Improving Behavioral Health Coordination and Care by Strengthening Community Collaboration

Judy Bergh
Minnesota Flex Program Coordinator

Alyssa L Meller
Chief Operating Officer

September 2017
Minnesota Flex Program

• 78 Critical Access Hospitals

• Focus Areas
  • Quality
  • Finance and Operations
  • Population Health

• Flex dedicated staff:
  • Flex Program Coordinator
  • Financial Analyst
  • Research Analyst
Population Health

• Understand Community Health and EMS Needs of CAHs
  • Determine community health issues and trends
  • Improve EMS capacity and performance, and integrate EMS in local systems of care

• Enhance the health of rural communities through community and population health improvement
  • Assist CAHs to develop strategies for engaging with community partners and targeting specific health needs
Community Health Needs Assessments

Analyzed 59 CHNAs from MN CAHs

• Behavioral health one of two most frequently cited needs
  • 16 said it was the top priority
  • Identified need for community partnerships
  • Described goals to integrate behavioral health and outreach
Other assessments

Local Public Health Department
Findings
• Aggregated LPH findings identified access to behavioral services was the top identified need statewide

ORHPC Community Forums
• Need for access to behavioral health services was identified as a significant need at multiple regional community listening sessions held throughout the state
Rural Mental Health Shortages

Source: Minnesota Department of Health
Office of Rural Health & Primary Care, June 2017
MN HPSA 6_2017.pdf
The Plan

Identify a contractor who can:

• Monitor CHNAs
• Establish an advisory council
• Identify CAHs to participate in behavioral health cohorts
• Conduct customized onsite and remote technical assistance to CAHs
• Identify measures and collect data
• Evaluate and share the results
The contractor is chosen, and the hard work begins:

Rural Health Innovations (RHI),
a subsidiary of the National Rural Health Resource Center
Duluth, MN

Alyssa Meller
Kami Norland
Rhonda Barcus
Bridget Hart
Rural Health Innovations (RHI), LLC, is a subsidiary of the National Rural Health Resource Center (The Center), a non-profit organization. Together, RHI and The Center are the nation’s leading technical assistance and knowledge centers in rural health. In partnership with The Center, RHI connects rural health organizations with innovations that enhance the health of rural communities.
This project is supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under grant number H54RH00023. The information, conclusions and opinions expressed in this document are those of the authors and no endorsement by FORHP, HRSA or HHS is intended or should be inferred.
Why Integrate Behavior Health?

• 26% of Americans 18 years + suffer from a diagnosable mental disorder
• 2 million people discharged from hospitals have a primary behavioral health diagnosis
• States cut $5 billion from mental health services nationwide from 2009-2012
• US lost 10% (4,500) public psychiatric beds 2009-2012
• Only a handful of CAHs provide inpatient psychiatric units nationwide
• 9 out of 10 ED physicians report that psychiatric patients were being held in their ED
• 28% of patient re-admissions are due to mental illness

Data source: http://www.trusteemag.com/articles/918-three-ways-hospitals-are-improving-behavioral-health-ca
"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Mental Health Impacts Clinical Conditions

**Physical Diagnosis**

- 29% of adults with medical conditions also have mental health conditions

**Mental Diagnosis**

- 68% of adults with mental health conditions also have medical conditions

Data source: Epstein Becker Green
Impact on Chronic Health Care Costs

<table>
<thead>
<tr>
<th>Condition</th>
<th>Annual Per Capita Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma and/or COPD</td>
<td>$24,598</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$24,927</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>$24,443</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$36,730</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$35,840</td>
</tr>
</tbody>
</table>

- **Dark green**: No Mental Illness and No Drug/Alcohol Abuse
- **Light green**: With Undiagnosed and/or Untreated MI & Drug Abuse

Data source: Epstein Becker Green
Predictors That Affect Health Outcomes

10% Clinical Care
10% Genes and Biology
40% Social and Economic
30% Behavioral
10% Environmental

The ah-ha: Healthcare providers cannot change the U.S. health outcomes alone.

Project Vision

To provide whole person care through the integration of behavioral health
Essential Organizational Components

- Leadership
- Strategic Planning
- Patients, Partners and Communities
- Measurement, Feedback and Knowledge Management
- Workforce and Culture
- Operations and Processes
- Impact and Outcomes
Essential Operational Components

Addresses Behavioral Health Needs in Transitions of Care

Screens All Patients for Depression and/or Substance Abuse

Provides Support to all Patient Care Staff on Managing Their Own Behavioral Health

Maintains an Updated Resource Directory

Invests Times and Energy Building Relationships with Behavioral Health Resources in Their Community

Have Credentialed Behavioral Health on Staff
Selecting Critical Access Hospitals

Criteria:

- Strength of organizational and operational structure based on the Readiness Assessment
- Self identified technical assistance needs for integrating behavioral health
- Thoroughness of essay questions
- High percentage of behavioral health needs in the county based on secondary data
- General information to obtain diversification of selected CAHs (independent, ACO member, etc.)
- Geographic distribution across the state
Organizational Structure Assessment Results

Percent of Total Score

Cohort 1  Cohort 2

<table>
<thead>
<tr>
<th>Category</th>
<th>Cohort 1</th>
<th>Cohort 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>98%</td>
<td>91%</td>
</tr>
<tr>
<td>Strategic Planning</td>
<td>94%</td>
<td>94%</td>
</tr>
<tr>
<td>Patients, Partners, Communities</td>
<td>92%</td>
<td>94%</td>
</tr>
<tr>
<td>Measurement &amp; Knowledge Management</td>
<td>97%</td>
<td>92%</td>
</tr>
<tr>
<td>Workforce &amp; Culture</td>
<td>88%</td>
<td>98%</td>
</tr>
<tr>
<td>Operations &amp; Processes</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>Impact &amp; Outcomes</td>
<td>97%</td>
<td>95%</td>
</tr>
</tbody>
</table>
Operational Structure Assessment Results

Percent of Total Score

- **Cohort 1**: 71% - 100%
- **Cohort 2**: 38% - 100%
- Both: 100% “Maintains an updated list of behavioral health resources in our community”
Expectations of Critical Access Hospitals

• Participate in educational calls and events
• Identify a specific target population
• Convene providers and community organizations
• Implement at least three best practices
• Identify at least two organizational and two operational process improvements towards integration
• Create evaluation metrics
• Utilize a Balance Scorecard to measure and monitor progress
• Showcase findings statewide and nationally
RHI Technical Assistance

Our support is structured over 12 months, through:

• One in-person kick-off event
• One community strategic planning event
• Quarterly peer sharing calls
• Quarterly evaluation calls (Recommended Adoption Progress)
• Educational Webinars
• Workshop–focused on sustainability practices
• Ad hoc 1:1 calls with subject matter experts
In-Person Kick Off Event

- Get to know each other
- Refine the target population
- Identify partners
- Inspire collaboration
Target Population

GOAL

- Increase understanding of and how to access available outpatient services
- Enhance coordination of care
- Decrease emergency department and inpatient admissions

Target Population: People who present in the Emergency Department in Behavioral Health Crisis

Refined by:
- Age
- Specific Diagnoses
Providers and Community Organizations

- Hospitals
- Clinics
- Mental Health
- Schools
- Government
- Businesses
- Long-Term Care
- Housing
- Public Health
- Faith-based Organizations

Rural Health Innovations
NATIONAL RURAL HEALTH RESOURCE CENTER
Community Strategic Planning

Objectives:

• Determine how to best work towards meeting the behavioral health needs of the target population

• Evaluate partnerships that can contribute towards helping meet the behavioral health needs of the target population
Consensus Based Approach

• Confirmed target population
• Identified opportunities and strengths

“What are the gaps of care in meeting this population’s behavioral health needs?”

“What are you already doing to help this population with their behavioral health needs?”

• Developed strategies

“What activities can be done to positively impact this population’s behavioral health needs?”
## Community Objectives and Activities

<table>
<thead>
<tr>
<th>Community Awareness</th>
<th>Coordination of Care</th>
<th>Collaboration</th>
<th>Education</th>
<th>Access &amp; Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource Directory</td>
<td>Understand Regulatory Requirements</td>
<td>Continue Working Together</td>
<td>Social Media &amp; Local Papers</td>
<td>Telehealth</td>
</tr>
<tr>
<td>Community Champion</td>
<td>Multi-Agency Release of Information</td>
<td>Create Subgroups</td>
<td>Mental Health First Aid</td>
<td>On Call Therapists</td>
</tr>
<tr>
<td>Through School Events</td>
<td>Care Team Meetings</td>
<td>Rotate Locations</td>
<td>Crisis Response Teams</td>
<td>Support Groups</td>
</tr>
<tr>
<td>Community Education Nights</td>
<td>Technology</td>
<td></td>
<td>Provider &amp; Staff</td>
<td>Mentors &amp; Peer Support</td>
</tr>
<tr>
<td>Personal Stories</td>
<td></td>
<td></td>
<td></td>
<td>Local Advisory Council</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Youth Activities</td>
</tr>
</tbody>
</table>
Recommended Adoption Progress (RAP)

- Quarterly calls are held with each hospital team
- Conversation focuses on “telling the story”
- Each quarterly call “picks up the story” from the prior quarterly call
- Measurable outcomes are noted at each call
- At the end of the year, the series of RAP calls will result in a complete picture of the progress on the project
How would you rate your progress moving forward on your community strategic planning objectives?

<table>
<thead>
<tr>
<th>Organization</th>
<th>Qtr. 1</th>
<th>Qtr. 2</th>
<th>Qtr. 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essentia Health Northern Pines</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Sanford Luverne</td>
<td>2.5</td>
<td>3.2</td>
<td>3.7</td>
</tr>
<tr>
<td>FirstLight Health System</td>
<td>4</td>
<td>4.25</td>
<td>4.7</td>
</tr>
<tr>
<td>Renville County Hospital &amp; Clinic</td>
<td>4</td>
<td>4.1</td>
<td>4.3</td>
</tr>
<tr>
<td>LifeCare Medical Center</td>
<td>3.5</td>
<td>4</td>
<td>4.2</td>
</tr>
</tbody>
</table>
## Evaluation Measures

<table>
<thead>
<tr>
<th>Measure Area and Hospital’s specific chosen measure</th>
<th>Pre-Project Values and time frame</th>
<th>November 2016 values</th>
<th>February 2017 values</th>
<th>May 2017 values</th>
<th>August 2017 values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Utilization of services measure:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decrease number of ED visits for those with depression dx code</td>
<td>July-Sept. 2016 35 visit</td>
<td>38</td>
<td>29</td>
<td>30</td>
<td>17</td>
</tr>
<tr>
<td><strong>Cost of services measure:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decrease in cost of ED visits for those presenting with depression dx</td>
<td>No baseline</td>
<td>$7600</td>
<td>$5800</td>
<td>$6000</td>
<td>$3400</td>
</tr>
<tr>
<td><strong>Health outcomes measure:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the number of people screened for depression</td>
<td>0</td>
<td>5</td>
<td>15</td>
<td>12</td>
<td>32</td>
</tr>
<tr>
<td><strong>Individual measure:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of referrals to community based care coordination team</td>
<td>No baseline</td>
<td>No measure</td>
<td>3 referrals</td>
<td>2 referrals</td>
<td>4 referrals</td>
</tr>
</tbody>
</table>
Essentia Health Northern Pines

Behavioral Health Emergency Department Visits

<table>
<thead>
<tr>
<th></th>
<th>Baseline (Previous Quarter)</th>
<th>Q1</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits</td>
<td>26</td>
<td>23</td>
<td>23</td>
</tr>
</tbody>
</table>

Increase Behavioral Health Access

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Q1</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 provider 1 time a week</td>
<td>4 providers 3 times a week</td>
<td>4 providers 3 times per week</td>
</tr>
</tbody>
</table>
Patients Screened for Suicidal Tendencies
Mental Health Holds

- Screens: 13 (Q1: 4, Q2: 9)
- Holds: 4 (Q1: 4, Q2: 0)

Renville County Hospital & Clinic
Sanford Luverne

Emergency Department Visits Discharge Location

Baseline

<table>
<thead>
<tr>
<th>12 mo.</th>
<th>Discharged Home</th>
<th>Inpatient</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>62%</td>
<td>35%</td>
<td>3%</td>
<td></td>
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</tbody>
</table>

Q1

<table>
<thead>
<tr>
<th>Q1</th>
<th>Discharged Home</th>
<th>Inpatient</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>53.30%</td>
<td>40%</td>
<td>6.70%</td>
<td></td>
</tr>
</tbody>
</table>

Q2

<table>
<thead>
<tr>
<th>Q2</th>
<th>Discharged Home</th>
<th>Inpatient</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>57.10%</td>
<td>38.60%</td>
<td>4.30%</td>
<td></td>
</tr>
</tbody>
</table>

Q3

<table>
<thead>
<tr>
<th>Q3</th>
<th>Discharged Home</th>
<th>Inpatient</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>70.30%</td>
<td>25.50%</td>
<td>4.20%</td>
<td></td>
</tr>
</tbody>
</table>
Sanford Luverne

Mental Health Crisis Team Response

Baseline

<table>
<thead>
<tr>
<th>Emergency Department</th>
<th>Home</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Q2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Q3</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Rural Health Innovations
Sanford Luverne

Average Costs of Emergency Department Visits (Facility)

Baseline

Yearly Average Cost per Visit

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Average Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>$1,980.50</td>
</tr>
<tr>
<td>Q2</td>
<td>$1,547.63</td>
</tr>
<tr>
<td>Q3</td>
<td>$3,736.80</td>
</tr>
</tbody>
</table>
LifeCare Medical Center

Behavioral Health Providers - Patient No-Show Rate

*Average Quarterly Baseline: 458 Behavioral Health Visits
LifeCare Medical Center

- Created a Roving Therapist position in January 2016
- Counsels inmates with depression and anxiety
- Since then:
  - Patients brought to the Emergency Department from the jail has decreased
  - Inmates seen by the Roving Therapist in the jail have resulted in ZERO In-Patient Psych transfers
LifeCare Medical Center

https://lifecaremedicalcenter.org/minnesota-hospitals-video/
Sanford Luverne

Integrated Behavioral Health: Improving the Human Condition through Continuity of Care

Sanford Luverne Team Members:
- Laurie Jensen, Director of Clinic Operations
- Nyla Sandbulte, Chief Nursing Officer
- Trent Bullerman, RN Health Coach
- Angela Nolz, MS, LPCC Integrated Health Therapist
- Vicki Nelson, MA Care Coordinator Assistant

Study

Outcomes:
- Developed new Release of Information form to be used by Sanford Health Community Health Agency (Southwest Mental Health and crisis mental Health and Human Services) (Southwest Mental Health and Human Services), Retirement communities, Nursing homes, Law Enforcement and Local Schools
- Increased confidence reported by non mental health professionals who attended Mental Health First Aid
- Increased in communication between community members, patient’s team members
- Information has been gathered from patients to evaluate outcomes
  - 228 (179 unique patients): Emergency Department visits that were mental health related in 2015
  - An average of 55% of mental health related emergency visits went home following discharge from the ED, 30% went to inpatient care, and 0% and other arrangements made
  - Minimizes of mobile crisis team (5 total in 2015)
- Increased referrals to Integrated Health Therapist from the Emergency Department for patients presenting with mental health crisis to ensure follow up and decrease likelihood of mental health visit to the Emergency Department
- Clinician and hospital staff have a better knowledge of where to best refer these patients when a mental health crisis arises
- Increase in scenarios where patients have been gone from meeting with Integrated Health Therapist to Inpatient behavioral health without going through the Emergency Department
- Opportunities increased to discuss better options of care, thus improving communication with the inpatient behavioral health to better manage patients post crisis

Challenges:
- Accommodating schedules of all involved community members
- Legal challenges regarding HIPAA and developing a new Release of Information for all patients involved
- Developing a process to alert staff that a patient has a ROI in place and making it visible in the patient chart
- Educating providers on changes being developed and keeping everyone informed to work for the best outcomes for the patient

Act

- Continues to gather data from partners to evaluate expected or unexpected outcomes
- Continues to track utilization of mobile crisis response team both in and out of the Emergency Department
- Involves other partners in ongoing service areas as needs arise
- Continues communication between team members to explore ways to ensure determinants of health are being assessed and support in these areas are provided

Plan

Launch an Integrated Behavioral Health project in July 2017 to provide whole person health services at Sanford Luverne.

Apply for the project through Rural Health Innovations and the office of Rural Health and Primary Care Minnesota

Community team collaboration determined that the focus of this project would be:
- Reducing emergency department acuity visits
- Identifying community resources and gaps in care with the establishment of a community based coordination team
- Targeted population is patients over the age of 18 who present to the Emergency Department in acute behavioral health or social crisis

Do

- Applied for, and was one of six rural hospitals in MN to receive acceptance into the Rural Health Innovations project
- Integrated Behavioral Health Community Forum through the National Rural Health Resource Center, Rural Health Innovations, LLC
- Identified and invited community partners to meet and explore ideas about team collaboration and continuity of care, as well as gaps in services
- Developed and sought approval for a new Release of Information form that allows for team collaboration
- Increased communication between individual patients’ care teams
- Educated community partners and patients on the Release of Information form to coordinate care between community resources more effectively and to connect patients to resources with ease and efficiency
- Implemented Integrated Health Therapist in clinic setting to meet with patients with increased stress and/or symptoms of mental health concerns to begin the process of connection prior to crisis
- Developed increased communication post mental health crisis to explore ways to create improvements to care where possible
- Educated community on Mental Health First Aid and increase comfort in assisting individuals struggling with mental health crisis
- Developed ways to increase utilization of mobile crisis team to assist patients at home and in community

BACKGROUND INFORMATION:
According to the National Institute of Mental Health, collaborative care has been found to improve quality of care, satisfaction with care, and both mental and physical health outcomes. By implementing collaboration, it is our hope that we will be able to keep patients from utilizing the Emergency Department, but rather receive assistance for their mental health needs prior to crisis. The focus of team collaboration, in part, is to assist in improving determinates of health. Areas of health in which this collaboration hopes to assist includes: support in seeking financial resources, adequate housing and employment, social support, education, child development, access to health services, personal health practices and coping skills.
Multi- Organizational Release of Information

Sanford Luverne Medical Center
Consent to Release and Exchange Personal Information Between Your Care Team Agencies

Purpose of the exchange of information: Coordination of your care
This release will permit the individuals and agencies involved in your care, to work together in a confidential, professional manner to meet your needs.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Address:</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td>Maiden/ Previous Name:</td>
</tr>
<tr>
<td>PCP:</td>
<td>Primary Clinic:</td>
</tr>
</tbody>
</table>

Type(s) of information to be exchanged, verbally & written, if necessary to coordinate your care and improve your wellness:
- History and Physical
- Diagnoses
- Medications
- Progress Notes
- HIV AIDS testing
- Care Plan or Treatment Plan
- School IEP & Assessments
- Immunizations
- Emergency and Urgent Care Reports
- Discharge/ Treatment Summary
- Mental and Chemical Health Diagnoses
- Treatment Plan, Treatment Summary, Diagnostic Assessment and Medications

Identify which of the following agencies and/or Individuals are important in coordinating your care and give them permission to collaborate on your care by sharing information as noted above. Cross out and initial any agency you do not give permission to share information with.
- Southwest Mental Health
- Southwest Health and Human Services
- Sanford Health
- Rock County Food Shelf
- School District
- Head Start
- Good Samaritan Society (Mary Jane Brown)
  Home, Poplar Creek, The Oaks
- Minnesota West - Luverne Campus
- Rock County Law Enforcement
- Southwest Minnesota Crisis Center
- Rock County Crisis Response Team
- Avera Behavioral Health
- Avera Marshall Behavioral Health
- Minnesota Veterans Home
- Other: ___________________________

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance and this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. If you allow the release and exchange of information, this consent will expire in one year and/or you may cancel this consent at any time in writing to any agency to which you authorized us to share information on your original, signed consent form.

Signature (required): ___________________________ Date Signed (required): __________ Time Signed (required): __________
Printed Name of Person Signing (if not patient): ___________________________

Sanford Luverne Medical Center
Consent to Release and Exchange Personal Information Between Your Care Team Agencies
018019-00364 Rev. 1/17

Rural Health Innovations
NATIONAL RURAL HEALTH RESOURCES CENTER
Documenting The Project - Toolkit

• Integrative Behavioral Health Project-The Process
  ◦ Background
  ◦ The Readiness Assessment
  ◦ The selection process
  ◦ Technical Assistance (TA)
  ◦ Evaluation of project outcomes
  ◦ Promising Practices
  ◦ Lessons Learned

• The Hospital and Community Teams
  ◦ Strategic objectives
  ◦ Promising practices
  ◦ Lessons learned
  ◦ Project outcomes
Alyssa L Meller
Chief Operating Officer
218-216-7040
ameller@ruralcenter.org

Get to know us better:
http://www.ruralcenter.org