

STORIES OF CHANGE

CLINICAL CARE TO TREAT THE WHOLE PERSON



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HOW WE'RE TRANSFORMING CLINICAL PRACTICE TO BETTER TREAT MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Well Being Trust is led by clinical experts who've dedicated their lives and careers to improving the well-being of patients and communities. We know the challenges patients, practitioners, and health systems face when it comes to addressing mental health and substance use disorders. Just as importantly, we know there are solutions and opportunities for change, and we understand the nation must work together to transform the way mental health care is provided and ensure everyone has access to high quality care.

To that end, one of the first things we did after our founding in 2016 was work with Providence St. Joseph Health to create, fund, and lead the Clinical Performance Group, a system-wide learning collaborative that aims to improve care and delivery. Transforming mental health care will help end the mental health and substance misuse crisis our nation faces and ensure our youngest live healthier, longer lives. Through this learning collaborative, we've unearthed solutions that cut across care environments, focusing on five critical areas: integrating behavioral health into primary care; transforming substance use treatment and services; finding better ways to care for people with mental health issues in the emergency department and address upstream non-medical factors; spreading high quality solutions for telebehavioral health; and implementing the Zero Suicide initiative system wide.

We envision a world in which no one struggles alone. The Clinical Performance Group is helping to move us closer to that vision. As our learning grows, we believe it will lead to best-in-class solutions that deliver the highest quality care; improved outcomes for patients and quality of work and life for caregivers; a blueprint for other systems and care settings to begin their own transformations; and a strong return on investment.

FIVE CRITICAL AREAS



INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY CARE



TRANSFORMING SUBSTANCE USE TREATMENT AND SERVICES



FINDING BETTER WAYS TO CARE FOR PEOPLE WITH MENTAL HEALTH ISSUES IN THE EMERGENCY DEPARTMENT AND ADDRESS UPSTREAM NON-MEDICAL FACTORS



SPREADING HIGH QUALITY SOLUTIONS FOR TELEBEHAVIORAL HEALTH



IMPLEMENTING THE ZERO SUICIDE INITIATIVE SYSTEM WIDE



IN THE EMERGENCY DEPARTMENT, SOMEONE WHO'S 'BEEN THERE'

A partnership between Hoag and NAMI Orange County aims to improve emergency care for mental health patients



Hoag Memorial Hospital Presbyterian's emergency department, in Newport Beach, California, saw very few patients who were in the midst of a mental health crisis when Christopher Childress first joined as a charge nurse 15 years ago.

But the volume of patients dealing with severe anxiety, depression, schizophrenia, suicidal ideation or other mental health issues increased exponentially over the years, he says, a [trend researchers have observed](#) across the country. Today, 10 or more Hoag emergency patients need psychiatric care each day, and their needs vary drastically from those of patients with physical ailments.

"I wouldn't describe an emergency room as a calm environment, and these patients would benefit from a calm environment," says Childress, who became the Hoag emergency department's nursing director last year.

Emergency departments have traditionally not been well-prepared to treat mental illnesses. And emergency mental health and substance using patients typically stay longer than medical patients, sometimes as long as several days. Patients must be stabilized (for example, if they have misused drugs or alcohol) and receive medical clearance. Sometimes, they have to wait for a psychiatric consult or transfer to a psychiatric bed.

INTEGRATING MENTAL HEALTH

Recognizing this lack of parity, Hoag and nine other hospitals across the nation are working with Well Being Trust and the Institute for Healthcare Improvement to find



ways to fully integrate care for those with mental health and substance use issues into emergency departments and the community. Michael Rose, director of the hospital's community benefit efforts, says some of the questions Hoag's emergency practitioners have been asking include:

- "What can we do to help people get on the right track to recovery and offer them hope?"
- "How can we connect them to resources while they're waiting?"

One answer was to tweak a program that NAMI Orange County, a nonprofit organization that supports people with mental illness and their families, already had underway. The organization had previously placed volunteer mentors in other hospitals' emergency waiting rooms to support family members. But



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— Aisha Khan
Mentor, NAMI Connects



they’d never had mentors in the “back” of the department, where patients spend long periods.

Last year, Hoag invited the program, called NAMI Connects, to place two part-time, paid mentors alongside the emergency department’s nurses, doctors and social workers. Using community benefit funds, the hospital enables NAMI to pay the mentors’ salaries. The two NAMI Connects mentors have lived experience with mental illness and specialized training to de-escalate tense or dangerous situations, calm patients down, empathetically connect with patients and their families, and provide social support.

They also can recommend services run by NAMI and other community organizations, including NAMI Orange County’s training programs that help families cope with a loved-one’s mental illness. About 20 percent of patients ask for follow-up phone calls from the mentors. On the calls, the mentors inquire how patients are doing and whether they are using prescribed medications or therapies, and walk them through how to get any additional help they need.

Mentor Aisha Khan uses her own history of anxiety and psychiatric hospitalization to put herself in patients’ shoes, build rapport and offer comfort.

“Stigma around mental health and mental illness is so prevalent. ... Even opening up and talking about their struggles is an intimate thing for patients to share,” she says. “I can say, ‘It’s OK. I’ve been there myself.’”

The mentors are able to bond with patients in a way that clinical staff just aren’t able to do, given their responsibilities in the emergency department, Childress says. For example, he’s witnessed mentors sitting and talking with patients for two hours straight. “It’s just not feasible for an R.N. to have the time to do that,” he says.

BUILDING MOMENTUM

As health systems across the nation grapple with how to better integrate mental health care into their emergency departments, innovative partnerships like Hoag’s and NAMI’s are an important step, says psychiatrist Arpan Waghray, M.D., Well Being Trust’s chief medical officer and system director for behavioral health at Swedish Health Services.

“An important component of improving mental health and stopping the alarming [rise in deaths of despair](#) from drug or alcohol misuse or suicide is transforming clinical care,” he says. “And we have to do that in a way that fits how patients actually seek care. If they go to the emergency room, we have to be in the emergency room.”

Childress says Hoag’s emergency department is taking other steps to make mental health patients feel cared-for and safe. His staff members have been trained in trauma-informed care, which takes patients’ past experiences into account when approaching their current behavior. And the hospital plans to bring psychiatric nurse practitioners into the emergency department within the next six months, to streamline mental health evaluations and appropriate treatment interventions.

For their part, NAMI’s mentors have begun looking for ways to also help other patients in the emergency department, many of whom may be struggling with mental health issues in addition to their presenting problems. The organization also is exploring expanding its program to the hospital’s acute medical floors.

That’s a testament to NAMI Connects’ success. “There isn’t a day where I feel that I haven’t helped somebody,” Khan says.



MAKING GOOD ON THE PROMISE OF COMPUTERIZED THERAPY

Can technology dismantle barriers to mental health treatment?



SWEDISH

Licensed clinical social worker Josh Cutler has helped many navigate the mental health care system. The process, he says, can be frustrating, even more so because people seeking care for mental health issues may already be incredibly stressed. When they bump up against difficulty getting the help they need, they can become even more distressed or drop life-saving treatments.

“People might reach out to a hotline, and they’re given a list of counselors,” Cutler says. “Then they call 10 and sometimes no one calls back. The road to obtaining really good care is rife with difficulty and has great potential for exacerbating despair.”

Now, as manager of telebehavioral health at Seattle health care network Swedish, part of the Providence St. Joseph Health system, Cutler is helping change how primary care clinicians deliver mental health care to their patients. He’s building



a team of clinicians who can offer virtual visits, blended therapy that happens both electronically and in person, and computerized screening tools that more efficiently pinpoint patients’ needs.

MENTAL HEALTH CRISIS

Approximately [44 million U.S. adults](#) face mental illness. And yet [six in 10 people](#) with mental illness did not get treatment in the past year.

“We have not been able to bend the curve and give people the treatment they need,” says Dr. Arpan Waghray, M.D., chief medical officer at the Well Being Trust and system director for behavioral medicine at Swedish.

The most pressing reason for untreated mental illness is that many people simply lack access to mental health care clinicians. [More than 6 in 10 U.S. counties](#) don’t have a single psychiatrist. And [many people](#) don’t try to get care, or don’t talk to others about the care they are getting, because of negative attitudes about seeking mental health care and lack of support from family and friends.

Of those who are treated, not many are able to access the best, evidence-based care available. And the way the health care system works means patients’ medical, psychiatric and family-support needs are handled separately. For example, when a diabetes patient is also suffering depression, their primary care physician may tell them to seek therapy. But the patient may not feel they got solid guidance from their physician or insurance company about where to get high quality therapy. This fragmentation can confuse patients and keep them from seeking or continuing care, leading them to do worse than they might have otherwise.

"Fragmentation just results in poor outcomes, people slipping through cracks," says Eviatar Frankel, director of digital strategy at Providence St. Joseph Health.

PILOTING SOLUTIONS

Along with Waghray and Cutler, Frankel is looking at how to use technology to improve patient care, empower clinicians and better address the mental health crisis in the communities where Providence St. Joseph Health works.

To start, they turned to primary care physicians and patients to learn what is keeping patients from getting the care they need.

In one-on-one guided interviews, patients reported difficulty finding a psychiatrist who was a good fit and fitting appointments into their daily lives. They said they were unable to get questions answered, and they experienced "screening fatigue" from being asked to answer the same questions over and over. Often, they said, these obstacles kept them from completing treatment plans, and their depression or anxiety would come back.

Using that feedback, the Providence St. Joseph Health team chose two digital solutions — [SilverCloud](#) and [myStrength](#) — which they piloted for six months in primary care clinics in Washington and Oregon. The tools supplemented in-person doctors' visits with computerized screening to measure patients' depression and provided educational content to help patients understand and cope with the condition. In addition, patients could undergo computerized cognitive behavioral therapy and mindfulness training, both shown to help people manage depression.

Because technology, in the form of a smartphone, is literally in the palm of many

patients' hands, digital mental health platforms like these have the potential to dramatically increase access, Waghray says.

"Patients don't have to drive across town and take off time from work for therapy, and it's not seven weeks from now," he says.

In other words, mental health care no longer has to be confined to the clinic.

RIGHT COMBINATION

Technology also has the potential to improve quality of mental health care by making it more uniform and measurable, as well as relieving some of the burden from primary care physicians, who deal with many competing priorities. And, with major improvements in artificial intelligence, computerized mental health screening and treatment can adapt to patients' needs, eliminating screening fatigue and more quickly matching patients with the right therapies.

"We want to make it as easy for doctors to prescribe digital therapeutic tools that reduce the symptoms of depression as it is for them to prescribe antidepressants, so that patients can get the right combination of treatments for them," Waghray says.

The team says so far 120 patients of the Oregon and Washington clinics have used the two solutions in the pilot.

"Now we're working on, 'How do we get this in hands of more patients, including through mechanisms that don't rely on doctors,'" Frankel says. "So much is going on in a primary care setting — finding a pathway to get as many patients on board as possible is our immediate next step."



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— Arpan Waghray, M.D.

Chief Medical Officer, Well Being Trust; System Director for Behavioral Medicine, Swedish Health Services





BRIDGING TREATMENT IN ALASKA

How an Anchorage hospital is transforming care for patients with substance use disorder



Amidst the nation's staggering opioid crisis, nurses like Kelly Ogden, who manages nursing staff at Providence Alaska Medical Center's medical unit, face the growing challenge of caring for patients who are struggling with substance misuse and withdrawal.

They come to Ogden's Anchorage hospital for medical conditions such as skin infections, abscesses, and infections of the heart and bones caused by injecting drugs. Patients with substance use disorder also have a high incidence of HIV and hepatitis C. Some are injured in accidents while under the influence of substances.

Until recently, Ogden said, conflict often flared at the Anchorage hospital between clinical staff and patients with substance use disorders. "We weren't treating the patients for their substance use disorders, so when they had withdrawal symptoms or uncontrolled pain, they were medicating themselves and going outside and using," she said. Many patients left too soon, against medical advice, because they felt stigmatized or marginalized. Their risk of overdose and ongoing drug use after discharge was high.

Others, said Ogden, were reluctant to come to the hospital at all because they feared being stigmatized by the clinical staff. Patients put off treatment until their medical illnesses had gotten much worse and more difficult to treat.

Now, the medical center is piloting several initiatives that enable patients to get the help they need for substance use disorders and other medical conditions. In April, the center launched a clinical pathway — a set of tools, procedures, and medications — for dealing with patients who experience substance use disorders. Medication assisted treatment, or MAT, helps to minimize withdrawal while at the hospital, and other medications are used to treat the symptoms of withdrawal that some patients may suffer.



"The bridge treatment center is a great test case that can provide a **proof point for the future of integrated care."**

— Robin Henderson

PsyD, Chief Executive Behavioral Health,
Providence Oregon & Clinical Liaison to Well Being Trust

The medical center also opened a bridge clinic that provides MAT to recently discharged patients. In these efforts, the center is supported by Well Being Trust and the Clinical Performance Group, which aims to better integrate mental health and substance use treatment into the nation's health care system, as well as by Providence St. Joseph Health and the State of Alaska.

"In the past, we primarily treated substance use disorders in specialty behavioral health settings," said Renee Rafferty, regional director of behavioral health for Providence Health and Services Alaska and co-leader of the Clinical Performance Group's Addiction Focus Group. "With these pilots, we're changing that."

A BETTER WAY

Under the clinical pathway, health clinicians at Providence Alaska Medical Center are trained to see opioid use disorder as a neurological condition that should be treated as soon as possible, Rafferty said. They assess whether patients in their inpatient units have opioid use disorder, and where they are on a withdrawal scale. If the patient needs it, they can prescribe drugs such as methadone and buprenorphine, which help ease symptoms of withdrawal so that clinicians can treat their medical problems.

At the same time, clinical staff focus on building positive relationships with patients, Rafferty said. "Making patients feel safe is part of exceptional care. Patients can't engage in care unless they feel they can safely talk about what's happening to them."

That means making sure staff don't view substance use disorders as a "moralistic or hedonistic failing" and that clinicians have the tools to adequately support patients in withdrawal, she said. It also means working closely with hospital security and the police to ensure staff are safe.

"When there's illegal or criminal behaviors, such as violent escalations or dealing drugs on our

campus, we want to make sure we're partnering with security — but it's grounded in our mission of reducing harm to patients," she said.

'HUGE WIN'

Once patients leave the hospital, it's critical they have support to continue on the path toward better health. So the hospital's new bridge treatment center offers recently discharged patients a range of outpatient services. These include MAT, peer support, individual intervention with a therapist, a prescribing clinician, brief intervention, and stabilization so patients can transition to a substance use treatment center if necessary.

"Without specific and integrated connections between physical treatment and mental health care, it is incredibly hard to solve the deeply rooted issues dealing with poor health and well-being," said Robin Henderson, PsyD, chief executive, Behavioral Health, Providence Oregon, and clinical liaison to Well Being Trust. "The bridge treatment center is a great test case that can provide a proof point for the future of integrated care."

In just a month, Ogden has seen four patients from her unit go on to the bridge clinic or other community treatment options. "To get someone treated for substance use after they leave the hospital is a huge win," she said.

Though the clinical pathway and bridge clinic are still new and their full impact is yet to be seen, clinicians and system leaders have high hopes the approach could work across health care and systems.

"The outcomes will prove that integrated, whole-person treatment improves health and drives down cost," said Philip K. Capp, MD, medical director of Providence Health Plans, in Seattle. "All that aside, it is the mission of Providence to serve the vulnerable. We will not leave anyone behind."



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Regional Director of Behavioral Health,
Providence Health and Services Alaska





MEASURING THE VALUE OF INTEGRATED CARE

To bring behavioral health and primary care together, health systems must first make the financial case



When someone with diabetes also has depression, they will likely have [more trouble keeping their diabetes under control](#) than a diabetic who is not depressed. Physical and mental health, in other words, are inexorably linked. Yet in general, American health care is divided in two: medical care on one side, mental health care on the other. And, although experts have for [decades](#) made the case for joining the two together at the primary care office, where most people seek help when they face mental health issues, progress has been slow.

A key obstacle, said Benjamin F. Miller, PsyD, chief strategy officer for Well Being Trust, is the way we pay for health care.

"Health care is paid for out of two pots of money, physical and mental," he said. "Integrating mental health into primary care is about a team of clinicians working in concert with a patient to give them what they need in a timely manner. But our payment system pays for individual clinicians and not a team, and it doesn't support primary care physicians and mental health specialists working together."

Already, [up to 60 percent of mental health treatment happens in primary care](#). Looked at the other way, [1 in 5 visits to primary care is related to mental health](#), a number that likely should be higher since [many mental health conditions go untreated](#). Yet, when mental health care comes in the form of a referral, many patients fail to get the additional help they need. Those who do get care, often don't get the best evidence-based treatment.

Miller believes more health care institutions would launch efforts to combine



behavioral health and primary care if they could easily show those who pay for care — insurers, Medicaid, Medicare —how much they could save on other aspects of health. So, he asked Denver-based actuary Steve Melek, of the global actuarial firm Milliman, to design a tool that can project exactly that.

“We want health care systems to be able to tailor solutions to their unique setting and population: how old their patients are, their payer mix, their staff,” Miller said.

Melek built the tool using commercially-insured, Medicare and Medicaid claim and membership data and patient outcomes in effective integrated programs. By averaging the impact effective integrated care programs have on healthcare costs, the tool projects healthcare cost savings over a five-year period. In the projections, users can simulate how an effective integrated care program’s positive results might grow over time. The tool reveals savings in pharmacy costs, emergency room visits, and inpatient and outpatient visits for both physical and mental health care.

“Some healthcare costs will go up,” Melek said. “If you integrate, you’re going to spend more time on some elements of healthcare in primary care settings. But then you get patients healthier, so you spend less in high-cost facilities and emergency rooms.”

Melek’s tool illustrates how the complex interaction between mental and physical health conditions drives cost across the health care continuum, said Philip K. Capp, M.D., medical director of Providence Health Plans, in Seattle.

“Accurately describing the cost impact of new delivery models is difficult due to how the money works,” Capp said. “The Milliman tool shows where savings might accrue if mental health care was embedded at multiple levels in the system. The most important setting is the medical home.”

Eventually, health care systems could use the tool to change the conversation around health care payment, he said.

“Carriers and clinicians understand that untreated mental illness and substance use lead to avoidable expense,” he said. “Sustainable care models addressing the whole person are predicated on reimbursement that incentivizes the same. This tool can start a reasoned fiscal conversation tuned to regional need to drive innovative care. The money is the money. It is what we prioritize that matters.”

Ultimately, the goal for health systems is to meet patients’ behavioral health needs wherever they go for care, said Robin Henderson, PsyD, chief executive, Behavioral Health, Providence Oregon, and clinical liaison to Well Being Trust.

“We have years of research showing integration helps patients do better,” she said. “But progress has not been swift enough. Now we’re making the business case to bring better care to patients sooner, rather than later.”



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— **Benjamin F. Miller**
PsyD, Chief Strategy Officer, Well Being Trust



