Developing a Behavioral Health Care Service Line at a Small Rural Hospital

Mike Glenn, CEO, Jefferson Healthcare
Joe Mattern, MD, CMO, Jefferson Healthcare
Sue Ehrlich, MD, Medical Director, Discovery Behavioral Healthcare
Who We Are

• A 25 bed, full service, fully accredited critical access hospital meeting the healthcare needs of 27,000 residents of east Jefferson county.

• The owner and operator of Jefferson Healthcare Home Health and Hospice Services.

• The largest employer in Jefferson County, employing 465 FTE’s and generating over $45 million in annual payroll.

The healthcare system of East Jefferson County.
Our clinics
• 5 Primary Care Clinics
• Orthopedic clinic
• Cardiology clinic
• Women’s Health Center
• Wound Care Clinic

• Dermatology Clinic and MOHS Lab
• Sleep Clinic and 4 bed Sleep Lab
• Urology Clinic
• General Surgery Clinic and Endoscopy Suite
The Community We Serve

- Population 30,333 *(ACS 2016)*
- Washington State’s oldest population;
  - Median age of 56.2 years;
  - 18 years above the median age of the U.S.;
  - 9,598 people are 65 years old and older; this is 32% of the total population.
- 51.2% Female *(ACS 2016)*
Defining the Problem

“The first step in solving a problem is to recognize that it does exist.”

Zig Ziglar
National Landscape: We are in crisis.

An inability to afford the cost of care was the most commonly reported reason for not receiving mental health services.

Any Mental Illness in 2015

- 56.9% (24.8 million) received mental health services
- 43.1% (18.6 million) no services

Severe Mental Illness

- 35% (3.4 million) received mental health services
- 65% (6.4 million) no services

*Serious mental illness is defined as adults who had, in the last year, a diagnosable mental, behavioral, or emotional disorder and has resulted in serious functional impairment that substantially interferes with major life activities.

Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2015 National Survey on Drug Use and Health. SAMHSA, 2016.
Washington State: Trailing behind

National Ranking:
Highest prevalence of mental illness and lowest rates of access to care.

Parity or Disparity: State of Mental Health in America
Mental Health America 2015
Rural Communities in Particular are Struggling

Between 2001-2015, suicide rates were higher in rural/non-metro than metropolitan areas

Suicide by firearm in rural was twice the rate of large metro areas

In 2015, drug overdose rates in rural areas surpassed metropolitan rates.
And the access to behavioral health services crisis is much worse in rural communities.
“While a variety of professionals that can provide care for a broad range of behavioral health issues are usually available in urban areas, residents of rural areas often fall short of behavioral health providers. In addition, primary care providers often play a much larger role in behavioral health care delivery than they do in urban settings, requiring integration of primary care and behavioral health services.”

Rural Health Research and Policy Center
Data Brief #160

#tellmesomethingIdontknow
The Local Context

How does this play out in Jefferson County
JEFFERSON COUNTY: COMMUNITY HEALTH IMPROVEMENT PROCESS

Community Health Assessment

Top Issues Identified

Final Priorities

- Mental Health and Chemical Dependency
- Chronic Disease Prevention
- Access to Care
- Immunizations

Safety and Access
Morbidity and mortality
Behaviors

Morbidity
Mortality
Mental Health
Clinical Care
Healthy Eating/Active Living
Substance Abuse
Social Outcomes
Mental Health in Jefferson County: #1 Priority by the CHIP Workgroup

- 10% of adults reporting poor mental health more days than not in the past month
- 33% of adolescents reporting depression (24% with thoughts of suicide)
- Adolescent substance abuse at or higher than state average

2017 Update: Community Health Improvement Plan Executive Director was hired to move this work forward.
But this doesn’t fall into the role of a hospital or primary care clinics...
### Inpatient

- Medicaid patients with coexisting mental health disorders were 1.6 times more likely to be admitted than patients with private insurance for Ambulatory Care Sensitive Conditions (ACSC)

- Medicare patients nearly twice as likely to be admitted for ACSC if they have depression

### Emergency Department

- Between 2006-2011, ED visits for people with mental health disorders (MHD) increased while rates of utilization for people without MHD’s decreased

- For adults > 65 in 2012:
  - 5.1% anxiety disorders
  - 7.1% mood disorders
  - 10.45% delirium/dementia
  - 1.6% alcohol abuse
  - 0.6% other substance abuse disorders
  - 0.2% suicide/suicide attempts

### Primary Care

- 2010 survey 20% of all primary care visits had one of the following:
  - Depression counseling
  - Mental health diagnosis
  - Psychotherapy
  - Provision of a psychotropic drug.

- At least 25% of primary care visits for adults older than 44 were associated with mental health care.
But this doesn’t fall into the role of a hospital or primary care clinics…

Reality Check:

You’re doing behavioral healthcare whether you have a service line or not.
Case Presentation: 46 year old female “Alice”

Medical and Behavioral Health History
- Schizoaffective disorder, multi-substance abuse, uncontrolled mania and psychosis.

Social History
- Homelessness, jail stays, and significant trauma.

Care Team
- Orthopedics (specialty clinic), Primary Care, Emergency Department, Intensive Care Unit, Acute Care Unit, Ancillary Services (Lab and Xray)
- Relationship with local community mental health agency

Utilization Patterns
- 10+ days of hospitalization including ICU stay for hypothermia and drug overdose.
End of 2015 – 2016: 11 visits to the emergency room

2016 Health Care Spend at Jefferson Healthcare: $117,212.86
End of 2015 – 2016: 11 visits to the emergency room

2016 Health Care Spend at Jefferson Healthcare:  
$117,212.86

“The definition of insanity is doing the same thing over and over again and expecting different results.”

- Narcotics Anonymous
Just because primary care and emergency care clinicians are default mental health providers does not mean they should be.
What we are trying to do

Respond to a number of separate but related behavioral health needs and/or opportunities

While staying in business.

#whatwerewethinking
What we are trying to do

Respond to a number of separate but related behavioral health needs and/or opportunities

Create a rural hospital behavioral health service line.
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- Contracted with InSight, a national telepsych provider, to provide 24/7 psychiatric consultation and medical management in the ED, clinics, and inpatient units.
- Hired LCSW’s to provide behavioral health care services in the primary care clinics.

### Primary Care Clinics (RHC)

- Social workers are embedded in the rural health clinics to provide individual therapy and engage in case conferences with primary care providers. *These are billable services in an RHC setting.*
- Initiated a process to train primary care providers to provide Medication Assisted Treatment (MAT) to our patients.
Co-hired a psychiatrist (Dr. Sue Ehrlich) and a psychiatric ARNP with substance use expertise (Alethea Fournier)

Contracted with InSight, a national telepsych provider, to provide 24/7 psychiatric consultation and medical management in the ED, clinics, and inpatient units.

Hired LCSW's to provide behavioral health care services in the primary care clinics. Social workers are embedded in the rural health clinics to provide individual therapy and engage in case conferences with primary care providers. These are billable services in an RHC setting.

Initiated a process to train primary care providers to provide Medication Assisted Treatment (MAT) to our patients.

Converted one inpatient room into an psychiatric bed and developed a psychiatric tool-kit for staff.

Equipped two rooms in the emergency department into mental health crisis safe rooms.
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<td><strong>Partnering with Local Mental Health Agency</strong></td>
<td>Extended electronic medical record access to key Discovery Behavioral Healthcare staff to improve inter-agency communication and streamline patient care.</td>
</tr>
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<td>Seat Jefferson Healthcare provider on Discovery Behavioral Healthcare board.</td>
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<td>Initiated acquisition/affiliation discussions with Discovery Behavioral Healthcare.</td>
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Community Mental Health Centers in WA State

The majority of CMHCs in WA are contracted to provide specialty services for the most acutely ill. In Jefferson County, most of these clients are on Medicaid.

As the public hospital we are responsible for the health of all 27,000 residents in our district.

DBH cares for the 1,000 most acutely ill citizens of our county.

As the hospital, we will focus on the remaining 26,000 residents.
Potential Solutions

What is clinical integration anyway?
Origins of Behavioral Health Integration

- Hawaii Project I
- Hawaii Integrated Healthcare Project II
- US Department of Defense
- Veterans Administration
- Cherokee Health System
- Kaiser Permanente of Northern California
The Primary Components of Integrated Care

A behavioral health clinician is always available for warm hand-offs.

There is a minimum of one behavioral health clinical per six primary care providers.

Best results come from a model that has scheduled psychiatric supervision of behavioral health clinicians.
Integrated Care Models: Take Your Pick

- PC-MHI (VA Model)
- MHI
- Collaborative Integration
- Collaborative Care/AIMS/MHIP
- Impact/Diamond
- COMPASS
- Team-based, Stepped Care in Primary Care Clinics
- Basic screening of the population with on-site support
The results are in.

Integrated behavioral health is **clinically** and **cost** effective.

- 85-90% adherence to behavioral health treatment plans (versus 10%)
- 20-30% net reduction in cost.
- Better leveraging of physicians’ time and expertise.
- 40-80% of mental health treatment can be accomplished within a primary care setting.
The results are in.

Integrated behavioral health is **clinically** and **cost** effective.

Medical treatment is more effective.

*Meta-analysis of psychosocial intervention for diabetics patients indicate improved glycemic control.*

*COPD patients that were treated for depression had higher rates of adherence and use of maintenance inhalers.*
Spectrum of Care

PREVENTION AND SCREENING

Primary Care Clinicians/Staff
- Primary Care Team
- LCSW/Psychologist
- Psychiatric ARNP/Physician
- Behavioral Care Coordinator

INTEGRATED PRIMARY CARE

Primary Care Team
- LCSW/Psychologist
- Psychiatric ARNP/Physician
- Behavioral Care Coordinator

SPECIALTY MENTAL HEALTH AND CHEMICAL DEPENDENCY

- Specialized Psychiatric Consultation
- Individual and Group Therapy
- Case Management
- Intensive Day Programming
- Embedded Primary Care

SINGLE BED CERTIFICATION/SHORT HOSPITALIZATION

- ED evaluation and management
- Safe Room/Behavioral Health Care Planning in Medical Inpatient Setting
- Psychiatric Consultative Services

SPECIALTY HOSPITALIZATION

- Capacity for prolonged inpatient care
- Specialized psychiatric consultation
- Specialized therapeutic services

CDMHP’s Social Services/Community Organizations/Mental Health Professionals
Getting ahead of the curve through *prevention* and *awareness*.

Beware of screening for something that you are not sure you can treat.
Behavioral Health at Jefferson Healthcare: This is **not** a stand-alone mental health clinic.
Behavioral Health at Jefferson Healthcare: Clinical Attributes

- Stepped, on-site psychiatric support for primary care providers.
- Weekly staffing meetings with LCSW’s and psychiatric providers
- Utilizing educational opportunities for integration
- Face to face introduction, education and coaching
- Working with care coordinators through our ACO
# Improving Behavioral Health Quality

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<tr>
<th>Primary Care Provider without BH support</th>
<th>Integrated model</th>
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<tr>
<td>More limited scope of diagnosis</td>
<td>Greater diagnostic (and likely more accurate) evaluation</td>
</tr>
<tr>
<td>Limited comfort in medication use</td>
<td>Comfort with greater array of medications including options for poor responders</td>
</tr>
<tr>
<td>Limited counseling skills</td>
<td>Specific behavioral therapy interventions (e.g. CBT, activation therapy, EMDR)</td>
</tr>
<tr>
<td>Uncertainty with how to proceed with poor responders</td>
<td>Greater experience in dealing with poor responders</td>
</tr>
<tr>
<td>Access to specialty care is strange environment</td>
<td>Access to specialty care is in familiar environment</td>
</tr>
<tr>
<td>Referral communication/progress reports/follow up tends to be poor</td>
<td>Patient gets a warm handoff, communication and documentation within same medical record</td>
</tr>
<tr>
<td>Primary Care Clinician without support</td>
<td>Integrated model</td>
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<td>---------------------------------------------------------------------------</td>
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<tr>
<td>Adolescent female brought into clinic with mother – declares suicidal</td>
<td>Adolescent female brought into clinic with mother – declares suicidal thinking/</td>
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<tr>
<td>thinking/depression.</td>
<td>depression.</td>
</tr>
<tr>
<td>Primary care provider spends 45-60 minutes with patient/family. Contracts</td>
<td>Primary care provider spends 15 minutes listening with empathy then expressing</td>
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<tr>
<td>for safety.</td>
<td>importance of urgent support.</td>
</tr>
<tr>
<td>Asks office to call crisis center at other facility. Negotiates possible</td>
<td>Walks down hall to psychiatric provider who comes with PCP and is introduced to</td>
</tr>
<tr>
<td>transfer to ER from clinic.</td>
<td>patient.</td>
</tr>
<tr>
<td>Asks staff to find therapists in community who take insurance.</td>
<td>Psychiatrist does assessment and calls crisis team who she knows directly. PCP</td>
</tr>
<tr>
<td>Discusses medication for depression even though limited experience</td>
<td>has moved to next patient.</td>
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<tr>
<td>prescribing in this age group.</td>
<td>Intake at mental health center arranged for that morning. Psychiatrist will see</td>
</tr>
<tr>
<td>Now 40+ minutes behind in morning schedule – other patients canceled.</td>
<td>review chart and discuss with team there this afternoon to fast track prescribing.</td>
</tr>
<tr>
<td></td>
<td>Crisis team and mental health center coordinate care at mental health center for</td>
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<td>safety contracting. Psychiatrist sends EMR message to PCP to update.</td>
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Whatever happened to Alice?
Alice: A New Approach

- One primary care provider designated for the patient.
- Additional primary care provider with experience in palliative care consulted to assist with pain management.
- Psychiatrist initial consultation with psychiatric ARNP follow up.
- Designated case manager and therapist through mental health center.
- Agreement from mental health center to do all med dispensing (behavioral and other medical condition treatments).
- Monitoring plan including urine drug screening in compliance with court.
- Comprehensive mental health plan.
- Monthly primary care visits.
- Communication between mental health center and primary care through EMR portal and case conferences.
Alice: The Outcome

• Reduction in delusional thinking and hallucinations.
• No further inpatient hospitalizations.
• Control of acute and chronic pain initially with taper of opioids down to 30 mg MED by end of 2017.
• Undergoing diagnosis and treatment of underlying rheumatologic and neurologic conditions.
• Received preventive health care.
• Achieved stable housing.
End of 2015 – 2016: 11 visits to the emergency room

2016 Health Care Spend at Jefferson Healthcare: $117,212.86

2017: 3 visits to the emergency room

2017 Health Care Spend at Jefferson Healthcare: $15,422.66
Lessons Learned

If you think you have it figured out, think again...and hope to fail fast and fail forward.

Beware of the cultural divide.
“\textit{You hospital folks just don’t get it.}” CEO of Nearby Mental Health Agency

Planning has limited utility during times of rapid, dramatic change.
“\textit{Everyone has a plan until they get punched in the mouth.}”
-Mike Tyson

Leverage community partners.

Understand the critical access hospital penalty associated with mental health services. And structure your deal accordingly.
Critical Access Hospitals and Community Mental Health Centers

Aligned strategic vision.

Goals

- Increased coordination of care for patients.
- Enhanced relationships across other departments.

Critical access hospitals and community mental health centers need to collaborate.
Thank you

Mike Glenn  mglenn@jeffersonhealthcare.org
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