

# STORIES OF CHANGE

CLINICAL CARE TO TREAT THE WHOLE PERSON



# 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 Mental Health and Substance Use Disorder 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 Mental Health and Substance Use Disorder 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

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# 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

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.



"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. I can say, 'It's OK. I've been there myself.'"

— Aisha Khan  
Mentor, NAMI Connects





# CARING FOR CHILDREN'S MENTAL HEALTH NEEDS IN—AND OUT—OF THE EMERGENCY DEPARTMENT

A collaboration in Oregon could be a model for dealing with a troubling national trend.



Across the United States, emergency departments have seen a troubling rise in the rates of children and youth arriving in mental health crisis — [a 28% increase from 2011 to 2015](#). Within that overall

trend, emergency department visits by young patients who have attempted or contemplated suicide [doubled between 2007 and 2015](#). Visits by children and teenagers who've deliberately physically harmed themselves, with or without intent to end their own lives, [have also increased](#).

Strained emergency department staff are struggling to keep up with these trends, says Andrew Grover, executive director of [Youth Villages Oregon](#), which supports youth with emotional and behavioral issues. And, families with children who are suicidal, or dealing with other serious mental conditions or substance misuse issues, often leave the emergency department in need of intensive support, something hospital social workers typically are unable to provide.

"Families are overwhelmed with pain, grief and confusion when their children are contemplating suicide and even the most competent people are not good on following up on plans," Grover says. "They're just surviving."

To deal with the growing problem and make sure families are connected to the proper resources, several Oregon hospitals, including Providence St. Joseph Health's Providence St. Vincent Medical Center in Portland, Oregon, have asked

Youth Villages Oregon for help. In response, the organization adapted a mental health crisis response program originally developed by Youth Villages in Tennessee. In the Oregon program, members of a team of eight family intervention specialists are on call 24 hours a day. Within an hour of a young patient's arrival in the emergency department with a behavioral health issue, Youth Villages staff are on the scene to evaluate the young person, recommend a treatment plan and follow up for two weeks after discharge, if the family agrees.

"We become a part of the hospital team, but are also able to work beyond the walls of the hospital in the weeks following a family's crisis," Grover says.

## ROOTS OF THE CRISIS

The partnership has a number of goals: Ensure the youth and families get what they need to safely manage the crisis, establish stable connections to longer term treatment, avoid unnecessary hospitalizations, and prevent these families from needing to come back to the emergency department for help. The team also works to get children out of the emergency department as quickly as possible, because it's not a good environment for children in mental health crisis.

In pursuit of those outcomes, the family intervention team thoroughly assesses the young person's condition and needs, says Kandi Shearer, Youth Villages Oregon's assistant director of community services.

"We're unique in our capacity to gather information not only from the youth, but

also the parent or caregiver, emergency department staff, and/or community providers youth have worked with," she says. "We have a really good relationship with the schools, and we call them right away. By speaking to all those people, we get a clearer picture of what's going on so we can make the best recommendations for care."

For example, if the root cause of the child's distress can be traced back to school, Shearer and her colleagues meet with parents, school administrators and the child at school and make a plan to reduce triggers in that environment, as well as at home.

"We work on a safety plan with every family, but we also come up with a plan to reduce the factors that led to the crisis," she says.

### TRACKING PROGRESS

Since the program launched in January 2017, it's served more than 600 families a year and made a big difference, says Aaron Baker, PsyD, behavioral health outcomes program manager at Providence Oregon.

- **The rate of children staying in the Providence St. Vincent emergency department for 12 hours (or longer) during emergency visits for behavioral health complaints decreased 23% from 2016 to 2019.**
- **During the same period, the rate of children in the emergency department for a behavioral complaint who stayed 24 hours (or longer) also decreased by more than half (53%).**
- **In three years, the number of children with a behavioral health issue who visited the emergency department and returned within 7 days decreased by 60%.**
- **92% of children return home safely with support, rather than being admitted to an inpatient psychiatric program.**

"There's a lot of value to the education and support Youth Villages gives families after they go home," Baker says. "Transitions are hard and getting connected to care is hard. If you can have that support and get connections going, then things can improve, and the family doesn't have to go back to the hospital for another behavioral health emergency."

"Our partnership with Youth Villages Oregon is a wonderful model for supporting families during and after their visit to the emergency department, at what is an incredibly stressful time," says Robin Henderson, PsyD, Providence Oregon's chief executive for behavioral health and Providence St. Joseph Health's clinical liaison to the Well Being Trust. "But to make sure every child gets the right level of behavioral health treatment, communities must have a range of programs available."

### WARNING SIGNS OF SUICIDE

- **Talking about wanting to die or to kill themselves.**
- **Looking for a way to kill themselves, like searching online or buying a gun.**
- **Talking about feeling hopeless or having no reason to live.**
- **Talking about feeling trapped or in unbearable pain.**
- **Talking about being a burden to others.**
- **Increasing the use of alcohol or drugs.**
- **Acting anxious or agitated; behaving recklessly.**
- **Sleeping too little or too much.**
- **Withdrawing or isolating themselves.**
- **Showing rage or talking about seeking revenge.**
- **Extreme mood swings.**

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*National Suicide Lifeline, 1-800-273-8255*



**"We work on a safety plan with every family, but we also come up with a plan to reduce the factors that led to the crisis."**

**— Kandi Shearer**

Assistant Director of Community Services, Youth Villages Oregon





# SEEKING BETTER RESULTS FOR BEHAVIORAL HEALTH PATIENTS

Emergency departments aren't set up for patients with behavioral health concerns. Providence Regional Medical Center Everett is redesigning its standard of care.



Emergency departments are well-designed to understand patients' medical needs and how urgently they need help. If a patient has chest pain or is turning blue, they're automatically triaged/prioritized out of the

waiting room. But when it comes to treating people with behavioral health issues, standard protocol often fails to adequately provide the most effective care.

"Unfortunately, emergency departments have become the last safety nets for communities," says Arpan Waghay, M.D., chief medical officer for Well Being Trust and system director for behavioral medicine at Swedish Health Services in Seattle. "If there's a substance misuse or mental health crisis, the only place people can go tends to be the emergency department."

The trend has continued to worsen over the years — today, one in eight visits to emergency departments in America is related to a behavioral health concern. Even less considered, according to Waghay, is the nearly 30 percent of patients who come into emergency departments with medical complaints and also have an underlying behavioral health complaint, that might be contributing to that ED visit.

In an effort to correct a fragmented system, the Well Being Trust funded the Providence Regional Medical Center in Everett, Washington, to work with the nonprofit Institute for Healthcare Improvement. They're testing new tools and standards to improve the quality of care provided to behavioral health patients in emergency departments across the Providence system.

## SYSTEMATIC APPROACH

As a result, a national learning collaborative with eight leading health systems across the country was launched to consider the patient's journey from the moment they come to the emergency department to the follow-up care they receive post-discharge.

"If you don't take a systematic approach to behavioral health patient care, you'll only see a piece of the puzzle," Waghay says. "And then you're just putting a band-aid on the problem, and that's bound to set patients up for failure."

To ensure behavioral health patients don't have expensive and ineffective care experiences, Providence Regional Medical Center is adopting a nursing triage tool developed in Australia that takes behavioral health factors into consideration when processing where patients should be in the line of care.

Consider a patient coming into the emergency department with an asthma attack. Emergency departments will begin treatment, follow up to see if the treatment is effective in stabilizing the patient, and adjust accordingly to ensure they are receiving the proper care. Emergency departments typically don't use a similar protocol for behavioral health patients.

"There's a determination that the patient is either going in for inpatient psychiatric care, or they're going home with generic follow-up care information," Waghay says. "There's less focus on trying to treat and stabilize the patient in a way similar to that asthma patient."

This new standardized assessment will ensure emergency departments consider



behavioral patients' health status during triage and follow protocols that ensure their care is taken step by step, just as it would be for a medical health complaint. The goal is to equip emergency departments to treat behavioral health patients in a more thoughtful and timely manner to prevent a crisis and improve quality of care.

### TRAUMA-INFORMED

Better triage is only one part of the equation, though, as the medical center considered ways to more effectively treat behavioral health patients, including trauma-informed care, says Medical Director Ryan Keay, M.D.

A trauma-informed approach to health considers the trauma people have experienced in their lives and aims to treat patients with empathy and understanding of those experiences, she says. Currently, staff and providers working in the medical center's emergency department are undergoing trauma-informed care training. The goal is to incorporate the lessons into new employee training in the future.

This approach is also being prioritized across other parts of the Providence system. Angela Graves, professional practice and development, systems and quality manager, at Oregon Regional Emergency Services, says trauma-informed care has become a focus within the registered nurse residency program there, as well.

"Trauma-informed care requires us to consider more than the medical part of a patient's experience," Graves says. "We have to think about what else we should know about the patient to improve their quality of care. A large part of that is about asking the right questions, but it's just as much about picking up on non-verbal cues, which can be difficult if you don't know what to look for."

### BEYOND THE EMERGENCY DEPARTMENT

Traditionally, behavioral health patients who are discharged from emergency departments don't leave with a treatment plan, as a medical patient would. Under Providence Regional Medical Center's new approach to care, patients will leave with an at-home treatment strategy, Keay said. They are also now receiving follow-up calls from a nurse, who will help them overcome any barriers to accessing care they may have encountered.

Community partners now play a major role in ensuring a smooth transition of care following discharge. Providence Regional Medical Center has reached out to community health partners, law enforcement, emergency responders, and others to share best practices for supporting behavioral health patients. The medical center also works with these partners to develop and follow community-based care plans, in which various partners create a uniform standard of care for behavioral health patients, no matter who is providing it.

These partnerships ensure penetration of methods, such as mental health first aid training and de-escalation methods, are in place within the community. This ensures people experiencing behavioral health issues have greater support, which could keep them from landing in the emergency department.

To Waghray, these efforts are part of a greater moral obligation to properly care for every patient that walks in the emergency department doors.

"If someone comes in with a stroke, there are specific expectations of care that are consistently followed using the best science we have available," he says. "I want to bring the same expectations to behavioral health."



**"Trauma-informed care requires us to consider more than the medical part of a patient's experience. We have to think about what else we should know about the patient to improve their quality of care."**

— **Angela Graves**

Professional Practice and Development,  
Systems and Quality Manager,  
Oregon Regional Emergency Services





# CARING FOR THE CAREGIVERS— AND THEIR FAMILIES

Well Being Trust is helping Providence St. Joseph Health make sure its staff members are well taken care of so they can provide high-quality, passionate care for patients.



**SWEDISH**

Burnout rates among health care staff have long been a concern. Today, about 44% of caregivers in health professions experience signs of burnout — feeling disengaged, cynical, or apathetic. A stressful work environment and taxing schedule take a toll on the health of these professionals — but organizations are stepping up to safeguard the well-being of those who care for people in need.

“Caregivers face long hours and work trauma, caused by navigating death and human suffering on a daily basis,” said Arpan Waghray, M.D., chief medical officer for Well Being Trust and system director for behavioral medicine at Swedish Health Services in Seattle. “And because they always have so much on their plates, it’s difficult for them to even find time for selfcare, let alone to seek professional help should they need it.”

With this in mind, Waghray and his team are going upstream to improve the well-being of caregivers and ensure they receive timely care. In June 2019, they launched a behavioral health “concierge” program, piloting it within Providence St. Joseph Health’s Seattle-area staff. The program provides virtual counseling to caregivers and their dependents to increase access to critical services in a way that best fits busy schedules and needs.

## A MODEL THAT WORKS

In the few months since the program’s launch, about 100 caregivers have made more than 300 visits to the service for a range of reasons. For example, when one Swedish Health Services employee unexpectedly lost a loved one, they had panic attacks, couldn’t sleep or eat, and didn’t function well at work. They called the behavioral health



**“Telehealth is a great  
tool to deliver mental  
health services.”**

— **Josh Cutler**

Clinical Lead for the Behavioral Health Concierge  
Program at Swedish Health Services

concierge program and had a virtual appointment just one hour later. A member of the program's counseling team offered supportive listening and an emotional safe space to work through what had happened, all while the caregiver was comfortable in their own home.

"Telehealth is a great tool to deliver mental health services," said Swedish's Josh Cutler, who manages and is clinical lead for the concierge program.

Feedback from caregivers and leadership gave rise to the program. While Providence was making strides prioritizing the mental health and well-being of patients, caregivers continued to struggle with mental health concerns and reported not having adequate resources to address them.

In response, Providence's telehealth team created a program that ensures caregivers will have a place to talk about their struggles and receive support. A counseling team consisting of five licensed clinical social workers offers same-day and next-day appointments as much as possible, ensuring accessibility when caregivers need it most.

"This program provides solutions that fit modern life — no one has to take time off to travel to an appointment because it's virtual and that makes the program incredibly accessible," said Patrick Lee, product director of telepsychiatry and telebehavioral health at Providence.

To better fit behavioral health care into caregivers' busy days, Providence landed on a brief yet intensive evidence-based therapy model. Staff can also opt for computerized cognitive therapy, which consists of tailored online therapy modules that can be completed at the caregivers' desired pace. The modules have demonstrated results comparable to traditional, in-person counseling services, Cutler said.

#### FILLING A GAP IN CARE

In many regions where Providence has a presence, mental health providers are scarce and hard to access, fueling the need for more in-house mental health services across Providence's map. In fact, 68% of caregivers who have used the program at Swedish say they wouldn't know how to get care if the concierge program didn't exist, Waghray said.

Confidentiality was a major concern prior to the program's roll-out. Providence went to great lengths to ensure documentation and scheduling would live in a highly restricted place in health records that only the counseling team could see.

Lee and his team are focused on making sure the program is effective. To that end, they are measuring service use and volume of consultations to determine what might need to be improved moving forward. They're also prioritizing employee satisfaction and looking to decrease burnout. Their net promoter score — which measures how likely a user would be to recommend the service to someone else — is in the 80s, Lee said. And they are using other clinical evaluations and tools to track improvement in health among caregivers over time.

Soon, Providence will roll the program out to all the regions it covers: first, to the rest of Washington and Montana, then to California, Texas, Alaska, Oregon and New Mexico in a phased approach during 2020. At that point, the program will be available to 110,000 caregivers and 80,000 to 90,000 dependents, Waghray said.

"I think everyone clearly understands that you need to take care of your caregivers if you want to provide the best care to patients," he said. "But we knew we could do more, so we created this program — and, so far, it's been tremendously successful."



**"This program provides solutions that fit modern life — no one has to take time off to travel to an appointment because it's virtual and that makes the program incredibly accessible."**

— **Patrick Lee**

Product Director of Telepsychiatry  
and Telebehavioral Health at  
Providence St. Joseph Health





# MAKING GOOD ON THE PROMISE OF COMPUTERIZED THERAPY

## Can technology dismantle barriers to mental health treatment?

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 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."



**"We want to make it as easy for doctors to prescribe digital therapeutic tools as it is to prescribe antidepressants."**

— **Dr. Arpan Waghray**

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





# 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.



**"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."**

— **Renee Rafferty**

Regional Director of Behavioral Health, Providence Health and Services Alaska

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 Mental Health and Substance Use Disorder 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 Mental Health and Substance Use Disorder 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, M.D., 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."



"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





# PROMOTING STUDENT WELL-BEING TO SAVE LIVES

Providence St. Joseph Health and Well Being Trust are working with young people and schools to talk about teen mental health and take action to improve it.

As an advocate for teen mental health, JJ Riddell believes in breaking silences.

“For a long time, many viewed mental health as a more personal thing that you shouldn’t talk about, but just deal with,” said the high school senior from Redmond, Oregon. “But, our generation is bringing the topic into more conversations and more actively seeking help.”

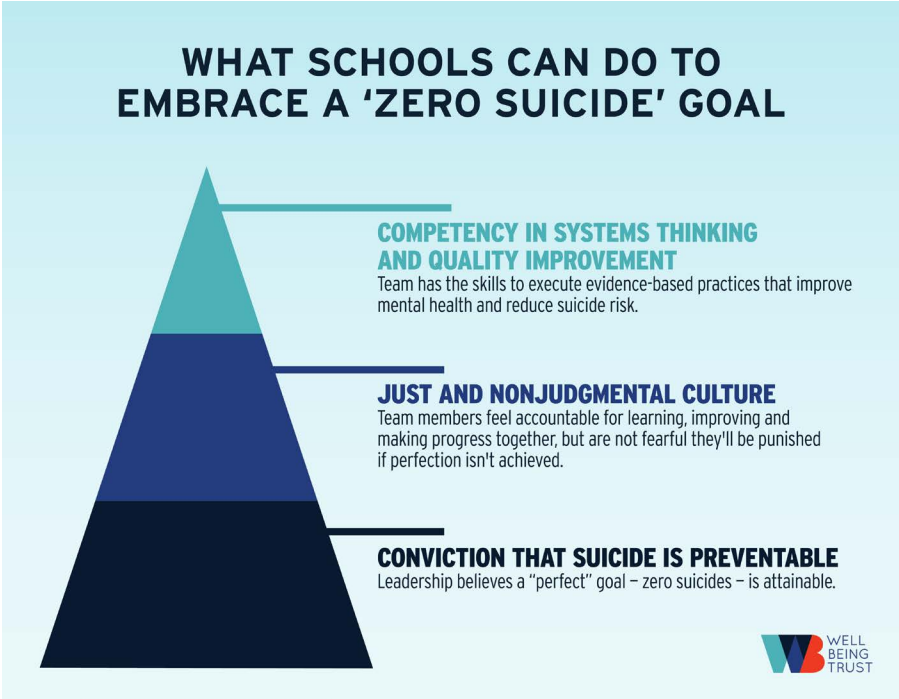
Riddell is a member of the Be Well Student Advisory Board, a project of Well Being Trust and Providence St. Joseph Health through which Oregon student leaders promote awareness of behavioral health issues and advocate for policies that benefit their peers. He’s also lost a friend to suicide.

“It was a very hard thing to go through,” he said. “Students at my school felt a great loss that flooded throughout the community.” Students and parents at Riddell’s school, Redmond High School, responded by filming [“Your Life Matters,”](#) a video about the challenges people throughout a school and community face every day. But, Riddell said, “The school could have provided more help and resources to the students.”

With U.S. teens [naming anxiety and depression as top problems](#) for them and their peers — more so than bullying, drugs and alcohol, or poverty — students and adults who work with them are calling for change. So, as Providence St. Joseph Health and Well Being Trust look for ways to better the mental health and well-being of young people, they’re including student leaders and schools in the solution.

### STUDENT ACTION

With a strong conviction that schools and society at large should prioritize students’ mental and emotional well-being, Riddell and other members of the Be



Well advisory board are building momentum among students and educators to create change. The advisory board helped shape a [“Be Well” radio campaign to initiate dialogue around mental well-being](#) and successfully advocated for Oregon legislation that allows students to take [sick days for mental health](#).



They also created a podcast, Talk2BeWell, that addresses issues teens care about such as healthy relationships and gun violence prevention. And earlier this year, they [hosted a conversation](#) among Oregon school administrators, student councils and Dr. Justin Coffey, a co-founder of the Zero Suicide movement, about how suicide impacts everyone in the community.

[Developed at Henry Ford Health System](#), in Detroit, the Zero Suicide approach maintains that suicide can be prevented and even eliminated when certain elements are in place.

The advisory boards' efforts, said Robin Henderson, PsyD, chief executive of behavioral health at Providence Oregon and Providence St. Joseph Health's clinical liaison to the Well Being Trust, are "opening up the conversation about adolescent mental health and emotional well-being."

Students can take action in their own lives, too, Riddell said. "I think students can keep aware of themselves and the people around them. To always make sure they understand how they are feeling and if it's healthy."

#### WHAT SCHOOLS CAN DO

Because schools are where students spend most of their time — and build, grow, and maintain many important social relationships — they are essential partners in boosting a culture of well-being among young people. Riddell said to help more students facing behavioral health issues, it's important to

"break the divide" between them and teachers so that everyone can communicate openly.

"Schools can start the conversations with their students, letting students know that the school is a resource," he said. "I also believe that schools should implement a mental health curriculum so students can be educated on the topic."

Coffey said schools or districts that want to take a Zero Suicide approach, with the goal of having no suicides among members of their community, must embrace a certain philosophy.

"The foundation of Zero Suicide is a conviction that eliminating suicides is possible," he said. "If your team holds that conviction, then suicide does in fact become preventable."

The next layer is what Coffey calls a "just culture" in which leaders promote learning and improvement without judgment. "Eliminating suicide is an audacious goal, so people must be inspired to work hard in pursuit of that goal rather than being criticized if they fall short of it."

Kelly Beaudry, special programs administrator at Oregon's Lincoln County School District, was among the school staff who attended the conversation with Coffey. She said her district is working to adopt a more systematic and proactive approach to promoting its students' mental well-being.

"We already have a suicide prevention protocol," Beaudry said. "Now, we're looking at 'How does student well-being and suicide prevention fit into our K-12 curriculum?' We want to be able to have this be a core part of our counseling program."

She is also working with other institutions in the community, such as a crisis hotline and behavioral health providers, to align their protocols so that students receive the same help no matter who they turn to. In the same vein, Beaudry envisions the counseling staff training teachers and other staff down the road, so everyone who works for the school district is equipped to guide students toward better mental health and well-being.

Meeting children's mental health needs is a goal the entire nation should embrace, Henderson said. "If we can help students care for themselves now, we will build a generation of adults able to care for their own mental health and well-being — and that of their children and grandchildren down the line, creating lasting benefits."

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*If you or someone you know is having a difficult time and would like to talk to someone about it, there are people who want to help. Call the National Suicide Prevention Lifeline at 1-800-273-8255. Or for teens who want to talk to other teens, call Teen Line at 310-855-4673, or text TEEN to 839863. You can also text LA to 741741 to talk with a trained Crisis Counselor for free, 24/7. For more information check out [www.crisistextline.org](http://www.crisistextline.org).*



**"The foundation of Zero Suicide is a conviction that eliminating suicides is possible. If your team holds that conviction, then suicide does in fact become preventable."**

**— Dr. M. Justin Coffey**

Pioneering member of the Zero Suicide Initiative





# AIMING FOR ZERO

**Dr. Arpan Waghray discusses how Well Being Trust is supporting Providence St. Joseph Health in working to reduce deaths by suicide.**

Pioneered by the Henry Ford Health System, Zero Suicide develops a systematic process through which caregivers assess and reduce the risk of suicide among their patients. The model gained widespread recognition after Henry Ford experienced an 18-month period with no suicide deaths in 2009-2010.

As Well Being Trust's Chief Medical Officer, Dr. Arpan Waghray (who is also system director for behavioral medicine at Swedish Health Services, within Providence St. Joseph's health) is working with a team, including Drs. Robin Henderson, Paul Giger, and Howard Mun to help guide an effort to implement Zero Suicide across a system that spans seven states.

We spoke to Dr. Waghray about why Well Being Trust and Providence are aiming for zero suicides, challenges to the approach, and how the initiative is being rolled out.

## **WHY IS THE ZERO SUICIDE MOVEMENT IMPORTANT WITHIN THE HEALTH CARE INDUSTRY?**

Zero Suicide is a cultural shift for health care organizations. To move from a resigned acceptance of deaths by suicide to implementing an active process to prevent such deaths is a significant change in the way we work and deliver care.

The movement has been taking off for quite some time. Deaths by suicide impact caregivers, patients and family members alike, and people recognize it's time to do better. Zero Suicide is driven by aspiration, but the rationale and core components of the initiative are based in good science. As we consider how to reliably and consistently provide for patients in crisis, we need to ensure that every place where we offer care is prepared to carry out these new standards.

## **WHERE ARE YOU IN THE IMPLEMENTATION PROCESS?**

The first step is to complete a Zero Suicide self-study which helps organizations understand their readiness to implement the initiative. It takes into consideration our current state of care to help create a plan that meets us where we're at. This includes looking at things like how well we screen for warning signs in our various care centers, what protocols we have in place to ensure evidence-based care for patients in need of a safety plan, and how we provide care in context and connect patients with next levels of care.

Each of our seven regions — Washington, Montana, Oregon, California, Texas, Alaska, and New Mexico — is completing the self-study for their system, as well as for their various service areas in order to identify higher risk areas that may need a different or more specific approach. Once we have completed this process, we will use the information to develop a strategic plan for implementing Zero Suicide across the entire Providence system.



### WHAT ARE THE CHALLENGES IN MAKING SUCH A WIDE-SCALE CHANGE?

Right now, there's a lot of variability across service areas and regions. Caregivers in some areas know how to address the subject; others do not. We're trying to move toward a place where we can provide patients with a high level of reliability and best practices no matter where they are in our system, but we need to be very thoughtful about how we do so.

The goal of Zero Suicide is for there to be no harm done or errors made, but it's unrealistic to aim that high without what the Zero Suicide movement's founders call a "just culture." The expectation of no errors can generate anxiety among caregivers, so we have to be clear that this isn't about shaming them or putting them under scrutiny over things that may have been out of their control. Rather, it's about driving a cultural shift and putting processes in place to ensure everyone can do their very best to help patients in moments of despair.

### WHAT ELSE WILL NEED TO BE DONE FOR ZERO SUICIDE TO BE FULLY EFFECTIVE?

Right now, we're focused on getting ourselves organized around a common cause — ending deaths by suicide — and creating a process to help understand where we are and what we need to do to reach that goal. In the years to come, we will have to figure out how to best allocate resources and measure effectiveness of the initiative's various interventions.

And, while we want to do the best we can, we can't prevent deaths by suicide by focusing only on our health system. Another significant part of this process is finding ways to partner with the communities we're in, such as schools, law enforcement, first responders and faith-based communities.

Ultimately, we don't need to be constantly reinventing the wheel. There are many groups implementing Zero Suicide, like the Henry Ford Health System. As we move ahead, we look forward to sharing and learning from others along the way.

That said, Well Being Trust hopes our implementation can become a gold standard model for other large health systems that span across multiple regions, so we can advance an integrated approach to suicide prevention — and get to zero — across the country.

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*If you or someone you know is having a difficult time and would like to talk to someone about it, there are people who want to help. Call the National Suicide Prevention Lifeline at 1-800-273-8255. Or for teens who want to talk to other teens, call Teen Line at 310-855-4673, or text TEEN to 839863. You can also text LA to 741741 to talk with a trained Crisis Counselor for free, 24/7. For more information check out [www.crisistextline.org](http://www.crisistextline.org).*



**“Zero Suicide is a cultural shift for health care organizations. To move from a resigned acceptance of deaths by suicide to implementing an active process to prevent such deaths is a significant change in the way we work and deliver care.”**

— **Dr. Arpan Waghray**

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





# CLINICS TRAINING CLINICS ON HOW TO EXPAND BEHAVIORAL HEALTH CARE

## How Oregon's Providence Medical Group is helping a PSJH's Northern California system integrate mental health into primary care.

As many as **two out of five** patients seen in primary care also have behavioral health concerns. And though primary care clinics are where many patients turn to seek mental health consultation and treatment, many U.S. health care providers still struggle to meet their needs.

Dr. Vanessa Casillas, Providence Medical Group's director of psychology, knows change is possible for Americans suffering from behavioral health problems who think they have nowhere to turn. Over the course of nearly a decade, she's led Providence Medical Group, in Oregon, on a journey to make behavioral health care as seamlessly available as possible in its primary care clinics.

"A different approach, known as behavioral health integration in primary care, improves access and addresses a lot of patient's needs — biological, psychological,



social and spiritual — in the context of the medical home in a way that improves coordination of care and helps patients manage their whole health," she said.

Promoting behavioral health integration in primary care is a top priority for Well Being Trust, which works alongside Providence St. Joseph Health to fund the Mental Health and Substance Use Disorder Clinical Performance Group — a learning collaborative working to improve the quality of care, especially behavioral health care, and delivery across health systems.

Since implementing the behavioral health integration in primary care model, Casillas and her colleagues have seen significant improvements in access to care as well as improved treatments for depression and anxiety.

Now, they are working to share what they have learned by partnering with St. Joseph Medical Group in northern California to provide consultation as they find a place for behavioral health integration in their clinics, too, and aim to meet more patients' mental health needs.

### FINDING THE RIGHT MODEL

Though Providence Medical Group has had measurable success using embedded care, putting it in place involved a great deal of trial-and-error and took years to perfect. From assigning billing codes to determining the best division of work among providers, Casillas and her team had to consider the impact of every decision, learning as they went. All the while, they kept in mind the stigma around mental health and staff's facility with addressing these concerns so the medical group could make sure patients would feel comfortable seeking and receiving care.

The most challenging — and most important — decision came in the beginning, when they had to decide on the right model of care. Casillas and her team weighed whether a traditional 45- to 60-minute therapy model or a brief, 15- to 30-minute consultation model would best fit the needs of their patient population.

Though the brief consultation model would require Providence to identify other places in the community or along their care continuum where they could refer patients who needed a higher level of care, the traditional therapy model would limit the number of patients that providers would be able to see each day.

Ultimately, Providence opted for the former to reach more patients, Casillas said. And, in the last 12 months, the team has completed 47,000 appointments.

### **PARTNERSHIP FOR SUCCESS**

After all of their efforts, Providence behavioral health leadership team was more than ready to share their years of learnings and help St. Joseph Health Medical Group (SJHMG) integrate behavioral health and primary care in a way that is tailored to the needs of its community. Representing three large areas from wine country to the Oregon border, the northern California system serves a vast region where behavioral health resources are in high demand but low supply.

"There's a huge need for behavioral health care in northern California that's going unmet," said Dr. James DeVore, chief medical officer of St. Joseph Health Medical Group (SJHMG). Most patients have to find private behavioral health providers on their own, but that's tough, he said, because steep housing costs, destruction from wildfires and, in remote Humboldt County, a wet climate deter behavioral health specialists from coming to the area.

Since January, the team at Providence has been guiding DeVore and his northern California SJHMG team as they develop protocols for a new embedded care model and work to recruit providers. So far, St. Joseph has hired a psychiatrist who will serve as a regional resource to the entire behavioral program. The next step is to hire five behavioral health providers — two each for Sonoma and Humboldt Counties, and one for Napa County.

The two medical groups also have been shadowing each other's clinic staff and meeting to discuss the structure and needs of each of their communities. In the future, Casillas said they hope to help St. Joseph scale and spread their behavioral health work across their entire group.

Those involved say the partnership has benefitted both sides, with providers of both systems sharing resources and knowledge and reaching out to each other for help and guidance.

"In addition to learning from the other region — whether it's about workflows and assessment tools or integrating behavioral health care — we're forming valuable relationships with colleagues in California who want to work together," said Robin Henderson, PsyD, chief executive of behavioral health at Providence Medical Group and clinical liaison to Well Being Trust. The ultimate beneficiaries of those relationships, she said, will be both systems' patients.

"We could not be more appreciative of the support and expertise we have received from Robin and Vanessa and the Oregon team," states DeVore. "Aside from our deeply held dispute about Oregon vs. Sonoma pinot noir, we have a fantastic relationship!"



**"There's a huge need for behavioral health in northern California that's going unmet."**

**— Dr. James DeVore**

Chief Medical Officer, St. Joseph Health Medical Group in northern California





# A STANDARD OF CARE FOR DEPRESSION

Addressing one of America's most common mental illnesses can be challenging for primary care providers. This is one example of practitioners working to change that.



One of the most common mental illnesses in the United States, depression affects about 17.3 million adults — more

than the number of people who have survived cancer. The disease deeply impacts people's health and their ability to live a good, productive life. And it often goes [hand-in-hand](#) with other diseases, like cancer, heart disease and HIV. When people with these medical conditions also develop depression, the cooccurrence can greatly affect their response to medical treatment and their ability to recover.

"Major depression is a treatable cause of pain, suffering, disability and death," says Arpan Waghray, M.D., chief medical officer for Well Being Trust and system director for behavioral medicine at Swedish Health Services in Seattle. "Effective treatment is essential for helping people realize their fullest potential for well-being."

Yet only about [half of adults](#) with depression are treated for the disease, he says, and only about [20 percent to 40 percent](#) of those patients show substantial improvement.

## CREATING A PATHWAY

All of this makes depression an important condition for health systems to tackle head on. To that end, Providence St. Joseph Health gathered input from primary care physicians across its systems and developed what is known as a care pathway for depression. Integrated into the health system's electronic medical records, the pathway aimed to guide physicians through screening patients for depression and diagnosing the disease; treating the disease or connecting patients to care online or via a specialist; and helping patients manage medication and symptoms.



**"The depression pathway will likely be really helpful, too, in places that don't have embedded behavioral health providers."**

— **Vanessa Casillas**

PysD, Director of Psychology in Oregon and Southwest Washington for Providence Medical Group

The goal, Waghray says, was to enable doctors to give patients with depression a consistent standard of care and, ultimately, bring the disease into remission for more patients.

“Primary care providers are frequently asked to do more with less,” Waghray says. “The depression care pathway was created with providers in mind, to help make the right thing easy to do.”

Within three months of rolling out the pathway in one clinic, 30 percent of patients had been screened for depression — but the goal is to expand further and wider.

In June, a new workgroup convened for the first time to begin assessing the existing pathway and determining the steps needed to improve it and create what they are calling the Depression Care Pathway 2.0.

#### WHOLE PERSON CARE

An important component of the new effort will be assuring doctors that they will be supported throughout the process of identifying and treating patients with depression, says workgroup co-leader Megan Chiarelli, M.D., Providence St. Joseph’s medical director for behavioral health integration into primary care in Southern California.

“Physicians are concerned that if they get a positive depression screen, or have a patient with suicidal ideation, they won’t know what to do, or they don’t have psychiatric resources,” Chiarelli says. “We’re going to emphasize that medicine is constantly evolving and let physicians know, ‘This is another aspect of whole person care, and we will give you the tools to manage it.’”

The pathway will have to be flexible, taking into account regional differences and the patient-physician relationship, says Vanessa Casillas, PsyD,

director of psychology in Oregon and Southwest Washington for Providence Medical Group, a five-state network of clinics and physicians. The group’s Oregon practices have behavioral health providers embedded into their medical-home teams, but other regions are at different points in the process of developing and implementing behavioral health care in their primary care clinics, Casillas says.

“The depression pathway will likely be really helpful too in places that don’t have embedded behavioral health providers,” she says. “The pathway provides guidance based on best practices for everything from screening for depression to a prescribing algorithm for medical providers when needed. It also leaves room for clinical judgment and shared decision-making based on the patient’s history and current status. There’s usually a number of relevant factors to consider.”

Workgroup co-leader Howard Mun, PharmD, who directs Clinical Quality and Governance for Providence Saint Joseph Health’s Physician Enterprise, serving 9,000 providers and over 900 ambulatory clinics, says the team working on this project will also keep in mind the changing nature of technology.

“We knew, when we developed the original pathway, that what we had then wasn’t going to be our final destination. We knew technology and the electronic medical records were going to change,” he says. “And they really have. As we develop Depression Care Pathway 2.0, our electronic medical records experts will help us imagine the ideal solution and guide us through what the technology can do so we can implement our clinic workflows and standards around that.”

Waghray puts it this way: “If we know that, when we put certain best practices in place, more people with depression can get better, it’s our moral imperative to take those steps.”



**“Major depression is a treatable cause of pain, suffering, disability and death. Effective treatment is essential for helping people realize their fullest potential for well-being.”**

— **Dr. Arpan Waghray**

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





# 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.”



“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.”

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



