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Triple Aim Strategies to Improve Behavioral Health Care

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American Hospital Association®

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Executive Summary

Using the Triple Aim framework, hospitals and health systems can effectively address behavioral health issues in the community.

- Improve the patient experience of care by **integrating behavioral and physical health care services**
- Improve the health of populations by **building networks or partnerships with community stakeholders to coordinate behavioral health care**
- Reduce the per capita cost of health care by **implementing alternative payment models to sustain needed services**

True behavioral and physical integration is the preferred model of care to achieve the best outcomes. For hospitals and health systems, an important element in integrating and improving access to behavioral health services is building community networks and partnerships to decrease care fragmentation and address gaps in care. Collaboration between hospitals and community stakeholders on behavioral health will create opportunities to:

- Respond to a high-priority community health need
- Integrate primary and behavioral health care services for patients
- Emphasize preventive care
- Implement new payment models and financial incentives

Actions steps, described in this guide, to start or enhance work by hospitals and communities to improve behavioral health include:

- Bring together community stakeholders and establish a shared strategic mission and vision, so all have ownership
- Involve a variety of community stakeholders, recognizing each partner's strengths
- Ensure the engagement and participation of patients and families
- Get buy-in as well as mutual investment by community partners; clarify roles
- Develop a multiyear, multiorganization plan, including opportunities and barriers
- Collect and report behavioral health metrics related to quality and access

Introduction

This guide describes strategies, action steps and examples for hospitals, health systems and community stakeholders working together to develop a well-coordinated, accessible, affordable and accountable system for delivering behavioral health care. Case studies in the guide provide examples of how hospitals and health systems, working with community partners, can improve the quality of and access to behavioral health care, while bending the cost curve and improving community health.

Addressing behavioral health in the health care community has become one of the most promising and challenging issues facing hospitals and health systems today. Consider that half of all Americans will develop a behavioral health disorder in their lifetime, with 25 percent of adults experiencing a mental illness each year.[1] Research shows that adults with serious mental illness die earlier at a disproportionate rate than that of the general population. In addition, rates of illness and death in this population have been increasing.[2] One recent research study estimates that about 8 million deaths worldwide each year can be linked to mental illness.[3]

Behavioral health disorders also are prevalent among children. Studies show that 13 percent to 17 percent of children living in the United States experience a mental disorder each year.[4] According to the Centers for Disease Control and Prevention, without early diagnosis and treatment, children with behavioral health disorders can have problems at home, in school and in forming friendships—all of which can interfere with a child's development and continue into adulthood. Improving early identification, intervention and treatment of behavioral health disorders for children and adolescents is crucial, as 50 percent of chronic mental illness can be identified by age 14, and 75 percent by age 24.[5]

To maintain and improve the health of their patients and communities, hospitals and health systems are working to achieve the Triple Aim: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care. Integrating physical and behavioral health services throughout and across the continuum of care, while partnering with community stakeholders to expand access to appropriate behavioral health services in the least restrictive setting, can help hospitals and health systems achieve Triple Aim goals.

Behavioral and physical health

Historically, behavioral health care and physical health care have operated as separate and minimally coordinated systems of services in the United States.[6] Yet if we envision health as "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity," it becomes evident that addressing the behavioral health needs of a population is crucial to achieving a healthy community.[7] Behavioral health is intertwined with physical health: The mind and body are connected, with each affecting the other.

Behavioral health disorders encompass both mental illness and substance abuse disorders. Mental illnesses are specific, diagnosable disorders. Each is characterized by intense alterations in thinking, mood and/or behavior over time. Substance abuse disorders are conditions resulting from the inappropriate use of alcohol, prescription drugs and/or illegal drugs. Behavioral health disorders may also include a range of addictive behaviors, such as gambling or eating disorders, characterized by an inability to abstain from the behavior and a lack of awareness of the problem.

Sources: HHS, Mental Health: A Report of the Surgeon General, 1999
American Society of Addiction Medicine, 2011

It is estimated that nearly 17 percent of adults in the United States have co-occurring physical and behavioral health conditions, which combined present many treatment challenges.[8] A physical health condition may exacerbate a behavioral health condition, while a behavioral health condition may hinder compliance with treatment for a physical health ailment. In addition, patients with comorbid behavioral and physical health conditions incur high health care costs, with much of the difference attributable to higher medical costs—estimated to be tens of billions of dollars.[9]

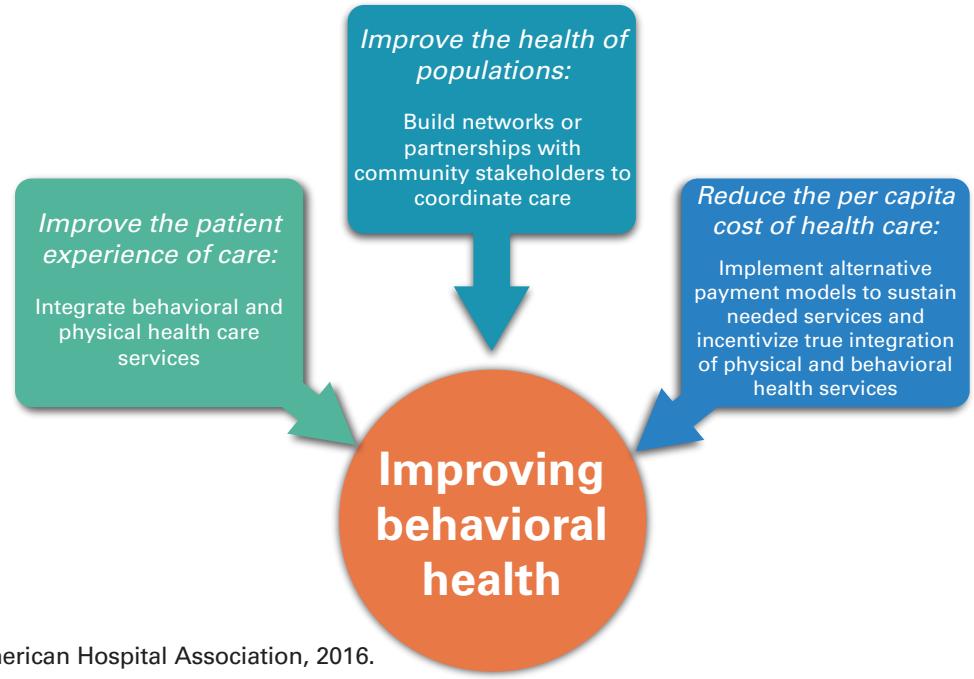
Identified community health need

Hospitals and health systems are increasingly identifying behavioral health as a pressing health care need in their communities. In 2014, the Health Research & Educational Trust reviewed 300 nationally representative community health needs assessments to identify key trends. Behavioral health was the second-most commonly prioritized community health need (64 percent of hospitals) after obesity (70 percent), while related issues such as substance abuse and chronic disease management were also commonly ranked (44 percent and 32 percent of hospitals, respectively).[10] Although behavioral health disorders are gaining prominence as a population health issue, comprehensive models to improve and integrate behavioral and physical health care can be challenging to find and implement.

The Triple Aim and Behavioral Health

Effectively addressing behavioral health issues in the community calls for hospitals and health systems to: 1) integrate behavioral and physical health care services; 2) build networks or partnerships with community stakeholders—other hospitals or health systems, clinics, social service agencies, and local and state organizations—to coordinate care; and 3) implement alternative payment models to sustain needed services. This approach aligns with the Triple Aim to improve the patient experience of care, improve the health of populations and reduce the per capita cost of health care. See Figure 1.

Figure 1. Using Triple Aim Strategies to Improve Behavioral Health



Source: American Hospital Association, 2016.

Improve the Patient Experience of Care:

Integrate Behavioral and Physical Health Care Services

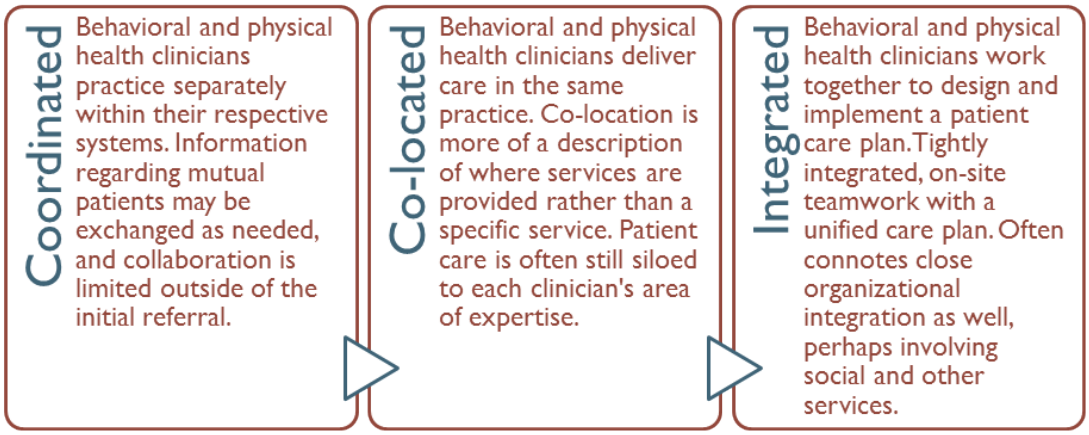
Despite the high rate of comorbidities among people with behavioral health disorders, behavioral health care historically has been separated from physical health care, with minimal coordination of care. This fragmentation of the health care system can lead to ineffective, disjointed and redundant care, as well as gaps in care.[11] It is estimated that, among people who have a behavioral health issue, about 20 percent will see a primary care provider for treatment, another 20 percent will see a mental health provider—such as a psychiatrist or therapist—and 60 percent will get no treatment.[12]

Unaddressed behavioral health issues can lead to unnecessary emergency department visits and uncontrolled chronic diseases, increasing the cost of care. According to recent studies, people with a chronic illness like arthritis, asthma and diabetes are 30 percent to 35 percent more likely to have a comorbid mental health condition, with annual costs ranging from 60 percent to nearly 170 percent more. Among people with a chronic illness such as migraine or chronic obstructive pulmonary disease, about 40 percent or more have a comorbid mental health condition, with annual costs increasing from about 150 percent to nearly 190 percent.[13]

True behavioral and physical health **integration**, as described in Figure 2, is the preferred model of care to achieve the best outcomes. **Coordinated** care and **co-located** care, while positive, are less desirable and often achieve suboptimal outcomes, which can frustrate providers. The Agency for Healthcare Research and Quality outlined stages of integration. The AHA's Hospitals in Pursuit of Excellence guide "Integrating Behavioral Health Across the Continuum of Care" provides information about frameworks and models for behavioral health integration and includes a list of key questions for hospital and health system leaders to begin integrating behavioral health or to enhance current efforts.

> *Integrated behavioral and physical health care results from a "team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."*
>
> *—Agency for Healthcare Research and Quality*

Figure 2. Stages of Behavioral Health Integration



Source: Agency for Healthcare Resource and Quality, 2011.

Improve the Health of Populations:

Build Networks or Partnerships with Community Stakeholders to Coordinate Care

For hospitals and health systems, an important element in integrating and improving access to behavioral health services is building community networks and partnerships to decrease care fragmentation and address gaps in care.

Examples of networks and partnerships include:

- Coordination with local organizations and stakeholders—such as schools, pediatricians, primary care physicians, employers and health plans—for prevention, screening and education
- Collaboration in a structured network with many community stakeholders—such as community-based clinics, federally qualified health centers, community mental health agencies, primary care providers, public health departments, schools, law enforcement agencies, housing authorities, homeless shelters, faith-based organizations, health insurance companies, community development financial institutions, employers and relevant state agencies
- Contractual affiliations, such as joint ventures

Table 1 outlines considerations for hospitals and health systems as they develop partnerships with community stakeholders to improve behavioral health. In addition, the case studies in this guide highlight examples of hospitals collaborating in a structured network with many community stakeholders.

Table 1. Building Community Networks and Partnerships to Improve Behavioral Health

General Considerations for Hospitals and Health Systems:

- What is the rate of comorbidities between chronic diseases and behavioral health issues in your patient population? How do these comorbidities affect readmissions?
- Where does behavioral health (including substance abuse) rank in your community health needs assessment?
- Which populations in your community are most at risk?

Coordination and Integration for Prevention and Screening:

- How could a screening process be integrated into regular appointments? Component on electronic health record? How can this approach be applied to children and youth?
- Is there a process for clinicians to follow if they suspect behavioral health issues? What other staff could be engaged for prevention or screening?
- What training do clinicians need to detect behavioral health issues?
- To what extent can you identify and address risk factors of behavioral health issues? To what extent can you improve preventive factors?
- What social and economic circumstances in your community are contributing to the development of behavioral health issues?

Community Collaboration or Network:

- Which stakeholders in your community are concerned with behavioral health issues? Schools? Public health organizations? Community-based clinics/federally qualified health centers? Law enforcement agencies? Health insurance companies? Community development financial institutions?
- What skills and resources are unique to each stakeholder? How can those skills and resources be leveraged to address behavioral health needs in the community?
- What gaps exist in community services?

Payment Models to Sustain the Work:

- Are there any organizations in your community that specialize in behavioral health?
- What payment models exist in your state to cover integrated behavioral health services?
- What payers are interested in trying alternative payment methodologies?
- How are physical and behavioral health care services between providers and different organizations being coordinated?

Source: American Hospital Association, 2016.

Action steps

Collaboration between hospitals and community stakeholders on behavioral health will create opportunities to respond to a high-priority community health need, integrate primary and behavioral care for patients, emphasize preventive care, and implement new payment models and financial incentives. As collaborations between hospitals and commnity stakeholders form, it is important that both groups determine resources and access points for care. Recommended steps to start the work toward aligning efforts and building community networks or partnerships to improve behavioral health include:

1. Bring together community stakeholders to work toward one goal of improving behavioral health and overall health. Establish a **strategic mission and vision** for health shared by all the community partners so that all partners have a sense of ownership. Conducting a community health needs assessment that includes survey questions about behavioral health issues will help the stakeholders identify and prioritize health needs.
2. Involve **a variety of community stakeholders** as partners. It is important to recognize the quality of the community partners and what strengths each partner brings to the table to align toward the vision and goals. Stakeholders may include primary care providers, pediatricians, emergency medical personnel, law enforcement agencies, community mental health agencies, housing authority agencies, homeless shelters, patients, family members, community members, independent mental health providers, relevant state agencies, local businesses, rural health clinics, federally qualified health clinics, peer counselors, local NAMI (National Association of Mental Illness) chapters, United Way, Salvation Army, schools and universities.
3. Ensure the **engagement and participation of patients and their families**.
4. Get **buy-in as well as mutual investment by community partners**, at a level appropriate for each partner's size. Investment can include in-kind services, staffing, facility resources as well as financial and other types of support. Clarify the roles and responsibilities of each partner.
5. Develop a **multiyear, multiorganization plan** that is updated biennially to address community needs. This plan describes the strategic mission and vision and identifies potential barriers and opportunities unique to the community.
6. Focus on the data. Collect and report **behavioral health metrics** related to quality of care and patient access. At hospitals and health systems, multidisciplinary teams may need to help customize the electronic health record system for behavioral health. Clinicians can use registries and data tracking tools to manage the care of patients with chronic diseases, and to monitor screening and health maintenance activities.

These action steps call for effective communication, teamwork, and well-coordinated workflows between health care professionals in a hospital or health system, as well as strong collaboration between organization and community leaders, staff, patients and families. This guide includes case studies and a list of resources with further information and best practices in all of these topic areas.

Metrics

To evaluate the effectiveness of community networks and partnerships established to integrate and improve behavioral health care and achieve the Triple Aim, the participating organizations and the network or partnership should track specific measures, such as:

- Number of patients referred from a hospital and successfully connected with treatment in the community
- Increase in percentage of patients who keep their initial, scheduled appointment
- Percentage of patients screened for depression and Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs – and referred to treatment if needed
- Percentage of patients not improving that received case review and psychiatric recommendations and referral to psychiatric services, and received same
- Percentage of patients not improving who are referred to and treated by a specialty behavior health provider
- Reduction in total number of psychiatric emergency department visits by people with a primary psychiatric/addiction disorder and by those with physical health disorders and comorbid behavioral health disorders
- Reduction of inpatient days after admission to a community mental health center intensive outpatient program, residential treatment center, partial hospitalization program or other appropriate post-acute treatment services
- Reduction in six-month hospital readmissions of patients with a primary psychiatric/addiction disorder and by those with physical health disorders and comorbid behavioral health disorders
- Patient improvement on the Global Assessment of Functioning scale at one-year follow-up appointment
- Return on investment, based on average Medicaid claim cost savings per patient annually for all health care services

In addition, the Institute of Medicine report "Vital Signs: Core Metrics for Health and Health Care Progress" identifies a core measure set that includes best current measures for "well-being," "addictive behavior," and "life expectancy." These measures could be used to evaluate individual and community health outcomes related to behavioral health.

Reduce the Per Capita Cost of Health Care:

Implement Alternative Payment Models to Sustain Needed Services

Delivering better integrated behavioral health care can be impeded by policies that may separate the payment of physical and behavioral health services. Separate payment structures compel some providers to operate within professional silos. Behavioral health interventions in an integrated model can reduce costs and readmissions. Savings from reduced costs could be accrued and reapplied to behavioral health to support providers' services.[14] An integrated model focuses on total value across the care continuum, across any setting. Care should be integrated not only within health care settings but also with community partners, to provide the best care in the right setting at the best value.

Payment reform

The current health care payment model—fee for service—is becoming outdated as government entities, payers, consumers and providers move to value-based payment models. Hospitals and health systems will need to adapt and deploy a variety of payment models that best fit within the structure of their organization.[15] New payment methods can assist in better financing and sustaining integrated behavioral health care. For example, many health care organizations bundle payments for specific illnesses or episodes of care. Others are moving toward global payment models for primary care that could include behavioral health.[16]

Improving care, reducing costs

Research studies confirm that an integrated care model that includes behavioral health has a

significantly positive effect on the patient's health and reduces the total cost of care. Examples of integrated models are accountable care organizations, community care organizations, integrated delivery systems, clinically integrated networks and patient-centered medical homes. These models raise the quality of care and reduce costs, and they also include some form of a global or capitated payment system that allows a hospital or health system to recover costs, given reductions in the use of more expensive services.[17]

A Milliman report on the economic impact of integrated health care found that "effective integration of medical and behavioral care could save $26 billion to $48 billion annually in general health care costs." Integrated medical and behavioral health models expand access to quality care and leverage limited resources, according to the report. When a patient's mental illness is effectively addressed, the individual is better able to manage chronic medical illness, which reduces the risk for continual and new medical problems.[18]

Health care providers and payers can work toward structuring medical care payment policy to promote behavioral health interventions, linking with supportive resources and organizations in the community and rewarding efforts to improve population health. Financial incentives also may be tied to promoting healthy behaviors and community initiatives. Future guides may address strategies and recommendations and highlight case studies about these topics.

Conclusion

The rapidly changing health care field demands a well-coordinated, accessible, affordable and accountable system for providing quality care to patients. By integrating behavioral and physical health care services, building networks or partnerships with community stakeholders to coordinate patient care and implementing alternative payment models to sustain needed services, hospitals and health systems can achieve the Triple Aim. All these efforts will improve the patient experience of care, improve population health and reduce per capita cost.

Case Studies

Behavioral Health Network of Greater St. Louis

Overview

The Behavioral Health Network of Greater St. Louis (BHN) was established in 2010 based on recommendations from a four-year Eastern Regional Behavioral Health Initiative, which was coordinated by the St. Louis Regional Health Commission. Recommendations called for a "permanent structure for ongoing…behavioral health system planning and coordination" across the region. A nonprofit 501(c)(3) organization, the BHN coordinates prevention, treatment and recovery support services for children and adults—targeting uninsured, underinsured and underserved populations, in particular—residing in the city of St. Louis and six surrounding counties. More than 35 key organizations make up the network, which includes clinical and nonclinical staff from hospitals, health systems and health centers; representatives from local and state agencies and organizations, such as the St. Louis County Department of Health, St. Louis County Police Department, and Missouri Department of Mental Health; staff from local universities; and community advocates and volunteers.

Interventions

The BHN works to eliminate barriers that prevent people from getting needed care and treatment, including:

- Sponsoring and promoting forums for planning and events that build public awareness and understanding
- Increasing efficiencies in the health system through collaborative planning and coordinating care across organizations that touch the lives of people with mental illness and addiction problems
- Advocating for needed policy, program and financing changes to facilitate early intervention and effective treatment
- Conducting gap assessments, including on youth transition to adulthood, and continuing to build capacity to track and analyze behavioral health data

The BHN's Hospital-Community Linkages Project helps improve care coordination for patients between the region's local hospitals and community mental health providers. The project targets 1) adults who are discharged from acute care behavioral health hospital units and 2) frequent users of hospital emergency departments and inpatient settings, with the primary goal to reduce preventable hospital readmissions across the region. These initiatives serve patients with ongoing behavioral health needs who are uninsured or underinsured and not currently connected to a health provider for follow-up care coordination. Liaisons from participating providers meet regularly, along with a policy workgroup, to discuss coordination issues, identify best practices in follow-up care coordination and ensure the regional action plan is being implemented.

The Regional Housing Collaborative was formed after a needs assessment and resources inventory of the region identified the lack of housing as a critical need of people with mental illness and substance issues. The collaborative is working to address five priority areas, including developing and implementing a plan to increase capacity to provide supported housing services; developing a streamlined information and access system in the region; expanding partnerships and participation in regional planning with key stakeholders; and fostering a common regional agenda for housing supports. The BHN serves as the convener for the collaborative, with four other agencies leading the priority areas.

The Bridges to Care and Recovery initiative has a mission to mobilize clusters of churches in North St. Louis City and North County to support the behavioral health treatment and recovery of congregants and other community members with behavioral health disorders. Key objectives are to reduce stigma through creating "behavioral health friendly" churches; divert residents from health emergency and the criminal justice systems; and strengthen partnerships between the safety-net system of care and the faith-based community. This is part of the program's and network's overall mission of extending the system of care for people challenged with behavioral health disorders. This initiative evolved from an examination of the "critical interface between the hospital, homeless service, law enforcement and behavioral health systems in their work with people with behavioral health needs." To develop Bridges, the BHN convened community stakeholders to develop recommendations to address service gaps and strengthen collaboration to improve behavioral health care in the region. This initiative is funded by SSM Health St. Mary's Hospital, SSM Health Saint Louis University Hospital and the Missouri Department of Mental Health.

Results

Results from BHN programs include:

- Nearly 2,800 clients referred by area hospitals successfully connected with community treatment
- 47 percent reduction in psychiatric ED visits
- 57 percent reduction in inpatient days after admission to a community mental health center
- Significant improvements in clients' quality of life, including a decrease in unemployment and homelessness and increase in overall functioning based on the Global Assessment of Functioning scale at six-month follow-up
- Projected 287 percent return on investment with an average Medicaid claim costs savings of $5,450 per patient annually for all health care services
- 25 churches trained as "behavioral health friendly" churches (requires 19 hours of training, part of Bridges to Care and Recovery initiative)
- 33 BCR wellness champions completed mental health first aid training
- 42 BCR volunteers completed training
- 70 people identified through the BCR faith community were referred to behavioral health treatment

Lessons Learned

Keys to success of the Behavioral Health Network of Greater St. Louis have been:

- Inclusiveness—structuring forums so a variety of stakeholders can contribute to planning; securing the input of top leadership, mid-level managers, front-line staff, consumers of services, and caregivers has been particularly important
- Accountability—supported by incorporating, tracking and reporting performance measures to inform policy and service development decisions and processes
- Transparency—characterized by all stakeholders openly sharing the collective work of the behavioral health network with each other

The BHN focuses on planning and coordinating, not on service delivery, so the organization remains neutral and avoids competing with providers involved in the network. Whenever possible, the network seeks ways to bring constituents together to better serve the region, identifying opportunities to build on connections among safety-net providers and help those with behavioral health challenges.

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Norwalk Hospital, Greater Norwalk Community Care Team
Connecticut

Overview

In April 2014, Norwalk Hospital, located in Connecticut, partnered with community stakeholders to establish the Greater Norwalk Community Care Team (CCT), a collaborative network of local organizations and agencies. The CCT's objective is to deliver enhanced care to individuals with complex medical and psychosocial challenges, in effect providing wraparound services to individuals with housing instability who are suffering from behavioral health and/or substance abuse issues or serious medical conditions. The CCT was formed to function as a "population-based treatment model that aligns with a current national move toward patient-centered and accountable care goals."

The Greater Norwalk CCT is comprised of representatives from local community and state programs, agencies and institutions. Their mission is to develop, review, implement and monitor treatment plans for identified at-risk individuals. In addition to representatives from Norwalk Hospital, this diverse group includes representatives from AmeriCares, Behavioral Health Partnership, Bureau of Rehabilitation Services, Catholic Charities, Connecticut Counseling Centers, Connecticut Renaissance, Continuum of Care, Inc., Day Street Clinic, Domestic Violence Crisis Center, DuBois Center, Family and Children's Agency, Homes with Hope, Husky Health Program/Community Health Network of CT, Keystone House, Liberation Programs Inc., Mid-Fairfield AIDS Project, New Reach, Norwalk Board of Education, Norwalk Community Health Center, Norwalk Health Department, Norwalk Housing Authority, Norwalk Police Department, Norwalk Probation Department, Open Door Shelter, Public Defender's Office, Recovery Network of Programs, Shelter for the Homeless, State of CT, State of CT Department of Mental Health & Addiction Services, State of CT Department of Social Services, Supportive Housing WORKS, Triangle Community Center, U.S. Department of Veterans Affairs, U.S. Social Security Administration, Westport Department of Human Services, Westport Police Department and Workplace, Inc.—among others.

Interventions

A grant-funded CCT navigator organizes and facilitates the CCT's collaborative weekly meetings, keeping notes of patients' individual treatment plans and coordinating the work among the different organizations to ensure follow-up. The navigator works to improve outcomes by referring targeted individuals to appropriate community-based mental health and substance abuse services and also serves as a liaison to coordinate and leverage existing community-based resources. Funding from the United Way of Coastal Fairfield County, Norwalk Hospital Foundation and Fairfield County's Community Foundation supports the navigator's work.

Approximately 15 representatives from various community agencies—listed in the Overview section—are present at the weekly meetings. The group discusses 12 to 17 "clients" or cases each week. Typically, one or two are new cases and the remaining are follow-up discussions. Clients sign a "shared consent" before their case is discussed at the CCT meetings. The consent must be renewed annually by each client. Individuals referred meet the general criteria of ED visit threshold of seven visits in six months and/or status of being homeless. Examples of referrals include a middle-aged, homeless immigrant with several alcohol use disorder and more than 70 visits to the ED in one year and an older client with mental illness, diabetes, cancer, substance abuse disorder and nearly 15 ED visits in one year.

The weekly community-based meetings provide an opportunity for team members to collaborate and regularly analyze utilization data, including demographics and diagnoses; connection to medical, psychiatric, substance abuse and case management services; housing placement; maintenance of insurance coverage; and frequency of emergency department visits. This data analysis guides the team's efforts in creating individualized care plans. CCT members work to ensure the health and social needs of individuals are addressed in a timely manner and that no one falls through the cracks. The navigator monitors ED utilization on a monthly basis, with near real-time results that allow for quick determination of program effectiveness.

Results

From spring 2014 to fall 2015, the Greater Norwalk CCT developed care plans for 177 individuals. Outcomes for patients with care plans include maintained sobriety, mental health stabilization, improved access to care, a reduction in inappropriate ED visits by nearly 27 percent and reduced homelessness by 25 percent. In addition, a second CCT has been established to address the needs of vulnerable populations across the Western Connecticut Health Network.

Lessons Learned

The past 18 months have illustrated that CCT-inspired community collaboration extends well beyond the weekly meetings. The relationships formed between community providers have opened other avenues for communication and improved care for patients outside the CCT. To further break down silos, a regional CCT leadership committee, Opening Doors of Fairfield County, was formed and includes Norwalk, Danbury, Stamford and Bridgeport hospitals. This group organized and conducted a well-received regional CCT forum to provide education and strategic planning for newly developing teams. Opening Doors of Fairfield County also hosted a substance abuse forum in December 2015 to help provide further momentum to improve access to treatment.

Although there has been significant success, limited access to substance abuse treatment and lack of patient motivation have been barriers to further improving CCT outcomes. Norwalk data has shown the subset of frequent users with substance abuse and alcohol dependence accounts for the largest number of homeless individuals and ED visitors. The Norwalk CCT is working to fill this treatment gap by collaborating with Liberation Programs Inc. for access to a rehabilitation bed (housing), irrespective of insurance coverage. Adding peer outreach specialists to improve patient engagement is another goal of the team. Moreover, to provide continued success, CCTs require a dedicated navigator, engaged community providers and support of the local hospital leadership, which Norwalk has been fortunate to have.

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Sanpete Behavioral Community Health Network
Sanpete County, Utah

Overview

Sanpete Valley Hospital, a critical access hospital with 18 licensed beds in Mount Pleasant, Utah, is leading behavioral health outreach efforts in rural Sanpete County. Clinicians at the hospital, which is part of Intermountain Healthcare, had noticed individuals with behavioral health issues who were becoming repeat patients in the emergency department. About the same time, Intermountain Healthcare was looking to roll out the behavioral health community networks it had started in urban areas into rural areas, and a retired physician from Sanpete Valley Hospital was interested and tapped to lead the program. This physician had been involved in many meetings and activities throughout the state to address health care for underserved populations. When employees from Intermountain Healthcare and the physician crossed paths at a state meeting on health care, the planning started.

Interventions

In October 2013, Sanpete Valley Hospital began working with the Central Utah Counseling Center, a local agency that treats patients who receive Medicaid and have substance abuse issues. Sanpete Valley Hospital initially had two private therapists, one who focused on individuals with mental issues, and the other, on individuals with substance abuse issues. Two months later, to address another identified need, the network added a therapist to work with adolescents and children. Intermountain provides a yearly grant that the hospital uses to provide free or discounted medications for these patients.

The Sanpete Behavioral Community Health Network officially launched in 2014. One of the requirements to get the grant from Intermountain Healthcare to establish the initiative was creating a community network. Several people from Sanpete Valley Hospital met to brainstorm and identify people and organizations in the community who had a vested interest in mental health. The group was able to bring together representatives from several cities in the county, religious leaders, school administrators from the K-12 school district and the local junior college along with people who ran support and addiction recovery groups, therapists, staff from medical clinics and prominent citizens. After bringing together these people, the health network created brochures and went out into the community to talk about what the new network was offering. The main focus was reaching out to the hospital, clinics, workforce services and schools.

About 15 different organizations are currently involved with the health network, which includes church groups, school districts, the Central Utah Counseling Center, behavioral therapists, community leaders and hospital staff (social worker, patient advocate, administrator, two nurse managers, therapists and a physician). The network meets monthly, and a subgroup for youth meets every other month. Sanpete Valley Hospital helped start the network's subgroup that focuses on adolescents. Two local school districts became more invested in the program after two high school students committed suicide in one weekend.

Sanpete Valley Hospital and the health network offer multiple behavioral health services, including grief support services, a free parenting group, mental health first aid classes and periodic screenings. The grief support group was already in place but not well attended before being linked to the behavioral community health network. All other services are new.

The hospital's social worker coordinates the behavioral health screenings, conducted separately and also in conjunction with diabetes education days and health fairs. Clinicians in the area volunteer their time to lead the other groups and classes. In addition, a physician at the hospital oversees medication management for adults and adolescents. The hospital partners with the National Alliance on Mental Illness to offer several support groups. Many of the services are provided at low or no cost to patients who qualify

Results

The Sanpete Behavioral Community Health Network served more than 130 patients in 2014 and more than 300 patients in 2015. The network's efforts have helped reduce stigma about behavioral health issues and led to open discussions throughout the community. Hospital staff have been invited to talk about behavioral health on the radio, in churches and at other venues. In addition, physicians, nurses, other hospital staff and community leaders are being more proactive about behavioral health while also training people in the community about what to look for. For example, local schools have started the Hope Squad, which trains students to recognize the signs of depression and be available to talk with other students to get them the help needed to prevent suicide.

In addition, the number of behavioral health patients who present at the hospital's emergency room has decreased. For example, since working with the program, one patient who had visited the ED weekly has not visited for the past three years. Many people who were frequent ED visitors had anxiety or depression that would manifest itself as headaches, chest pain, stomachaches, pain in general, panic attacks, suicidal thoughts or suicidal attempts. By starting these patients in therapy and managing their medications, the behavioral community health network helps them manage their symptoms without it becoming a crisis. The network also links patients to support groups so they can continue to manage their behavioral health at little or no cost.

Lessons Learned

The first nine months were slow in getting the behavioral community health network going, but it grew exponentially after catching hold. Going out into the community, talking about behavioral health issues and being persistent were key in encouraging other people and organizations in the community to step forward and participate. A designated leader or champion is needed. Sanpete Valley Hospital is working to become self-sustaining in providing therapy services, especially as visits from repeat patients to the ED decrease. The cost savings are being put back into the health network—providing better care for the community in a more cost-efficient way. The network has released a community health resource guide and plans to set up a website and increase preventive measures.

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Resources

General

"Behavioral Health" on American Hospital Association website
http://www.aha.org/advocacy-issues/initiatives/behavioral/index.shtml

A Guidebook of Professional Practice for Behavioral Health and Primary Care Integration: Observations from Exemplary Sites (by Deborah J. Cohen, et al., Agency for Healthcare Research and Quality, March 2015)
http://integrationacademy.ahrq.gov/sites/default/files/AHRQ_AcademyGuidebook.pdf

The Lexicon for Behavioral Health and Primary Care Integration (April 2013)
http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

Improve the Patient Experience of Care: Integrate Behavioral and Physical Health Care Services

"Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes" (TrendWatch, American Hospital Association, January 2012)

Integrating Behavioral Health Across the Continuum of Care (American Hospital Association, February 2014)
http://www.hpoe.org/resources/hpoehretaha-guides/1588

Improve the Health of Populations: Build Networks or Partnerships with Community Stakeholders to Coordinate Care

"Community Partnerships" (by Rebecca Chickey in *Spectrum*, September/October 2015)
http://www.shsmd.org/resources/files/SHSMDSpectrumSeptember-October%202015-Chickey.pdf

Hospital-based Strategies for Creating a Culture of Health (American Hospital Association and Robert Wood Johnson Foundation, October 2014)
http://www.rwjf.org/en/library/annual-reports/presidents-message-2014.html

Improving Patient Safety Culture Through Teamwork and Communication: TeamSTEPPS (American Hospital Association, 2015)
http://www.hpoe.org/resources/hpoehretaha-guides/2598

The Role of Small and Rural Hospitals and Care Systems in Effective Population Health Partnerships (American Hospital Association, June 2013)
http://www.hpoe.org/resources/hpoehretaha-guides/1385

Reduce the Per Capita Cost of Health Care: Implement Alternative Payment Models to Sustain Needed Services

Care and Payment Models to Achieve the Triple Aim (American Hospital Association, 2016)
http://www.aha.org/research/cor/care-payment/index.shtml

Cost Assessment of Collaborative HealthCare (CoACH). (Eugene S. Farley, Jr. Health Policy Center, 2015)
http://www.farleypolicycenter.org/coach/coachcosttool/welcome.html

Economic Impact of Integrated Medical-Behavioral Healthcare (Milliman Inc., April 2014) http://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Milliman-Report-Economic-Impact-Integrated-Implications-Psychiatry.pdf

Endnotes

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