Getting Mental Health Right—
In Challenging Times

NC Institute of Medicine Annual Meeting

Mike Hogan Ph.D. August 2012

Many Challenges. NC "Resilience, Recovery"

NC has Long Standing Challenges

- Waiting lists everywhere
- Excess institutionalization (state hospitals, adult homes) *and* poor access to acute care/over- crowded ED's
- Burden on criminal justice system
- Many people have multiple needs, services are siloed
- Most people with behavioral needs show up in primary care, but these settings often can't meet these needs
- Continuous, disconnected change, Lack of agreement on the playlist

And Assets: Resilience and Recovery

- Community care "provider survivors"
- Long experience with primary care CM
- "Recovery" is a fact
- All needed models have already worked… somewhere in NC
- A federal reform path has been identified
- A state reform path has been identified
- This ***could*** work

Opportunities: Can NC Capitalize?

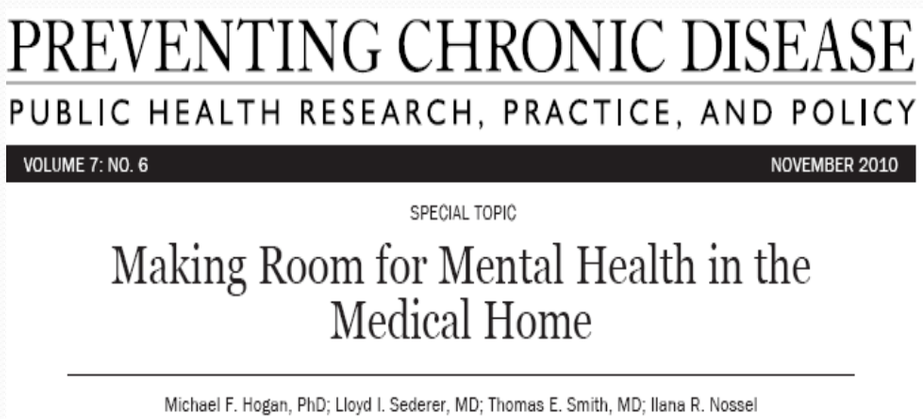
Policy and Systems Changes

- Federally: MHEAPA, PPACA promise coverage, better benefits, care management… ACO's, MCO's, HH's
  - More people with coverage
  - Coverage includes BH benefits
  - Emphasis on continuous integrated care
- Within NC: Continuous change (e.g. CABHA's, LME's) has a new direction (waiver)
- We must remember: change is mandatory…progress is optional

Can Change be used to fix Systemic Deficits in Care?

1. Late entry, poor detection, undertreatment in primary care
2. FFS reimbursement for care of episodic conditions has bad "side effects"
3. Can we make suicide prevention a clinical as well as public health concern?
4. A new reform agenda every 5-10 years doesn't help; Can this be the time NC gets it right?

1) Addressing Behavioral Health Issues in Primary Care and Medical Homes


PREVENTING CHRONIC DISEASE

PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY

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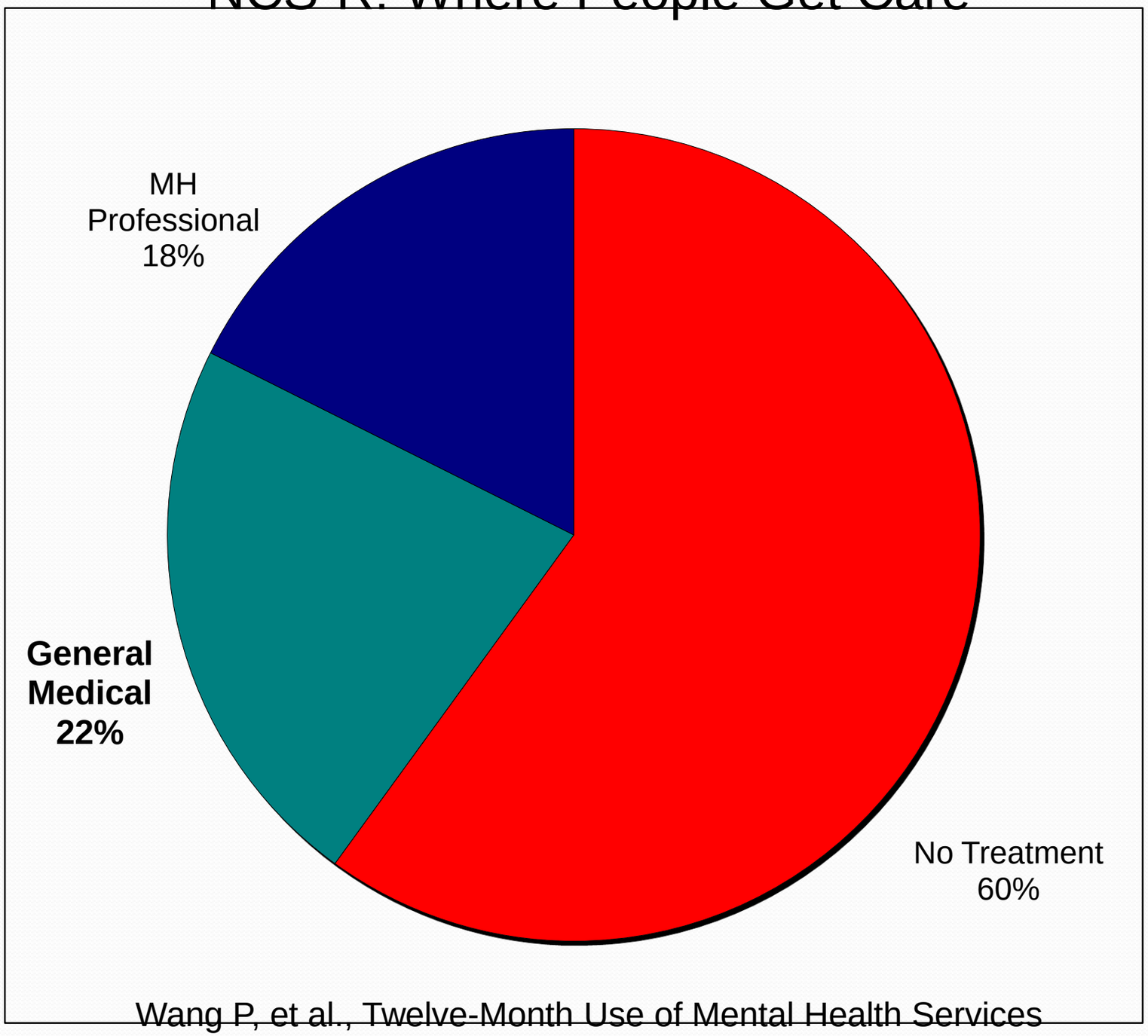
SPECIAL TOPIC

Making Room for Mental Health in the Medical Home

Michael F. Hogan, PhD; Lloyd I. Sederer, MD; Thomas E. Smith, MD; Ilana R. Nossel



Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

"We couldn't get a psychiatrist, but perhaps you'd like to talk about your skin. Dr. Perry here is a dermatologist."

66% of PCPs Report Poor Access to Specialty Mental Health Care for Their Patients

Cunningham PJ, *Health Affairs* 2009;28(3)490-501

Without Support in Primary Care Depression Care* Is Generally Inadequate

- 1/8 of depressed people in primary care receive "minimally adequate care" (Kessler).
  - *YET, research shows treatment is effective: 75–80% of individuals with depression will improve with appropriate diagnosis, treatment, and ongoing monitoring.*
  - *(In specialty care, about 50% get "adequate" care)*
  - We have the opportunity to fix MH care in Primary care…can it be done?

* Or Anxiety, ADHD, Problem Drinking Care….

BH Care in PC: Key Elements

PCP supported by Behavioral Health Care Manager

Practice Support

Informed, Active Patient

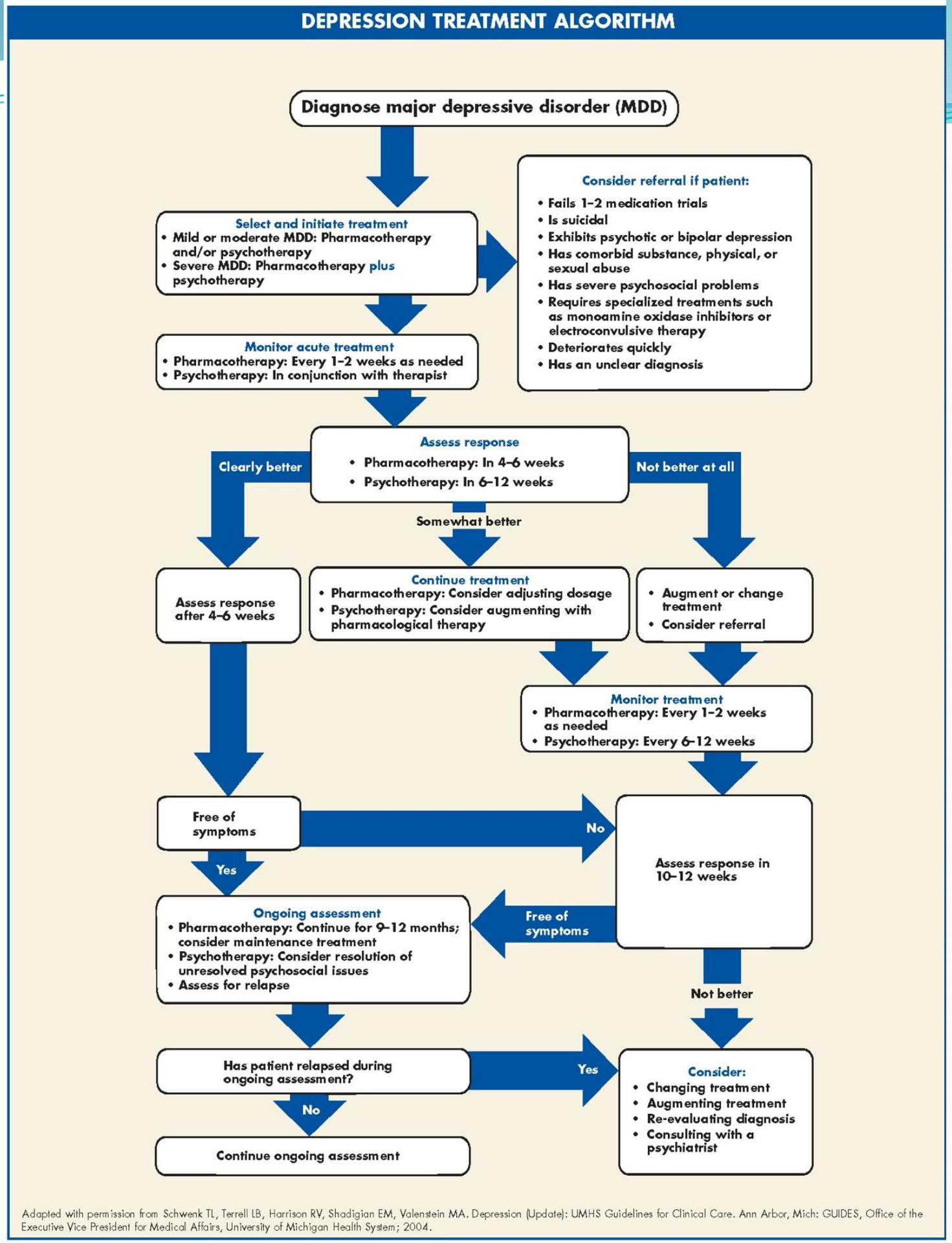
Integrated Care

Measurement-based Stepped Care

Caseload-focused Psychiatric Consultation

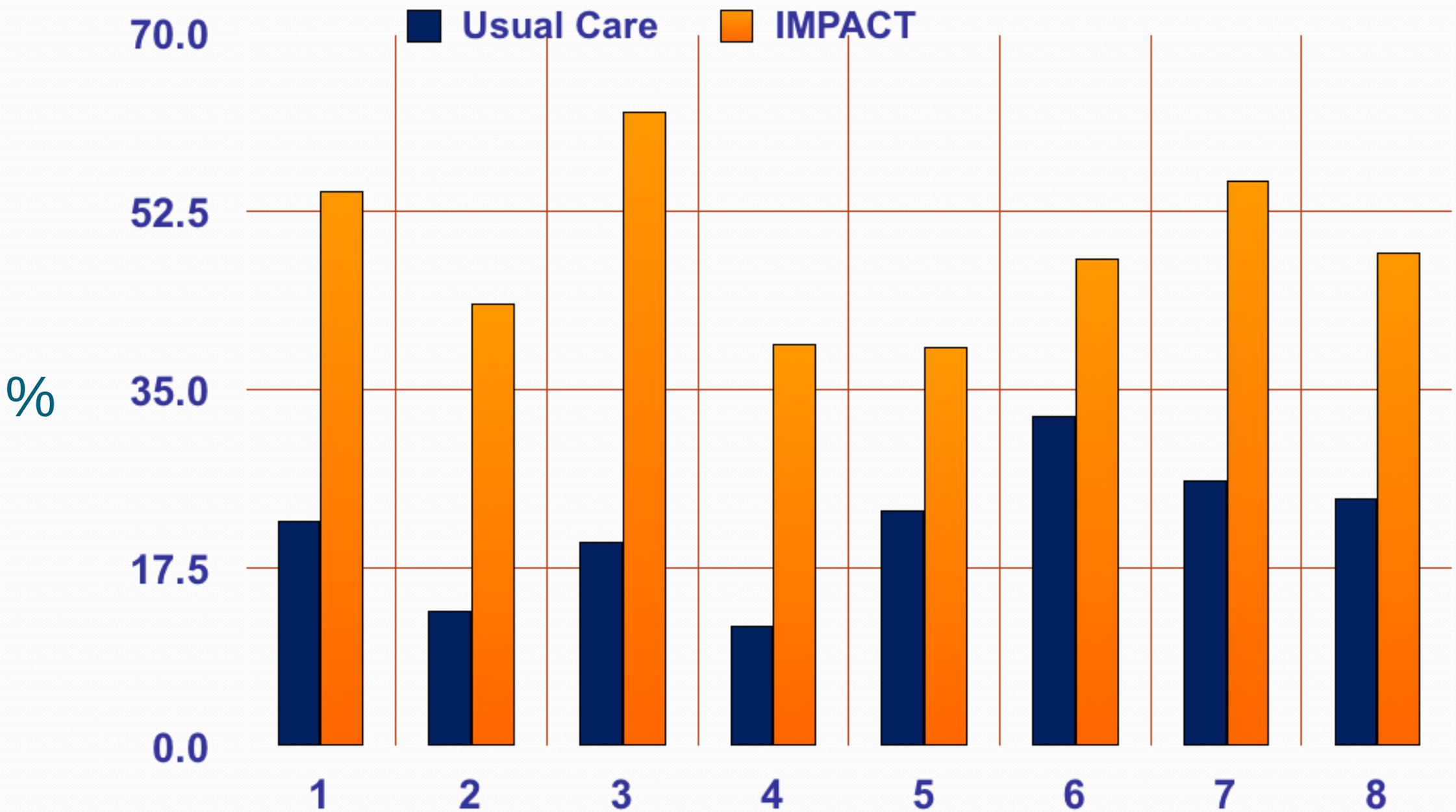
Training

Depression Care Path



CC Doubles Effectiveness of Care for Depression

50 % or greater improvement in depression at 12 months



Unützer et al., Psych Clin NA 2004

Participating Organizations

The Case for Integrated Care and What to do Now

- ***The Case***
- Over 40 randomized controlled trials (RCTs)
  - Depression and other common behavioral conditions
  - CC consistently more effective than usual care
- Long experience with primary care case management in NC
-

What's Needed Now?

- Integrated care requires some support "on the floor" via BH professional, EMR adaptation, teamwork
- Resolving potential tensions: carved out specialty management *and* integrated primary care

2) A FFS Model Without Care Management Cannot Work for Care of Episodic, Behavioral Conditions

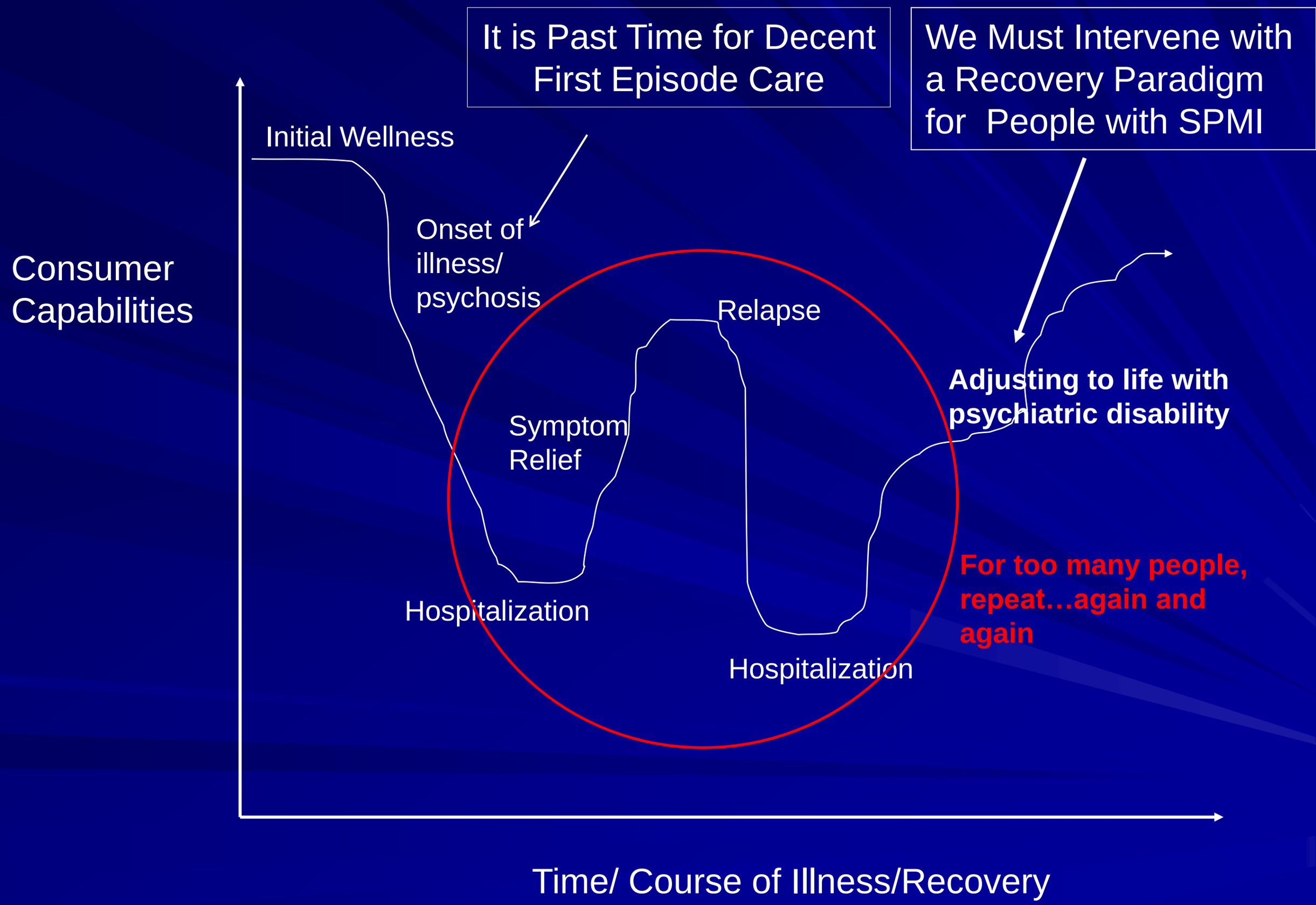
Systemic Problems with "Unmanaged Care"

- Overutilization of acute care and of maintenance services
- Problems with hand-offs
- Gaps with services that are:
  - Systemic (e.g. crisis respite)
  - Off-benefit (e.g. peer services, housing, employment)

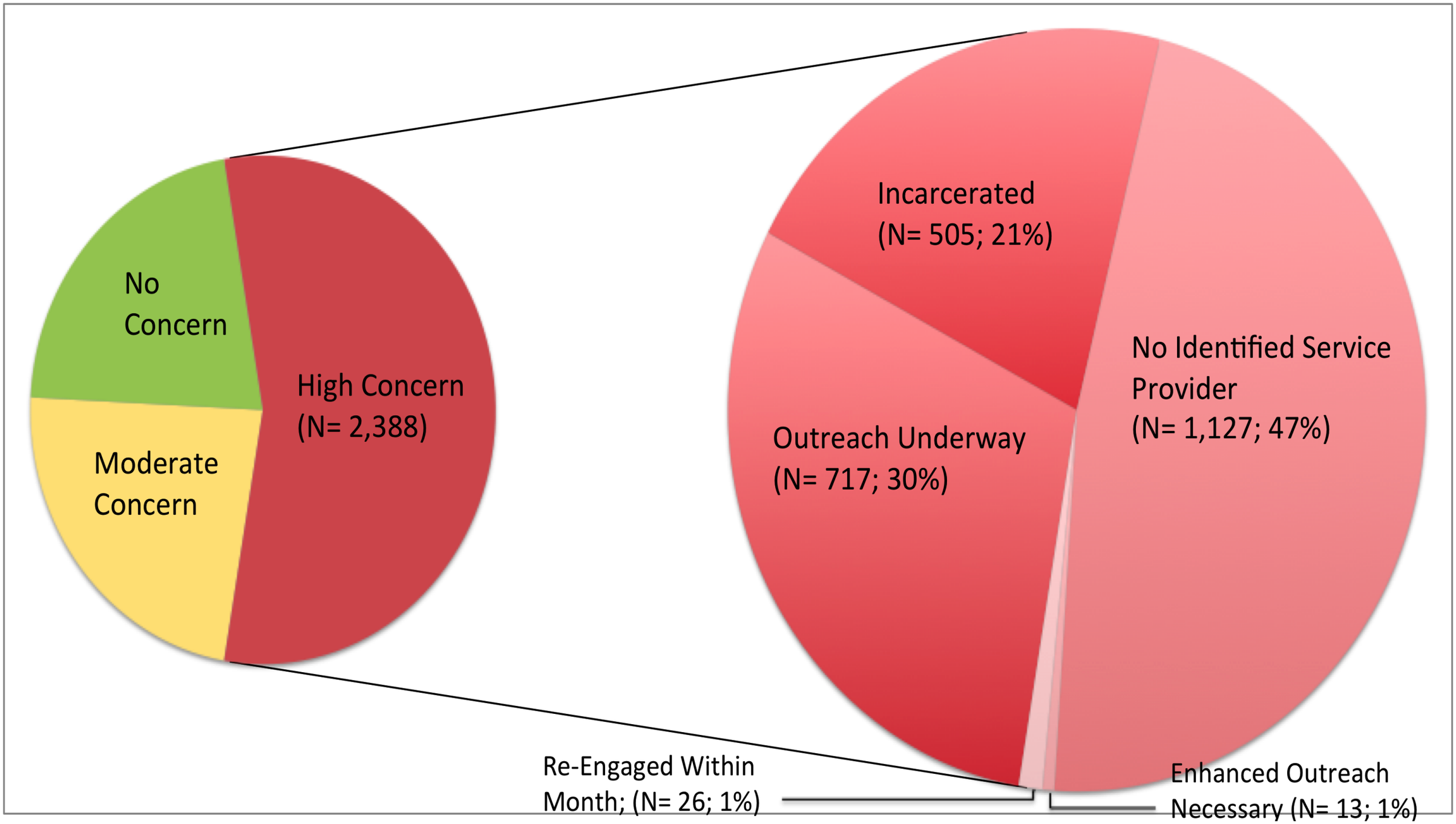
Familiar Symptoms

- Too many beds filled, but not enough beds available/empty
- People are pushed to other systems: criminal justice, homelessness, disability
- Lack of high-value, non "clinical" supports; expensive clinical services are substituted for supports

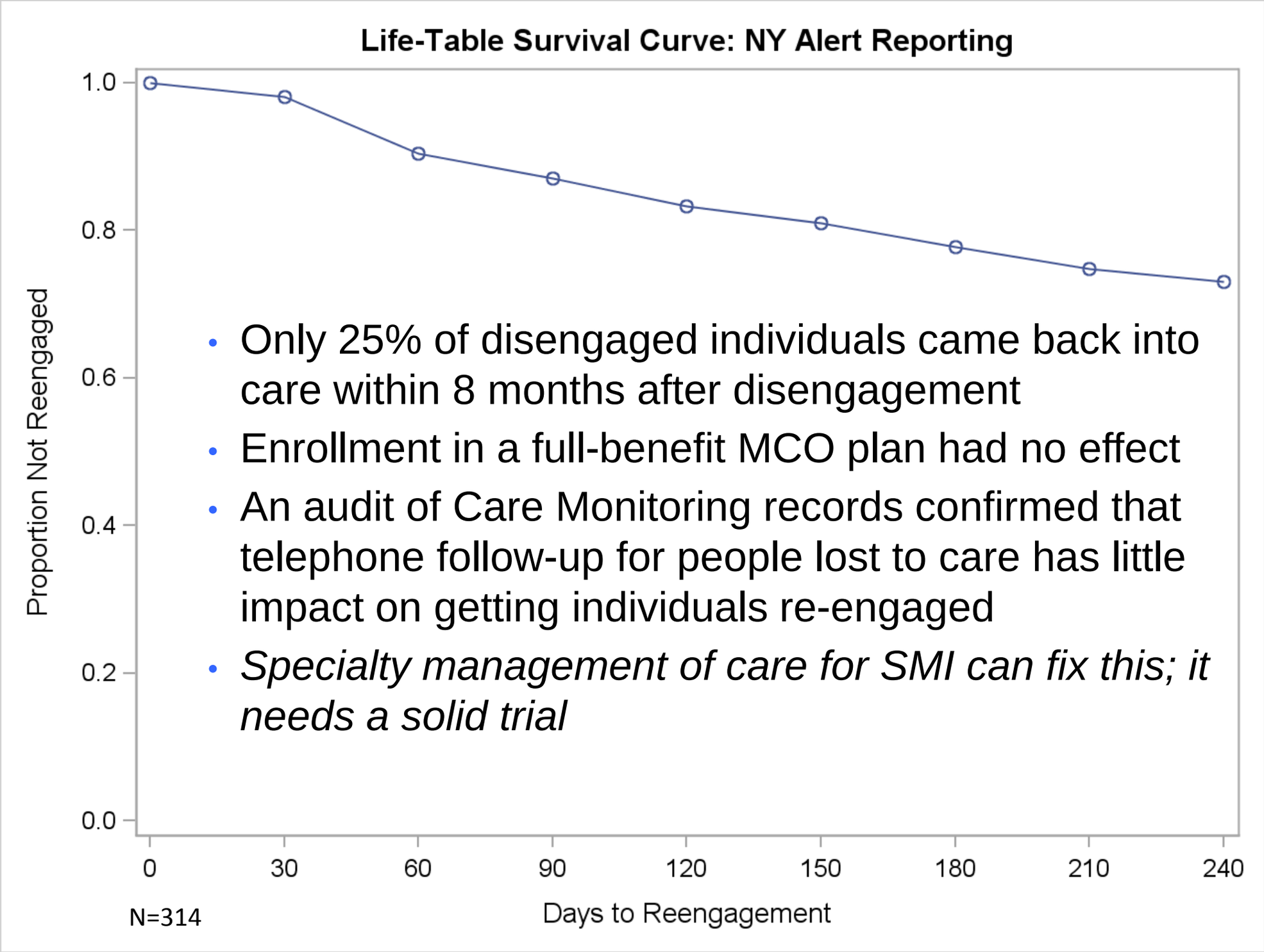
FFS Care is a Disaster for People with Psychotic Illness: We Can do Better



NYC Example of "Unmanaged Care"
Tracking High Risk People With Gaps in Care in a FFS System:
What Did We Learn About 4,000 At Risk People With Gaps in Care?



How many high concern individuals re-engage and how long does it take in an urban FFS system ?



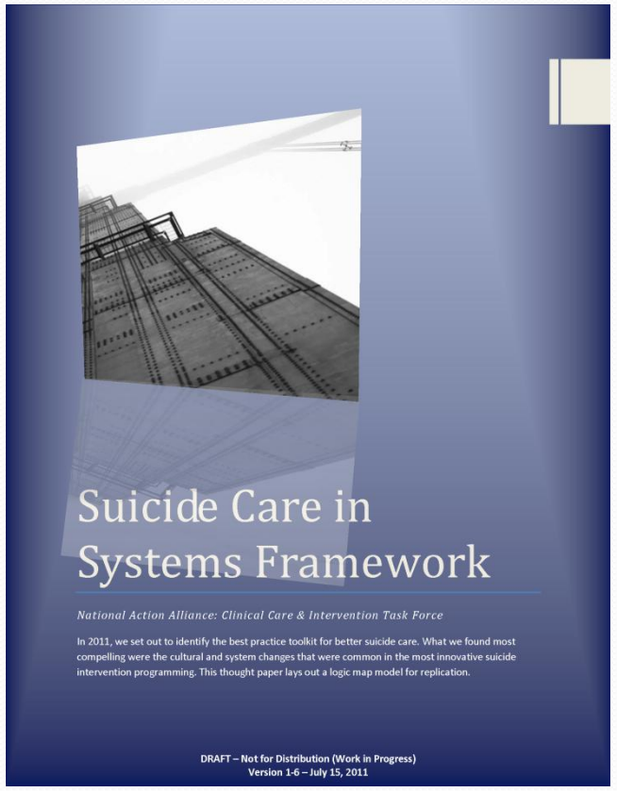
- Only 25% of disengaged individuals came back into care within 8 months after disengagement
- Enrollment in a full-benefit MCO plan had no effect
- An audit of Care Monitoring records confirmed that telephone follow-up for people lost to care has little impact on getting individuals re-engaged
- *Specialty management of care for SMI can fix this; it needs a solid trial*

Inclusion criteria: All individuals categorized as high clinical concern from January-September 2010

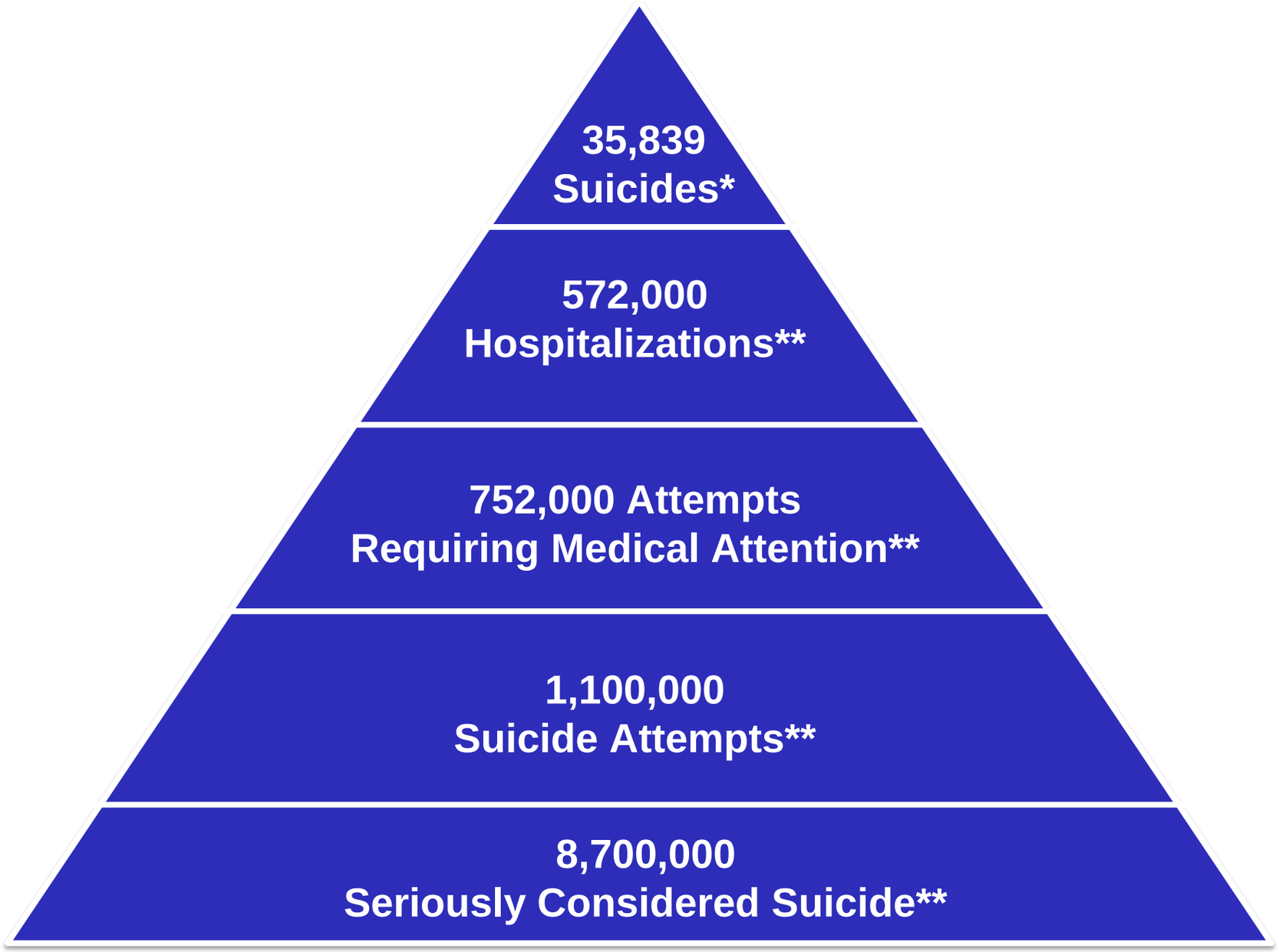
3) Suicide Prevention: a Clinical and Public Health Priority?

NATIONAL Action Alliance FOR SUICIDE PREVENTION

- Action Alliance Launched 9/10/12
- Recommendations by Clinical Care Task Force
- National Strategy for Suicide Prevention Update due: Sept 10 2012



Background: Pyramid of Suicidal Behaviors--U.S.



Source:
* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2009). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Available from: **www.cdc.gov/injury/wisqars/index.html.**
**Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-42, HHS Publication No. (SMA) 11-4667. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

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Suicide prevention efforts tend to focus on "at-risk" groups

(rates greater than general population)

White Males 65+ 3-4x

Veterans/Military 2-4x

Alaskan Natives/ American Indians (AN/AI) 2-4x

Lesbian, Gay, Bisexual, Transgender (LGBT) Youth 2-3x

We should focus intervention on those at highest risk

Individuals with Serious Mental Illness (SMI) 6-12x

White Males 65+
The American Association of Suicidology reports the 2006 suicide rate for elderly white males was 31 per 100,000, but 48 per 100,000 for those over 85. *http://bit.ly/men-s*

Veterans/Military
In 2010, *USA Today* reported the current U.S. Army suicide rate at 22 per 100,000 *(http://usat.ly/army-s)*, but the Fort Hood rate was 47 per 100,000. *http://bit.ly/ft-s*

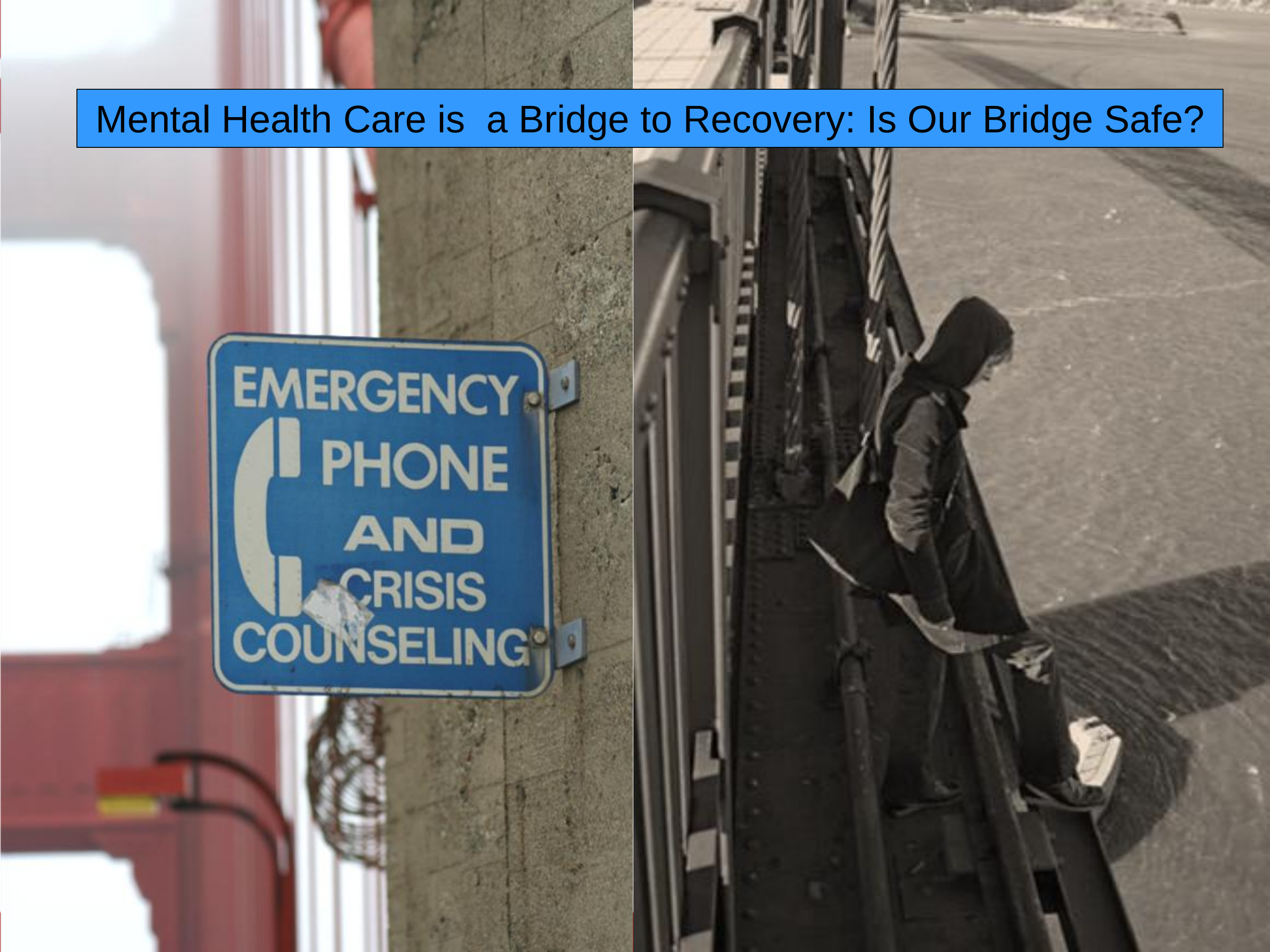
AN/AI
In the Suicide Prevention Resource Center (SPRC) library, Alaskan Native/American Indian males ages 15 to 24 had the highest rate at 28 per 100,000. *USA Today* reported in 2010 a suicide rate for those AN living in Alaska of 42 per 100,000. *http://usat.ly/an-ak*

LGBT Youth
The SPRC library says little can be said with certainty about death rates. However, other research suggests two to three times the national rate. *http://bit.ly/wik-lgbt*

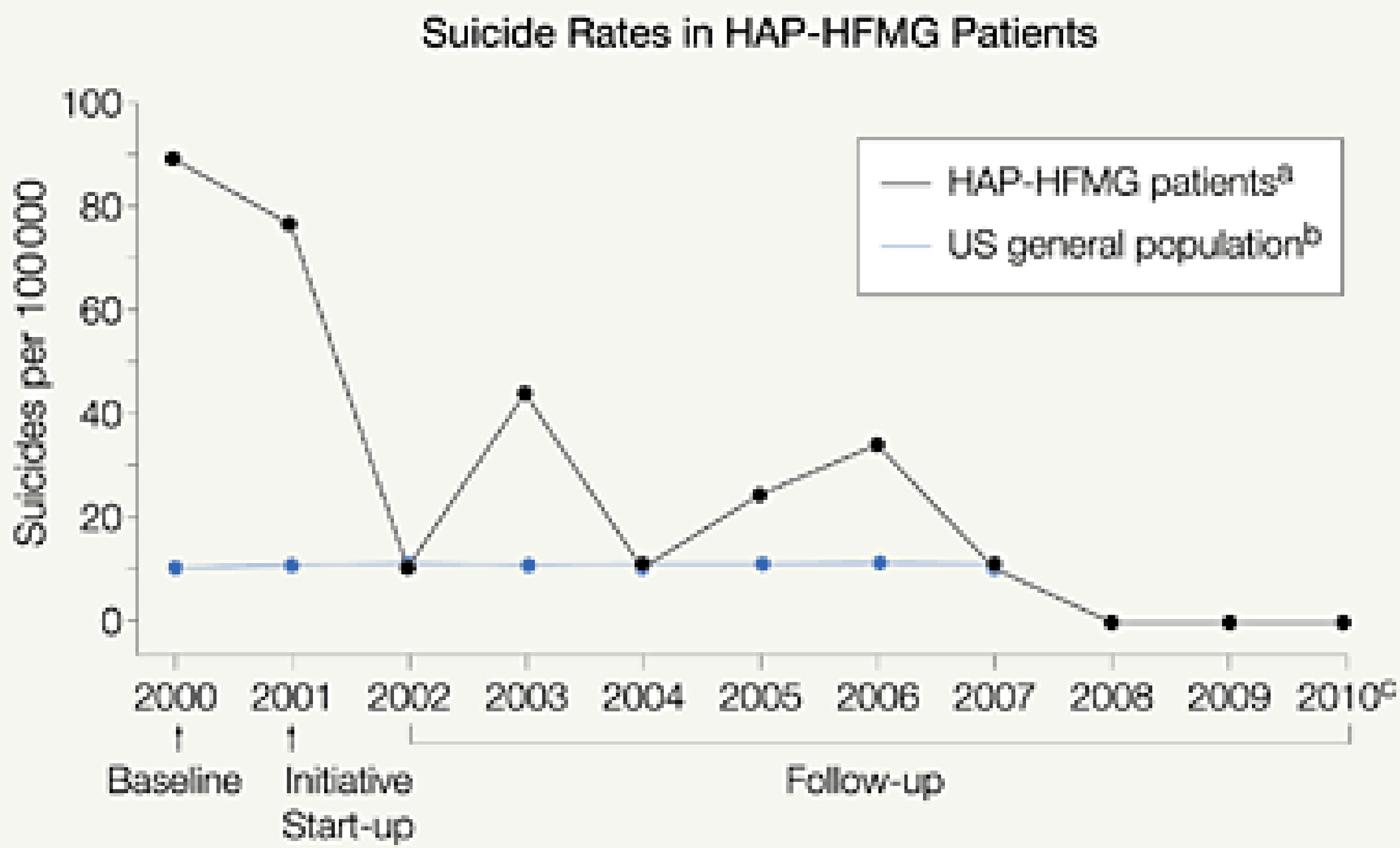
Individuals with SMI
In 2008, a UK study by Osborn et al. found the hazard ratio for individuals with SMI, including schizophrenia, to be nearly 13 times the general population. In Dec. 2010, King's Health Partners found the risk to be 12 times greater during the first year following diagnosis of a serious mental illness. *http://bit.ly/SMI-suicide-12x*

Note: The suicide rate in the general population was 11.5 per 100,000 in 2007.

Mental Health Care is a Bridge to Recovery: Is Our Bridge Safe?



Henry Ford Health System



[a]Health Alliance Plan (HAP) health maintenance organization members receiving care from the Henry Ford Medical Group (HFMG). Data source: C. Edward Coffey, MD/Henry Ford Health System.

[b]Data sources: Heron MP et al. Deaths: final data for 2006. *Natl Vital Stat Rep*. 2009;57(14):30. Xu J et al. Preliminary data for 2007. *Natl Vital Stat Rep*. 2009;58(1):20.

[c]Includes first quarter of 2010.

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What Can Leaders Do, And What Help Is Available?

- Use Leadership and Leverage: Seek Innovators who will Implement a Systems Approach and Commit to Working Toward Zero Suicide for Their Members
- Key Elements:
  - Leadership Commitment to Goal, to a Culture of Safety and to Continuous Improvement
  - Staff Awareness (Training) on Suicidality (e.g. ASIST)
  - Screening/Risk Stratification and Pathways to Indicated Care
    - Screening Example: **Columbia Suicide Severity Rating Scale***
  - Address Suicidality, not Just Mental Illness
    - Examples: EBP's (CBT, DBT), **Safety Planning***
  - **Follow-Up*** After Attempts, ED visits, Hospitalization
    - Example: Lifelines Follow-Up

***On Line** Training Modules in Development by NY OMH/Columbia

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4) Getting Mental Health Right: What's Essential and What's Desirable in Care Management

The Absolute Fundamentals

- A Parent's Comment, to Frame the Issue
- An Empowered Regional Entity, with the clout, time, and support to make it work
  - Note differing needs of DD population
  - Note: the need for integrated care

Some Key Considerations

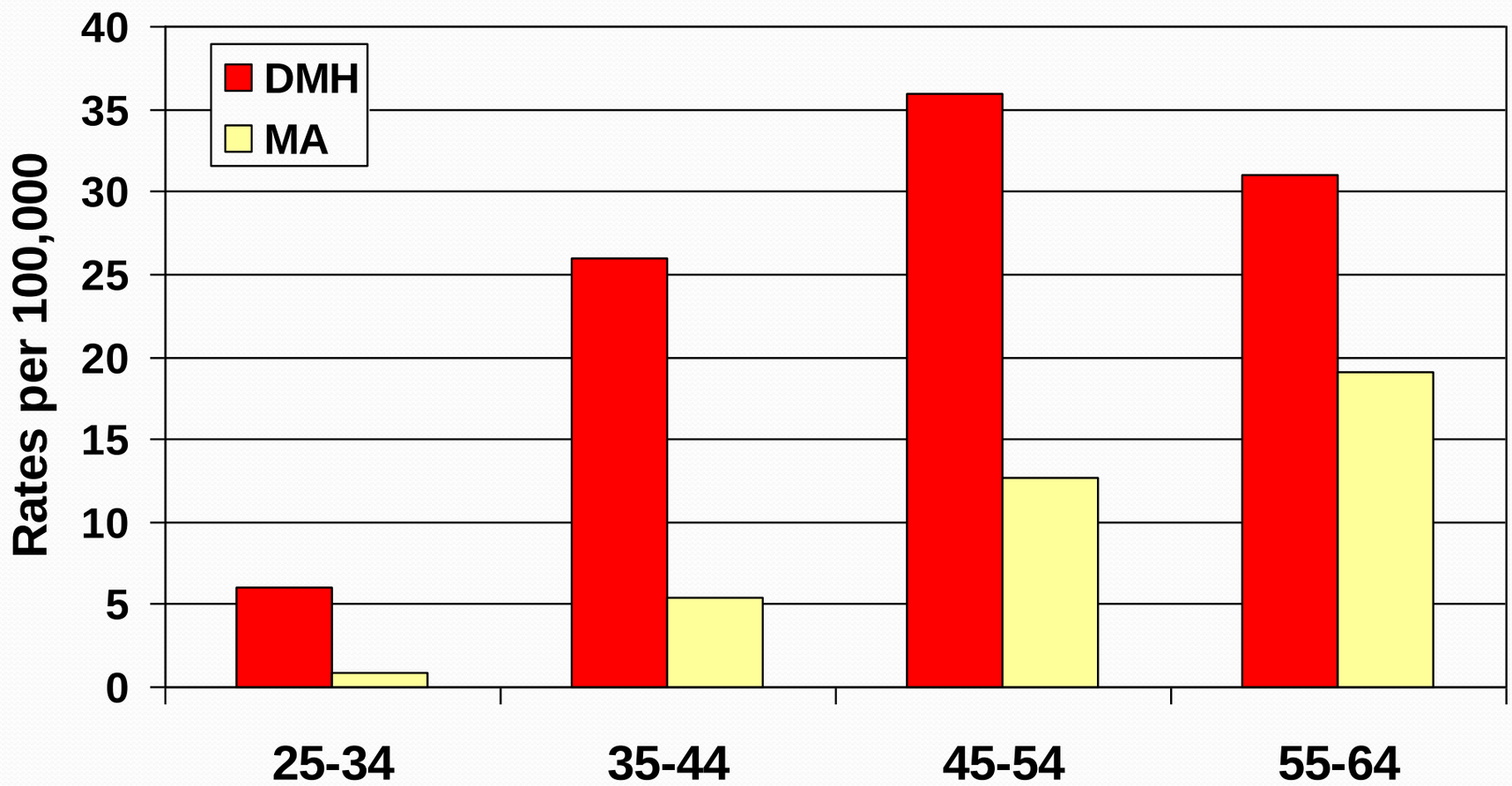
- Adequate and manageable regional boundaries, all clinical resources "in"
- A workable approach to other key resources e.g. housing, state hospitals, non-Medicaid
- Phased implementation, and staying the course
  - Rome wasn't built in a day, neither is care management
  - Provide time for complex change to work, but monitor and adjust (formative evaluation, with stakeholders?)

People Have Screwed This Up Before: Some Things to Probably Not Do

- Do, or expect too much on Day I
- Manage the wrong stuff too much (e.g. clinic visits)
- Just Say No
- Take too much money out, especially too soon
- Encourage or allow cost shifting/dumping (e.g. into state hospitals, criminal justice)
- Use the same care management logic for people with DD and MH/SUD concerns
- Change the whole approach again in a couple of years
- Forget that we need integration of care everywhere

Integrating Medical Care in Specialty Mental Health Settings

Demonstrating The Need: Heart Disease Death Rates of People in MA Public Mental Health Care vs. MA Overall



Some Obvious Tips for Success

- (With appreciation to Stephen Covey) *First Things First*
  - Basic consumer and provider enrollment, payment systems come before UM
- Remember the basics of behavioral health care
  - Most people do fine with only clinic care. Increase access
  - Episodic, relapsing conditions: continuous and mobile care/care monitoring is crucial for many people.
  - Maximize the 3 R's: Resiliency, Recovery, and Risk Management
  - Replace excess inpatient with alternatives at the front door (mobile crisis, crisis respite, intensive outpatient) and back (housing with titered treatment and supports)
  - The fewer inpatient beds you have, the more important it is to always have one available
- Problems will occur. Expect them, deal with them. Stay the course. *You can make this work.*

Thank You