Cook County Behavioral Health Continuum of Care

RECOMMENDATIONS FOR STRATEGIC DIRECTION TO COOK COUNTY HEALTH & HOSPITALS SYSTEM

Scope of Project and Recommendations

In February 2015, Cook County Health & Hospitals System (CCHHS) engaged Health Management Associates (HMA) to provide a strategic review and assessment of its behavioral health continuum of care including:

- Review of outpatient and inpatient mental health services and sites, including the Cermak facility
- Environmental scan of national and state health care policy changes and trends
- Interviews with internal and external stakeholders
- Review of CCHHS documents, data sets and other publicly available information on the current behavioral health delivery system
- Identification of strategic recommendations for behavioral health care within CCHHS

CCHHS Behavioral Health Services Steering Committee	
Virgilio Arenas MD	Addiction Psychiatrist
Christine Brown MSW, LCSW, ACM	Director – Social Service/ACHN
Debra Carey	Chief Operating Officer for Ambulatory Services
Michael Colombatto PsyD	Director of Behavioral Health, ACHN
Krishna Das MD	Chief Quality Officer
Doug Elwell	Deputy Chief Executive Officer of Finance and Strategy & Interim Deputy CEO of Operations
Claudia Fegan MD	Executive Medical Director
Steven Glass	Executive Director of Managed Care
Andrew Segovia Kulik MD	Interim Chair, Psychiatry
Mark Loafman MD	Chair, Family and Community Medicine
Juleigh Nowinski Konchak MD	Preventive Medicine Residency
Mary Sajdak	Senior Director, Integrated Care
Agnes Therady	Executive Director of Nursing

National Trends in Behavioral Health

Importance of Mental Health. Untreated depression and other serious mental illness have both a negative financial and health impact; early identification and access to treatment for these disorders can lead to improved outcomes.

Integration. Health systems and communities are realizing an integrated behavioral health strategy is essential to achieving the Triple Aim (improving patient experience of care, improving the health of populations and reducing cost). Behavioral health care is becoming more accessible and connected to the broader health care system

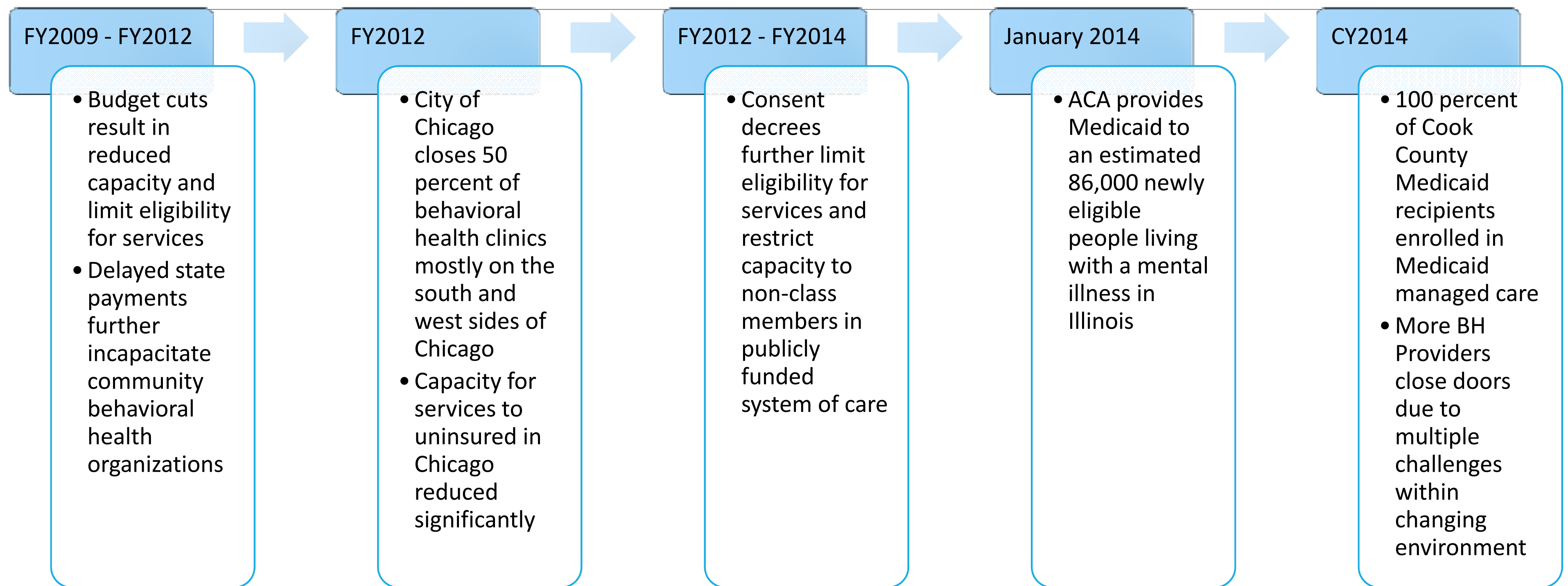
Health Disparities. Other factors such as race/ethnicity, income level, geographic location, and insurance status are key determinants of disparities in both physical and behavioral health across populations and specifically within the populations served by CCHHS. Amid the focus on the health disparities of adults and youth with behavioral health disorders, state and federal policy makers have paid particular attention to quality and coordination of care.

Managed Care. Reimbursement to and by managed care organizations is incentivizing, using bonus payments or sharing savings across providers, attention to the holistic health care needs of individuals through improved care coordination across primary care, behavioral health, and other specialty providers.

Diversion. As community-based mental health services have been challenged to meet the service needs, many believe law enforcement departments and jails have become de facto service providers to persons with behavioral health disorders. Jail diversion programs have emerged as a viable alternative to the criminalization and inappropriate criminal detention of individuals with mental health and substance use disorders. In addition, several models for addressing re-entry into the community following incarceration have been found helpful in reducing recidivism for these individuals.

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS

State and County Behavioral Health Context



PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS

Impact of the State System for CCHHS

Since 2009, the impact of these changes include:

- Emergency room visits for people experiencing psychiatric crises increased by 19 percent between 2009 and 2012. If the year following the closure of the city clinics is included (through 2013), 37 percent more people were discharged from emergency rooms for psychiatric treatment.
- Studies show that between 20- 60 percent of incarcerated individuals have a mental illness.
- The National Alliance to End Homelessness estimates that approximately 32 percent of the 14,144 individuals who currently experience homelessness on any given night in Illinois have a serious mental illness.

The FY2016 proposed Illinois budget, which includes significant cuts to Medicaid and other publically funded mental health services will continue to impact behavioral health services and the individuals living with serious metal illness.

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS

As a result of these system changes, more newly insured and others with behavioral health conditions are seeking care within the CCHHS system.

Many of these individuals have been unable to access services in the community and as a result are seeking care in crisis through the ED.

CountyCare

In late 2012, Illinois obtained a Section 1115 demonstration waiver that allowed the state to get an early start on the Affordable Care Act (ACA) Medicaid expansion for adults in Cook County.

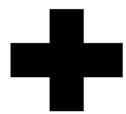
The demonstration was designed to help the state and CCHHS build capacity and experience to support implementation of the expansion in 2014 and get a jump-start on enrollment.

CCHHS incorporated the new health plan as CountyCare.

Over 618,000 uninsured adults are estimated to be eligible for the ACA's Medicaid expansion in Illinois, with over 341,000 of them residing in Cook County. CCHHS serves as a large public hospital system and a key safety-net provider for the low-income uninsured population in Cook County.

Top 1 Percent of CountyCare Members by Average Total Cost and IP/ED Utilization

3 of Top 5 are BH



Volume Ranking	Diagnosis/Condition	Count of Members	Average of Total	Maximum of Total	Minimum of Total	Average of IP	Average of ED
1	Psychiatry- Psychotic and Schizophrenic Disorder	77	$26,670	$103,924	$7,466	3.8	7.8
2	Cardiology- Ischemic Heart Disease	75	$34,030	$205,728	$9,912	1.8	2.5
3	Psychiatry- Mood Disorder, Depressed	68	$25,318	$85,442	$7,432	4.1	7.3
4	Psychiatry – Mood Disorder, Bi-Polar	63	$25,936	$71,332	$8,382	4.8	9.4
5	Cardiology- Cardiovascular Diseases, Signs and Symptoms	62	$23,972	$112,591	$7,500	1.8	7.5
10	Chemical Dependency – Alcohol Dependence	45	$25,508	$146,324	$8,165	4.9	10.7
14	Psychiatry- Organic Drug or Metabolic Disorders	35	$20,703	$56,402	$7,575	6.7	6.5
38	Chemical Dependency – Acute Alcohol Intoxication	12	$28,677	$77,182	$11,539	2.3	27.8

SOURCE: CountyCare Health Plan, Executive Committee, May 26, 2015 (July 2014 – March 2015 Claims)

High Emergency Room and Inpatient Utilization at CCHHS for Behavioral Health

Total Number of Patients receiving Behavioral Health Services: 79,508
January 1, 2013 – April 1, 2015 (27 months)

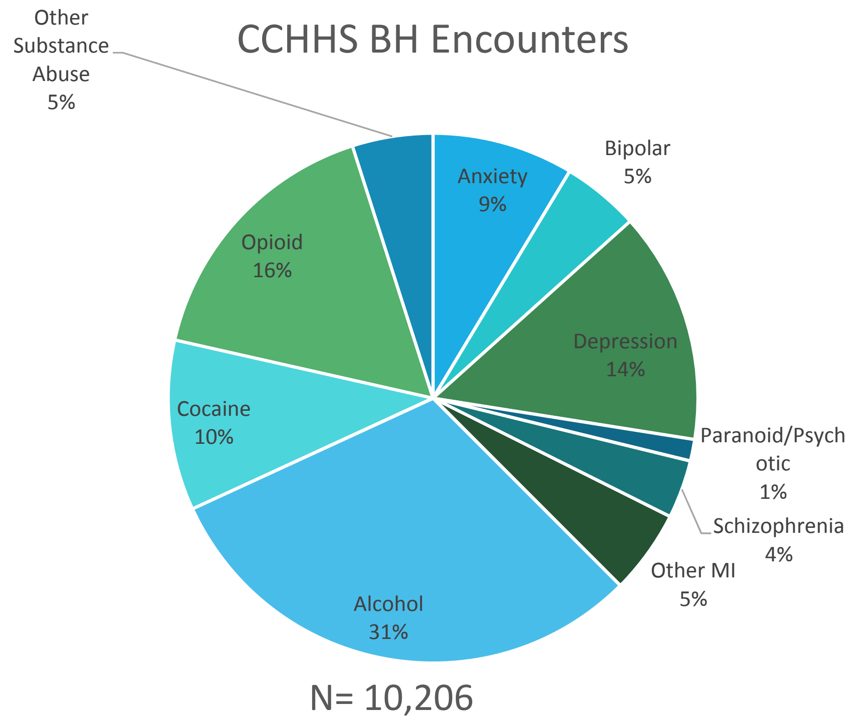
- Number of Individuals with Admissions: 10,206
- Number of Individuals with High IP Utilization (>=10 visits): 17
- Mean: 1.35
- Range: 1-20

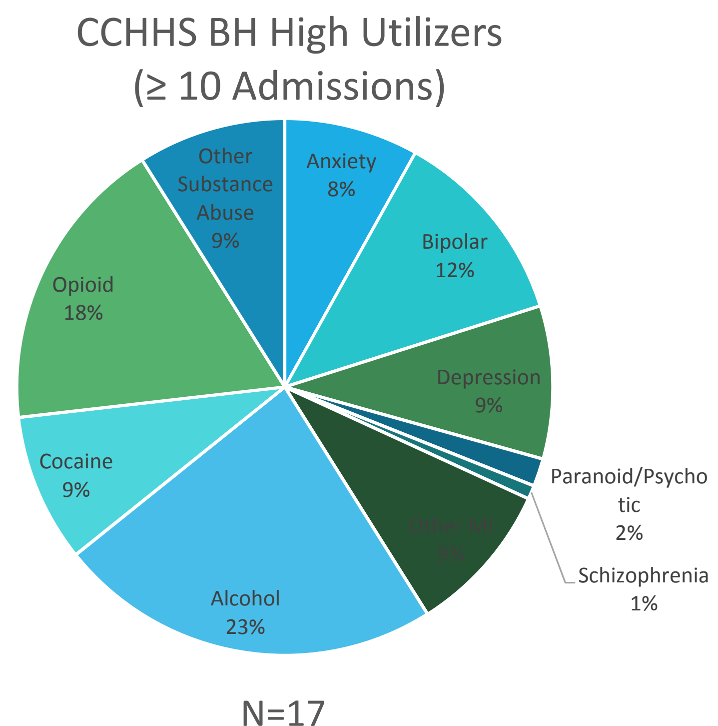
- Number of Individuals who visited the ED: 21,079
- Number of Individuals with High ED Utilization (>=20 visits): 36
- Mean: 1.67
- Range: 1-67

Data Represents Individuals with a Behavioral Health Diagnosis at Any Diagnostic Level (Primary, Secondary, Tertiary, etc.)

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS

IP Visits by Behavioral Health Diagnosis, January 1, 2013 – April 1, 2015





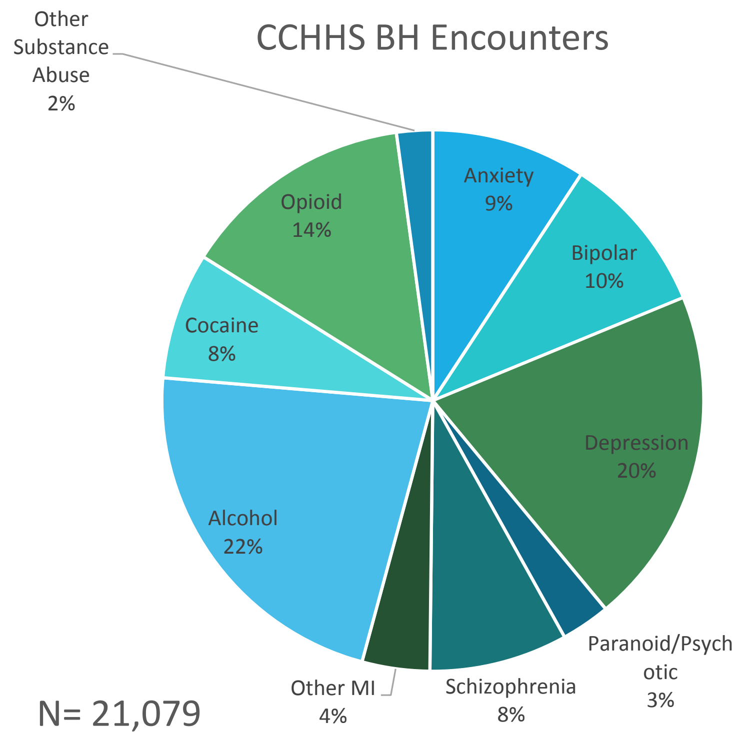
PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS

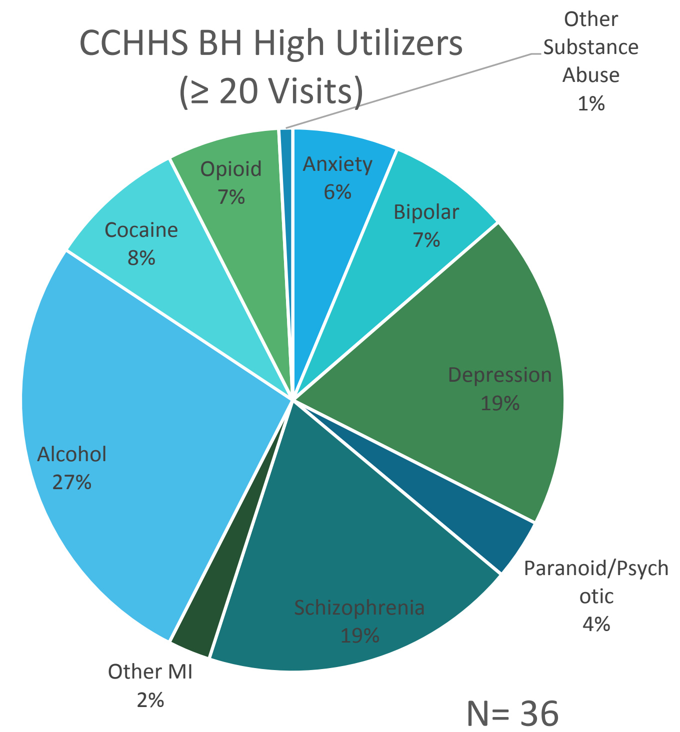
CCHHS Behavioral Health Service Resources

Emergency Department (ED)

- CCHHS currently provides crisis mental health and substance abuse services within the Stroger Emergency Department utilizing multiple providers from both within and outside its network.
- The Department of Psychiatry provides limited screening, brief intervention, and referrals to treatment for substance use related concerns through its SBIRT Team.
- The Department also provides psychiatric consultation to ED staff, primarily telephonically, to support assessment and medication interventions by ED physicians.
- CCHHS currently utilizes a local community mental health provider contracted to offer crisis mental health services within the Stroger ED. Within this no-cost arrangement, the provider bills Medicaid and retains reimbursement for services delivered.

ED Visits by Behavioral Health Diagnosis, January 1, 2013 – April 1, 2015





PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS

There are large numbers of individuals coming into the emergency room and being admitted to the hospital for behavioral health disorders.

Despite its role and size, CCHHS has limited capacity to provide specialty behavioral health services to its patients. Therefore CountyCare members are seeking behavioral health services outside of CCHHS and experiencing delays in obtaining access to services.

CCHHS Behavioral Health Resources

Department of Psychiatry

Budgeted for 37.0 FTE staff members

- 4.0 FTE staff members (Oak Forest Health Center)
- Psychiatrist (0.2 FTE- Sengstacke Health Center)
- Majority of staff (33 FTE) at John H. Stroger, Jr. Hospital medical campus

- Psychologists (2) retiring within 90 days
- Vacant positions (3: psychologist, substance abuse counselor and consult liaison psychiatrist)

- Administration: 3.2 FTE [includes Chair-.5 FTE & Staff Psychiatrist (.7 FTE) and Administrator/ Assistant Administrator (2 FTE)

The Department of Psychiatry provides between 26,000 to 30,000 patient visits yearly

There is no designated inpatient psychiatric unit within CCHHS

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS

CCHHS Behavioral Health Resources

Department of Psychiatry Consultation services provided to general medical units at Stroger and Provident Hospitals to address behavioral health needs of patients

Consult Liaison/ JSH Inpatient: (3.2 FTE)

FTE	Position	Core Responsibilities
1.2	Psychiatrist	Assessment/ Medical Consultation
1.0	Registered Nurse	MH Screening/ HP Assessment/ Medical Chart Review/ Training
1.0	Licensed Clinical Social Worker	MH Screening/ Assessment/ Medical Chart Review

SBIRT (Consult Liaison/ JSH Inpatient): (5.6 FTE)

FTE	Position	Core Responsibilities
0.1	Psychiatrist	Medication Management/ Assessments/ Case Supervision
1.0	Director/ Counselor III	Manage Operations/ Women Peer Program
3.0	Counselor II	Identify/ Screen Assessment/ Refer/ Individual/Group Counsel/ Brief Intervention/ Assessment
1.5	Psychologist	Pain Clinic-Biofeedback / Assessment/Individual & Group Therapy/ Neuro-Psych testing

Fantus Health Center Staffing (14.6 FTE)

FTE	Position	Core Responsibilities
7.1	Psychiatrist	Medication Management/ Assessments/ Case Supervision
1.6	Nurse Practitioner	Medication Management/ Assessments/ Injections
3.7	Psychologist	Psychotherapy, Neuro-Psych testing, Individual/ Group Counseling/ Assessment
2.0	Clinic Administrators	Oversee Clinic Flow and Manage Support Staff

Core Center Staffing (2.6 FTE)

FTE	Position	Core Responsibilities
0.6	Psychiatrist	Medication Management/ Assessments/ Case Supervision
0.4	Nurse Practitioner	Medication Management/ Assessments/ Injections
0.2	Psychologist	Psychotherapy, Individual/ Group Counseling/ Assessment
1.0	Psychologist	Research

CCHHS Behavioral Health Resources

Correctional Health/Cermak Health Services

Department of Mental Health Services at Cermak Health Services

- Onsite mental health screening, 24-hour crisis intervention and stabilization, psychiatric services, therapeutic services
- 200-300 new detainees screened daily
- Male infirmary units = 62 beds (3 units)
- Female acute and chronic mental health infirmary unit = 20 beds (1 unit)

- CCDOC houses typically 8500 individuals (capacity: 10,000)
- Twenty (20) percent estimated to have behavioral health conditions

Cermak Staffing

- 93 employees, 9-10 psychiatrists, psychologists, social workers and other staff

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS

CCHHS Behavioral Health Resources

Current ACHN Behavioral Health Staffing Plan (15 Centers including GMC)

Social Work (FTE) FTE	Psychologist	Psychiatrist	APN
14 Budgeted	5.64 Budgeted		3 Budgeted
	2 FTE report to Department of Psychiatry .32 FTE employed by Loyola	1 FTE (.2 FTE and .8 FTE) report to Department of Psychiatry	3 FTE report to Department of Psychiatry
5 Vacancies	Vacancies: 2 - .5 FTE positions		Vacancies: 3
Total includes 6 LCSWs			

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS

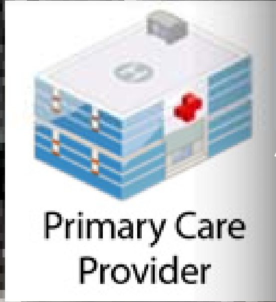
Summary of Current State

Limited Behavioral Health Outpatient Leads to High Utilization of Other Services.

Individuals with Behavioral Health Conditions Cannot Access Specific Behavioral Health Services Needed (failed referral, long waits, and under identified need).

Symptoms Exacerbate and Reach Crisis Level and then Require Intensive and Expensive Services.

Unaddressed Behavioral Health Conditions Complicate Uncontrolled Physical Chronic Health Needs and Add to Higher Utilization of Services.


Primary Care
Provider

BH Provider

BH
Community

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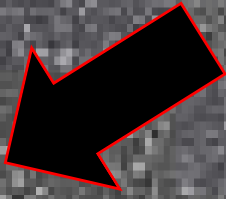
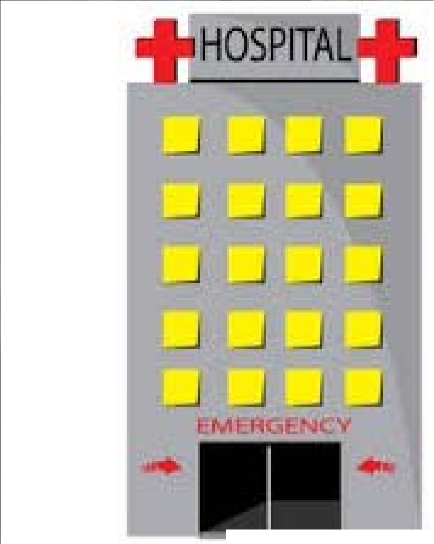
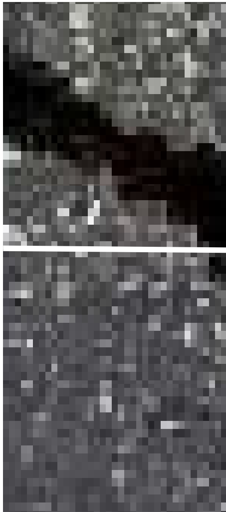
CRISIS



BH Provider


HOSPITAL
EMERGENCY



SHERIFF

BH Provider

Recommendations to the Board for Behavioral Health Strategic Direction

Integration of Primary Care and Behavioral Health

- Expanded and improved implementation of integration of behavioral health into primary care.
- Engage individuals with behavioral health conditions earlier in the treatment process in order to reduce the need for more intensive services.
- Develop and implement a well defined model and commit additional investments in additional staff, formalized training, and other supports for improved implementation of the model.

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS

Limitations of Current Integration Model

Efforts to integrate behavioral health into primary care have been substantially focused on the co-location of behavioral health services with primary care and the emergency department. Based on the SAMHSA-HRSA levels of integrated care, CCHHS services mainly fall in level 2-4 services.

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	**LEVEL 2** Basic Collaboration at a Distance	**LEVEL 3** Basic Collaboration Onsite	**LEVEL 4** Close Collaboration Onsite with Some System Integration	**LEVEL 5** Close Collaboration Approaching an Integrated Practice	**LEVEL 6** Full Collaboration in a Transformed/Merged Integrated Practice

- Limited capacity to provide care due to the utilization of traditional models of therapy and psychiatric care.
- CCHHS social work staff are providing case management services rather than supports a social worker could provide if they were working “at the top of their license” and as necessary in an efficient integrated care model.

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS

Integration Model Expansion-Challenges

- CCHHS' larger system planning for integrated care has been under resourced
- Space limitations for additional services
- Provider readiness for change
- Culture shift to team based care

Integration- Opportunities

- Many of the limitations of the current models of integration at CCHHS and the problematic trends such as high use of intensive services and poor outcomes could be reversed or at least improved with a more refined implementation of the model and realignment of resources across the system.
  - CCHHS must utilize its resources in the most efficient and effective manner currently the provider resource is not maximized across disciplines (e.g., social work, psychology, psychiatry, primary care).
  - Analysis of provider functions and movement towards a stepped model of care would significantly improve the system approach. Clinical care in integrated settings follows a system of “stepped care” to allow effective treatment to be provided with the minimum amount of intervention and cost necessary at that level.

Specific Recommendations for Developing and Expanding Integrated Care

1. **Conduct a Provider Function Assessment**—Examine the functions that are currently being provided on care teams across providers. In addition identify the additional functions that CCHHS desires in an integrated care model (e.g., screening, registry tracking, health promotion, brief intervention, psychiatry consult).
2. **Re-align Provider Time**—Establish re-alignment of provider time to maximize providers practicing at the top of their license.
3. **Brief Intervention**— Reorient social work staff and psychologists to provide brief intervention rather than traditional 40-60 minute therapy, to spread resources across a far larger population and implement issue/problem specific behavioral change.
4. **Re-vamp SBIRT**—Provide SBIRT with fidelity to the model and train a broader group of staff in the model, facilitating expanded services to a broader population, enabling SBIRT team members to be the referral source for individuals needing specialty services.
5. **Workforce and Training—**Evaluate workforce readiness, provider preferences, and training as provider functions are re-aligned. Commit resources to address needs will be critical to success.
6. **Reimbursement—** Actively pursue improved billing process for many of the services outlined for the PCMH care manager can be reimbursed as well as other services that behavioral health providers will perform in the stepped care model,.
7. **Emergency Department Services-Crisis Intervention**— Address concerns regarding the current arrangements for behavioral health services in the ED (use of multiple different resources and processes to meet patient mental health and SUD needs and lack of psychiatry oversight and access to the full record for consults performed by Thresholds) and integrate behavioral health services within the emergency department.

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS

Recommendations to the Board for Behavioral Health Strategic Direction

Expanding Specialty Behavioral Health Services

Recommendations for expansion of behavioral health services include the addition of specialty behavioral health services within CCHHS to complete the Stepped Care Model.

- Data reviewed and information gathered in interviews indicated waits and other potential access problems for specialty behavioral health services within the Cook County service area.
- Lack of access likely contributes to the significant use of emergency department and inpatient services, and is often linked to the significant number of individuals served through the criminal justice settings including Cermak.

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Recommendations to the Board for Behavioral Health Strategic Direction

Expanding Specialty Behavioral Health Services

Recommendations for expansion of behavioral health services include the addition of specialty behavioral health services within CCHHS to complete the Stepped Care Model.

- Engage in more detailed review of utilization data as well as assessment of the impact of additional services in primary care to assist in determining the right balance of primary care and community based specialty services necessary to support CCHHS patients
- Expand CCHHS Medicaid provider profile and obtain certification as a community mental health provider to receive Medicaid reimbursement.

Opportunities to Expand Specialty Behavioral Health Services

Medicaid Specialty Mental Health Services	
Mental Health Assessment Psychological Evaluation Treatment Plan Development, Review and Modification Assertive Community Treatment Case Management—Mental Health Case Management—Transition Linkage and Aftercare Community Support (Individual, Group) Community Support—Team	Crisis Intervention Crisis Intervention— Pre-Hospitalization Screening Psychosocial Rehabilitation Psychotropic Medication Administration Psychotropic Medication Monitoring Psychotropic Medication Training Therapy/Counseling
Non-Medicaid Services funded by DHS Addressing Social Determinants of Health	
Assertive Community Treatment –Vocational Services	Job Finding Supports
Specialty Substance Use Disorder (SUD) Services	
Outpatient (group or individual) Intensive Outpatient (group or individual)	Day Detoxification Day Treatment

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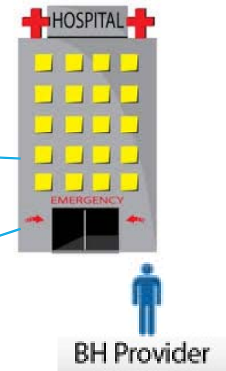

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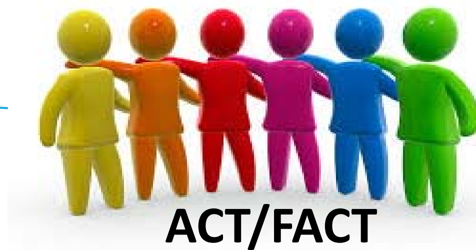
Behavioral Health
Continuum of
Services



Summary and Next Steps

National, state, and local environmental factors have led to a gap in needed mental health and substance use disorder services for residents in Cook County, leading to high utilization of emergency and inpatient services, contributing to increased costs and less than desired health outcomes.

Recognizing the need for more access to behavioral health services combined with CCHHS's role as a safety net provider for Cook County, it is essential for the system to expand its integration of behavioral health services and develop access to needed specialty services for individuals with chronic and persistent mental illness and emerging or existing substance use disorders.

Successful achievement of this goal will result in improved outcomes for patients and reduced costs to both CCHHS and the Cook County Jail. This initiative will not be without its challenges. However CCHHS also brings strengths through existing resources and partnerships to support success.

This strategic initiative will require a multi-year commitment, including dedicated staff and facility resources.