



# Mental Health at Mercy Health: Treating the Whole Person

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**Mercy Health Physician Partners**  
**President and CMO**

# Trinity Health's 22-state diversified system today

**\$17.6B**

In Revenue

**1.3M**

Attributed  
Lives

**\$1.1B**

Community  
Benefit Ministry

**131K**

Colleagues

**7.5K**

Employed Physicians  
& Clinicians

**25.6K**

Affiliated  
Physicians

**94**

Hospitals\*  
in 22 states

**22**

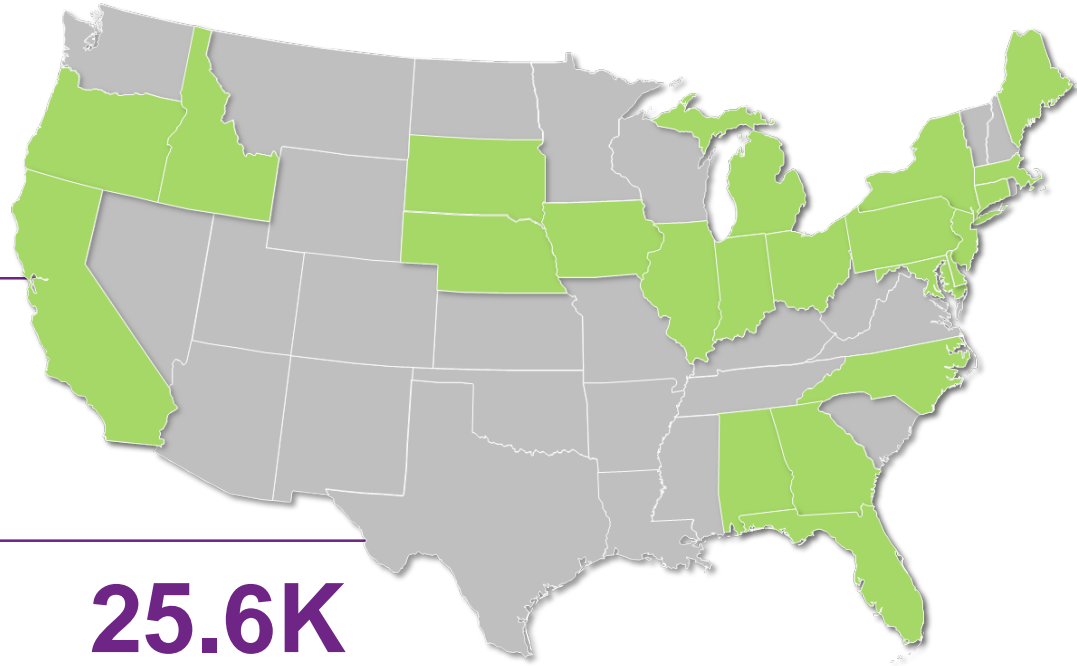
Clinically  
Integrated  
Networks

**13**

PACE  
Programs

**109**

Continuing  
Care Locations





### *Hospital Locations*

General Campus  
Hackley Campus  
Lakeshore Campus  
Mercy Campus  
Saint Mary's Campus

### *Outpatient Centers*

Lakes Village  
Rockford  
Byron Center



### *Hospital Locations*

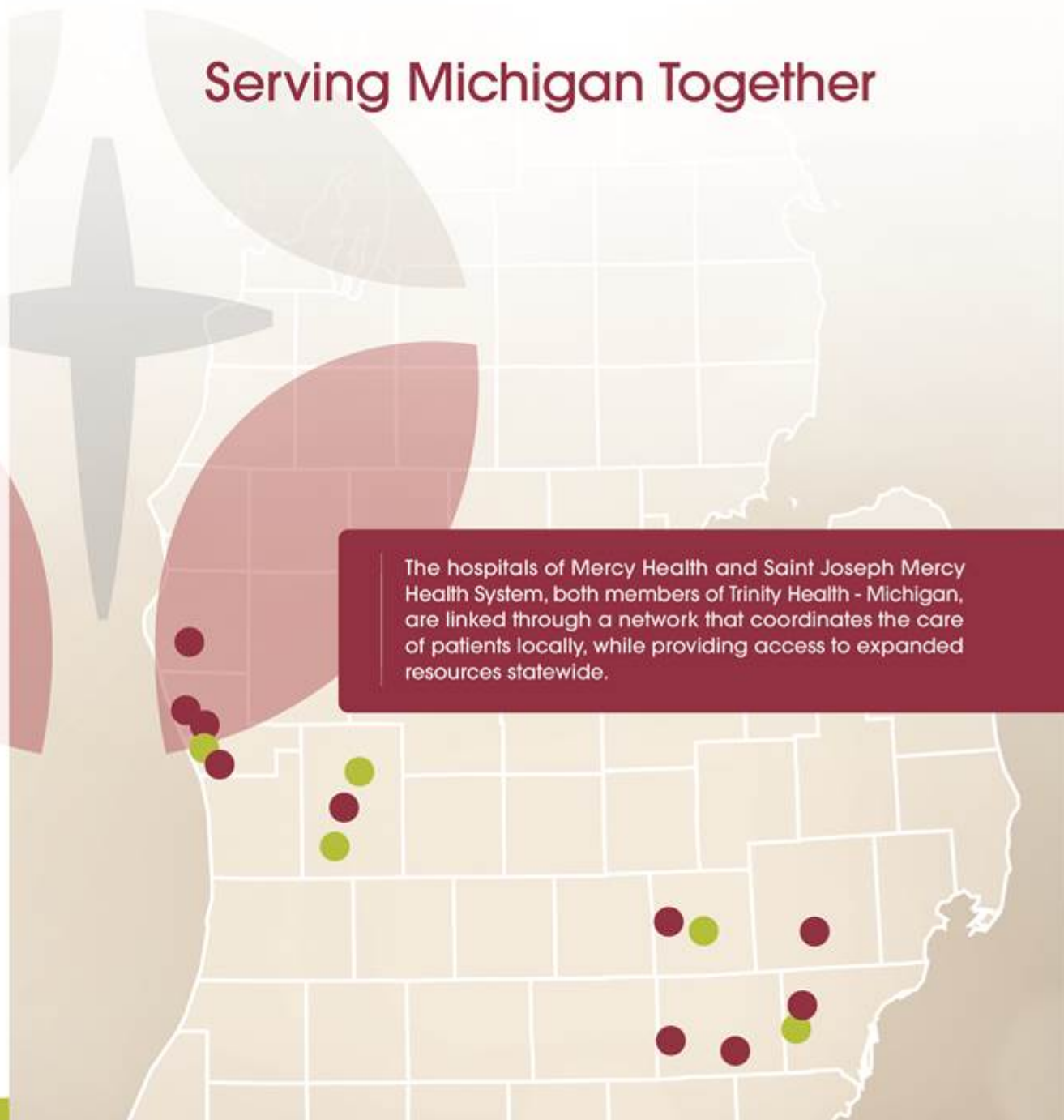
St. Joseph Mercy Ann Arbor  
St. Joseph Mercy Chelsea  
St. Joseph Mercy Livingston  
St. Joseph Mercy Oakland  
St. Mary Mercy Livonia

### *Outpatient Centers*

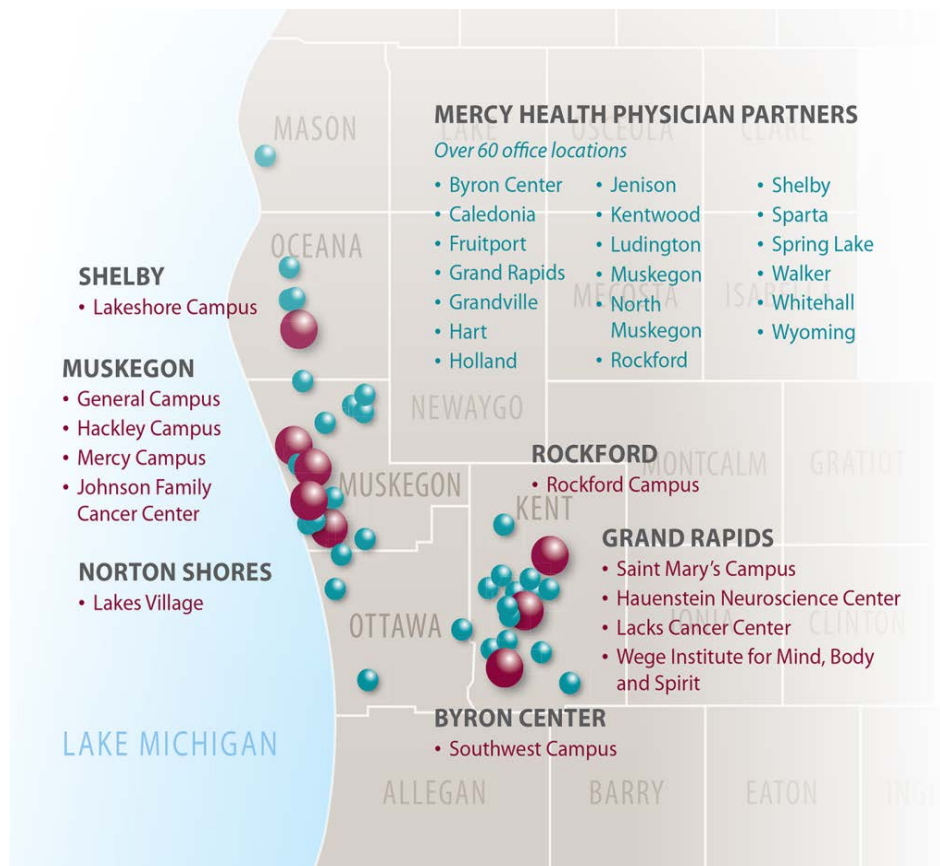
St. Joseph Mercy Brighton  
St. Joseph Mercy Canton

# Serving Michigan Together

The hospitals of Mercy Health and Saint Joseph Mercy Health System, both members of Trinity Health - Michigan, are linked through a network that coordinates the care of patients locally, while providing access to expanded resources statewide.



# Mercy Health West Michigan



## • Grand Rapids

- Hauenstein Neuroscience Center
- Lacks Cancer Center
- Mercy Health Physician Partners
- Rockford Campus
- Saint Mary's Campus
- Southwest Campus
- Wege Institute for Mind, Body, and Spirit

## • Muskegon

- General Campus
- Hackley Campus
- Johnson Family Cancer Center
- Lakes Village
- Lakeshore Campus
- Mercy Campus
- Mercy Health Physician Partners

## Mission

We serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.



## Vision

As a mission-driven innovative health organization, we will become the national leader in improving the health of our communities and each person we serve. We will be the most trusted health partner for life.

## Our Core Values

Reverence

Commitment  
to those who  
are poor

Justice

Stewardship

Integrity





*Serve a growing community by providing high quality care that is the most **compassionate**, **personalized** and **accessible** in West Michigan.*

## Overview of Presentation

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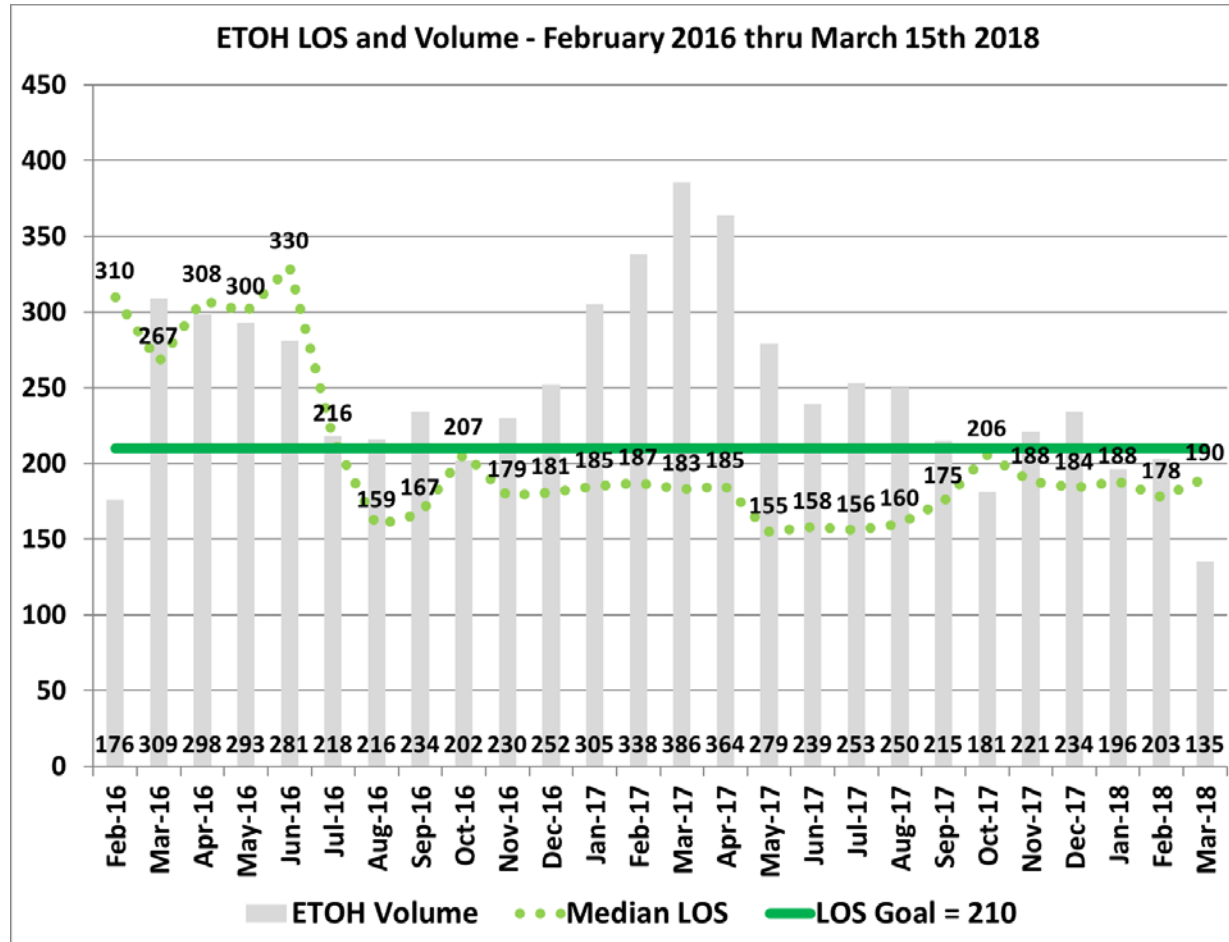
### A. System / Location of Care

- ER
- Hospital
- Ambulatory

### B. Developing Initiatives

- Growing a Team of Mental Health Providers
- SDOH
- Care Management
- Opioid Management

## Emergency: ETOH LOS and Volume





## Standardize Care

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## Respectful, Dignified Care

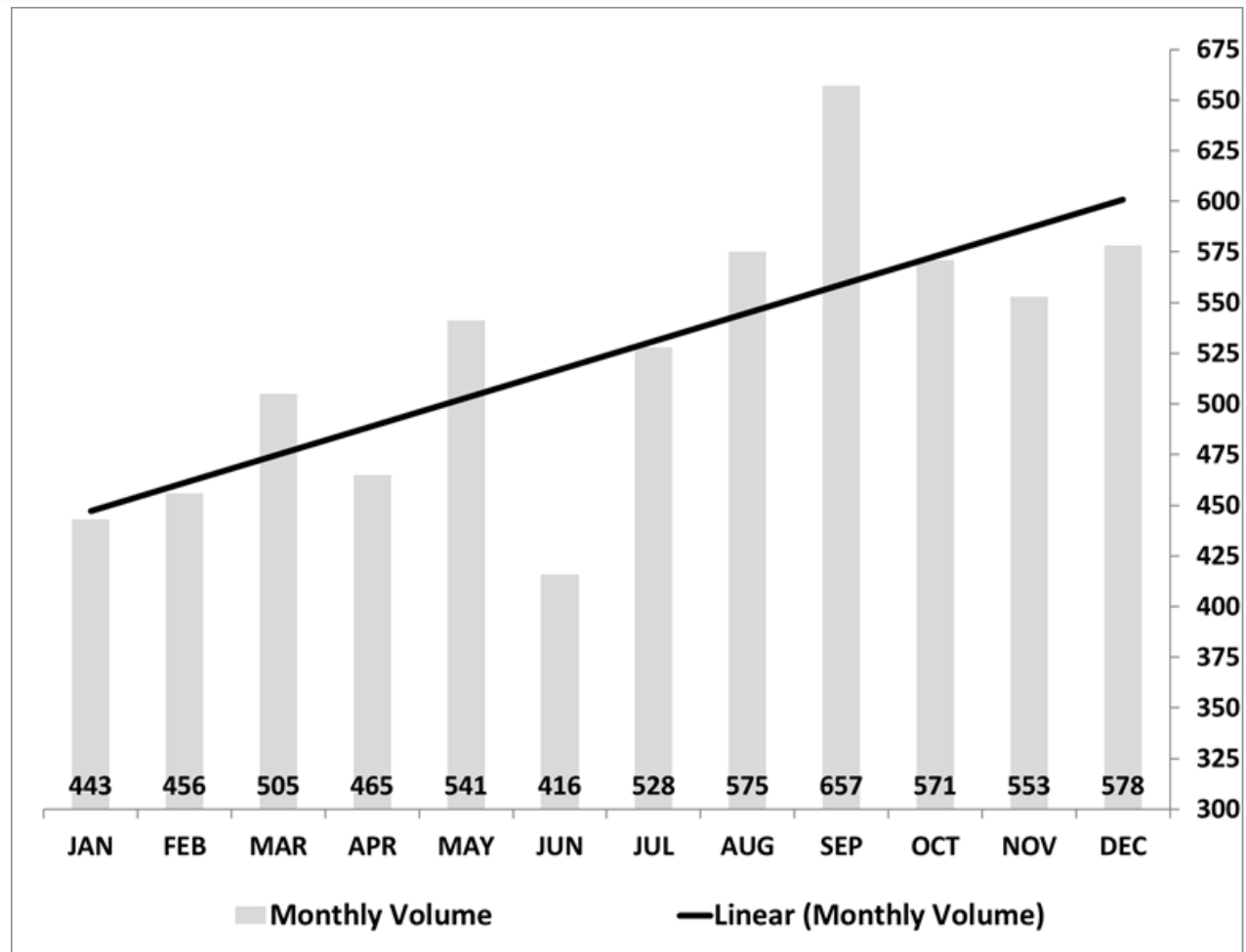
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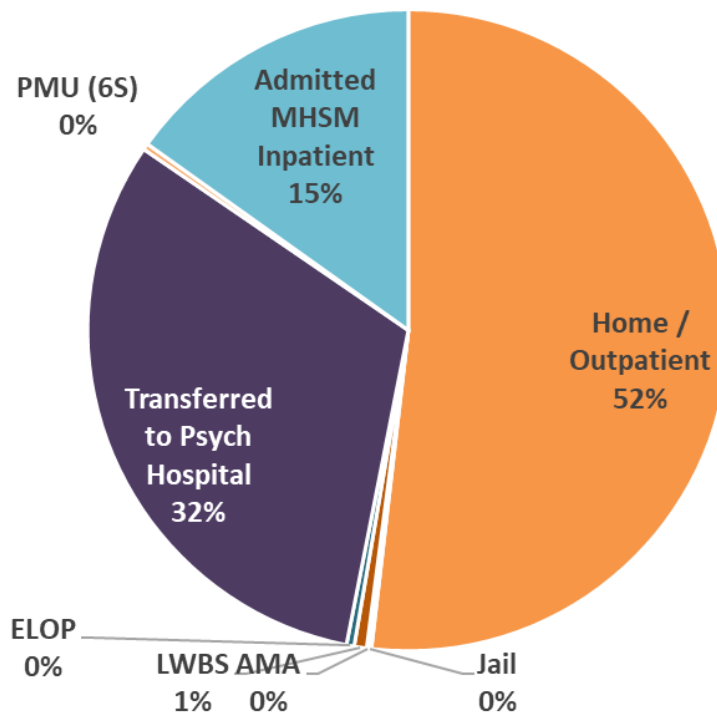
In the Emergency Department, our doors are always open  
and all patients are welcome.

## Volume of Behavioral Health patients in the ED, CY2016

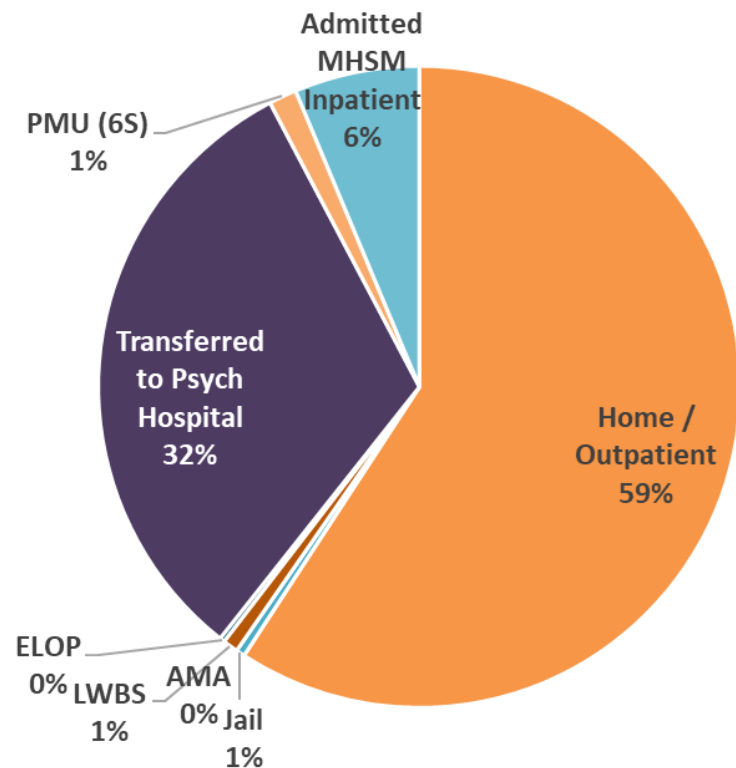


## Mental Health Discharge Disposition

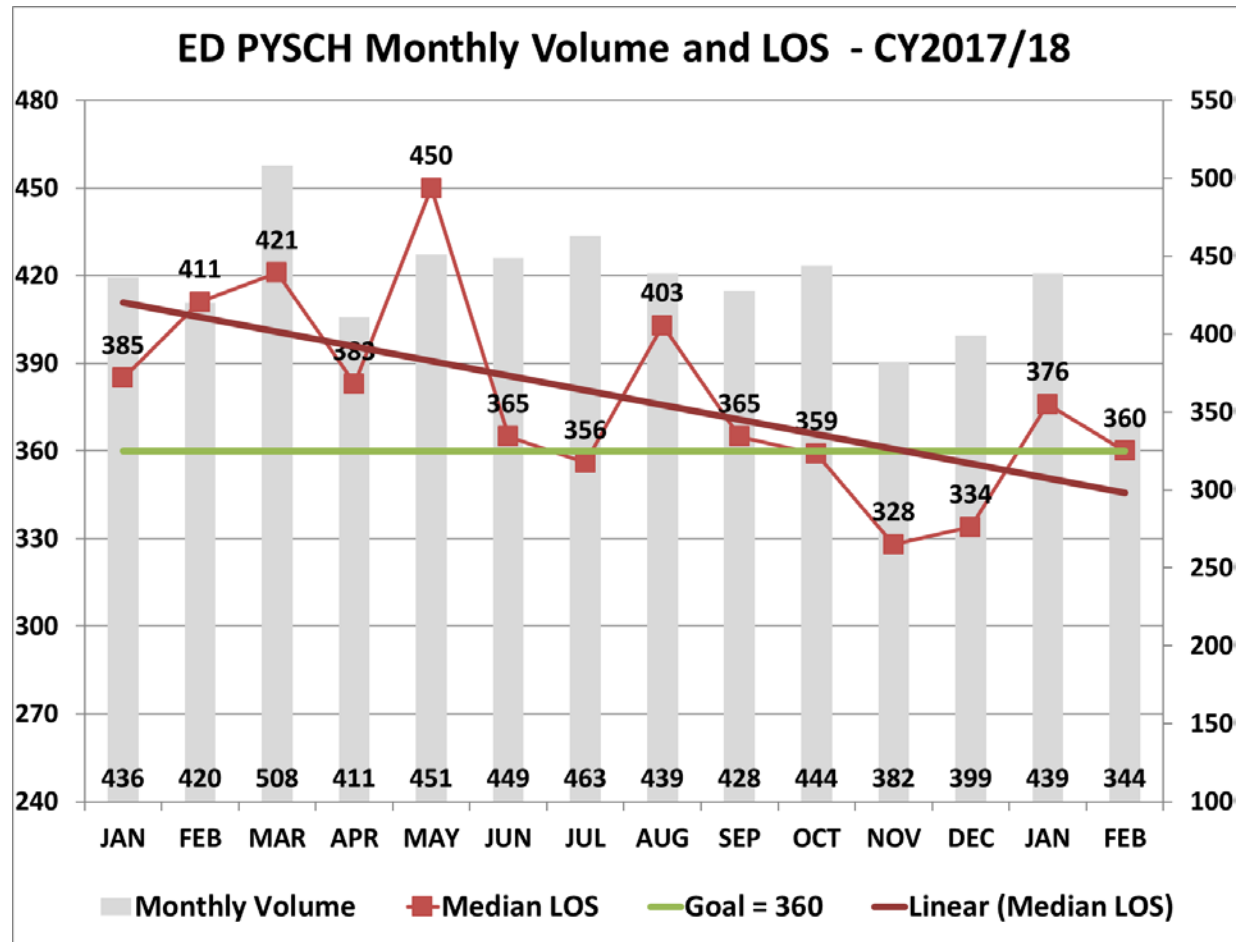
Mental Health Patient Discharge  
Disposition AUG 2017 thru OCT 2017



Mental Health Patient Discharge  
Disposition NOV 2017 thru FEB 2018



## Mental Health LOS and Volume





## In-Patient: Psychiatric-Medical Unit

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- 28 bed inpatient unit
- Catchment area: most of the lower peninsula
- 657 discharges for calendar year 2017 (97% bed occupancy)
- Specialty:
  - Patients with co-existing psychiatric and medical needs
  - Patients with complex neuro-psychiatric illness (Parkinson's Disease, Post-stroke psychiatric illness, etc.)

## Psychiatric-Medical Unit

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- Most Common Psychiatric Diagnoses:
  - Schizophrenia / Schizoaffective Disorder
  - Bipolar Disorder
  - Major Depression with suicidal ideation
  - Mood / Psychotic Disorder associated with other medical conditions
- Common Medical Co-Existing Conditions:
  - Uncontrolled Diabetes
  - Renal Failure (hemodialysis available on the unit)
  - Cardiomyopathy / Peripheral Vascular Disease
  - Infection requiring complex care

## Behavioral Health Integration - Inpatient

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- **Psychiatric Resource Team:**
  - Experienced RN certified in Psychiatric-Mental Health visits all inpatient units at least twice daily to help problem-solve behavioral issues and facilitate additional care
- **Embedded Emergency Department Psychiatric NP**
  - Psychiatric consults prior to admissions
  - Management of complex psychiatric med regimens while in ED
  - Assistance with alternate treatments – significant reduction in inpatient referrals
- **Psychiatric Consultation Team:**
  - Approximately 15 – 20 initial inpatient consults per week
  - In-service lectures / liaison with hospitalist group on management options

## Behavioral Health Integration - Outpatient

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- In development: Integrated Psychiatric Care with Primary Care Offices
  - Psychiatrist meets weekly with behavioral health manager at primary care office
    - Answer questions, update treatment plans, determine who needs additional care
  - Psychiatrist available anytime for quick consult with primary docs
  - Patients needing further evaluation return to primary care office for assessment via telemedicine link with psychiatric provider
    - Increases likelihood of completing visit
    - Patient remains in a familiar setting
    - Insures integration of care

## Psychiatric Treatment Team

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- Three full-time psychiatrists (as of May 2018)
- Four full-time advanced practice professionals (as of May 2018)
- Future Consideration
  - Expanded outpatient integration care
  - Increased services to Hauenstein Neuroscience
  - Potential additional cooperation with Mercy Health Muskegon

## Ambulatory Patients with Psych Diagnosis

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Grand Rapids – Diagnosis of 31,943 patients

| Diagnosis                                       | Quantity      |
|---|---------------|
| Anxiety   | 18,541        |
| Bipolar   | 1,967         |
| Depression                                      | 16,542        |
| Mixed   | 241           |
| <b>TOTAL</b>                                    | <b>37,291</b> |
| <b>18,603 patients have a medical diagnosis</b> |               |



## Ambulatory Patients with Psych Diagnosis

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Muskegon – Diagnosis of 24,111 patients

| Diagnosis                                       | Quantity      |
|---|---------------|
| Anxiety   | 13,990        |
| Bipolar   | 1,521         |
| Depression                                      | 12,745        |
| Mixed   | 210           |
| <b>TOTAL</b>                                    | <b>28,466</b> |
| <b>16,167 patients have a medical diagnosis</b> |               |

## Integrated Health Care

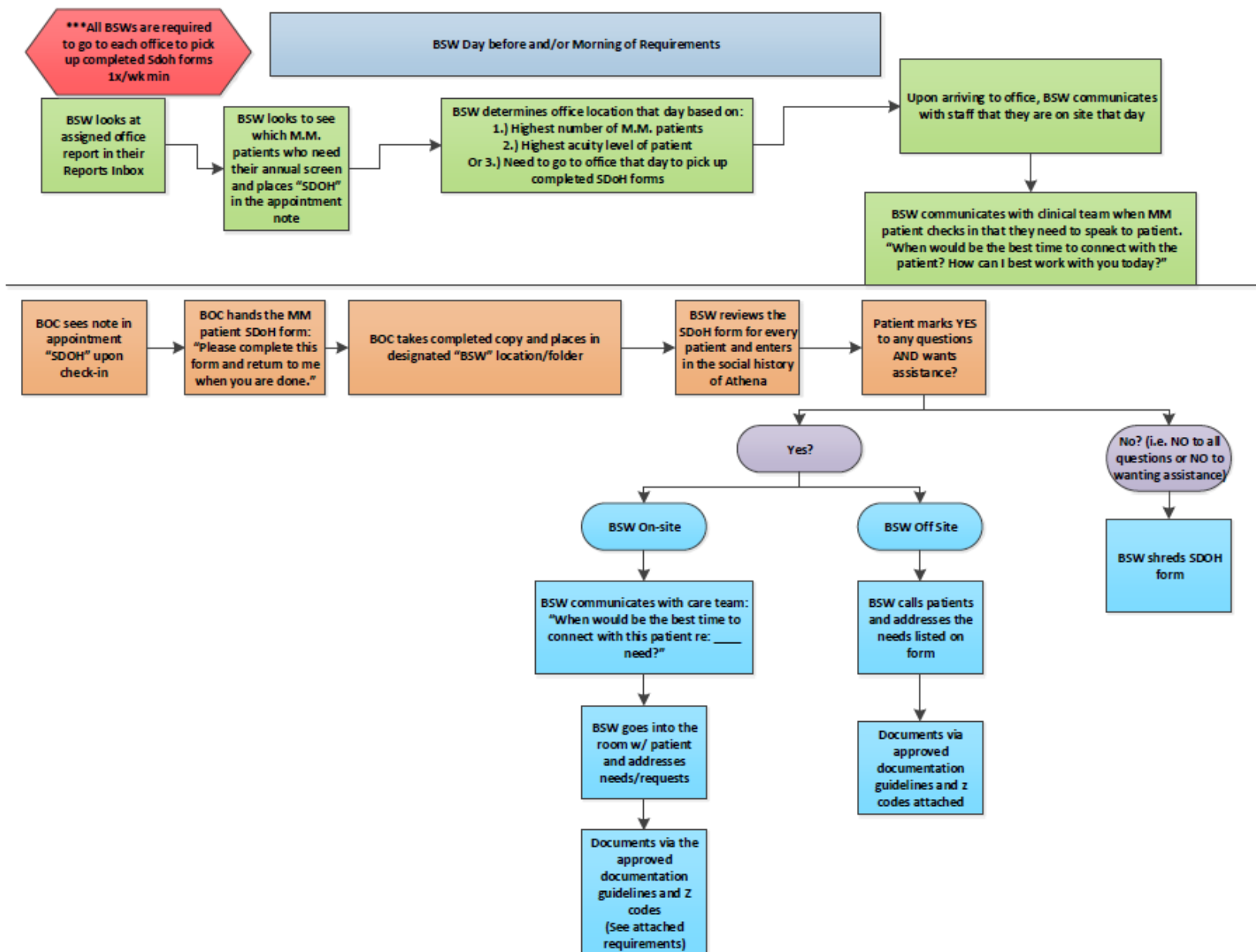
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- Physical
- Mental
- Social
- Spiritual

## SIM Grant

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- Social Determinants of Health
  - Gender
  - Alcohol Misuse
  - Drug Use
  - Unprotected Sex
  - Smoking
  - Limited Income
  - Discrimination
  - Housing or Lack There of
  - Lack of Health Insurance



## Ambulatory Care Management

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- Care Managers work directly with providers in the office in which they are embedded to provide ongoing long term Care Management for patients.
- Works directly with patients to develop care plans which improve quality outcomes and overall quality of life.
- Upon initial visit Care Managers complete comprehensive assessments regarding patient needs and chronic conditions including a PHQ-9 and Gad-7 alerting a possible COMPASS enrollment
- Care Managers educate patients on how to manage multiple chronic disease processes as well as ensure patients are following plans of care.

## Ambulatory Care Management

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- Care Managers meet with patients in person as well as follow up telephonically. Some contacts are weekly while some are daily depending on what the individual care plan requires
- Ensures patients social determinates of health are being met by referring and enrolling patients into hospital based and community based programs the patient may be eligible for to include the COMPASS program
- Clinical outcomes have shown a large decrease in hospitalizations as well as readmissions for patients who are enrolled in the Care management program



## COMPASS

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- Care Managed patients who have diagnosed comorbid clinical **depression** are enrolled into the COMPASS program
- COMPASS review board consists of a physician from Internal Medicine, Family Medicine, Psychiatry, as well as a clinical pharmacist
- Care Manager presents the patient cases to the COMPASS board weekly and updates the PCP any recommendations for changes to the plan of care regarding the patients depression
- Care Manager implements these changes to the patient plan of care and works with the patient to improve their depression. Goals are PHQ-9 < 5

## COMPASS

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- Outcomes have been dramatic
- An average of 18% of enrolled patients with comorbid diabetes reach the goal of an A1C < 7
- 58% of enrolled patients achieve blood pressure control
- One in five patients enrolled have achieved and remained in remission from clinical depression

## Opioid Crisis

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- Much attention to managing opioid starts
- Less attention to dealing with long term use
- Patient pain is real
- Abuse is real
- Responsibility: Identify and deliver “Best Practice”

## What is Best Practice: Maintenance?

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- CSA
- UDS
- Tapering Guidelines
- MAPS Registration
- MEU/day
- Opioid Ranges
  - Less than 50
  - 50 – 90
  - Over 90
- Provider Coaching



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**Thank you!**