

Addressing Mental Health and Addiction to Improve Health Value



HealthCare Perspective

Full-Service Health System Management Consulting

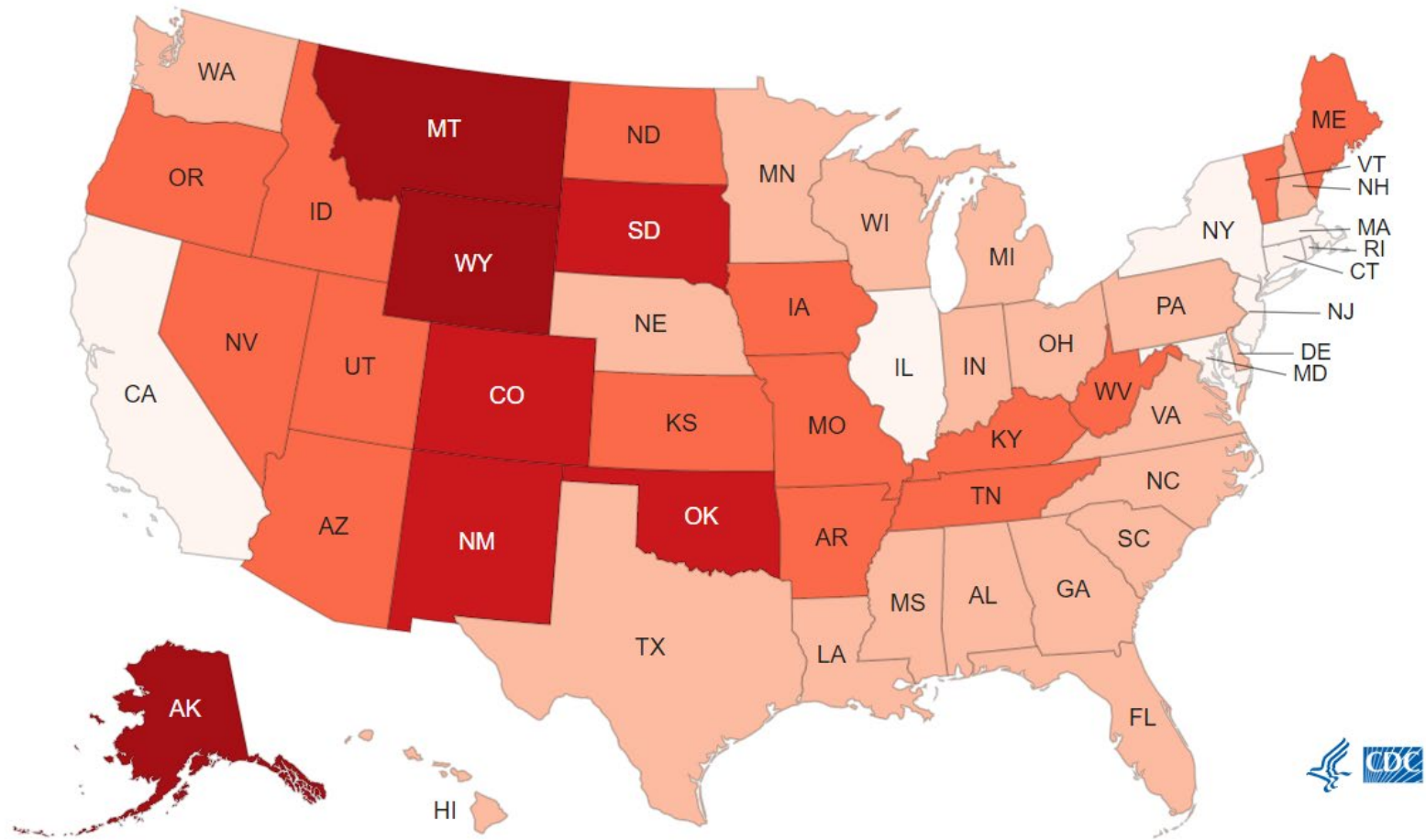


Kris Vilamaa

- ▶ Chief Executive Officer - HealthCare Perspective, LLC
- ▶ Named one of the Top 50 Healthcare Leaders in Consulting for 2022 by *The Consulting Report*
- ▶ Fifteen years in state government, seven years in healthcare consulting
- ▶ Recently completed projects with State of Ohio MHAS and State of Maryland Behavioral Health Authority on BH crisis initiatives. Currently engaged with the Eastern Tribe of Cherokee Indians (NC), community health plans and multiple information technology and pharmaceutical firms
- ▶ Worked with Boards, Providers and Plans in Ohio and around the country (25 different states) over the last eight years

The Problem





Suicide Mortality by State

SOURCE: <https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm>

Mental Health America Rankings

For Youth
Ohio is 19th

The 7 measures that make up the Youth Ranking include:

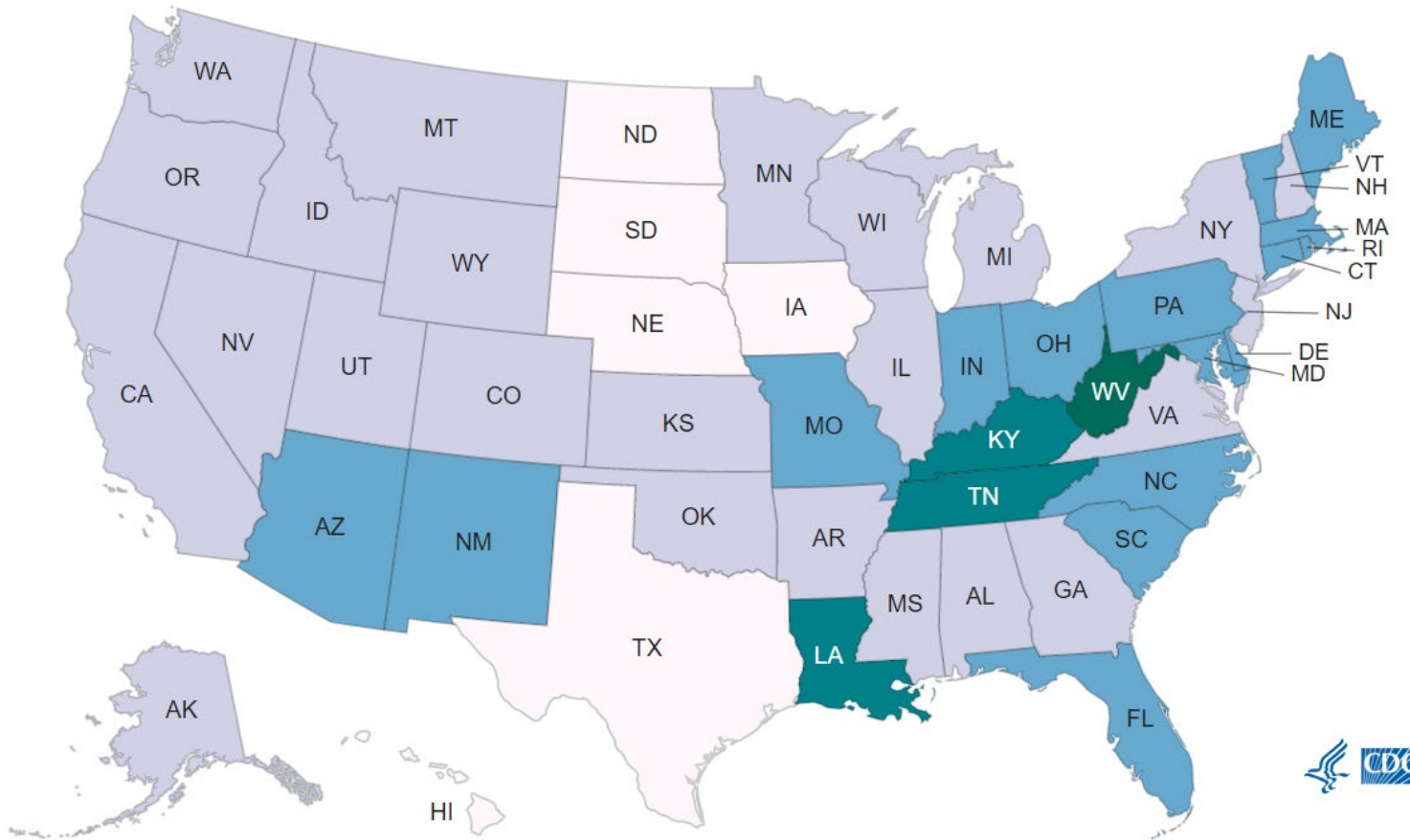
1. Youth with At Least One Major Depressive Episode (MDE) in the Past Year
2. Youth with Substance Use Disorder in the Past Year
3. Youth with Severe MDE
4. Youth with MDE who Did Not Receive Mental Health Services
5. Youth with Severe MDE who Received Some Consistent Treatment
6. Children with Private Insurance that Did Not Cover Mental or Emotional Problems
7. Students Identified with Emotional Disturbance for an Individualized Education Program.

Mental Health America Rankings

For Adults
Ohio is 36th

The 7 measures that make up the Adult Ranking include:

1. Adults with Any Mental Illness (AMI)
2. Adults with Substance Use Disorder in the Past Year
3. Adults with Serious Thoughts of Suicide
4. Adults with AMI who Did Not Receive Treatment
5. Adults with AMI Reporting Unmet Need
6. Adults with AMI who are Uninsured
7. Adults with Cognitive Disability Who Could Not See a Doctor Due to Costs

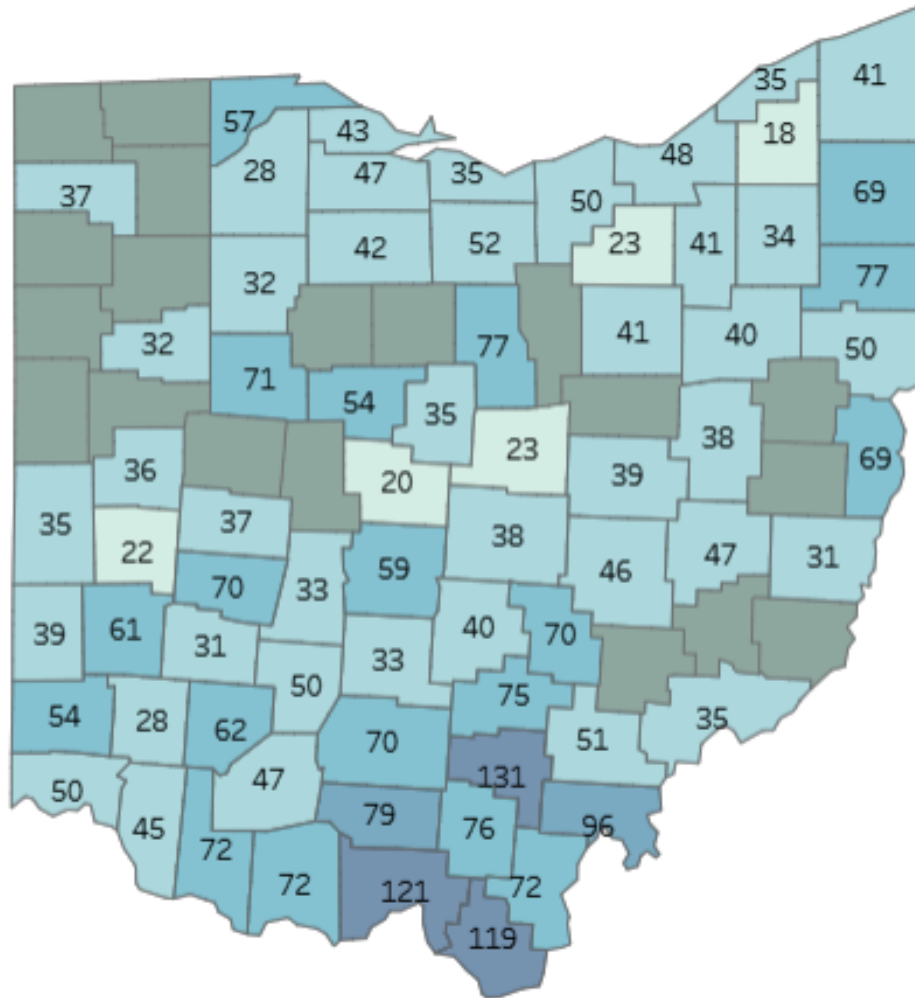


Drug Overdoses Mortality by State

SOURCE:

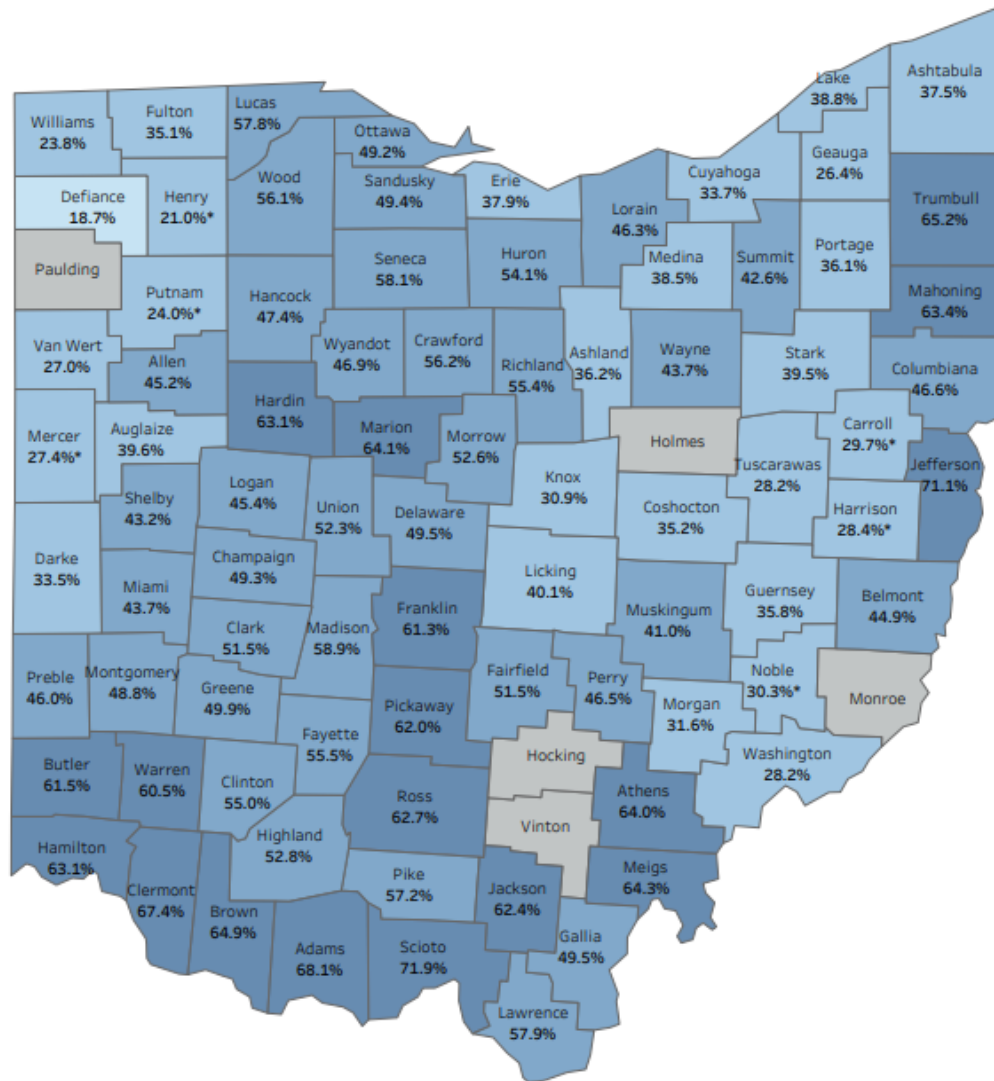
https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm

Unintentional Drug Overdose Deaths (Rate per 100K): Map



Source: OMHAS Dashboard
<https://analytics.das.ohio.gov/t/MHAPUB/views/AO-DDashboard/>

Percentage of SFY 2021 SUD Treatment Claims with Primary Diagnosis of Opiate Use Disorder



This map represents the percentage of unduplicated clients with a primary diagnosis of opioid use disorder (OUD) served in each county during SFY 2021. Counties that reported fewer than 25 clients are signified by gray, and no percentage is given. Counties that reported between 25 and 50 clients have an asterisk after the percentage; statistics based on a low number of cases should be interpreted with caution.

The statewide average percentage of SUD treatment clients with a primary diagnosis of OUD was 51.5%. The highest rates were found in Scioto county (71.9%), Jefferson county (71.1%), and Adams county (68.1%). The lowest rates were found in Defiance county (18.7%), Henry county (21.0%), and Williams county (23.8%).

Legend

- Fewer than 25 cases
- 20.0% or less
- Between 20.1% and 40.0%
- Between 40.1% and 60.0%
- More than 60.0%

Map produced February 2023
 Data Source: Ohio MHAS Community Behavioral Health Claims Data



The Solution



Our Vision

- Visible and accessible crisis services.
- Supports that are person-centered and quality-driven.
- Ensuring people are stabilized and thriving in their community.

- Someone to TALK TO.
- Someone to RESPOND.
- A PLACE TO GO.

Ohio's Ideal Crisis Continuum



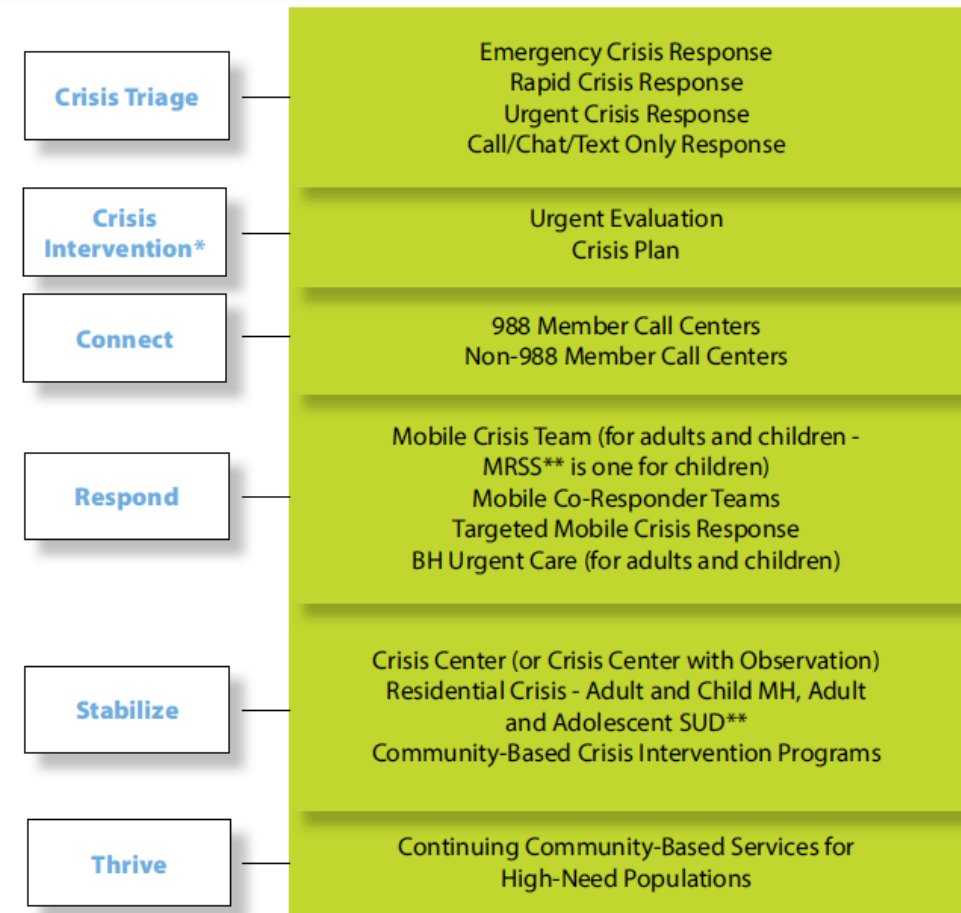
Ohio- Developed Principles

Ohio's BH Crisis System:

- Is for anyone experiencing a mental health (MH) and/or substance use disorder (SUD) crisis in Ohio
- Ensures services are welcoming, safe, hopeful, person and family-driven, empowering, trauma-informed, and culturally competent
- Is designed to help every person and family experiencing a crisis to get the right help in the right place at the right time, and to get help not only to stabilize but also to thrive
- Is forward thinking, looking beyond our current service and funding models to design the services needed for Ohioans in accordance with our values
- Belongs to everyone and requires collaboration, contribution and partnership from everyone, locally and statewide
- Should be in parity with the system of services for individuals who experience any other type of health crisis
- Uses data for continuous quality improvement to be in better alignment with the needs of people with behavioral health needs and the needs of communities

Crisis Continuum Services

- ▶ Necessary for successful system of care
- ▶ How they are provided may look different in different communities



*This service has a current OhioMHAS definition.

**These services have an OhioMHAS definition and is billable through Ohio Medicaid.

Service	Need
Call center (988 or non-988) – linkage to receive handoffs from a 988 center	YES
Mobile crisis team (multiple teams needed, some may be child specific)	YES – Note: in an ADAMHS Board region with multiple small counties, there may need to be a team in each county.
BH urgent care capacity (both business hours and after hours)	YES – Note: In an ADAMHS Board region with multiple small counties, there should be walk-in BH urgent care in each county and can be built into and onto other services (medical urgent care; CMHC).
Crisis center with observation	NO – Volume too small. *
Residential crisis services for adults (MH and SUD) and children (MH)	NO – Not enough volume to sustain a freestanding program for each. **
Intensive crisis intervention follow-up	YES - This should be developed for both adults and children so it can happen on a case-by-case basis when needed. Multiple options, including building it into mobile crisis. MRSS is one option for children, but there are other approaches for adults, as well as for children.

Small County or ADAMHS Board Region Planning Estimates

Anticipated total crisis episodes (beyond calls) based on Crisis Now Calculator

Adults:
100-300/month; 5.5-10/day
Children:
25-75/month; 1-2.5/day

Total episodes that can be managed with only mobile crisis or urgent care

Adults:
75-225/month; 2.5-7.5/day
Children:
18-54/month; .5-2/day

Total "chairs" needed for crisis center with observation (based on 16 beds for 500,000)

Adults:
1.6-5
Children:
0.4-1.25

Small County or Board Region Planning

Service	Need
Call center (988 or non-988) – linkage to receive handoffs from a 988 center	YES
Mobile crisis team (multiple teams needed, some may be child specific)	YES – Note: in an ADAMHS Board region with multiple small counties, there may need to be a team in each county.
BH urgent care capacity (both business hours and after hours)	YES – Note: In an ADAMHS Board region with multiple small counties, there should be walk in BH urgent care in each county and can be built into and onto other services (medical urgent care; CMHC).
Crisis center with observation	MAYBE – The projected need for 5-10 chairs is on the cusp of feasibility for a non-hospital-based crisis center. Some communities may be able to implement; others may have the ability to create a hospital-based crisis center. For others, partnering with other ADAMHS Board regions may be needed.
Residential crisis services for adults (MH and SUD) and children (MH)	YES - The need for these services will usually support one of each type of program. Even for populations of 150,000, smaller size programs may be feasible, or the modifications suggested in the small county ADAMHS Board checklist can be considered. Some ADAMHS Boards may elect to partner with neighboring ADAMHS Board regions if a suitable location for residential crisis services that is accessible in a timely fashion to both ADAMHS Board regions is available.
Intensive crisis intervention follow-up	YES - This should be developed for both adults and children so it can happen on a case-by-case basis when needed. Multiple options, including building it into mobile crisis. MRSS is one option for children, but there are other approaches for adults, as well as for children. In multi-county regions, there should be provision for intensive crisis intervention in each county.

Medium County or ADAMHS Board Region Planning Estimates

Total crisis episodes (beyond calls) based on Crisis Now Calculator	Adults: 300-600/month; 10-20/day Children: 75-150/month; 2.5-5/day
Total episodes that can be managed with only mobile crisis or urgent care	Adults: 225-450/month; 7.5-15/day Children: 54-108/month; 2-3.5/day
Total "chairs" needed for crisis center with observation (based on 16 beds for 500,000)	Adults: 5-10 Children: 1.25-2.5

Medium County or Board Region Planning

Service	Need
Call center (988 or non-988) – linkage to receive handoffs from a 988 center	YES
Mobile Crisis Team (multiple teams needed, some may be child specific)	YES – Note: in a Board region with multiple small counties, there may need to be a team in each county. Further, in a large county, there may need to be teams focused on different geographic regions within the county.
Behavioral Health Urgent Care capacity (both business hours and after hours)	YES – For larger population centers, can be free standing, but also can be built into other services (Medical Urgent Care; CMHC). In a Board region with multiple small counties, there should be walk in BHUC in each County. Large counties will need multiple BHUCs serving different geographies.
Crisis Center with Observation	YES – Even the “smallest” large counties have feasibility for a non-hospital crisis center, that can also support surrounding smaller counties. The largest counties will need multiple crisis centers (2-3) to serve different geographies and may have both hospital and non-hospital crisis centers.
Residential Crisis Services for Adults (MH and SUD) and Children (MH)	YES – Should have at least one of each type of program. The largest counties will need two-four of each type of program.
Intensive Crisis Intervention Follow-Up	YES – This should be developed for both adults and children so it can be provided whenever needed. Multiple options, including building it into mobile crisis. MRSS is one option for children, but there are other approaches for adults, as well as for children. In multi-county regions, there should be provision for intensive crisis intervention in each county. In the largest counties, there will need to be intensive crisis intervention programs for different regions in the county.

Large County or ADAMHS Board Region Planning Estimates	
Total crisis episodes (beyond calls) based on Crisis Now Calculator	Adults: 600-2,000/month; 20-65/day Children: 150-500/month; 5-17/day
Total episodes that can be managed with only mobile crisis or urgent care	Adults: 450-1,500/month; 15-50/day Children: 108-375/month; 3.5-12.5/day
Total “chairs” needed for crisis center with observation (based on 16 beds for 500,000)	Adults: 10-32 Children: 2.5-8

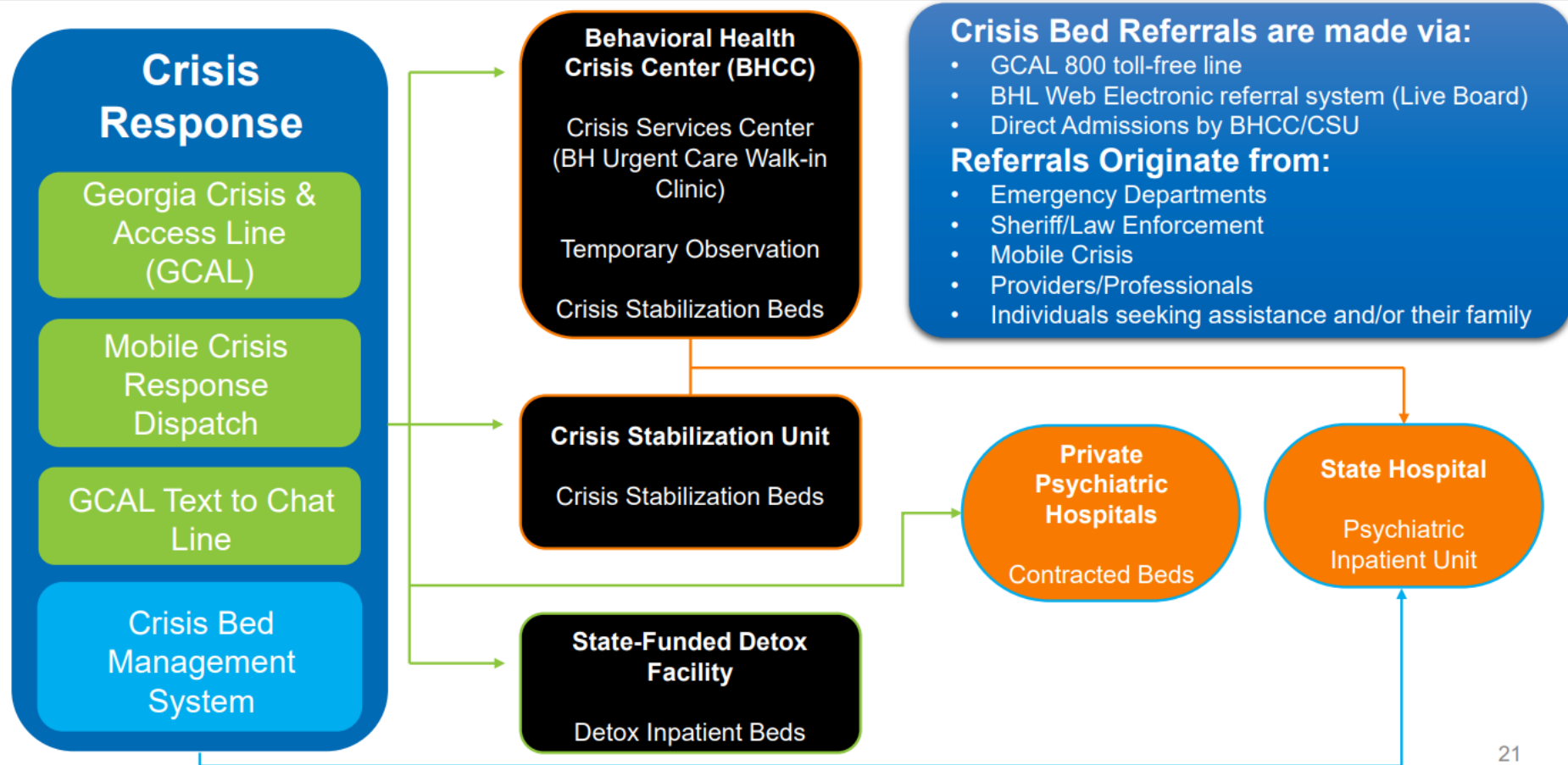
Large County or Board Region Planning

Successes



Georgia

Behavioral Health Crisis Continuum



Virginia

- ▶ Implemented six new services that had not previously been funded by Medicaid to complete their continuum

Partial Hospitalization Program (PHP):

Time-limited, non-residential, non-inpatient programs that deliver services on a level of intensity similar to inpatient programs but not on a 24-hour basis.

Multi-Systemic Therapy (MST):

An evidence-based program designed for youth with serious antisocial behavior, juvenile offenders, families with child welfare involvement, youth in psychiatric crisis (suicidal ideation, psychosis), youth with severe emotional disorders, and youth with comorbid physical health problems

Program of Assertive Community Treatment (PACT):

An intensive, client-centered, recovery-oriented evidence-based practice delivers integrated community-based treatment, rehabilitation, and support services to help persons with severe and persistent mental illness to avoid psychiatric hospitalization and to live independently in natural community settings.

Intensive Outpatient Program (IOP):

A structured, outpatient program that allows individuals to remain integrated within their daily lives by attending school or work, yet provide more intensity than routine outpatient care.

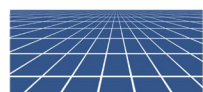
Functional Family Therapy (FFT):

A evidence based, short-term (approx. 30 hours) family-based therapeutic intervention for youth at risk for institutionalization and their families. FFT has resulted in decreases in recidivism and out-of-home placement and improvements in family interaction patterns.

Comprehensive Crisis Services:

Crisis Services assist individuals currently experiencing or having recently experienced a mental health crisis. These services may include 23-hour crisis stabilization, short-term crisis residential stabilization services, mobile crisis services, 24/7 crisis hotlines, warm lines, and peer crisis services.

Questions?





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