

Case Examples



Behavioral Health Challenges in the General Hospital Practical Help for Hospital Leaders



American Hospital
Association

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Introduction

The case examples in this booklet were developed to accompany the AHA Behavioral Health Task Force's recommendations, most of which are listed to the left. See page 37 for a complete listing. Please refer to the "Recommendations" booklet for a comprehensive discussion of the task force's work. The Case Examples, Recommendations and a TrendWatch issue brief are components of the AHA's resource *Behavioral Health Challenges in the General Hospital: Practical Help for Hospital Leaders*, available at www.aha.org

Recommendation 1

Hospital leaders should ensure that assessments of the health needs and resources in their community include specific attention to behavioral illness.

Collaborating with Community Partners for a Community Health Assessment

Edward Hospital & Health Services, Naperville, IL

Summary

Edward Hospital & Health Services collaborated with the local United Way and the county health department to conduct a comprehensive, multimodal needs assessment for their community. The results of the assessment assisted Edward Hospital in allocating resources to meet the behavioral health needs identified.

Community and Hospital

The city of Naperville, IL, located 28 miles west of downtown Chicago in DuPage County, is one of the fastest growing cities in the country. As of 2005, the population was estimated at 147,779 with a median income of \$93,338 per household. Approximately 2.5 percent of the population lives below the Federal Poverty Level. Naperville has been ranked as one of the top 100 best places to live in the U.S.

Edward Hospital & Health Services consists of a 236-bed, not-for-profit, acute care hospital (Edward Hospital); a 110-bed psychiatric hospital (Linden Oaks Hospital) that provides a wide range of inpatient and outpatient behavioral health services; two health and fitness centers; and a variety of related health services.

Program Overview

Edward Hospital has had a strong focus on mental health since 1995 when it was identified as one of the top issues in Edward's Community Health & Human Needs Assessment Survey. Conducted again in 2000, the survey is a collaborative effort between Edward Hospital and Naperville United Way. The results of the assessment assist Edward Hospital in allocating resources to address the health care needs of Naperville residents and assist the Naperville United Way in identifying new agencies and programs to support and in allocating funds to its affiliated agencies.

There are four components to the needs assessment: the Behavioral Risk Factor Survey (conducted in conjunction with the DuPage County Health Department); supportive data obtained from secondary sources; a supplemental survey (mailed with the assistance of the City of Naperville); and community focus groups.

The Behavioral Risk Factor Survey is a randomized phone survey of the health and behaviors of adult and child residents of Naperville. Secondary data from public health data sources and statewide risk assessments complete the survey process and provide a benchmark against which certain results of the survey can be compared. A supplemental survey questionnaire sent to all households in Naperville asks respondents to identify specific human care service needs and to evaluate the level of satisfaction with these services.

To supplement the survey results, focus groups involving individuals who are leaders of or have special insight into different segments of the population are conducted. The focus group participants identify primary concerns of the populations they represent and of the community overall.

Results of the Edward Community Health & Human Needs Assessment of 1995 identified untreated mental illness and depression as key community concerns. The assessment also demonstrated the need to focus on the quality and availability of both psychiatric and substance abuse services, particularly outpatient services. The 2000 survey indicated that these issues are still concerns.

Program Impact

As a result of the 1995 assessment, Edward targeted behavioral health as one of its top three priorities, with the following objectives:

- Increase access to inpatient and outpatient behavioral health services in Edward's community.
- Expand awareness of behavioral health issues and treatment options available at Edward.
- Focus on providing comprehensive, high quality behavioral health treatment options for patients across the continuum of care.

In the past year, Edward completed the following initiatives to meet these objectives:

- Strengthened and expanded Linden Oaks' Resource & Referral services to meet a growing community need.
- Expanded child and adolescent services available within the community with the opening of the Linden Oaks Child & Adolescent Center.

- Developed intensive outpatient and traditional outpatient services to treat patients suffering from anxiety disorders.
- Redesigned the child/adolescent inpatient program to better serve patients and families.
- Strengthened relationships with schools, professional providers, and the faith community.

Program Funding

Funding for the assessment is shared primarily between Edward Hospital and the United Way of Naperville. The City of Naperville pays the cost of mailing the supplemental survey questionnaires. The hospital takes a lead role in data collection and analysis.

Obstacles or Challenges

Because of the hospital's strong position in the community, there are no obstacles to the collaborative assessment.

Success Factors

This type of broad community assessment can only be successful with collaboration. Edward has a strong presence in the community and ongoing involvement in

collaborative initiatives with other community organizations. One of their management team is on the board of the Naperville United Way.

Lessons Learned and Advice to Others

The hospital's mission to serve the community can best be met when services are designed to meet identified needs of the local market. Working collaboratively with local community government and agencies ensures the appropriate delivery of needed services. The benefits of collaboration extended well beyond the scope of this project to the wider organizations. Tremendous feelings of accomplishment, good will, and collegiality resulted from the project.

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Discovering What the Community Believes Is Lacking in Mental Health Services

Stormont-Vail Regional Health Center, Topeka, KS

Summary

Partnering with the local United Way and other health care providers in a community needs assessment, Stormont-Vail Regional Health Center identified community needs related to behavioral health services in the area and developed goals to meet these needs as part of the system's strategic planning process.

Community and Hospital

Topeka is the capital of Kansas and the fourth largest city in the state. As of 2005, the population of Topeka was estimated at 117,326. The median income is \$35,726 per household. Approximately 14.6 percent of the county lives below the Federal Poverty Level.

The second oldest hospital in Kansas, Stormont-Vail Regional Health Center, Topeka, is a 586-bed acute care referral center for northeast Kansas. The hospital is part of Stormont-Vail HealthCare, an integrated health care system serving a 12-county area.

Program Overview

For the past several years, Stormont-Vail Regional Health Center, along with other health providers and community organizations in Topeka, has collaborated with the local United Way in conducting a community

needs assessment. The purpose of the assessment is to gather information from residents and community leaders related to health and social welfare conditions. Stormont-Vail uses findings from the survey to help identify key health care needs and set priorities as part of their strategic planning process.

Among the top issues identified in a recent community needs assessment were concerns about the availability of quality mental health services in the Topeka area. Leaders from organizations involved in behavioral health – including Stormont-Vail – came together to determine whether these concerns were valid, and if they were, to develop strategies to meet the needs.

As the group evaluated the survey results, it became evident that two issues needed be addressed. The first was a lack of public awareness of behavioral health care options available in the community. The recent loss of two major mental health providers in the area contributed to a public perception of a significant loss in inpatient services; however, Stormont-Vail had begun to expand services to offset this loss as early as 2001, when they opened Stormont-Vail West as a freestanding behavioral health center. They tripled the number of inpatient beds available within the organization and

expanded services to include child and adolescent units. Although the public's perception regarding the availability and quality of inpatient services was not valid, Stormont-Vail viewed these observations as valuable feedback. As a result, the hospital intensified its efforts to increase public awareness of available services and to communicate information on how these services can be accessed by those in the community.

The second behavioral health care issue to emerge from the needs assessment was a shortage of behavioral health outpatient services. Outpatient service providers were turning patients away because they were unable to provide the services needed. Stormont-Vail worked with local community mental health centers to revise policies that adversely affected access to outpatient care. At the same time, Stormont-Vail began to evaluate its own behavioral health plan in light of the community assessment findings and to explore viable options for expanding outpatient services.

Program Impact

Because behavioral health is a core service of the organization, goals to advance the development of additional outpatient behavioral health services were incorporated into Stormont-Vail's strategic plan. In the current year's plan, one of the goals is to analyze outpatient needs for specialized services such as dementia care and senior partial hospitalization.

Additionally, the plan calls for the formalization of a medical detoxification program as a base for future substance abuse services. The elements of the program include: providing formal education to nursing staff on detoxification protocols, providing formal substance abuse education to all social work staff, adding detoxification protocols to the nursing assessment tool, identifying designated detoxification beds, and developing trauma requirements for substance abuse screening.

Program Funding

Primary funding for the community needs assessment is supported by the United Way and its partners.

Obstacles or Challenges

The major challenges in responding to the community needs assessment were operational in nature. The development of additional services required additional space. Making programmatic and facility changes had impacts on other services that had to be addressed.

Success Factors

The major factor for success was the high level of support for behavioral health services within the organization.

Lessons Learned and Advice to Others

For others interested in being involved in similar programs, the Stormont-Vail Regional Health Center experience provides some helpful advice:

- A community needs assessment is a key tool for identifying community needs that can help shape an organization's behavioral health services.
- Don't discount the subjective feedback that is received as part of a community assessment. Even if the public's perceptions are incorrect, they may provide insights into the need for greater or more targeted marketing and communications efforts.
- Participation with other stakeholders in the needs assessment review process provides opportunities for increased communication and potential collaboration among community behavioral health organizations.

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Recommendation 2

Hospital leaders should review and evaluate the organization's behavioral health plan in light of identified community needs, the behavioral health needs of their patients, and available community resources.

Leveraging Resources to Meet the Needs of Underserved Populations

California Hospital Medical Center, Los Angeles, CA

Summary

California Hospital Medical Center (CHMC) collaborated with local hospitals to conduct a community assessment. Findings from the assessment suggested a need for increased capacity to provide more culturally sensitive and competent mental health services in a timelier manner. CHMC set strategic priorities that leverage hospital and community resources to meet these needs.

Community and Hospital

In 2005, Los Angeles County, CA, had an estimated population of 9,758,886 with a median income of \$48,248 per household. Approximately 16.3 percent of the population lives below the Federal Poverty Level. The community served by CHMC – a total population of around 1.2 million people – has the highest population density, lowest median income (\$23,000), highest proportion of immigrants, lowest educational levels, and highest unemployment and underemployment rates in the county.

California Hospital Medical Center is a 316-bed not-for-profit hospital that has been a member of the downtown Los Angeles community since 1887. The hospital is an affiliate of the not-for-profit Catholic Healthcare West (CHW), a system of 41 hospitals and medical centers in California, Arizona, and Nevada.

Program Overview

Every three years, each Catholic Healthcare West hospital conducts a community health assessment and identifies strategic priorities based on this assessment. The CHW Community Grants Program awards grants to address the priorities identified in the health assessment and/or the community benefit plans of CHW hospitals. CHW grant funds are to be used to provide services to underserved populations: the economically poor, women and children, mentally or physically disabled, or other disenfranchised populations. Each hospital identifies nonprofit organizations in their service areas whose projects advance the objectives of the grants program.

In 2004, California Hospital Medical Center collaborated with a group of local hospitals to conduct a community

assessment in the greater Los Angeles metropolitan area. The assessment identified a number of mental health conditions in the community, including depressive disorders, past trauma, acculturation problems, marital difficulties, parenting problems, domestic violence, stress, and poverty. Many adults with these types of mental health problems fail to receive treatment because of lack of health insurance coverage or other funding. Findings from the assessment suggested a great and growing need for increased capacity to provide more culturally sensitive and competent mental health services in a timelier manner.

In an effort to address this need, CHMC incorporated a focus on behavioral health in its request for letters of intent for the 2005 grant program, including:

- Outpatient mental health services that address depression, anxiety, and post traumatic stress
- Mental health services for adults that address common sub-clinical problems such as acculturation, marital difficulties, parenting problems, domestic violence, stress, and poverty

Six of the seven projects awarded grants in 2005 had a behavioral health component:

- **Amanecer Community Counseling Services** was awarded \$12,500 for its Indigent Adult Mental Health Services Program, which provides a range of service for the severely mentally ill, primarily Latino, indigent adults living in Central/Downtown Los Angeles.
- **Jewish Family Services of Los Angeles Gramercy Place Shelter** was awarded \$12,500 to be used for a comprehensive package of services being provided to shelter clients, including critical mental health services for homeless families with children.
- **Immanuel Presbyterian Church** was awarded \$12,500 for its Community Yoga Classes. The classes will provide physical exercise as well as breathing and relaxation techniques that help to reduce feelings of stress and anxiety and improve concentration.
- **Los Angeles Child Guidance Clinic** was awarded \$12,500 for its First Steps Program. This program used an evidence-based, home-based intervention model and targets families with infants and toddlers who are at risk of entering mental health or special

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education services in the future.

- **The Wellness Community-West Los Angeles** was awarded \$12,500 for its Psychosocial Support for Cancer Patients at CHMC's Donald P. Loker Cancer Center. The Wellness Community provides two psychosocial support groups to help cancer patients learn to manage the anxiety and uncertainty about their disease.
- **The Jumbo Shrimp Circus Academy** was awarded \$12,500 for its Hope Street Youth Circus that involves young people age 8-18 in circus training. Circus training provides physical activity, fitness training, and skill development. Participants gain a sense of pride and accomplishment in mastering tricks few people can do.

Program Impact

Impact is measured at the individual project level. Each grant project must have a strong evaluation component. The applicant must describe how progress and success will be measured. At the completion of the grant, each grantee sends a report to the hospital and to CHW.

Program Funding

All CHMC Community Benefits programs are funded through grants. The money available for the Community Grants program is based on a designated percentage of the total audited expenses of the hospital. Each hospital manages its own grants program, with the final review of projects and disbursement of funds administered by CHW.

In 2005, CHMC sent information on the Community Grants program to approximately 100 community organizations, with a request for letters of intent. To process the letters of intent, the hospital grants program director convened a grant review committee that included the president of the hospital's foundation, the director of grants and contracts, the grants and contracts manager, the hospital's director of mission integration, the hospital librarian, and the director of community benefits. Committee members read and scored the letters of intent. Those projects with the highest scores were invited to submit full proposals, which were also reviewed and scored by the committee.

CHMC received 38 letters of intent from nonprofit

organizations serving individuals and families located in the hospital's service area. The funds requested totaled \$467,500. Total funds available for the grants were \$87,500. The hospital announced its new grantees at an awards dinner in December 2005.

Obstacles or Challenges

The greatest challenge in the community grants program is determining how to use the limited funds available to most effectively support community organizations. There is a high level of competition for these grants; therefore, applicants must write strong letters of intent and proposals in order to receive funding.

Success Factors

The level of community need for behavioral health services contributes to the success of the program. There are many community organizations trying to meet this need in creative ways. The Community Grants program provides a means for evaluating various community-based organizations and directing monies to those with the most effective programs.

Lessons Learned and Advice to Others

For others interested in setting up similar programs, the California Hospital Medical Center experience provides some helpful advice:

- The Community Grants Program is a superb way to help local community-based organizations achieve their goals. It requires limited staffing and operational support.
- The proposal evaluation process is important. Be sure you have individuals on your grant review team who are familiar with grants and who understand the factors that contribute to a strong grant proposal.

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Collaborating to Address the Behavioral Health Needs of Homeless Children

Memorial Hospital of South Bend, South Bend, IN

Summary

By identifying a need for services targeted at children living in homelessness, Memorial Hospital of South Bend was able to partner with a local community organization to create the Play, Exploration & Developmental Support program, a unique program that addresses a complex range of develop-

mental, behavioral, and social needs for very young children in homeless families.

Community and Hospital

South Bend, IN, is located in the northernmost part of the state in an area commonly referred to as "Michiana." In

2005, the population of South Bend was estimated at 97,070, with a median income of \$31,867 per household. Approximately 22.8 percent of the population lives below the Federal Poverty Level.

Memorial Hospital of South Bend is a 526-bed regional referral center for cardiac, cancer, childbirth, emergency medicine, and rehabilitation services. Memorial Health System Inc., established in 1984, serves as the parent company of Memorial Hospital, as well as Memorial Health Foundation, Memorial Home Care, and Memorial Medical Group.

Program Overview

Memorial Hospital has developed a number of strategic alliances or partnerships in the implementation of initiatives to aid in the creation of a healthier community. Their partnership with the Center for the Homeless has included several distinct initiatives, including the Play, Exploration & Developmental Support (PEDS) program.

It has been estimated that families with young children constitute 40 percent of the homeless population. Children, in particular, are severely impacted by the consequences of homelessness. They may experience poorer health; more developmental delays; more anxiety, depression, and behavioral problems; and lower educational achievement. It was this wide range of issues that attracted the attention of the hospital, especially once a gap in services was identified for children from birth to age 3.

Several meetings were held between Memorial and Center staff to discuss the needs of homeless children in this age range. Subsequently, funding was solicited from the Memorial Tithing Program to create PEDS, a unique program that addresses a complex range of developmental, behavioral, and social needs for very young children in homeless families. Risk factors for this population include premature births, developmental delays, exposure to drugs and alcohol, feeding disorders, exposure to impoverished environments, exposure to violence and abuse, sensory processing disorders, and exposure to neglect. Studies have found that children who are homeless are more likely to have learning disabilities or emotional disturbance than children who are not homeless.

The PEDS curriculum, developed at Memorial Hospital, follows a sensory integration model, with interventions that are culturally competent and family centered. Occupational therapy student interns were the major source of staffing for the program until the Center took over the program in 2005. Qualified staff with early childhood experience were hired and trained to continue the model that had been already established. The PEDS staff help with developmental screenings, make referrals and implement individualized intervention plans, and

monitor the progress of each child weekly. They also attend weekly interdisciplinary case management meetings with Center staff and partner agencies.

Developmental screenings are an important element of the program because children with developmental delays are at higher risk for behavioral problems. Also, the screenings serve as a means of identifying children with special needs and making appropriate referrals to community resources.

All the mothers and children in the program are guests at the Center for the Homeless. Many of the mothers have been in abusive situations or were abused as children and are at high risk to perpetuate the cycle. Through their exposure to healthy role models and parenting experiences with their children in a safe, family-friendly environment, the risk of child abuse is reduced.

Program Impact

The PEDS program has impacted the lives of more than 500 children and mothers over the 7.5 years of its existence. Children have been provided nurturing relationships and opportunities for developing trust, positive self-awareness, and self-mastery skills. The program has increased the mothers' sense of confidence and competence when caring for their children, enhanced their ability to nurture and promote their children's growth and development, and increased their awareness of early intervention services.

Program Funding

The main source of funding for PEDS is from Memorial's tithing program. Each year, 10 percent of the hospital's bottom line is set aside to help local organizations develop innovative programs that address a vast range of risks to community health. Proposals are submitted to the Community Health Action Group (CHAG), a team made up of community leaders and hospital administrators. CHAG members meet bi-monthly to review proposals, discuss resource allocation, review outcomes of funded partnerships, and share information about other community health initiatives.

Obstacles or Challenges

The only challenges were those of any collaborative relationship. There were no internal obstacles because Memorial is very involved in and committed to projects that impact community health.

Success Factors

Success factors for this project included the following: The missions of both organizations (Memorial Hospital and the Center for the Homeless) were similar and very compatible. Staff who developed and worked on the project shared the same values and worked toward the same vision. There was significant community need. To obtain funding, the team used a pilot project to highlight this need and

demonstrate the potential impact of the program. When they established the program, the PEDS team identified the model that would work most effectively for the environment in which it was used.

Lessons Learned and Advice to Others

For others interested in setting up similar programs, the experience of Memorial Hospital provides some helpful advice, including:

- Think broadly about behavioral health services. Look for opportunities to address behavioral needs within the context of more comprehensive programs.
- Don't duplicate services in your community. Collaborate with other organizations to pull together the right resources for the best programs. Be creative and innovative in your approach but don't try to recreate the wheel. There are many models already in place and people are willing to share their experiences.
- Be clear about the purpose of your program. Use the right model for the right purpose, for the right length of time.
- Don't start with finances. Instead, start with possibili-

ties and move from idea development and story telling to resource development.

- Don't get lost in the planning. Start with a small prototype, if possible, and focus on execution. Clarify roles, trust your partners, and don't micromanage.
- Seek a good community partner. Look for mission compatibility, executive leadership commitment, and demonstrated innovation. Shared values and visions will help your collaborative relationship weather any storms.
- Hospital partnerships can help community organizations get programs started so that, eventually, they can become self-sustaining.

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Meeting the Need for More Effective Treatment Options for Juvenile Sex Offenders

Tanner Medical Center, Carrollton, GA

Summary

Tanner Medical Center first became aware of the need for more effective treatment options for juveniles with sexual behavior problems through their behavioral health needs assessment services. At the urging of local juvenile judges, they developed the Tanner Intensive Program for Behavioral Change, a partial hospitalization program with an intensive outpatient treatment component for adolescent sex offenders.

Community and Hospital

The city of Carrollton is located in west Georgia, a few miles east of Alabama and approximately 50 miles from Atlanta. In 2000, the population of Carrollton was 19,843, with a median income of \$27,559 per household. Approximately 23.4 percent of the population lives below the Federal Poverty Level.

Tanner Medical Center-Carrollton is a 202-bed acute inpatient hospital. Tanner Behavioral Health (TBH), a component of Tanner Medical Center, serves adults, adolescents, and children with emotional, behavioral, and chemical dependency problems. Services include an adult inpatient unit; partial hospitalization and intensive outpatient treatment for children and adults at two separate sites; an in-home counseling program for children and families; a crisis line; and mobile needs assessment services.

Program Overview

Tanner Behavioral Health leadership first became aware of the need for more effective treatment options for juveniles with sexual behavior problems through their needs assessment services. At the same time, local juvenile judges began urging TBH to develop a program that would provide a viable alternative to incarceration without putting the community at further risk. Adolescent sex offenders were considered unsuitable for the partial hospitalization program because of the potential proximity to victims undergoing treatment. Local outpatient programs tended not to be successful in achieving long-term behavioral change for this population. Because there were no available residential treatment programs for sex offenders in western Georgia, referrals were often made to providers as far away as Atlanta, creating additional problems related to transportation and financing for treatment.

TBH was initially reluctant to consider a program of this nature, due to the high level of liability involved and their commitment to treating the victims of sexual abuse. After two years of research and consultation, and with full support of the hospital governing board, the Tanner Intensive Program for Behavioral Change (TIP) was opened in June 2003. TIP is a partial hospitalization program with an intensive outpatient treatment component for males ages 12 to 17 who have committed sexual offenses. Originally

established to address the needs of Carroll County, the program now serves seven counties in western Georgia.

The program's treatment components include group, individual, and family therapy; multi-family group therapy; polygraph assessments for treatment planning and therapy; case management and collaboration with the Department of Children and Family Services, Department of Juvenile Justice, and the school system; medical and psychiatric oversight, including medication management; and in-home/in-school monitoring and treatment planning by a victim prevention specialist.

TIP reaches individuals who typically would not have received treatment for their sexual offending behavior. Without treatment, supervision, and safety planning, these patients have a moderate to high risk to re-offend. The goal of the program is to increase an offender's chance for success in life, decrease the likelihood of re-offense now and in the future, and protect members of the community from sexual victimization.

Program Impact

In order to track the effectiveness of the program, TIP monitors the recidivism of patients. To date, only 8 of 117 patients have re-offended. These results are exceptional compared to national norms of adolescents at moderate to high risk for sexually re-offending after treatment.

Program Funding

The program is supported primarily by reimbursement for services provided. Most of the program participants are Medicaid patients; however, because sex offenders occur across all social and economic levels, there are also patients in the program covered by private insurance.

Obstacles or Challenges

The greatest challenge has been securing adequate reimbursement for services. When the state of Georgia transitioned to a managed Medicaid arrangement with private insurers in 2005, funding for the long-term treatment needed for juvenile sex offenders became increasingly difficult to obtain. Because the managed care organizations (MCOs) measured TIP against standard medical necessity criteria, there were constant efforts to deny treatment or discharge to a lower level of care. To combat these problems, TBH wrote medical necessity criteria specifically for TIP and attempted to get buy-in from the MCOs. TBH leadership continue to devote considerable time and energy fighting for timely, consistent reimbursement of services and challenging multiple obstacles that result in denial of payments.

A second challenge was patient transportation. Consistent participation in therapy is a key factor for success; however, many patients do not have the resources to attend therapy far from home. Because rural communities tend to be far

apart, TIP had to address transportation issues early in the program development process. They worked with local publicly-funded medical transportation providers to ensure that patients have access to the services they need.

Success Factors

- Strong support from the governing board and executive staff has been a key factor for success. Programs of this type are highly labor intensive and tend to have narrow margins. The board is committed to meeting the needs of the community, not just achieving financial success.
- The program is a total wraparound, educating not just the patient but those around him. The victim prevention specialist helps create safer home environments, educates caregivers, and assists schools in supporting these youth while protecting other children.
- Treatment occurs in real time and in the community where patients are exposed to and stimulated by the things that affect them. They are forced to deal with urges and cycles in real time and in their natural environment.

Lessons Learned and Advice to Others

For others interested in this type of initiative, the Tanner Medical Center experience provides some helpful advice:

- Research the need for this type of treatment program in your community. Talk with members of the juvenile justice system, government and social services agencies, and school personnel to determine both the level of need and the level of support in the community.
- Make sure you have a solid clinical approach and that you build in a measure of clinical accountability for patients.
- Continually educate community partners (law enforcement, school personnel, religious and social organizations, government and social services agencies, and justice system personnel) on the need for and benefits of treatment for juvenile sex offenders.
- Commit to intensive training of your staff. Few staff are trained or skilled in treating sex offenders—a population that is different in many ways from other behavioral health patients.
- Secure the services of an experienced polygraph expert who is certified for sex offenders.
- Establish appropriate housing with separate, defined areas so that offenders and victims do not cross paths.

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Recommendation 2a

Hospital leaders should use a comprehensive financial and operational assessment to evaluate the benefits and economic value of behavioral health services to all operational components of the hospital.

Using Key Performance Indicators as a Tool for Demonstrating Value

Northeast Hospital Corporation, Beverly, MA

Summary

Behavioral health leaders at Northeast Hospital Corporation developed a “dashboard” of key performance indicators in order to provide information to executive leadership and governing board members regarding trends in behavioral health service utilization and the value the service provides to the overall system of care.

Community and Hospital

The North Shore region of Massachusetts is in Essex County, approximately 20 miles northeast of Boston. In 2005, the estimated population of the county was 721,625, with a median income of \$57,164 per household. Approximately 11.4 percent of the population lives below the Federal Poverty Level.

Northeast Hospital Corporation is a family of health care organizations, including two acute care hospitals (Addison Gilbert Hospital in Gloucester and Beverly Hospital in Beverly) and a 62-bed behavioral health facility (BayRidge Hospital in Lynn). Both of the acute care hospitals have inpatient psychiatric units as well as partial hospitalization and outpatient services.

Program Overview

As recently as eight years ago, leaders at Northeast Hospital Corporation were reviewing the sustainability of inpatient behavioral health services in a community hospital setting. Hospital financial margins were a challenge and all services had to demonstrate value to the organization, both clinically and financially. Other acute care hospitals in the area had closed inpatient behavioral health units in order to develop more productive service lines. Behavioral health leaders recognized that in order to demonstrate the value of their services, they needed to make certain the entire Northeast Hospital community understood the need for and benefits of behavioral health services.

The first step focused on demonstrating the clinical value of behavioral health services within the hospital. The behavioral health team evaluated the existing consultation and liaison service to ensure that its value to

medical/surgical patient care was not just theoretical but also practical. They reviewed and revised protocols to make the program more responsive to physicians' and nurses' needs. The team developed a strategy for strengthening their connection to physicians by working with the new hospitalist program to educate medical staff on the impact of behavioral health services in improving outcomes and reducing medical/surgical length of stay.

In order to remain competitive within the hospital system, however, behavioral health services had to be viewed as financially viable as well as clinically beneficial. Behavioral health leaders worked with financial services staff to adapt the hospital's profit and loss (P&L) statement for behavioral health services. To develop the necessary data sets, they reviewed with finance staff the clinical care program differences between behavioral health and medical/surgical care, including cost structures, compensation structures, managed care “carve outs,” per diem rates, and reimbursement mechanisms. The behavioral health services P&L dashboard statement that was developed included revenue trends and drivers, expense data, volume trends, payer mix trends, net gain (or loss) from operations, and the contribution margin provided by the service line.

This dashboard of indicators allows behavioral health leaders to review at a glance the operational and financial performance of all inpatient behavioral health services in the system. Using this tool, they can readily identify areas where performance improvement is needed in order to maintain clinically appropriate efficiencies. The data also allows them to see areas where service volumes indicate a community need that may not have been addressed.

Behavioral health leaders use the P&L statement as both an educational and informational tool for hospital executive leadership and board members. The data is shared on a monthly basis, providing an opportunity not only to highlight the range and volume of behavioral health services provided to the community but also to point out the financial contributions made by these services to

the entire system of care. It also offers an opportunity to routinely discuss the operational and financial challenges of behavioral health services. This open and transparent approach to information sharing builds mutual understanding and trust among hospital leaders, which become key factors in setting strategic direction and facilitating effective problem solving.

Program Impact

Maintaining clear and consistent communications on the clinical and financial contributions of behavioral health services has established these services as an integral part of the overall system of care. The ability to demonstrate added value and contributions to the system has enabled behavioral health leadership to focus on program needs and enhanced services, rather than having to defend the “status quo” of current levels of care.

Analysis of data from the P&L statement has led behavioral health leaders not only to implement operational improvements but also to respond to the need for new programs and services. For example, the growing volume and increased length of stay of geriatric patients in the behavioral health inpatient unit resulted in the recent development of a distinct gero-psychiatric unit with a medical/behavioral health interface. This unit has provided further support to the medical/ surgical floors of the hospital, reducing more costly medical lengths of stay, and has removed frail elderly from the general psychiatric units where they may be at greater risk in an active, adult psychiatric unit.

Obstacles or Challenges

The behavioral health team recognized that they needed to collaborate closely with financial services staff in order to gain the support needed to develop the P&L/benchmark formats. Over time, the teams have developed a level of mutual commitment and a shared vision of how behavioral health service performance indicators could be useful to the entire hospital.

Success Factors

- In order to become an integral part of the system of care, behavioral health services leaders had to be sure that their program goals aligned with the overall goals of the hospital and that, as a management team, they were united in commitment to these goals.
- Behavioral health services leaders looked for or created opportunities to demystify behavioral health services to medical staff, executive management, and board members.
- Information technology systems that supported adequate data collection and analysis were key to the success of the strategy.

Lessons Learned and Advice to Others

For others interested in demonstrating operational and financial value of behavioral health services, the Northeast Hospital Corporation experience provides some helpful advice, including:

- Use data sharing as a framework for educating internal stakeholders about behavioral health services.
- Make use of data not only to demonstrate success but also to identify challenges. Always being open about your service, operational, and financial challenges may be difficult, but it allows problem solving to occur in an atmosphere of mutuality rather than distrust.
- Be proactive in communicating challenges or shortfalls in a timely manner. Be prepared to speak to anticipated losses and steps you are taking to correct problems.
- Present the whole picture of how your program is doing. Not painting the whole picture leads to more questions and less trust.

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Building Behavioral Health Services as a Strong Contributor to the Bottom Line

St. Helena Hospital, St. Helena, CA

Summary

St. Helena Hospital conducted a comprehensive review of their behavioral health services in order to achieve the clinical and operational levels required to become a center of excellence within the organization. Their goal was to build a firm financial base for behavioral health services while continuing to provide effective patient care.

Community and Hospital

The city of St. Helena is located in the center of the Napa Valley, California’s premier wine-growing region. From its inception, St. Helena has served as a rural agricultural center. In recent years, it has also become a business center for the wine industry. As of 2005, the population in the immediate county was estimated at 127,445. The median income is \$65,260 per house-

hold. Approximately seven percent of the population lives below the Federal Poverty Level.

St. Helena Hospital, located in St. Helena, is a 181-bed community hospital and a member of Adventist Health. A comprehensive range of acute care, behavioral health, and wellness programs draw patients throughout Northern California. The Center for Behavioral Health includes two campuses: a 21-bed adult unit and 39-bed chemical dependency unit in St. Helena, and a 61-bed inpatient psychiatric facility in Vallejo for adults, adolescents, and children.

Program Overview

In contrast to other local hospitals that are reducing behavioral health services or eliminating the service line altogether, St. Helena Hospital has experienced a 32 percent increase in its behavioral health patient volume over the past five years. More strikingly, the hospital realizes a positive margin in behavioral health services, demonstrating the economic contribution that these services can make to the organization.

The hospital's Center for Behavior Health prioritized the goal of establishing a firm financial base for behavioral health services while continuing to provide safe and effective patient care. Four key strategies allowed the Center to turn the corner financially:

- Get expenses under control by increasing productivity as well as improving supply management.
- Conduct thorough contract reviews, making sure that contract rates are competitive and that increases in rates are lining up with increases received by the health plans.
- Evaluate the individual service lines in terms of their mission-centeredness, utilization levels, and profitability.
- Manage payer mix by implementing marketing methodologies that tend to drive payers to their services and position behavioral services as a Center of Excellence within St. Helena Hospital

The Center's second goal was to enhance the clinical services of the organization, both by improving the services already in place and developing new programs. The first step toward this goal was restructuring the leadership team to ensure that the right skill set was in place and that they had the entrepreneurial mind-set necessary to build a successful behavioral health services organization.

Program Impact

For the past three years, the Center has experienced strong bottom lines, grown the business, and successfully managed productivity. It has also become a major player in behavioral health services in California.

Obstacles or Challenges

One of the obstacles to success in the Center for Behavioral Health was what has been identified as the

“stepchild” mind-set. For years, staff had seen themselves as the stepchildren of the organization, that is, peripheral to St. Helena's core mission and mainstream operation, when in fact the Center's role was key to achieving both the hospital's and the system's mission of “healing the whole person – physically, emotionally, and spiritually.” Staff needed to be continually reminded of the importance and value of their services so that they could broaden their vision of how the Center could contribute to the hospital and to their communities.

The greatest challenge is “keeping an eye on all the balls at once.” The only way to do that is to have effective dashboard tools and highly skilled managers. Denials, census, and productivity are reviewed daily. Referrals are followed on a weekly basis, and downtrends in utilization are watched, so adjustments can be made as needed. At the end of each month, a broad range of utilization data and patient financial services key indicators are reviewed.

Success Factors

- Getting their expenses under control through day-to-day management of the details
- Understanding where referrals are coming from and managing those relationships
- Having a medical staff that understands and supports the goals of the hospital
- Consistently marketing to consumers and referral sources

Lessons Learned and Advice to Others

For others interested in emulating the financial success of St. Helena's Center for Behavioral Health, their experience provides some helpful advice:

- Be sure you have a leadership team with “can do” attitudes; otherwise, your organization will be satisfied with the status quo and eventually stagnate.
- Spend time, energy, and resources to develop relationships and maintain communications with payers and referral sources.
- Keep a close eye on trends and closely manage expenses and referral relationships.
- The secret is in the details. Continually review and evaluate your operational and financial progress, so that you can effectively communicate the benefits and economic value of your services back to the organization.

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Recommendation 3

Hospital leaders should encourage and actively participate in (1) developing a community-wide and/or regional plan for persons with behavioral health disorders and (2) coordinating community agencies addressing behavioral health needs.

Creating an Integrated Delivery System for Behavioral Health Care

AtlantiCare, Egg Harbor Township, NJ

Summary

To achieve its vision of a seamless system of behavioral health care for the residents of southeastern New Jersey, AtlantiCare integrated the capabilities, facilities, information systems, and resources of two health care organizations. The merger has expanded outreach capability for psychiatric emergency services throughout the region.

Community and Hospital

Egg Harbor Township, NJ, is located in the geographical center of Atlantic County near Atlantic City, a major tourist destination in the state of New Jersey. The population of Atlantic County was estimated at 264,403 in 2005. The average income in the county is \$50,377 per household, with 8.9 percent of the population living below the Federal Poverty Level.

AtlantiCare Health System includes AtlantiCare Regional Medical Center, a 567-bed teaching hospital with two campuses; AtlantiCare Health Services; AtlantiCare Behavioral Health; the AtlantiCare Foundation; AtlantiCare Health Plans; and InfoShare. AtlantiCare is the region's largest health care organization and largest non-casino employer.

Program Overview

In 1994, leaders of AtlantiCare Health System had a vision for a more comprehensive, coordinated, and seamless system of care for the residents of southeastern New Jersey. They were concerned about the fragmentation in the mental health system and committed to the value of integrated delivery systems as a key approach to improving the physical and behavioral health of the community.

Atlantic City Medical Center was the area's only inpatient psychiatric facility, with a 30-bed psychiatric unit and psychiatric emergency screening and crisis program. Atlantic Mental Health Center, a freestanding not-for-profit community mental health center, was the county's largest provider of outpatient mental health and addiction treatment services. The two organizations often found themselves serving same the population with limited communication and without a coordinated approach to care.

When the board of the mental health center voted to merge with AtlantiCare in 1994, the goal was to establish a stronger, more seamless behavioral health care delivery system. By combining their capabilities, facilities, and resources, the two organizations could better serve the behavioral health needs of the region. In order to maintain behavioral health as a strong focus within the system, AtlantiCare Behavioral Health was created as a wholly owned subsidiary of AtlantiCare, with a separate board. This unique positioning ensured that behavioral health services would receive the proper level of attention and importance needed in remaining responsive to the behavioral health care needs of the communities served by AtlantiCare.

To fully realize an integrated delivery system, AtlantiCare needed not only integrated services but also an integrated clinical information system. Six years after the merger, they acquired a system that could successfully support electronic medical records for both inpatient and outpatient behavioral health services and interface with the existing hospital information system. Developing a culture of electronic documentation in a paper-intensive environment presented challenges, but the ability to access treatment plans and track medications facilitated more informed treatment decision-making across the continuum of care and improved patient safety practices around medication reconciliation, standardized suicide risk assessments, and patient identification.

Program Impact

Following the merger, stakeholders almost immediately began to see improvements in the coordination and delivery of care to the community. The use of a multidisciplinary team approach allowed AtlantiCare to realize the positive impact of behavioral health care across clinical areas. Within the organization, behavioral health leaders have been able to demonstrate the clinical and economic benefits of integrating mental health services into various hospital-based programs including cardiac surgery, obstetrics care, bariatric surgery programs, and trauma services. Currently, AtlantiCare Behavioral Health is partnering with AtlantiCare's Federally

Qualified Health Center to integrate mental health and substance use treatment services in this primary care setting. They are also working with a multidisciplinary team designing a new cancer center to address the development of behavioral health services for cancer patients.

The merger of the two organizations laid the groundwork for expanded outreach capability for psychiatric emergency services. Through AtlantiCare's Psychiatric Intervention Program (PIP), mobile treatment teams service the entire region. The 24/7 teams respond to hospital emergency departments, nursing homes, and residences to conduct initial evaluations and determine the most appropriate level of care for the patient. Recently, the PIP collaborated with a local rescue mission and a homeless shelter to provide behavioral health services at their locations. The Psychiatric Intervention Program is a key strategy for addressing overcrowding and inappropriate emergency department use.

Program Funding

The Psychiatric Intervention Program is primarily funded through annual community block grants for mental health services secured through the state, with the balance of support from public and private third party billings.

Obstacles or Challenges

The primary challenges in developing an integrated behavioral health delivery system were the political and control issues that tend to accompany mergers. Concerns around loss of identity and differences in the

philosophical approaches of the two organizations were issues that had to be addressed.

Success Factors

A strong governing board committed to behavioral health services and not averse to risk was essential to developing an integrated behavioral health care delivery system.

Lessons Learned and Advice to Others

For others interested in creating an integrated delivery system for behavioral health care, the AtlantiCare experience provides some helpful advice:

- Behavioral health services tend to be distributed among small outpatient providers that have a long tradition of independent service; however, communities are best served by integrated systems that coordinate the delivery of care. Look for opportunities to consolidate services and reduce service fragmentation.
- There are greater opportunities to improve the overall health of the community as coordinated systems of care partner with the rest of the medical establishment and reach beyond traditional behavioral health services.

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Collaborating to Provide Prevention and Early Intervention Services Across a Region

Central Peninsula Hospital, Soldotna, AK

Summary

Central Peninsula Hospital led the creation of a 10-agency coalition that provides prevention and early intervention services in communities in the Central Kenai Peninsula. Goals are to reduce the adverse effects of substance abuse, especially during the prenatal period; reduce suicide and parasuicidal behaviors; and increase community protective factors among residents.

Community and Hospital

Located at the heart of the Kenai Peninsula of Alaska, the city of Soldotna is a year-round recreation center. Tourism is the fastest growing industry in the area. As of 2000, Soldotna's population was 3,759. The median income is \$48,420 per household. Approximately 6.6 percent of the population lives below the Federal Poverty Level.

Central Peninsula Hospital is a borough-owned, not-for-profit facility located in Soldotna, with a service area of over 25,600 square miles. The hospital is administered by a corporation, CPGH, Inc., and operates through a lease and operating agreement with the Kenai Peninsula Borough.

Program Overview

Central Peninsula Hospital is no stranger to regional collaboration. The hospital has been involved in three major and successful collaborative efforts over the past several years, including helping fund a broad-based community organization called the Community Action Coalition (CAC) for Prevention. Members of the coalition include youth, parents, business leaders, media, schools, adolescent service agencies, law enforcement, faith-based groups, civic organizations, health care providers, and

mental health and substance abuse agencies. This coalition served as the cornerstone for the development of prevention strategies on a much larger scale.

The merger of mental health and substances abuse services in the state government provided an unparalleled opportunity to secure resources for expanded collaboration. In an effort to foster the integration of behavioral health services in the community, the Alaska Department of Health and Human Services announced the availability of grants for regional collaboration. Central Peninsula took the lead in developing a proposal for a 10-agency Community Prevention Team to provide prevention and early intervention services within the Central Kenai Peninsula. As the project coordinator, Central Peninsula Hospital anticipates receiving funds for the third and final year of a \$1.04 million grant in fiscal year 2008.

Three goals were identified for the collaborative initiative: reduce the adverse effects of substance abuse, especially during the prenatal period; reduce the numbers of suicide and parasuicidal behaviors; and increase community protective factors among residents in the region. An integrated, comprehensive model of prevention targeting each of these areas was defined, using established interventions that could be tailored to local needs.

Two approaches formed the basis for the project. The first was a focus on an empirical methodology in the development of the prevention plan. Coalition members looked for outcomes-focused and evidence-based intervention programs that would yield valid measures of change. The second approach was the creation of formal interdisciplinary and inter-agency partnerships to serve as vehicles for the interventions. These partnerships produced organized and coordinated interventions that increased efficiencies, reduced redundancies of effort, extended the reach of individual programs, and broadened the base of review and oversight.

Now in its third year, the Community Prevention Team meets at least monthly to identify needs and to discuss progress toward programmatic goals. Current projects include family and parenting programs, suicide education in schools, brief depression and alcohol screenings by primary care providers, community-based depression screenings and resiliency-building education, and focused interventions for very high-risk incarcerated youth.

Program Impact

Because nearly all of the behavioral health organizations and agencies in the region are involved in the coalition, they are able to capitalize on their combined knowledge of populations, resources, and available expertise. Working collaboratively, the coalition has identified and

harnessed resources in a way that no organization or agency could have accomplished alone.

The emphasis on adopting outcomes-based interventions has improved the quality of programs supported. Six of the participating agencies now have Substance Abuse and Mental Health Services Administration (SAMHSA) Model or Promising Programs in place.

One example of a successful collaboration includes serving over 30 families in the intensive, 14-week Strengthening Families Program, which has been staffed by employees of the hospital, Community Action Coalition, mental health center, and volunteers. Similarly, four organizations—mental health center, federally qualified health center, hospital, and developmental disabilities provider—helped provide free community depression screenings for over 100 individuals the first year of the program. The diagnostic clinic for fetal alcohol spectrum disorders has provided over 40 trainings annually, including to staff at nearly all the agencies participating in this collaborative. Finally, the CAC conducted a state-of-the-art evaluation of the public schools in the region to assess for substance use and belief patterns. This survey will be conducted every other year to determine whether interventions are having a positive impact.

Program Funding

The Kenai Peninsula Community Prevention Team programs are funded through a three-year state grant, with the funds allocated on an annual basis. As the project coordinator, Central Peninsula Hospital provides the organizational resources to manage the grant funds. Approximately 70 percent of the funds are distributed to the partner agencies.

The collaborative has already begun building infrastructure to pursue additional funding beyond 2008. It is anticipated that one or more grant applications will be submitted for 2009. Even in the absence of grant funding, some of the specific programs can be absorbed into existing revenue streams.

Obstacles or Challenges

Although Central Peninsula Hospital had the accounting infrastructure needed to oversee the grant funds, they did not have a structure for managing the types of contractual relationships that were an integral part of the initiative. There was a steep learning curve associated with developing protocols and processes that met the audit needs of the hospital while facilitating the distribution of funds among multiple agencies.

Success Factors

The primary factor for the success of this collaborative effort was the level of concern felt by the participants.

Coalition team members recognized that if they could not work together, these services probably would not exist in their community. They were willing to take the long view, develop long-term relationships, and commit to interpersonal transparency in order to establish effective prevention programs that have lasting value for the community.

Lessons Learned and Advice to Others

For others interested in setting up similar programs, the Central Peninsula Hospital experience provides some helpful advice:

- In order for regional collaboration to succeed, there has to be a level of deep concern among service providers related to unmet community needs.
- Start small, with small collaborative projects; build on experience and success.
- Hospital leaders have to be willing to take risks to

meet community needs in unconventional ways.

- Multi-organizational coalitions may benefit from a neutral mediator to facilitate funding decisions so that all the participants feel that they have equal standing.
- When serving as the lead organization in a community coalition, the hospital has to demonstrate that its goal is not primarily financial gain but the improved health of the community.

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Building a Coalition to Address Substance Abuse Issues in an Urban Community

Massachusetts General Hospital, Boston, MA

Summary

Trends in substance abuse-related hospitalizations and deaths in the Charlestown area of Boston prompted the Massachusetts General Hospital (MGH) to create a coalition of community leaders who work together to reduce substance abuse in the community by utilizing existing community resources and organizing programs to meet identified needs.

Community and Hospital

Charlestown is the second oldest neighborhood in Boston, MA. In 2000, the population of Charlestown was 15,195. The median income was \$56,145 per household, with 18 percent of the families living below the Federal Poverty Level. Thirty-seven percent of children 18 years and under live below poverty level.

Founded in 1811, the Massachusetts General Hospital is the third oldest general hospital in the United States and the oldest and largest in New England. Affiliated with Partners Healthcare, the 902-bed medical center includes a main campus in Boston as well as five community health centers. MGH Charlestown HealthCare Center offers comprehensive primary care for children, adolescents, adults, and seniors from a location in the heart of Charlestown.

Program Overview

According to the Massachusetts Department of Public Health, hospital admissions for treatment of heroin abuse in Massachusetts are three times the national average and highest of all the New England states. As staggering as the Massachusetts numbers are, the statistics

for the one square mile of Charlestown are even more sobering. The rate of substance abuse-related hospitalizations among Charlestown residents is more than twice the rate of Boston overall. The number of drug-related deaths among Charlestown residents was nearly 50 percent higher than the city of Boston as a whole from 1999-2002.

In response to these alarming trends, business and community leaders, the police, social service agencies, the Massachusetts General Hospital health center and providers, representatives of elected officials, residents, and others came together in the winter of 2004 to form the Charlestown Substance Abuse Coalition (CSAC). Convened by MGH Charlestown and the MGH Community Benefit Program, the coalition was further galvanized by the tragic overdose of two prominent youth in April 2004, including the death of one.

Following the success of the first community meeting held in November 2004, CSAC conducted a comprehensive community assessment that included a community-wide survey, focus groups, and key informant interviews. The survey, distributed to 7,000 households, revealed that 97 percent of respondents believe Charlestown has a medium to large substance abuse problem. Respondents also indicated that the most effective strategies to combat this problem are to increase police presence, change community norms, increase treatment resources, and provide prevention and education services. Responses from focus groups and interviews supported the survey results.

A CSAC community forum was held to present the assessment results to the community. Over 120 residents and interested parties attended, and many were shocked by the results. The meeting further stimulated community action through initiation of four work groups that focused on implementation of the four strategies identified by the survey as the most effective ways to address the community's substance abuse problem.

In 2005, CSAC formulated a comprehensive strategic plan using funds from a Massachusetts Department of Public Health planning grant received through the Boston Public Health Commission. The plan affirmed the coalition's overall goal and defined four objectives:

- Change community norms, attitudes, and behaviors about alcohol and other substance use, while building community cohesion and collective response across all sectors of the community.
- Increase safety of neighborhood and quality of life for all by decreasing the supply of drugs, levels of crime, violence, and other consequences of substance abuse in the neighborhood through a collaborative effort with law enforcement and judicial systems.
- Increase access and resources for successful treatment and recovery from substance abuse for Charlestown residents and families afflicted with addiction.
- Strengthen protective factors and decrease risk factors of families, youth, and young adults through education, prevention, and intervention strategies.

Program Impact

The work of the CSAC has resulted in increased dialogue and communication across organizations, as well as among residents and resident groups; greater willingness of community residents to discuss substance abuse and other concerns openly; higher levels of resident participation in CSAC and other community efforts and events; and increased access to and engagement of underserved populations. The CSAC is seen as a resource and community partner to community organizations and initiatives.

Program Funding

Primary funding for the coalition is through the MGH Community Benefits program, with additional funding through grants. Recently, CSAC received a Drug Free Communities Support Program grant from the Substance Abuse and Mental Health Services Administration, an agency of the U.S. Department of Health and Human Services. DFC grant funds are intended to “establish and strengthen collaboration among communities, private nonprofit agencies, and Federal, State, local, and tribal governments to support the efforts of community coalitions to prevent and reduce substance abuse among youth.”

Obstacles or Challenges

The greatest challenge in establishing the coalition was getting key community stakeholders to the table. The community's ability to build cohesiveness was limited by factors such as: competition for financial resources; ownership issues related to changing demographics; the political undertones of being a small community in a larger city; and perceived racial, ethnic, and socioeconomic divisions. In the beginning, there was a core group of community leaders who responded. Now the challenge is to identify key stakeholders missing from the table and build on the coalition's success to expand collaboration.

Success Factors

The primary factor for the success of this initiative was the readiness of residents in the community to address substance abuse issues. The problem of substance abuse was so widespread that people could see it affecting their lives, the lives of their family members, and the future of their neighborhood.

A second factor contributing to success was that the hospital and health center had a history of responsiveness to community needs. Because of its long-term presence in Charlestown, MGH was able to involve people in the development of the coalition who had established relationships in the community. Community activists saw MGH as an organization with the will and the resources to sustain the initiative over time.

Lessons Learned and Advice to Others

For others interested in setting up similar programs, the experience of the Massachusetts General Hospital provides some helpful advice, including:

- Creating a successful coalition to address serious behavioral health issues takes a lot of time. You may not see tangible results in the short term or even in the intermediate term. Effective solutions require a sustained commitment to the community.
- Look for ways to present the realities of the situation so that people become engaged in the initiative. The community assessment data were powerful and eye opening to both residents and community leaders and served as a reminder to everyone that the bottom line was concern for the children and families of their neighborhood.

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Recommendation 3a

Hospital leaders should work with community agencies and support services and with state and local governmental authorities to ensure that all patients are treated in the most appropriate setting so that the hospital's backstop role is appropriately limited.

Partnering to Provide an Appropriate Setting for Care of the Seriously Mentally Ill

St. Mary's Hospital, Tucson, AZ

Summary

Carondelet Health Network at St. Mary's Hospital collaborated with the local regional behavioral health authority to create an extended care unit for high-risk patients as a diversion from the state hospital. The interdisciplinary, inter-agency program helps to achieve the best possible clinical outcomes for the seriously mentally ill and reduce the downstream costs associated with emergency department visits, hospital stays, and crisis management.

Community and Hospital

Tucson, AZ, one of the oldest towns in the U.S., is the county seat of Pima County. The population of Tucson was estimated at 507,362 in 2005. The county, which covers 9,184 square miles, has a population of 902,720. The average income in the county is \$41,521 per household, with 14.7 percent of the population living below the Federal Poverty Level.

The only hospital on Tucson's west side, St. Mary's Hospital is a 402-bed facility with a full range of comprehensive inpatient and outpatient services. St. Mary's is part of Carondelet Health Network, southern Arizona's oldest and largest not-for-profit health care provider.

Program Overview

In Pima County, over 30,000 individuals receive some type of publicly funded behavioral health service, most with diagnosed mental health disorders. It has been estimated that up to 25 percent of the 2,000 detainees in the county jail are mentally ill or require mental health or substance abuse treatment. Individuals requiring mental health or substance abuse services, particularly high-risk patients, often end up in a hospital or a hospital emergency department because of the shortage of outpatient, crisis, and residential services and facilities.

As the Regional Behavioral Health Authority for southern and southeastern Arizona, the Community Partnership of Southern Arizona (CPSA) coordinates publicly funded behavioral health treatment and preven-

tion services. Over the last several years, CPSA has experienced growing need for available placement options for individuals with severe and persistent mental disorders. With a view to potential collaboration, CPSA approached St. Mary's Hospital regarding the need for community-based rehabilitation services for high-risk patients as a diversion from the state hospital.

The hospital and the agency worked together to develop a 16-bed, Level 1 subacute inpatient adult psychiatric unit. Most of the patients in the unit are on court-ordered status and are assigned to the Extended Care Unit for an average of 90 days. The goal of the intensive psychiatric rehabilitation program is to give patients the skills to make lifestyle changes that will allow them to live successfully in the community.

Using a strong interdisciplinary model, program staff works closely with community service agencies to coordinate care. Weekly staff meetings bring together the entire interdisciplinary team to review the patient's treatment plan and evaluate progress. The team includes psychiatrists, the nurse manager, the social worker, and nursing staff from the inpatient unit; the case manager and psychiatrists from the local outpatient services agency; the patient advocate; family members if available; and the clinical liaison from CPSA. Every month, the patient attends and participates in treatment planning.

As the partnership between CPSA and St. Mary's Hospital has evolved, the emphasis has been on finding ways to collaborate more effectively to meet the needs of patients. CPSA staff is proactive in identifying patients in the community who may benefit from the extended care program, particularly those who are high-volume users of community services. St. Mary's program leaders have been responsive to requests for changes in the program, including incorporating a stronger focus on substance abuse treatment, developing more individualized treatment plans for patients with challenging or problematic behaviors, and implementing a more effective staffing pattern for care of those patients.

Program Impact

The community, community agencies, and the court system have responded positively to the extended care program. Local judges often choose not to refer patients to the state hospital because they view the extended care unit as a more desirable alternative. The success of this program has led to discussions of additional models to assist with the severely mentally ill population, including housing for those who need supervision.

The extended care program represents a small first step in addressing hospital emergency department overcrowding by providing appropriate community-based services for people with serious mental illness. Increased collaboration among agencies that care for the seriously mentally ill helps to achieve the best possible clinical outcomes for these individuals and reduce the downstream costs associated with emergency department visits, hospital stays, and crisis management.

Program Funding

The program is funded by CPSA through their role as a state Regional Behavioral Health Authority.

Obstacles or Challenges

- Finding leaders with the skill sets required to work in a collaborative way with a community partnership.
- Identifying staff that possessed the skill set and philosophy needed for the population served.
- Balancing fiscal responsibility with patient care needs.
- The need for several private rooms was identified in the first year, but space constraints have prevented development of these rooms.

Success Factors

- Executive leadership of the parent organization, Carondelet Health Network, is committed to success in every venture.
- Because Carondelet is a mission-based organization, there is significant focus on attending to patients' spiritual needs as a component of care. Its mission values life and respects diversity.

- Carondelet reviews evidence-based practice issues on an ongoing basis. There is a strong emphasis on continual learning and improvement.
- The partnering organizations are committed to each other and continually seek ways to extend and enhance their collaboration.
- Program leaders listen to stakeholders – patients, families, staff, the community, and other agencies – and respond to their views, concerns, and issues.

Lessons Learned and Advice to Others

For others interested in setting up similar programs, the St. Mary's Hospital experience provides some helpful advice:

- Determine at the outset what your mission and goals are for the unit.
- Both partners need to continually evaluate the partnership, identify what is working and what is not working, and find ways to make the collaboration successful.
- Put in place leaders who not only have strong clinical skills but also have experience and expertise in developing and sustaining collaborative efforts.
- Anticipate community needs and gaps in service that may impact admissions.
- Anticipate and plan for the milieu and treatment challenges that the mixing of special needs population patients (e.g., developmentally delayed) with the seriously mentally ill population may present.
- Anticipate the special needs of patients living together for long periods of time with special attention to privacy, recreation, and private time.

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Coordinating Services to Patients in Urgent Need of Care through a Psychiatric ED

University of New Mexico Hospitals, Albuquerque, NM

Summary

By implementing a psychiatric emergency department (ED), University of New Mexico Hospitals ensures that patients in urgent need of behavioral health services receive them in the most appropriate setting. The psychiatric ED also eases the pressure of overcrowding in the main ED and helps the whole system to function more responsively.

Community and Hospital

Albuquerque is the county seat of Bernalillo County and the largest city in New Mexico. As of the 2005 census estimate, the city had a total population of 488,133. The median income is \$41,820 per household. Approximately 13.7 percent of the population lives below the Federal Poverty Level.

Case Examples

UNM Hospitals is the only academic medical center in New Mexico and an integrated hospital system that consists of University Hospital – a 384-bed acute, tertiary care facility – as well as the Children’s Hospital of New Mexico, the UNM Cancer Research and Treatment Center, UNM Psychiatric Center, UNM Children’s Psychiatric Hospital, UNM Carrie Tingley Hospital, UNM School of Medicine, College of Nursing and Pharmacy, and the Health Sciences Center Library. UNM Hospitals is also designated as a Level 1 regional trauma center.

Program Overview

UNM Hospitals has two emergency departments, one in the main hospital and a psychiatric ED in the Psychiatric Center. In the psychiatric emergency department, the on-site psychiatric consultation team consists of a psychiatrist (or clinical nurse specialist), nurses, licensed clinical social workers, and licensed clinical counselors. The main ED’s psychiatric consultation team, which consists of psychiatrists and psychiatric residents, transfers patients with psychiatric emergencies to the psychiatric ED, if appropriate. Police and ambulances transporting individuals in need of emergency mental health treatment often bring them directly to the psychiatric ED.

The UNM Psychiatric Emergency Services (PES) program operates 24 hours a day and includes services such as diagnostic psychiatric evaluations; crisis intervention; medication management for crisis stabilization and limited follow-up care; referrals for medical, dental, legal, social, or substance abuse services; and admission to the inpatient facility, when necessary. Crisis stabilization services are also provided in a cooperative venture with the City of Albuquerque to provide shelter and stabilization services including nursing and case management services for up to 72 hours. These services are provided at the Metropolitan Treatment and Assessment Center run by Bernalillo County. Referrals into crisis stabilization come through PES.

As a Level 1 regional trauma center and a safety net hospital for the area, the whole health system benefits greatly from being able to move patients with psychiatric emergencies to the psychiatric ED. The separate emergency department provides a safety valve that eases the pressure of overcrowding in the main ED. It also works better for patients, who are seen and treated more quickly and more appropriately.

To allow this system to function effectively, all psychiatric clinical staff receive some medical training. A clinical nurse specialist is available in the psychiatric ED to help stabilize a patient medically if the patient comes in with a medical issue – for example, diabetes – in addition to the psychiatric emergency. The psychiatric ED has feeding

tubes available if needed, but no continuous IVs or other more invasive medical or surgical treatments.

Psychiatric Emergency Services clinicians are trained in avoiding restraint and seclusion, and children’s psychiatric services have been very successful in aggression reduction. Adult patients are expected to take some responsibility for their own crisis plans – clinicians work with them to develop a clear statement of their “hot buttons” and what kinds of actions might calm them down if they get agitated or upset.

The psychiatric crisis stabilization service, which allows a patient a 72-hour stay, helps prevent inpatient admissions. A comprehensive case management component of the program helps coordinate psychiatric and medical care, thereby supporting the individual’s ability to live in the community.

Obstacles or Challenges

Physician coverage is an ongoing challenge, even though physicians are more plentiful because UNM Hospitals is an academic medical center. Another continuing challenge is increasing overall awareness about the appropriate use of a psychiatric ED.

Success Factors

The successful implementation of the psychiatric ED lessened the burden of psychiatric emergencies on the main ED, resulting in more cost-effective and appropriate emergency care to patients struggling with mental illness. Contributing to this success were the following factors:

- Good movement and collaboration between the two emergency departments.
- Immediate psychiatric consults.
- A team approach at all levels. The medical director brings all involved stakeholders into collaborative discussions for problem solving and planning.
- Awareness of the contribution made by different types of clinicians.
- On-site medical professionals on the psychiatric side (a pediatrician for children’s psychiatric emergencies and a nurse practitioner for adults) supporting a “global approach to the customer.”
- Being located in a large city and a teaching hospital.

Lessons Learned and Advice to Others

For others interested in setting up similar programs, the University of New Mexico Hospitals experience provides some helpful advice:

- Be explicit about admissions criteria for your psychiatric ED. Define which patients will first require a medical screening.
- Choose clinicians carefully. Working with psychiatric patients demands a special kind of clinician, particularly one who can de-escalate volatile situations.

- Think at a systems level and provide appropriate training to staff and physicians.

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Solving Problems in the ED through a Coalition of Behavioral Health Stakeholders

Utah Valley Regional Medical Center, Provo, UT

Summary

Through the Coalition for Crisis Intervention at the Utah Valley Regional Medical Center, the hospital, local health and social service agencies, law enforcement, and other providers collaborated to ensure that behavioral health patients in the emergency department receive the appropriate level of care in the most appropriate setting.

Community and Hospital

The city of Provo sits in the heart of Utah Valley between the eastern shore of Utah Lake and the towering Wasatch Mountains. The second largest city in the state, Provo is the county seat of Utah County, one of the fastest growing counties in the country. In 2005 the population of Provo was estimated at 101,164 and the population of Utah County at 434,677. The median income of the county is \$47,428 per household. Approximately 12.2 percent of the population lives below the Federal Poverty Level.

Utah Valley Regional Medical Center (UVRMC) is a 330-bed, not-for-profit hospital serving Utah County and central and southern Utah. A part of Intermountain Health Care's system of 21 hospitals, UVRMC has a full-service psychiatric unit with 20 adult beds and seven child/adolescent beds. UVRMC's emergency department is one of the largest and busiest in Utah, treating more than 45,000 patients each year.

Program Overview

The Coalition for Crisis Intervention at the UVRMC began in 1999 as a diverse group of behavioral health stakeholders who came together around a single issue: handling psychiatric and substance abuse patients in the emergency department (ED). Convened by the regional administrative director for Intermountain's Behavioral Health Network, the coalition met on a monthly basis initially and now meets quarterly. Representatives from the various police agencies in the county, the county health department, crisis workers in the hospital emergency department, the sheriff's department, the local public mental health agency, and the county substance abuse agency were among the early participants. Later, a repre-

sentative from the county jail was added to the group.

The initial meetings revealed high levels of frustration among the participants. The area police agencies were frustrated because of the long wait times experienced by their officers, who usually accompanied the individual to the ED. Because some of the small outlying municipalities have only a few officers on staff, the time they spent waiting in the ED left a shortage in their home area for police coverage. The local drug and alcohol agency was frustrated because they did not have the facilities to perform detoxification or to hospitalize substance abuse patients – they only operated a residential program – so they wanted the hospital to keep these patients. The hospital was frustrated because it does not have a dedicated chemical dependency program, and these patients were not appropriate for admission to a psychiatric unit.

Not only were the professionals involved in the system experiencing frustration, but patients were falling through the cracks because of the continuous disagreements and friction among the organizations.

The coalition has seen a number of positive outcomes from their collaboration:

- To improve the care for substance abuse patients, the drug and alcohol agency agreed to triage patients at their new facility before sending them to the hospital. This approach reduced the number of patients coming to the ED.
- Hospital security had maintained that staying with psychiatric/substance abuse patients presented to the ED was the responsibility of law enforcement personnel, not hospital staff. The police agencies collaborated to obtain legal advice on this issue and found they were not obligated to stay with the patient, just to deliver the individual to the ED. The hospital security director secured approval to hire psychiatric technicians who now sit with psychiatric/substance abuse patients in the ED.
- Formerly, ED physicians were upset and uncooperative in response to pressure from the drug and alcohol agency to provide drugs for discharged patients until the patients were stabilized. Drug treatment protocols that the ED physicians could accept were developed, and the

Case Examples

physicians now provide some medications until the triage facility can take over.

- The local mental health agency and UVRMC agreed to share the costs of caring for medically indigent, substance abuse patients admitted to the hospital. The agency supports physician services, and the hospital provides staff and hospital care.
- To increase the skill of law enforcement personnel in responding to individuals in psychiatric crisis, the local police departments appointed a chairman to receive training and operate a Crisis Intervention Team (CIT) program for all police agencies in the county. The CIT program has been adopted in hundreds of communities throughout the U.S. and has demonstrated successes in linking people with timely and effective mental health services. Officers are taught about severe mental illnesses and how to respond to people experiencing psychiatric crises in ways that defuse rather than escalate these crises.

Program Impact

The work of the Coalition for Crisis Intervention has resulted in improved collaboration and communication between the hospital, local health agencies, law enforcement, the public mental health agency, and substance abuse treatment programs. Over the years, the coalition has been successful in identifying key problems in the system and coming up with viable solutions.

Obstacles or Challenges

The greatest obstacle faced by the coalition initially was the defensiveness of the participants when problems were discussed. As a group, however, they recognized that they all had problems when it came to resources for mental health services and that cooperation was the only way they could make a significant impact on their communities. There was no additional funding available to

solve their problems. If they were going to be successful, they had to focus on solutions, not problems.

Success Factors

The primary factor for the success of this project was the willingness of coalition participants to stay focused on the purpose, to share and accept different points of view, and to keep coming back to the table to seek solutions.

Lessons Learned and Advice to Others

For others interested in setting up similar programs, the Utah Valley Regional Medical Center experience provides some helpful advice:

- Take the risk to be the leader in collaboration. You may think it's going to cost a lot of money if you take the lead, but that isn't necessarily the case. Initiate the process, get people talking, and watch for results.
- Allow the coalition to evolve over time, as needed. Originally formed to address issues around psychiatric and substance abuse patients, the Coalition for Crisis Intervention is now dealing with the appropriate treatment and disposition of mentally retarded patients in the community.
- Problem solving and training are ongoing efforts. The coalition continues to run into some of the same problems because of new staff in the participating organizations or staff who are inadequately informed or trained.

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Recommendation 3b

Hospital leaders should create a formal plan that clearly defines its role and its established relationships for behavioral health with other providers, practitioners, and governmental and community agencies.

Affiliating to Coordinate Services and Improve the Delivery of Care

Baptist Health Care and Lakeview Center, Pensacola, FL

Summary

Prior to their affiliation, Baptist Hospital, a general acute care hospital, and Lakeview Center, a community behavioral health center, had overlapping service areas and service lines. The subsequent realignment of services not only created more efficient and effective organizational

relationships but also allowed public and private funding sources to be managed in a complementary manner.

Community and Hospital

Pensacola is located in the westernmost part of the Florida panhandle and serves as the county seat for

Escambia County. With a population estimated in 2005 at 274,663 and a median income of \$40,384 per household, Escambia County is often referred to as Florida's poorest large county. Approximately 15.7 percent of the county lives below the Federal Poverty Level.

Baptist Health Care (BHC), Pensacola, is a not-for-profit health care system composed of Baptist Hospital, three satellite acute care hospitals, and Lakeview Center, Inc (LCI). Baptist Hospital is the system's flagship facility with a primary service area of Escambia County. As part of its complement of 520 beds, Baptist Hospital has 68 beds licensed as inpatient psychiatric beds. Lakeview Center is a community mental health center offering a full continuum of behavioral health services for adolescents and adults.

Program Overview

Although Baptist Hospital and Lakeview Center have always shared community service as a core value, the years prior to their affiliation through Baptist Health Care were primarily characterized by competition for scarce behavioral health funding sources, interspersed with brief periods of collaboration. There were overlapping service areas and overlapping service lines.

In 1995, leaders of the two organizations perceived the potential synergies and community benefit to be gained from a formal alliance. Following a protracted period of negotiations, the affiliation of Lakeview Center with the Baptist Health Care system was finalized in June 1996. As a result of the alliance, services were realigned into a more efficient and effective organizational structure. The visiting nurse association operated by Lakeview Center was transferred to BHC's acute care system. The mental health clinic and residential substance abuse treatment beds operated by BHC were transferred to LCI. In addition, Lakeview entered into a contractual agreement with Baptist Hospital to manage the hospital's 68 inpatient psychiatric beds.

The realignment of service lines resulted in a system of care that allows public and private funding sources to be managed in a highly complementary manner. There is an efficient "braiding" of scarce resources into an efficient and comprehensive system of care distinguished by the lack of fragmentation so often associated with behavioral health services. Not only does this structure ensure that inpatient funding streams are managed efficiently, but it also provides a comprehensive array of recovery-based community services to individuals discharged from inpatient care.

Affiliation with BHC has served to support and stimulate the continued growth of Lakeview Center. In return, this growth has enriched the contribution of

Baptist Health Care to the communities it serves.

Program Impact

At the time of the affiliation in 1996, Lakeview Center employed approximately 800 staff, with total revenues of approximately \$37 million. Today, with total revenues in excess of \$120 million and approximately 2,300 staff, Lakeview Center touches over 35,000 lives annually and has expanded its services beyond well beyond that of traditional behavioral health. In the years since the affiliation, Lakeview's vocational services division has grown significantly, now operating in five states and the District of Columbia with over 1,200 employees and revenues exceeding \$30 million.

As part of the privatization of Florida's Child Welfare system, Lakeview assumed the role of lead agency for a four-county area in 2001. This project operates under a fixed-price contract of approximately \$33 million, employs a staff of approximately 250 employees, and requires an extensive level of collaboration with numerous community agencies across the service area. Responsible for providing protective supervision, foster care, and adoption services for approximately 5,500 abused or neglected children annually, Lakeview Center and Baptist Health Care have made a significant commitment to protect one of the community's most valuable resources: its children.

Program Funding

In addition to the traditional payment sources of Medicare, Medicaid, and commercial insurers associated with health care providers, Lakeview taps into a broad array of other funding sources: the Florida Department of Children and Families for mental health, substance abuse, and child welfare; Agency for Persons with Disabilities; Florida Department of Vocational Rehabilitation; Escambia County School Board; Escambia Board of County Commissioners; Santa Rosa County School Board; Santa Rosa Board of County Commissioners; Florida Department of Health; Federal Grants for Homeless; HUD Housing Assistance; and Department of Defense for food service and custodial contracts with the Army, Air Force, and Navy.

Obstacles or Challenges

One potential obstacle facing hospital leaders who wish to pursue affiliations with behavioral health providers is that individual service lines may be offered by several different providers or agencies within each community, rather than by a single provider with a full continuum of services, as was the case with Lakeview Center. This fragmentation of services could result in affiliation or collaboration discussions becoming multi-organizational affairs, with an accompanying increase in complexity.

Success Factors

The primary factors contributing to the success of the affiliation were:

- Vision and commitment of the leaders and board members of both organizations.
- A shared commitment to service excellence and community support.
- Both organizations were financially sound and recognized as leaders in their respective fields.

Lessons Learned and Advice to Others

For others interested in pursuing collaborative relationships with community behavioral health partners, the experience of Baptist Health Care and Lakeview Center provides some helpful advice, including:

- One way to initiate a relationship with local providers might be to begin a dialogue regarding advocacy efforts to increase funding or support of community-based behavioral health services. This serves to meet two goals: it develops a sense of trust between the acute care and community-based provider and it helps assure the acute care system that any potential affiliation candidates are financially sound.
- In affiliations or mergers there is often an immediate goal

to reduce administrative costs by combining and/or eliminating what is viewed as duplicative support costs. This may result in underestimating the specialized nature of management and reporting systems found at many behavioral health providers, particularly if a significant portion of their funding comes from public sources. Unless there is an immediate critical need, give due consideration as to when, if at all, you consolidate the community-based provider into the acute care system's financial and information management systems.

- Generally speaking, community-based behavioral health providers have relatively modest capital outlay requirements, as compared to acute care hospitals.

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Collaborating with Community Physicians to Improve Access for Children with ADHD

Cincinnati Children's Hospital Medical Center, Cincinnati, OH

Summary

Cincinnati Children's Hospital Medical Center created the Attention Deficit Hyperactivity Disorder (ADHD) Collaborative to increase local physicians' involvement in diagnosing and treating straightforward presentations of ADHD. This arrangement improves patients' access to care and emphasizes the hospital's role as a referral point for more complex ADHD cases.

Community and Hospital

The Cincinnati metropolitan area includes 15 counties in Ohio, Kentucky, and Indiana with a total population of over two million people. The population of the city proper was estimated at 287,540 in 2005. The average income in Cincinnati is \$29,554 per household, with 25 percent of the population living below the Federal Poverty Level.

Cincinnati Children's Hospital Medical Center (CCHMC) is a 423-bed not-for-profit hospital. One of the largest hospitals in the tri-state region, Cincinnati Children's is committed to evidence-based pediatric care. This ensures that the care and treatment provided are based on the best scientific information and medical practices available.

Program Overview

Attention deficit hyperactivity disorder (ADHD) is one of the most common behavioral disorders affecting children. Approximately 9 percent of males and 3 percent of females are affected by the disorder, which is marked by inattention, hyperactivity, lack of concentration, and impulsivity.

In response to concerns expressed by community parents and physicians regarding care for children with ADHD in the Cincinnati area, Cincinnati Children's Hospital Medical Center created a task force to determine the scope of the problem and develop recommendations. The task force soon realized that any approach to addressing ADHD that was based at the medical center would quickly reach capacity, so they began to look at community-based options.

The task force applied to the Cincinnati Children's Patient Innovation Fund, a hospital-based grant program that supports innovative projects to improve patient care. They received a five-year, \$1.8 million grant and created the ADHD Collaborative. This quality improvement initiative is designed to improve access to evidence-based care for children in the com-

munity with ADHD by helping community physicians to develop more skill and confidence in making ADHD diagnoses. This increased role for physicians reduces wait time for patients who would otherwise be referred to CCHMC to diagnose their condition. In addition, it reduces the need for CCHMC staff to be involved in diagnosing and treating straightforward presentations of ADHD and, therefore, allows more ready access to care for referrals of complex ADHD cases.

Physicians who participate in the Collaborative receive specialized training in diagnosing and managing ADHD according to the evidence-based guidelines. The Collaborative team conducts chart reviews to obtain a baseline of how frequently the various components of evidence-based care are delivered, such as collection of rating scales from both parents and teachers for diagnosis and ongoing monitoring of care, use of written care management plans, timely phone and office visits for titration of medication, and assessment of side effects. Physician practices are given their performance data and taught to use quality improvement tools to organize their office to promote the implementation of evidence-based guidelines. The team works with the physician practices to help them understand and follow the evidence-based guidelines, such as how to score and interpret behavioral rating scales, when to schedule follow-up appointments, and titration of medication. The team also makes suggestions regarding billing and coding and provides data on third-party reimbursement for ADHD-related visits.

The primary incentive for physicians to participate in the program is the priority access they receive to subspecialty services of psychiatry, psychology, and developmental and behavioral pediatrics at Cincinnati Children's through a consult phone line in the Psychiatry Intake Response Center. The consult line assists the primary care physician in obtaining access to the appropriate subspecialty service for further evaluation and consultation or treatment for children with ADHD and co-morbid conditions.

In year three of the grant, there are 120 pediatricians participating in the ADHD Collaborative. The goal is to reach 70 percent (i.e., 238 physicians) of the approximately 340 physicians on the medical staff at CCHMC who practice in the community. Once the program is fully implemented, the community will have a cadre of physicians who have the knowledge, skills, and tools to accurately assess ADHD and co-morbid conditions, such as depression, anxiety, and learning disabilities; offer appropriate medical management; set treatment goals; and coordinate care with the child's school.

Program Impact

To date, all participating pediatric practices have substantially increased their adherence to evidence-based guidelines. The collection of behavioral rating scales from parents and teachers has increased from an average of 38 percent at baseline chart review to 95 percent. At baseline, only 25 percent of children diagnosed with ADHD met DSM IV criteria, but post training, the goal of 70 percent has been consistently achieved. Finally, the change in care has resulted in 76 percent of patients showing a 25 percent reduction in symptoms on follow-up Vanderbilt rating scales by parents, and 85 percent of patients showing a 25 percent reduction in symptoms on follow-up Vanderbilt rating scales by teachers.

Program Funding

See the program overview.

Obstacles or Challenges

The greatest challenge in implementing the project was recruitment of physicians to participate. Initially, the pediatrician leading the Collaborative made personal contacts with physicians he knew to get them involved. Once those contacts were exhausted, they used direct mailings to send out a brochure describing the project and enlisted the hospital's physician representatives to describe the Collaborative during their visits to community pediatric offices.

One of the obstacles to recruitment was the amount of time the physician needed to invest to complete the training. To overcome this barrier, the team has continually sought to reduce the number of training sessions. Currently, there are two sessions at the Medical Center and two sessions at the practice's office.

Success Factors

The main factor contributing to the success of the program was that primary care physicians in the community wanted to do a better job of providing care and obtaining appropriate assistance and services for children with ADHD and their families. Because Cincinnati Children's relates well to community physicians and has built and fostered these relationships over time, it was evident to the physicians that the hospital wanted to partner with them to develop and support a system that worked for them and their patients.

Lessons Learned and Advice to Others

For others interested in setting up similar programs, the experience of Cincinnati Children's Hospital Medical Center provides some helpful advice, including:

- Enlisting a key opinion leader – in this case, a community pediatrician – to lead the community initiative is a crucial factor to success.
- To ensure an adequate level of evidence-based ADHD

care, it is important to work with the entire practice, not just the physicians, so that you can establish systems that support workflow and facilitate care management across all office personnel, including schedulers, receptionists, and nurses, as well as the physician.

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Using Psychiatric Assessment and Liaison Services to Improve the System of Care

John Muir Health, Concord, CA

Summary

Behavioral health leaders at John Muir Health collaborated with acute care hospitals in the system to develop psychiatric assessment and liaison services. These services leverage behavioral health expertise in a collaborative effort to improve operating efficiencies and enhance patient care throughout the system.

Community and Hospital

Contra Costa is one of nine counties in the San Francisco-Oakland Bay Area. The ninth most populous county in California, it has one of the fastest growing workforces in the Bay Area. In 2005 the population of Contra Costa was estimated at over one million. The median income was \$69,487 per household, with 8.1 percent of the population living below the Federal Poverty Level.

John Muir Health is a locally owned and governed private health system composed of three hospitals. John Muir Medical Center, Walnut Creek Campus, is a 321-bed acute care facility that is designated as the only trauma center for Contra Costa County. John Muir Medical Center, Concord Campus, is a 259-bed acute care facility serving Contra Costa and southern Solano counties. John Muir Behavioral Health Center, a 73-bed acute psychiatric hospital, provides child, adolescent, and adult inpatient and outpatient behavioral health services and adult chemical dependency services.

Program Overview

John Muir Health emergency departments (EDs) were the recipients of both mental health and substance abuse patients whose aggressive or escalating behavior often resulted in ED disruption and created anxiety among staff. It was important to develop a consistent approach throughout the system for handling these patients at a clinical staff level, thus avoiding some of the negative outcomes that can occur when a security approach to behavioral problems is applied without clinical input. Additionally, ensuring correct procedures for the application of involuntary holds in the ED were a concern.

Overdose patients and those experiencing acute withdrawal were frequently placed in the acute care hospital intensive care units (ICUs), where staff could stabilize the patients, monitor the safe detoxification experience, and help minimize negative effects from withdrawal. In the ICUs and other medical/surgical units, however, staff tended to be nervous about psychiatric and substance abuse patients – afraid of not doing the right thing or concerned that someone might get hurt.

In response to these and other issues, John Muir behavioral health leaders developed psychiatric assessment and liaison services to assist with behavioral health patients in the acute care setting. The goal was to leverage behavioral health expertise in a collaborative effort to improve operating efficiencies and enhance patient care throughout the system. The services provided to the acute care hospitals include:

- **Psychiatric assessment services.** Registered nurses (RNs) respond within one hour to provide assessments of psychiatric patients who present to the hospital EDs.
- **Staff training for crisis intervention.** ED staff are trained in crisis prevention and intervention. Certified trainers are available to conduct regular trainings of ED staff.
- **Inpatient psychiatric consultation.** Psychiatrists from John Muir Behavioral Health Center are available on a daily basis to consult on medical/surgical patients with psychiatric or chemical dependency issues.
- **Liaison nurse service.** An RN clinical specialist or advanced practice nurse provides inpatient consultation to develop behavioral treatments plans with other clinicians.
- **Inpatient chemical dependency assessment and consultation.** Chemical dependency staff are available to meet with medical/surgical patients regarding follow-up chemical dependency treatment.
- **Certified addictionologist.** A physician certified by the American Society of Addiction Medicine provides education for staff of medical/surgical and intensive care units regarding detoxification protocols and complications.

To address involuntary holds in the EDs, hospital representatives, physicians, ED staff, and county health leaders formed a task force that clarified the criteria for holds, developed policies and procedures, and prepared a video-based training program. ED physicians are required to participate in the training on an annual basis and sign off on the policies and procedures.

Program Impact

John Muir Health has realized a number of benefits from these services, including:

- The use of psychiatric assessment in the ED has improved hospital emergency department throughput by moving the patient to the most appropriate level of care as quickly as possible and avoiding unnecessary admissions.
- The services related to medical/surgical inpatients with behavioral health co-morbidities have reduced length of stay for these patients; decreased staff injuries and anxieties; improved patient care and the patient experience; enhanced patient safety; and reduced negative outcomes such as delirium tremens, suicide attempts, and agitation.
- The training programs have not only improved the ability of ED staff to deal with patients in crisis but have also reduced liability regarding the application of involuntary holds.

Program Funding

To support the psychiatric assessment and liaison services, the acute care hospitals contract with behavioral health services, which provides the nursing staff for the assessment service and contracts with independent psychiatrists for the consultation services.

Obstacles or Challenges

The development of each service component posed its own challenges. For example, when the ED assessment service was begun, mental health counselors were used to provide the assessments. However, because of the

needs of the emergency departments and the extensive physician/nursing interaction required, the decision was made to use only RNs in the ED assessment role. In order to gain greater acceptance of the psychiatric nurse liaison service, the liaison nurse spent several months meeting with all of the appropriate disciplines to clarify roles and boundaries.

Success Factors

Because behavioral health care is an integral part of the mission of John Muir Health, the system has been strongly supportive of the program. Behavioral health leaders have consistently educated colleagues and system leaders on the value of behavioral health services and the importance of collaborative efforts in meeting the behavioral health needs of their community.

Lessons Learned and Advice to Others

For others interested in setting up similar programs, the John Muir Health experience provides some helpful advice:

- Health systems that do not have a behavioral health service or hospital should consider partnering with other hospitals or health systems for the components of a psychiatric assessment and liaison service.
- Collaboration with local government and social service agencies is also important. Hospital and community leaders should work together to ensure that behavioral health patients have access to community resources and care.

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Recommendation 4

Hospital leaders should clearly communicate to public and private payers the costs required to care for behavioral health patients, especially those with chronic and severe conditions, and the costs to society of not treating those patients.

Ensuring Funding for Early-Intervention Services for Inner-City Children

Bridgeport Hospital, Bridgeport, CT

Summary

The Child FIRST program at Bridgeport Hospital, Bridgeport, CT, provides early-intervention behavioral health services and comprehensive supports for vulnerable, underserved young children. Program leaders have developed consistent and varied funding streams by emphasizing the fact that these services prevent conditions that require much more costly and generally less effective services later on in these children's lives.

Community and Hospital

Situated around a harbor on the Long Island Sound, Bridgeport is the largest city in Connecticut. According to the 2005 estimates, the city's population is 132,011, and the median income for a household in the city is \$36,976. Approximately 17.9 percent of the population lives below the Federal Poverty Level.

Bridgeport Hospital is a 354-bed not-for-profit hospital and the principal affiliate of Bridgeport Hospital & Healthcare Services, Inc. with Ahlbin Rehabilitation Centers and the Bridgeport Hospital Foundation. The hospital is also a member of the Yale New Haven Health System.

Program Overview

Babies born to inner city Bridgeport mothers face multiple barriers to success. Over 25 percent of Bridgeport's 13,600 young children live below federal poverty levels. In the Bridgeport Hospital Pediatric Primary Care Center, more than 50 percent of children screened under age six years have behavioral problems and more than 45 percent face multiple environmental risks, including those related to domestic violence, maternal depression, substance abuse, unstable housing, inadequate health care, poor education, illiteracy, unemployment, and teen- and single-parenting.

A considerable portion of behavioral health dollars invested in the later years of childhood is in interventions to address conditions that could have been prevented through increased interventions in early childhood. The challenge is to develop consistent funding streams to support early intervention services. Child FIRST (Child and Family Interagency Resource, Support, and Training) at Bridgeport Hospital was officially established in 2001 with a grant of \$80,000

from the Connecticut Health Foundation. The goal of the program is to identify and assess children and families at risk for emotional, developmental, and learning problems as early as possible. Each year, Child FIRST serves 900 vulnerable, underserved children from birth through five years of age and their families, providing them with screening, assessment, consultation, care coordination, and intensive home-based mental health treatment, as needed.

Program Impact

Research data demonstrate that Child FIRST has contributed to a statistically significant decrease in children's emotional and behavioral problems, a decrease in parental depression and stress, and a decrease in protective service involvement. There is improvement in language development and in parent-child interactions in families with multiple challenges, as well as increase in access to services for all family members served by Child FIRST.

Program Funding

In order to continue the services and expand the reach of this valuable program, Child FIRST leaders have tapped a variety of funding sources, local and national, public and private. In addition to grants from the Connecticut Health Foundation, funds have been secured from the Substance Abuse & Mental Health Services Administration, the U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention, and the U.S. Department of Education. Through the Robert Wood Johnson Foundation (RWJF) Local Initiative Funding Partners Program, Child FIRST received financial support from multiple organizations concerned with the welfare of young children and their families, as well as matching funds from RWJF.

While grant support has been a significant factor in establishing and sustaining Child FIRST, program leaders recognize that this "patchwork" approach to funding services does not provide stability over time. For several years, Child FIRST leaders have worked to get access to state and federal dollars for the program through Medicaid. In 2005, Child FIRST became the first home-based, psychotherapeutic intervention for young children in Connecticut to receive approval for Medicaid reimburse-

ment for children with mental health diagnoses. Program leaders are now advocating for the use of Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program for reimbursement for screening, assessment, and treatment for very young children who show "medical necessity," but are not yet diagnosable.

Although both grant funds and Medicaid reimbursement are essential components of the Child FIRST fiscal strategy, neither provide support for all the services that the program's high-risk population needs. Longer term, the goal is to secure funding for Child FIRST through state budget appropriations so that the services can be expanded and developed in other locations in the state. Currently, research staff are analyzing data from a randomized trial to prove the effectiveness of this model. They plan to conduct cost-benefit analyses in order to demonstrate to state agencies and the state legislature that investing resources on intervening at the earliest signs of problems can save thousands of dollars per child on costs for serious emotional disturbance, special education, foster care, juvenile justice, and teen pregnancy.

Obstacles or Challenges

- Securing funds through grants has been a time-consuming and labor-intensive process.
- Making changes in the publicly funded health care system from the bottom up is difficult and complex. In Connecticut, Child FIRST program leaders have worked with seven different state agencies in advocating for behavioral health care dollars.

Success Factors

The support of hospital leadership is key to the success of any community initiative. The connection of Child FIRST to the hospital was an important factor for making contacts, building trust, and linking to clinicians.

Lessons Learned and Advice to Others

For others interested in setting up similar programs, the experience of the Child FIRST program at Bridgeport Hospital provides some helpful advice, including:

- Be sure that hospital leaders understand how your community-based program benefits both the hospital and the community.
- This must be a collaborative effort if it is to be successful. Build partnerships with all other community providers serving families with young children.
- Applying for grants or advocating before government agencies requires a thorough knowledge of your target population and its behavioral health care needs. You must have a passion for your program and be able to convey that passion clearly and concisely.
- Understand the mission and the goals of each grant-making organization to which you apply. Know what the organization wants, answer their specific questions, and provide the information they request.
- Do not extend your program outside its mission. Find foundations whose interests align with yours. Avoid developing fragmented services by chasing after money.
- Never start a program without identifying the outcomes that you want to measure. All funders – private and public – want to see outcomes.
- Always look ahead at how you will sustain the program. Think outside the box.

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Negotiating with Payers and Legislators for Addiction Treatment Services

Mercy Medical Center, Williston, ND

Summary

To meet the addiction treatment needs of its region, Mercy Medical Center helped create a coalition to represent those needs to legislators and payers. The coalition spurred the passage of legislation to cover residential services, which allowed Mercy to provide day treatment services to a population that is dispersed across a large service area.

Community and Hospital

Williston, ND, is the county seat of Williams County. As of 2000, the population of Williston was 12,512 with a median income of \$29,962 per household.

Approximately 13.4 percent of the population lives below the Federal Poverty Level.

Mercy Medical Center is an 87-bed regional medical facility that serves approximately 50,000 people in western North Dakota and eastern Montana. In 1996, Mercy Medical Center became part of Catholic Health Initiatives.

Program Overview

In the 1980s, behavioral health care providers in North Dakota were faced with increasing costs, declining reimbursement, and growing payer restrictions on hospital

Case Examples

stays and treatment options. Efforts to develop innovative treatment programs were stymied by insurers' unwillingness to pay for the appropriate levels of care. In response to these challenges, the North Dakota Addiction Treatment Providers Coalition, a statewide network of both public and private organizations, was created. Through the coalition, providers of substance abuse treatment services established a consolidated and coordinated approach for representing the needs of their patients and their organizations to legislators and payers. Leaders from Mercy Medical Center have played an active role in the coalition from its founding.

One of the key needs identified by coalition members was more effective communication with Blue Cross Blue Shield of North Dakota (BCBSND), the state's largest insurer. To that end, staff from Mercy worked with other coalition members to develop a list of the providers' leading concerns and shared this list with BCBSND. The goal was to ensure that both providers and insurers were on the same page and speaking the same language with regard to the costs and benefits of various treatment options and levels of care. In the late 1980s, the coalition was able to negotiate for more realistic allowable days of care so that individual providers did not have to be in continual conflict with the insurer over treatment coverage.

To increase their leverage, coalition members also began developing political contacts and educating legislators with regard to behavioral health services. In the North Dakota legislature, individuals may testify in any committee hearing. Mercy Medical Center leaders and other coalition representatives often testify at hearings for legislation related to behavioral health services. Their presence on the political scene ensures that legislators understand the issues from the providers' as well as the insurers' point of view and are able to make well-informed decisions about proposed legislation.

The work of Mercy Medical Center with the North Dakota Addiction Treatment Providers Coalition has "paid off" in very specific ways. In the early 1990s, Mercy transitioned out of inpatient substance abuse services. To meet the needs of their patients, the hospital developed a residential partial hospitalization/day treatment program. They use 14 beds in an open wing of the hospital for overnight "guesting" of patients who travel long distances.

Initially, BCBSND payments covered only the day treatment portion of the stay. In 2005, the coalition approached their contacts in the legislature to present the case for coverage of the residential portion also. Meeting with resistance from BCBSND, coalition members were successful in gaining support from the state attorney general's office. Legislation requiring insurance and managed care companies to include coverage of residential treat-

ment services was subsequently passed. With this added financial support for the guesting program, Mercy Medical Center is able to more effectively meet the needs of a population dispersed across a large service area.

The success achieved by the coalition has stimulated Mercy to look for new opportunities to extend their services. Mercy has recently contracted with the state to provide addiction treatment for patients who are unable to pay, with reimbursement provided on a capitated basis. They have also contracted with an Indian reservation to provide intensive levels of addiction care that are not available in the tribal program.

Program Impact

The impact of the coalition's work has gone beyond achieving success in the legislature and with the insurance companies. When the governor created the North Dakota Commission on Drug and Alcohol Abuse in 2002, the coalition was asked to have a representative on the commission. Staff from Mercy Medical Center served in that role. As a result of the commission's work, legislation was passed addressing treatment for methamphetamine abuse – a growing problem in the Midwest – including matching funds for a federal grant supporting specific methamphetamine treatment programs.

Obstacles or Challenges

The greatest challenge the coalition faced in negotiating with legislators and payers was establishing credibility. In order to build credibility, coalition members had to prove themselves by making sure that any position they advanced related to treatment coverage was supported by data and case examples.

Success Factors

Over the years, the coalition established credibility with BCBSND, resulting in mutual trust and respect between providers and the insurer. Coalition members have learned to wield their influence effectively, so that if the insurers are not responsive, members feel confident going to the insurance commissioners, their legislators, and other power sources.

Lessons Learned and Advice to Others

For others interested in this type of initiative, the Mercy Medical Center experience provides some helpful advice:

- Before you appear before legislators or payers, set well-defined goals for what you want to achieve.
- Present your case from a negotiating, not adversarial, stance.
- Do your homework and be prepared. Be sure your position is well documented and supported by the facts.
- Be honest and don't try to embellish or distort the facts. If you don't know, don't bluff.
- Be proactive and stay ahead of the game. Use your

contacts to get all the information you can about what may be coming down the road.

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Addressing the Costs of Fragmentation in the Behavioral Health Care System

Ohio State University Medical Center, Columbus, OH

Summary

Hospital leaders at Ohio State University Medical Center have actively communicated with both internal and external stakeholders the clinical and economic benefits of developing better-coordinated systems of care for behavioral health needs and the costs to the community of not doing so.

Community and Hospital

Located near the geographic center of the state, Columbus is the capital of Ohio. In 2005, the estimated population was 693,983, with a median income of \$40,405 per household. Approximately 18.5 percent of the population lives below the Federal Poverty Level.

Ohio State University (OSU) Medical Center is central and southeastern Ohio's only academic medical center. Located on the OSU Medical Center campus, OSU Harding Hospital offers comprehensive behavioral health care services and programs for children and adolescents, adults, and older adults.

Program Overview

Out of Ohio's population of 11.4 million, it has been estimated that more than 2 million individuals experience a mental disorder. Only about half of those who need mental health treatment actually receive services. Expanding needs and limited resources have stressed the publicly funded system. Fragmentation and lack of coordination of behavioral health services have added to the cost of care and created challenges for patients, providers, and payers.

OSU Medical Center leaders have been on the forefront of advocacy for more integrated systems of care as a strategy for improving care and reducing costs. They have worked closely with the Ohio Department of Mental Health and the local Alcohol, Drug and Mental Health (ADAMH) Board to develop better coordination of inpatient and outpatient behavioral health services and more integration of medical and behavioral health care. A key message has been the high cost to the community of not treating the mental health disor-

ders of patients with significant medical problems. As a further step toward integrated services, hospital leaders have advocated before legislators and county commissioners for centers of excellence where both medical care and psychiatric care can be delivered. In Ohio's current system, patients with medical problems receive care at community health centers, many of which do not provide psychiatric services. Those with psychiatric problems go to community mental health centers. For patients who require both medical and behavioral health care, the system is complex and difficult to navigate. There is a lack of clinical coordination and communication among agencies and providers.

In order for integrated care to work, however, changes have to be made in the reimbursement system. Public payers and many private insurers will not cover charges for a medical visit and a psychiatric visit on the same day. OSU Medical Center leaders have begun to address this issue with the state department of mental health and the local behavioral health authority and have worked to convince legislators of the necessity of changing funding rules. They have also talked with some of the large employers and managed care companies in Columbus, communicating the message that providing coverage for medical/psychiatric care on the same day is beneficial to the patient, increases patient compliance, and ultimately saves money.

Hospital leaders have communicated the clinical value and long-term cost-effectiveness of service integration to internal stakeholders as well as external. Because primary care physicians are frequently the initial health care contact for patients with mental disorders, they are in a unique position to provide integrated care for persons with coexisting medical/psychiatric illnesses. Each year, OSU Harding offers web-based continuing medical education programs for primary care physicians on depression and chronic medical illness. They also conduct symposia directed toward both psychiatrists and primary care physicians on identifying and delivering emergency psychiatric services to various populations. A psychiatric consultation liaison program for medical/surgical

Case Examples

patients at the medical center has been very successful.

Program Impact

OSU Medical Center has realized a number of outcomes in response to their ongoing efforts to communicate the value of integrated care:

- The local ADAMH board has contracted with OSU Harding to provide psychiatric care to their patients with significant medical illnesses.
- OSU recently partnered with the Ohio Department of Mental Health and the local ADAMH board to develop and fund a professor of public psychiatry position within the OSU Department of Psychiatry. The goals of this placement are to improve and expand the behavioral health workforce, provide community-focused training experiences, and create a center of excellence for integrated care.
- OSU Department of Psychiatry was asked to create a system for psychiatric evaluation and treatment for depression for all patients admitted to the OSU Medical Center's heart hospital.

Obstacles and Challenges

The key challenge is convincing both public and private payers that the cost to cover behavioral health services is not prohibitive and pays off in the long run.

Success Factors

OSU Medical Center staff have been successful in getting their message across because they consistently advocate on many fronts — hospital administrators, physicians, state and local agencies, legislators, employers, insurers, and managed care companies.

Lessons Learned and Advice to Others

For hospital leaders interested in getting more involved in communicating the cost of care, OSU Medical Center's experience provides some helpful advice, including:

- No single component of the system can make the changes that are needed for integrated care because each is responsible for a different aspect of care and financing. Bring them all to the table and help them understand that providing behavioral health care and coverage is good for the patient, good for the community, and good for the economy.
- Tailor your message to your audience. For employers, provide data that clearly show that the cost of behavioral health care is small compared to the costs of employee absenteeism, loss of productivity, and extended medical care due to untreated psychiatric disorders. When working with state or community agencies, focus on how system improvements and evidence-based care can deliver more effective and more efficient services that reverse the higher costs of poor treatment. When talking with legislators, describe patients and their problems first, to create an emotional connection; then produce data to support the need for change.

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Recommendation 4b

Hospital leaders and their associations should become advocates for the public mental health system and its adequate funding.

Building a Coalition to Reform the Children's Mental Health System

Children's Hospital Boston, Boston, MA

Summary

Children's Hospital Boston collaborated with four other organizations to launch a long-term campaign calling for major reform of the state's mental health care system for children. They are not only seeking legislative remedies, but are also working with state administrative offices and with private payers to reach their goal of a more effective children's mental health system.

Community and Hospital

Boston is the capital of Massachusetts and the largest city in the New England states. In 2005, the population of Boston was estimated at 520,702. The average income in the city is \$42,562 per household, with 22.3 percent of the population living below the Federal Poverty Level.

Children's Hospital Boston is a 347-bed comprehensive center for pediatric health care located in the Longwood

Medical Area. In addition to serving its local community, Children's attracts patients from across the U.S. and from more than 100 countries each year.

Program Overview

It has been estimated that more than 100,000 – 70 percent – of the children and adolescents who need mental health services in Massachusetts do not receive them. Inconsistent mental health policy among state agencies and multiple but separate funding streams have resulted in a fragmented delivery system that is difficult to access and navigate.

Children's began to address mental health system reform issues internally and externally six years ago with the inception of the Child and Adolescent Mental Health Advocacy Initiative (CAMHAI). CAMHAI reflects the hospital's belief that systemic advocacy and policy reform are crucial to improving child mental health in Massachusetts. CAMHAI engages and interacts with a broad array of external partners, including policymakers, provider coalitions, parents, and community advocates, to further its agenda.

In 2006, Children's collaborated with the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), Health Care For All, Health Law Advocates, Inc., and the Parent/Professional Advocacy League to launch a long-term campaign calling for major reform of the state's mental health care system for children. The campaign was introduced by the release of a paper, "Children's Mental Health in the Commonwealth: The Time is Now," co-authored by Children's and the MSPCC. The paper describes a seriously flawed mental health care system and advances specific recommendations for prevention, timely diagnosis, and appropriate intervention for children.

One of the events providing impetus for the campaign was the decision in January 2006 in the *Rosie D. v. Romney* case. In that case, the U.S. District Court judge ruled that the Commonwealth of Massachusetts violated the federal Medicaid Act by failing to provide appropriate home-based mental health care to an estimated 15,000 children. This landmark decision and the subsequent remedies advanced by the Commonwealth will significantly alter the mental health system for children with publicly funded insurance. The coalition seized the opportunity for a call to action to address the needs of all children needing mental health care and treatment, regardless of their insurance type or level of need.

Just six weeks after the launch of the campaign, the coalition was successful in getting a bill introduced in both houses of the state legislature that incorporates ele-

ments of each of the coalition's recommendations. The legislation calls for changes that will:

- Identify mental illness earlier in children by reaching them in familiar and easily accessible settings, especially schools, early education programs, and pediatricians' offices.
- Ensure that when identified, the illness is treated in the least restrictive, appropriate setting.
- Improve insurance coverage for children with mental health needs.
- Restructure the oversight, evaluation, and provision of children's mental health services administered by the state.

Leaders of the campaign will continue to work on redrafting the bill and providing advocacy input and support as needed. The outcome of legislative activity will not be determined for another year; however, the coalition is already anticipating needs related to implementation and evaluation of new legislation.

Coalition leaders view their partnership as a five-year project. They are not only seeking legislative remedies, but are also working with state administrative offices and with private payers to reach their goal of an integrated mental health care system for all children needing care.

Program Impact

Although it is too early to gauge the full impact of this campaign, the coalition has succeeded in getting issues related to the children's mental health system in the public eye and on the platform for public debate. One recommendation advanced by the coalition – the need for a coordinator to oversee compliance in the implementation of remedial plans and court orders in *Rosie D. v. Romney* – has already been put into action by the administration.

Program Funding

Initially, each partner organization contributed fiscal, personnel, and material resources to support the initiative; however, as it became apparent that long-term resources were needed, the coalition began to consider alternative funding sources. In order to ensure that the partner organizations were not competing against each other in the philanthropic community, they developed a funding consortium for the campaign. Children's Hospital Boston provides the organizational resources to secure, manage, and distribute the funds.

Obstacles or Challenges

Because the behavioral health field tends to have a "siloed" and turf-based approach to system problem solving, organizations often advance their individual "fixes" for the portion of the system that affects their primary constituents, rather than for the system as a whole. The challenge for coalition leaders was to con-

vince participating organizations to see beyond their narrow interests and take a more holistic approach in order to build an enduring platform for change.

Success Factors

- Leaders at Children’s Hospital Boston view advocacy as a core component of their mission.
- The hospital has a proven track record for advocacy on a broad range of issues related to child and adolescent health.
- Over the last several years, hospital advocacy leaders have established strong relationships with other providers, consumer organizations, public and private agencies, government staff, philanthropic organizations, and others who share their interests and concerns.
- For a campaign of this magnitude, hospital leaders recognized that it was important to get senior staff from each of the partner organizations on board so that these individuals could network and get others engaged.
- The coalition established at the outset that they wanted not to just heighten awareness of the problems but actually drive policy solutions. They consciously and deliberately shaped every aspect of the initiative toward that purpose.

Lessons Learned and Advice to Others

For hospital leaders interested in advancing major advocacy campaigns, the Children’s Hospital Boston experi-

ence provides some helpful advice, including:

- Be sure you have buy-in and support from your hospital’s senior leadership for your advocacy campaign.
- Before you begin, assess where you are and where you need to invest your resources. You may need to start with building awareness or developing relationships before you can advance a major campaign.
- Recognize and leverage opportunities created by changing political climates, heightened public awareness of issues, media coverage of significant events in the field, or synergies with potential partners.
- Keep your advocacy campaign focused on issues that address the needs of your community or your target population, not just the needs of your individual institution. Sound advocacy can bring solutions that ultimately address your hospital’s concerns.
- Make sure that everyone at the coalition table has a voice and that coalition leaders are skilled in building consensus even when partners disagree.

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Supporting Advocacy for the Behavioral Health System

Moses Cone Health System, Greensboro, NC

Summary

Leaders and staff at Moses Cone Health System are strongly encouraged to become active in advocating for their areas of responsibility. Health system leadership have actively addressed the needs of behavioral health care at local and regional levels and have cultivated relationships with elected officials, opinion leaders, and policymakers, as well as local and national grassroots organizations.

Community and Hospital

Greensboro is located in central North Carolina, in the heart of the Piedmont Triad Region. In 2005, Greensboro had an estimated population of 208,552, with a median income of \$36,733 per household. Approximately 17.3 percent of the population lives below the Federal Poverty Level.

Moses Cone Health System, Greensboro, NC, is a multi-hospital system with a primary service area that covers five counties. The Behavioral Health Center, also located in Greensboro, is an 80-bed facility (50 adult

beds and 30 child and adolescent beds) that features three outpatient center programs and space for outdoor recreation opportunities.

Program Overview

Involvement in health care advocacy efforts at all levels has been a long-standing tradition at Moses Cone Health System. Members of the leadership team are encouraged to take active roles in advocacy and to be leaders in civic and community organizations. Hospital leaders participate in local and regional grassroots efforts through affiliation with agencies like the Mental Health Association in Greensboro, the North Carolina Psychiatric Association, and the North Carolina Hospital Association.

In 2001, the North Carolina General Assembly passed legislation that dramatically changed the delivery of publicly funded mental health care in the state, with the goal of shifting care to counties and the private sector and thereby reducing reliance on state hospitals. The

impacts of reforming the delivery system – both anticipated and unanticipated – have been key targets for advocacy efforts at the local and state levels.

In his role on the board of the Mental Health Association in Greensboro, the Moses Cone Health System Behavioral Health Center administrator helped prepare a letter to all members of the General Assembly advocating a moratorium on further state-mandated terminations of local mental health services and requesting additional funding to support the mental health system. Also sent to local newspapers and county commissioners, the letter pointed out that reforms have not only resulted in more limited and less effective care for consumers of mental health services, but at the same time have created problems elsewhere, such as in hospital emergency departments, homeless shelters, and jails. Although the moratorium was not adopted, approximately \$100 million was added to the budget of the state Division of Mental Health, Substance Abuse and Developmental Disorders.

Moses Cone Health System leaders partner with other community leaders to speak out on those issues that are the priorities of its community so that they can get attention from county commissioners, legislators, and other decision makers. Moses Cone, as the largest private employer in Guilford County, has a wide range of contacts and exposure in the community. They can leverage those connections to build relationships with local opinion leaders.

For example, after hearing about a mental health court that had been established in a neighboring county, Moses Cone leadership approached local district court judges to gather support for a similar court in Guilford County. Mental health courts have a separate docket for defendants, are handled by a designated judge, and incorporate a non-adversarial, team approach. They seek to reduce offenses by providing treatment for the mentally ill rather than punishment.

The judges were supportive, but there was no funding available. When the courts failed to obtain a grant from the state to fund this initiative, the Moses Cone Wesley Long Community Foundation was recommended as a source of funding. With support from the Mental Health Association and other providers, the foundation awarded the Guilford County Court System a \$261,000 grant over three years to launch the “alternative court.”

In addition to local involvements, Moses Cone leadership actively participates in national organizations that

are key players in advocating for better financing and better care for behavioral health patients. These organizations include the Section for Psychiatric and Substance Abuse Services of the American Hospital Association and the Committee on Behavioral Health Services within General Healthcare Systems of the National Association of Psychiatric Health Systems. Moses Cone Health System leadership emphasize the importance of being involved at every policy-making level because behavioral health services are impacted by every level.

Obstacles or Challenges

The greatest challenge has been getting the attention of those who are in positions to make decisions or influence change, such as executives of non-health care businesses, elected officials, and law enforcement personnel. Sometimes they are not knowledgeable and therefore not interested in behavioral health issues, but it is still necessary to keep trying to get the message across.

Success Factors

Moses Cone’s four essentials for successful advocacy are passion, commitment, perseverance, and involvement.

Lessons Learned and Advice to Others

For hospital leaders interested in getting more involved in advocacy, Moses Cone Health System’s experience provides some helpful advice, including:

- If you feel strongly about a specific matter, it’s important to make it known. Get your own message out, rather than letting others communicate for you.
- Find out who the key opinion leaders and decision makers are and spend time with them.
- Don’t wait for things to happen—make them happen. Be involved in creating the future. Don’t sit back and let others decide the future for you.
- Develop strong relationships with state legislators so that you can make sure they are getting the right messages. Any time you can supply one more piece of information to supplement – or counteract – other information they receive, you have a chance of creating another advocate for behavioral health care.

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Recommendations Summary

Community Needs Assessment

Recommendation 1

Hospital leaders should ensure that assessments of the health needs and resources in their community include specific attention to behavioral illness.

Hospital Behavioral Health Plan

Recommendation 2

Hospital leaders should review and evaluate the organization's behavioral health plan in light of identified community needs, the behavioral health needs of their patients, and available community resources.

Recommendation 2a

Hospital leaders should use a comprehensive financial and operational assessment to evaluate the benefits and economic value of behavioral health services to all operational components of the hospital.

Community Collaboration

Recommendation 3

Hospital leaders should encourage and actively participate in (1) developing a community-wide and/or regional plan for persons with behavioral health disorders and (2) coordinating community agencies addressing behavioral health needs.

Recommendation 3a

Hospital leaders should work with community agencies and support services and with state and local governmental authorities to ensure that all patients are treated in the most appropriate setting so that the hospital's backstop role is appropriately limited.

Recommendation 3b

Hospital leaders should create a formal plan that clearly defines its role and its established relationships for behavioral health with other providers, practitioners, and governmental and community agencies.

Recommendation 3c

Where inpatient acute beds for behavioral health patients are not available in a region, hospital leaders should seek governmental assistance that would allow hospitals to collaborate across multiple institutions in order to develop needed regional inpatient behavioral health services.

Adequate Financing

Recommendation 4

Hospital leaders should clearly communicate to public and private payers the costs required to care for behavioral health patients, especially those with chronic and severe conditions, and the costs to society of not treating those patients.

Recommendation 4a

To supplement public and private insurance for behavioral health services, hospital leaders should seek additional and specialized funding from foundations, employers, community philanthropies, grants, and governmental appropriations.

Recommendation 4b

Hospital leaders and their associations should become advocates for the public mental health system and its adequate funding.

Employer Practices

Recommendation 5

Hospital leaders should incorporate, as feasible and appropriate, the employer practices recommended by the National Business Group on Health in "An Employer's Guide to Behavioral Health Services" and share the recommendations with other employers in their community.

Advocacy

Recommendation 6

Hospital leaders should encourage and be actively involved with their regional, state, and national associations to broaden their engagement and advocacy for behavioral health, including:

- Promoting recognition that behavioral health is an essential component of positive health status;
- Continuing to advocate for parity in behavioral health coverage;
- Broadening the behavioral health advocacy agenda beyond payment;
- Supporting initiatives to increase the supply of behavioral health clinicians, including psychiatrists, psychologists, advanced practice nurses, and social workers;
- Encouraging primary care practitioners to identify and treat the behavioral health needs of their patients;
- Obtaining adequate payment rates for Medicaid and Medicare patients with behavioral health disorders;
- Assuring behavioral health is included in chronic care demonstration projects supported by Medicare and other payers;
- Supporting the financial needs of the public mental health system and increased public accountability for its performance;
- Monitoring major behavioral health initiatives (e.g., New Mexico's pooling of public funds) and sharing lessons learned with the membership, and
- Forming behavioral health partnerships and joint initiatives at the state and national level that mirror those needed in local communities.



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