SOUTH JERSEY BEHAVIORAL HEALTH INNOVATION COLLABORATIVE

Year-End Report

EXECUTIVE SUMMARY

INTRODUCTION

Every day people like "Jane", a 40-year-old woman with multiple chronic conditions including mental illness and substance use disorder diagnoses, seek treatment at New Jersey's hospitals. In a five-year span (2010-2014), Jane has lived at four different addresses in South Jersey and has visited hospitals in five different healthcare systems a total of 77 times. Her hospital stays have totaled 294 days at a cost of $4.4 million, with the hospitals receiving $386,000 in payment. Jane is a real-life example of one patient struggling to navigate an outdated system where services and needs are mismatched.

The story of Jane – and hundreds of other patients with similar stories – highlights the results of complex, high-need patients navigating a system of services ill-equipped to meet their physical, behavioral and social service needs.

Improvements to treatment access for mental illness and substance use disorders were officially identified as health priorities for southern New Jersey in 2013, through the Tri-County Health Needs Assessment. In response, five health systems in southern New Jersey – Cooper Health System, Kennedy Health, Lourdes Health System, Inspira Health Network and Virtua – joined together to form the South Jersey Behavioral Health Innovation Collaborative (SJBHIC) in 2014.

The SJBHIC aims to improve the quality, accessibility, capacity and coordination of behavioral health services for residents in southern New Jersey. To gain an initial understanding of the scope of challenges and opportunities within the current behavioral health system, the SJBHIC completed an assessment drawing on a variety of data sources, including analysis of five years of member hospital claims data and more than 50 interviews with key stakeholders throughout the state. The result of this qualitative and quantitative analysis provides a look at the degree to which the behavioral health system is not fully meeting the needs of patients.

CASE STUDY:
*Jane**

- About 40 years old, female
- Insured by Medicare parts A and B
- Dual substance use disorder and mental health issues: alcohol, anxiety, severe depression and drug use
- Has 15 chronic conditions
- Lived at 4 different addresses from 2010-2014
- 77 hospital visits spanning all 5 hospitals in 5 years: 58 emergency department, 19 inpatient
- Accumulated 294 days in the hospital, $4.4 million in charges during those 5 years
- Hospitals reimbursed $386,000 for her care

**Jane is a real person, whose name has been changed and data anonymized to prevent identification.*

PATIENTS' NEEDS UNMET: A DATA-DRIVEN OVERVIEW

Reports show that nearly 15 percent of adults in the state have been diagnosed with a mental illness, and about 260,000 adults live with a severe mental illness. These patients face challenges in accessing the care they need, leaving many patients to turn to insufficient solutions for obtaining care, including visiting emergency departments in lieu of a consistent outpatient provider.[1]

In New Jersey, the number of emergency department visits and inpatient admissions where mental health or addiction was the primary or secondary diagnosis increased by almost 30 percent from 2010 to 2014.[2] Jane's situation highlights the result of this problem; far from unique, she is one of more than 800 patients who visited all five health systems over the five-year period. Of these patients, 100 percent had at least one behavioral health diagnosis and almost 75 percent had both mental illness and substance use disorder challenges. Together, these patients had more than 31,000 hospital visits over the five-year span with more than $260 million in charges to hospitals. For patients with visits to five hospitals in 2010, their median charges were $53,633; for patients visiting five hospitals in 2014, median charges increased to $123,518.

DISJOINTED SERVICE DELIVERY

The current behavioral health system, described during stakeholder interviews, is "well-intentioned," "with a tremendous amount of services" but "siloed" and "disjointed" without enough access to appropriate services, leaving patients "unserved."

Underscoring this characterization is the divided nature of the behavioral health system; separation of mental health, addiction services, housing and primary care renders coordinated care challenging. Jane has been diagnosed with diabetes, chronic heart failure and kidney disease in addition to her struggles with substance use and mental health issues. Care coordination between the providers treating her for her different health concerns would be particularly difficult as the system is set up now. Outdated models for how care is delivered, managed, paid for and regulated within each of these sectors are also strong barriers to getting patients the care and services they need in the appropriate setting.

Driving this mismatch between the care needed and the way services are delivered is a system becoming outdated. The previously-mentioned divisions between healthcare, social services and behavioral health services, as succinctly described by one stakeholder, means "there is a lack of integrated care, there's a lack of one system...we have multiple systems." Another added that these multiple systems result in "not really treating the whole person," but rather "silos based on the payment systems (and) licensure."

Equally impactful are outdated frameworks and incentives for how we think about and deliver behavioral health care, from point-of-care delivery to training to payment models, up through regulatory structures. This includes care delivery and training not based on current evidence; payment models that do not reward care in appropriate settings; and regulatory frameworks that divide a patient's caregivers, rather than encourage collaboration.

[1] NAMI State Advocacy 2010. State Statistics: New Jersey. Retrieved from http://www2.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93509.

[2] 2015 New Jersey Acute Care Hospital Mental Health and Addictions Volume Report, NJHA

At each of these levels, incentives must be altered so that complex patients, like Jane, are at the forefront of decision making and delivery of care. Table 1 illustrates the perceptions of these outdated frameworks from the people who influence and deliver behavioral health services:

Table 1: Outdated Frameworks

FRAMEWORK	ILLUSTRATIVE QUOTE
Care Delivery	*It would be wonderful if we could ensure quality standards across our system of care, ensure that people are using evidence-based practices. That's not happening at this point*.
Provider Training	*I love the concept of…having primary care physicians and internal medicine have more training in behavioral health. And I mean, really do screenings at annual physicals. And if people are experiencing hypertension or depression, be able to… encourage them to seek help.*
Payment Models	*People say that there are not resources in New Jersey. I don't believe that's true. I believe there are resources in New Jersey. The resources that are used are not well applied to the situation.*
Regulatory Apparatus	*(There are) different divisions of state government managing these things. And all those (divisions) are barriers to effective integration.* *A redesign of the financing, the regulatory, the legislative framework needs to be put into place in order to enable integrated care…Until all of that is done, people (are) having to...make extraordinary efforts to try to bring physical and behavioral health together.*

SHIFTING TOWARD A PERSON-CENTERED HEALTH CARE SYSTEM

Despite these significant challenges, New Jersey is currently at a pivotal moment toward overcoming these systemic barriers. There is a recognized need for system redesign to one that is person-centered, addresses social challenges, integrates care across all providers and is supported through coordinated governance and financing.

However, there is a gulf between the siloed, disjointed system that currently exists and the desired person-centered system. Bridging this divide will require a significant shift in the principles that underlie how mental health, addiction services, primary care and housing care are delivered.

Fortunately, there are bright spots of innovation and evidence-based care delivery being implemented across the state and country. These providers embrace the shifts in principles, and they may hold the key toward achieving the mental health and substance use disorder system envisioned. Table 2 highlights some of the shifts in principles beginning to be employed that need to be adopted on a wide scale to transform the entire system.

Table 2: Systemic Shifts Required

	PROBLEM-CENTERED APPROACH: DISJOINTED	**PERSON-CENTERED APPROACH: ALIGNED**
Mental Health	• Disability lens, medication focused • Hierarchical • Authoritarian • Institutional • Not comfortable with co-occurring substance use disorder	• Wellness and recovery focused • Consumer and peer driven • Trauma informed • Community based • Comfortable with co-occurring substance use disorder
Substance Use Disorder	• Moral failing • Under-trained staff • 12-step focused • Inpatient detoxification and rehab focused	• Treatable chronic medical condition • Addiction specialty, harm reduction • Evidence based, trauma informed • Outpatient detoxification and treatment
Primary Care	• 15-minute, volume-based visits • Panel size too large • Medicalizing social, behavioral problems • Mental health, addiction carved out from scope	• Ambulatory ICU • Panel management • Integrated with mental health and substance use disorder treatment • Health homes
Housing	• Shelter model • Sobriety-based, rule-focused culture • Separate from other services	• Housing first/supportive housing • Harm reduction • Integrated with mental health, addiction services, education and job training

SJBHIC TAKING ACTION

The hospital systems that comprise the SJBHIC are invested in ensuring a shift to patient-centered care. They are already implementing interventions aimed at the goal of an integrated, coordinated and efficient mental health and substance use disorder system:

- **REGIONAL BEHAVIORAL HEALTH COMPLEX CASE CONFERENCING:** Joint case conferencing for patients who regularly visit multiple hospitals in the region; selected patients will receive a care plan shared by each participating hospital.
- **SHARED PROTOCOLS AND EDUCATION:** Shared learning to develop and implement evidence-based practice protocols for care across the region.
- **INTEGRATION OF PSYCHIATRIC SPECIALISTS INTO EDS:** Integration of new clinical staff with psychiatric specializations into EDs to implement new care models and serve as champions for change.
- **SHARED MEASUREMENT SYSTEM:** Collection and review of regional core quality measures to assess collective progress, such as length of hospital stay.
- **HOUSING FIRST PILOT:** Recovery-oriented approach whereby housing-instable individuals are first provided with permanent housing and then offered additional services as needed.
- **LEGISLATION:** Support for legislation aimed at innovative, evidence-based models for care delivery.
- **REGIONAL PSYCHIATRIC EMERGENCY SERVICES:** Explore implementation of psychiatric emergency services centers based on a national model being employed regionally throughout the country.

What is hoped for from these pilot programs is a better idea of how to treat complex patients like Jane as a whole person with coordinated care. The system will be able to better anticipate her needs and prevent costly hospitalizations.

The South Jersey Behavioral health Innovation Collaborative was founded in 2014 to address the growing need for integrated mental illness and substance use disorder healthcare. Founded by the CEOs of five hospital systems – Cooper University Health Care, Inspira health Network, Kennedy Health, Lourdes Health System and Virtua – the collaborative is partnering with the Camden Coalition of Healthcare Providers and the New Jersey Hospital Association to improve quality, access, coordination and follow-up among patients in need of mental illness and addiction treatment.