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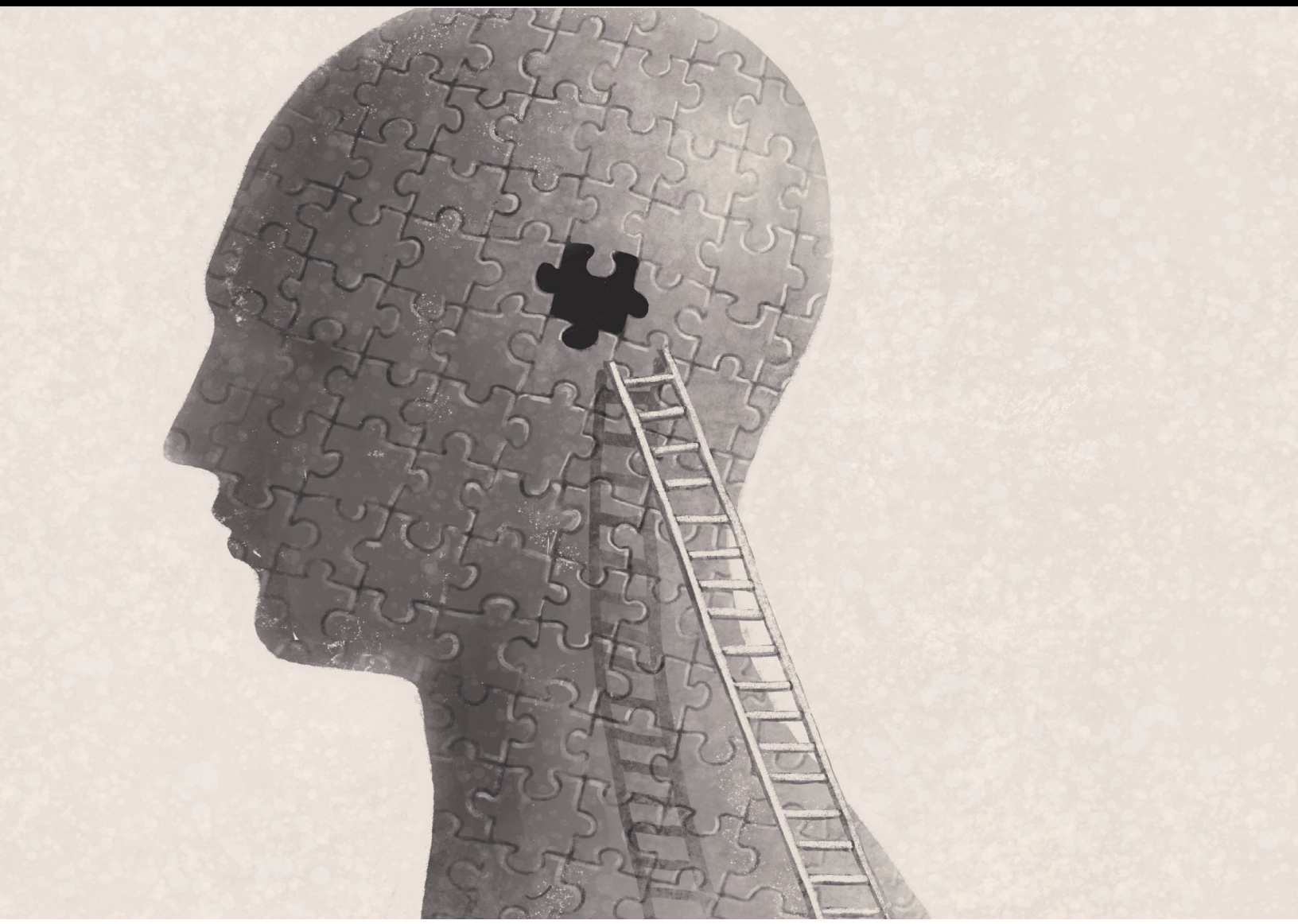

KNOWLEDGE EXCHANGE

Transforming the Behavioral Health Journey

Finding the Path to a Sustainable, Service Continuum

Introduction

Transforming the Behavioral Health Journey

Finding the Path to a Sustainable, Service Continuum

By 2026, an estimated one in four Americans will require behavioral health services according to Trilliant Health research. Behavioral health disorders include both mental illness and substance use disorders. To drive meaningful change and solve critical challenges affecting behavioral health care delivery, health systems increasingly are seeking ways to drive innovative, transformative change around this service line. This Knowledge Exchange ebook explores how hospitals and health systems are investing and partnering in behavioral health, where they face challenges and opportunities for strategic alignment and financial sustainability, and how they aim to leverage behavioral health to support their communities.

10 strategic initiatives and investments

that health leaders can prioritize for sustainable behavioral health services in their communities

01

Identify community behavioral health needs and gaps in care to develop a comprehensive, integrated strategy across disciplines and settings as part of health and the continuum of care.

02

Integrate physical and behavioral care in primary care settings, including pediatrics and obstetrics, as a way to focus on early prevention, screening and treatment of all individuals who need behavioral health services.

03

Partner, collaborate and joint venture with other hospitals, providers,schools, community organizations, including CMHCs and CCBHCs, and companies to build and create sustainable and coordinated behavioral health services.

04

Research new approaches to addressing psychiatric emergencies, such as EmPath units, behavioral health urgent care; integrated physical and behavioral health services in the emergency department; and stabilization programs to determine the best fit for the needs of your community.

05

Establish a coordinated community response to crisis situations, working in partnership with other health care providers, EMS, and law enforcement to provide the patient with the appropriate level of treatment and stabilization; often avoiding incarceration, admission or boarding in the emergency department.

06

Consider alternative use of vacant space in facilities and malls as locations for pieces of the behavioral health care continuum, such as outpatient and/or intensive outpatient programs.

07

Examine the existing continuum of behavioral health services, matched against community needs, and research options, such as joint ventures, grants, or partnerships to fill the gaps and enhance the continuum.

08

Where needed, augment substance use disorder care with detox units, long term injectables, and support with health related social needs, such as housing and employment.

09

Improve access to behavioral health care in a multitude of ways, including but not limited to telehealth, transportation to in-person care, peer-delivered interventions, and use of prescription digital therapeutics.

10

Address workforce shortages through a multi-pronged approach including expansion of telehealth services across the care continuum, provision of integrated physical and behavioral care, use of peers/ individuals with lived experience, and supporting the mental well-being of the behavioral health workforce.

Participants

Marc Augsburger, MBA, BSN, RHCEOC
President and CEO
Edgerton (Wis.) Hospital and Health Services

Andrew Flanagan
CEO
Iris Telehealth
Austin, Texas

Jeremiah Hodshire
President and CEO
Hillsdale (Mich.) Hospital

Ruby Kirby, R.N.
CEO
West Tennessee Healthcare (Bolivar and Camden hospitals)
Bolivar, Tenn.

Doug Koekkoek, M.D., FACP, SFHM
Chief physician and clinical executive
PeaceHealth
Vancouver, Wash.

Judy LaFrance, MSN, R.N., NE-BC
Chief administrative officer
Hendrick Medical Center South
Abilene, Texas

Edward Moore
President
UMass Memorial Health Harrington Hospital
Southbridge, Mass.

Melinda Muller, M.D.
Chief medical officer
Legacy Health
Portland, Ore.

Brenda Romero, R.N., MSN
Hospital chief executive
Presbyterian Española (N.M.) Hospital

Robert Trestman, Ph.D., M.D.
Professor and chair, department of psychiatry
Carilion Clinic
Roanoke, Va.

MODERATOR
Suzanna Hoppszallern
Senior Editor
Center for Health Innovation
American Hospital Association, Chicago

MODERATOR SUZANNA HOPPSZALLERN *(American Hospital Association):* **What is your behavioral health strategy and where does it fit in your organization's priorities?**

EDWARD MOORE *(UMass Memorial Health Harrington Hospital):* My head of behavioral health came to me and asked, 'When a patient goes to our emergency department (ED) and gets a diagnosis of cancer, we know what to do, but what do we do for behavioral health patients?' How do we make the bold move to say it's a critical issue, which I think we all believe it is? That has always struck me and prompted the development of a unique program, addiction immediate care. We've made conscious decisions to provide behavioral health services because in our market, if they don't receive the services from us, they won't get them.

DOUG KOEKKOEK *(PeaceHealth):* PeaceHealth is a health system in the Pacific Northwest, with facilities in Oregon, Washington and Alaska. But our markets are geographically distinct, which means that we can't move patients or providers across those markets. Like other health systems, we are trying to deal with growing demand, especially at the intersection of behavioral health and substance use, a shrinking workforce and inadequate reimbursement.

We have a service-line orientation to behavioral health, primarily an employed provider model. There really isn't a private practice psychiatry presence in our hospitals. Historically, we've provided inpatient and outpatient services, and we're now in the midst of building day treatment, partial hospitalization programs (PHP), and intensive outpatient programs (IOP). In addition, we use a medical home collaborative care model. We are also exploring joint venture partnerships with external behavioral health providers. And we've been working with Iris Telehealth to use virtual/telehealth formats to extend our services.

JEREMIAH HODSHIRE *(Hillsdale Hospital):* Our hospital is in a rural area of Michigan and the only hospital within about a 35-mile region. It's one of the few rural hospitals remaining in the state, a midsize, vital hospital providing care to a challenging population in rural America; 72% of our payer mix is the government — Medicaid and Medicare. There is a lack of mental health services in our state. We have the only 10-bed inpatient behavioral health unit in the tri-county region.

Our community has no public transportation, so there is no convenient way for community members to get to places. We also serve a population of Amish who still drive horses and buggies. We have a hitch and post where they come in to receive care.

Getting patients out of the ED has been the most significant challenge, which is not a proper place for mental health patients. That's been intensified by a lack of telehealth services in our community; parts of the community still have no internet service.

JUDY LAFRANCE *(Hendrick Medical Center South):* We're a system of three hospitals. Two of the hospitals are in Abilene, and I'm at the smaller of the two. We serve the 24 counties surrounding us, approximately 9% of the Texas land mass, and a population of more than 400,000. Our community has mental health resources and addiction treatment centers, including inpatient and outpatient, pediatric and adult, but not enough to adequately meet the needs.

EDWARD MOORE | UMASS MEMORIAL HEALTH-HARRINGTON HOSPITAL

"When a patient goes to our emergency department (ED) and gets a diagnosis of cancer, we know what to do, but what do we do for behavioral health patients? How do we make the bold move to say it's a critical issue, which I think we all believe it is? That has always struck me and prompted the development of a unique program, addiction immediate care."

In addition to having telepsychiatry support, Hendrick has great partnerships with various resources in town. Together, we have created a behavioral advisory team and crisis response teams with community behavioral health services, emergency medical technicians and law enforcement to respond to home and scene location calls which have behavioral health concerns to connect patients to appropriate care as opposed to going to the ED or jail when possible. After hours, patients come through the ED. Our challenge in the Abilene market, specifically for inpatients, is the lack of available government beds, which is especially challenging because 65% of our patients are on Medicare or Medicaid.

BRENDA ROMERO *(Presbyterian Española Hospital):* We're part of Presbyterian Healthcare Services and our system operates nine hospitals in New Mexico. We're considered rural, not frontier. Presbyterian provides telepsychiatry for our patients. We serve a county of about 40,000 residents — 120,000 including surrounding counties — and we are known for having the highest number of deaths per capita due to heroin.

We have focused on treating patients with alcohol-use and substance-use disorders. We're starting medication-assisted treatment in the ED and then following up with patients in the clinic. Our two addiction medicine physicians have been working with a group of physicians throughout the country to figure out how to deal with the withdrawals from fentanyl and prevent patients from having seizures and being placed on a ventilator. While we have peer counseling, we don't have psychiatrists or behavioral health units, so we must refer those patients who need inpatient care.

ROBERT TRESTMAN *(Carilion Clinic):* We're rural, in an eastern chunk of Appalachia, and serve more than 1 million people over 250 miles with seven hospitals, 240 points of care and patient-centered homes. We've begun to grow substantially because of the commitment of our board and executive team to meet the needs of our communities. Like many of you, transportation is horrible and bandwidth access is lousy. However, we've been able to build and recruit a team of 40 psychiatrists, 12 nurse practitioners, nine psychologists and a range of therapists.

Some of our ZIP codes near the hospital have the highest levels of child trauma, asthma, depression, anxiety and acting-out disorders and we're targeting those populations. Last year, we opened a 40,000-square-foot mental health ambulatory program in our shopping mall in Roanoke. We offer interventional psychiatry, including transcranial magnetic stimulation (TMS), ketamine, vagal nerve stimulation and Botox. We're also still doing electroconvulsive therapy (ECT) in the main hospitals.

We are working to integrate our Center for Healthy Aging and partner with geriatrics to deliver care to our geriatric population in collaboration with geriatricians, home health and our geriatric psychiatrist. That program has enabled us to recruit into the geriatric fellowship position and build our geriatric psychiatry team.

RUBY KIRBY *(West Tennessee Healthcare–Bolivar and Camden hospitals):* I run two critical access hospitals that are part of West Tennessee Healthcare. In Hardeman County, we have one of the state's behavioral health hospitals that holds as many as 170 patients. Getting patients placed didn't used to be a problem,

BRENDA ROMERO | PRESBYTERIAN ESPAÑOLA HOSPITAL

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but now they only accept suicidal and homicidal patients. The state sends a lot of forensic patients over there because the ones in Memphis and Nashville are full. We do still work with them though.

Most of our psychiatry is telehealth. We work with psychiatric and behavioral health substance-use counselors appointed by the state. They help us set up treatment in the ED until we can place patients. They also assist with those placements. West Tennessee Healthcare has a behavioral health hospital, but it's voluntary. We have another counseling service that comes into the inpatient setting and helps patients get connected to behavioral health resources/providers after discharge. We may send patients, especially pediatric patients, as far as Mississippi for placement. That's how difficult it is. We try to work with patients to help them with medications and treat them in their communities. Fortunately, I have federally qualified health centers (FQHCs) in my community that provide psychiatric care, and they assist us.

In Benton County, most patients are adults in need of behavioral health and substance-use disorder services. We have a strong group of providers who treat substance-use disorders in this community. They come to the ED to help place patients and get them started on medication, as well as find housing for them.

MODERATOR: What new programs, technologies and partnerships are you exploring to transform patients' behavioral health journeys?

MELINDA MULLER *(Legacy Health):* Seven years ago, four big systems in Portland — OHSU, Legacy, Adventist and Kaiser — all came together to create a collaborative partnership where we moved all their psych beds to Unity Center for Behavioral Health. We built a new hospital in 2017 that has 85 adult beds, 22 adolescent beds, and a psychiatric ED with 50 beds.

Unity was built as an acute inpatient psychiatric hospital, but we recognize we have to expand from there. In our other acute care hospitals, we have telepsychiatry in the EDs as well as some psych consults in the hospital. In our primary care clinics, we have integrated behavioral health.

HODSHIRE: Our full-time psychiatrist, who's been with the unit since its inception 20 years ago, is retiring. We're looking at technologies and their best use, e.g., iPads in our ED.

At the state level, funds have been earmarked to build an inpatient pediatric unit at one of the community hospitals. That will be huge for us, because these patients are without services now.

MOORE: Three years ago, 120-bed Harrington Hospital officially became part of UMass Memorial Health, an acquisition that we wanted. It was an opportunity for each of us to learn from each other. We recognized that we had a stronger behavioral health program and now our head of behavioral health is the interim service-line director for the UMass system.

MODERATOR: How do you define success for your health system regarding behavioral health? What valuable outcomes is your organization demonstrating for patients and the community?

MARC AUGSBURGER *(Edgerton Hospital and Health Services):* We're a 16-bed critical access hospital. Of the seven top areas on our community health needs assessment, four were related to behavioral health and we weren't addressing them. In three and a half years, we have done amazing things. As a result, we've added be-

MELINDA MULLER | LEGACY HEALTH

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havioral health nurse practitioner prescribers and three behavioral health counselors for outpatient services.

With Psychiatric Medical Care, Brentwood, Tenn., we started Senior Life Solutions, a behavioral health counseling group for those aged 65 and older. The therapist, a master social worker, sees them in group therapy three mornings a week and, once a month, they see a psychiatrist one-on-one. The seniors as well as our primary care providers love it.

On the adolescent side, I worked with two of our local school systems. The schools are overwhelmed with so many kids who need to be seen — 20 to 30 children never get seen during a year. I hired a counselor, one of our employees, but we never see her because she works full-time in the school systems — three days a week in one system and two in another. We're looking at trying to hire a second counselor. Financially, it's a bit of a losing situation, but it helps to meet the community health needs.

KOEKKOEK: For us, success in behavioral health is more prevention and ambulatory stabilization, and fewer acute care hospitalizations for psychiatric conditions. It's a stabilized workforce that provides reliable staffing, and a financial model in which physician reimbursement for behavioral health services is adequate to cover expenses.

KIRBY: In Hardeman County, there's a federal prison that often discharges prisoners into the community with substance-use disorders. They come out and often start using again to the levels they were using before. Unfortunately, we see a high incidence of overdose. We are working with our emergency medical services (EMS) and community providers to reach those patients early in the prisons and begin counseling before they are discharged into the community. Pathways, our behavioral health division, has a mobile unit that goes out into the community, where we know these individuals are going to settle, and provides behavioral health and substance-use services, and some primary care. We are seeing positive results and community acceptance, especially because some agencies have opened up housing, so they aren't living on the street.

ROMERO: For the first time, a number of patients with alcohol- and substance-use disorders are saying that the medications are working. With guidance from the addiction medicine physicians, they can overcome their addiction or receive additional treatment. Patients are hearing about our success, coming to the ED asking for treatment, and then going home and starting treatment in the comfort of their own homes. For those who don't have a home, it becomes harder. The patients who are the sickest and living on the streets usually don't have Medicaid or any payer source. The medication regimen costs about $500 a month.

Learning what barriers patients are facing is really important. I went with a patient to a pharmacy that wouldn't give him the medications because he didn't have an address, a home or a cellphone. I said, 'It's obvious that he's starting treatment for alcohol- and substance-use disorder, and if it's successful, maybe he'll be able to get a home or cellphone.' The pharmacist replied, 'OK, I'll give it to you this time, but next time he'll have to come in with either an ID card or driver's license.'

Unless they have the money, which they don't, or they have somebody who's willing to put up the money, often they're not going to receive treatment. It's hard work to help these patients. One of the medications that we're bringing on to the formulary is Brixadi. It is given by subcutaneous injection and lasts a month. It's more expensive for the facility, but patients can get it without having to go through the experience that I just mentioned. The EMS service that Presbyterian owns also is asking to be allowed to use a medication like this when they work with the homeless so that we can treat more people.

TRESTMAN: Our successes include our ability to integrate and partner across the disciplines. We have built a phenomenal partnership with OB-GYN and targeted neonatal abstinence syndrome in the last year. One of my psychiatrists is trained in obstetrics. One of my fellowships is in addiction medicine, and we have a team of OBs who also are trained in addiction medicine.

None of the babies in our Emerald Program have needed the neonatal intensive care unit for birth. We have

step-down programs in which patients spend six weeks on a dedicated inpatient medical unit where they are given Suboxone to treat their dependence on opioids. This can be a behavioral challenge for the nursing staff.

We've partnered with our cardiothoracic surgeons and hospitalists. Psychiatry provides psychotherapy and peer recovery specialists. We even partnered with home health. Selected patients can go home with a PICC [peripherally inserted central catheter] line and will receive the last four weeks of their IV antibiotics at home.

MODERATOR: How will increasing behavioral health access and capacity create cascading benefits for your patients and across your health system?

MULLER: Right now, we're preparing to open a nine-bed emergency substance-use disorder unit adjacent to the ED at Unity because the detox units in town have closed due to a lack of funding. Also, we're building bridge clinics for both adults and pediatric patients to provide care while they wait to get into community mental health. As part of this expansion, we're planning in the future to add IOP, TMS and electroconvulsive therapy (ECT) on-site. Right now, the only ECT is at OHSU. We're doing a lot and trying to create it ourselves because the broader system isn't there.

TRESTMAN: I originally trained in New York with an emergency psychiatry system called the comprehensive psychiatric emergency program (CPEP), and at Carilion we have now a similar seven-day-a-week CPEP. It doesn't have all the bells and whistles, but provides a broad range of services. We don't have the public funding for mobile outreach, but we're delivering care in an integrated way, we've dramatically reduced inappropriate, unnecessary admissions and we are treating people in the ED. They're not being warehoused, which is a profound rethink.

MODERATOR: Over the next three to five years, what strategic investments will your organization be making to address workforce challenges and improve behavioral health services?

LAFRANCE: From a strategic perspective, we are evaluating demand versus supply in our region and how we gain more inpatient behavioral health services to our communities. We are exploring several options to provide increased access to this type of care in our region. Many challenges are at play, not the least of which includes difficulties in recruiting psychiatrists and global staffing shortages. Despite our relatively low level of patient boarding, we are all compelled to be in constant search of additional resources and ways to provide access to health care needs.

TRESTMAN: We have seven EDs across the system and about 7% to 8% of the patients are psychiatric. We've leveraged telehealth so we can have psychiatric care in all our critical access hospitals as well as the primary teaching hospitals. In partnership with Iris Telehealth, our consult-liaison program now has four full-time, board-certified psychiatrists and a teaching team leveraged with telehealth. With support from Iris Telehealth, we've added capacity to deliver the necessary psychiatric care on the medical floors, which has substantially reduced behavioral disruption and violence against staff and reduced lengths of stay.

HODSHIRE: In our three-year strategic plan, we've identified that outpatient services are critical, with nurse practitioners, physician assistants and primary health clinics taking on some of this burden. Currently, it takes eight to 10 weeks to see a primary care pro-

ROBERT TRESTMAN | CARILION CLINIC

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vider in my county because recruiting PCPs to rural America is a challenge, let alone behavioral health specialists. Medication management is being done by pediatricians and family practitioners.

KIRBY: I don't know that we will look at behavioral health in these two small hospitals because it's difficult even to get primary care, let alone psychiatric providers into those communities who are willing to stay. We do a lot of telemedicine with everything. Our strategy is to interact with patients before they overdose, set them up with treatment, housing and services that we offer in addition to referring them for other services.

MODERATOR: What opportunities is your organization pursuing to achieve better financial sustainability in behavioral health to meet community needs?

MOORE: I'm proud of our scope of services. With my vice president of behavioral health in his system role, we've done a broad review of what's working within the system and where the gaps are. I think we have an opportunity to do even more. We invested in a 24-bed, co-occurring disorder unit for which the state assumed some of the construction cost. We developed addiction immediate care in response to an increase in overdoses and deaths. We already had a 14-bed locked, adult psych unit and psych emergency services. We added PHP and IOP, which are important step-down or step-up services, along with a variety of outpatient services at multiple locations that are financially sustainable. I want to highlight TMS, which we've provided for nearly two years. It is financially viable and has resulted in incredible patient outcomes. We also have clinicians in the school system and the courts. We do not have child inpatient beds.

Another hospital in the town of Webster was within two months of bankruptcy, so we saved it and now have a second ED with two inpatient psych units on that campus, but no other medical inpatient beds. It's a satellite emergency facility that works well in meeting the community needs.

ANDREW FLANAGAN *(Iris Telehealth):* We see great innovation and areas of opportunity. I think the high note for me, is that many of your programs are so well integrated. The idea of thinking about the behavioral health holistically is still a new idea for many health systems, and it takes CEO and executive leadership, board support and service-line leadership in addition to all the great clinicians. We've seen great strides at a hospital and system level when the strategy is in place, and we always start there. When the strategy is in place, we work together to do the job that needs to be done and that's different in every place. Our job is to be flexible.

We focus on an enterprise approach to solve the financial sustainability of behavioral health strategies. We appreciate the partnerships that we have with Carilion Clinic, UMass, Legacy Health and PeaceHealth. Most of our providers are rural. We are evenly split between FQHCs and Community Mental Health Centers along with health systems and hospitals. Sharing best practices is the answer, and we're cataloging best practices to share the education and learning. I love the commitment that everybody here has to our children and the community, and that's why I work where I work and the same with my team. ●

ANDREW FLANAGAN | IRIS TELEHEALTH

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Sponsor

Iris Telehealth helps health care organizations consistently increase access to quality behavioral health care for their patients by providing the care models, clinicians, analytics and expertise to build a sustainable behavioral health program. With clinical grounding and emphasis on human relationships, Iris Telehealth identifies best-fit providers for each unique organization and ensures long-term commitment to meeting their partner's needs, allowing them to provide the highest quality care to their patients and community.

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