Community Metrics

2015 Summary Statistics

Executive summary

Project description

The East Metro Mental Health Roundtable is a collaboration of law enforcement, social service agencies, health systems, hospitals, and others who address mental health care in the Twin Cities east metro in Minnesota. A subcommittee of the Roundtable, the Measurement Committee, was charged with 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.

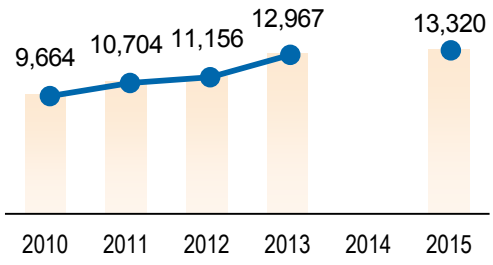
The data suggest there are increased demands on the east metro mental health system and capacity is not meeting this demand

The subcommittee identified key community metrics to track quarterly progress toward the above goals. Data collection for most metrics began January 1, 2010. This summary briefly highlights key findings from data collected through December 2015.

Summary of key trends

Each of the community metrics describes an important piece of information that can be used to better understand the availability of mental health services and overall capacity of the adult mental health system in the east metro. However, this report does not explore potential reasons for changes in referral patterns and wait times.

Total behavioral health patient visits in emergency department



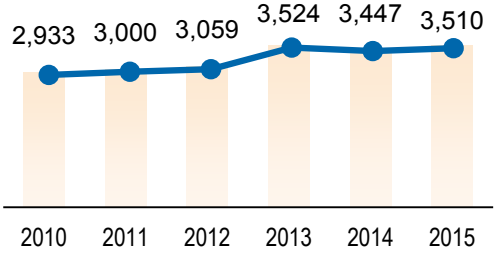
Since 2010, the overall number of emergency department behavioral health visits has increased, though there is evidence of a slight decrease at Regions and United in 2015. Overall, the combined number of visits for Regions, United, and St. Joseph's in 2010 was 9,664 and in 2014 it rose to 13,320. St. Joseph's does not have data available for 2014, but both United and Regions have had a slight decrease in patients compared to 2014.

Emergency department wait times have also increased. Compared to previous years, all three hospitals report longer average or median wait times in the emergency department for behavioral health patients in 2015. In 2015, the average wait time at Regions was nearly 12 hours, while at St. Joseph's it was 16 hours. The median wait time at United was over 5 hours.

In January and February 2016, all three St. Paul hospitals have implemented emergency department mental health closure status (i.e., psych diverts), in which patients are diverted to other hospitals for mental health issues because the emergency departments are over capacity, for between 52 and 111 hours**.**

Regions reported a steady increase in the number of behavioral health admissions from the emergency department through 2013, when the number leveled off at about 3,500 admissions. The total number of Non-Qualified Admissions (NQAs) for behavioral health has remained relatively low at Regions, and it dropped to 0 in 2015.

Number of behavioral health admissions from emergency department: Regions Hospital



Wait times for psychiatry at Urgent Care have increased. The average wait time for psychiatry at Urgent Care was two days longer in 2015 (5.8 days) than it was in 2014 (3.8 days).

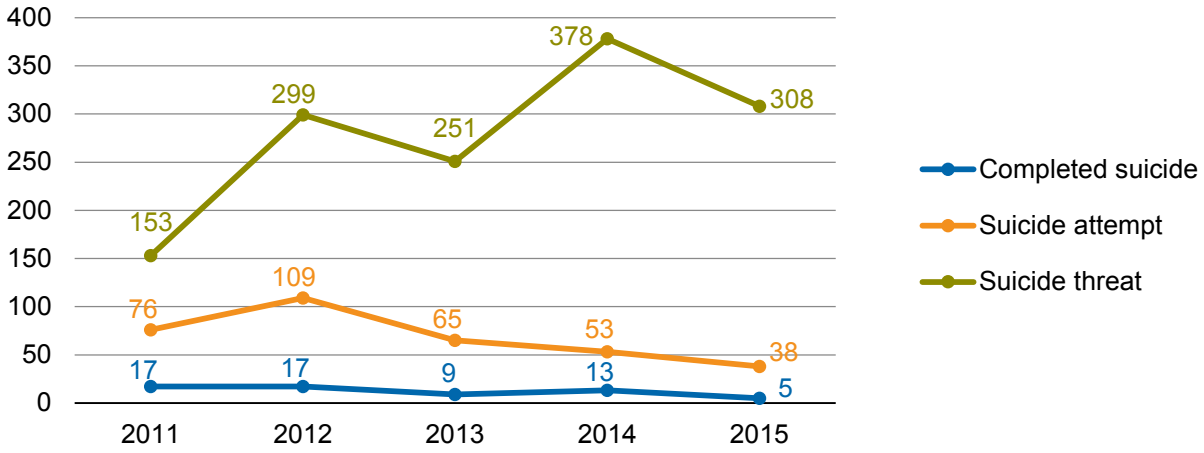
In 2015, only 8 percent of individuals referred to Anoka Metro Regional Treatment Center from Saint Paul hospitals were admitted, and only 14 percent of individuals referred from east metro counties were admitted. Of those who were admitted from Saint Paul hospitals, they had to wait more than 80 days, on average, before admission, and those referred from east metro counties had to wait over a month, on average. These wait times exceed the statewide average.

Community needs

Suicide calls to law enforcement

The number of police calls that are suicide-related threats, attempts, and completions are tracked and reported by the Saint Paul Police Department. Information about the number of calls devoted to emotionally disturbed persons is not readily available and has not been tracked. Local data suggests there was a spike in suicide-related calls in 2014, though the number of attempts, completions, and threats all decreased in 2015 (Figure 1). Since 2011, the total number of suicide-related calls accounts for approximately one call per every 1,000 Saint Paul residents.

1. Saint Paul Police Department suicide and suicidal behavior tracking, 2011-2015



Suicide rates

According to the Minnesota Department of Health natality and mortality data, the statewide suicide rate remained at its highest recent level in 2014. The rates for Dakota and Ramsey counties increased notably in 2014, while rates in Washington County remained stable (Figure 2).

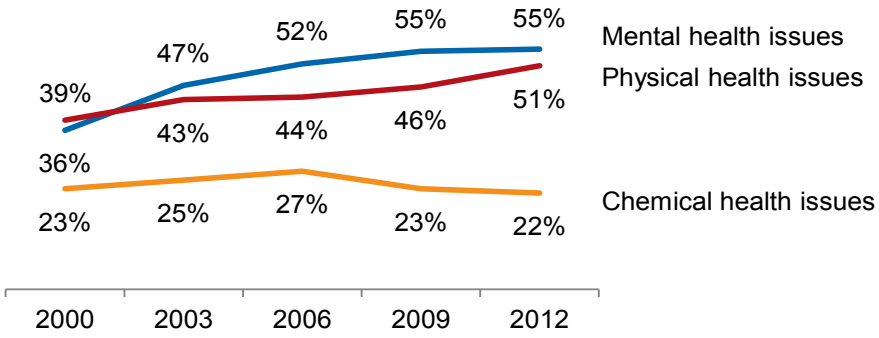
2. Number of suicides, 2009-2014

	2009	2010	2011	2012	2013	2014
Minnesota	581	599	682	660	683	683
Dakota County	43	41	63	45	42	52
Ramsey County	48	53	58	52	49	71
Washington County	23	22	29	25	28	25

Homelessness and mental illness

In 2012, over half of adults experiencing homelessness in Minnesota had a serious mental illness. The proportion of adults experiencing homelessness in Minnesota who had a serious mental illness rose from 2000 to 2009, and remained stable from 2009 to 2012 (Figure 3). In 2012, among those adults experiencing homelessness and a serious mental illness, 22 percent also had a chronic health condition, and seven percent also had a substance abuse disorder. Eleven percent had a serious mental illness, chronic health condition, and substance abuse disorder (Figure 4).

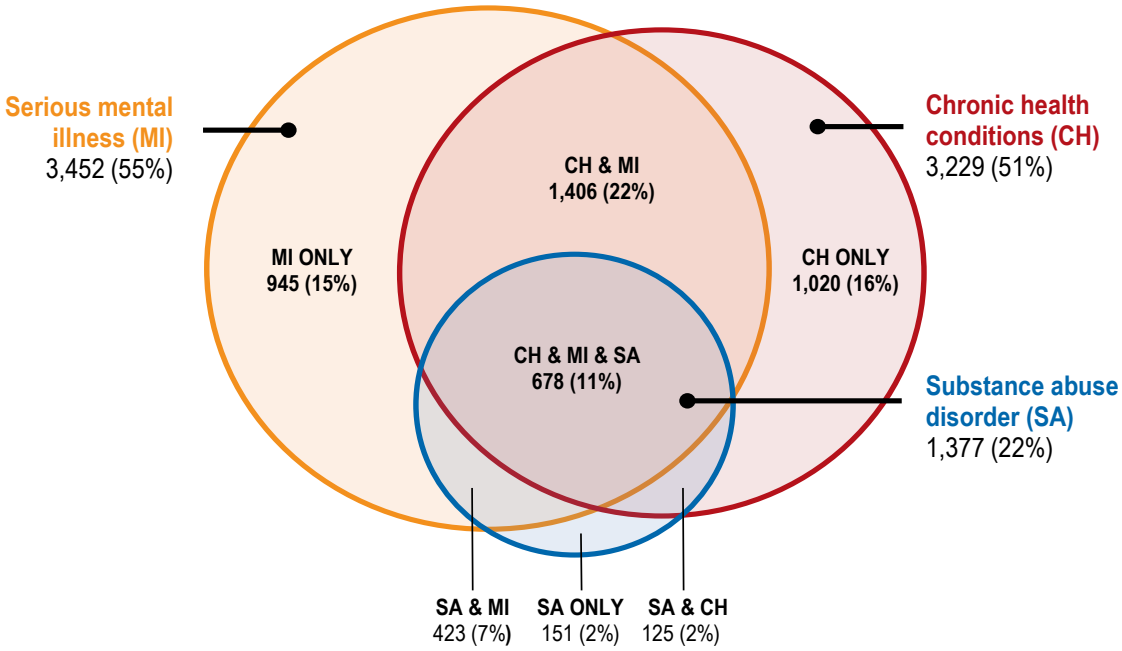
3. Physical, mental, and chemical health issues among homeless adults, 2000-2012



Homelessness in Minnesota, 2012 results. Wilder Research, 2013. Homelessness study is conducted every three years; detailed results from the 2015 study will be released in May 2016.

4. Incidence and co-occurrence of health conditions among homeless adults

Total homeless adults surveyed: 6,273 (100%)
Proportion with none of these three disabilities: 1,525 (24%)
Proportion with multiple: 2,632 (42%)



Homelessness in Minnesota, 2012 results. Wilder Research, 2013. Homelessness study is conducted every three years. Homelessness study is conducted every three years; detailed results from the 2015 study will be released in May 2016.

The Homeless Management Information System (HMIS) tracks homeless individuals using different types of shelter throughout Minnesota, including emergency shelter, permanent supportive housing, rapid re-housing, and transitional housing. As part of the shelter intake, adults are asked whether or not they have a "mental health problem" and if so, whether or not they are currently receiving services or treatment for their mental health problem. This number is duplicated if an individual visits multiple different shelters over the course of the year.

When looking across different types of shelters, the majority of individuals staying in permanent supportive housing have a self-reported mental health problem and are receiving services for their condition (Figure 5). Permanent supportive housing is housing with support services included, and the U.S. Housing and Urban Development definition includes a requirement of a disability, which can be a serious and persistent mental illness. Individuals in emergency shelter are less likely to have a self-reported mental health problem and they are much less likely to be receiving treatment or services for their condition.

5. Sheltered individuals with mental health problems and receiving services by shelter type, 2014-2015

	Percent of sheltered individuals with a mental health problem		Percent individuals with a mental health problem receiving services or treatment	
Type of east metro Shelter	2014 N (%)	2015 N (%)	2014 N (%)	2015 N (%)
Emergency shelter	129 (27%)	195 (24%)	88 (68%)	129 (66%)
Permanent supportive housing	1,477 (69%)	1,448 (69%)	1,187 (80%)	1,171 (81%)
Rapid re-housing program	121 (54%)	107 (43%)	109 (90%)	97 (91%)
Transitional housing	310 (50%)	213 (48%)	257 (83%)	180 (85%)

Minnesota Homeless Management Information System. Shelter types are defined as: Emergency Shelter: a project that offers temporary shelter (lodging) for the homeless in general or for specific populations of the homeless. Transitional Housing: a project that provides temporary lodging and is designed to facilitate the movement of homeless individuals and families into permanent housing within a specified period of time, but no longer than 24 months. Rapid Re-housing: a permanent housing project that provides housing relocation and stabilization services and short- and/or medium-term rental assistance as necessary to help a homeless individual or family move as quickly as possible into permanent housing and achieve stability in that housing. Permanent Supportive Housing: a project that offers permanent housing and supportive services to assist homeless persons with a disability (individuals with disabilities or families in which one adult or child has a disability) to live independently.

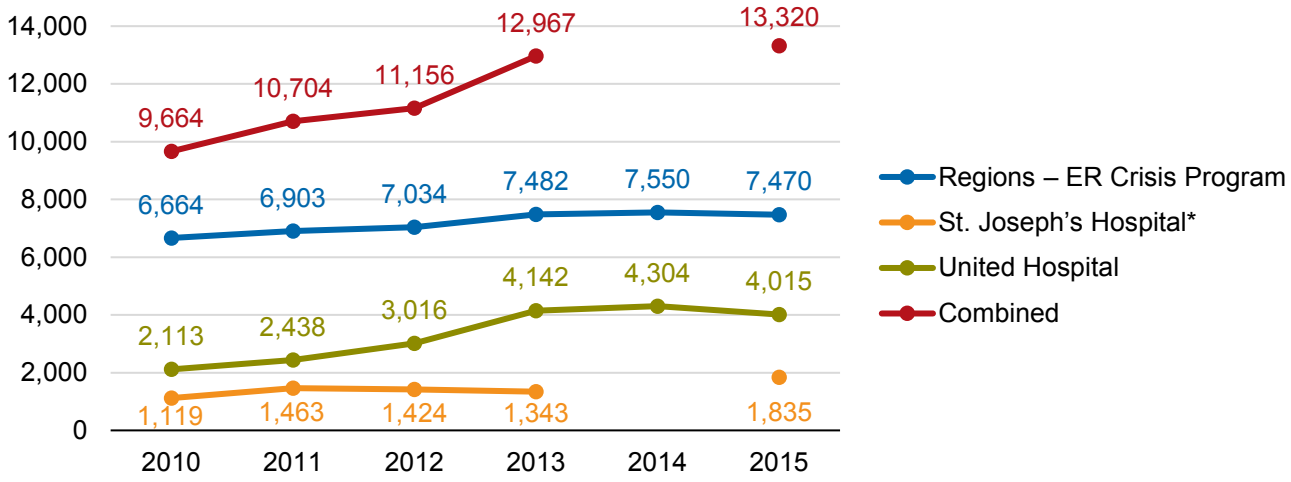
Behavioral health services

Behavioral health-related emergency department (ED) visits

Data collected from east metro hospitals showed an increase in the total number of behavioral health-related emergency department visits over time. However, there was a decrease in 2015 at Regions and United, while there appears to be an increase at St. Joseph's, though there is no comparable data for 2014 (Figure 6). Urgent Care for Adult Mental Health, which serves any adult experiencing a mental health crisis in Ramsey, Dakota, and Washington Counties, opened in 2011. While the need for emergency department visits continued to increase after that time, the impact of Urgent Care can be found in Figure 10.

Although there are some data limitations to consider, the data reported by hospitals demonstrate that average wait times for behavioral health emergency department visits have increased over time, especially in 2015 (Figure 7).

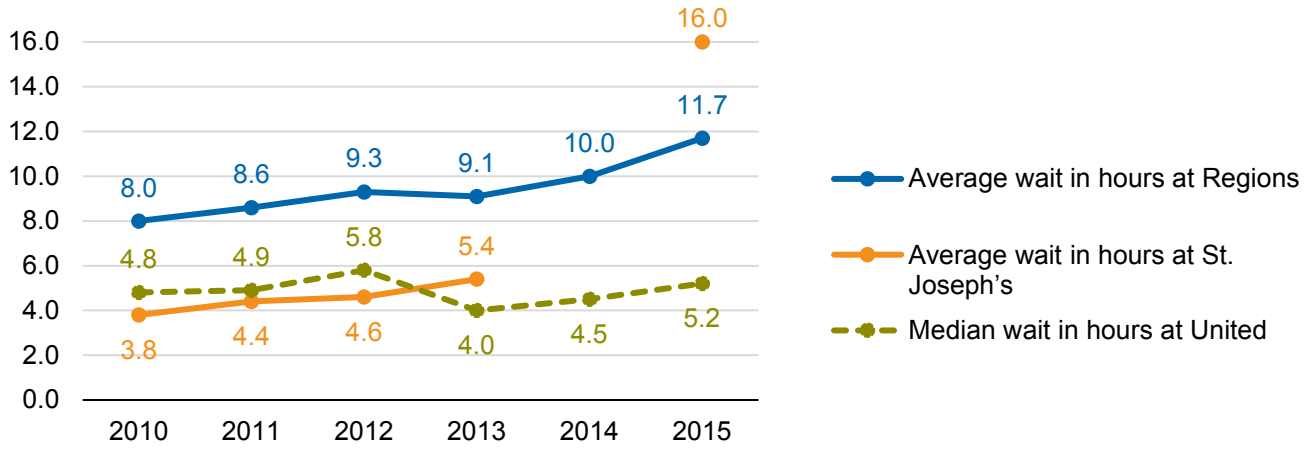
6. Total behavioral health patient visits in emergency department, 2010-2015



** St. Joseph's Hospital does not have data available for 2014, so a combined total is not available.*

Note: *The totals refer to the number of patient visits, not unique patients seen at each hospital.*

7. Average or median time behavioral health patients spent in emergency departments, 2010-2015



Regions Hospital and St. Joseph's Hospital provided average length of stay rather than median length of stay.
United Hospital provided median length of stay rather than average length of stay.
St. Joseph's Hospital does not have data available for 2014.

Note: *Time spent in the ED was not collected and reported for all patients; patients with invalid or illogical dates/times were excluded from the average. This data should be interpreted with caution by an internal audience only.*

Hospitals turning patients away (diverts)

Beginning in January 2015, Regions began tracking their mental health closure practice in which the hospital can use a "closed mental health" status (also known as "psych diverts") when the number of mental health patients who are in the emergency department exceeds the department's capacity by 25 percent. When this status is used, emergency personnel (i.e., ambulance and police) with mental health patients who do not require medical intervention will be told to divert the patients to another hospital. As of January 1, 2016, both United and St. Joseph's are also implementing closed mental health status. Prior to January 1, 2016, Regions' closed mental health status included accepting every third patient while on divert. Currently, if a hospital is on closed mental health status, all patients are diverted and if all three hospitals use this status at the same time, patients will be rotated among the hospitals.

In January 2016, Regions was on divert for 111 hours, while neither United nor St. Joseph's spent any time on mental health closure status. However, in February 2016, United was on closed mental health status for over 52 hours, and St. Joseph's was on closed mental health status for over 93 hours.

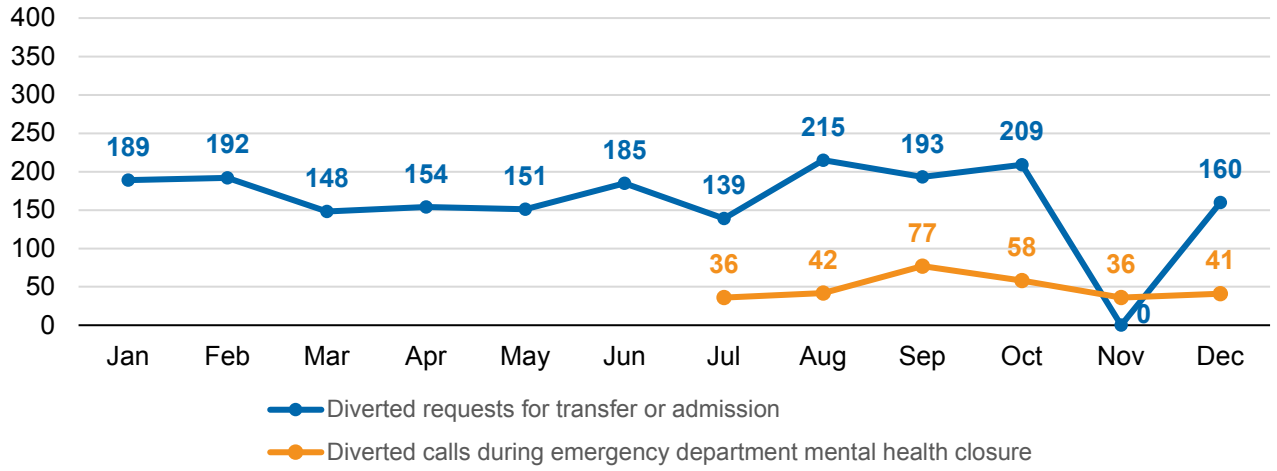
8. Total time on emergency department mental health closure status, 2016 to-date

	January 2016	February 2016
Regions Hospital	111 hours	N/A
St. Joseph's Hospital	0 hours	93.75 hours
United Hospital	0 hours	52.5 hours

Note: February 2016 data about Regions emergency department mental health closure status is not yet available.

In 2015, Regions diverted 290 calls due to emergency department mental health closure status. In addition, Regions is the only St. Paul hospital that currently tracks diverted requests for transfer or admission from other facilities, usually other hospital inpatient units, emergency departments, or primary care clinics. Throughout 2015, Regions hospital diverted a total of 1,935 calls for transfer. The highest number of diverted calls were in August, September, and October of 2015. In November of 2015, there was a drastic drop in diverted calls for transfer, but the number rebounded in December.

9. Diverted telephone requests for transfer/admission: Regions, 2015



Urgent Care utilization

Service utilization at Urgent Care has remained relatively stable from 2012 through 2015 (Figure 10).

10. Services received at Urgent Care, 2012-2015

	2012	2013	2014	2015
Assessment	1,500	1,358	1,503	1,573
Stabilization	360	500	520	506
Psychiatry[a]	677[b]	642	733	698

[a] *Psychiatry appointments were difficult to track in 2012 and 2013. Differences in changes from year to year may be a reflection of differences in how these appointments have been counted/collected, rather than true changes in the amount of service provided.*

[b] *Does not include November-December 2012*

Impact of Urgent Care services

Figure 11 shows likely outcomes for patients if they would not have had access to Urgent Care. This information is gathered using a brief written survey which asks consumers what they would have most likely done if they were unable to receive Urgent Care services. A similar proportion of consumers reported they would have gone to the emergency department if Urgent Care was not available in 2015 as did in 2014. The proportion who reported they would have called 911 went down from 2014 to 2015 (Figure 11).

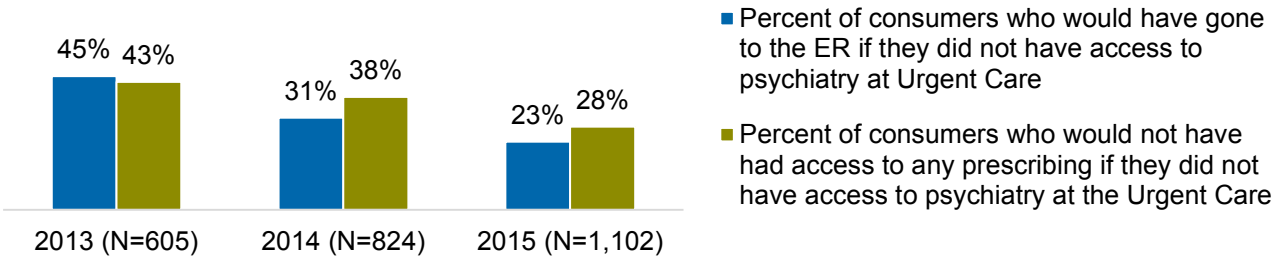
11. Number and percentage of people who would have gone to an emergency department or called 911 if Urgent Care was not available, 2012-2015

If this person had not been seen by staff from the Urgent Care Center, they would have:	2012 total (N=540) %	2013 total (N=794) %	2014 total (N=962) %	2015 total (N=818) %
Gone to the emergency department	26%	17%	14%	15%
Called 911	6%	2%	4%	1%

Note: *Other possible response options included: Gone to a therapist/other mental health provider, gone to a primary care physician, other, done nothing/don't know. Consumers could select multiple response options.*

Another key outcome is to assess potential alternative outcomes for patients who access psychiatry services through Urgent Care. At intake, staff reported that 23 percent of consumers would have likely needed to go to the emergency department if they had been unable to access services from Urgent Care, a 22 percentage point reduction from 2013 (Figure 12).

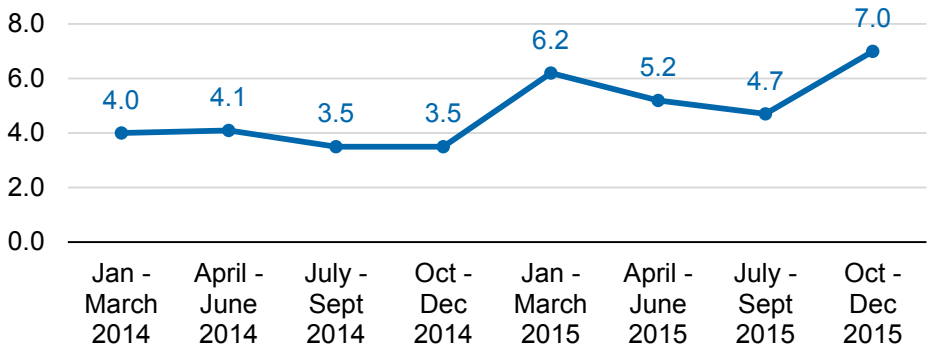
12. Access to psychiatry services from Urgent Care, 2013 – 2015



Note: *Multiple options may have been selected by some staff. Forms received from Urgent Care were assumed to be intake forms unless data from a follow-up visit was included.*

The average wait time for psychiatry at Urgent Care was two days longer in 2015 (5.8 days) than it was in 2014 (3.8 days). There was a notable increase in wait times from the fourth quarter of 2014 to the first quarter of 2015. The last quarter of 2015 saw the longest wait times of the last two years (Figure 13).

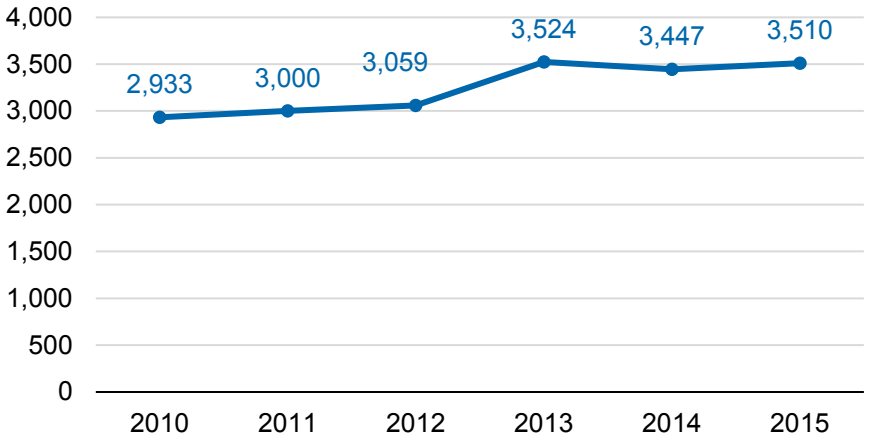
13. Average wait time for psychiatry at Urgent Care. 2014 - 2015



Behavioral health hospital admissions

Behavioral health admissions from the ED rose between 2012 and 2013 and has remained relatively stable through 2015 (Figure 14).

14. Number of behavioral health admissions from ED: Regions, 2010-2015



Non-Qualified Admissions (NQAs)

A Non-Qualified Admission (NQA) occurs when a patient is admitted to inpatient care, but does not meet inpatient admission criteria. The total number of NQAs is relatively low (<1%); however, NQAs increased in 2014 before dropping to zero in 2015 (Figure 15).

15. Behavioral health Non-Qualified Admissions (NQAs) from ED: Regions, 2010-2015

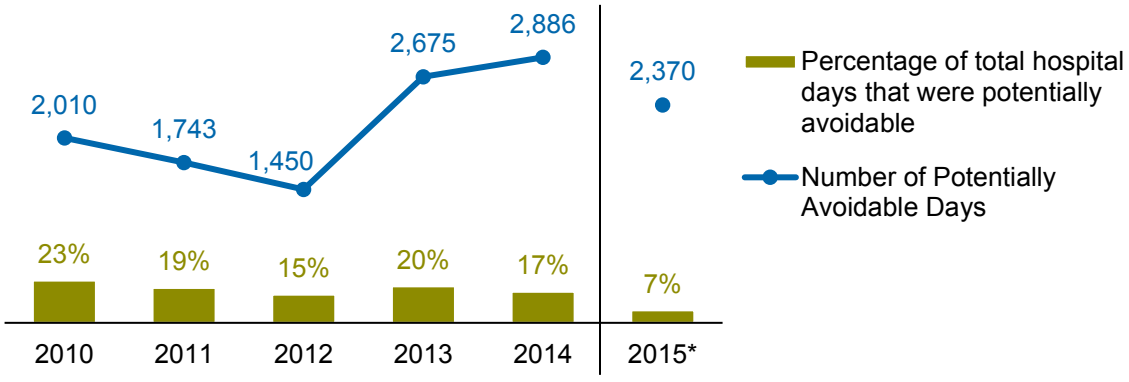
	2010	2011	2012	2013	2014	2015
Number of NQAs	12	16	10	5	19	0
Percent of NQAs	0.4%	0.5%	0.3%	0.1%	0.6%	N/A

Potentially-Avoidable Days (PADs)

Regions also provided data describing the total number of Potentially-Avoidable Days (PADs) attributed to behavioral health inpatient stays. A PAD occurs when a patient is stabilized and ready to be discharged to a less intensive level of care, but is unable to be discharged. The number and percentage of PADs decreased in 2015. It is important to note that this data is incomplete because in February 2015 Regions social work staff stopped tracking potentially avoidable days due to AMRTC wait lists because patients were rarely, if ever, admitted (Figure 16).

The most common reasons for delays were attributed to delays with outside facilities, including IRTS, chemical dependency treatment, AMRTC, and nursing homes. Many delays were also attributed to CADI waivers or insurance issues. The longest delays were for AMRTC, group homes, and county processes (Figure 17).

16. Potentially-Avoidable Days (PADs) for behavioral health patients: Regions, 2010-2015



** In February 2015, Regions social work staff stopped tracking potentially avoidable days due to AMRTC wait lists.*

17. Most common reasons for PADs: Regions, 2015

	Number of cases	Number of days	Average days/patient
IRTS delays	26	252	10
Chemical dependency treatment delays	20	166	8
Other facility delays	16	213	13
AMRTC delays [a]	15	916	61
Nursing home delays	12	175	15
CADI waiver or insurance delays	11	117	11
Group home delays	10	343	34
Legal issues of patient	10	109	11
County delays	3	74	25
Patient delays	3	5	2

[a] *Regions social work staff stopped tracking potentially avoidable days due to AMRTC wait lists in February 2015*

Referrals made to Anoka Medical Regional Treatment Center (AMRTC)

About one-quarter (24%) of AMRTC's statewide referrals in 2014 and 2015 are for people from the east metro, particularly Ramsey County (14%; Figure 18). The east metro population is approximately 21 percent of Minnesota's population, so the rate of referral is greater than the percentage of the population. In 2015, Regions referred more than twice as many people to AMRTC than United and nearly three times as many as St. Joseph's. However, the proportion of patients *admitted* to AMRTC is very low across east metro counties (11-23%) and Saint Paul hospitals (7-12%), which is in contrast to referrals from corrections (over 100% due to referrals prior to the calendar year). This is likely due in large part to the 48-hour rule, which gives priority for admission to people from corrections.

18. Number of people referred for admission to AMRTC

	2014		2015		
	Number of referrals	Percent of statewide referrals	Number of referrals	Percent of statewide referrals	Percent of referrals admitted[a]
Statewide	1,063	-	892	-	31%
From the east metro	250	24%	216	24%	14%
Dakota County	87	8%	70	8%	11%
Ramsey County	146	14%	124	14%	14%
Washington County	17	2%	22	2%	23%
From Saint Paul hospitals	223	21%	169	19%	8%
Regions Hospital	140	13%	91	10%	7%
St. Joseph's Hospital	39	4%	35	4%	12%
United Hospital	44	4%	43	5%	7%
From corrections statewide	95	9%	134	15%	112%

[a] *These rates are based on the date of referral or admission; some patients may have been referred in a different year than they were admitted.*

When looking at referrals and admissions across 2015, referrals from east metro counties and Saint Paul hospitals were highest in the first quarter of the year before decreasing throughout the remainder of the year. This same pattern occurred for referrals throughout the state. In east metro counties and Saint Paul hospitals, there was a slight uptick in referrals during the last quarter of 2015. However, admissions tended to remain low, particularly for people referred from Saint Paul hospitals, though there was a small increase in admissions from east metro counties in the last quarter of the year. During this same time, the number of admissions for people in corrections increased (Figure 19).

19. Number of people referred and admitted to AMRTC by quarter, 2015

		Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Oct-Dec 2015
Statewide	Number of referrals	283	234	189	186
	Number of admissions	75	55	73	75
	Percent of referrals admitted	27%	24%	39%	40%
People from the east metro counties	Number of referrals	68	58	42	48
	Number of admissions	14	2	4	10
	Percent of referrals admitted	21%	3%	10%	21%
People from Saint Paul hospitals	Number of referrals	58	48	34	37
	Number of admissions	8	0	4	2
	Percent of referrals admitted	14%	0%	12%	5%
People from corrections statewide	Number of referrals	34	31	33	38
	Number of admissions	30	34	44	44
	Percent of referrals admitted	88%	110%	133%	116%

Note: These rates are based on the date of referral or admission, so some patients may have been referred in a different quarter than they were admitted.

Compared to all AMRTC admissions in 2015, the individuals referred from east metro counties had longer average waits before being admitted. Those referred from Saint Paul hospitals had even longer waits. Both groups had to wait more than one month before being admitted. Those referred from Saint Paul hospitals had to wait two and a half months, on average. In addition, both groups' waits exceeded the average length of time between referral and removal from the wait list, and the average wait times in 2014 (Figure 20).

20. Average number of days between referral and AMRTC admission or removal from wait list

	Average number of days in 2014	Average number of days in 2015
Days between referral and removal from wait list (statewide)	27.89	32.67
Days between referral and admission		
Statewide admissions	27.60	25.27
Admissions for people from east metro counties	34.24	38.61
Admissions referred from Saint Paul hospitals	48.54	81.71

Appendix

Future Community Metrics data collection

Future Community Metrics reports will include additional information about the availability of mental health services and overall capacity of the adult mental health system in the east metro. These additional data include:

- Data from all three Saint Paul hospitals about:
  - the number and average time for emergency department mental health closures
  - the number of and reasons for Non-Qualified Admissions
  - the number of and reasons for PADs for behavioral health admissions
- More detailed information from AMRTC and east metro hospitals about the reasons for NQAs and PADs
- Information about mental health screenings in county correctional settings

Detailed data tables

A1. Saint Paul Police Department suicide and suicidal behavior tracking, 2011-2015

	2009	2010	2011	2012	2013	2014	2015
Completed suicide	24	24	17	17	9	13	5
Suicide attempt	15	31	76	109	65	53	38
Suicide threat	13	24	153	299	251	378	308

A2. Total behavioral health patient visits in emergency department, 2010-2015

	2010	2011	2012	2013	2014	2015
Regions – ER Crisis Program	6,664	6,903	7,034	7,482	7,550	7,470
St. Joseph's[a]	1,119	1,463	1,424	1,343	N/A	1,835
United	2,113	2,438	3,016	4,142	4,304	4,015
Combined	9,664	10,704	11,156	12,967	N/A	13,320

[a] *St. Joseph's Hospital does not have data available for 2014, so a combined total is not available.*

Note: *The totals refer to the number of patient visits, not unique patients seen at each hospital.*

A3. Average or median time behavioral health patients spent in emergency departments, 2010-2015

	2010	2011	2012	2013	2014	2015
Average wait in hours at Regions	8	8.6	9.3	9.1	10	11.7
Average wait in hours at St. Joseph's	3.8	4.4	4.6	5.4	N/A	16
Median wait in hours at United	4.8	4.9	5.8	4	4.5	5.2

Regions Hospital and St. Joseph's Hospital provided average length of stay rather than median length of stay.
United Hospital provided median length of stay rather than average length of stay.
St. Joseph's Hospital does not have data available for 2014.

Note: *Time spent in the ED was not collected and reported for all patients; patients with invalid or illogical dates/times were excluded from the average. Due to concerns about the integrity of this data point, this observed change should be interpreted with caution by an internal audience only.*

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