



# East Metro Mental Health Roundtable

## *Community metrics*

### Project description

The East Metro Mental Health Roundtable aims to accelerate improvements in the Twin Cities east metro mental health system through partnerships that deliver high quality mental health services.

A Coordinated Care/Community Metrics sub-committee chaired by Dr. Michael Trangle, Regions Hospital, convened in 2009 with the goal of quantifying the effects of the Roundtable's efforts to reduce barriers to patient flow between hospitals and community services, better match available resources to needs, and reduce gaps in the continuum of care. The subcommittee developed a shared measurement system, and identified 10 key community metrics to track progress. These include average wait time in hospital emergency departments; number and percentage of people in jail and correction facilities who need mental health follow-up; number and percentage of police/sheriff calls related to emotionally disturbed people; and several measures to determine wait times of hospital inpatient for referrals to community-based services.

In 2011, the Minnesota Community Foundation awarded Wilder Research funding to continue and expand this initiative through 2013. In addition to continuing to monitor trends associated with the original 10 key community metrics, this project will expand to collect additional metrics of interest, conduct several special projects designed to further inform

service delivery gaps and flow, and disseminate the findings to a large audience of engaged stakeholders.

### Findings

The following summarizes findings from January 2010 through December 2011. Subsequent briefs will be made available on a semi-annual basis.

#### **Inpatient/residential chemical dependency treatment**

**All hospitals:** A total of 300 patients were referred to an inpatient or residential chemical dependency program from each of the three hospitals in 2011. Delays in admission were captured for 109 patients. Patients were delayed an average of five days between Rule 25 assessment and admission to a facility. This is comparable to 2010, where nearly 300 patients were admitted. Patients were delayed, on average, five days in 2010.

Delayed admissions to an inpatient or residential treatment program may be attributed largely to wait times between authorization for services and admission to facilities. At United and Saint Joseph's Hospitals, patients waited six to eight days between authorization and admission to a facility. The wait times between Rule 25 and authorization were shorter at both facilities.

### *Issues to consider*

- Stakeholders should assess whether patients remain in an inpatient setting due to their medical/psychiatric needs, or if patients are delayed admission into treatment programs due to lack of capacity or other factors.

### **Intensive Residential Treatment Service (IRTS)**

**All hospitals:** In 2011, hospitals reported that 143 patients were referred to an IRTS program from an inpatient unit. Delays in admission were captured for 113 patients. Patients were delayed an average of 8 days between referral and admission to the facility. Patients from Regions Hospital experience substantially shorter delays in admission, an average of five days compared to 16 and 18 days at United and St. Joseph's, respectively.

These delays have been stable for the past two years. In 2010, 149 patients were admitted from hospital inpatient units, and were delayed an average of 8 days.

**IRTS providers (7 of 8 reporting):** In 2011, 115 patients were admitted to seven of eight IRTS providers from east metro inpatient units; 90 percent of those were delayed by more than 3 days, with an average delay of 10 days. In 2010, 84 percent of patients were delayed by more than 3 days, with an average delay of 11 days.

### **Reasons for delay in IRTS admission**

The three East Metro hospitals reported reasons for delay to an IRTS facility upon referral. For those reporting reasons for delay, hospitals identified that most delays were due to **lack of available bed space** (48%) or **delays for an IRTS interview** (37%) in 2011. These delays are comparable to 2010, where 46 percent of delays were due to lack of bed space, and 25 percent due to delays in getting an IRTS interview.

IRTS providers noted that delays were due to **lack of bed space** for more nearly half (46%) of known delays. Additionally, 17 percent of delays were due to **patients**

**not being ready for discharge from inpatient**, and 12 percent were due to **delays in getting an IRTS interview** or other IRTS staff issues. These barriers are similar to those reported in 2010.

IRTS providers reported that 49 patients were referred for admission from the three psychiatric inpatient hospitals in the East Metro but not admitted between in 2011. The most common reasons for non-admission included **patients not ready for discharge** (20%), **lack of bed space** (15%), or **client refusal** (15%). It should be noted that it is likely that IRTS providers are generally under-reporting the number of patients who are referred for services but not admitted to their facilities, as it is common practice for multiple IRTS providers to receive referrals for a single patient. Determining a consistent point of referral for each provider remains challenging.

### *Issues to consider*

- IRTS providers and hospitals reported that a major reason for delayed admission to IRTS programs from inpatient was due to lack of available bed space. Consider expanding the number of available IRTS beds to improve flow.
- IRTS providers and hospitals reported some disagreement related to patient readiness for admission to an IRTS. Hospital and IRTS staff should consider developing a shared behavioral definition of when patients/clients are ready for admission to IRTS facilities, and identify strategies to expedite the interview process.

### **AMRTC (Anoka Metro Regional Treatment Center)**

Regions Hospital reported the number of patients admitted to AMRTC who waited more than three days for admission. In 2011, 59 patients were admitted to AMRTC from Regions; patients waited an average of 25 days between referral and admission. This is comparable to figures from 2010, where 76 patients were admitted, and were on the wait list for an average of 24 days. It should be noted that the wait time reflects

the time on the wait list after patients had been through the commitment process, which can be quite lengthy (two to three weeks per Regions Hospital). Saint Joseph's and United Hospitals reported the number of days patients referred to AMRTC waited before either admission to the facility or removal from the list. Very few patients were reported from either United or Saint Joseph's. Of the eight patients who were reported between the two hospitals, the wait time was between 35 and 38 days.

This is likely a conservative estimate of the amount of non-acute bed days, as patients are not placed on the wait list until after the commitment process is completed, and time spent on the wait list before diversion to other services is not captured.

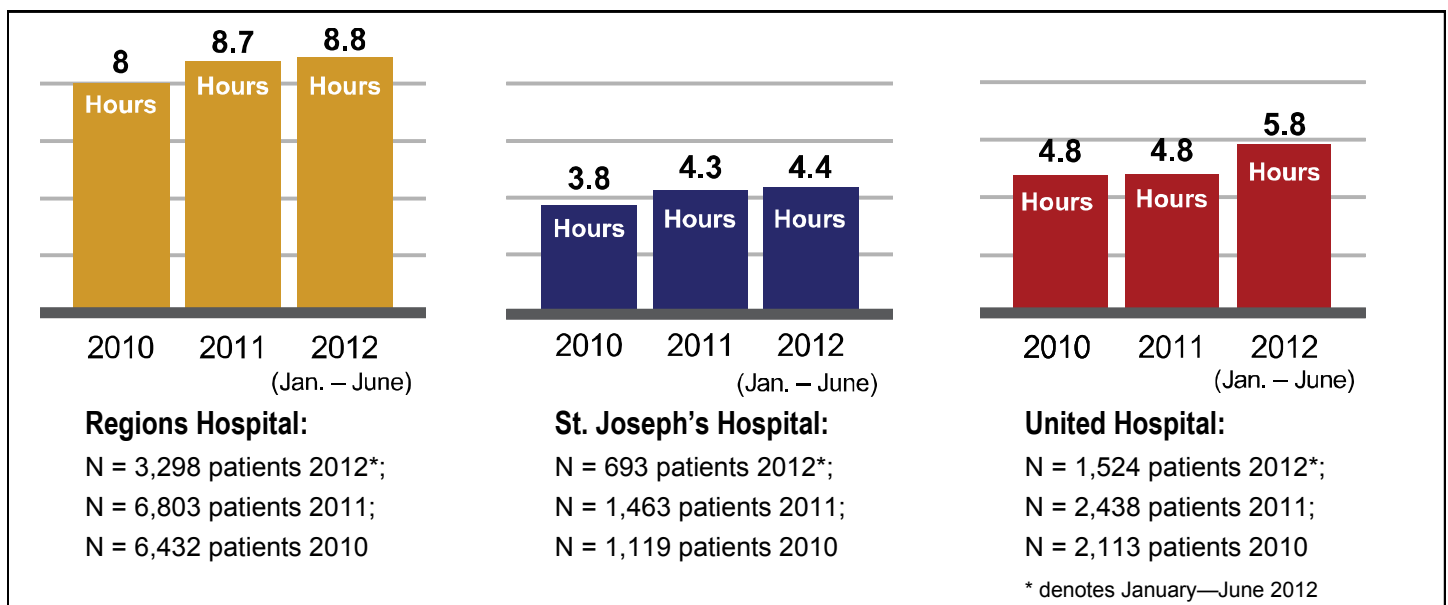
## Healthcare Effectiveness Data and Information Set (HEDIS)

Health plans report the frequency with which discharged behavioral health inpatients are seen by a mental health provider within seven days of discharge as part of Healthcare Effectiveness Data and Information Set (HEDIS) reporting. Data was requested for 2010, but it was determined that collecting HEDIS data from each of the health plans would be challenging for 2010 and beyond, given confidentiality concerns. It was also estimated that there would be little variability between 2009, 2010 and 2011 related to the HEDIS measure for 7-day follow-up post hospitalization. Rather than continuing to report on the HEDIS measure, the community metrics committee followed-up with two different committees operating statewide to reduce re-admission to inpatient hospitalization, and will continue

## Emergency Department

Each of the behavioral health emergency departments report the length of stay in the emergency department before patients are admitted, discharged, or there is another final disposition. The number of patients increased in each of the emergency departments between 2010 and 2011, although numbers were beginning to stabilize at Regions and St. Joseph's for the first half of 2012. United is on track to see more patients in 2012, if the current rates continue. Wait times within each emergency department were relatively consistent between 2010 and 2011, although wait times at Saint Joseph's and Regions did increase between 2010 and 2011. In the first part of 2012, wait times continued to rise, especially at United.

### Average number of hours behavioral health patients spent in the emergency department (ED)



to explore opportunities to explore collaboration with these committees.

### Law enforcement

During 2011, the Saint Paul Police Department identified 17 residents who died by suicide, and an additional 76 who made serious suicide attempts. More than 150 individuals made serious suicide threats that were responded to by SPPD during 2011. The number individuals making serious suicide attempts and threats increased in 2011 compared to 2009 and 2010.

In 2011, the Washington County Sheriff's Department reported 153 suicide attempt or threat reports, compared to 164 in 2010. Additionally, there were 99 reports related to emotional disturbance in 2011, compared to 47 in 2010.

### Next Steps

The past two years of data collected through this project continues to identify challenges with patient flow from inpatient to community-based services. In addition, the advisory committee and other stakeholders have expressed interest in exploring challenges with clients accessing services outside of the inpatient system. In order to better assess the current needs and capacity for services outside the inpatient mental health system, the community metrics project will be conducting a comprehensive needs assessment with a variety of mental health providers and programs in the east metro in winter 2012. This needs assessment will better inform where there is currently adequate capacity for specific levels of service need, and where there are opportunities to expand services in the east metro for adults living with serious and persistent mental illness. Results will be shared at future Roundtable meetings .

## TYPES OF MENTAL HEALTH SERVICES TRACKED FOR THIS PROJECT

- **Anoka-Metro Regional Treatment Center (AMRTC)** is a State Operated Services (SOS) hospital located in the Metro area that serves people who are mentally ill in a large campus-based setting. AMRTC provides 24-hour-a-day care for patients in need of comprehensive medical, nursing, or psychosocial services.
- **Assertive Community Treatment (ACT)** is an intensive, non-residential rehabilitative mental health service that is an identified evidence-based practice. ACT is provided by multidisciplinary staff using a total team approach, and directed to adults with a serious mental illness who require intensive services. This includes a "prescriber."
- **Chemical dependency inpatient or residential treatment facilities** provide chemical dependency treatment onsite. Patients or residents live onsite while receiving services.
- **Facilities treating medical and psychiatric conditions** include nursing homes, Board and Care, Assisted Living, Minnesota Extended Treatment Options (METO), and others in the Twin Cities Metro and outstate.
- **Intensive Rehabilitation Treatment Services (IRTS)** are time-limited rehabilitation mental health services provided in a residential setting to clients who need 24-hour staff.
- **Intensive Team +** refers to ACT teams and other intensive teams without a prescriber.



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### For more information

Summaries will be available at [www.wilderresearch.org](http://www.wilderresearch.org)

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