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Riverview Psychiatric Center — an Analysis of Requests for Admission, 2007

Maine State Legislature

Office of Program Evaluation and Government Accountability

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Analytical Study

FINAL REPORT

Riverview Psychiatric Center — an Analysis of Requests for Admission

Report No. FU-RPC-06

a report to the
Government Oversight Committee
from the
Office of Program Evaluation & Government Accountability
of the Maine State Legislature

August
2007

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ABOUT OPEGA & THE GOVERNMENT OVERSIGHT COMMITTEE

The Office of Program Evaluation and Government Accountability (OPEGA) was created by statute in 2003 to assist the Legislature in its oversight role by providing independent reviews of the agencies and programs of State Government. The Office began operation in January 2005. Oversight is an essential function because legislators need to know if current laws and appropriations are achieving intended results.

Although the Maine Legislature has always conducted budget reviews and legislative studies, until OPEGA, the Legislature had no independent staff unit with sufficient resources and authority to evaluate the efficiency and effectiveness of Maine government. The joint legislative Government Oversight Committee (GOC) was established as a bipartisan committee to oversee OPEGA's activities.

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EXECUTIVE SUMMARY

Riverview Psychiatric Center — an Analysis of Requests for Admission

Introduction

The Maine State Legislature's Office of Program Evaluation and Government Accountability (OPEGA) has completed an analytical study of Requests for Admission to Riverview Psychiatric Center (RPC) at the direction of the joint legislative Government Oversight Committee. OPEGA conducted this study in accordance with MRSA Title 3, Chapter 37, §991-997.

The purpose of this analytical study was to produce credible, objective information about requests for admission that would be useful to the Legislature in considering capacity concerns at RPC and within the State's mental health system as a whole. Specifically, OPEGA sought to answer the following questions:

This study's purpose was to produce objective, credible and useful information about requests for admission to RPC.

1. How many requests do not result in immediate admission[1] due to lack of capacity?
2. How many appropriate individuals[2] (civil or forensic) are not immediately admitted to RPC due to lack of capacity?
3. Where are requests for admission originating from?
4. Are there multiple admission requests for the same individual(s)?
5. What are the major reasons for admission requests?
6. What happens to individuals who are denied immediate admission to RPC?

While the answers to these questions are presented in the remainder of this report, many other questions might be answered by OPEGA's data analysis. Additional analyses performed by OPEGA are presented in Appendix B.

[1] Immediate admission means individuals were either admitted or scheduled for admission upon initial contact with RPC. Those put on the wait list were not considered immediately admitted.

[2] Appropriate individuals are those that met the criteria for admission to RPC. For example, mental retardation, substance abuse or medical issues would result in an individual being ineligible for admission.

Summary of Analysis

From May-Sept 2006, RPC received 437 admission requests for 353 different individuals. 14% of the individuals had multiple requests accounting for about 30% of the requests.

During the period May-September 2006, Riverview Psychiatric Center received 437 admission requests[3] related to 353 different individuals. The majority of these individuals (304 or 86%) had just one request in this period. The rest of them (49 or 14%) had multiple requests accounting for approximately 30% of all requests.

The majority of the 437 requests (82%) came from either emergency rooms (48%) or community and specialty hospitals (34%). Those requests were primarily for civil beds. Another 16% of the requests originated from jails or prisons; primarily for forensic beds. Most of the requests from emergency rooms appeared to come from the Lewiston area, followed by Augusta/Waterville, Portland and then Bangor. Forty-one percent of the community or specialty hospital requests came from the two specialty hospitals (Acadia and Spring Harbor) with another 25% of those requests coming from Maine General Medical Center. Androscoggin County, Cumberland County and Kennebec County were the top sources of requests from jails and prisons.

85% of the individuals were not immediately admitted to RPC due to a lack of capacity. Nonetheless, the data suggests that most received the care they needed in a timely manner through other services and facilities as admission to RPC was not repeatedly sought.[6]

Thirty-nine percent of the 437 requests were made because the individual had a high acuity level[4] or violent/aggressive behavior. For another 31% of the requests, the reason for requesting admission was given as "Other". The most common "Other" reasons given were that the individual was suicidal or was experiencing a particular type of mental illness (i.e. psychotic, paranoid schizophrenic, delusional bi-polar).

Eighty-five percent of the individuals (299) seeking admission to RPC were not immediately admitted due to a lack of capacity at the facility[5]. Nonetheless, the data collected suggests that most of the 353 individuals requesting admission to RPC (323 or 92%) received the care they needed in a timely fashion through other facilities and services as per the current design of Maine's adult mental health system.[6] It seems the remainder, however, (30 individuals or 8%) were not served as satisfactorily since they appeared to have extended stays in emergency rooms, lengthy episodes while in jail or made multiple trips to ERs and hospitals during the same mental health episode.

A smaller group of individuals with particular characteristics appeared harder to place in community hospitals. OPEGA identified 30 of these individuals that did not appear to have been satisfactorily served in the time period reviewed.

OPEGA also noted 43 of the total 353 individuals (12%) seeking admission to RPC appeared to be particularly hard to place and were at higher risk of not being satisfactorily served. Nearly all of these individuals apparently had a high acuity level or violent/aggressive behavior, or were suicidal, homicidal, psychotic or delusional. It appears other hospitals, even if they did have beds available, were not willing or able to take individuals that may have been harder to manage.

[3] This total does not include 70 repeat requests made by the same requestor (institution) for the same individual during the same mental health crisis. Except where specifically stated in the report, all figures and analyses relate to these 437 non-repeat requests.

[4] The individual could not be safely and appropriately cared for in another hospital setting.

[5] These individuals represented 87% of the 437 requests.

[6] Follow-up on specific individuals would be required to ascertain the full details of their experiences in order to assess whether they actually received satisfactory care.

FULL REPORT

Riverview Psychiatric Center — an Analysis of Requests for Admission

Introduction

In early 2006, based on data collected by RPC, the Riverview Bed Committee concluded that capacity at RPC was inadequate and recommended increasing its size.

The Maine State Legislature's Office of Program Evaluation and Government Accountability (OPEGA) has completed an analytical study of Requests for Admission to Riverview Psychiatric Center (RPC) at the direction of the joint legislative Government Oversight Committee. OPEGA conducted this study in accordance with MRSA Title 3, Chapter 37, §991-997.

During 2005, in response to citizen and legislative concerns that the new Riverview Psychiatric Center was not large enough, RPC collected data on requests for admission and reported that data to the Riverview Bed Committee (RBC). The Committee analyzed the data and, in early 2006, reported their results to the Legislature's Joint Standing Committee on Health and Human Services. The RBC concluded bed capacity at RPC was inadequate and recommended increasing the size of RPC. The RBC was particularly concerned that individuals experiencing mental health crises were spending long periods of time in hospital emergency rooms because of a shortage of available beds at RPC.

DHHS agreed requests for admission were being denied because no beds were available, but disagreed that increasing the size of RPC was the solution. DHHS maintained that resolving other issues in the mental health system would alleviate this problem.

The Department of Health and Human Services agreed that requests for admission to RPC were regularly being denied because beds were not available, but disagreed that increasing capacity was the solution. The Department maintained instead that resolving other issues within the State's mental health system would result in both fewer requests for admission to RPC and more of the existing beds at RPC being available. DHHS also believed lengthy patient stays in emergency rooms were not regular occurrences, but had just begun to gather data from hospitals in an attempt to objectively assess that assumption.

In an effort to assure legislative discussions and decisions about possible expansion of RPC were based on sound, objective information, the Government Oversight Committee (GOC) directed OPEGA to conduct a review of the admission request data collected by RPC and used by the Riverview Bed Committee. The purpose of the review was to determine whether conclusions being drawn from the data were valid and whether any additional information collected could be useful to the Legislature in assessing the situation. OPEGA's report from that review, entitled *Bed Capacity at Riverview Psychiatric Center*, was released in April 2006.[1] OPEGA concluded no valid conclusions could be drawn from the data collected and there was no additional data to analyze. OPEGA also noted, however, that RPC was

[1] For a full copy of the report, visit OPEGA's website at www.maine.gov/legis/opega or contact OPEGA at (207) 287-1901. Copies of the report are also available through the Maine State Library and the Law and Legislative Reference Library.

OPEGA reviewed the 2005 RPC data the Bed Committee's recommendation was based on and found the data collection process was flawed. Therefore, no valid conclusions could be drawn from the data.

only a piece of the State's mental health system, and other factors related to the whole system should be considered before deciding whether to expand RPC.

In response to OPEGA's findings, the GOC and DHHS agreed that:

- DHHS would continue to collect data on requests for admission to RPC for a specified period of time using a process designed by OPEGA;
- Collected data would be submitted to OPEGA; and
- OPEGA would analyze the data and report results to the GOC and the Joint Standing Committee on Health and Human Services.

It was agreed RPC would continue to collect request data using a process and tools designed by OPEGA and would submit the data to OPEGA for analysis.

The purpose of this subsequent analytical study was to produce credible, objective information about requests for admission useful to the Legislature in considering capacity at RPC, and regarding the State's mental health system as a whole. Specifically, OPEGA sought to answer the following questions:

1. How many requests do not result in immediate admission[2] due to lack of capacity?
2. How many appropriate individuals[3] (civil or forensic) are not immediately admitted to RPC due to lack of capacity?
3. Where are requests for admission originating from?
4. Are there multiple admission requests for the same individual(s)?
5. What are the major reasons for admission requests?
6. What happens to individuals who are denied immediate admission to RPC?

This study's purpose was to produce objective, credible information about requests for admission to RPC that would be useful to the Legislature.

While the answers to these questions are presented in the remainder of this report, many other questions might be answered by OPEGA's data analysis. Additional analyses performed by OPEGA are presented in Appendix B.

Methods and Scope

The analyses presented in this report are based on data collected for the period May–September 2006. Using a data collection form designed by OPEGA (see Appendix A), RPC staff gathered specific information about each request for admission when the request was received. Most of the information captured on

[2] Immediate admission means individuals were either admitted or scheduled for admission upon initial contact with RPC. Those put on the wait list were not considered immediately admitted.

[3] Appropriate individuals are those that met the criteria for admission to RPC. For example, mental retardation, substance abuse or medical issues would result in an individual being ineligible for admission.

The analyses in this report are based on data collected for the period May-Sept 2006. RPC staff collected specific information about each request for admission using a form designed by OPEGA.

each request was provided by the person making the request and has not been verified by either RPC staff or OPEGA.

RPC's Director of Finance and Ambulatory Care entered data from the forms into a spreadsheet and submitted both electronic file and data forms to OPEGA each month. OPEGA verified the data in the spreadsheet against the data forms and made corrections as necessary. The data formats were also standardized to facilitate further analysis using automated tools.

At the end of the period, OPEGA combined the monthly files and sorted the records to identify unique individuals, requests[4], episodes[5] and hospitalizations[6]. For example:

From this data, OPEGA identified the number of unique individuals, requests, episodes and hospitalizations included in its analyses.

- an individual in an emergency room (ER), where 3 different calls were made to RPC while the individual was there, constituted one non-repeat request for admission (the first call) and two repeat requests;
- an individual in an ER where a request to RPC was made, but the individual was instead transferred to a community hospital which then later also requested RPC admission for this patient, constituted one episode and one hospitalization but multiple non-repeat requests (one from the ER and one from the community hospital);
- an individual who went to an emergency room several different times over the course of two weeks, where a request for admission to RPC was made each time, constituted one episode, multiple hospitalizations and multiple non-repeat requests (a new one each time the individual went to the ER); and
- an individual who went to an ER three times spread out over the course of the five month period, with an RPC request for admission each time, constituted three different episodes, three hospitalizations and three non-repeat requests.

As part of this process, OPEGA was able to infer some data that had been missing in the original dataset because it was not collected at the time of the request. For individuals with multiple requests, some of the missing data elements on one request were included on another request. In these instances, OPEGA added the inferred data to the electronic file to allow for a more complete analysis.

See Appendix B for the selected data and analyses performed by OPEGA.

[4] Requests were coded to distinguish between the first requests coming from a requestor (institution) and repeat requests from that same requestor.

[5] Using request dates, OPEGA assigned a new episode number each separate span of time an individual appeared to be having a mental health crisis. To determine what constituted an episode, OPEGA assumed one episode lasted no more than two to three weeks.

[6] OPEGA assigned a new hospitalization number each time an individual entered a hospital or requested hospitalization (unless it was a repeat request). Each hospitalization began with the initial hospitalization or call seeking hospitalization and ended with discharge from the final hospital. All transfers between hospitals for an episode were captured within one hospitalization number.

Background

Effective continuity of care for the mentally ill depends upon coordination and collaboration among all components of Maine's mental health system. See Figure 1 for an overview.

Effective continuity of care for the mentally ill depends upon a high level of coordination and collaboration among all parts of the mental health system including: community services and placements; crisis services; emergency rooms; and community, specialty and State hospitals. Figure 1 provides an overview of the basic relationships among these components.

Community and crisis services are critical components of Maine's mental health system. Community services are designed to work with individuals wherever they are in the mental health system. These services include case management, assertive community treatment (ACT) teams and housing placements. Crisis workers assess whether people in crisis need stabilization beds, hospitalization, or may go home, and coordinate with community services to ensure continuity of care.

Maine's system includes three types of hospitals (community, specialty and State) which combined have about 270 in-patient adult psychiatric beds.

Within Maine's system, three types of hospitals provide in-patient hospitalization for mental health patients. There are eight community hospitals, two specialty hospitals (Acadia in Bangor and Spring Harbor in Portland) and two State hospitals (RPC in Augusta and Dorothea Dix in Bangor). The two specialty hospitals and the two State hospitals are also known as Institutes for Mental Disease (IMD's). Guiding Principles[7] exist which define the differing roles of these hospitals and specify what types of patients each will serve. These Principles describe the two State hospitals as tertiary, meaning that they take patients with higher acuity[8] or who need more than 30 days of in-patient care.

There are approximately 270 in-patient psychiatric adult beds throughout the State in the three types of hospitals. A few of these are observation beds where a patient may stay for up to 72 hours while it is determined whether hospitalization is necessary or whether discharge to another setting is more appropriate. Under their licenses, community and specialty hospitals are limited to 30 day patient stays.

DHHS must manage the complex network of contracted and licensed providers to assure satisfactory care for Maine's mental health population. A recent effort to improve the system was occurring during the time period of this study.

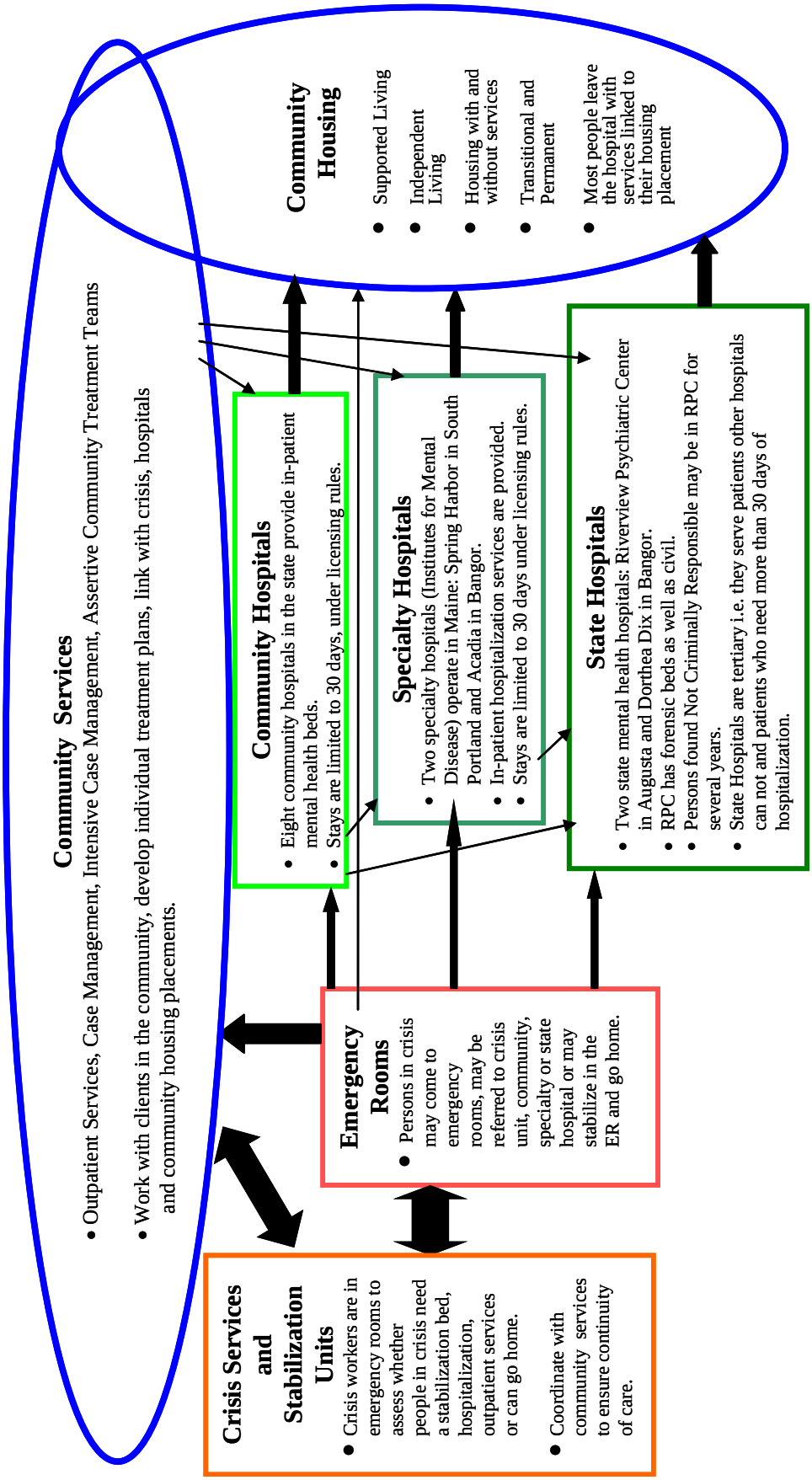
DHHS must manage the complex network of contracted and licensed providers to assure that the State's mental health population has adequate and accessible services and facilities. Adequate levels of appropriately trained staff system-wide are also vital to the success of Maine's mental health system.

DHHS has adopted many plans and made efforts over the years to improve the system. One such effort was occurring during the time period of this study. In June 2006, the four IMD's formed a committee to develop a comprehensive strategic plan for hospital-based mental health services. The committee presented its results to the Legislature's Joint Standing Committee on Health and Human Services in May 2007. See a copy of that report along with a response letter from DHHS at the end of this report.

[7] The Statement of Guiding Principals for the Delivery of Behavioral Health Services was developed in 2001 by the then Department of Mental Health, Mental Retardation and Substance Abuse Services, the specialty hospitals and the private non-profit hospital community.

[8] The individual can not be safely and appropriately cared for in another hospital setting.

Figure 1. Adult Mental Health System Overview



Summary of Analysis

From May-Sept 2006, RPC received 437 admission requests for 353 different individuals. 14% of the individuals had multiple requests accounting for about 30% of the requests.

During the period May-September 2006, Riverview Psychiatric Center received 437 admission requests[9] related to 353 different individuals. The majority of these individuals (304 or 86%) had just one request in this period. The rest of them (49 or 14%) had multiple requests accounting for approximately 30% of all requests.

The majority of the 437 requests (82%) came from either emergency rooms (48%) or community and specialty hospitals (34%). Those requests were primarily for civil beds. Another 16% of the requests originated from jails or prisons; primarily for forensic beds. Most of the requests from emergency rooms appeared to come from the Lewiston area, followed by Augusta/Waterville, Portland and then Bangor. Forty-one percent of the community or specialty hospital requests came from the two specialty hospitals (Acadia and Spring Harbor) with another 25% of those requests coming from Maine General Medical Center. Androscoggin County, Cumberland County and Kennebec County were the top sources of requests from jails and prisons.

85% of the individuals were not immediately admitted to RPC due to a lack of capacity. Nonetheless, the data suggests that most received the care they needed in a timely manner through other services and facilities as admission to RPC was not repeatedly sought.[12]

Thirty-nine percent of the 437 requests were made because the individual had a high acuity level[10] or violent/aggressive behavior. For another 31% of the requests, the reason for requesting admission was given as "Other". The most common "Other" reasons given were that the individual was suicidal or was experiencing a particular type of mental illness (i.e. psychotic, paranoid schizophrenic, delusional bi-polar).

Eighty-five percent of the individuals (299) seeking admission to RPC were not immediately admitted due to a lack of capacity at the facility[11]. Nonetheless, the data collected suggests that most of the 353 individuals requesting admission to RPC (323 or 92%) received the care they needed in a timely fashion through other facilities and services as per the current design of Maine's adult mental health system.[12] It seems the remainder, however, (30 individuals or 8%) were not served as satisfactorily since they appeared to have extended stays in emergency rooms, lengthy episodes while in jail or made multiple trips to ERs and hospitals during the same mental health episode.

A smaller group of individuals with particular characteristics appeared harder to place in community hospitals. OPEGA identified 30 of these individuals that did not appear to have been satisfactorily served in the time period reviewed.

OPEGA also noted 43 of the total 353 individuals (12%) seeking admission to RPC appeared to be particularly hard to place and were at higher risk of not being satisfactorily served. Nearly all of these individuals apparently had a high acuity level or violent/aggressive behavior, or were suicidal, homicidal, psychotic or delusional. It appears other hospitals, even if they did have beds available, were not willing or able to take individuals that may have been harder to manage.

[9] This total does not include 70 repeat requests made by the same requestor (institution) for the same individual during the same mental health crisis. Except where specifically stated in the report, all figures and analyses relate to these 437 non-repeat requests.

[10] The individual could not be safely and appropriately cared for in another hospital setting.

[11] These individuals represented 87% of the 437 requests.

[12] Follow-up on specific individuals would be required to ascertain the full details of their experiences in order to assess whether they actually received satisfactory care.

Detailed Analysis

How many requests do not result in immediate admission[2] due to lack of capacity?

Ninety-four percent of requests in May-Sept 2006 were not immediately admitted. For 87% of these, lack of capacity was the reason for non-admittance.

RPC received 437 requests for admission during the period May-September 2006 - 357 (82%) for civil beds and 77 (18%) for forensic beds. [13]

Of the 437 requests, 412 (94%) were not immediately admitted[14]. Three hundred sixty of the 412 (87%) did not result in admittance due to lack of capacity, and of these 193 were put on a wait list. The remaining 52 requests (13%) did not result in admittance for reasons other than lack of capacity[15].

The breakdown of requests and percentages by type of bed requested (i.e. civil or forensic) is shown in Table 1.

Table 1. Number and Percent of Requests by Resolution and Type of Bed Requested	All Beds		Civil Beds		Forensic Beds	
	#	%	#	%	#	%
# of Requests	437		357		77	
# of Requests that were Not Admitted (NA)	412		340		70	
Not Admitted as Percent of Requests		94%		95%		91%
# of Requests Not Admitted Due to Lack of Capacity (NALC)	360		300		59	
NALC as Percent of NA		87%		88%		84%
# of Requests Not Admitted For Other Reasons (NAO)	52		40		11	
NAO as Percent of NA		13%		12%		16%
# of NALC Put on Wait List (NALCW)	193		151		42	
NALCW as Percent of NALC		54%		50%		71%

[13] The status of civil or forensic could not be determined for 3 requests as sufficient data was not collected.

[14] There are 8 requests for which no resolution of the request (i.e. admitted, scheduled, wait list or not admitted) was given.

[15] There are 7 not admitted requests where reason for non-admittance was not given.

How many appropriate individuals[3] (civil or forensic) are not immediately admitted to RPC due to lack of capacity?

Eighty-five percent of individuals seeking beds met RPC criteria but were not admitted due to lack of capacity.

In the period May–September 2006, requests for admission to RPC were made for a total of 353 different individuals. Civil beds were requested for 282 individuals while forensic beds were requested for 73 individuals. The type of bed needed was undetermined for another 3 individuals.[16]

Of the 353 different individuals seeking beds at RPC, a total of 299 (85%) met the criteria for admission to RPC but were not immediately admitted due to a lack of capacity. Table 2 shows the number of individuals not admitted due to lack of capacity each month by type of bed requested

Table 2. Number of Appropriate Individuals Not Admitted Due to Lack of Capacity by Month

Type of Bed Requested	Entire Period*	May	June	July	Aug*	Sept**
Total Individuals Requesting Beds at RPC	353	95	85	70	69	83
# Not Admitted Due to Lack of Capacity	299	87	82	63	32	64
% of Total Not Admitted Due to Lack of Capacity	85%	92%	96%	90%	46%	77%
Total Individuals Requesting Civil Beds	282	78	67	59	57	63
# Civil Not Admitted Due to Lack of Capacity	241	71	64	53	29	52
% of Total Civil Not Admitted Due to Lack of Capacity	85%	91%	96%	90%	51%	83%
Total Individuals Requesting Forensic Beds	73	17	19	12	11	19
# Forensic Not Admitted Due to Lack of Capacity	57	15	18	10	3	12
% of Total Forensic Not Admitted Due to Lack of Capacity	78%	88%	95%	83%	27%	63%

* The total of the monthly figures exceeds the total for the entire period for each category because some individuals requested admission in multiple months.

** There was a higher number of not admitted due to not meeting criteria and not admitted for other reasons in these months. Majority of other reasons given are patient's location is located out of RPC's catchment area or requestor is still seeking beds at community hospitals.

[16] There were five individuals who had requests for both civil and forensic beds at different times. Consequently, the sum of the number of individuals seeking civil beds, the number seeking forensic beds and the number seeking undetermined beds is greater than the overall total of different individuals involved.

Where are requests for admission originating from?

The majority of the 437 requests (82%) came from either emergency rooms (48%) or from community and specialty hospitals (34%) where individuals were already occupying in-patient beds. Another 16% of the requests originated from jails and prisons. Table 3 shows the breakdown of requests by type of bed sought and where individuals were located when requests were made.

Table 3. Requests by Individual's Location & Type of Bed

	All Beds*		Civil Beds		Forensic Beds	
Location	# of Requests	% of Total All Bed	# of Requests	% of Total Civil	# of Requests	% of Total Forensic
Blank	1	<1%	1	<1%	0	0%
CR - Crisis Facility	3	1%	3	1%	0	0%
ER - Emergency Room	208	48%	200	56%	5	6%
IC - In-Patient at Comm/Specialty Hosp	147	34%	144	40%	3	4%
O - Other	10	2%	8	2%	2	3%
P – Jail/Prison	68	16%	1	<1%	67	87%
Total Non-repeat Requests	437	100%	357	100%	77	100%

*The sum of civil and forensic bed requests does not equal total requests for all beds in the emergency room category as there were 3 requests for which the type of bed being sought could not be determined.

Requests for Civil Beds

Most requests for civil beds came from ERs (56%) or community/specialty hospitals (40%) where the individual was already a psychiatric patient.

Ninety-six percent of the 357 requests for civil beds came from either emergency rooms (ERs) or community and specialty hospitals, with the majority (200 requests or 56%) coming from ERs.

For 173 of the 200 requests from ERs (87%), requestors reported contacting community or specialty hospitals seeking beds prior to calling RPC. Approximately 74% of the 173 reported contacting 5 or more other hospitals.[17]

The majority of requests from ERs appeared to come from the Lewiston area followed by Augusta/Waterville, Portland and then Bangor.

The highest numbers of requests from ERs came from St. Mary's Hospital (41) followed by Maine General Medical Center – Augusta (21), Eastern Maine Medical Center (16) and Maine Medical Center (16). In terms of geographic region, the majority of requests from ERs appeared to come from the Lewiston area followed by Augusta/Waterville, Portland and then Bangor.

For 32 of the 144 requests coming from community and specialty hospitals (22%), requestors reported contacting other hospitals seeking beds prior to calling RPC. This rate is most likely lower than the rate for requests from ERs because many of these requests (58 or 41%) came from one of the two specialty hospitals. As per

[17] Approximately 3% of the requestors reporting they had contacted other hospitals did not provide information on how many they had contacted before calling RPC.

Most of the requests from other hospitals came from Acadia and Spring Harbor (specialty hospitals) or Maine General Medical Center (community hospital).

the design of the mental health system, these are the two hospitals patients from community hospitals are supposed to flow through before admission to the State's hospitals (RPC and Dorothea Dix) is sought.

The lower rate, however, is also partly due to the fact that approximately 25% or 36 of the requests from community hospitals came from Maine General Medical Center (MGMC), with MGMC first contacting other hospitals for only 4 of those requests. In keeping with the design of the system, MGMC should have first contacted Acadia and Spring Harbor Hospitals before seeking to transfer a patient to RPC. MGMC may have contacted RPC first because of its proximity.

Requests for Forensic Beds

Eighty-seven percent of forensic bed requests came from jails or prisons with the highest numbers coming from Androscoggin, Cumberland or Kennebec County jails.

Eighty-seven percent of the 77 requests for forensic beds came from jails or prisons. Only 8 requests (10%) came from emergency rooms or community/specialty hospitals.

Requestors reported contacting community or specialty hospitals prior to calling RPC for only 33% of the 67 requests coming from jails or prisons. The low percentage of requestors who had contacted other hospitals is likely because only the two specialty hospitals are able to take forensic patients and then only with special accommodations. The highest numbers of requests from jails came from Androscoggin County Jail (13), Cumberland County Jail (10), and Kennebec County Jail (9).

As for the 5 requests for forensic beds that came from ERs, 4 of the requestors had sought beds in community or specialty hospitals before contacting RPC. The five requests were spread among 5 different hospitals.

Are there multiple admission requests for the same individual(s)?

Forty-nine individuals (14%) had multiple requests accounting for 30% of all requests. Nineteen of these individuals (5% of all individuals) accounted for about 17% of all requests.

Yes. Of the 353 individuals for whom requests for admission to RPC were made in May-September 2006, 304 (86%) had just one request. Forty-nine individuals (14% of the total) had multiple requests for admission accounting for approximately 133 of the 437 total requests (30%). Nineteen individuals (5% of the total 353 individuals) had 3 or more requests, accounting for about 73 of the total requests (17%). Individuals with multiple requests typically had requests in more than one month.

Table 4 below shows a breakdown of the number of individuals by number of requests for types of beds sought.

Table 4. Individuals by Number of Requests and Type of Bed Sought	Figures Represent # of Individuals					
Type of Bed Sought	Total # of Individuals*	# with 1 Request	# with 2 or more Requests	# with 3 or more Requests	# with 4 or more Requests	# with 5 or more Requests
Total Civil Beds	282	240	42	17	8	4
Total Forensic Beds	73	69	4	0	0	0
Undetermined	3	3	0	0	0	0

* There were five individuals who had requests for both civil and forensic beds at different times. Therefore, the sum of numbers of individuals for civil beds, forensic beds and undetermined beds is greater than the total overall number of individuals seeking beds.

What are the major reasons for admission requests?

Overall, most requests were made because the individual had a high acuity level, displayed violent behavior, was suicidal or exhibited particular types of mental illness.

Thirty-nine percent of the 437 requests for admission were made because the individual had a high acuity level or violent/aggressive behavior. For another 31%, the reason for requesting admission was given as "Other". Table 5 below shows the breakdown of reasons for requests by type of bed sought. The most common "Other" reasons given, whether the request was for a civil or forensic bed, were that the individual was suicidal or was exhibiting particular types of mental illness (i.e. psychotic, schizoaffective, paranoid schizophrenic, delusion bi-polar).

Table 5. Number and Percent of Requests by Reason and Type of Bed Sought				
	Civil Beds		Forensic Beds	
Reason	# of Requests	% of Total	# of Requests	% of Total
Blank	4	1.1%	1	1.3%
1 - 30 day limit approaching	63	17.6%	0	0.0%
2 - High acuity/violence	141	39.5%	27	35.1%
3 - No community beds available	58	16.2%	3	3.9%
4 - Interstate compact	1	0.3%	0	0.0%
5 - Other	90	25.2%	46	59.7%
Total Requests*	357	100.0%	77	100.0%

* The sum of civil and forensic requests is less than 437 because there were 3 requests for which the type of bed sought was undetermined.

Requests for Civil Beds

The primary reason for civil bed requests was that the patient had a high acuity level or was displaying violent/aggressive behavior. As shown in Table 6, this was particularly true if the patient was in an emergency room at the time the request was made as opposed to a community/specialty hospital.

The percent of requests coming from ERs because there were no community hospital beds available is also higher than for patients already in beds at community

and specialty hospitals. The primary reason for community/specialty hospitals to request a patient transfer to RPC is that the patient will need longer term hospitalization than the 30 days a community or specialty hospital can provide.

These reasons were especially prevalent for individuals located in ERs or jails.

For nearly all the requests where the reason given was that there were no community hospital beds available, requestors had reported contacting other hospitals prior to contacting RPC. Approximately 77% of them reported contacting 5 or more hospitals before contacting RPC.

Table 6. Requests by Reason and Location	Emergency Room		Community Hospital	
Reason	# of Requests	% of Total	# of Requests	% of Total
Blank	1	<1%	2	1%
1 - 30 day limit approaching	0	0%	63	44%
2 - High acuity/violence	89	45%	49	34%
3 - No community beds available	52	26%	3	2%
4 - Interstate compact	1	<1%	0	0%
5 - Other	57	29%	27	19%
Total Civil Requests	200	100%	144	100%

In addition, many requests from community/specialty hospitals were made because the licensed 30-day limit was approaching.

There are also a fair percentage of requests for civil beds where the reason given fell into the "Other" category. The most common "Other" reasons cited, in order of frequency, were:

- individual is suicidal/homicidal;
- individual is requesting RPC or has history with RPC;
- individual is psychotic/schizoaffective/paranoid-schizophrenic/delusional bi-polar; or
- individual needs long stay bed.

Requests for Forensic Beds

The "Other" category was the primary reason given for requesting forensic beds at RPC, followed by high acuity level or violent/aggressive behavior. Nearly all the requests for forensic beds were made while the patient was located in a jail or prison. The most common "Other" reasons given for forensic bed requests, in order of frequency, were:

- individual is suicidal/homicidal;
- individual is psychotic/bipolar/paranoid/delusional;
- individual is a legal hold; or
- individual needs Stage III evaluation.

What happens to individuals who are denied immediate admission to RPC?

Actual experiences cannot be determined without follow-up on specific individuals. However, the data suggests that most individuals not admitted to RPC received the care they needed elsewhere as admission to RPC was not repeatedly sought.

This question cannot be definitively answered by the data gathered by RPC and analyzed by OPEGA. Follow-up on specific individuals would be required to ascertain the full details of their experiences. A review of the number, timing and resolution of the requests, however, does suggest some themes for the 353 individuals with requests for admission to RPC in May–September 2006 (most of whom were not immediately admitted to RPC).

The data collected suggests the majority of individuals (323 or 92%) received the care they needed in a timely fashion in line with the current design of the mental health system.[18] In fact, 277 of those individuals (78%) had just one request for admission to RPC, indicating that they either did not experience further episodes that required hospitalization or were hospitalized in facilities other than RPC.

Thirty individuals though did not appear to be served satisfactorily as they seemed to have long stays in ERs, lengthy episodes in jail or multiple trips to hospitals during one episode.

The remainder of the 353 individuals (30 or 8%) did not appear to be served as satisfactorily. There were 11 individuals who appeared to experience stays in ERs that were longer than 24 hours, 6 individuals who appeared to have lengthy episodes while in jail and 14 who appeared to have made multiple trips to ERs or community/specialty hospitals during the same episode.[19] OPEGA noted that individuals with 3 or more requests over the five months were much more likely to have not been satisfactorily served. Of the 30 individuals who had not been satisfactorily served, 23 of them had requested civil beds, 4 of them had requested forensic beds and 3 of them had requested both civil and forensic beds at different times.

OPEGA also noted that there were 43 of the 353 individuals (12%) that appeared to be particularly hard to place as requestors reported contacting many other hospitals before contacting RPC. The individuals that were harder to place were, of course, at greater risk of not being satisfactorily served. The data suggests fifteen of these individuals were ultimately satisfactorily served while 28 of them were not. For nearly all of these 43 individuals, the reason for seeking beds at RPC was high acuity, violent/aggressive behavior and/or the individual was suicidal, homicidal, psychotic or delusional. It appears that other hospitals, even if they did have beds available, were not willing or able to take individuals who may have been harder to manage.

In terms of requests for admission, Table 7 summarizes the final status, as near as could be determined, of those requests that did not result in immediate admission.

[18] For example, under the current system, the progression is for individuals to move from ERs to community hospitals, then to Acadia or Spring Harbor and finally to RPC or Dorothea Dix. Acadia and Spring Harbor are also able to take forensic patients under special arrangements.

[19] Some individuals experienced more than one of these conditions.

Table 7. Number of Requests Not Immediately Admitted by Final Status and Type of Bed Sought				
	Civil Beds # of Requests		**Forensic Beds** # of Requests	
Final Status	Not Admitted	Wait List	Not Admitted	Wait List
Final Status Unknown	173	6	23	2
Admit Acadia	2	3	1	0
Admit Dorothea Dix	1	1	0	0
Admit MGMC-Augusta	3	0	0	0
Admit MGMC-Waterville	2	0	0	0
Admit Mid Coast	1	0	0	0
Admit Nursing Home	0	1	0	0
Admit PenBay	1	0	0	0
Admit RPC	2	30	4	7
Admit RPC - 72 Hr. Bed	0	0	0	2
Admit Spring Harbor Hospital	2	0	0	0
Admit Seton	1	0	0	0
Admit St. Mary's	1	0	0	0
Off the list	0	110	0	31
Total Requests Not Admitted	189	151	28	42

Requests for Civil Beds

There were a total of 340 requests for civil beds where the request did not result in immediate admission. Forty-four percent of these (151 requests) resulted in the individual being put on RPC's wait list. OPEGA followed up with RPC to try to determine whether those requests had ultimately resulted in admission to RPC. RPC reported that 30 of them (20% of 151 requests) ultimately resulted in admissions to RPC, mostly as transfers from community and specialty hospitals. RPC also reported that another four requests on the wait list ended up being admitted to other community/specialty hospitals while 110 (73% of 151 requests) dropped off the wait list for reasons unknown to RPC before ever being admitted to RPC.

As for the other 189 requests (56%) that did not result in immediate admission and were not put on the wait list, two of them ultimately resulted in admission to RPC and another 14 were admitted to other hospitals. Whether the other 173 requests ever resulted in admittance to a hospital is unknown although, as noted earlier, there were many individuals who had just one request for admission to RPC and so appeared to be satisfactorily served.

Requests for Forensic Beds

There were 70 requests for forensic beds that did not result in immediate admission. Sixty percent of these (42 requests) resulted in the individual being put on RPC's wait list. RPC reported that 9 of these requests (21%) ultimately resulted

in admission to RPC with two of them going to the 72 hour observation beds. Another 74% (31 requests) dropped off the wait list for reasons unknown to RPC before ever being admitted to RPC.

As for the other 28 requests (40%) that did not result in immediate admission and were not put on the wait list, four of them were ultimately admitted to RPC and another one was admitted to Acadia Hospital. Whether the other 23 requests ever resulted in admittance to a hospital is unknown.

Department Response

In accordance with Title 3, Chapter 37 §996, the Department of Health and Human Services was provided with an opportunity to submit comments on the draft of this report. The Department's response letter can be found at the end of this report. At the request of DHHS, the May 2007 report to the Joint Standing Committee on Health and Human Services regarding the *Resolve to Improve the Quality and Access to Mental Health Care through the Development of a Joint Strategic Plan* is also included.

Acknowledgements

OPEGA would like to thank the management and staff at Riverview Psychiatric Center who worked with us to collect the data for this study. We would also like to thank the management at RPC and the Department of Health and Human Services for sharing their knowledge of the State's mental health system and potential issues affecting requests for admission to RPC. This cooperation assisted us in collecting data and performing analyses that would be as informative as possible.

Appendix A. Data Collection Form for RPC Admission Requests

1. Date of Request*: _____ **3.** RPC Staff Person Taking Request: _____
4. Request Received Via: ___ P-Phone ___ I - In person
2. Time of Request*: _____am/pm ___ F- Fax ___ O - Other

Person requesting admission:

5. Name*: _____ **6.** Organization*: _____ **7.** Phone #*: _____

Patient to be admitted:

8. First and last initials*: _____ **9.** Sex*: M F **10.** Date of Birth (mm/dd/yy)*: _____
11. City/town of residence*: _____ **12.** Last 4 digits of SS#*: _____

13. Legal Status of patient*: ___ C - Civil ___ F - Forensic

14. Patient is currently located in/at:
___ ER – Emergency Room, Name of hospital: _____
___ IC – Inpatient Bed at Community/Specialty Hospital, Name of hospital: _____
___ OC – Observation Bed at Community/Specialty Hospital, Name of hospital: _____
___ CS – Crisis bed at crisis facility, Name of facility: _____
___ P –Prison or Jail, Name of prison or jail: _____
___ O – Other, please specify: _____

15. Date patient was admitted to their current location (except for code P and O): _____

About the Request:

16. Reason for request:
___ 1 – 30 day limit is approaching/reached
___ 2 – High acuity/violence or aggressive behavior
___ 3 – No community/specialty hospital beds available
___ 4 – Interstate compact
___ 5 – Other, please specify: _____

17. Has requestor already sought community/specialty hospital bed? __ Yes __ No __ Doesn't apply
If yes: **17A.** How many hospitals contacted? _____
17B. How many claimed no capacity? _____
17C. How many claimed no capability? ____

18. Resolution of request:
___ A – Admitted
___ S – Scheduled for admission.
___ W – Put on waiting list
___ NA – Not admitted, scheduled or put on waiting list

18A. If not admitted, reason for not admitting: ___NA1 – Admission criteria not met
___ NA2 – RPC lack of capacity
___ NA3 – Other, please specify: _____

Appendix B. Selected Data and Analyses of Admission Requests[20]

All Requests for Admission to Riverview by Month for May-Sept 2006							
	Total	% of Total	May	June	July	Aug	Sept
Requests							
Total Requests	507		130	118	84	71	104
Total Non-repeat Requests (NR)	437	86%	103	100	71	70	93
Total NR Requests Not Immediately Admitted	412	81%	102	99	70	54	87
Total NR Requests Not Immediately Admitted Due to Lack of Capacity	360	71%	95	97	65	33	70
Individuals							
Total Individuals	353		95	85	70	69	83
Total Individuals Not Immediately Admitted	333	94%	93	83	67	53	77
Total Individuals Not Immediately Admitted Due to Lack of Capacity	299	85%	87	82	63	32	64

Civil Requests for Admission to Riverview by Month for May-Sept 2006							
	Total	% of Total	May	June	July	Aug	Sept
Requests							
Total Requests	405		101	95	68	59	82
Total Non-repeat Requests (NR)	357	88%	85	81	60	58	73
Total NR Requests Not Immediately Admitted	340	84%	84	80	59	47	70
Total NR Requests Not Immediately Admitted Due to Lack of Capacity	300	74%	79	79	54	30	58
Individuals							
Total Individuals	282		78	67	59	57	63
Total Individuals Not Immediately Admitted	269	95%	75	65	58	46	60
Total Individuals Not Immediately Admitted Due to Lack of Capacity	241	85%	71	64	53	29	52

Forensic Requests for Admission to Riverview by Month for May-Sept 2006							
	Total	% of Total	May	June	July	Aug	Sept
Requests							
Total Requests	99		28	23	16	11	21
Total Non-repeat Requests (NR)	77	78%	17	19	11	11	19
Total NR Requests Not Immediately Admitted	70	71%	17	19	11	6	17
Total NR Requests Not Immediately Admitted Due to Lack of Capacity	59	60%	15	18	11	3	12
Individuals							
Total Individuals	73		17	19	12	11	19
Total Individuals Not Immediately Admitted	67	92%	17	19	10	6	17
Total Individuals Not Immediately Admitted Due to Lack of Capacity	57	78%	15	18	10	3	12

[20] There were three individuals (each with one request) for whom the status of civil or forensic could not be determined. There were also five individuals who had both civil and forensic requests at different times. Consequently, the sum of civil and forensic requests or individuals will not exactly equal the totals for all requests or all individuals. In addition, where monthly figures for individuals are given, the sum of figures for the individual months will exceed the overall total of individuals in each category as some individuals had requests in more than one month.

Appendix B. Selected Data and Analyses of Admission Requests (continued)

Detailed Analyses for Non-repeat Civil Requests

Requests by Whether Other Hospitals Were Contacted and Month							
Other Hospitals Contacted?	May	June	July	Aug	Sept	Total	% of Total
Blank	6	3	6	16	4	35	10%
Doesn't Apply	18	0	2	3	4	27	8%
No	21	26	8	16	14	85	24%
Yes	40	52	44	23	51	210	59%
Total Non-Repeat Requests	85	81	60	58	73	357	100%

Requestors that Contacted Other Hospitals by # Contacted and Month							
# of Hospitals Contacted	May	June	July	Aug	Sept	Total	% of Total
Did not specify	1	2	3	2	1	9	4%
1 to 2 Contacted	14	8	6	5	11	44	21%
3 to 4 Contacted	7	6	5	1	1	20	10%
5 to 9 Contacted	14	28	24	11	19	96	46%
10 or More Contacted	4	8	6	4	19	41	20%
Total Non-repeat Requests with other hospitals contacted	40	52	44	23	51	210	100%

Requests by Reason for Request and Whether Other Hospitals Were Contacted					
	Other Hospitals Contacted?				
Reason	Blank	Doesn't Apply	No	Yes	Total
Blank	2	0	1	1	4
1 - 30 day limit approaching	14	7	34	8	63
2 - High acuity/violence	8	11	26	96	141
3 - No comm beds avail	3	0	2	53	58
4 - Interstate compact	0	0	0	1	1
5 - Other	8	9	22	51	90
Total Non-Repeat Requests	35	27	85	210	357

Requests by Location and Whether Other Hospitals Were Contacted					
	Other Hospitals Contacted?				
Individual's Location	Blank	Doesn't Apply	No	Yes	Total
Blank	1	0	0	0	1
CS - Crisis Facility	1	0	0	2	3
ER - Emergency Room	9	3	15	173	200
IC - Inpatient Bed	23	24	65	32	144
P - Prison	0	0	1	0	1
O - Other	1	0	4	3	8
Total Non-Repeat Requests	35	27	85	210	357

Appendix B. Selected Data and Analyses of Admission Requests (continued)

Detailed Analyses for Non-repeat Civil Requests (continued)

Number of Non-Repeat Requests by Resolution				
Request Resolution	# Requests		% of Total	% of Total
Blank		6		2%
A - Admitted		9		3%
NA - Not Admitted		189		53%
No Reason Given	6		2%	
NA1 - Didn't Meet Criteria	11		3%	
NA2 - Lack of Capacity	149		42%	
NA3 - Other	23		6%	
S - Scheduled for Admission		2		1%
W - Added to Wait List		151		42%
Total Non-repeat Requests	189	357	53%	100%

Requests by Location and Resolution of Request						
	Request Resolution					
Individual's Location	Blank	Admitted	Not Admitted	Scheduled	Wait List	Total
Blank	0	0	1	0	0	1
CS - Crisis Facility	0	0	2	0	1	3
ER - Emergency Room	6	7	159	0	28	200
IC - Inpatient Bed	0	2	20	2	120	144
P - Prison	0	0	0	0	1	1
O - Other	0	0	7	0	1	8
Total Non-repeat Requests	6	9	189	2	151	357

Appendix B. Selected Data and Analyses of Admission Requests (continued)

Detailed Analyses for Non-repeat Forensic Requests

Requests by Whether Other Hospitals Were Contacted and Month							
Other Hospitals Contacted?	May	June	July	Aug	Sept	Total	% of Total
Blank	1	0	2	4	2	9	12%
Doesn't Apply	1	1	0	3	5	10	13%
No	9	10	8	2	3	32	42%
Yes	6	8	1	2	9	26	34%
Total Non-Repeat Requests	17	19	11	11	19	77	100%

Requestors that Contacted Other Hospitals by # Contacted and Month							
# of Hospitals Contacted	May	June	July	Aug	Sept	Total	% of Total
None Contacted	0	1	0	0	0	1	4%
1 to 2 Contacted	6	3	1	1	8	19	73%
3 to 4 Contacted	0	3	0	1	1	5	19%
5 to 9 Contacted	0	1	0	0	0	1	4%
10 or More Contacted	0	0	0	0	0	0	0%
Total Non-repeat Requests	6	8	1	2	9	26	100%

Requests by Reason for Request and Whether Other Hospitals Were Contacted					
	Other Hospitals Contacted?				
Reason	Blank	Doesn't Apply	No	Yes	Total
Blank	1	0	0	0	1
2 - High acuity/violence	4	4	8	11	27
3 - No community beds available	0	0	1	2	3
5 - Other	4	6	23	13	46
Total Non-Repeat Requests	9	10	32	26	77

Requests by Location and Whether Other Hospitals Were Contacted					
	Other Hospitals Contacted?				
Individual's Location	Blank	Doesn't Apply	No	Yes	Total
ER - Emergency Room	0	1	0	4	5
IC - Inpatient Bed	0	0	3	0	3
P - Prison	9	9	27	22	67
O - Other	0	0	2	0	2
Total Non-Repeat Requests	9	10	32	26	77

Appendix B. Selected Data and Analyses of Admission Requests (continued)

Detailed Analyses for Non-repeat Forensic Requests (continued)

Number of Non-Repeat Requests by Resolution				
Request Resolution	# Requests		% of Total	% of Total
Blank		1		1%
A - Admitted		5		6%
NA - Not Admitted		28		36%
NA1 - Didn't Meet Criteria	5		22%	
NA2 - Lack of Capacity	17		8%	
NA3 - Other	6			1%
S - Scheduled for Admission		1		55%
W - Added to Wait List		42		1%
Total Non-repeat Requests	28	77	36%	100%

Requests by Location and Resolution of Request						
	Request Resolution					
Individual's Location	Blank	Admitted	Not Admitted	Scheduled	Wait List	Total
ER - Emergency Room	0	0	2	0	3	5
IC - Inpatient Bed	0	0	1	0	2	3
P - Prison	1	5	24	1	36	67
O - Other	0	0	1	0	1	2
Total Non-repeat Requests	1	5	28	1	42	77

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Maine Department of Health and Human Services

John Elias Baldacci
Governor

221 State Street
#11 State House Station
Augusta, ME 04333-0011

Brenda M. Harvey
Commissioner

MEMORANDUM

TO: Senator Elizabeth H. Mitchell
Representative Marilyn E. Canavan
and Members of the Government Oversight Committee

FROM: Brenda M. Harvey
Commissioner

SUBJECT: Riverview Psychiatric Center – An Analysis of Requests for Admission

I am taking this opportunity to comment on the draft copy of the report entitled, Riverview Psychiatric Center – An Analysis of Requests for Admission, sent to us by Beth Ashcroft, Director of OPEGA. She has worked closely with our staff to guarantee us the opportunity to see the information she is presenting to you regarding Riverview, and to share her methodology with us. We appreciate her willingness to spend time with staff to check facts for accuracy and clarity. The report contains information and data that was gathered between May and September, 2006. I will attempt to broaden the scope and context of the issue of bed availability at Riverview Psychiatric Center.

Riverview Psychiatric Center is a part of a complex system of mental health care delivery involving an array of Crisis Workers, Case Mangers, Assertive Community Treatment Teams, Medication Clinics, Residential Support providers, local community emergency departments, nine psychiatric hospitals with psychiatric inpatient services, and additional components many with varying degrees of capacity. Changes in any one component affects the demands on the others. Collaboration and synchronization are essential to maximizing effectiveness. Resource creation, such as building new capacity, is only requested by the department when a full system assessment determines such is necessary to provide essential services to Maine's citizens.

First, a little recent history. DHHS received approval from Court Master Dan Wathen on October 13, 2006 for its Compliance Plan for the AMHI Consent Decree. In short, this is the chart that the state must navigate by in completing its work to reach compliance. There are two dimensions to the Compliance Plan. The first speaks to the eight core services of the system ranging from peer or consumer- run services to in-patient hospitalization. The other dimension focuses on the continuity of care, which, in essence, is how the providers, consumers, and family members work together to ensure that services are provided in a seamless way.

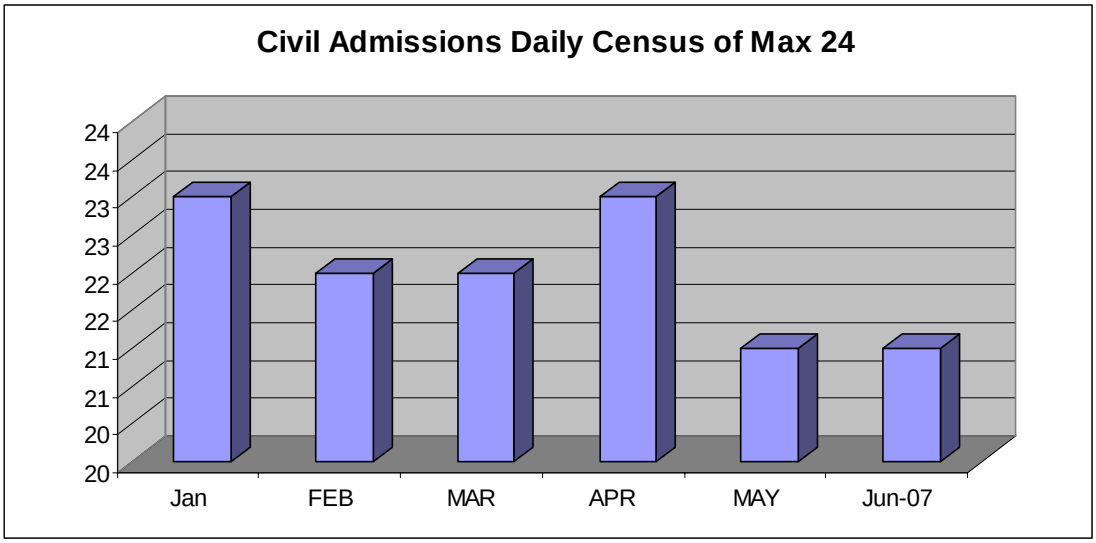
In Maine, we have done a rather excellent job in funding the core services (fifth in the nation to be exact!). Continuity in the provision of care, however, is a bigger challenge, especially when one is in crisis and in need of hospitalization. Our approach here is to require, through contracts, that all providers funded with public resources participate in a local Community Services Network (CSN). There are seven in Maine. They are responsible for assuring that the population with mental illness living in their respective areas, receive services seamlessly. DHHS provides monthly data to each CSN to evaluate how well they are doing that, and where mid-course corrections are in order.

As part of this initiative, I made what many people might say was a crucial administrative decision. I placed the Riverview Psychiatric Center, the Dorethea Dix Psychiatric Center, and the Maine Forensic Services, all within the Office of Adult Mental Health Services, which historically had had responsibility only for community services. This constituted a major shift in policy and practice. We need both quality hospital care, as close to home as possible, and we need effective community-based treatment and support services that are provided hand in glove with hospital care.

It is important to remember that the data collection and analysis of the OPEGA study is for the period between May and September, 2006. In November, 2006, in an effort to be responsive to the concerns of access to psychiatric beds, the department implemented a plan to have the four designated Institutes Mental Disease (IMD) in Maine (2 private hospitals: Arcadia and Spring Harbor and 2 public hospitals: DDPC and RPC), work closely together to better ensure persons in need of psychiatric hospitalization in Maine receive care at the most appropriate site, at the right time, and in a manner consistent with the state plan. This approach takes into consideration that the 92 hospital beds at Riverview are a part of over 270 psychiatric inpatient beds available through out the state. In addition, this plan builds upon the knowledge that within the 270 inpatient beds, different specialties are maintained to enhance the spectrum of services available to all Maine Citizens.

This tactic has resulted in specific system performance improvements. At the time of the OPEGA study, prior to November, 2006, Riverview routinely maintained a waiting list for admission of approximately 5 to 8 persons who were seeking services from either emergency rooms or one of the nine other psychiatric hospitals in the state. Realizing that most persons are best served in brief hospitalizations at local community hospitals and that extended psychiatric rehabilitation resources (such as the state hospital) should be used selectively for persons who are assessed to need this specialty care, the department implemented a local screening process to ensure that psychiatric hospital resources are being accessed appropriately and efficiently.

In the past seven months Riverview has accepted all referrals meeting admission criteria reviewed by Spring Harbor Hospital. Spring Harbor has served the role of ensuring that persons are served at the closest appropriate setting and referring (or reviewing and concurring) all requests for a bed at Riverview. Since this strategy has been deployed, Riverview has accepted all transfers, has no waiting list on most days, and has been able to maintain an immediate admission capacity. Below is the average daily census demonstrating bed availability for civil admission inpatient beds over the last seven months.



I hope this information on the current access availability for Riverview and a brief explanation of its place in a much larger system of care, is helpful in understanding the information contained in the OPEGA study in a more comprehensive context.

As always, the department maintains a vigorous and continuous challenge to enhance services and improve effectiveness and efficiency of mental health service delivery. This effort must always maintain the paradigm that the state owned resources are only part of a complex web of services that are interdependent.

Please let me know if there is anything further my staff or I can do as you work through this difficult and complex issue of assuring appropriate help and support for all Mainers who suffer with mental illness.

BMH/klv

Resolve, To Improve Quality and Access to Mental Health Care

Through the Development of a Joint Strategic Plan

Second Regular Session, 122nd Legislature

Prepared for the Joint Standing Committee on Health & Human Services

May 2007

Statement of Guiding Philosophy:

To develop a comprehensive strategic plan for the provision of hospital-based mental health services at Maine's four Institutes of Mental Disease (IMD), in accordance with the State's mental health plan and a shared vision of consumer recovery. Within the context of the Office of Adult Mental Health Services' Community Service Networks, the plan will support a coordinated safety net of programs and services that will serve Maine's citizens in the future.

Process summary

To accomplish the work of the IMD Strategic Planning Resolve, the four Institutes of Mental Disease (IMD) Psychiatric Hospitals (Riverview Psychiatric Hospital, Dorothea Dix Psychiatric Hospital, Spring Harbor Hospital and Acadia Hospital) created a strategic planning workgroup comprised of the following representatives of each organization:

Department of Health and Human Services:
Ronald S. Welch – Director, Adult Mental Health Services
David Proffitt – Superintendent, Riverview Psychiatric Center
Mary Louise McEwen – Superintendent, Dorothea Dix Psychiatric Hospital

Spring Harbor Hospital:
Dennis King - CEO
Greg Bowers – Chief Financial Officer
Gail Wilkerson – Chief Planning Officer
Elizabeth Mitchell – Director, Governmental Relations, MaineHealth
Mary Jane Krebs – Chief Nursing Officer
Dr. Jerry Robinson –Chief Medical Officer

Acadia Hospital:
Dottie Hill - CEO
Bill Wypyski – VP, Clinical Services
Marie Suitter – Director of Finance
Dr. Paul Tisher – Medical Director
Steve Allen – Finance, Eastern Maine Healthcare Systems
Lisa Harvey-McPherson –Director, Health Policy, Eastern Maine Healthcare Systems

The workgroup met monthly to accomplish the two-step outcomes identified in the Resolve:

Step one, in which the four mental health hospitals shall work together with the department to compile a first draft of the strategic plan; and

Step two, in which the community hospitals that have psychiatric beds shall work together with the four mental health hospitals and the Department of Health & Human Services to compile a second draft of the strategic plan. This plan must be presented to the joint standing committee of the Legislature having jurisdiction over health and human services matters.

The strategic recommendations identified in this report reflect the consensus of the IMD psychiatric hospitals and have been reviewed by Maine community hospitals that have psychiatric beds.

The following definitions (concepts) will be helpful in reviewing this report:

Institute of Mental Disease (IMD)
A hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care to persons with mental disease, including medical attention, nursing care, and related services.

Disproportionate Share Hospital (DSH) Funding
Beginning in the early 1980s, Congress took steps to authorize payments to Disproportionate Share Hospitals (DSH), which are those like Maine's IMDs that serve a disproportionately high share of low-income patients. A hospital will generally qualify as a DSH if it has a Medicaid utilization rate more than one standard deviation above the mean Medicaid utilization rate for all hospitals in a state and a low-income utilization rate exceeding 25 percent. Since patients of an IMD are often indigent, states are able to obtain DSH funding for IMDs, even though they are otherwise excluded from Medicaid reimbursement.

Observation Beds

Observation beds are a brief but intensive hospital-based outpatient diagnostic service designed to reduce the need for inpatient admission, when appropriate. Staffed 24/7 by psychiatric nurses and supported by a psychiatrist and psychiatric social worker, observation beds offer medical psychiatric evaluation and treatment, nursing assessment every two hours, therapeutic interventions as needed, discharge planning, and a diagnosis and level-of-care recommendation from a psychiatrist or independently licensed psychiatric practitioner within a period of up to 48 hours.

Crisis Bed
Crisis Stabilization Units (CSUs) provide short-term, supportive and supervised community residences, where the person in crisis can receive assessment and interventions that will stabilize the crisis and can readjust to community life. CSUs provide an alternative to hospitalization for a person in crisis who needs a more intensive level of care than outpatient services can safely provide. Goals of CSUs are assessment, stabilization, and preparation of the person for return to a home environment. When clinically necessary, the person will be referred fro a more intensive level of care.

Crisis stabilization counselors, certified as MHRT I's or above and supervised according to State licensing standards, staff these residences 24/7 to provide a safe environment, promote health-coping mechanisms, assist in daily living skills, monitor medication administration, assist in behavioral management, provide supportive crisis interventions, and perform discharge-planning functions.

Executive Summary

In June 2006, representatives from each of Maine's four freestanding Institutes of Mental Disease (IMDs), or psychiatric hospitals, gathered to form a strategic planning committee to work on LD 1973, *A Resolve to Improve the Quality and Access to Mental Health Care through the Development of a Joint Strategic Plan*. The purpose of the Resolve was to develop a comprehensive strategic plan for the provision of hospital-based mental health services in accordance with the State's mental health plan and a shared vision of consumer recovery. The plan would support a coordinated safety net of programs and services to serve Maine's citizens in the future.

The Resolve directed several phases of strategic-planning collaboration, beginning with the two State psychiatric hospitals (Riverview and Dorothea Dix), the two specialty psychiatric hospitals (Acadia and Spring Harbor), and Maine's community hospitals with psychiatric beds. Consumers of mental health services and community mental health service providers offered input after initial review of the plan by the Health & Human Services Committee in January 2007.

As part of the planning process, the four IMD hospitals (named above) have summarized and shared their clinical philosophies and operational data, including: staffing and patient volume information; admission and discharge volumes; and administrative costs. The hospitals paired off by service region (Riverview and Spring Harbor in southern Maine; Dorothea Dix and Acadia in northern Maine) to discuss their criteria and procedures for admitting and transferring patients. The group also discussed the financial challenges facing all four hospitals and the problem of insufficient funding provided by federal disproportionate share hospital (DSH) dollars.

Planning committee members began their work by endorsing the vision of a tiered system of psychiatric hospital services in Maine, where the overarching goal is recovery focused and clinically appropriate care delivered closest to the patient's home. Under this vision, the system of triaging mental health patients begins in Maine community hospitals that have psychiatric beds. Only patients with clinically complex mental health needs requiring intensive treatment would be admitted to the private IMDs (Acadia and Spring Harbor). Finally, those patients with longer-term biopsychosocial treatment needs (and forensic patients, in the case of Riverview) would be served by the State IMDs.

For its part, The State of Maine has stated that it envisions the following system of care for those requiring hospital-based mental health services:

Specialty Hospitals
Maine's two specialty hospitals, Acadia and Spring Harbor, follow community hospitals in the line of treatment and will take admissions from the community hospitals. These freestanding psychiatric hospitals are designed to safely treat consumers who present with greater acuity and clinical complexity than community hospitals are able to effectively and safely serve. Additionally, Acadia and Spring Harbor serve as community hospitals for their local areas. Consumers who need specialty hospitalization will transfer to the specialty hospital closest to their home community.

Public Hospitals
Riverview Psychiatric Center and Dorothea Dix Psychiatric Center are the tertiary hospitals and will take referrals from Spring Harbor and Acadia, forensic admissions, and other admissions based on unique clinical needs, within the statutory authority of the hospitals or based on unusual circumstances as described below. Riverview Psychiatric Center will be paired with Spring Harbor and Dorothea Dix Psychiatric Center will be paired with Acadia Hospital.

Unusual Circumstances

Consumers who are hospitalized in a community hospital and who need specialty hospitalization will transfer to the specialty hospital closest to the consumer's home community. Consumers in community hospitals may bypass hospitalization in a specialty hospital when:

- A consumer's history and current presentation indicate that a longer term of stay is likely;
- A consumer's documented clinical history makes a particular hospital inappropriate;
- A consumer has serious objections based on a documented serious incident or experience that would make a particular facility inappropriate.

If the community hospital finds that unusual circumstances, as described above, apply, then it must confer with the closest specialty hospital. The specialty hospital retains authority to decide whether to refer the patient directly to one of the state facilities, provided, however, that if there is a disagreement between the specialty and community hospital about a proposed referral, that disagreement will be resolved by the Office of Adult Mental Health Services.

The planning workgroup then identified five areas for strategic focus:

- Timely and appropriate patient access to IMD services
- Long-term financial viability of the IMDs
- Program development/refinement to accommodate unmet patient needs
- Restructuring the mental health system to support provision of the most evidence-based, recovery-focused, efficient, efficacious, and high-quality services
- Maximizing information and technologies to better serve patients

Recommended strategic initiatives within each strategic focus area appear below:

Access

- Develop admission criteria that clearly delineate patients to be served by the private IMD hospitals and the State IMD hospitals
- Ensure ongoing, real-time reporting of psychiatric bed capacity (and demand for psychiatric beds) linked back to the admission criteria for the State IMD hospitals, private IMD hospitals, and community hospitals with psychiatric beds

Financial Viability

- Assess current State-funded treatment for highly complex patients served within both State and Private IMD's and determine feasibility of developing specialty service line for cognitively impaired individuals with behavioral disregulation.
- The State will collaborate with all IMD's to examine reasonable compensation options for services provided, including those services provided in response to an increase in demand within the communities they serve.

Program Development/Refinement

The Consent Decree Plan, approved on October 13, 2007, created seven community service networks (CSNs) to coordinate services and reflect a collective responsibility to all adult consumers in the network area. The CSNs include consumers, service providers, community hospitals with and without psychiatric inpatient units, and the IMDs. Three of the charges of the CSNs are: 1) Planning based on data and consumer outcomes; 2) Engaging in network problem solving to ensure that consumers with complex needs are appropriately served; 3) Assessing the service offering to determine whether they provide adequate geographical coverage to serve the entire network, identify resource gaps, and establish remedial measures. Thus, program development and refinement are done by OAMHS with the assistance of the CSNs.

- OAMHS, with assistance from the Community Service Networks, will develop cooperative relationships with existing and developing community-based transitional living arrangements to allow for the safe transition of patients who no longer require inpatient care but need ongoing services.

- OAMHS will complete a needs analysis, with assistance from the Community Service Networks, to determine whether additional community mental health services are required in northern Maine.
- OAMHS and the Office of Adults with Cognitive and Physical Disabilities (OACPD), with assistance from the CSNs and stakeholders groups of the OACPD, will create a plan for treatment and services for specialty mental health populations; brain injured, developmentally delayed adults, perpetrators and cognitively impaired individuals
- An emerging issue is the service needs of those patients who require long-term care for complex medical conditions, and psychiatric illness. The four IMDs will collect data to assess future needs.
- **Mental Health System Development/Refinement**
- The Office of Adult Mental Health Services, with advice from the CSNs, will perform a critical review of the clinical and economic benefit of creating regional psychiatric observation beds within centers of psychiatric expertise in southern, central, and northern Maine.
- The Office of Adult Mental Health Services will evaluate the impact of LD 151, which shortens the timeframe for making an involuntary hospitalization determination from 5 business days to 3 days

Information Systems & Technology

- Private IMD hospitals and community hospitals will be financially resourced to provide psychiatric expertise to community hospital emergency rooms via telemedicine, and to the extent possible, provide consult support to crisis workers situated in those emergency rooms.
- The State and private IMD hospitals will create systems to provide for efficient transfer of patient information for involuntarily committed patients

In summary, the strategic planning among the four IMD hospitals was the start of a more efficient, effective, and recovery-focused system of hospitalization. The specific outcomes include better understanding among the four institutions, more detailed criteria for transferring patients among the IMDs, and a plan for how to best use limited mental health resources while supporting recovery for each individual served in a specialty or State psychiatric hospital in Maine. Any continued work related to this process will take place within the existing CSNs. All efforts were designed to better serve consumers of mental health services and the citizens of Maine.

STRATEGIC FOCUS # *1:* Access to Maine's IMD's

STRATEGY: Clearly delineate and communicate the role of each Maine IMD in the coordinated "safety net", as defined in Title 34-B, Behavioral & Developmental Services (Chapter 3: Mental Health, Subsection 3610), within the context of the Community Service Networks.

STAKEHOLDERS	Committee Sponsors
DHHS, Riverview Psychiatric Hospital, Dorothea Dix Psychiatric Hospital, Spring Harbor Hospital, Acadia Hospital, Maine Hospital Association, patients & families, Maine taxpayers, Community Service Network providers	

MEASUREMENT			
Indicators	**Target Outcomes**	**Monitoring Tool**	**Accountability / Due Date**
1. Complete admission criteria for each IMD that is mutually agreed upon, adopted, and widely communicated	1. Timely patient access to appropriate Maine IMD	1. Data base of patient wait times for appropriate placement	
2. Launch official, ongoing reporting system of psychiatric bed capacity within Maine IMD's	1. Accurate, real-time data regarding IMD capacity to accept patients	1. Report on percentage of time real-time data is not available for referral decisions	

STRATEGIC FOCUS # *2:* Financial Viability of Maine's IMD's

STRATEGY: To ensure that each Maine IMD can appropriately meet demand for its services through the elimination of duplication and the most efficient delivery channels, while maintaining high standards of treatment quality, all within the context of the Community Service Networks.

STAKEHOLDERS	Committee Sponsors
Maine's IMD's; Maine taxpayers, patients & families, State Legislature, Maine DHHS, Community Service Network providers, Maine Office of Cognitive Disabilities	

MEASUREMENT			
Indicators	**Target Outcomes**	**Monitoring Tool**	**Accountability / Due Date**
1. Assess current State-funded treatment for highly complex patients served within both State and Private IMD's and determine feasibility of developing specialty service line for cognitively impaired individuals who also experience behavioral disregulation	1. Based upon the assessment, a State funding agreement will be consummated to reimburse private Maine IMD's for treating highly complex or long-stay patients for whom the State can provide no other appropriate inpatient treatment program.	1. Funding agreement adherence	
2. The State will collaborate with all IMD's to examine reasonable compensation options for services provided, including those services provided in response to an increase in demand within the communities they serve.	2. All Maine IMD's to be included in any financial planning mechanisms in a fair and consistent manner	2. Concurrent transition of all Maine IMDs to any new financial plan	

STRATEGIC FOCUS #*3:* Program Development/Refinement

STRATEGY: Within the context of the Community Service Networks, ensure timely and adequate capacity within Maine IMD's by developing/refining complementary treatment services.

STAKEHOLDERS	Committee Sponsors
Maine's IMD's; Maine taxpayers, patients & families, State Legislature, Maine DHHS, Community Service Network providers, Office of Adults with Cognitive and Physical Disabilities	

MEASUREMENT			
Indicators	**Target Outcomes**	**Monitoring Tool**	**Accountability / Due Date**
. 1. OAMHS completes Residential Services program assessment for current long-term IMD patients who no longer require inpatient care	1. Complete plan and submit to DHHS for consideration if new resources are required	1. Plan/budget completion & submission	
2. OAMHS and OACPD complete program development plan & budget for serving high-needs populations for whom there are no current treatment programs in Maine	1. Submit to DHHS for budget consideration, need studies and budgets for the following special populations: • Brain injured/cognitively impaired • DD/MR adults • Sexual perpetrators	1. Plan/budget completion & submission	
3.OAMHS completes need and resource distribution analysis to determine whether additional community mental health services are required in northern Maine	1.Complete study and submit to DHHS if new resources are required	1. Study completion & submission	

STRATEGIC FOCUS *#4:* Mental Health System Development/Refinement

STRATEGY: Within the context of the Community Service Networks, ensure Maine's Mental Health System supports the provision of the most evidence-based, efficient, efficacious, and high-quality services.

STAKEHOLDERS	Committee Sponsors
Maine's IMD's; Maine taxpayers, patients & families, State Legislature, Maine DHHS, Community Service Network providers	

MEASUREMENT			
Indicators	**Target Outcomes**	**Monitoring Tool**	**Accountability / Due Date**
1. The Office of Adult Mental Health Services will, with input from the CSNs, perform a critical review of the clinical and economic benefit of creating regional psychiatric observation beds within centers of psychiatric expertise in southern, central, and northern Maine.	1. Submit review and recommendations to State Legislature	1. Review completed & submitted	
2. The Office of Adult Mental Health Services will evaluate the impact of LD 151, which shortens the timeframe for making an involuntary hospitalization determination from 5 business days to 3 days	2. Submit review and recommendations to State Legislature	2. Data gathered by IMD's on application for court pre- and post- LD 151	

STRATEGIC FOCUS #*5:* Information Systems & Technology

STRATEGY: Within the context of the Community Service Networks, improve information-sharing among and technology used by Maine's IMD's to ensure timely access to treatment and maximum treatment-quality and patient-safety outcomes.

STAKEHOLDERS	Committee Sponsors
Maine's IMD's; Maine taxpayers, patients & families, State Legislature, Maine DHHS, Community Service Network providers	

MEASUREMENT			
Indicators	**Target Outcomes**	**Monitoring Tool**	**Accountability / Due Date**
1. Develop technical and financial mechanisms for Maine's IMD's to provide timely psychiatric consultation to Maine's community hospital emergency rooms (e.g., via telemedicine), and to the extent possible, provide consult support to crisis workers situated in those emergency rooms.	1. Timely access to Maine's IMD psychiatric professionals by community hospital emergency rooms	1. Wait times for psychiatric consults in community emergency rooms	
2. Develop information systems that support efficient transfer of patient information for involuntarily committed patients of Maine's IMD's	2. Timely access to patient information among Maine's IMD's	2. System response time concerning requests for patient information	