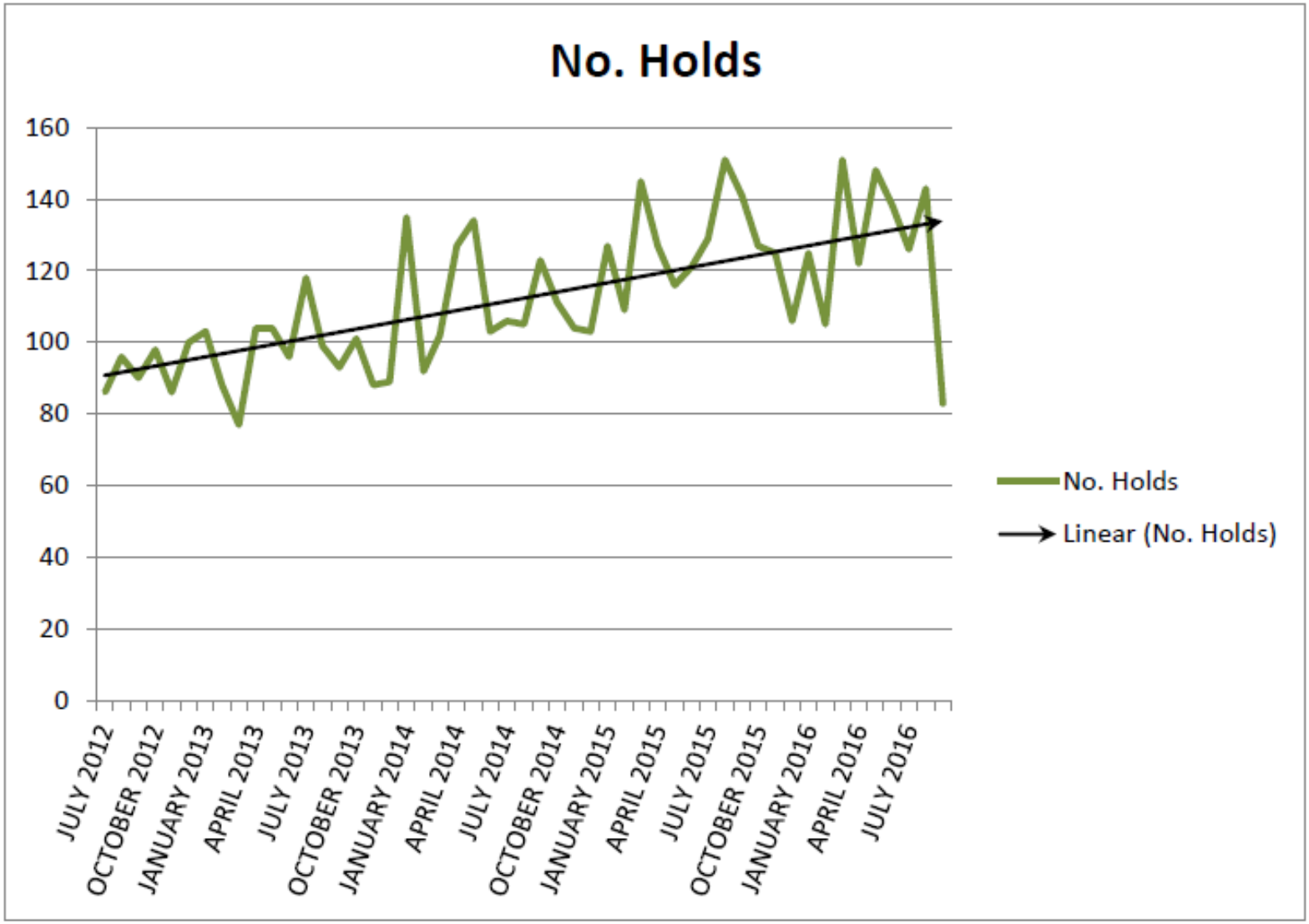
S.133 Findings

- We support the goal of providing the right care at the right time in the right location.
- Emergency Departments wait times are just one of the most visible symptoms
- The causes lie at multiple layers throughout the system of care from inpatient, to crisis beds, to outpatient care

RRMC Emergency Dept. Psychiatric Crisis Services: Hold Time



RRMC Emergency Dept. Psychiatric Crisis Services: 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
- Level 1
  - ALOS improved in 2016
  - 14 (25%) more patients served
  - FY '17 ALOS trending over 53 days

FY	Total Adm.	Avg. LOS	LOS Over 45 days	% Over 45 days	LOS Over 100 days	% Over 100 days	Max LOS
2014	558	8.06	14	3%	-	0%	83
2015	624	7.84	10	2%	3	0%	133
2016	579	8.74	8	1%	1	0%	166

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

LOS, LOS, LOS !!!

- 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
143	**10**	**5,220**		
	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
45	**50**	**329**		
	45	365	37	11%
	40	411	82	25%
	35	469	141	43%
	30	548	219	67%

S.133 Action Plan

- Agree that analysis is necessary before moving ahead
- Expectations for what can be achieved by the September 1 deadline for a report need to be tempered by an understanding that systems to assess and monitor system functioning need to be built almost from scratch.

S. 133 Operation of Mental Health System

- Emphasis needs to be on development of an on-going, system-wide monitoring of system flow.
  - **Average Length of Stay** is the most important metric for examining current state and tracking system functioning related to **flow** of patients throughout the system.
- We should let flow data drive solutions rather than point in time data (or great story-telling)
- The system needs clear metrics which can establish shared accountability at all levels of care
- Investments should be paired with expected improvements in the system of care

Key Issues

- 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 Level 1 capacity
- Wide regional disparities in service availability across the State need to be addressed

Inpatient Data Pilot

- Pilot developed as a result of Secretary Gobeille' s mental health workgroup
- RRMC and CVMC submitting data daily
- Includes ALL patients
- Will expand to all DHs and DAs
- Will allow in depth analysis of flow and identification of barriers
- Will allow all parts of the system (DHs, DAs, DMH) to share accountability
- Near "Real-time" system feedback

- <u>Data Elements</u>
  - Unique ID
  - Age
  - Admit Date
  - Patient Zip
  - Payer
  - Sex
  - CRT
  - Level_1 Status
  - Forensic Status
  - Voluntary Status
  - Discharge Date
  - DC Disposition

S.133 Care Coordination System

- Shared accountability is the key to develop systemic change
- We need DMH to monitor metrics, not cases.
- Each community has different strengths and challenges

Secure Recovery Residential Beds

- 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
- Focus is on transition back to the community
  - Will have an impact on ED wait times and access to Level 1 beds

S.133 Psychiatric Access Parity

- Patients should not be denied access to appropriate care for hours or days
- Solutions include lowering demand by:
  - Increasing system flow/functional capacity, AND
  - Supporting DAs to provide:
    - Increased access to outpatient care
    - Increased mobile crisis and outreach services
    - Best practice DBT / ACT models of care

S.133 Geriatric and Forensic Beds

- Clinically these programs are very much needed
- General psychiatric units are not adequately designed, staffed, and trained to serve specialty populations
- These programs, because of limited flow, are unlikely to have a significant impact on ED wait times.

S.133 Support for DAs

- Hospitals need strong DAs as partners to address identify and address the unique flow issues in each community
- 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