CONTACT
Ann Lewis
Ann.Lewis@caresouth-carolina.com

The case for collaborative behavioral health integration in rural South Carolina:

CareSouth Carolina and the Northeastern Rural Health Network

In a nutshell

When analyzing the 2013 use of acute care hospitals for ambulatory care sensitive conditions, behavioral health patients in South Carolina spent, or average, 77% more time in the hospital than the non-behaviorally ill. The Pee Dee region in South Carolina is predominantly low-income, rural, and has consistently performed at the bottom of health rankings; however, two counties in this region, Marlboro and Chesterfield, seemed to be doing much better than the state average in the management of the primary care needs of the behaviorally ill.

This case study presents the story of CareSouth Carolina and the Northeastern Rural Health Network, a group of organizations that made the mental health of residents of Chesterfield and Marlboro County a priority, and have maximized the potential for primary care- behavioral health integration in an environment of economic instability and scarcity of psychiatric resources.

The change agents

CareSouth Carolina is a Federally Qualified Health Center that serves Marlboro and Chesterfield Counties. This FQHC is also part of one of the five rural health networks in the state, the Northeastern Rural Health Network. During the 2000s these two organizations prioritized actions to improve the behavioral health wellness of its patients and residents. Their approaches have been complementary and may offer an explanation for the good primary care outcomes of the behaviorally ill in these counties.

The Northeastern Rural Health Network is a public-private partnership between mental health providers, alcohol/drug abuse treatment providers, primary care providers, acute care providers, academic institutions, public health, the state office of rural health, and the two county inter-agency Councils.

Phased expansion of behavioral health integration services

The Behavioral Health integration process started with CareSouth in the early 90s and has gone through a four-phase process. The latest stage has been implemented in partnership with the members of the Northeastern Rural Health Network.

- Phase I - addressing post-partum depression: In the early 90s CareSouth pioneered behavioral health integration in the state through a program focused on post-partum depression.

- Phase II – addressing chronic disease and depression co-morbidity: Alarmed by the high percentage of chronically ill patients with depression co-morbidity (apx 40%), CareSouth expanded behavioral health integration services to all primary care patients they serve. At this time, they emphasized process adherence and provider accountability.

- Phase III – addressing higher complexity behavioral health patients in the primary care setting: Following the recession-driven downsizing of the public mental health system in the state, the FQHC saw the need to provide behavioral health services for patients with higher complexity and started hiring Licensed Independent Social Workers.

- Phase IV – supporting multi-layered approaches for preventing behavioral health issues in the community: The Northeastern Rural Health Network made improving behavioral health its number 1 priority. Since 2006, network partners have worked together on initiatives related to community-based detection of mental health problems, mental health first aid, and integration of primary care providers in the mental health center.

ALLIANCE FOR A HEALTHIER SOUTH CAROLINA

Case Study Series No. 2015-007

September 2015| This case study was produced by the Alliance for a Healthier South Carolina in partnership with the University of South Carolina Consortium for Latino Immigration Studies and CareSouth Carolina. It is part of Darius Fenelon's Masters of Public Health practicum project at the University of South Carolina Arnold School of Public Health.

Key elements of the CareSouth Carolina Behavioral Health Integration model

- Warm hand-offs:
  Primary care practitioners have not been traditionally comfortable diagnosing and treating behavioral health issues. To overcome this problem, CareSouth incorporated a behavioral health counselor in each primary care office. When the primary care practitioner considers a patient would benefit from a behavioral health consultation, CareSouth guarantees same day face-to-face interaction between the patient and the behavioral health counselor.

  This model decreases mental health stigma, improves care coordination, and increases the likelihood that patients will receive the physical and mental health support they need in order to be healthy.

- True integration:
  To foster the success of this collaborative approach, CareSouth ensures that the integration is not limited to the co-location of behavioral counselors and primary health care providers "in the same hall of the building". Behavioral health professionals alongside with primary care professionals and support staff are part of the care team, have common huddles, and must have excellent communication and understanding of each other's approach. The Electronic Medical Record integrates behavioral health information in order to make the process as smooth as possible.

- Adherence to evidence based processes:
  Around the year 2000 there were a series of articles highlighting generalized lack of adherence to evidence based protocols nationwide. So CareSouth's CEO, Ann Lewis an early adopter in the quality improvement movement, promoted the motto: "Improving processes, improving outcomes" and committed to:

  1. Preventing failure through adherence to protocols

  2. If failure happens, identify it and address it (identify if providers or patients are having challenges to follow the process/protocol as recommended)

  3. Once identified, designing a control mechanism that prevents failure from happening again.

  Ensuring adherence requires provider and patient "compliance"; but at CareSouth, no person is labeled as "non-compliant", instead, there are people who may need information or support in overcoming challenges.

  On the provider side, CareSouth implemented a provider dashboard that publicly reported outcomes of care. On the patient side, case managers worked with "non-compliant" patients to identify and address the challenges that were making it difficult for them to adhere to treatment (transportation, insurance, income, literacy, social support, etc).

  In regards to depression, CareSouth implemented evidence based guidelines for depression treatment in primary care, tracked depression outcomes of all patients through its EMR, screened all new adult and adolescent patients for depression, and monitored depression outcomes. At that time, CareSouth achieved 50% decrease in the PHQ9 score of 47% of its patients with major depression in a 4-month period.

  Today, all FQHC patients do the PHQ9 assessment at least once a year. CareSouth provides mental health support to clients of the Department of Social Services, Department of Juvenile Justice, geriatric patients in long term facilities, victims of domestic violence in the PeeDee, and HIV/AIDS patients in the Ryan White program.

- Provision of higher complexity behavioral health services:
  The Community Mental Health Center is a good partner of CareSouth Carolina, but during the recession, the state mental health system experienced severe budget cuts. Mental Health Centers had to narrow down their scope of services and take care only of those with highest need. In response to that, CareSouth expanded beyond depression services through the hiring of Licensed Independent Social Workers.

Key elements of the Chesterfield-Marlboro community-wide approach to mental health prevention

In 2008, the Northeastern rural health Network was created as a collaborative team of 11 members working together to make available increased access to needed services across Chesterfield, Marlboro and Dillon counties.

Early on, the network assessed behavioral health assets and needs through a study about the Personal Opinions Regarding the Community's Health (PORCH) which focused on mental health access and stigma. The network then prioritized the integration of primary care and mental health at all levels. These are some of the approaches:

- Prevention of chronic disease and related behavioral health co-morbidity:
  They incorporated depression and chronic disease messaging in community screenings, thus contributing to the reduction of stigma.

- Bi-directional integration of primary care and behavioral health providers:
  Depending on the degree of severity of the behavioral health issues, the integration of physical and behavioral health may yield a better result in different settings. CareSouth had already embedded behavioral health professionals in primary care, for those patients struggling with depression. The Healthy Mind Body Alliance embedded primary care providers in the mental health setting to address the primary care needs of complex mentally ill patients.

- Referral protocols:
  The Network developed referral protocols between the Emergency Department, mental health, and primary care providers.

- Mental Health First Aid:
  Training of community health workers, health care workers and community members in the early detection of mental health crisis and first aid.

Closing comments

Although CareSouth Carolina has implemented behavioral health integration enterprise-wide (5 counties), the best results are in the counties where the Northeastern Rural Health Network is present. Ann Lewis, CEO of CareSouth states that the regular monthly meetings of the Network facilitate interaction, referrals, and collective action to address major challenges.

Chesterfield and Marlboro counties need additional access to psychiatric resources in order to meet the needs of the most complex patients; however, they have done an outstanding job at taking care of the primary care needs of behaviorally ill patients.

As this case study was being completed it was announced that the Marlboro Hospital would close. The Network partners had been in a process to hire and keep as many practitioners as possible in this medically underserved area.

Contact:

Ann Lewis, CEO, CareSouth-Carolina, ann.lewis@caresouth-carolina.com

September 2015| This case study was produced by the Alliance for a Healthier South Carolina in partnership with the University of South Carolina Consortium for Latino Immigration Studies and CareSouth Carolina. It is part of Darius Fenelon's Masters of Public Health practicum project at the University of South Carolina Arnold School of Public Health.