Behavioral Health Webinar Series for Primary Care

Thursday, November 21, 2019
12:00 – 1:00 PM

Systems of Care: The New Big Lots Behavioral Health Pavilion
Presented by: David Axelson, MD

Join by Phone: 1-415-655-0001  Conference ID: 316 691 542
Join by WebEx: https://bit.ly/2X5MzSx

This session is eligible for 1.0 Category 1 CME credit upon completion of the CME Evaluation Survey.

Speaker, David Axelson, MD, discloses Other Activities with Remuneration Wolters-Kluwer / UpToDate. These conflicts of interest were resolved by the CME Office. No one else in a position to control content has any relationships with commercial interests.

Visit our website! https://www.nationwidechildrens.org/specialties/behavioral-health/for-providers/webinar-series

David Axelson, MD

Nationwide Children's
When your child needs a hospital, everything matters.
Reminders

• This webinar is being recorded.

• We have **muted** all participants.

• **Chat with us during the webinar.** To type a question or comment for the speaker or facilitator, type it directly into the WebEx chat box.
The Burden of Pediatric Mental Illness

11% of children (ages 8 to 11) have or have had a mental illness with severe impairment

22% of teens (ages 13 to 18) have had a mental illness with severe impairment in their lifetime

Only 50% of youth with a mental health disorder receive any behavioral health treatment

50% of all lifetime mental illnesses start by age 14

75% of all lifetime mental illnesses start by age 24

Mental Health Care Use in Children with MH Disorders

Figure. Prevalence of Mental Health Disorders and Mental Health Care Use Among US Youth

A. Prevalence of mental health disorders in children

B. Prevalence of not receiving care in children with mental health disorders

State-level prevalence presented as quartiles of at least 1 mental health disorder (i.e., depression, anxiety problems, and attention-deficit/hyperactivity disorder) in the total sample of children (weighted estimate, 46.6 million). B. State-level prevalence presented as quartiles of children with a mental health disorder not receiving needed treatment or counseling from a mental health professional (weighted estimate, 7.7 million).

Whitney DG & Peterson MD; JAMA Pediatrics (2019)
Rate of Death by Suicide in US: Ages 10-19

- 86% increase since 2007
- 2nd leading cause of death in 10-19 year olds
- 80-90% of youth who complete suicide have a mental health diagnosis
Steady Increase in Pediatric Mental Health Emergency Visits

Figure 2. Emergency department visits for mental health conditions per 1000 population of children and adolescents 6 to 20 years of age, 2001-2011.
Behavioral Health Strategic Plan

Our Aspiration:
To develop a national model for pediatric mental health care.

Expanding **clinical access** to pediatric mental health care

Developing targeted **prevention** efforts

Leading a coordinated, collaborative **system**

Researching the **causes and treatment** of behavioral health conditions
Behavioral Health Services Are Provided Across a Continuum of Care

- **Outpatient (Specialty MH, Primary Care)**
- **Community Based (In-home, School)**
- **Intermediate Levels of Care (Partial/Day Hospital, Intensive Outpatient)**
- **Residential**
- **Inpatient**

**Consultation (Inpatient / Outpatient / Primary Care / Juvenile Justice)**
NCH Big Lots Behavioral Health Service Line

**Prevention**
- PAX Good Behavior Game
- Signs of Suicide Curriculum
  (70 schools, 482 classrooms, 10,314 students)
- Preschool Expulsion Prevention Partnership
- Triple P

**Psychiatry**
- 1,784 Consults
- 1,676 Psychiatric Boarders
- 4,287 Boarder Days
- 4,947 assessments
  - 36% Admitted (88% as boarders)
  - 8,425 Crisis Line Calls
  - 653 NCH Provider Calls
  - ~ 1,800 Code Violet Responses

**Psychology**
- 3,827 Consults

**Provider Consultation/Education**
- Physicians Direct Connect
- Project ECHO
- E-consults to Primary Care
- Tele-Ed to Community Agency APP’s

**Psychiatry**
- 2,279 Eating Disorder PHP/IOP Days
- 2,098 Mood & Anxiety Disorder IOP Days

**Psychology**
- 16,137 Community Based Visits
- 22,237 School Visits

**Behavioral Health Outpatient**
- 82,960 Therapy Visits

**Volume Data from 2018**

- 578 discharges
- 5,369 patient days
- Average Length of Stay 3.7 days
- 95% discharged home

- 867 discharges
- 3,246 patient days
- Average Length of Stay 9.3 days

- 4,947 assessments
  - 36% Admitted (88% as boarders)
  - 8,425 Crisis Line Calls
  - 653 NCH Provider Calls
  - ~ 1,800 Code Violet Responses

- 16,137 Community Based Visits
- 22,237 School Visits

- 29,739 Clinic Visits
- 8,816 Patients

- 10,914 Clinic Visits
- 3,990 Primary Care Visits
- 9,313 Subspecialty Clinic Visits

- 52,842 Home, School and Clinic Visits

- 33,263 Unique Patients
- 229,335 Total Visits
Annual Number of Acute Visits

Source: EDW

* Represents patients discharged from YCSU & Psychiatric Inpatient
Big Lots Behavioral Health Pavilion
NCH Big Lots Behavioral Health Pavilion – A Hub

- Acute Clinical Services
- Clinical Services that benefit from proximity to Acute Services
- Administration
- Education
- Research
Pavilion Programs

Acute Services

- Psychiatric Crisis Department
- Youth Crisis Stabilization Unit
- Psychiatric Inpatient Units

Innovative Outpatient Programs

- Mood & Anxiety Program
- Family Based Intensive Therapy
- Critical Assessment & Treatment Clinic
- Partial Hospitalization Program
- Psychiatry Outpatient Clinic

Research

- Center for Suicide Prevention & Research/Behavioral Health Research Expansion
Stack Diagram Impact

PH

1

PSYCHIATRIC CRISIS DEPARTMENT + OBSERVATION SUITE – 10 BEDS

2

OUTPATIENT

3

YCSU - 16 BEDS

ADMINISTRATION

4

SHELL

5

COURTYARD

FAMILY AMENITY

SHELL

COURTYARD

PARTIAL PROGRAM

6

SHELL

7

INPATIENT – 30 BEDS

8

INPATIENT – 36 BEDS

MECHANICAL

OUTDOOR PLAY

GYM

MECHANICAL

MECHANICAL & BUILDING SUPPORT

CONFERENCING / TRAINING / CAFÉ
BHP – First Floor
Psychiatric Crisis Department

- Safe, secure facility to assess youth in crisis
- Triage screens for medical issues and psychiatric status
- Most patients can wait in lobby and be assessed in consult rooms
- Extended observation rooms for high acuity patients and those requiring longer assessment
Psychiatric Crisis Department

- 24/7 coverage with licensed BH clinicians, nursing and pediatric medical physician
- 8 AM – 12 MID: child psychiatrist on site
- 12 MID – 8 AM: psychiatrist coverage by phone
- Goal is to have sufficient time and space to be able to determine optimal disposition
Psychiatric Crisis Department

- All referrals for psychiatric admission will go through the Psychiatric Crisis Department
- No Direct Admissions
- Admission screening medical history and physical will be performed
- Suicide risk and monitoring status will be determined
- Admission orders written
Psychiatric Crisis Department – Lobby
Psychiatric Crisis Department – Lobby
Psychiatric Crisis Department

Entry to Vehicle Sally Port
Triage and Medical Exam Rooms

Consult Room
Extended Observation Suite
BHP – Fifth Floor
BHP – Fifth Floor
BHP – Seventh and Eighth Floors
BHP – Seventh and Eighth Floors
BHP – Ninth Floor
# Pavilion Bed Ramp Up

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Q1 2020</th>
<th>End of 2021</th>
</tr>
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<tbody>
<tr>
<td>Inpatient Psychiatry Units</td>
<td>16</td>
<td>22</td>
<td>48</td>
</tr>
<tr>
<td>Youth Crisis Stabilization</td>
<td>12</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Extended Observation</td>
<td>0</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

- **Total Beds**: 28
- **End of 2021**: 74

- **Unopened Capacity**
  - End of 2021: 18

- **Total Potential Capacity**: 28
- **End of 2021**: 92

*Represents only the 4th inpatient unit of 18 beds at end of 2021
92 total beds in the Pavilion*
Myth #1: All Behavioral Health Outpatient Services Will Be Housed in the Pavilion

Total Number of Behavioral Health Outpatient Visits

<table>
<thead>
<tr>
<th>Year</th>
<th>Visits</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>2016</td>
<td>179,713</td>
<td>12%</td>
</tr>
<tr>
<td>2017</td>
<td>208,623</td>
<td>9%</td>
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5 Clinics
- Mood & Anxiety
- Family Based Intensive Treatment
- Psychiatry
- Center for Suicide Prevention & Research
- Critical Assessment & Treatment Clinic

Source: EDW, Team Analysis, Estimated projections, subject to change
Myth #2: Psychiatric Patients Will No Longer Be Admitted to the Acute Hospital (C & D - Buildings)

1. Medically Complicated Patients Will Not Be Admitted to the Pavilion
2. During Peak Times and Pavilion Ramp Up Boarders Will Persist

Average Daily Census

~ 2 - 4

Average Daily Census

~ 0 – 6
(Could be higher in Feb-Apr & Oct-Nov)

Source: EDW, Team Analysis, Estimated projections, subject to change
Myth #3: Psychiatric Patients Will No Longer Be Seen in the Main Emergency Department

• Medically complex psychiatric patients will be triaged to the Emergency Department
  • Overdoses / Ingestions
  • Lacerations
  • Intoxication with drugs / alcohol
  • Delirium
  • Significantly abnormal vital signs or evidence of medical instability

• If stabilized in NCH ED, patients will be transferred to the Psychiatric Crisis Department
NCH Behavioral Health Strategic Plan

Our Aspiration:
To develop a national model for pediatric mental health care

Expanding clinical access to pediatric mental health care

Leading a coordinated, collaborative system

Developing targeted prevention efforts

Researching the causes and treatment of behavioral health conditions
~15% prevalence equates to
130,000
children & adolescents in
NCH’s service area

Regional Need

47,000
Franklin County

28,000
Primary Service Area

55,000
Secondary Service Area

Source: US Census, 2010
Community Engagement

• Outreach to providers in Central and SE Ohio

• Outreach to organizations (NAMI, Mental Health America)

• Partner with Columbus Foundation to foster Residential and Acute Care Providers Workgroup

• Work with Partners for Kids to develop primary care collaborations, coordinate network development with BH providers
How and why does NCH sustain suicide prevention?

• Consistent with our values & mission
• Reduced risk of suicide clusters and contagion
• Reduced individual, family and community suffering
• Decreased costs
  • For every 1,000 children, 5 fewer suicide attempts
  • For every $1 spent, estimated $4.50 ROI
• Reduction in ED visits
• Strong interest from donors & community leaders

Garraza et al., 2016; Walrath et al., 2015
Signs of Suicide (SOS)

- Evidence-based universal suicide prevention
- Three RCTs show 40-64% reduction in self-reported suicide attempts (Aseltine & DeMartino, 2004; Aseltine, 2007; Schilling et al., 2016) at 3-month follow-up
- Greater pre-post knowledge and attitudes about depression
- Increase in help-seeking behaviors not significant (Aseltine, 2007)
Signs of Suicide (SOS)

• Train all adults to identify depression symptoms and warning signs for suicide
• Teach action steps to students and adults when encountering suicidal behavior
• Increase student awareness and help-seeking

Acronym (ACT)

• Acknowledge
• Care - show that you care
• Tell a trusted adult
Advantages of SOS

- Implemented by school staff
- Engages existing supports including school staff, parents, peers, community
- Incorporates many best practice elements
- Increases dialogue around mental health
  - Reduces stigma
- Sustainable
NCH Signs of Suicide Implementation (October 2015 – June 2019)

- 134 schools, 1677 classrooms, 36,189 students

- 6,515 Yes Comment Cards
- 3,847 + BSAD Screens
- 9,285 Triage Assessments (25.7%)
- 1,206 Risk Assessments (3.3%)
- 209 Crisis Referrals (0.6%)
- 1,754 non-crisis Treatment Referrals (4.8%)
How do I access / refer?

- Referral to Psychiatric Crisis Department
  - 614-355-0221

- Referral for BH or Psychiatric Services
  - 614-355-8080
Thanks to the NCH team that has made this facility a reality.

Questions?
If you would like to receive CME credit for today’s presentation, please complete the following survey by Friday, November 29, 2019:

https://www.surveymonkey.com/r/FGPH7WP

Please note:
We are unable to provide CME credit past this deadline

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CME POSTING

Series Name: Behavioral Health Webinar Series for Primary Care
Date: November 21, 2019 / Noon-1PM
Presentation Title: Systems of Care: The New Big Lots Behavioral Health Pavilion
Speakers Name(s): David Axelson, MD
Planning Committee: Jennifer White, MD; William Long, MD; Nancy Cunningham, PsyD; Alex Bishara; Sherry Fletcher, Jessica Dudley

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Session Objectives:
At the conclusion of this activity, participants will:

1. Demonstrate an understanding of the principles driving the development of the forthcoming Big Lots Behavioral Health Pavilion (BHP) at Nationwide Children’s Hospital.
2. Recognize how the new constellation of services fit within the larger NCH Behavioral Health Strategic Plan and regional system of care to promote best outcomes for children, youth and families.
3. Discuss with familiarity the programs and services available in the BHP, how they can best be accessed and utilized by community providers in a manner that is family and patient centered.
4. Evaluate which clinical presentations are likely to benefit from these behavioral health programs and services, and appropriate service options when they are not.

Commercial Support: N/A

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