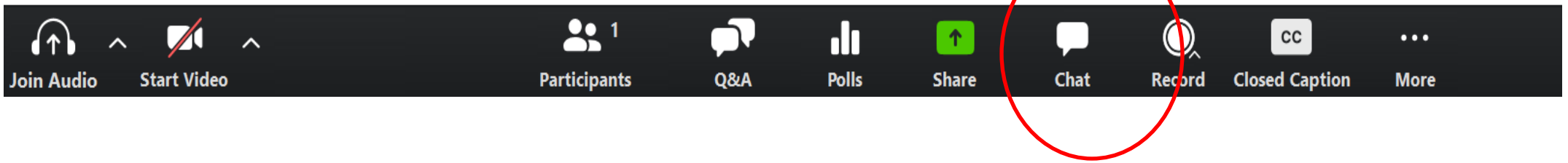
Building behavioral health ecosystems of care

July 10, 2023

Housekeeping

- This event will be recorded and sent out with the slides
- Put your organization in the chat – send it to all participants
- Put your questions in the chat throughout



Introductions

Anita Udaiyar
Director of Behavioral Health Clinical Strategies

Behavioral Health Network of Greater St. Louis

Patty Morrow
Vice President of Behavioral Health Services

Mercy Health

Wendy Orson
CEO

Behavioral Health Network of Greater St. Louis

Rhonda Coursey
Complex Care Team Leader

Places for People

Introductions

Mouy Eng K. Van Galen
Senior Program Manager

Camden Coalition

Leigh Wilson-Hall
Associate Director of Clinical Redesign Initiatives

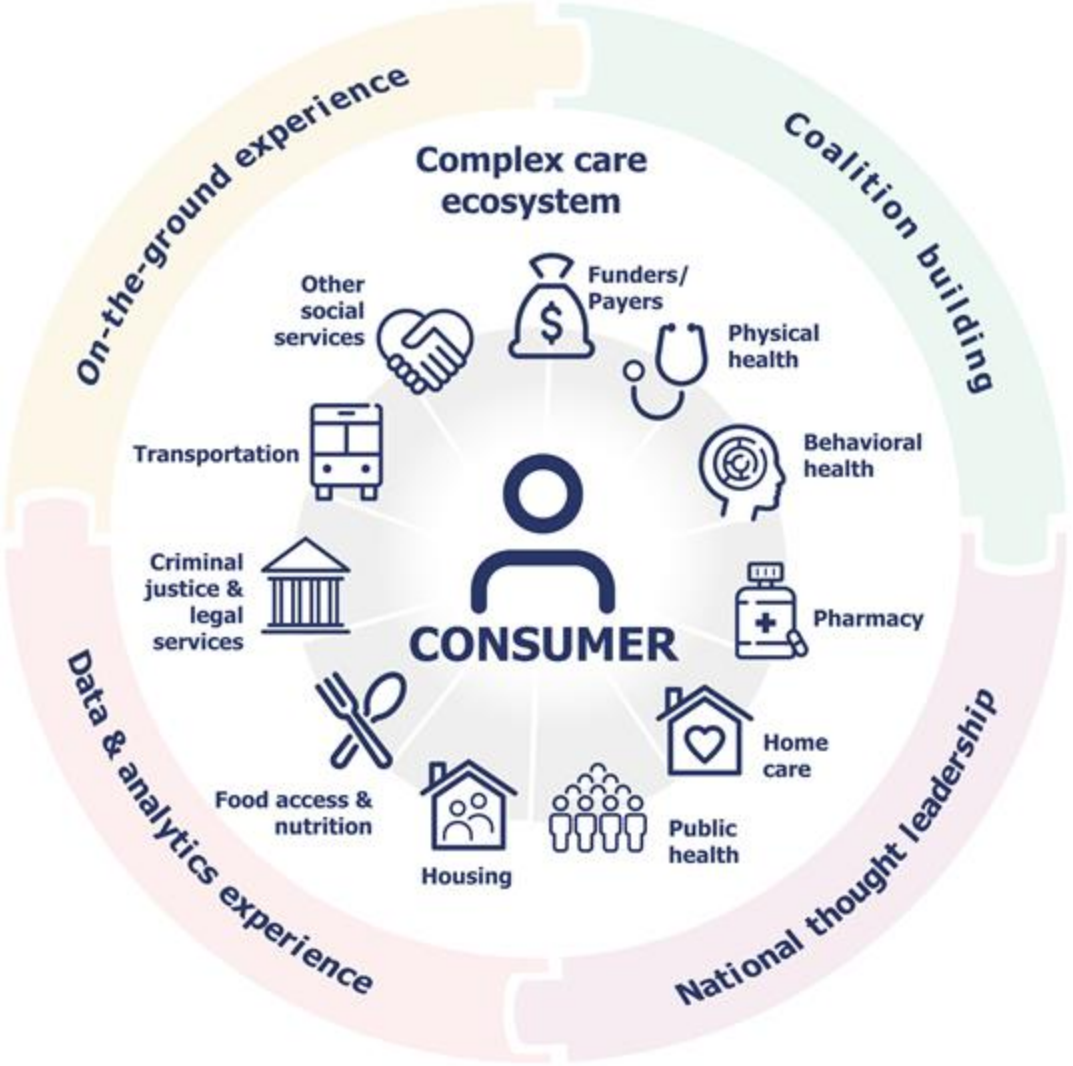
Camden Coalition

Michelle Joo
Director of Certified Community Behavioral Health Clinic

Oaks Integrated Care

THE CAMDEN COALITION APPROACH

We leverage our strengths to build ecosystems of care with a diverse set of stakeholders to better serve the needs of patients and practitioners



Strengthening ecosystems of care

- Alignment, coordination, and collaboration of local healthcare and social care systems, community organizations, government agencies, and people in the communities being served.
- They co-design, implement, and lead new or improved programs, systems, and policies that bridge organizations and sectors to better serve the health and well-being of individuals and communities.

How to build an ecosystem of care

Identify community needs

Define your population

Define your aim

Identify partners and allies

Continuous process and quality improvements

Create an intentional structure with a focus on sustainability

National update: strengthening behavioral health ecosystems of care to impact the most vulnerable populations is top priority

- **"Individuals living with severe mental illness die about 10–20 years earlier than the general population and evidence shows this mortality gap has been increasing over time"***
- Cross-sector collaborations, especially between community behavioral health centers, housing providers, criminal/legal authorities, and health systems are essential to addressing disparities in health outcomes, through improved access to and quality of comprehensive care.
- **Certified Community Behavioral Health Clinics (CCBHCs)** model is designed to ensure access to coordinated comprehensive behavioral health care, expansion efforts underway

*de Mooij LD, Kikkert M, Theunissen J, Beekman ATF, de Haan L, Duurkoop PWRA, Van HL, Dekker JJM. Dying Too Soon: Excess Mortality in Severe Mental Illness. Front Psychiatry. 2019 Dec 6;10:855. doi: 10.3389/fpsyt.2019.00855. PMID: 31920734; PMCID: PMC6918821.

Behavioral Health Network of Greater St. Louis

Complex Care

Regional Response

Rethinking Complex Care in Eastern Missouri

Our History

BHN was created as an entity for Regional Behavior Health Planning and Coordination.

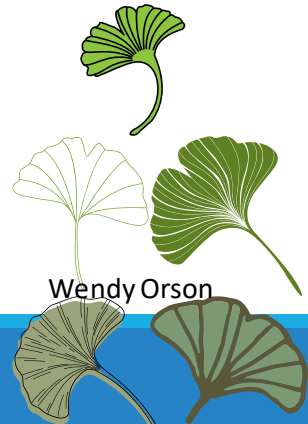
BHN grew from the St. Louis Regional Health Commission's four-year Missouri Foundation for Health-funded "Eastern Region Behavioral Health Initiative". The four-year initiative culminated with a set of recommendations to improve behavioral health services in the Eastern Region.

The final recommendation was to establish a permanent structure for ongoing regional behavioral health system planning and coordination.

BHN formed as a 501(c)3 non-profit in 2010, establishing corporate by-laws and began to work on the series of recommendations outlined by this planning group.

This initiative was also a component of the Governor's Mental Health Transformation effort and activities were included in the Missouri Comprehensive Plan for Mental Health.

Behavioral Health Network of Greater St. Louis



Behavioral Health Network

Improving the system of care

- Achieve breakthrough outcomes by overcoming a stubborn barrier or making an innovative leap forward to accelerate progress toward a longer-term goal

- Draw on a diverse set of stakeholders to participate in a curated experience that elicits a range of perspectives and ideas required to achieve a breakthrough

- Secure commitment for post-convening action, often mobilizing additional resources

- Spark unforeseen collaborations to address new challenges and opportunities

Behavioral Health Network of Greater St. Louis plays a unique role as a convener in the region that pushes boundaries to make an impact to improve health access for the safety net population

- *Identify Critical Gaps*
- *Connect/Coordinate the healthcare system*
- *Develop cross-sector relationships and initiatives*

Troup Geisenheimer, S., & Khan, Z. (2022). Convening by Design. *Stanford Social Innovation Review*. https://doi.org/10.48558/VRDP-ZC65

Wendy Orson

Partnerships

Behavioral Health Network Theory of Change

Mission & Vision

MISSION

To improve our community by leading BH planning and coordination through shared responsibility, accountability, transparency, mutual respect and racial equity

VISION

Through the development of a coordinated, accessible, effective, and accountable system of BH supported services, the people in our region will reach their highest potential

Wendy Orson

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Problem Statement

Individuals in the safety net population often find it difficult to access optimal behavioral health care due to various health and social barriers

Wendy Orson

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- Healthcare Systems/Hospitals
- Community Based Mental Health
- Substance Use Treatment Services
- Primary/Physical Healthcare
- Advocacy Groups & Coalitions
- Community Advocates
- State & Local Government
- Faith Community
- Social Services
- Criminal Justice
- Funders

Wendy Orson

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Strategies

- Increase care coordination and transitions of care to ensure individuals are linked and connected to services10
- Replicate best practice programs that divert from EDs and the criminal justice system
- Lead intentional efforts to address racial disparities in BH outcomes
- Design innovative programs that address emerging needs

Wendy Orson

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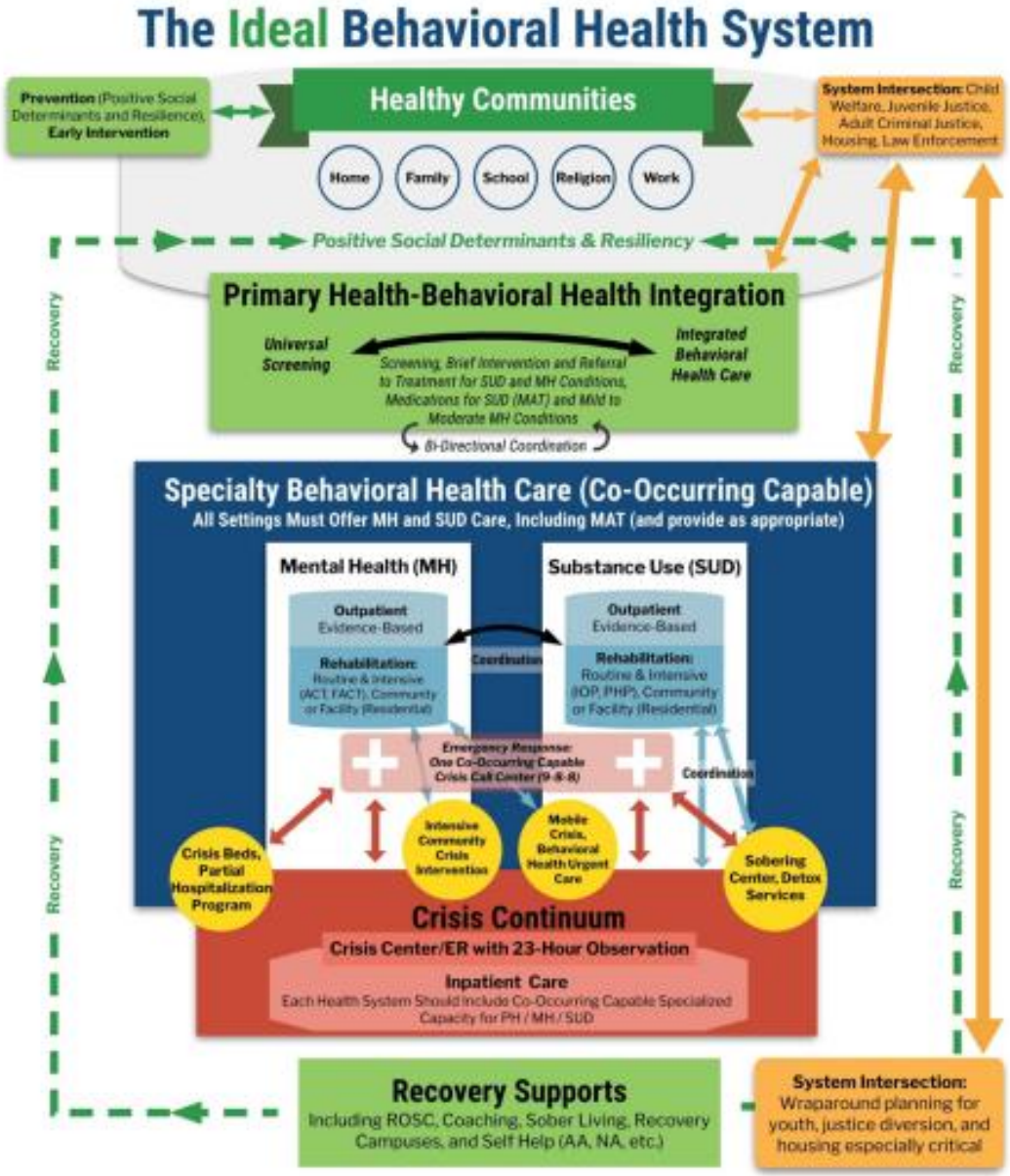
Desired Outcomes

- System change in Behavioral Healthcare delivery for complex patients
- Improving access for Youth with SI and SED.
- Reduction in Opioid Overdose deaths
- Reducing racial disparities in Behavioral Healthcare Access
- Improving Regional Collaborations
- Shared data & alerting systems for improved care coordination

Wendy Orson

Behavioral Health Ecosystem MO



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ZIA PARTNERS

TriWest

Regional-High & Super utilizers

- In the U.S. the top 1 percent of the population consumes more than 1/5 of healthcare resources.
- U.S.- top 5 percent account for more than 50% of all spending.

Missouri mirrors national trends for hospital super-utilizers

- In 2013, 50% of all Missouri IP and ER patients accounted for 96% of total costs.
- Top 10% accounted for 63 percent of total costs.
- Top 10% of cost more than $5.7 billion that included 145k patients with an average of $39,258 per person. This was more than 15 times the average expenditure for other patients in 2013.

https://web.mhanet.com/media-library/hospital-super-utilizers-and-the-importance-of-transitions-of-care-in-missouri/

Regional-High & Super utilizer Projects of BHN

LINCS

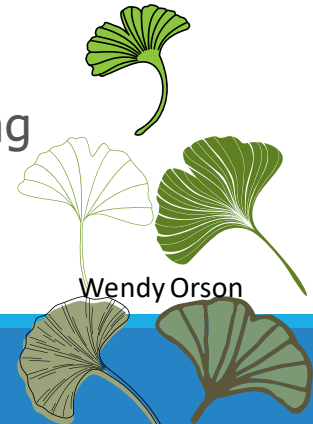
Linking Individuals to Needed Care and Supports

- is the re-branded, combined FY23 implementation of two grants that are Transition of Care programs connecting high utilizers from ED and IP to -> Community-based care.
- This program is in place for a decade and still is connecting high-need individuals to needed care.
- We found a subset of this population still had high utilization after multiple reconnections.
- Evidence pointed towards a need for a new model for care for patients with complex needs.

BEACN

Building Engagement to Address Complex Needs

"Creating Local Behavioral Health System Change": Implementing a complex care initiative, targeting patients with BH needs and extreme patterns of hospital utilization.



Cohort Demographic Profile- ERE & Clinical BEACN

FY2016-2021 Utilization	All	ERE	BEACN
Distinct patients after exclusions	3,491,820	2,302	53
Avg. Age	49.6	40.7	39.7
Female	52.8%	36.0%	24.5%
Male	47.2%	64.1%	77.4%
Avg. Visits	4.2	44.4	133.6
Emergency Department	3.8	39.9	120.9
Inpatient	0.9	12.1	36.9
IP Days	12.3	73.1	190.8
ALOS	4.5	6.1	5.7
Avg. Hospitals Visited	1.7	6.6	11.2
Avg. Distance Travelled	12.9	12.1	14.2
Avg. Total Charges	$53,990	$317,803	$737,730
Expired (excluded)	3.31%	3.52%	3.64%

DATA AND ANALYTICS POWERED BY HIDI

Super utilizers

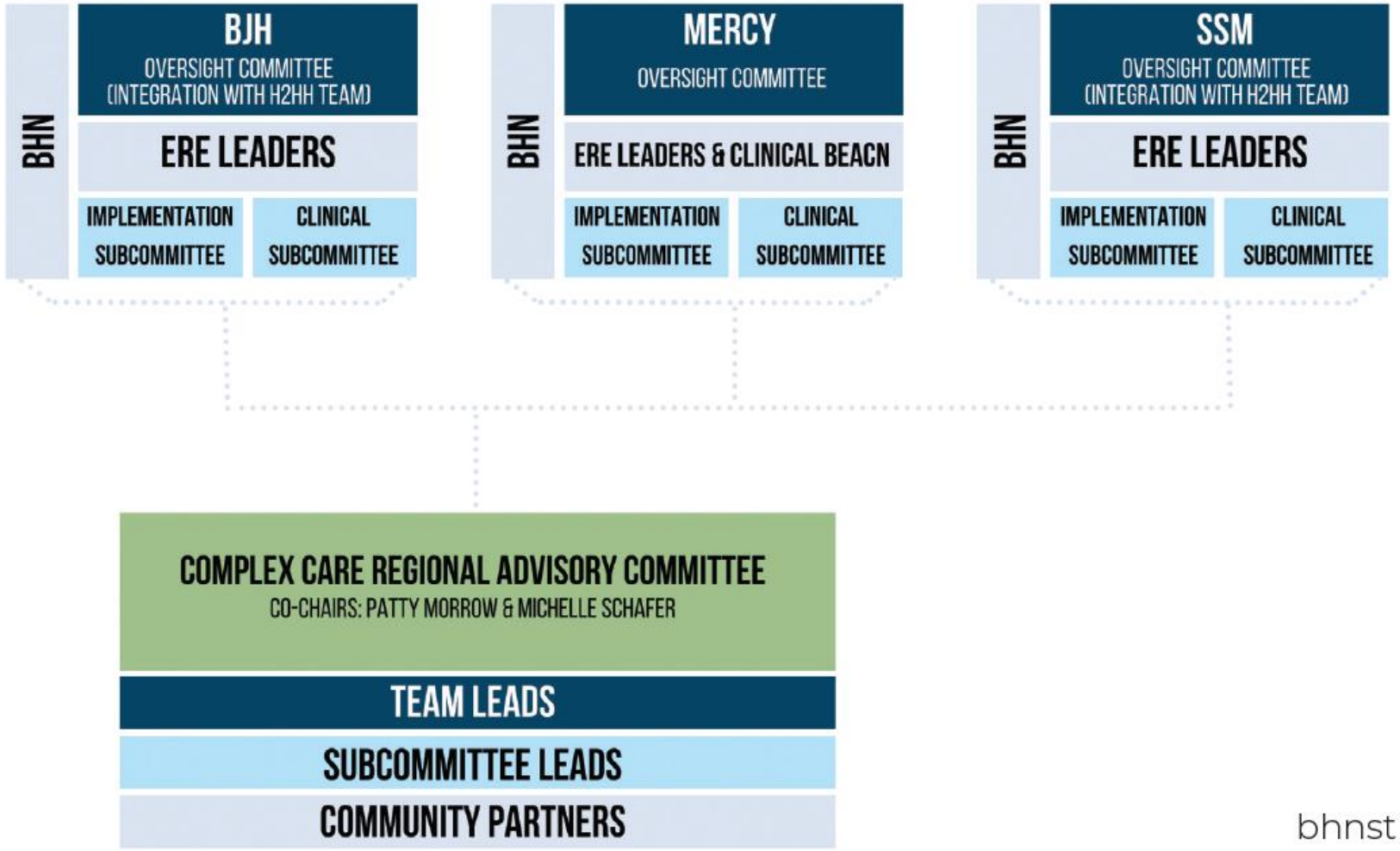
133
Average hospital visits for 1 Clinical BEACN patient/year

11.2
Hospitals visited by 1 Clinical BEACN patient/year

$737K
Average total charges 1 Clinical BEACN patient/year

Wendy Orson

Complex Care Structure To Impact System Change



BEACN

Building Engagement to Address Complex Needs

- Complex Care Initiatives - **Mercy, SSM, and BJH**
- Holistic, Person centric-Follow strategies from the recommended model.
- **Mercy BEACN-340B Funding** - Housing, Flex funds
- Regional Average- 74% drop in ED utilization 6 months post-intervention.

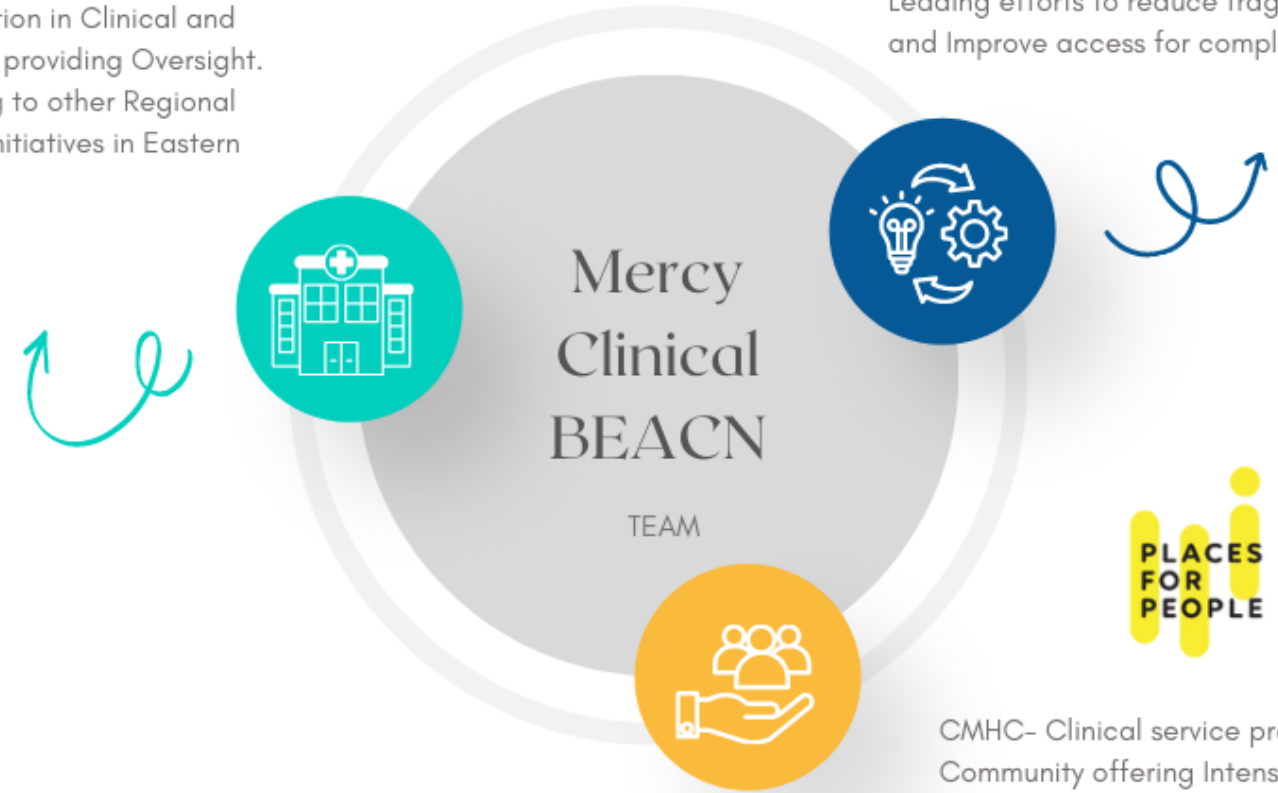
Wendy Orson

Mercy

Active participation in Clinical and Data teams and providing Oversight. Bringing learning to other Regional Complex Care Initiatives in Eastern MO.

Behavioral Health Network

Program Implementation, Co-ordination of Care, Building partnership, Data Analysis and Evaluation of Impact.
Leading efforts to reduce fragmented BH services and Improve access for complex patients



PLACES FOR PEOPLE

CMHC- Clinical service providers in the Community offering Intensive outreach, wrap around supports like Housing, Insurance, transportation, Medical and Psychiatric care

Inclusion Criteria- Clinical BEACN

- >10,000 month of hospital charges/2 years high utilization
- 11+ Emergency Department Visits in the last 12 months
- >3 Inpatient visits in a year
- Primary Diagnosis: Behavioral Health / Substance Use Disorder
- Co-morbid chronic condition

Mercy Clinical BEACN

Clinical BEACN - Mercy Hospital grant to BHN, 7/2020-6/2023. Sub-contract to Places for People(CCBHO) to deliver Clinical Services and Housing Support for 35+ targeted complex care patients per year (100+ patients)

Alerting System

Mercy partnered with BHN, Missouri Hospital Association & Collective Medical to develop and implement an alerting system to improve care

Care Team

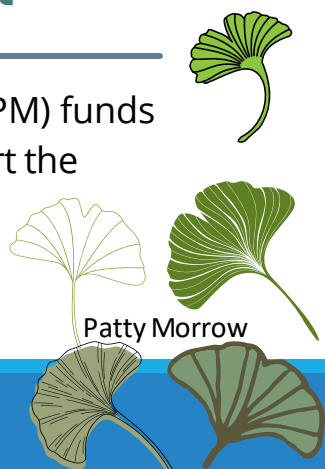
Multidisciplinary collaborative case staffing to address high needs of patients

Housing & Flex funds

Housing funds available for 15 people
Flex Funds - Medication, transportation, phone, food, clothing

Insurance support

Per Member Per Month (PMPM) funds for up to 6 months to support the uninsured



Leveraging 340 B- Clinical BEACN

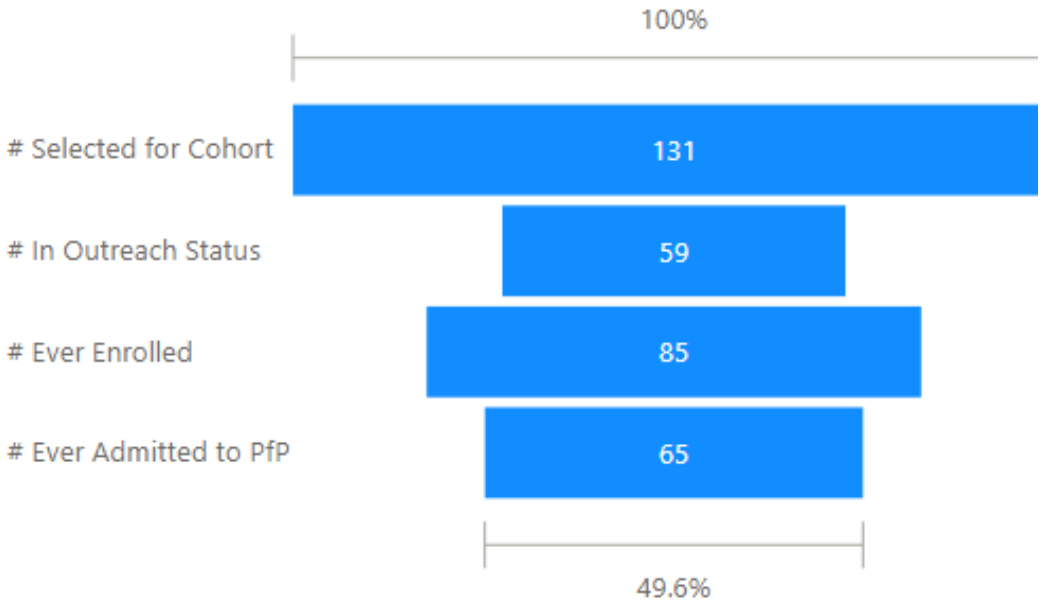
The **340B Program** enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.

Manufacturers participating in Medicaid agree to provide outpatient drugs to covered entities at significantly reduced prices.

Hospitals use 340B savings to provide, for example, free care for uninsured patients, offer free vaccines, provide services in mental health clinics, and implement medication management and community health programs.

Mercy Hospital system Leveraged 340B savings to serve complex super-utilizing patients

Clinical BEACN- Outcomes



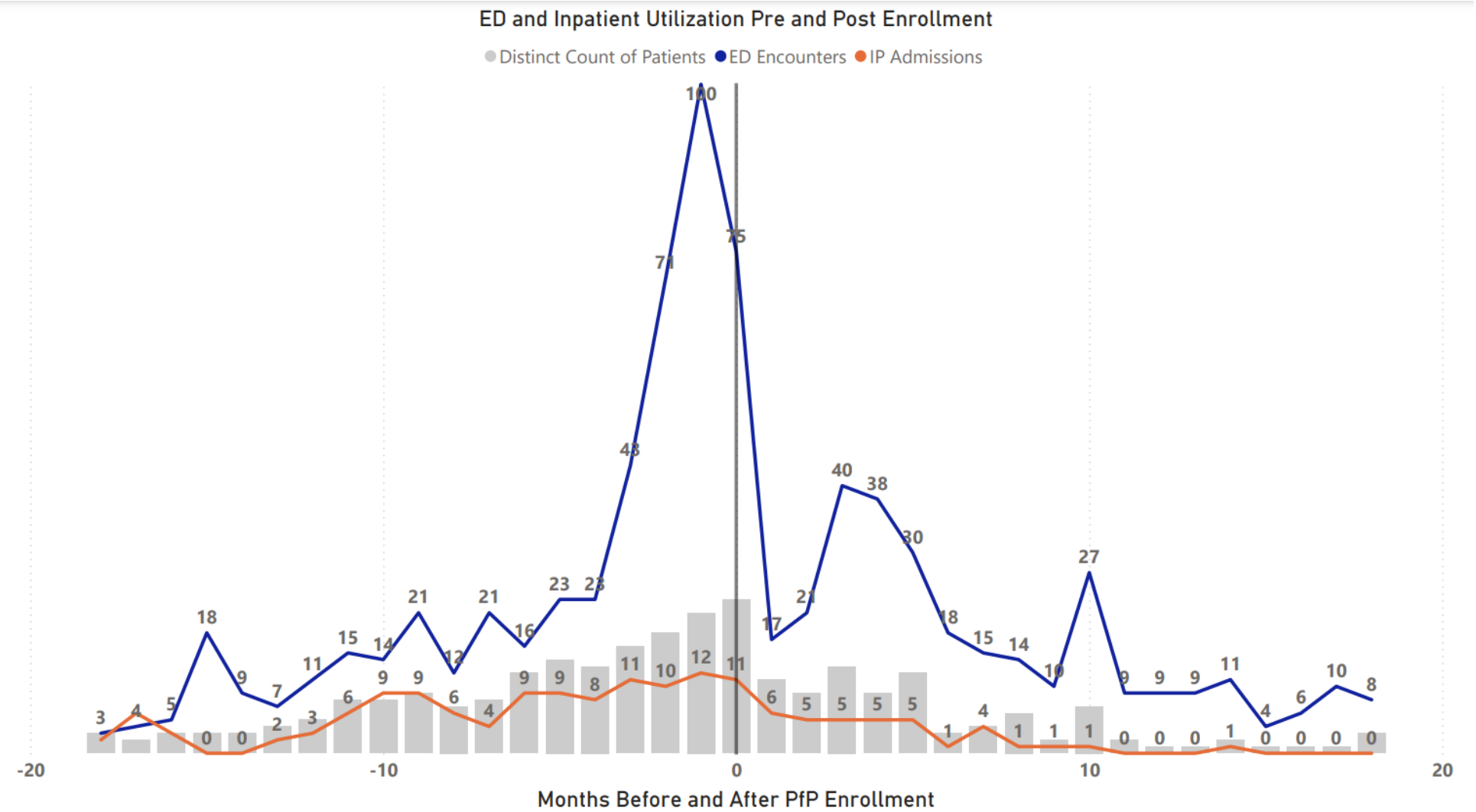
Housed
70%

Secured Insurance
66%

Improving Health outcomes
Monitoring HBA1C, BMI, Blood Pressure, and Cholesterol.

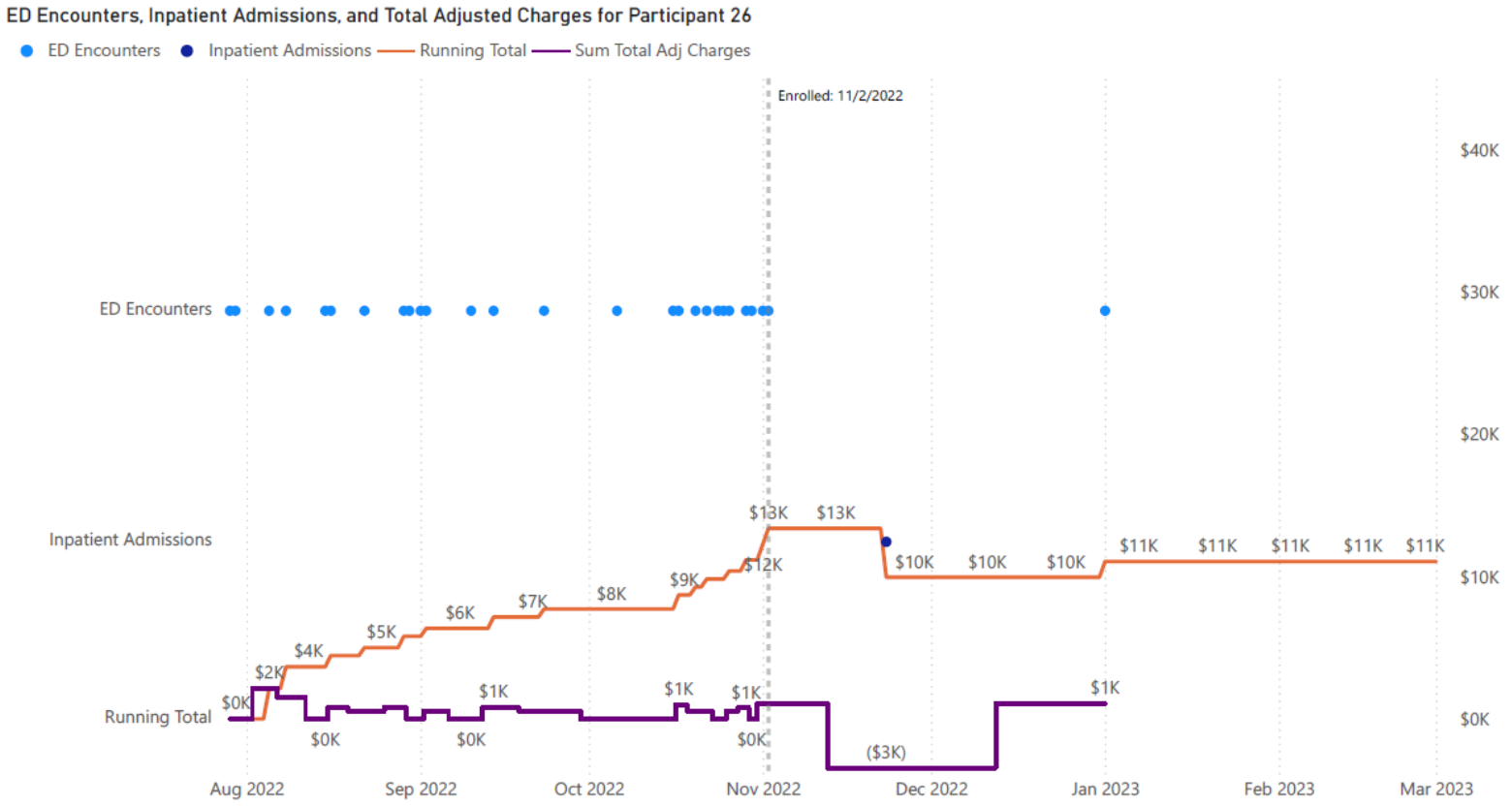
Patty Morrow

ED & IP Utilization pre/post enrollment



Patty Morrow

Patient profiles- A success story



Patient 26 is a 52-year-old male, BEACN team secured housing and supported him with medical follow-ups.

Regional Utilization

42 ED encounters in 1 year, 31 in Mercy hospitals.

Medical and Social risk factors

·Depression

·Unhoused

SUSTAINABILITY

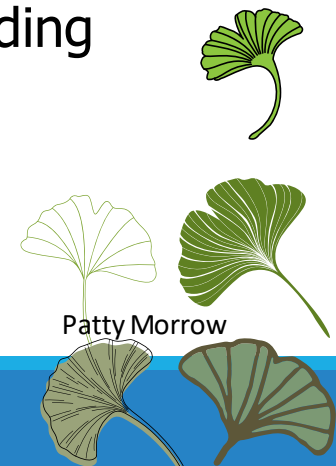
Behavioral Health Network of Greater St. Louis

- Align with State leadership, payers, and providers of MO Behavioral and Primary Care Health Homes with a focus on the value added from BEACN wrap-around service model.

- Leverage 340 B funds to resource community mental health providers and allow utilization of flexible funds for housing support to address SDOH.

- Engage Medicaid Managed Care Plans focused on population health management initiatives to impact high-cost and high-need.

- Apply a blending and braiding of Federal, State and local, and other grant-based funding to support and offset infrastructure, staffing, and service provision costs across Organizations



Contact and Virtual Flipbook

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Link to Virtual BEACN Flipbook
https://heyzine.com/flip-book/e8eff2c31e.html

Pledge to Connect: A Behavioral Health Transition of Care Pilot

Presenters:

Leigh Wilson-Hall, LSW
Michelle Joo, LPC, MPH
Mouy Van Galen, LSSBB

Camden Coalition

Oaks Integrated Care

Cooper University Health Care

Jefferson Health

Virtua Health

inspira Health Network

ACENDA Integrated Health

Presentation Outline

History, Landscape and Background

Program Overview & Shared Goals

Workflow Design and Iterations (QI)

Data and Progress

Future Steps

Behavioral Health: A Top Issue Facing the Region

NJ adults have low utilization of mental health treatment[1]:

- 69.7% with mild mental illness
- 53.5% with moderate mental illness
- 35.6% with serious mental illness

Did not receive Mental Health Treatment

2019-2021 South Jersey Community Health Needs Assessment named BH as the top issue facing the region; called for better coordination[2]

Camden Coalition's work found high prevalence of BH among clients; barrier to accessing to primary care[3]

Camden Coalition
of Healthcare Providers

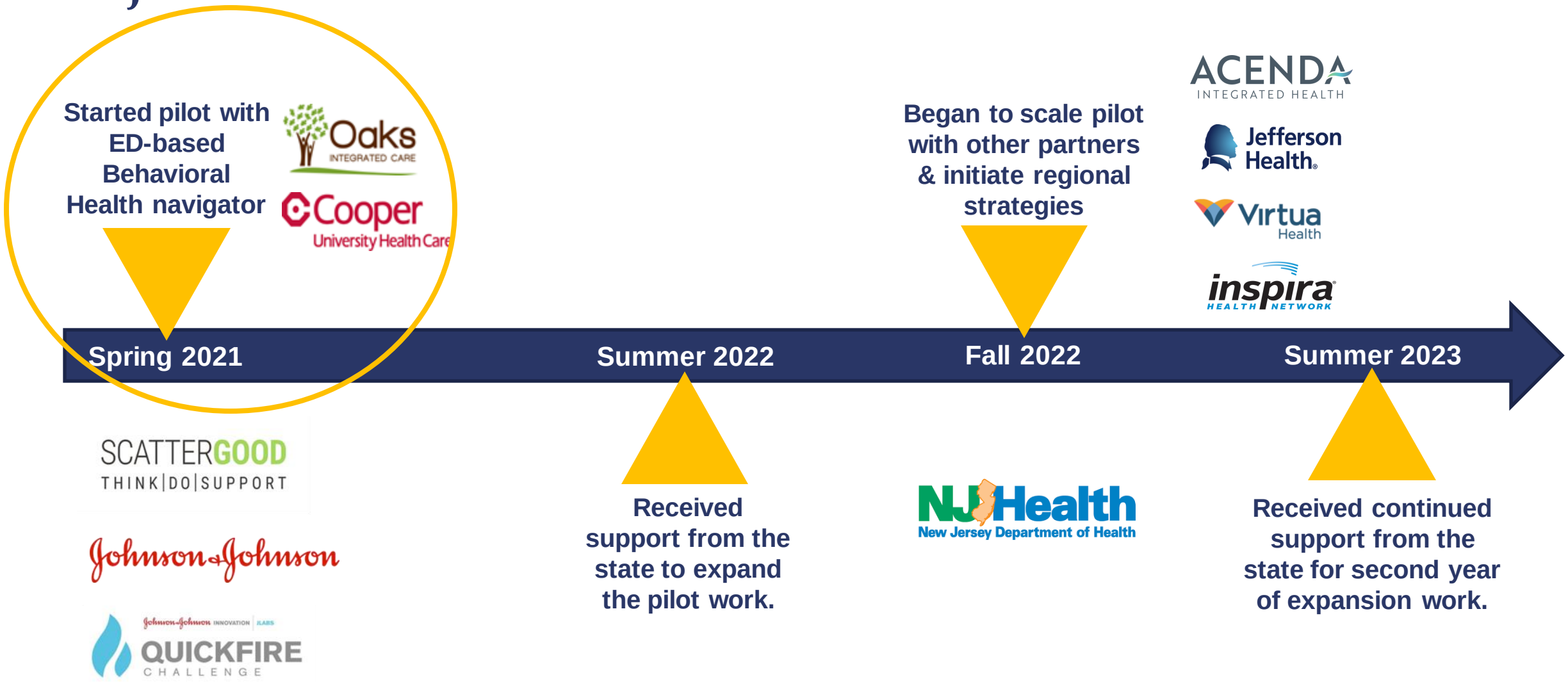
1) 2021 data: Adults with Mental Illness in Past Year Who Did Not Receive Treatment | KFF
2) Community Health Needs Assessment – Senator Walter Rand Institute for Public Affairs (rutgers.edu)
3) https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2722571

Proposed Solution:

The Pledge to Connect project is a cross-organizational collaboration to improve services for patients who visit the emergency department for behavioral health needs by connecting them to timely, appropriate, and person-centered outpatient services.

Camden Coalition
of Healthcare Providers

Project Timeline



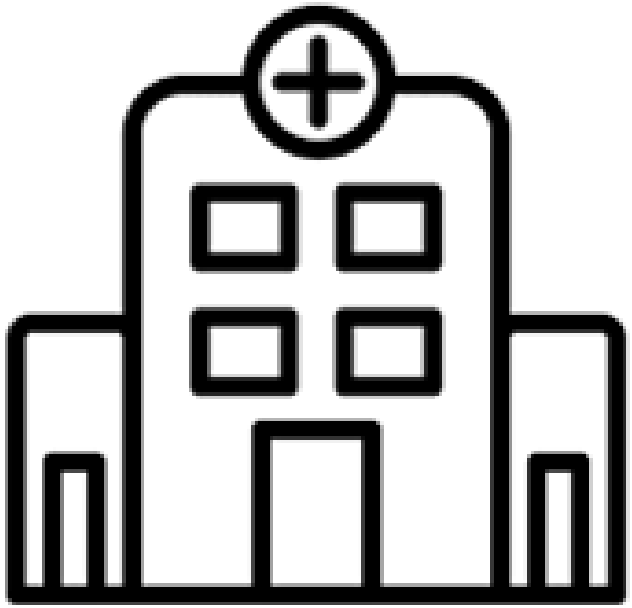
Landscape and Background: How The Collaboration Began

Shared Goals = Buy-In

Improve access to outpatient behavioral health by:

- Co-designing an ED-based navigator workflow
- Measuring feasibility of the workflow through quality improvement process
- Measuring impact of workflow on patient access and provider moral

Project Overview / Design



Individuals with BH needs seen in the Emergency Department

In-person engagement for individuals with higher-acuity needs

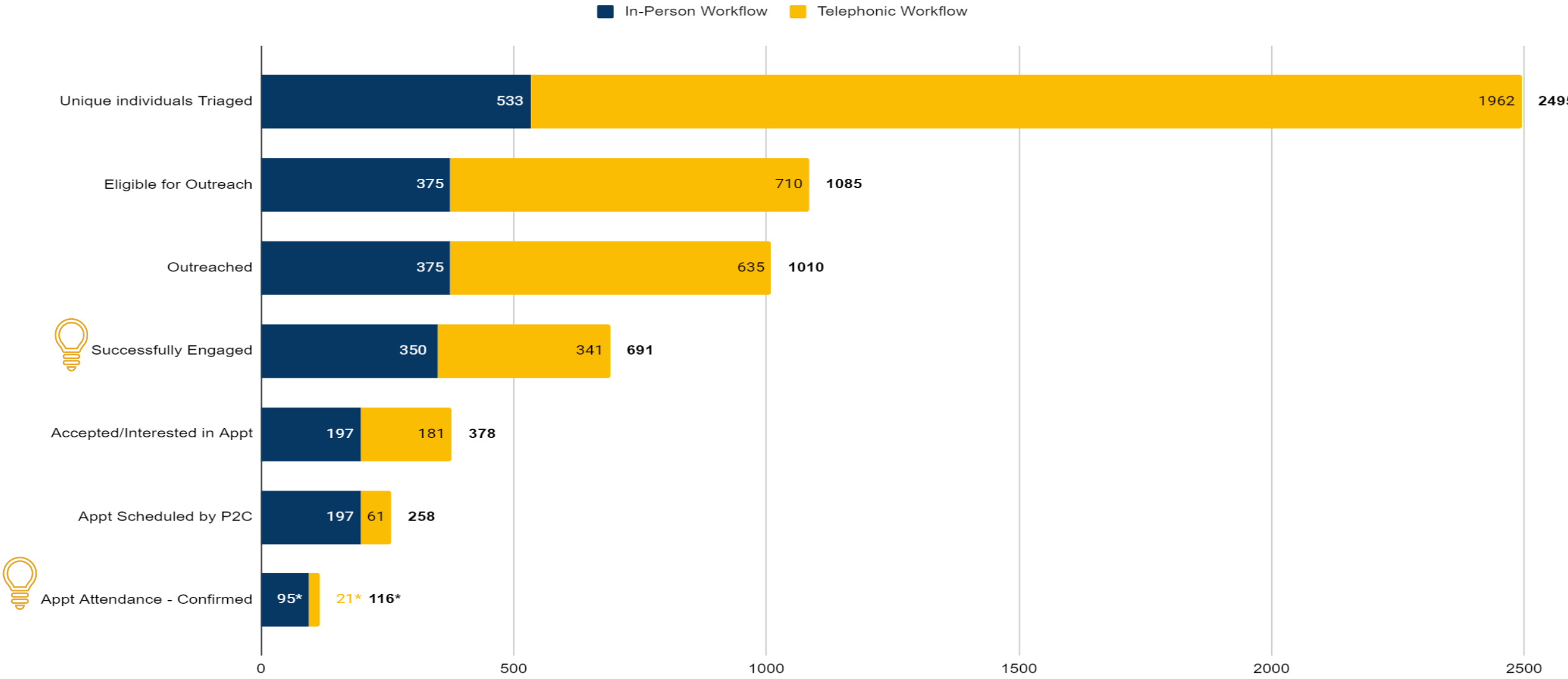
Telephonic outreach for people not engaged in person

Connected to MH Resources (Outpatient BH services, primary care, social service supports)

Camden Coalition
HEALTH INFORMATION EXCHANGE

Data and feedback are captured in the HIE to support reporting and feedback to the hospital stakeholders to improve workflow and patient experience

Process Measures: In-Person & Telephonic Interventions



Timeframe: July 1, 2022 to March 31, 2023

*An undercount due to appt being scheduled and attended outside of reporting timeframe

Future Steps (through June 30, 2024)

- Continue to scale/iterate on ED-based behavioral health navigator workflow with other health systems and build implementation guide.

- Launch additional initiatives such as:
  - Regional convenings
  - Collecting and sharing appointment availability

- Build a roadmap for BH data sharing through the Camden Coalition's Health Information Exchange

- Build a value case for scaling and make recommendations for sustainability

Q&A

The PATH Technical Assistance (TA) Marketplace initiative provides funding for California providers, community-based organizations, counties, and others to obtain technical assistance resources to establish the infrastructure needed to implement Enhanced Care Management (ECM) and Community Supports.

- ✓ **Domain 2:** Community Supports: Strengthening Services that Address the Social Drivers of Health
- ✓ **Domain 4:** Enhanced Care Management (ECM): Strengthening Care for ECM 'Population of Focus'
- ✓ **Domain 5:** Promoting Health Equity
- ✓ **Domain 6:** Supporting Cross-Sector Partnerships
- ✓ **Domain 7:** Workforce

Join us at

Putting Care at the Center 2023

Nov. 1-3, 2023 in Boston, MA

Early bird registration open March 29-July 3

Also available:

- Sponsorship opportunities
- Interprofessional CEUs
- Discounts
- Virtual access for those unable to travel

Putting Care at the Center 2023

Elevating behavioral health in whole-person care

Learn more → **camdenhealth.org/centeringcare23** | **#CenteringCare23**

Thank you!

National Center for Complex Health and Social Needs

An initiative of the Camden Coalition

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