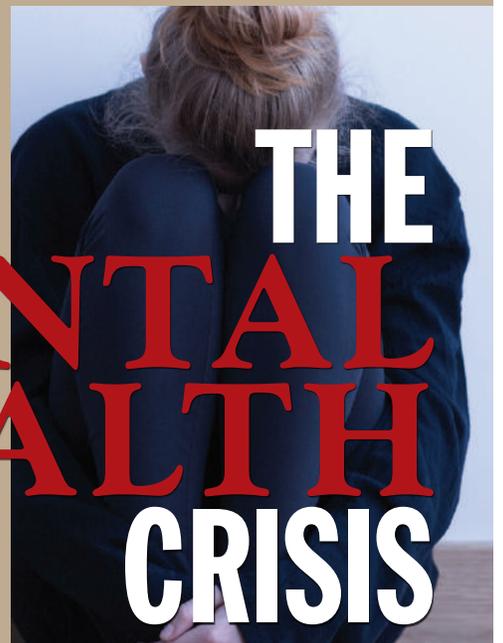
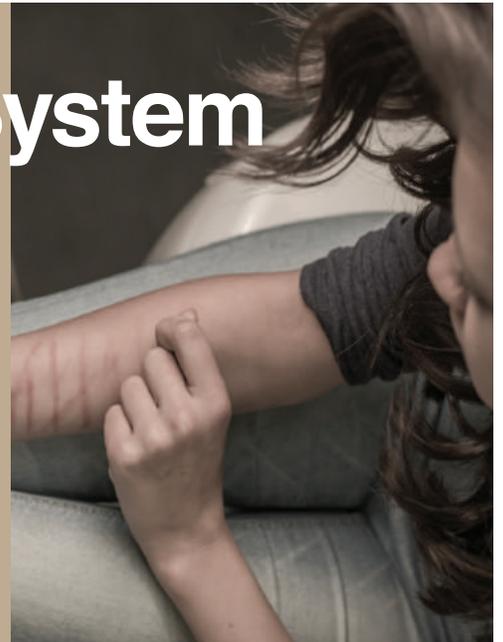


 Elliot Health System



**THE
MENTAL
HEALTH
CRISIS**



Elliot plays a **CRITICAL ROLE** in the **MENTAL HEALTH** **CRISIS**

A man walking down the street is stopped by a sudden but sure tightening in his chest. As he clutches at his shirt a sharp pain radiates down his arm. He can't quite catch his breath, as sweat beads on his brow and neck. A bystander calls an ambulance and he is whisked to an emergency room where he is told he's having a heart attack, but not to worry; he will get the treatment he needs in a week, or two at the most.

This depiction is obviously ironic; obviously someone suffering from an acute illness, like a heart attack, would receive immediate treatment.

"Mental health illness is no different than your husband's heart attack," says Meghan Baston, Director of Behavioral Health for Elliot Health System in Manchester.

Surely no hospital would ever treat a patient in acute medical distress this way. And yet, this is how hospitals around New Hampshire are forced to treat people who arrive in their emergency departments in crisis as a result of a behavioral health illness.

This problem has been on the rise since at least 2008, Baston says, and is the result of a perfect storm of troubles: an overall reduction in funding at the state level for behavioral health, a nationwide shortage of psychiatrists, and a growing opioid epidemic.

"When I work my clinical days, I see the crisis in mental health care in New Hampshire building," says Greg Baxter, Senior VP of Medical Affairs and Chief Medical Officer for Elliot Health System. "It's been building for my entire 14 years here. We used to see one or two patients a day, or about 100 a month. Now we see 500, 600 per month. We just reset the new normal each week; each year we tolerate more than we did the year before."

According to in-house data compiled by the Elliot, last year Elliot Behavioral Health Services logged 19,548 office visits, 6,088 of which were completed in a primary care provider's office.

Mental Health Providers are co-located at seven of Elliot's Primary Care practices located throughout the Greater Manchester Area, in the towns of Windham, Hooksett, Raymond, Bedford, Manchester, and Londonderry. Elliot also offers a number of outpatient group therapy and support groups to the public.

Elliot also counted 4,454 visits and consults through the Pathways Inpatient unit. As for the Elliot Emergency Department at the main campus, in FY 2016 they treated 5,150 patients with a primary diagnosis of a behavioral health condition. Meanwhile, the

number of patients seen in the Elliot Main Emergency Department with a substance misuse disorder increased 55% from 2014 to 2016.

And the hospital offered all of this at a loss, Baston says.

"Oh we definitely lose money," Baston says. "But it's never about finances here. . . . We've kind of patched together these resources to ensure that we're providing excellent care to our patients. . . . And these are all the right things to be doing for the patient; we *should* be doing these things. However, it's a poor substitute to getting the treatment you actually need at the facility where you need it."

What's truly troubling, Baston says, is that it wasn't always like this.

In the late 1980s New Hampshire was actually a best-practices state for mental health care, says Baston. At that time the state was working hard to deinstitutionalize mental health. To do that, they greatly reduced the number of beds at New Hampshire State Hospital while increasing community-based mental health services.

"The idea was to keep acutely ill patients, who needed stabilization in the hospital, but once a patient was stabilized, they were sent back out to the community," she says. "We also had our state broken up into 10 catchment areas, and hospitals within those 10 catchment areas were responsible for caring for mental illness in their own region."

Additional community resources included transitional housing, group homes and medication nurses to make house calls, among other things. And all of it was very well funded, Baston says.

But over time funding began to dry up. Community resources were discontinued and inpatient hospital units couldn't afford to stay open, or couldn't continue their services. Even New Hampshire Hospital closed its children's and neurodevelopment units and cut beds for other inpatients, Baston says.

"And so the reality of it is, while we're taking away acute inpatient beds, we're also taking away community resources that our patients so desperately need in order to stay out of the hospital," Baston says.

"So now what we have are a whole bunch of folks who are in the community who aren't receiving the level of community services they used to receive, who then become destabilized and need an acute inpatient hospitalization – only now, they have nowhere to get that," Baston says.

It also doesn't help that in the midst of all this, the country is seeing a shortage of mental health practitioners.

According to the American Medical Association, the number of adult and child psychiatrists rose by only 12% between 1995 and 2013. Additionally, the Association of American Medical Colleges reports that 59% of psychiatrists are 55 or older, indicating that many may soon retire, or are reducing their workload.

This dearth of doctors is due, in part, to relatively poor pay for mental health providers – given the demands of a job that usually requires practitioners to be on call on nights and weekends.

According to the U.S. Bureau of Labor Statistics the median average wage for a psychiatrist is about \$87 per hour as compared to an internist, who can make upwards of \$90 an hour.

Baston says this lack of doctors is leading hospitals to have to pay more to incentivize existing psychiatrists to take the open positions. This typically strains an already stretched-thin budget, which in turn has led to the closure of inpatient units around the state. This is further exacerbated by a reimbursement system that pays back less for behavioral health care than it does for medical care, even with provisions in the 2014 Affordable Care Act requiring parity between mental health services and medical doctor's visits.

A 2016 report from the National Alliance of Mental Illness bears out the systemic inequities: According to the NAMI study, 27% of mental health therapists and 24% of psychiatric providers were not covered by insurance, while just 3% of primary care providers and 8% of specialty medical providers were not covered by insurance.

The end result is that people suffering with mental health illness in New Hampshire are waiting for as long as two weeks in the emergency room for an inpatient bed, Baston says.

"Elliot has the largest community of

mentally ill people in the state of New Hampshire... And we accept patients from all over the state," Baston says. "We are obligated to provide them with services. We cannot expect that somebody else is going to do it, and keep demanding that other

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people do it. We are going to provide the services that our community needs.”

From his perspective as Chief Medical Officer, Baxter says the Elliot has made the best of a bad situation.

Over the past few years the hospital has dedicated resources to building a robust system for doing intake, which includes psychiatric nurses in the emergency room, mental health clinicians on staff and a psychiatrist. Hospital officials also put together a Behavioral Emergency Response Team that evaluates and assists patients on the medical floors who may be suffering from a mental health illness or substance abuse disorder.

In order to accomplish this, doctors, nurses and techs work together when a patient with a behavior health illness arrives to assess the immediate medical and behavioral needs. Once a determination is made that a patient is in need of behavioral health treatment, a mental health counselor is brought into the loop to evaluate the patient and develop a plan of care. Baxter says most patients at this point are discharged home with a plan to follow-up with some sort of community outpatient

treatment that will both accept the patient's insurance and can see that patient in a reasonable amount of time.

Even with that level of care, however, "The return rate of these patients to the ER is high," Baxter says.

For those looking for voluntary admission or those who need involuntary inpatient care, there are many roadblocks, Baxter says.

Elliot has 29 geriatric inpatient beds and is the designated receiving hospital for geriatric patients who have both dementia and other mental health illness. What that means is they are required to take these patients from all over the state.

Translation: Elliot never has an empty bed.

In addition, they have 12 inpatient adult beds in their behavioral health unit. Baston says these, too, are always full. "We never find ourselves in need of patients," she says. "One patient gets discharged and another comes in to take that patient's place."

Hospital officials say what would help would be to see some movement and funding at a legislative level commensurate with the demand for services. Baxter says they would also like to see an increase in the number of available inpatient beds in the state, as well as outpatient services.

Not only is it the right thing to do, Baxter says, but it's fiscally sound – untreated mental health issues ultimately increase the healthcare bills of everyone across the board. So putting money toward prevention and treatment up front would go a long way toward easing costs down the road.

Baston says she would also like to see parity when it comes to reimbursement. In other words, behavioral health care should be reimbursed at the same rate as medical health care.

However, persistent stigma surrounding mental health issues remains a barrier to that parity for the foreseeable future, says Baxter, with no shift in policy at the state level in sight.

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