CAPACITY OF THE NH BEHAVIORAL HEALTH SYSTEM

December 2017

POLICY BRIEF

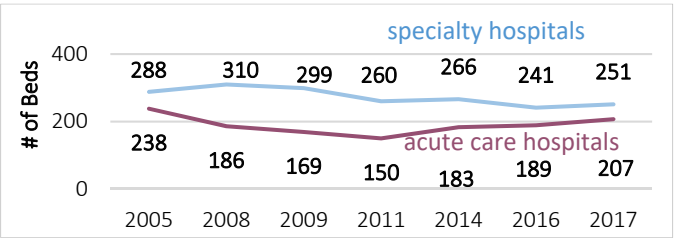
HSRI

The New Hampshire Legislature called for a comprehensive system evaluation to identify statewide behavioral health system needs, gaps, and recommendations. Under contract with the Department of Health and Human Services, HSRI used a mixed methods approach that consisted of three main elements: reviewing 53 unique documents and reports, conducting 55 interviews with a range of key informants, and analyzing data provided by DHHS.

Bed Capacity

As of 2016, NH had 11.9 beds per 100,000 population, slightly more than the national average of 11.7 per 100,000; and this was before the 28-bed increase from 2016-2017.

As of November 2017, NH had 458 psychiatric care beds, marking an increase from a recent low of 410 in 2011 – and on par with national averages per 100,000 population



A survey conducted in 2013-2014 using data from all New Hampshire CMHCs and the 10 hospitals with inpatient behavioral health services in the state found that:

- The most frequently cited barrier to discharge was a place to live or stay, which affected 71% of the survey sample.
- The average operating cost for a day of inpatient care in an acute care community hospital is $2,912, while the average operating cost for a day of supportive housing is $297 ($245 per day supportive care from CMHC care + $52 per day housing room & board).

These data, combined with the fact that New Hampshire does not appear to be facing a significant shortage in the number of beds expected based on population size, strongly support the view that increasing capacity of outpatient services and supports, especially housing, is at least as important as—and significantly more cost effective than—increasing the number of inpatient beds.

Service Gaps and Assets

Peer Supports: Many key informants recommended an increase in peer support services, but noted that recent plans for expansion were cancelled due to lack of funding.

ACT: Key informants generally endorsed the value of ACT teams. However, the behavioral health workforce shortage poses a challenge to the expansion of ACT and to program fidelity.

Supported Employment: CMHCs, with some exceptions, are meeting the CMHA target for supported employment penetration. The programs are challenged, however, by the same workforce shortage issues that affect ACT teams.

Children's Services: Community-based sub-acute services for children have some of the same gaps as those for adults, resulting in similar increased utilization of inpatient treatment according to many key informants. A lack of availability of child psychiatrists and clinicians trained in evidence-based trauma-informed treatment models was a noted gap. Several recent improvements were also noted, in particular the FAST Forward program and the establishment of the Children's Bureau of Behavioral Health.

Special populations: Lack of housing and community services for some sub-groups were identified by key informants as being especially challenging. These included for persons with co-occurring developmental disabilities, co-occurring substance use disorders, older adults and veterans.

Community Engagement: Many informants recommended increased efforts to engage the community in understanding and addressing behavioral health issues.

Criminal Justice: Individuals called for increased partnerships between behavioral health and criminal justice agencies while noting several successes—including re-entry programs in local jails, Integrated Delivery Networks (IDNs) resulting from the 1115 waiver, and the Manchester Mobile Crisis Response Team.

Mobile Crisis Units: A lack of mobile crisis units beyond the major population centers was identified by many as a gap.

Peer Respite Beds: Many endorsed the effectiveness of peer respite beds, though some suggested that a lack of awareness limited their use.

Law Enforcement Training: Increased training for law enforcement and other first responders was widely identified as a need. While some training is currently provided, it is not sufficient across the state.

Clinical and Support Services in ERs: Key informants identified a need for several types of services for people while in the ER, such as peer navigators and increased clinical support such as psychiatric consultation.

NGRI: Individuals with a not guilty by reason of insanity (NGRI) status in New Hampshire Hospital were identified as a major constraint on bed availability, and alternatives such as forensic ACT teams were recommended.

Housing Options: More housing is still needed, including additional transitional beds, despite recent efforts. The Bridge program was noted as a successful housing resource that should be expanded if possible.

Discharge Planning: Peer specialist involvement was noted as an asset, but a challenge is a general lack of care coordination by community service providers when their client is hospitalized.

Resources: Key informants universally expressed the view that the behavioral health system is drastically under-resourced, whether the topic was peer supports, mobile crisis rates, CMHC services, or any other service. One of the most common examples noted was that CMHC reimbursement rates have not seen an increase since the mid-2000s.

Workforce: Workforce capacity, combined with lack of funding, was frequently cited as a major barrier to the successful delivery

of services. Lack of adequate reimbursement for services delivered forces providers to manage costs in other ways; wages and benefits are depressed, which in turn makes positions less attractive, or even financially feasible, for those interested in pursuing careers in human services.

Collaboration: Many identified a need for additional cross-system collaboration to break down silos, though there was much optimism about the Delivery System Reform Incentive Payment (DSRIP) project as part of the 1115 waiver.

Planning: Systems planning through the 10 Year Plan was widely endorsed, though some expressed skepticism that the funding would be available to support the recommendations.

Data and Performance Metrics: The lack of coordination around the use of data and the exchange of data between the public health sector, hospitals, and CMHCs was identified as an area for improvement.

Recommendations

 short term;  long term

Crisis Prevention	Strategy Timeframe
DHHS should restore and expand the capacity of community-based services that have been shown to decrease the need for hospitalization and to promote recovery (e.g., enhance ACT teams)	 
Increase peer support services that offer diversion or transition services (e.g., recruit and certify additional peer specialists)	
Enhance the array of crisis services statewide (e.g., improve communication about available peer respite beds)	
Establish a coordinating mechanism and a centralized data system that would track people waiting in ERs and available crisis and peer respite beds (e.g., provide for transfer to open beds)	
Increase Permanent Supportive Housing (e.g., establish a housing registry, explore options for Medicaid reimbursement for PSH-related services)	
Review adequacy of specialty services for children (e.g., telepsychiatry, increase family supports, expand school programs)	 
Explore feasibility and options for expanding the First Episode Psychosis programs currently funded by a Block Grant set-aside	
Support and coordinate with efforts to enhance availability of behavioral health outpatient services in primary care	
Partner with Federally Qualified Health Centers and similar health centers as participants in the delivery of behavioral health outpatient services (e.g., ensure full utilization of FQHC behavioral health)	
Enhance collaboration and communication between criminal justice and behavioral health service systems (e.g., use of Sequential Intercept Model)	 
ED Diversion	
Develop and expand crisis alternatives (expand use of peer respite, establish alternative to ER for law enforcement)	 
Establish a centralized coordinating process and data system at the state level that would track people waiting in ERs and available beds, including peer respite and crisis stabilization (convene workgroup)	
Require timely linkage to community-based services following inpatient or ED admission (policies for warm handoff, outpatient discharge follow-up)	
Increase clinical support in ERs (e.g., consultation on complex cases)	
Increase support and training for law enforcement and first responders (e.g., replicate Manchester model, increase consultation)	
Disposition	
Develop a formal protocol, criteria or communication process for allocating admissions to public vs. private hospitals to ensure the most appropriate level of care	
Ensure the availability of re-entry programs from jails/prisons throughout the state	
Establish community-based forensic services as a step-down for individuals in New Hampshire Hospital who are able to transition	
Adopt advance discharge planning models that have been shown to reduce ED boarding by better management of inpatient capacity	
System-Wide Recommendations	
DHHS should support the formation of local planning committees, where they do not already exist, to address various system issues, devise solutions, and monitor progress	
Encourage communities to share responsibility with the state for promoting high quality behavioral health services (e.g., support public health approaches in 10 Year Plan, provide more communication about available services)	
Workforce development (e.g., consider curriculum on best practices, develop peers in workforce throughout the system)	 
Improve workforce recruitment and retention (e.g., form a group to foster public-private provider partnerships for recruitment, establishing non-monetary incentives such as training, supervision)	
Expand the use of remote health interventions (e.g., social media, psychiatry consultation to primary care)	
Increase the use of performance metrics (e.g., service utilization, peer specialist employment, ER encounters)	
Support current efforts to enhance and integrate data systems (e.g., training on data collection, supporting value-based care)	

The full report, *Evaluation of the Capacity of the New Hampshire Behavioral Health System*, is available at: https://www.dhhs.nh.gov/dcbcs/bbh/documents/nh-final-report-12222017.pdf