HEYWOOD HEALTH SYSTEM

BEHAVIORAL HEALTH NEEDS ASSESSMENT

PRESENTED BY: DMA HEALTH STRATEGIES

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DMA Health Strategies

The Team – DMA Health Strategies

- For more than 25 years, DMA Health Strategies (DMA) has worked with federal, state and local health and human service clients on strategic planning, change management, and quality improvement projects
- Broad and deep understanding of mental health and substance abuse services in Massachusetts and nationally
- Involved with Massachusetts' development of a system of care for children with serious emotional disturbance (SED); Health Planning Council Statewide Behavioral Needs Assessment; Adult Specialty Court System development; and EOHHS/DCF Family Resource Center 2014 system of care and re-procurement effort

Objectives

1. Assess regional behavioral health needs
2. Catalogue current capacity /demand (ER, IP, community) in meeting these needs
3. Identify innovative strategies to improve access to services and outcomes for the residents of North Central Massachusetts through a review of nationally-recognized evidence-based practices and programs
4. Consider collaborative-strategies and joint ventures with primary care and behavioral health providers within the region that would strengthen Heywood Hospital's ability to serve as a central resource to residents with behavioral health disorders

Structure of Report

1. Summary of Need
2. Summary of Demand
3. Summary of Key Questions
4. Recommendations

Problem Context

The Henry Heywood Hospital's service area encompasses the North Central region of Massachusetts. For this region, the prevalence and consequences of substance abuse and mental illness and their treatment is of grave public concern.

This has been affirmed through repeated community health assessments performed by the Joint Coalition and the Montachusetts Public Health Network over the past decade.

Methodology

A review of community-level data from:

- Community Health Assessment of Montachusett Public Health Network (Joint Coalition, Jan 2014)
- Community Health Assessment of North Central, MA (Oct 2011)
- Department of Public Health, Bureau of Substance Abuse Utilization Data, 2013
- Department of Public Health Community Level Health Data, 2010
- Massachusetts Behavioral Health Partnership Utilization Data, 2013

Methodology

- A review of Heywood Hospital documents, including:
  - The 2011 Kauffman Hall Strategic Plan
  - Data on Emergency Room, Mental Health Unit, Geriatric Psychiatry Unit, and Partial Hospitalization patients with behavioral health conditions during FY12 and 13 (and minimal data pulls from CY12 and 13)
- Interviews with Heywood Leadership, State Agency Representatives, and Community Partners
  - 30 interviews
    - 13 Heywood Hospital Leadership
    - 3 State Agency Representatives
    - 11 Community Partners
    - 2 Hospital s (McLean and Umass)
      - AdCare Hospital (SUD Only)

Methodology

- A review of the literature on evidence-based practices for:
  - Care coordination between primary and behavioral health
    - Screening and assessment
    - Physician linkages to behavioral health
  - Care navigation to ensure a continuity of care between levels of service
  - Telemedicine

Objective 1

Assess regional behavioral health needs using multiple sources of state, regional and hospital data.

NEED

Regional Social Determinants of Need

City/town In Heywood Service Areas	Total Population*	Households with Food Stamp/SNAP benefits in the past 12 months	All people with whose income in the past 12 months is below the poverty level	Median household income in the past 12 months	% of individuals 25 years or older who have a bachelor's degree or higher
Ashburnham	5,991	1.5%	5.4%	$80,000	34.8%
Ashby	2,987	1.2%	4.2%	$80,143	29.9%
Athol	11,559	10.2%	9.1%	$47,099	14.3%
Fitchburg	40,214	14.8%	19.4%	$47,019	20.7%
Gardner	20,386	12.0%	11.4%	$48,333	19.5%
Hubbardston	4,310	1.1%	9.5%	$82,443	28.0%
Leominster	40,941	8.8%	9.9%	$55,695	23.5%
Lunenburg	9,985	2.1%	5.5%	$86,568	33.6%
Orange	7,795	14.3%	11.8%	$42,809	18.0%
Phillipston	1,849	6.8%	3.5%	$70,493	20.3%
Royalston	1,101	4.2%	4.1%	$60,385	29.5%
Templeton	7,801	5.2%	8.1%	$66,138	17.4%
Townsend	8,871	4.3%	5.2%	$76,533	29.0%
Warwick	547	0.8%	5.4%	$67,554	29.2%
Westminster	7,225	4.4%	4.5%	$79,073	31.4%
Winchendon	10,212	8.50%	9.80%	$58,582	19.30%
CHNA 9*	262,605	5.3%	7.8%	$65,011	26.0%
Massachusetts	6,587,536	9.5%	10.7%	$65,981	22.1%

Regional Social Determinants of Need

- The total population of the Heywood service area is 181,774 - 65% of North Central's population lives in Fitchburg, Leominster, Athol and Gardner (State=10.5% in the State, up from 9.3% in 2000)
- The communities with the largest proportion of population below 100% of the poverty level:
  - Fitchburg at 19.4% (up from 15% in 2000)
  - Gardner at 11.4% (up from 9.6% in 2000Westminster had 45% increase from 2000-2010
  - Gardner's poverty rate among families with children rose by 44% between 2000 and 2010, from 10.5% to 15.1%

Regional Social Determinants of Need

- Five of the school districts within the Gardner service area had much higher percentages of low income students in 2012 – 2013 than the State average of 37%:
  - Fitchburg at 76.9%, more than twice that of the Commonwealth as a whole
  - Athol-Royalston Regional at 57%,
  - Gardner at 55.9%,
  - Leominster at 46.3%

Regional Social Determinants of Need

These social determinants of health and behavior are consistent with prevalence of disease and behavioral health issues.

Regional Physical Health Need Indicators *Per 100,000 Population

City/town	Asthma Hospitalizations	Diabetes Hospitalizations	Cancer Hospitalizations	Cardiovascular Disease Hospitalizations
Ashburnham	158.97	82.22	167.50	1373.53
Ashby	>5	140.97	307.59	820.23
Athol	158.26	241.71	479.04	2018.82
Fitchburg	118.52	107.05	329.77	1155.34
Gardner	211.65	157.08	276.45	1604.38
Hubbardston	60.86	68.46	299.54	1405.53
Leominster	154.57	115.31	318.14	1386.52
Lunenburg	142.11	79.32	389.69	1668.67
Orange	119.06	221.12	365.58	1893.20
Phillipston	198.18	>5	>5	1254.99
Royalston	>5	>5	>5	1390.92
Templeton	95.68	195.52	521.81	1940.06
Townsend	97.09	74.69	409.79	1164.67
Warwick	>5	>5	>5	1310.62
Westminster	73.29	105.35	339.77	1100.84
Winchendon	203.88	184.47	466.04	1636.09
Massachusetts	158.34	146.13	426.43	1587.49

Regional Physical Health Need Indicators

- Statewide: 16.2% of adults over age 18 reported smoking.
  - Tobacco use in the Athol area was almost 20%
  - Tobacco use in the Fitchburg/Leominster/Gardner area was 18.6%.

The larger North Central municipalities tend to have prevalence of at least one chronic disease that is significantly higher than the state average.

Regional Mental Health Indicators
(CY07-11) - Per 100,000 Population

City/town	Mental Health Hospitalizations	Suicide Rate	QUINTILES: Three years average prevalence of symptoms of depression in past two weeks by PHQ-8 among adults	QUINTILES: Five years average prevalence of poor mental health (>15 days poor mental health) among adults
Ashburnham	569.51	16.4	4	5
Ashby	546.82	too little data	4	3
Athol	1377.25	17.3	5	5
Fitchburg	472.74	2.5	5	5
Gardner	1147.75	14.8	5	5
Hubbardston	599.08	0.0	2	3
Leominster	740.74	4.9	5	5
Lunenburg	659.47	0.0	3	2
Orange	1083.69	12.8	5	5
Phillipston	741.59	0.0	4	4
Royalston	439.24	too little data	4	5
Templeton	883.06	12.5	5	5
Townsend	463.71	11.2	3	5
Warwick	569.51	0.0	4	4
Westminster	546.82	0.0	2	3
Winchendon	1377.25	19.4	5	5
CHNA 9	472.74	8.8	no data	no data
Massachusetts	873.82	9.0	not applicable	not applicable

Regional Mental Health Indicators

- Indicators of mental health issues in Fitchburg, Gardner, Athol and Leominster are among the highest in MA
- The average quintile for 5-year average prevalence of poor mental health and 3-year average prevalence of symptoms of depression among adults in the combined cities is 5, suggesting that the severity of mental health issues is particularly high in these municipalities
- Hospitalization rates for mental health are 1230.4 per 100,000 in this area compared to 873.8 in MA

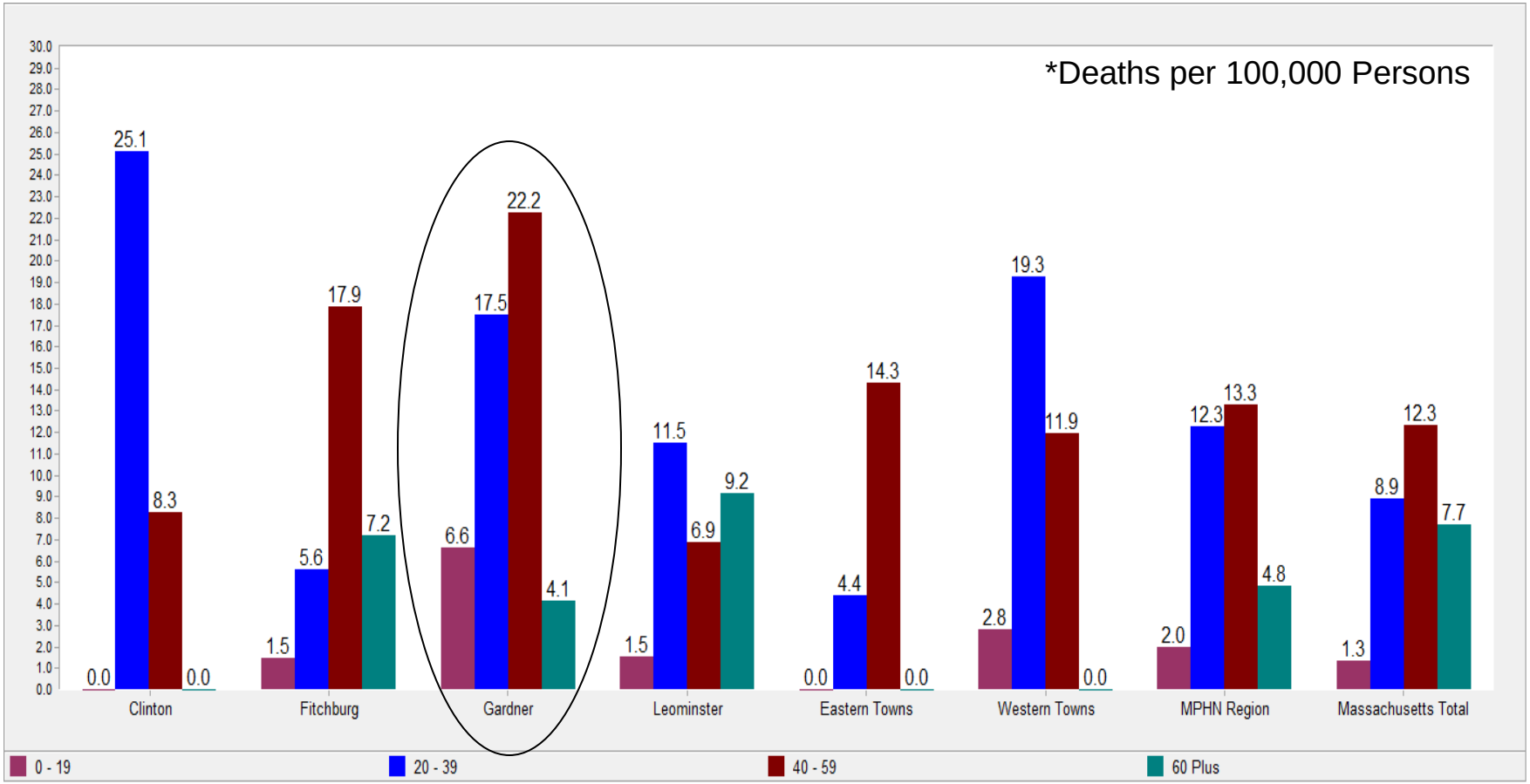
Suicide/Suicidal Tendencies

A greater number of North Central **youth** (16.2%) have considered or attempted suicide than their peers in Massachusetts and the United States (2005-2010).

Specifically, during the 12 months prior to the MPHN survey:

- 16.2% of area high school youth seriously considered suicide versus 13% of Massachusetts and 15.8% of US youth
- 14.0% of area youth developed suicide plans versus 12% of Massachusetts and 12.8% US youth
- 10.1 % of area high school youth attempted suicide at least one time versus 7% of Massachusetts and 7.8% of US youth
- 4.4% of area high school youth attempted suicide in such a way that they needed medical treatment versus 2% of Massachusetts and 2.4% of US youth

Suicide Mortality Rate by Age Range 2005 – 2010 (Age-Specific)



Suicide/Suicidal Tendencies

The 2011 suicide rate **overall** in the North Central area was higher than the state average: Gardner 14.8 (per 100,000) and Athol 17.3 vs. State 9. There were seven suicides this year in the Heywood service area.

*Awaiting release of more recent law enforcement suicide data.

There is no question that the Heywood Hospital System service area has disproportionate **need** for behavioral health services within the region as compared to state averages.

Objective 2

Catalogue current capacity/demand (ER, IP, community) in meeting these needs through available data, personal interviews with hospital leadership, and community providers

- Is Heywood serving patients who reside within its service regions?
- Is Heywood “keeping care local” or losing patients to other facilities?
- Does Heywood have sufficient inpatient capacity to meet demand?

DEMAND

National Policy Environment

- National capacity of psychiatric beds has declined since 1998:
  - poor reimbursement from all payment sources
  - conversion to medical-surgical beds, which contribute much more to hospital margins
- Substantial decline in the number of state operated hospital psychiatric beds since 2005
  - state public psychiatric hospital beds has declined by 14%, from a total of 50,509 to 43,318
  - estimated national deficit of 95,820 inpatient beds for mentally ill individuals

State Policy Environment

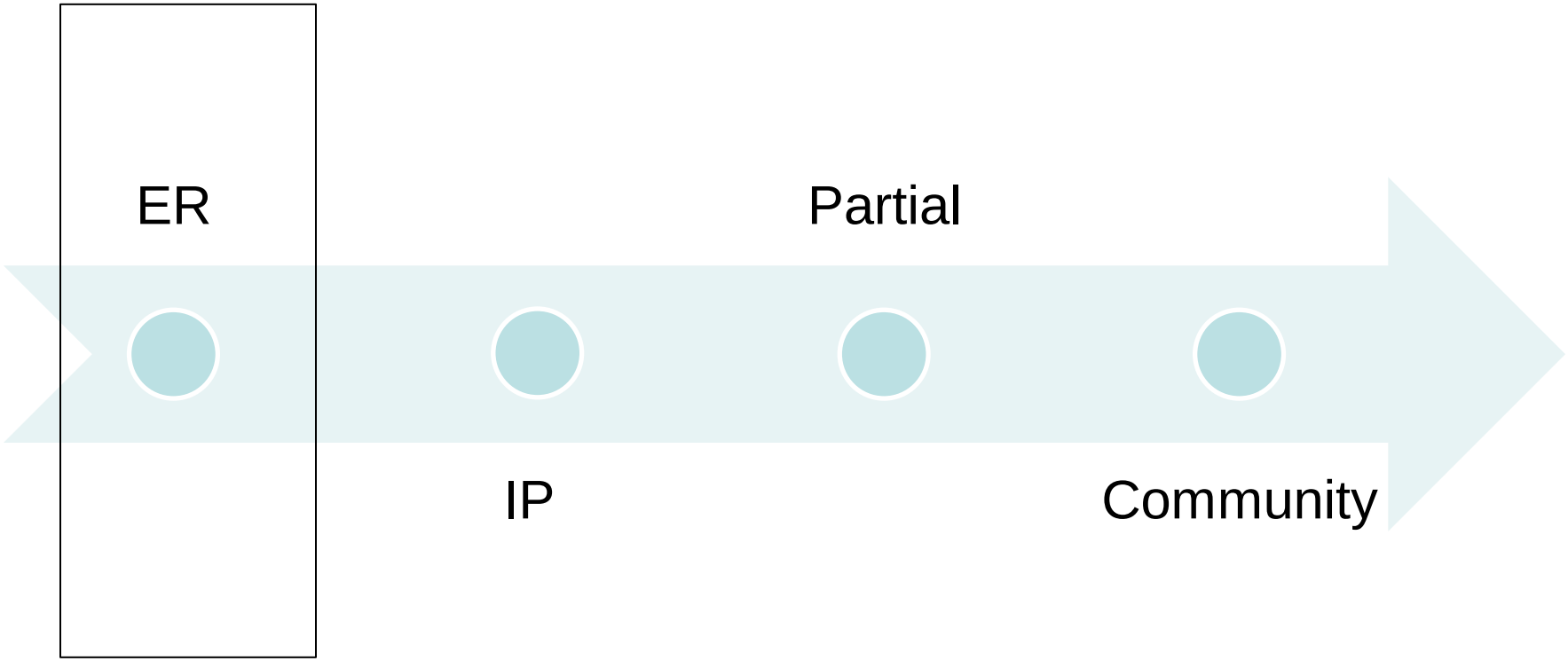
The Policy Impact: Nationally general hospitals have been admitting patients with more serious mental disorders with the locus of hospital care shifting from state psychiatric facilities to private non-profit hospitals:

- From 2012-2013 in MA, the decrease in state-funded inpatient beds from 836 to 658 statewide increased backups and wait times for patients in emergency rooms
- "Parity" still an issue in Massachusetts, where commercial insurers are required to provide coverage for behavioral health services. In addition, service capacity may be kept lower than demand because of the low rates that are typically paid for these services by both commercial insurers and MassHealth

Regional Environment

- Youth under age 21 with serious emotional disturbance Eligible for MassHealth may have the best behavioral health access and broadest range of program through the Children's Behavioral Health Initiative (CBHI)
- In North Central the CBHI system is robust, involving a number of large providers and a collaborative systems of care undergird by System of Care Committees
- Transportation has been clearly identified as a barrier to access in the North Central Area, especially for elderly and low-income populations and young families

Assessing Access at Each Intercept Point

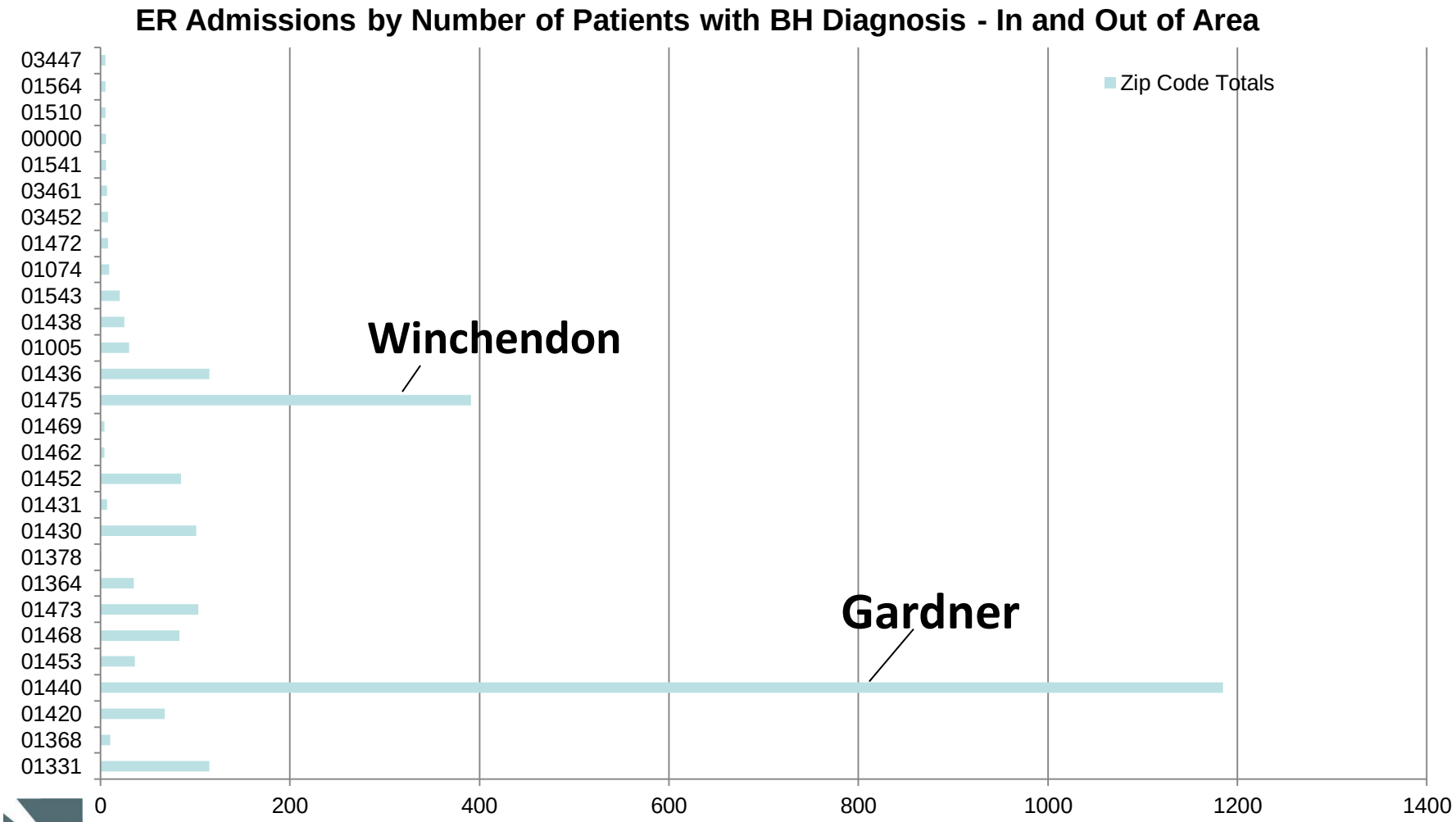


ER Behavioral Health: Staff Impressions (Winter/Spring 14)

Hospital Leadership Interviews:

- When patients with serious mental illness come into the emergency room, they may be difficult to place, causing substantial delays in disposition. The ER ends up “boarding” the patient in the ER
- “Frequent fliers,” who use the ER multiple times appear to put a strain on potential inpatient admissions for persons in serious mental health crisis

ER BH Admissions by Area (CY13)



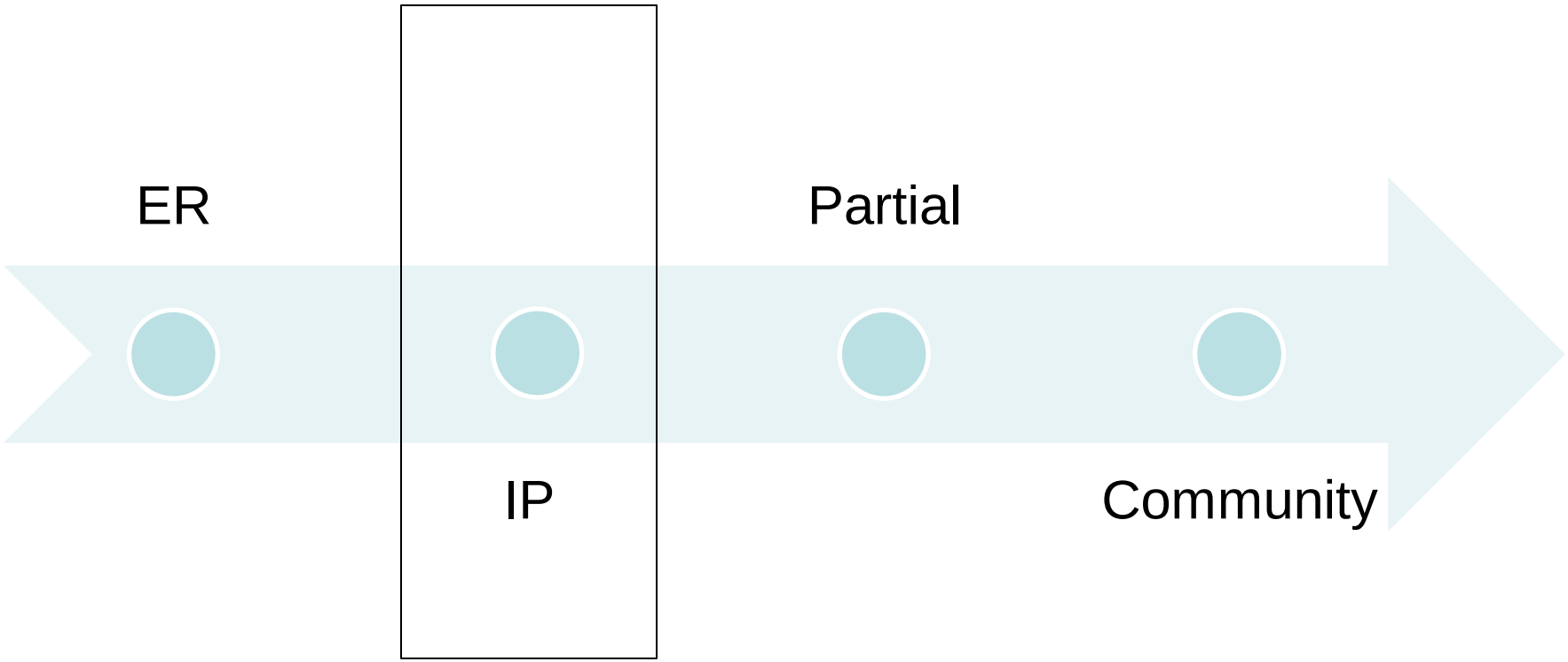
ER Behavioral Health-Heywood Data (CY12-13)

Diagnosis	Percentage of Patients
Alcohol abuse	22.96%
Alcohol/drug withdrawal	4.35%
Anxiety	20.56%
Drug dependence	1.67%
Bi-polar	7.31%
Depression	35.09%
Personality disorder	2.04%
Schizoaffective disorder	6.02%
	100.00%
TOTAL Sub Use Disorder	28.98%
TOTAL Beh Health	71.02%
EMERGENCY ROOM (n = 1080)	

ER Behavioral Health-Community Provider Perspective (Winter/Spring 14)

- Heywood staff are unhappy with response times from the regional Emergency Services Provider
- There has been some confusion with different protocols depending on insurance coverage
  - Increasingly, Heywood has taken over jurisdiction over non-Medicaid patients (commercially insured)

Assessing Access at Each Intercept Point



Heywood Behavioral Health Inpatient Admissions (CY13)

What we know:

- MBHP thinks Heywood manages its BH patients well
- As a Tier 3 facility in the MBHP system, Heywood manages complex admissions with a length of stay difference below the statewide adjusted mean
- DMH and MBHP both said that the Geriatric Psychiatry Unit is an asset
- 18% of inpatients admissions with a behavioral health diagnosis have a primary substance use disorder
- Heywood leadership perceive a shortage in inpatient mental health beds

Demand: Perception vs. Reality

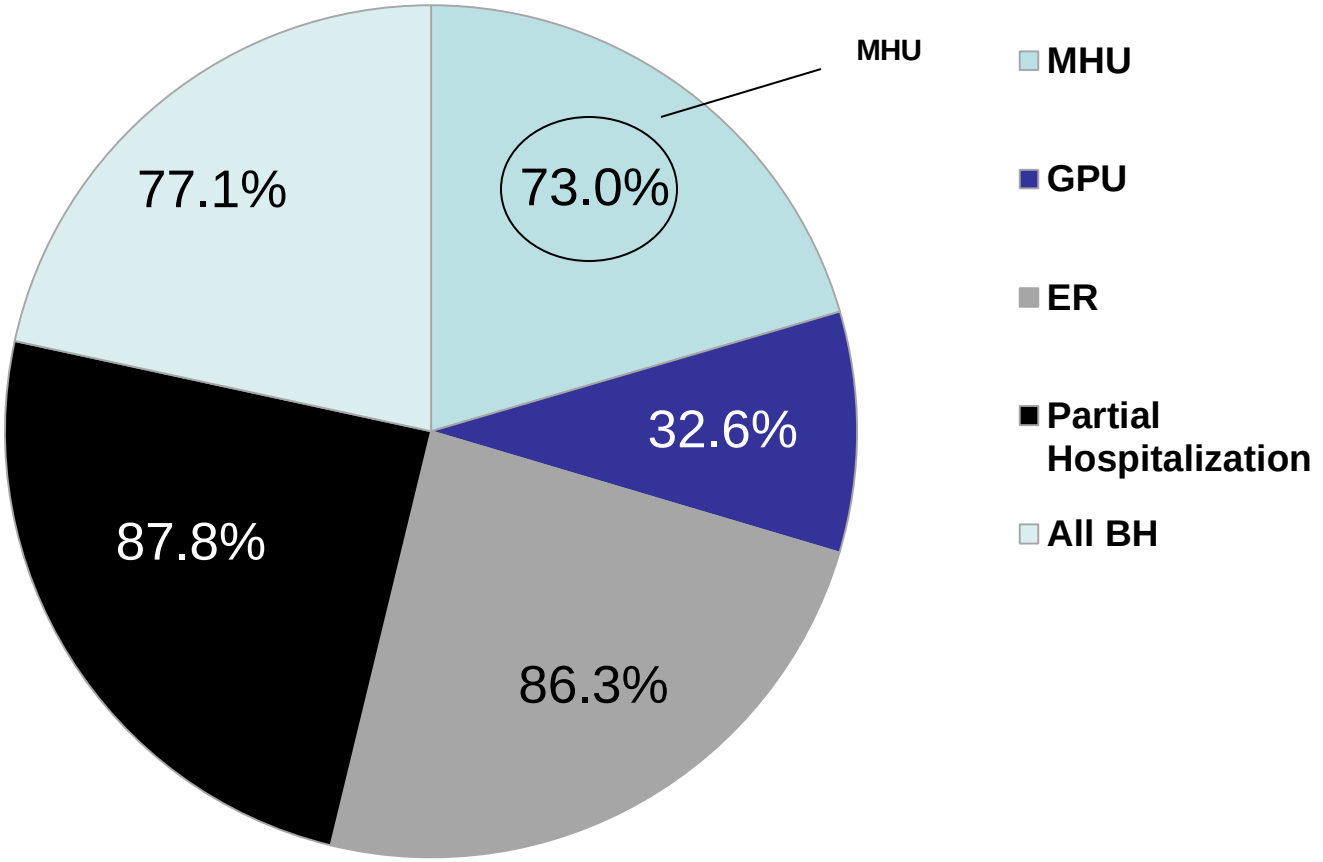
The primary care providers, ED personnel and clinicians overseeing inpatient services all perceive with remarkable consistency that substance abuse is widespread among patients they see and that there seem to be low capacity in the treatment available, a scarcity in the range of options, both being aspects in a deeply fragmented system of care.

Demand: Perception vs. Reality

Zip Codes Appearing 10 or More Times (all BH patients) – FY13			
Zip	**City/Town**	**In Heywood Area?**	**BH Admissions**
01440	Gardner, MA	Yes	1,424
01475	Winchendon, MA	Yes	442
01331	Athol & Phillipston, MA	Yes	159
01420	Fitchburg, MA	Yes	154
01436	Baldwinville, MA	No	123
01430	Ashburnham, MA	Yes	118
01473	Westminster, MA	Yes	115
01468	Templeton, MA	Yes	99
01452	Hubbardston, MA	Yes	91
01453	Leominster, MA	Yes	82
01364	Orange & Warwick, MA	Yes	56

Demand: Perception vs. Reality

Behavioral Health Admissions by Area - Percentages In Area

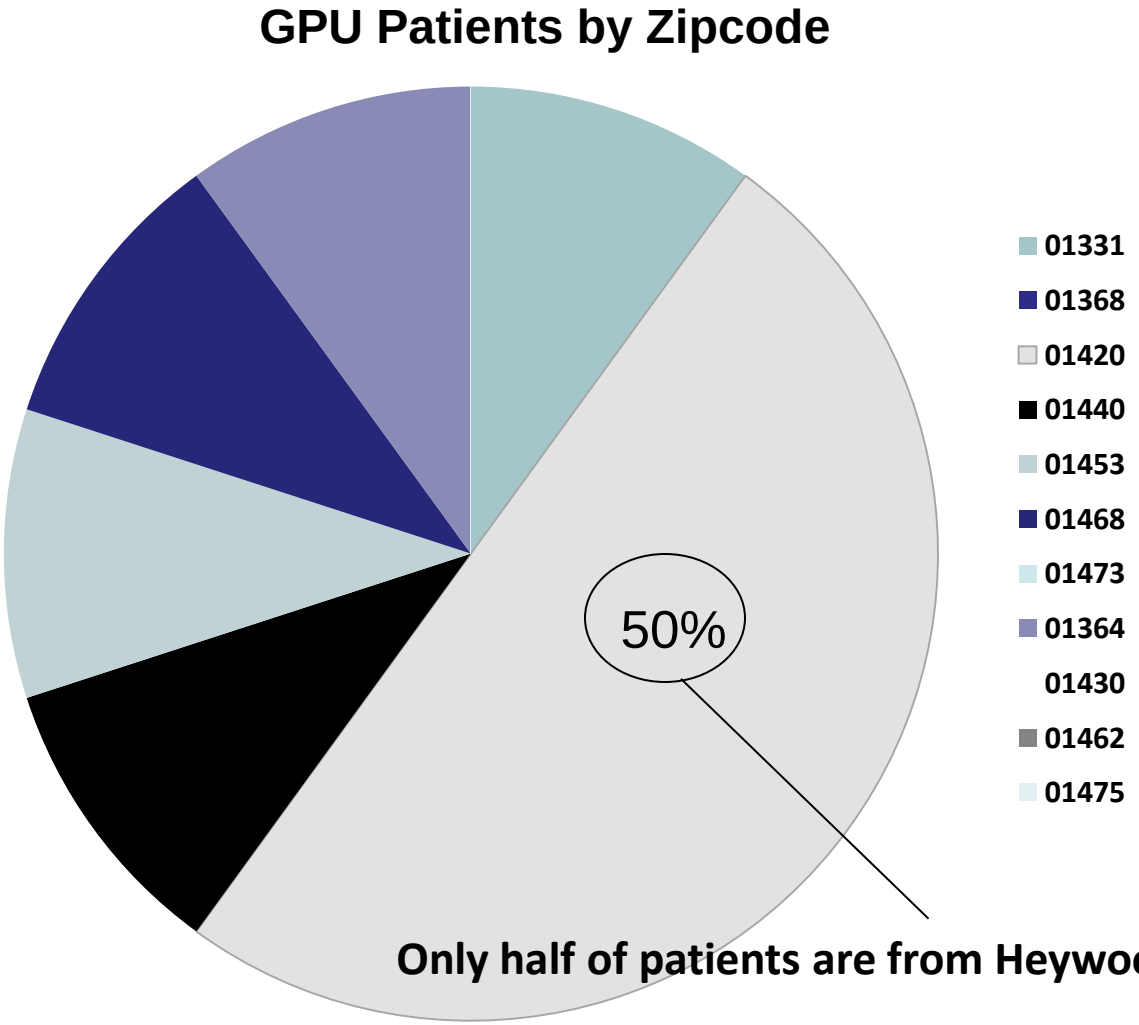


BH Inpatient Admissions by Diagnosis (CY12-13)

Diagnosis	Percentage of Patients
Alcohol abuse	1.14%
Alcohol/drug withdrawal	16.73%
Anxiety	1.52%
Bi-polar	23.95%
Depression	22.43%
Personality disorder	0.38%
Schizoaffective disorder	33.84%
	100.00%
TOTAL SUD	17.87%*
TOTAL BH	82.13%
INPATIENT (n = 263)	

***This is at odds with physician perspective that 30-50% is SUD**

Geriatric Psychiatry Admissions by Diagnosis (CY12-13)



Only half of patients are from Heywood service region

Geriatric Psychiatry Unit Patients by Diagnosis (CY12-13)

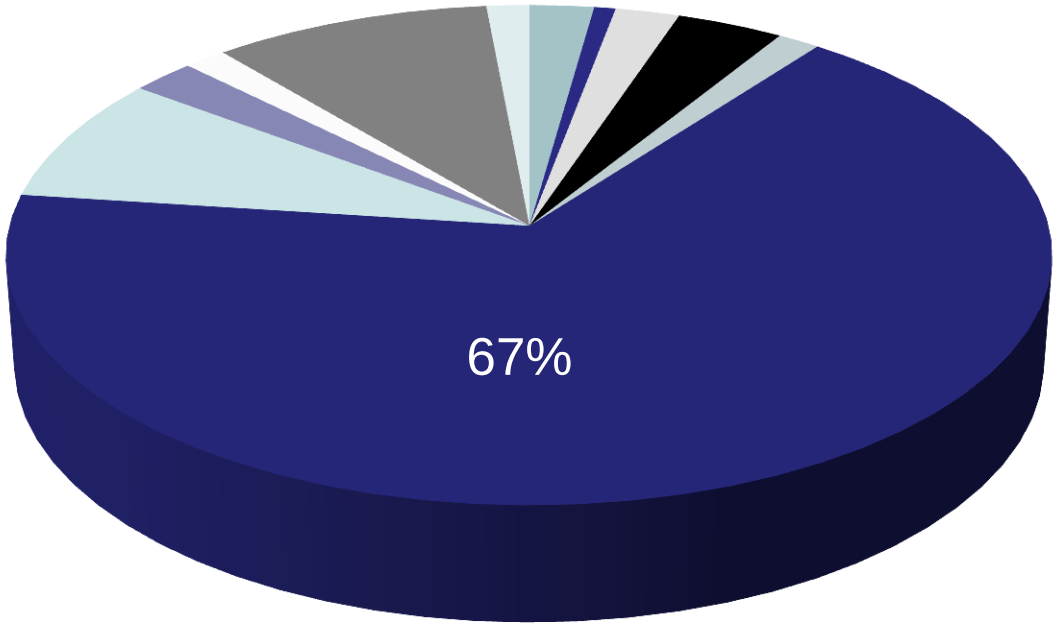
- About half of Geriatric Psychiatry Units admissions are from within the region – indicates HHS is serving as a regional/statewide Geri-psych resource
- Purchasers view the unit as an asset

Heywood Mental Health Unit Capacity
(4 month snapshot)

- The number of ***inquiries*** to the unit about available beds does not serve as a reliable proxy for inpatient demand. Clinicians will often call a number of inpatient units around the state to identify a number of options for patients and their families. ESP providers are required to make as least 3 calls a day in a search for a bed for a MBHP patient.

- Of all MHU "***referrals"*** that Heywood received:
  - Jan 2014: 87% declined due to no available beds in MHU
  - Feb 2014: 65% declined due to no available beds in MHU
  - March 2014: 67% declined due to no available beds in MHU
  - April 2014: 71% declined due to no available beds in MHU

March 2014 Snapshot: "Turned Away"

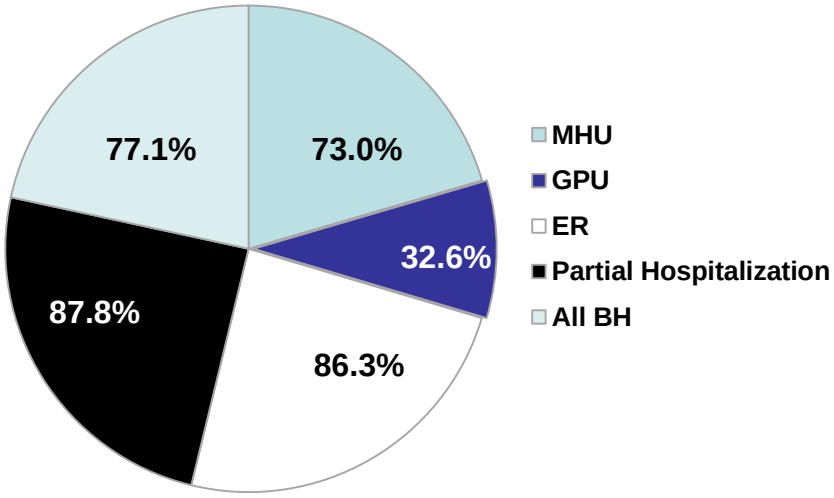


- Declined by Medical Coverage
- Family refused
- Found other placement
- Insurance Issues
- Needs Detox
- No available bed
- Not appropriate
- Too Acute
- Too Medical
- Unknown
- Will manage outpt

All BH Admissions By Unit (CY13)

Behavioral Health Admissions by Area (N)			
	In Area	**Out-of-Area**	**Total**
MHU	311	115	426
GPU	169	350	519
ER	2228	354	2582
Partial Hospitalization	79	11	90
All BH	**2787 (77%)**	**830 (23%)**	3617

Behavioral Health Admissions by Area - Percentages In Area



Heywood Inpatient Capacity

Key Question: How can you clearly differentiate inquiries vs. referrals?

From the agencies who call, how do you determine actual intention to place in HHS vs. meeting inquiry requirement?

- ✓ <u>Checklist</u>
- Actual referral made vs. inquiry?
- Records reviewed?
- Appropriate level of care determination made?
- Question caller about the status of their search?
- Alternative services ruled out?

Youth and Adolescents: Best Practice

- The **goal** of acute inpatient care for children and youth is stabilization
  - The child/adolescent poses a significant danger to self or others
  - ED visits should be reserved for except cases of psychoses or suicide attempts
  - All research since the late 1990s indicates that acute hospitalization is justified for limited reasons-predominantly for dangerousness

Youth and Adolescents: Best Practice

Since pediatric hospitalization is a costly and burdensome alternative for both families and the system as a whole, it should be avoided if there are better community- and home-based alternatives.

Youth and Adolescents: Inpatient Care

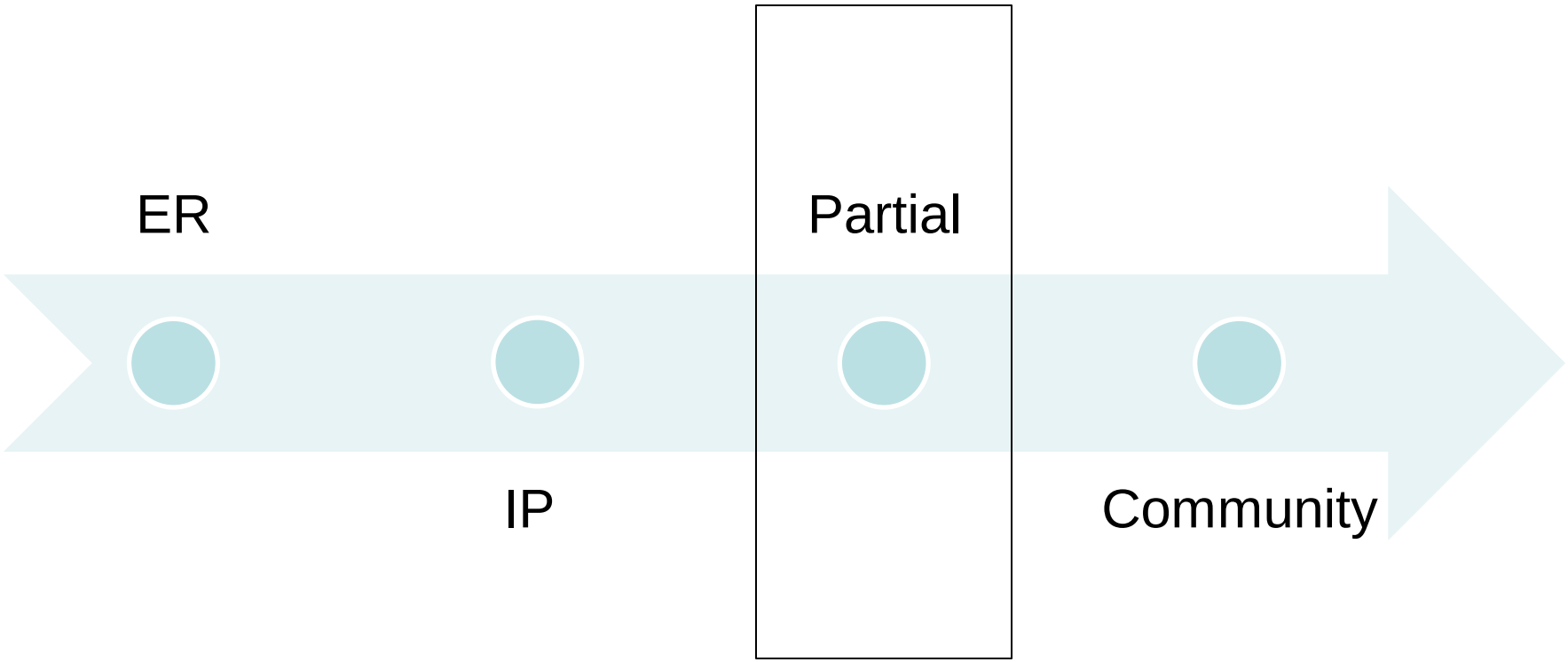
- Low-incidence population all children's inpatient units are considered statewide programs:
  - McLean Hospital, Brattleboro Retreat, Cambridge Health Alliance, Providence Behavioral Health Hospital, Anna Jacques Hospital, Franciscan Hospital for Children, Arbour Hospital, Arbour-Fuller Hospital, Pembroke Hospital and Lowell Treatment Center, Westwood Lodge and The Boston Center (Arbour) MetroWest Medical Center and others offer inpatient services for children, aged 5-18
  - Few of these programs also offer children's partial hospitalization (opportunity for exploration)

Youth and Adolescents: Inpatient Care vs. Other Levels of Care

Key Questions: Does Heywood want to fill the gap in partial hospitalization for children and adolescents?

- Mental Health outpatient care?
- Substance abuse outpatient treatment?

Assessing Access at Each Intercept Point

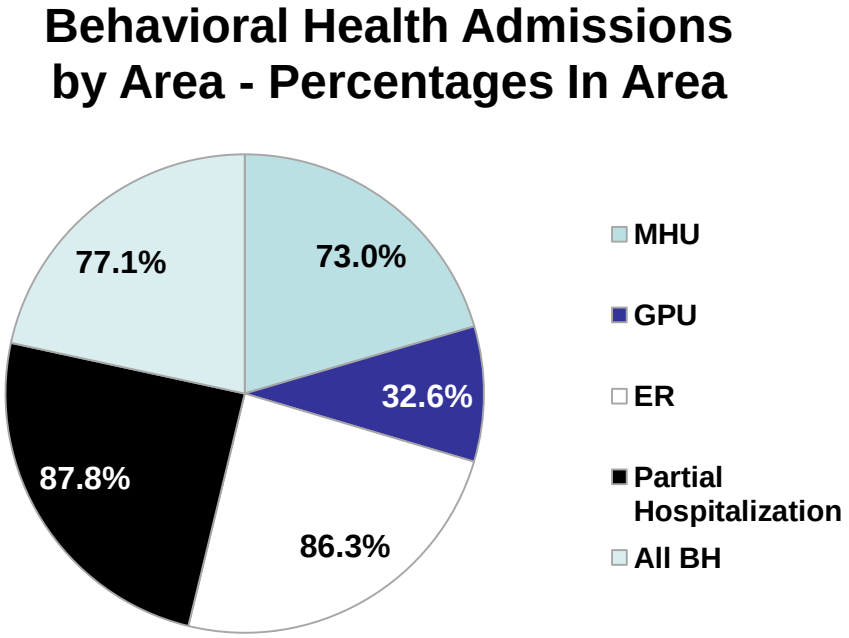


Partial Hospitalization: Heywood Data and Purchaser Perspectives

- The partial hospitalization program is meeting a great need in the region (88% of participants are in region)
  - Serving as a step-down program from inpatient and as an alternative to hospitalization
- MBHP is optimistic about the potential for the partial program to become a key diversionary/step-down service in the region
- DMH is concerned about the long-term viability of the model (completely subsidized by DMH)
  - There are several patients that are staying 5-6 weeks, a model which is unlikely to be acceptable to third party payers
  - Next year DMH would like Heywood to use the grant money to include community education, create rapid OP response capacity, and take on resource center type functions

Partial Hospitalization: Meeting Local Need

Behavioral Health Admissions by Area - Percentages			
	In Area	Out-of-Area	Total
MHU	73.0%	27.0%	100.0%
GPU	32.6%	67.4%	100.0%
ER	86.3%	13.7%	100.0%
Partial Hospitalization	87.8%	12.2%	100.0%
All BH	77.1%	22.9%	100.0%



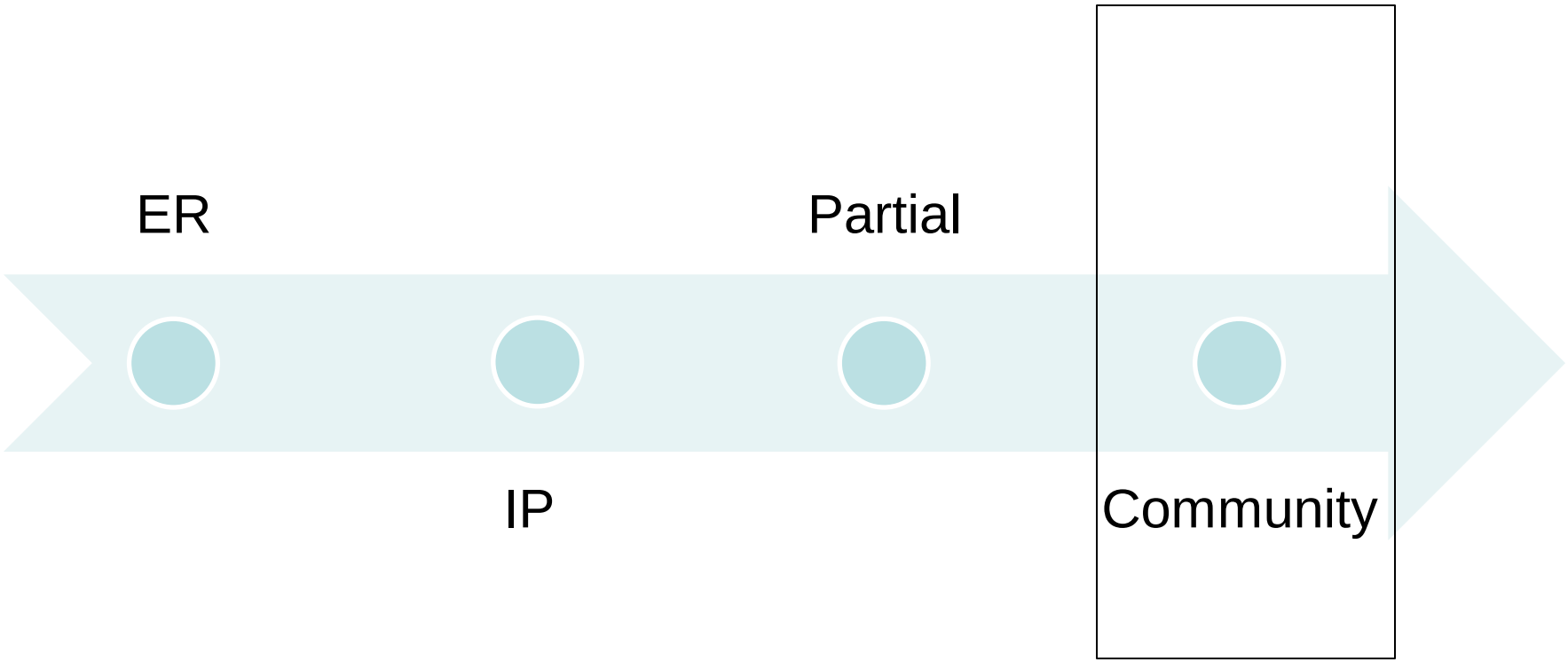
Partial Hospitalization: Meeting Local Need

Key questions:

- How does Heywood plan to sustain and/or expand its partial program?
  - Provider accountability for documentation
  - Mental health parity
  - Replacing state funding – transportation and services
- Can the model be used to meet demand for intensive outpatient Substance Use Disorder treatment?

*(*further discussed in community capacity section)*

Assessing Access at Each Intercept Point



Mental Health Demand Indicators: MBHP FY13

Poor State data for utilization for **all of Central region**. Can only infer what might be happening:

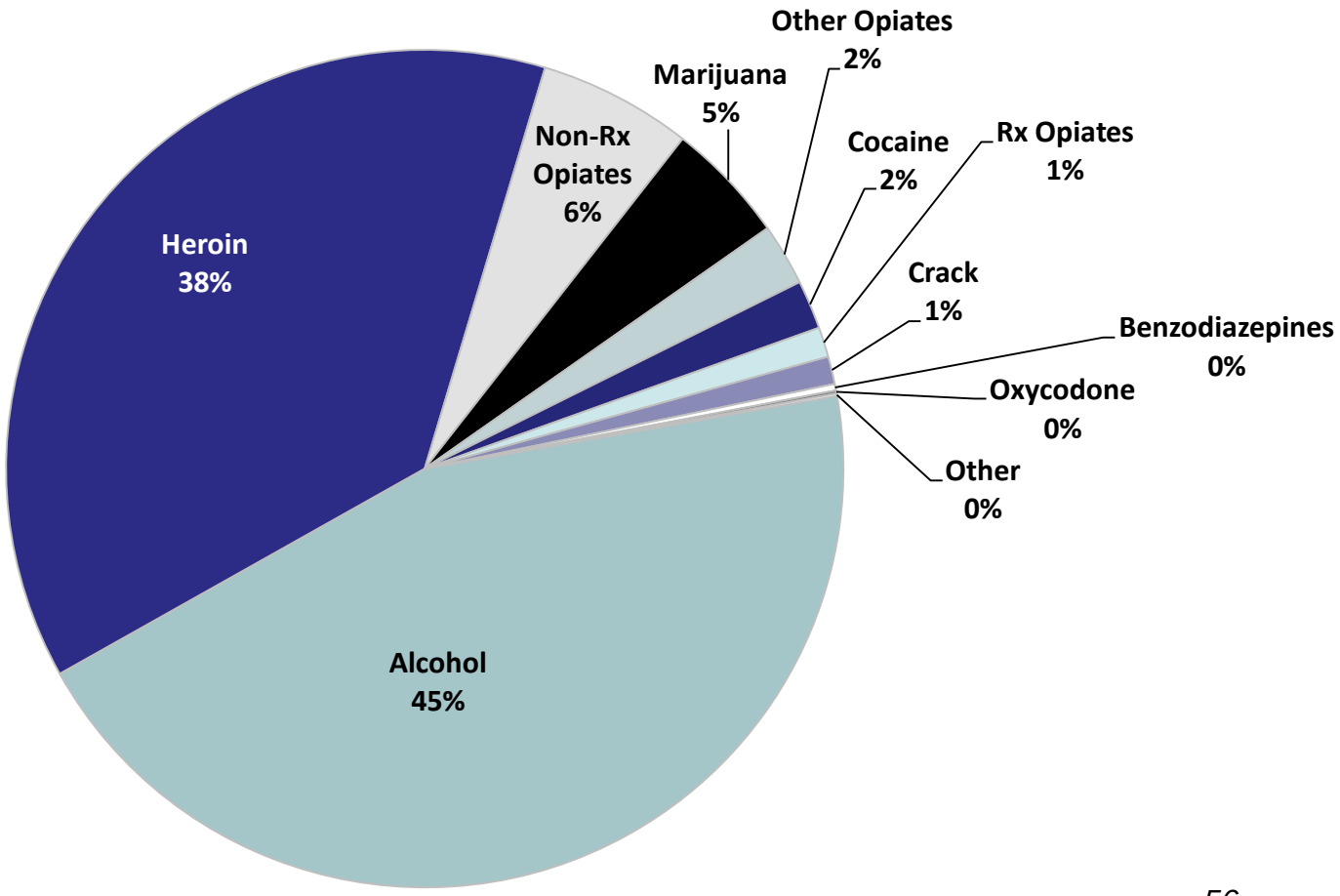
- Data on utilization are not available for only North Central
  - As a population, Medicaid recipients in the Central region use fewer services (have lower penetration rates) than the statewide average for all service types except for emergency services
- Similarly, when delivering services, providers in Central Mass deliver fewer units/recipient than the statewide average except for emergency services

Substance Abuse Demand Indicators Per 100,000 population

Residence Region or Town	Number of Enrollments	Population	% of population admitted to Tx
Berkshire County	3,581	131,219	2.73%
Franklin County	769	71,372	1.08%
Hampshire County	1,258	158,080	0.80%
CHNA 9	2,604	262,605	0.99%
Regional Service Area Indicators = N=2,237/1.2%			
Ashburnham	39	6,081	0.64%
Ashby	20	3,074	0.65%
Athol	121	11,584	1.04%
Fitchburg	693	40,318	1.72%
Gardner	305	20,228	1.51%
Hubbardston	38	4,382	0.87%
Leominster	486	40,759	1.19%
Lunenburg	87	10,086	0.86%
Orange	147	7,839	1.88%
Phillipston	11	1,682	0.65%
Royalston	0	1,258	0.00%
Templeton	83	8,013	1.04%
Townsend	70	8,926	0.78%
Warwick	0	780	0.00%
Westminster	47	7,277	0.65%
Winchendon	90	10,300	0.87%

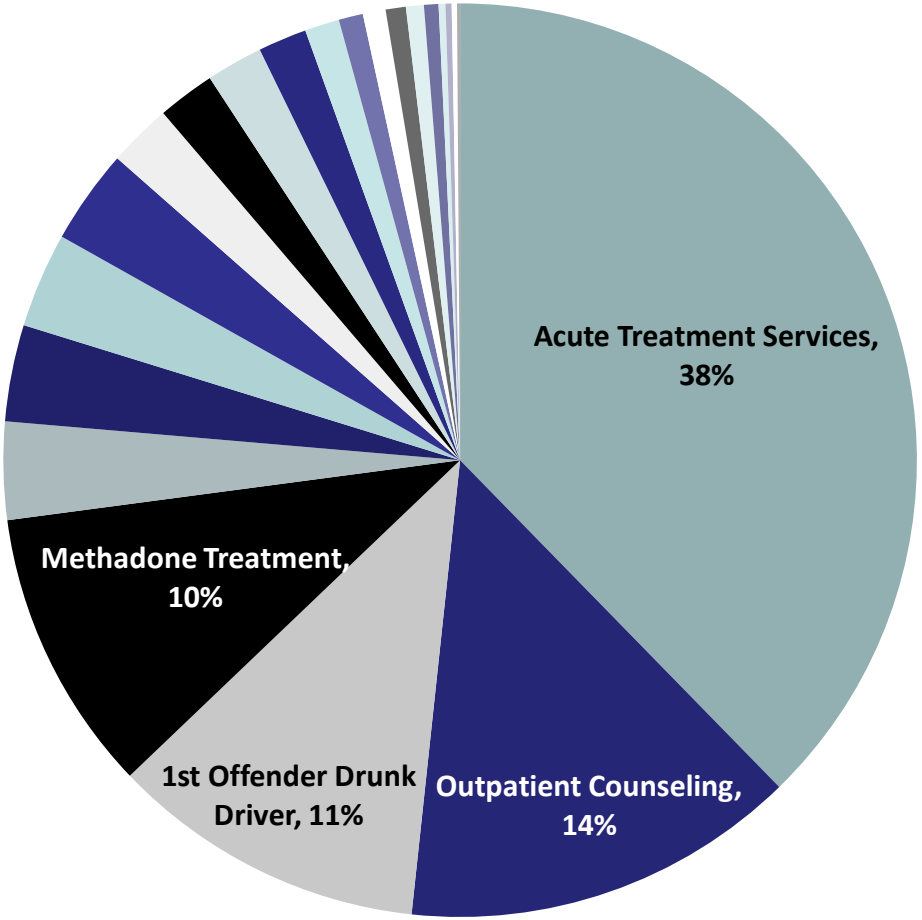
Substance Abuse Demand Indicators

BSAS Treatment Admissions: CY13 by Primary Drug of Choice



Substance Abuse Demand Indicators

BSAS Treatment Admissions: CY13 by Most Frequent Level of Care



Community Provider Perspectives

Overall Perception of Heywood - **Strengths:**

- Community providers and MBHP view Heywood in a positive light-they indicate that Heywood provides good services and is a good partner
- Heywood Inpatient provides quality care: Heywood's inpatient unit was widely viewed as providing good care
- Partial hospital program: Heywood's partial hospital program is generally perceived with optimism: most providers believe it represents an important new level of care to the continuum

Community Provider Perspectives

Community Behavioral Health Providers:

- While providers generally respect that Heywood continues to provide inpatient psychiatric services and applaud the hospital's efforts regarding the suicide prevention task force, they do not see the organization as a leader in the system of care
- AdCare is very interested in a partnership around everything from transportation, a joint-outpatient clinic, to IP treatment program at the Petersham property

Community Provider Perspectives

Primary Care Providers:

- PCPs have difficulty connecting with a live person when they have a patient they believe is in crisis
  - They use a list from the Heywood web site or perform their own Google searches to call for providers, but unable to reach anyone immediately; delays in call backs
  - Waits seem to be 4-6 weeks away even if they do get an appointment

Community Provider Perspectives

PCP's: The "pace" and structure of primary care delivery differs immensely from that of behavioral health:

- PCP's don't understand why they don't get a faster response, especially when they perceive the patient to be in crisis or near to one
- The pace of behavioral health treatment is slower and more "contemplative"
- Heywood and other area PCPs sees this as a lack of responsiveness to their and their patients' needs

Example: Primary Care vs. Behavioral Health

	Primary Care	Mental Health
Pace	15 minute appointment	50 minute sessions
Duration	Appointments once or a few times a year	Often, weekly appointments for several months
Setting	An exam room	A living room
Language	Diagnosis, medical terminology, complaints	Assessment, mental health terminology, issues
Hierarchy	Clear – Dr. in charge	Diffuse – Administrator in charge with medical dir.
Flow	Flexible patient flow	Scheduled client flow

Community Provider Perspectives

PCPs don't feel comfortable making decisions about medication:

- In North Central, few, if any, PCPs interviewed have used MCPAP - telephonic psychiatric and clinical guidance to primary care providers (PCPs) treating children with mental health problems, with a guaranteed call back within 30 minutes of the initial call

Community Provider Perspectives

Key Question regarding primary care:

Pharmacist consultation for medication therapy management directly with patients is reimbursable. Explore this option as a supplement to psychiatric medication consultations?

- Telemedicine options?

Community Provider Perspectives

Linkages to Community Providers (referral system):

The community providers think there is sufficient capacity to meet the needs of the population except perhaps for adult outpatient, while PCPs and Heywood think there is insufficient IP and community capacity and poor responsiveness on the part of providers:

- Linkages from hospital to community: Heywood struggles with linkages to community-based care. There is a need for a standardized process for discharge planning to properly link patients to community-based treatment and support providers
- There is a perceived need for better, ongoing relationships between Heywood and providers management that would support systemic improvements around transitions for patients to community based services

Community Provider Perspectives

Substance Abuse Treatment

- The primary care providers, ED personnel and clinicians overseeing inpatient services all agree with remarkable consistency that substance abuse is widespread among patients they see and that there seem to be low capacity in the treatment available and a scarcity in the range of options, both being aspects in a deeply fragmented system of care

(Repeated theme in both data and stakeholder perceptions)

Community Provider Perspectives

Outpatient/ambulatory behavioral health services, adults:

- The one service delivery mode that most interviewees agreed is in short supply in the North Central area
- This perception is based on the length of wait times for an appointment, confirmed by staff at the large behavioral health agencies
- Typical wait for OP services is 2-4 weeks (MBHP OP-finder system supports this) - Psychiatry is tougher (avg. 90 days)
  - Some agencies have open access for intake services. or open access for appointments on certain days of the week
  - It has been reported that patients may access crisis services or make ED visits as a front door to the outpatient service system

Community Provider Perspectives

Integration of primary and behavioral healthcare:

All providers agree that this is an important issue:

- New partnerships are taking form between Heywood and community providers

Examples of existing initiatives that Heywood can tap into include:

- CSO has been building technological infrastructure to support integration
- Alternatives Unlimited has developed an Adult Family Care (AFC) program, staffed by a clinician, RN, and a program developer that visit the doctor's offices to develop systems and manage tough cases
- You Inc. has a strong family prevention and wellness program (in Ashburnham)

In Summary

The Heywood Service Region has moderate to high rates of poverty, high rates of substance abuse, particularly opioid and alcohol abuse and high rates of mental health disorders, and adult and adolescent suicide.

Key questions regarding OP Capacity:

What service model is most appropriate for Heywood to help increase capacity within the service region?

- Care Coordination between primary and behavioral health?
- Partial Hospitalization/Intensive Outpatient?
- Traditional Outpatient for substance abuse and mental health?

Findings: Strategic Planning Behavioral Health

- Major crisis occurring – suicides, substance abuse, lack of access to behavioral health resources
- Both PCP and Behavioral Health professionals realize need for more primary care – behavioral health integration
- Heywood resources valued by community providers and MBHP – especially IP psych
- Heywood serving as a statewide IP Geri-Psych resource – appropriate?
- Lack of clear and comprehensive connection between Heywood and community resources – broken regional referral system

Findings:
Strategic Planning Behavioral Health

- Lack of depth in psychiatric and psychologist resources – long waits for medication management and counseling
- Development of Petersham property could be beneficial to all – Enhanced Detox, IP Mental Health and SUD
- Behavioral Health leader and care coordination resources needed for Heywood System

Discussion


Athol Hospital
Member of the Heywood Healthcare Family


Heywood Hospital