MENTAL HEALTH

Process

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We examined the following processes and data:

- Care in the Community for inpatient psychiatry focusing on Bed Days of Care and Cost
- Psychiatric and Substance Use admissions to other VA facilities
- Inpatient Mental Health Psychosocial Rehabilitation Treatment Programs at VA facilities close to Manchester
- Bed Days of Care and Average Length of Stay
- Outpatient mental health care, homeless, substance abuse and work therapy visits between 2015 and 2025 (projected)
- Cost of Community Care for Outpatient Services, Mental Health = $500 and Psychotherapy Episode of care = $7,500.

On September 19, 2017 we organized a total of 5 focus groups/listening sessions, three for the general staff, one for the Mental Health Supervisory team, and one for the Senior Leadership. Throughout the day the team also fielded 1 to 1 sessions for those who could not make the groups that were scheduled, or felt the need to speak 1 to 1. We met with over 40 frontline staff including MH supervisors. We were able to speak with the Acting Chief of Staff and the Associate Director of the facility. Topics ranged from

specific suggestions about improvement in care delivery and staffing to comments about working conditions and the culture of the Mental Health Service Line.

We reviewed the feedback from the Veterans and the Stake Holders compiled as part of the focus groups. Key Points Included:

- Whole Health Activities – Veteran Service Organization Focus Group
- Lack of MH Inpatient Services – Congressional Focus Group
- Transportation/Services in the available in community – Veterans Focus Group
- Increased Military Sexual Trauma (MST) Services in community/seacoast – Women Veterans Focus Group

Current Status of Mental Health Service Line

Total psychiatrist Full Time Employee (FTE) is only 0.86 FTE per 1000 Mental Health outpatient unique, which is less than the OMHO recommendation for 1.22 FTEE per 1000 unique. This impacts their ability to deliver specialty services to the Veterans.

Table 1. Five Year Trend – Manchester Mental Health Outpatient Unique

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Site	**FY12**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**Sparkline**
Manchester VAMC	4062	4140	4288	4371	4712	4648	
Portsmouth CBOC	130	260	355	356	332	296	
Somersworth CBOC	286	293	417	385	463	532	
Conway CBOC	200	219	181	152	121	81	
Tilton CBOC	232	248	207	192	145	309	

Source: VSSC –Encounter Form Pyramid

Table 2. Five Year Trend – Manchester Mental Health Outpatient Encounters

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Site	**FY12**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**Sparkline**
Manchester VAMC	25630	29471	30930	30268	34824	34285	
Portsmouth CBOC	505	995	1252	1324	1166	937	
Somersworth CBOC	982	909	2364	2078	2563	2674	
Conway CBOC	799	806	742	781	529	341	
Tilton CBOC	743	827	666	711	1382	1706	

Source: VSSC –Encounter Form Pyramid

Table 3. Current Square Footage and Space Gap

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Site	**SF**	**Needed Space**	**Current Space Gap**
Manchester VAMC	15270	30540	15270
Total	15270	30540	15270

Source: VHA Space Analysis Tool 2024 Projections

Table 4 represents the current Mental Health Programming across VISN 1. This analysis provides clarity of the services being provided at each facility including potential programming needs at the Manchester VA.

Table 4. Major MH services currently available at VA facilities across New England

Mental Health Services	Togus	WRJ	Bedford	Boston	Manchester	Northampton	Providence	Connecticut
Inpatient Care	✓	✓	✓	✓	⊘	✓	✓	✓
Residential Rehabiliataion (RRTP)	⊘	✓	✓	✓	⊘	✓	⊘	✓
Low Threshold Housing (SAFE Haven)	⊘	⊘	✓	✓	⊘	⊘	⊘	⊘
PCMHI	✓	✓	✓	✓	✓	✓	✓	✓
General Mental Health Ambulatory Care/BHIP	✓	✓	✓	✓	✓	✓	✓	✓
PTSD Care	✓	✓	✓	✓	✓	✓	✓	✓
SUD/Dual Diagnosis	✓	✓	✓	✓	✓	✓	✓	✓
Intensive Outpatient Services	✓	⊘	✓	✓	⊘	✓	⊘	✓
MH Intensive Case Management	⊘	⊘	✓	✓	⊘	⊘	✓	✓
Recovery/SMI	✓	✓	✓	✓	✓	✓	✓	✓

Source: Mental Health Uniform Services Package

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Projected Workload for Mental Health

The subgroup analyzed the projected utilization of the clinics over time as listed below. By doing so, this provided data of potential future gaps in services.

Table 5. Projected MH Outpatient Visits

Mental Health Outpatient in Manchester	2015 Visits	2025 Visits	% Change
Amb Mental Hlth: Homeless	3313	4021	21.37
Amb Mental Hlth: Mental Health Clinic	13238	16535	24.91
Amb Mental Hlth: Mental Health Clinic - Psychotherapy	12408	14275	15.05
Amb Mental Hlth: Substance Abuse Clinic	4775	4906	2.74
Amb Mental Hlth: Work Therapy	562	502	-10.68

Source: Milliman Resource Group

Table 6. Future Space Estimations

Table 5. Future Space Estimations				
Site	2025 Projected Workload	2025 Needed Space	Current Space Gap	Space Gap as % of Need
Manchester VAMC	40,239 Visits	34439	15270	31.1%

Source: VHA Space Analysis Tool 2024 Projections

Table 7. Inter-facility mental health service referrals (outpatient, residential or inpatient) sent from Manchester VA to other VISN locations during FY16.

	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	Total
WRJ HCS		2				3	3	1	6	4	3	5	27
Bedford, MA HCS	24	13	7	16	6	14	11	13	9	20	22	28	183
Boston, MA HCS	12	5	10	11	6	8	13	11	7	5	12	10	110
Central Western HCS	1	2			3	1		2			1		10
Connecticut HCS	19	14	1	2			1	1	1	7	31	22	99
Totals	56	36	18	29	15	26	28	28	23	36	69	65	429

Source: VSSC - Consult

Sent from Manchester VA to other VISN locations during FY16

As demonstrated above, a total of 429 inter-facility consults were sent in FY16 with Veterans that have a primary diagnosis of Mental Health. Of the overall total, 236

consults were for Acute Mental Health services including 117 for detox services. The average length of stay was 8 days (combining detox and psychiatry admissions).

Table 8 below demonstrated the projected costs for inpatient units based on inpatient bed numbers and provides examples of projected costs.

Table 8. Projected Costs of Inpatient Bed Construction

Table 8.

Mental Health Inpatient Beds	Base Construction Cost
11	$23,544,000
15	$25,118,000
20	$27,552,000

Source: VISN 1 Major Construction Estimates

The figures shown below (1, 2 and 3) provide projections for Market, VISN and National utilization. The data assisted the task force with making educated assumptions on the future needs of Veterans in regards to inpatient residential rehab and mental health programs.

Figure 1.

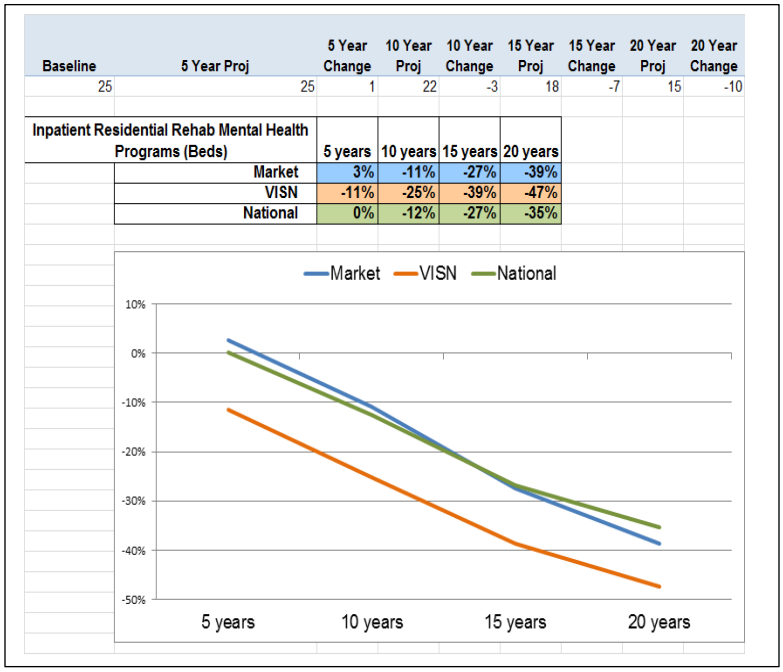

Figure 2.

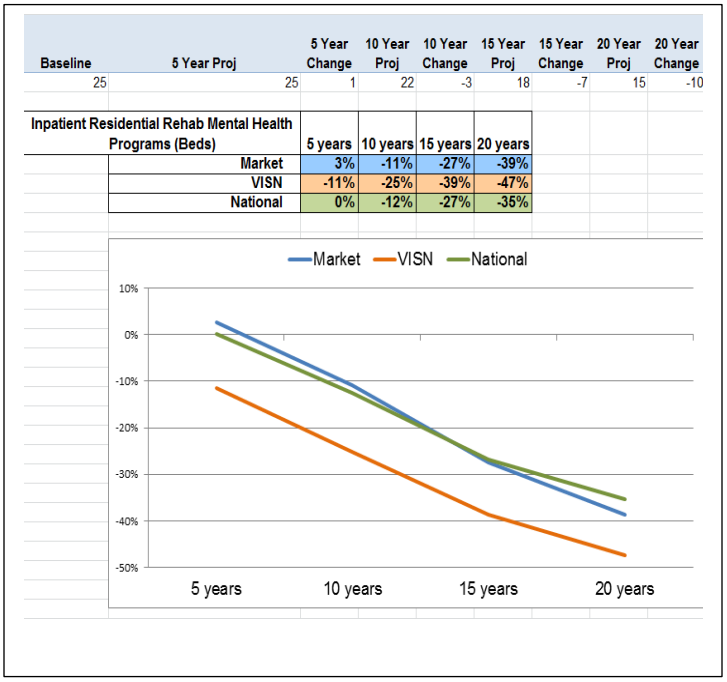

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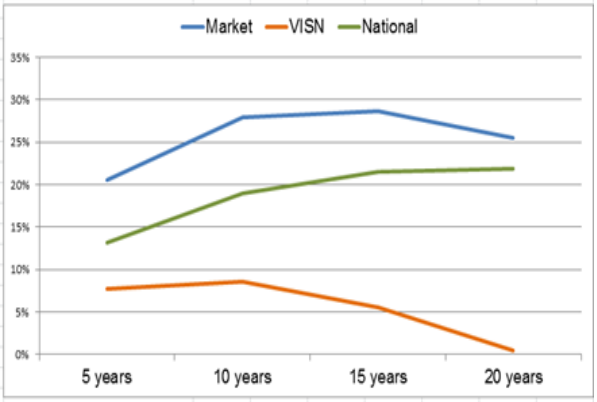
Figure 3.

Baseline	5 Year Proj	5 Year Change	10 Year Proj	10 Year Change	15 Year Proj	15 Year Change	20 Year Proj	20 Year Change
94,292	113,685	19,393	120,581	26,289	121,340	27,048	118,368	24,076

Amb: Mental Health Programs	5 years	10 years	15 years	20 years
Market	21%	28%	29%	26%
VISN	8%	9%	6%	0%
National	13%	19%	22%	22%



Source: Figure 1, 2 and 3, VSSC - Projected Enrollment and Vet Pop

To best determine current access to non-VA mental health care, the subgroup completed a review of MH services available in the state of New Hampshire. Although limited, there are current services available and included in the table below. This information was also used in determining potential opportunities for community partnerships.

Non-VA Mental Health Services

- Southern New Hampshire Hospital – Inpatient and Partial Hospitalization in Nashua, NH
- Monadnock Family Services – Outpatient Behavioral Health in Keene NH
- Portsmouth Regional Hospital – Inpatient and Outpatient in Portsmouth and Partial Hospitalization in Hampton
- Windham Mental Health Center/Springfield Hospital – 10 bed unit in Bellows Falls, VT
- Farnum Center, Manchester NH – Inpatient and Outpatient Programs
- Parkland Medical Center – Inpatient and Outpatient Services, Derry NH

Non-VA Supporting Services (Provide Case Management Services/Peer Support)

- New Hampshire Office of Veterans Services

- New Hampshire Department of Veterans Services
- Easter Seals Veteran Programs NH

Options Considered

Option 1: All Services In House Model

Table 9. Breakdown of Option 1

OPTION 1: Full MH continuum of care on Manchester campus				
Mental Health	**VA Onsite**	**Lease Non-VA space; staff by VA**	**Purchase in Community**	**Other VA**
Primary Care Mental Health Integration				
General MH Outpatient				
Subspecialty MH Outpatient				
MH Intensive Case Management				
Wellness Center/Intensive Outpatient Program				
Residential Rehabilitation Treatment Program				backup
Inpatient Mental Health	primary			backup

As represented above, in Option 1 all services would be on site at the Manchester VA. The idea would be that all new services would be **built** on the campus at the Manchester VA.

The new services would include the expansion of the existing General MH outpatient clinic, integrating Primary Care Mental Health and a sub-specialty MH outpatient Clinic.

The outpatient services would include the newly built Intensive Outpatient Program which would incorporate and house a Wellness Center and a MH Intensive Case Management Program. Veterans could enter the new program site to engage in case management services, MST services, nutrition, yoga, smoking cessation, coffee/social club, a small fitness center, occasional family-style meals, housing resources and art therapy.

Inpatient services would include a new on-site 12 bed in-patient/detox unit and a 20 bed Residential Rehabilitation Program (RRTP). And, create Intensive Outpatient Program (IOP) with a 20 bed lodging unit (this is not inpatient it's a place for the veterans to sleep while they complete their 2 week IOP.)

The subgroup developed an estimated staffing cost for all the programs being suggested. Below is list of the programs and estimated staffing costs.

Table 10. Staffing for Option 1

Staffing for Option 1 - All Services Inhouse			
Location	Discipline	FTEE	Estimated Cost
12 Acute/Detox Bed	Total	**21**	**$2,120,919**
IOP	Total	**7**	**$699,251**
20 Bed Lodging	Total	**4**	**$233,012**
Expand PCMHI	Total	**4**	**$524,492**
RRTP	Total	**5**	**$520,165**
MHICM	Total	**2.25**	**$331,908**
	Grand Totals	**43.25**	**$4,429,746**

Table 11. Pros and Cons for Option 1

PROS	CONS
1. Programs would work in a more coordinated fashion. 2. The care provided would be comprehensive (one stop shopping). 3. Same day services in all areas. 4. All care delivered by the VA	1. Transportation 2. Length of time to build new facility 3. Cost 4. Difficulty staffing 5. Matching/services to changing needs

In summary, the subgroup agreed that Option 1 would not be time or cost effective. Nor, would it be flexible with the potential changing needs of Veterans. In addition, it could feel institutional rather than assisting Veterans in feeling like a part of their community.

Option 2: Mental Health services provided through a combination of on-site care and community partnerships

Table 12. Breakdown of Option 2

Table is being updated and will be made available in a hardcopy of the report on the day of the meeting.

In Option 2, the subgroup decided to create a hybrid model of both programs, contracting some services out with a focus on leasing space and using VA staff to manage the programs as opposed to contracting for services. Some services would still need to contract out both the service itself and the staffing to give the VA control over the number of beds as the option to use them goes down. In this model the key is to optimize space that can be leased out in the community with VA staff managing the programs. This will give Manchester VA the needed exposure in the community and will keep the program under the auspice of the VA. In this model we'd still need to right-size outpatient space in Manchester to provide the correct level of space for staff.

As demonstrated above the following services would be expanded on the VA campus;

- Primary Care Mental Health Integration
- General MH Outpatient
- Subspecialty MH Outpatient

The following services would be located in the community through leased space. However, the programs would be staffed by VA funded providers.

- The Intensive Outpatient Program, which would incorporate and house a Wellness Center and a MH Intensive Case Management Program. Veterans

could enter the new program site to engage in case management services, nutrition, smoking cessation, coffee/social club, a small fitness center, occasional family-style meals, housing resources, art therapy, etc.

- Residential Rehabilitation Treatment Program

The contracted programs in the community would be the following;

- Acute Inpatient beds in partnership with a local private hospital
- Substance Abuse lodging (Safe Haven)
- Public/Private venture with local private hospital

By offering such programs at a contracted community location we would allow for conveniently located services that would be both cost effective and flexible as the population needs change over time.

As seen below, the subgroup developed an estimated cost for contracts and leases of all the programs being suggested.

Table 13. Staffing for Option 2

Table is being updated and will be made available in a hardcopy of the report on the day of the meeting.

Table 14. Pros and Cons for Option 2

PROS	CONS
1. Bringing VA care to the community 2. May not need to build a new facility 3. The footprint and extent of MH services are more flexible moving forward. 4. Staffing issues may be less of a problem moving forward. 5. Staffing issues may be less of a problem	1. Give up control of acute inpatient treatment programs 2. Contracting issues 3. Disconnect between the community provider and the Managed Care group. 4. Timely Payment through the VA payment system.

In summary, the subgroup agreed that Option 2 would be the best option.

Option 3: Contract New Services within the Community

Table 15. Breakdown of Option 3

Table is being updated and will be made available in a hardcopy of the report on the day of the meeting.

As represented above, Option 3 is an alternative track to Option 1. In this model, at the Manchester VA campus, current services (PCMHI and outpatient) would be maintained and right-sized to meet future workload demand. For MH services that are not currently offered at Manchester VA, the Medical Center would purchase services and space in the community.

By studying the data represented on Tables 9, 10 and 11, it appears that the projected beds needed in the northern market drop 11% in the next 10 years and drop 39% in the

next 20 years. With this in mind, allowing for contracting beds/services the VA would have the flexibility and control of purchasing/contracting for only the amount of beds needed on an annual basis.

For this reason, the subgroup recommends all of the following programs to be contracted in the community;

- MH Intensive Case Management
- Intensive Outpatient Treatment Program and Wellness Programming (to include nutrition services, smoking cessation, etc.)
- Residential Rehabilitation Treatment Program
- 12 Bed Inpatient Mental Health/Detox

Should the above services be contracted, the VA will need to create Care Management Teams to interface with the community resources purchased. Reponsibilities of these teams would include visiting and auditing the programs to make sure they are spending resources correctly and staffing is hired and working.

Services recommended in this Option to be expanded from the current state are the following;

- Primary Care Mental Health Integration
- General MH Outpatient
- Subspecialty

As seen below, the subgroup developed an estimated contracting cost for all the programs being suggested.

Table 16. Staffing for Option 3

Table is being updated and will be made available in a hardcopy of the report on the day of the meeting.

Table 17. Pros and Cons for Option 3

PROS	CONS
1. Space not needed in Manchester for these specialized programs. 2. Care Team who can interface with the community provider to make it work. 3. Follow up clinically and administratively. 4. Have a larger VA presence in the community	1. Communication issues (VA and Community provider) 2. Timely Payment? 3. Problems with VA Contracting 4. Not all care provided by VA 5.

In summary, the subgroup agreed that Option 3 would not be time or cost effective. Nor, would it offer the best flexibility with the potential changing needs of Veterans.

Recommendations

The task force came to this conclusion (see below) by conducting a current state review of Mental Health Services, reviewing focus group data from four groups; Mental Health staff, facility leadership, Congressional and Veterans. The task force used this information and compared it to the MH Uniformed Services Packet and the projected demographic outcomes through 2025.

Recommendation 1: Option 2 Hybrid inhouse/lease/contract

The Subgroup recommends *Option 2: Mental Health services provided through a combination of on-site care and community partnerships.*

Option 2 will provide expansion of services on the Manchester VA campus, which will include services currently being provided, 23 hour observation beds and on-site Wellness Recovery Center.

The Subgroup recommends contracting and leasing space in the community to maximize the availability of acute inpatient beds, substance abuse lodging, and residential services. By doing so, the VA will be expanding our ability to serve Veterans throughout the state of New Hampshire and better include rural areas.

This option increases the ability to be flexible in the number of beds utilized and services offered on an annual basis. This will allow better control should the NH Veteran population increase or decrease over time.

In conclusion, the Subgroup has faith that Option 2 is committed to meeting the needs of all the Veterans in the state of NH and providing an array of services that is not being currently offered.