Promoting Wellness and Recovery

John R. Kasich, *Governor*
Tracy J. Plouck, *Director*

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Health Transformation - OhioMHAS

- Health Homes for SPMI
- Workforce Challenges
- Trauma Informed Care
- Medicaid Expansion – what it means for mental health and addiction services

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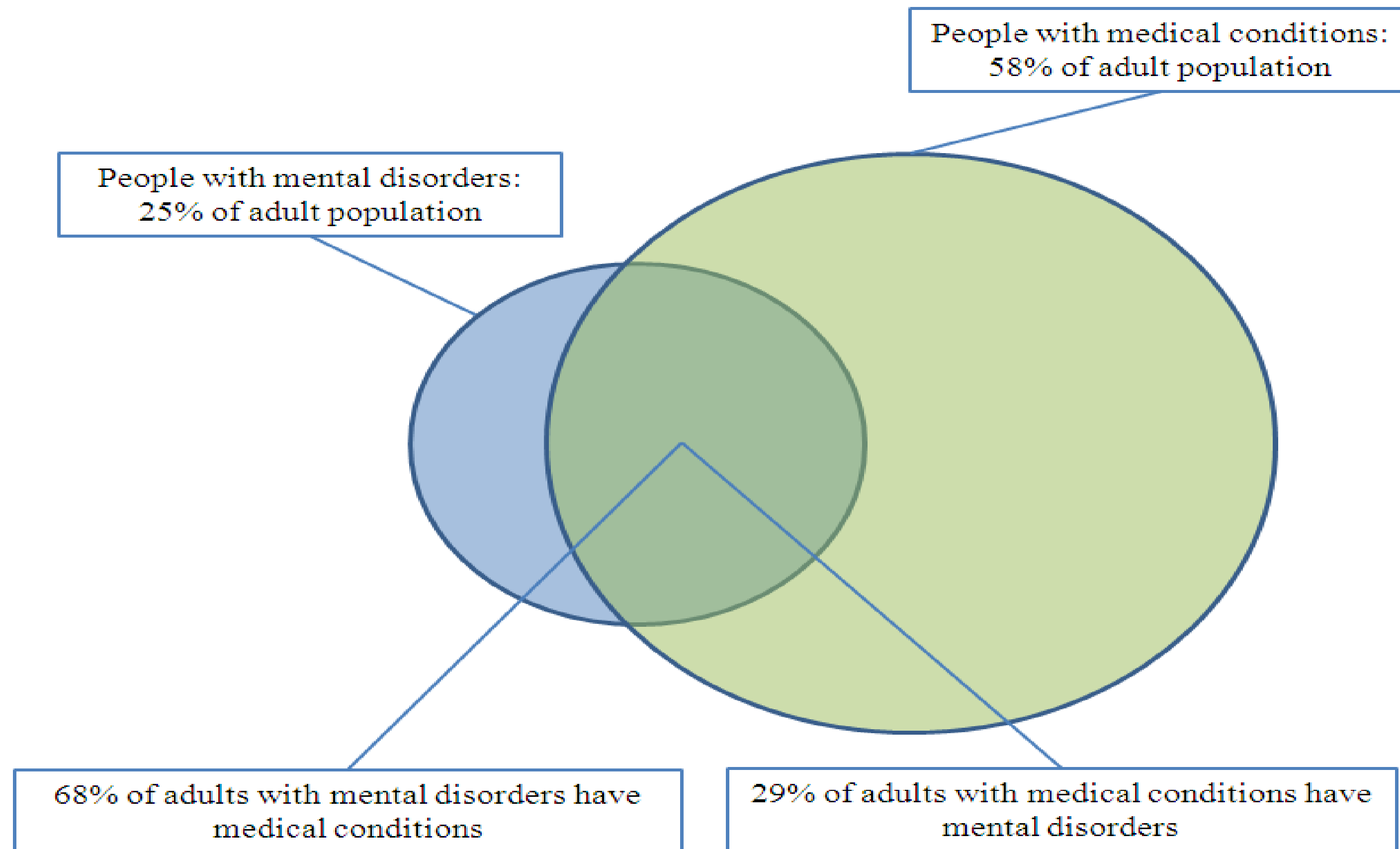
Health Homes

Health homes

- A health home is not a building; it is coordinated, person-centered system of care
- Health homes were launched as a first phase in September 2012 – Lucas, Butler, Scioto, Adams and Lawrence Counties
- Health homes are certified by the Ohio Department of Mental Health and Addiction Services
- Work toward a statewide launch is being overseen by a team including state agency staff and stakeholders

Why a health home?



National Comorbidity Survey Replication, 2001-2003

Why a health home?

- Adults with serious mental illness (SMI)
- represent:
  - About 10% of the Medicaid population
  - 26% of total Medicaid expenditures

- The rate of co-occurring chronic physical health conditions is higher among individuals with SMI, especially among individuals with schizophrenia and psychosis.

(Study funded by the Northeast Ohio Medical University's BeST Center and the Health Foundation of Greater Cincinnati and conducted by Health Management Associates and the Ohio Colleges of Medicine Government Resource Center)

Why a health home?

Individuals with Mental Illness:

- Are disproportionately affected by other medical problems
- They experience:
  - Higher symptom burden
  - More functional impairment
  - Premature death **(25 years)**
- Have difficulty accessing the healthcare system
- Receive inconsistent and fragmented care

Prevalence of Medical Disorders in Medicaid Recipients (Dickey, 2002)

	Subjects with a psychotic disorder (N=11,185)		Subjects without a psychotic disorder (N=15,147)	
Disorder	Adjusted N	%	Adjusted N	%
Diabetes	823.6	7.36	885.3	5.84
Hypertension	1,120.2	10.02	1,401.6	9.25
Heart disease	980.5	8.77	853.1	5.63
Asthma	952.2	8.51	829.6	5.48
Gastrointestinal disorders	1,353.9	12.10	1,157.7	7.64
Skin infections	1,031.0	9.22	990.2	6.54
Malignant neoplasms	243.3	2.18	228.6	1.51
Acute respiratory disorders	3,664.3	32.76	4,022.9	26.26

[a] All between-group comparisons were statistically significant (p= .001).

Bi-directional risk factors (Druss, 2011)

# of Chronic Medical Conditions	Rate of Major Depression
Zero	5 %
One	8%
Two	10%
Three	12%

Additionally, presence of schizophrenia or bipolar disorder increases risk of 3 or more medical conditions three-fold

Why the high comorbidity?

- High prevalence of both mental illness and other physical disorders (coincidence)
- Mental illness causes other physical disorders on a biological basis
- Physical disorders may cause symptoms of mental illness
- Treatments for one disorder causes the other(s)

Common risk factors exist

Common risk factors

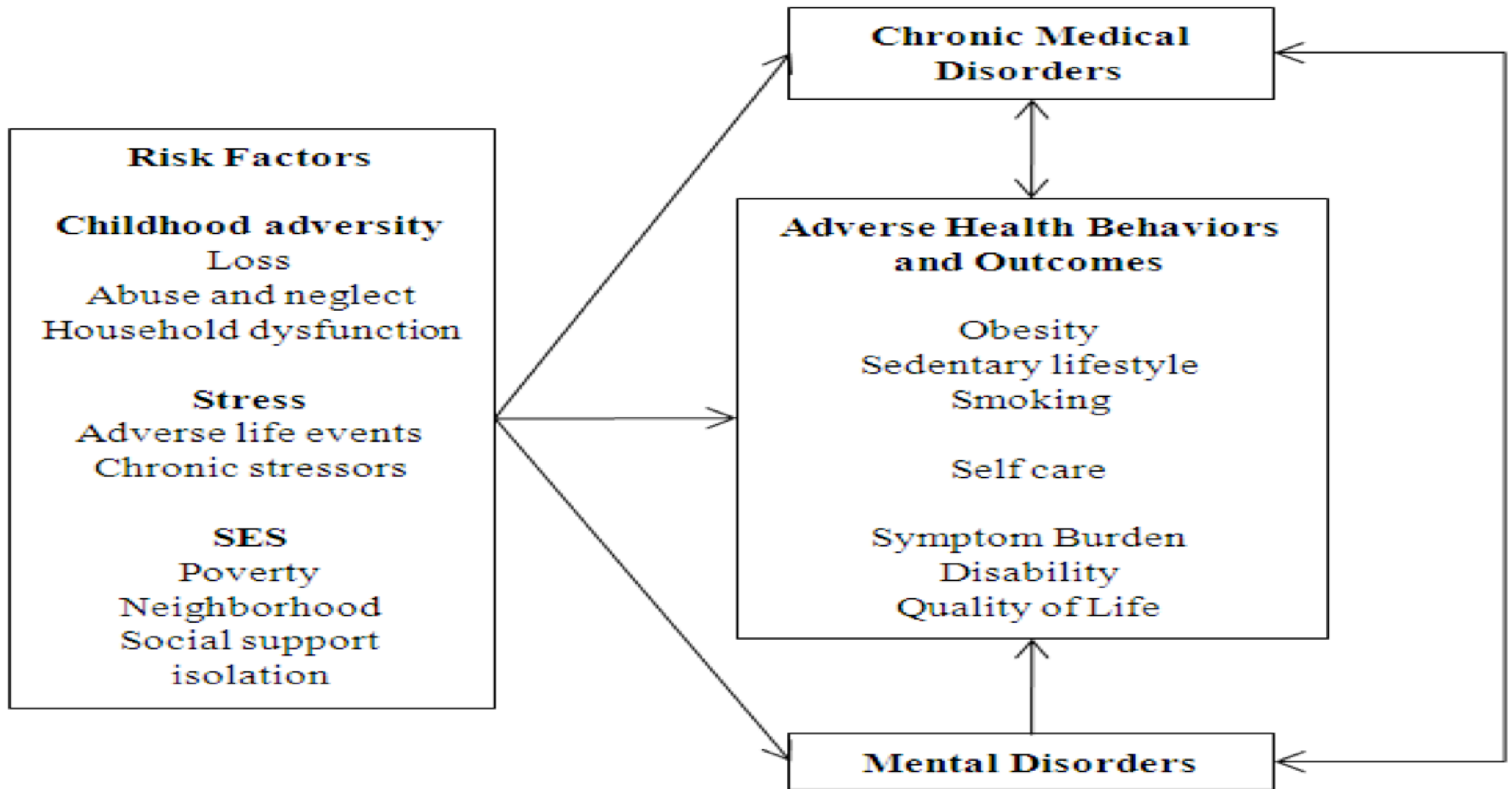
- Low socioeconomic status
- Low social supports
- Increased rates of modifiable risk factors
    - Tobacco Use
    - Other drug and alcohol use
    - Minimal physical activity
    - Poor nutrition

Risk factors: role of trauma

- Early life trauma exposure to childhood abuse and dysfunctional household
    - Increased rates of depression
    - Increased suicide attempts
    - Increased chronic medical illness
- Traumatic events later in life

Trauma is associated with inflammatory processes which are increasingly implicated in mental illness and physical disorders

Pathways to co-morbidity



Modified from Katon 2003

Treatment realities for individuals with MI

- Individuals with Mental Illness are less likely to
  - Access care
  - Receive preventative care: immunizations, smoking cessation counseling, cancer screening
  - Follow through with treatment

- This is partly due to symptoms of their illness, like
  - Lack of energy
  - Motivational issues
  - Impaired concentration
  - Cognitive deficits

Treatment realities for individuals with MI

- Provider issues also contribute:
  - Comfort level (bi-directional)
  - Attitude of healthcare providers
  - Care coordination problems
  - Stigma

How can we improve treatment and outcomes?

These don’t work too well:

- Divided treatment without collaboration
- Screening alone
- Provider education alone

What DOES work

Integrated approaches and collaborative care

- Treatment that deals with both mental and other physical needs of patients
- Type of treatment and intensity based on ***needs of patients*** which may vary from referral and good collaboration to fully integrated care at a common site

Treatment needs to consider the realities of patient abilities and the realities of the healthcare system as it exists

Back to health homes

Health homes aim to break down the silos that exist between physical healthcare benefits and providers and behavioral health services and funding streams by offering comprehensive medical, behavioral, long-term care and social services that are timely, of high quality, integrated and coordinated by a core team of multi-disciplinary professionals….*and address the issues that contribute to fragmented and ineffective care delivery to individuals with SPMI*

Important aspects of health homes

- **Whole person** care coordination / care management for consumers with complex conditions
- **Person-centered** planning approach to identify needed services and supports without compartmentalizing aspects of the person, his/her health, or his/her well-being
- Providing care and linkages to care that address all of the person's clinical ***and*** non-clinical needs

Health homes for SPMI

- Better care coordination can result in improved health outcomes while spending less of the taxpayer's dollars
- Health homes aim to integrate physical and behavioral healthcare by offering and facilitating access to medical, behavioral and social services that are timely, of high quality and coordinated by an individualized care team

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Workforce Issues

Workforce: Supply and Demand

Demand already outstrips supply, and the problem is getting worse:

- Fewer than five percent of medical school graduates select psychiatry residency
- Between 2000-2008, residency programs decreased from 186 to 181, and slots decreased from 1,142 to 985 per year
- Among all physicians, 36.7 percent are older than 55
- Among active psychiatrists, more than 55 percent are 55 or older
- Decrease in the number of psychiatrists by 27 percent, and increase of demand of 66 percent in recent 12-year period

Future shortages

- Concerns particularly in geriatric and child and adolescent areas
  - Only 20 percent of children and adolescents who need help are receiving it
  - Currently 8,000 child and adolescent psychiatrists in the U.S.
  - Estimated need: 16,000
- 70 percent of primary care doctors report difficulty finding high quality mental health services

Defining the problem

- Average debt after medical school is more than $200,000 for public medical colleges and $278,000 for private schools. (Association of American Medical Colleges)
- Difficult to enter lower paying fields such as primary care or psychiatry

Addressing the challenge: State hospitals

- State hospitals have had significant issues in maintaining physician staffing, particularly in already underserved areas of the state (Appalachia)
- Use of contract physicians is not ideal
  - Patients need continuity of care
  - Costly to taxpayers

Addressing the challenge: State hospitals

New physician recruitment program

- State hospitals are in continuous state of recruitment: http://mentalhealth.ohio.gov/who-we-are/continuous-recruitment-page.shtml
- Collaborating with the Ohio Department of Health for physician loan repayment program, and identifying regions and facilities as Health Professions Shortage Area (HPSA)
- ***Expanded Allied Health Professional roles/recruiting***

Addressing the workforce challenge: Medicaid Health Homes

- Improve care coordination, integration of physical and behavioral health care, health outcomes
- Reduce hospital admissions, lower rates of hospital emergency department use
- Team approach to care: for this model to work, all practitioners must be able to practice at the top of their expertise and license
- Work smarter, not faster

Addressing the challenge: Increasing expertise

- Primary care physicians are the leading prescribers of psychiatric medications
  - 70 percent of antidepressants are prescribed by primary care physicians
- Need to work collaboratively to increase mental health expertise in primary care and increase primary care expertise in psychiatry
  - Pediatric Psychiatry Network – approx. 30-35 calls/mo.
  - Minds Matter: Ohio Psychotropic Quality Improvement Collaborative
  - Telehealth Services

Future challenges

- Recruitment into public health arena
- Problem Gambling – not in scope of practice for chemical dependency counselors
- Lack of Medicaid expansion – leads to recruitment challenges
- With Medicaid expansion – a positive problem with more people needing coverage, need to meet workforce needs
- *Broad-based workforce initiatives needed*

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Trauma Informed Care

Ohio's Trauma Informed (TI) Care Initiative

- Addressing trauma can positively impact the physical, behavioral, social and economic health of Ohio and Ohioans
- Must be addressed in a comprehensive and cohesive manner for the best impact

MENTAL HEALTH & ADDICTION SERVICES Ohio

Ohio's Trauma Informed (TI) Care Initiative

- Many mental health and addiction treatment agencies, inpatient facilities, child-serving agencies and other community partners, have already provided training and consultation in trauma informed practice
- There continues to be a need for training for many providers/facilities and community system partners

MENTAL HEALTH & ADDICTION SERVICES
Ohio

Ohio's Trauma Informed (TI) Care Initiative

- The ability of all communities and providers to organize trauma trainings internally is often beyond their finances, time or capabilities, yet the need of persons served has not changed
- The Trauma Informed Practice (TI) initiative seeks to provide additional resources for agencies and programs in Ohio who may need this support
- Capitalize on internal Ohio resources/expertise, supplemented by national authorities such as National Center for Trauma Informed Care (NCTIC)

Ohio’s Trauma Informed (TI) Care Initiative

- Since Summer of 2013, an interagency workgroup comprised of leaders from Ohio MHAS and Ohio Department of Developmental Disabilities (DODD) and others has been meeting to formulate plans to expand TI across the state
- A portion of the “Youth at Risk” funds from the Governor’s Office have been earmarked for this purpose

MENTAL HEALTH & ADDICTION SERVICES Ohio

Ohio's Trauma Informed (TI) Care Initiative

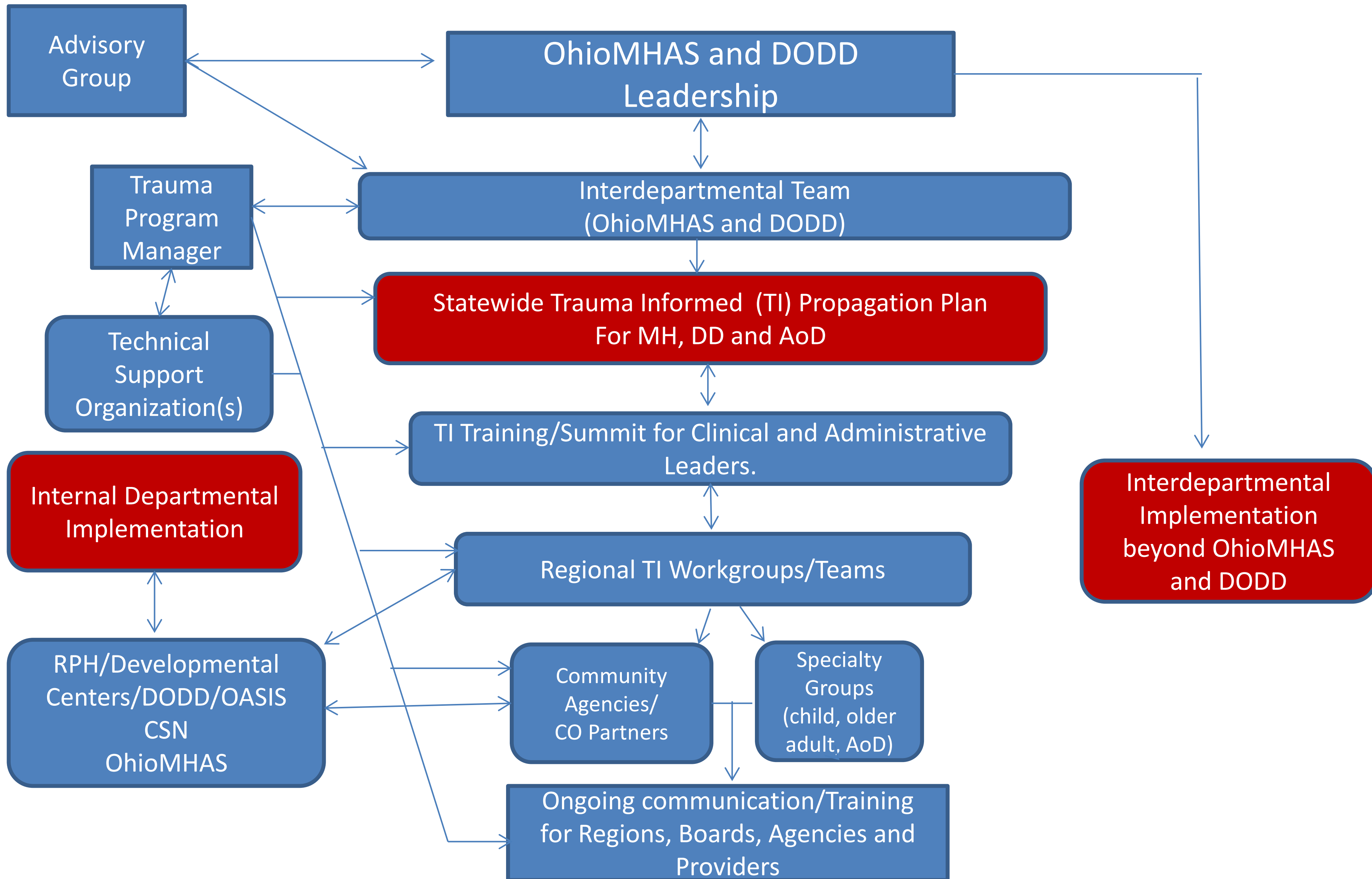
Vision:

To advance Trauma Informed practice (TI) as a cornerstone of Ohio's healthcare system

Mission:

To create the opportunity for every individual in Ohio to receive trauma informed interventions by assuring that every healthcare and human service provider, every facility and every agency becomes trauma informed and competent

Planning Framework for Ohio's Trauma Informed (TI) Care



Framework for Ohio's Trauma Informed (TI) Care

Next Steps:

- Trauma Coordinator
- Advisory Group
- Planning for TI Summit—Spring 2014 thematic broad-based training for clinical and administrative leaders
  - Regional breakouts to advance TIC within regions
  - Establish and support regional workgroups

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Medicaid Expansion

Medicaid Expansion – what it means for mental health and addiction

Offering coverage for 366,000 estimated to enroll and avoiding a coverage gap for childless adults – effective Jan. 1, 2014

- Childless adults struggling with substance use and unable to work – *NOW COVERED*
- Transition age youth in danger of losing services when entering adulthood – *NOW COVERED*
- Prisoners re-entering the community after getting treatment in corrections, but needing continued services to find employment and avoid recidivism – *NOW COVERED*

Medicaid Expansion – what it means for mental health and addiction

An estimated **$70 million** annually **($105 million** for the FY 14-15 biennium) in local board spending can be redirected to community services such as housing and transportation or addressing waiting lists

- Funds paying for 100% of services on the Medicaid service array for individuals who are not currently eligible but will become so 1/1/14
- Redirects state subsidy and county levy funds to address basic needs that ensure a person's ability to be a contributing member of the community

Questions??

Find us on:

http://www.mha.ohio.gov

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