Integration of Behavioral Health & Primary Care

Georgia Rural Health Association 2017 Membership Conference
Jekyll Island, GA
November 2017

ASPIRE Behavioral Health and Developmental Disability Services –
Kay Newberry Brooks, CEO

ASPIRE - a unit of Albany Area Community Service Board

Leading Our Communities Towards Health, Hope, & Recovery

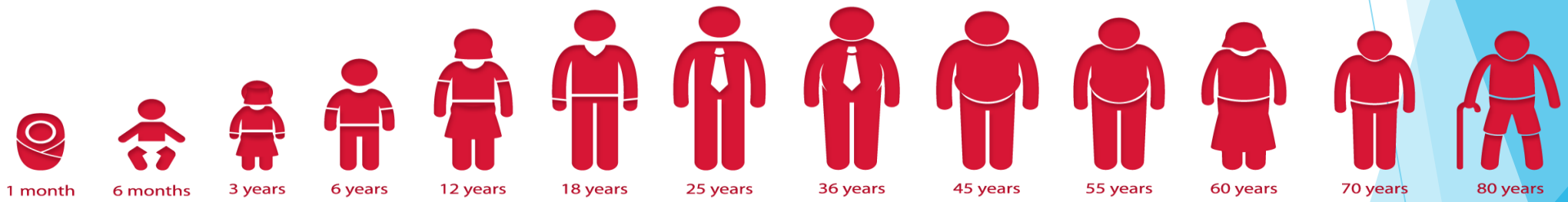
aspire
BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITY SERVICES

Integration of Behavioral Health & Rural Health Revealed

- Learning Objectives
  - What, Why and How of Integrated Care?
  - Behavioral Health – What??
  - Intellectual/Developmental Disability – What??
  - Georgia BH/DD Safety Net Providers – Who??
  - Identifying needs of your community/agency
  - Identifying strengths/challenges of your community/hospital/agency
  - Collaboration/Partner Opportunities
  - Building a Safer, Healthier community

CAN WE LIVE LONGER?

Integrated Healthcare's Promise



SAMHSA-HRSA
Center for Integrated Health Solutions

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
Healthy Minds. Strong Communities.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov 1-877-SAMHSA-7 (1-877-726-4727)

www.integration.samhsa.gov

The PROBLEM

People with mental illness die earlier than the general population and have more co-occurring health conditions.

68%

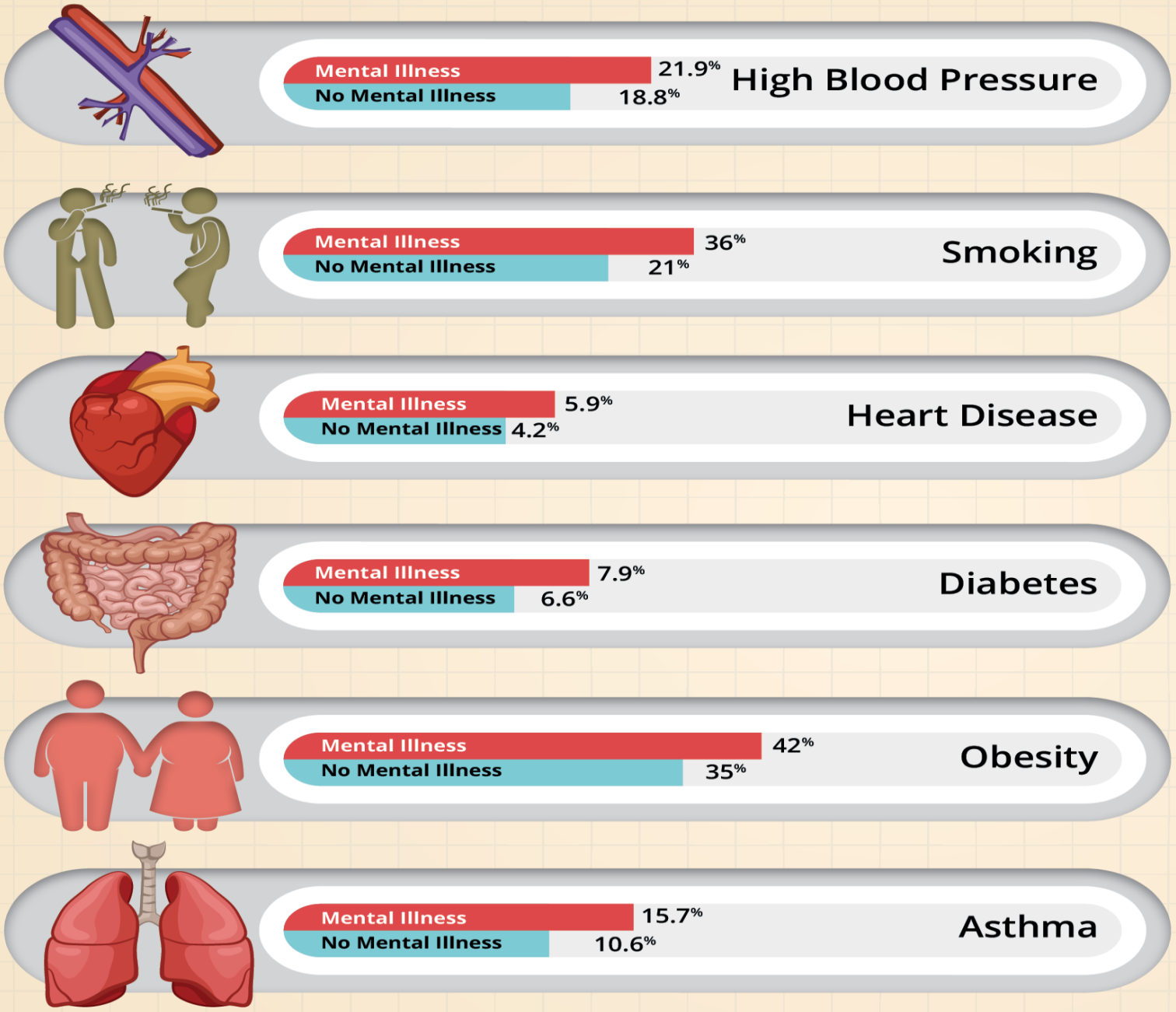
of adults with a mental illness have one or more chronic physical conditions

more than

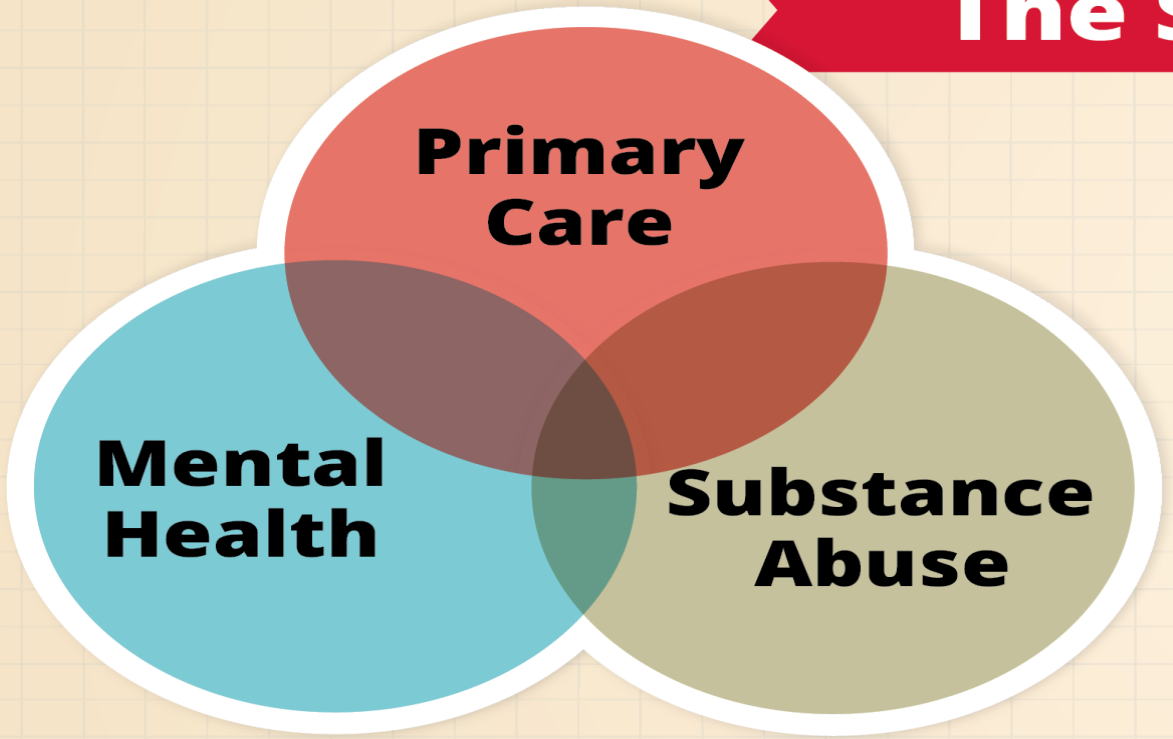
1 in 5

adults with mental illness have a co-occurring substance use disorder

Co-occurrence between mental illness and other chronic health conditions:



The SOLUTION

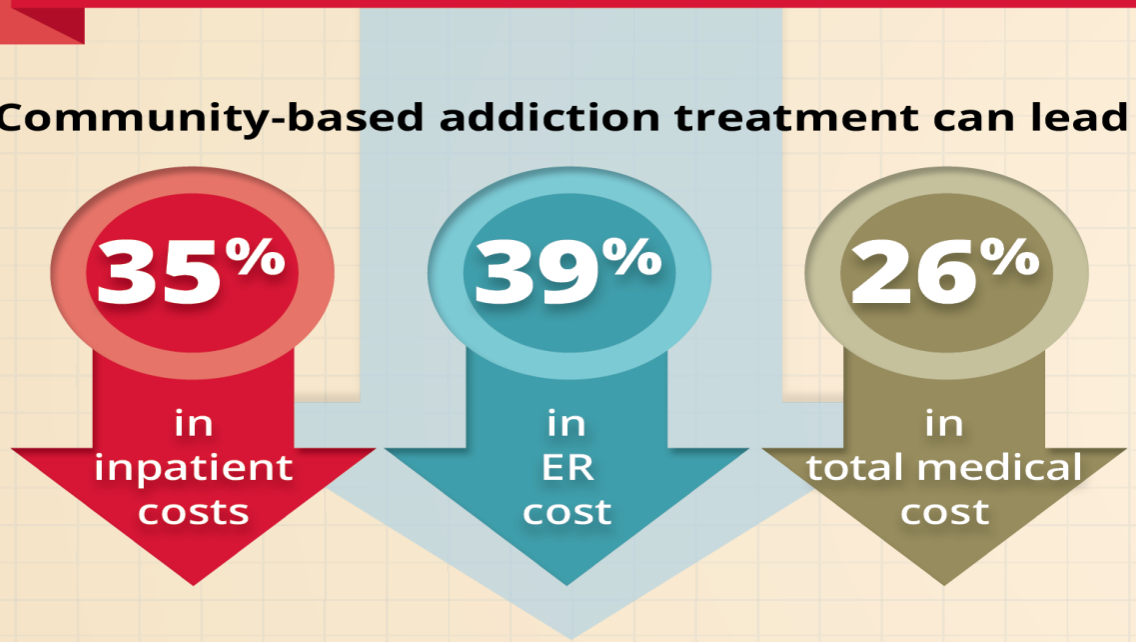


The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services.

Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.

INTEGRATION WORKS

Community-based addiction treatment can lead to...



Reduce Risk ➡ **Reduce Heart Disease**
(for people with mental illnesses)

Maintenance of ideal body weight (BMI = 18.5 – 25)	=	35%-55% decrease in risk of cardiovascular disease
Maintenance of active lifestyle (~30 min walk daily)	=	35%-55% decrease in risk of cardiovascular disease
Quit Smoking	=	50% decrease in risk of cardiovascular disease

One integration program* enrolled 170 people with mental illness. After one year in the program, in one month:

This is $213,000 of savings per month.

That's $2,500,000 in savings over the year.

Integration works.
It improves lives.
It saves lives.
And it reduces healthcare costs.

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Sources

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Heritage Behavioral Health Center, based on data in...
www.ahrq.gov/research/findings/evidence-based-reports/mhsapc-evidence-report.pdf

* A grantee of the Substance Abuse and Mental Health Services Administration's Primary and Behavioral Health Care Integration program.

What is Integrated Care?

Abstract: People with mental and substance abuse disorders may die decades earlier than the average person

People with mental and substance abuse disorders may die decades earlier than the average person — mostly from untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by poor health habits such as inadequate physical activity, poor nutrition, smoking, and substance abuse. Barriers to primary care — coupled with challenges in navigating complex healthcare systems — have been a major obstacle to care.

At the same time, primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and general healthcare needs. The solution lies in integrated care, the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

Whether services are organized via traditional models within **primary care settings** or **behavioral health settings** – or are **Health Homes models**, CIHS gathers current developments, research, models, and other important resources to ensure the success of healthcare's future: integration. CIHS

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Table 2A. Six Levels of Collaboration/Integration (Key Differentiators)

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Clinical Delivery					
▸▸ Screening and assessment done according to separate practice models ▸▸ Separate treatment plans ▸▸ Evidenced-based practices (EBP) implemented separately	▸▸ Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges ▸▸ Separate treatment plans shared based on established relationships between specific providers ▸▸ Separate responsibility for care/EBPs	▸▸ May agree on a specific screening or other criteria for more effective in-house referral ▸▸ Separate service plans with some shared information that informs them ▸▸ Some shared knowledge of each other's EBPs, especially for high utilizers	▸▸ Agree on specific screening, based on ability to respond to results ▸▸ Collaborative treatment planning for specific patients ▸▸ Some EBPs and some training shared, focused on interest or specific population needs	▸▸ Consistent set of agreed upon screenings across disciplines, which guide treatment interventions ▸▸ Collaborative treatment planning for all shared patients ▸▸ EBPs shared across system with some joint monitoring of health conditions for some patients	▸▸ Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place ▸▸ One treatment plan for all patients ▸▸ EBPs are team selected, trained and implemented across disciplines as standard practice
Key Differentiator: Patient Experience					
▸▸ Patient physical and behavioral health needs are treated as separate issues ▸▸ Patient must negotiate separate practices and sites on their own with varying degrees of success	▸▸ Patient health needs are treated separately, but records are shared, promoting better provider knowledge ▸▸ Patients may be referred, but a variety of barriers prevent many patients from accessing care	▸▸ Patient health needs are treated separately at the same location ▸▸ Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider	▸▸ Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers ▸▸ Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services	▸▸ Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others ▸▸ Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop	▸▸ All patient health needs are treated for all patients by a team, who function effectively together ▸▸ Patients experience a seamless response to all healthcare needs as they present, in a unified practice

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

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COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Practice/Organization					
▸▸ No coordination or management of collaborative efforts ▸▸ Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow	▸▸ Some practice leadership in more systematic information sharing ▸▸ Some provider buy-into collaboration and value placed on having needed information	▸▸ Organization leaders supportive but often co-location is viewed as a project or program ▸▸ Provider buy-in to making referrals work and appreciation of onsite availability	▸▸ Organization leaders support integration through mutual problem-solving of some system barriers ▸▸ More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components	▸▸ Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced ▸▸ Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers	▸▸ Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development ▸▸ Integrated care and all components embraced by all providers and active involvement in practice change
Key Differentiator: Business Model					
▸▸ Separate funding ▸▸ No sharing of resources ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share resources for single projects ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share facility expenses ▸▸ Separate billing practices	▸▸ Separate funding, but may share grants ▸▸ May share office expenses, staffing costs, or infrastructure ▸▸ Separate billing due to system barriers	▸▸ Blended funding based on contracts, grants or agreements ▸▸ Variety of ways to structure the sharing of all expenses ▸▸ Billing function combined or agreed upon process	▸▸ Integrated funding, based on multiple sources of revenue ▸▸ Resources shared and allocated across whole practice ▸▸ Billing maximized for integrated model and single billing structure

Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Advantages					
▸▸ Each practice can make timely and autonomous decisions about care ▸▸ Readily understood as a practice model by patients and providers	▸▸ Maintains each practice's basic operating structure, so change is not a disruptive factor ▸▸ Provides some coordination and information-sharing that is helpful to both patients and providers	▸▸ Colocation allows for more direct interaction and communication among professionals to impact patient care ▸▸ Referrals more successful due to proximity ▸▸ Opportunity to develop closer professional relationships	▸▸ Removal of some system barriers, like separate records, allows closer collaboration to occur ▸▸ Both behavioral health and medical providers can become more well-informed about what each can provide ▸▸ Patients are viewed as shared which facilitates more complete treatment plans	▸▸ High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans ▸▸ Provider flexibility increases as system issues and barriers are resolved ▸▸ Both provider and patient satisfaction may increase	▸▸ Opportunity to truly treat whole person ▸▸ All or almost all system barriers resolved, allowing providers to practice as high functioning team ▸▸ All patient needs addressed as they occur ▸▸ Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
▸▸ Services may overlap, be duplicated or even work against each other ▸▸ Important aspects of care may not be addressed or take a long time to be diagnosed	▸▸ Sharing of information may not be systematic enough to effect overall patient care ▸▸ No guarantee that information will change plan or strategy of each provider ▸▸ Referrals may fail due to barriers, leading to patient and provider frustration	▸▸ Proximity may not lead to greater collaboration, limiting value ▸▸ Effort is required to develop relationships ▸▸ Limited flexibility, if traditional roles are maintained	▸▸ System issues may limit collaboration ▸▸ Potential for tension and conflicting agendas among providers as practice boundaries loosen	▸▸ Practice changes may create lack of fit for some established providers ▸▸ Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	▸▸ Sustainability issues may stress the practice ▸▸ Few models at this level with enough experience to support value ▸▸ Outcome expectations not yet established

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BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITY SERVICES

Georgia Crisis & Access Line
1-800-715-4225
mygcal.com

Behavioral Health ??

- **Behavioral Health** refers to a **person's state of being** and how their **behaviors and choices affect their overall health and wellness.** Substance abuse and addictions of all kinds fall into the realm of behavioral health.

- **Behavioral health** is an umbrella term that refers to your overall wellbeing and how it is impacted by your behaviors. Because behavior is something that is generally seen as changeable, people suffering from behavioral health issues can be **empowered by knowing that their own choices can prevent, cure, or decrease symptoms** of a variety of behavioral health disorders. Behavioral health is just as complex as mental health, and the two terms are often used interchangeably.

- Many **mental health issues** may be impacted by behavior, many mental health disorders have **neurological or biological causes**, meaning that simply changing a person's behavior may not cure them of that illness. www.projectknow.com

Veterans Crisis Line
1-800-273-8255
PRESS 1

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

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What Is Mental Health?

- Mental health includes our emotional, psychological, and social well-being. Our mental health affects how we think, feel, and act.
- Over the course of our lives, if you experience mental health problems, your thinking, mood, and behavior could be affected. Many factors contribute to mental health problems, including:
  - Biological factors, such as genes or brain chemistry
  - Life experiences, such as trauma or abuse
  - Family history of mental health problems
- Mental health problems are common, treatment is available!

  www.mentalhealth.gov

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Addictive Disease

- According to the Substance Abuse and Mental Health Services Administration (SAMHSA), substance use disorders result from recurrent use of alcohol or drugs that causes clinically and functionally significant impairments.
- **Addiction treatment programs** can help people of all ages withdraw safely from the physical and psychological effects of drugs, learning to manage their substance use disorder.

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Intellectual/Development Disabilities

- **Intellectual disability** refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions.

- **Developmental disability** is a severe, long term disability that can affect cognitive ability, physical functioning, or both.

  nih.gov

Veterans Crisis Line
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mygcal.com

Recovery Focused Services

- Recovery is possible!
- This belief guides the approach to mental health, addiction treatment and developmental disability services.
- Services are centered on clients and focused on their recovery journeys! Helping them to achieve their goals, discover their strengths and identify what they need to make their recovery a reality.

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PRESS 1

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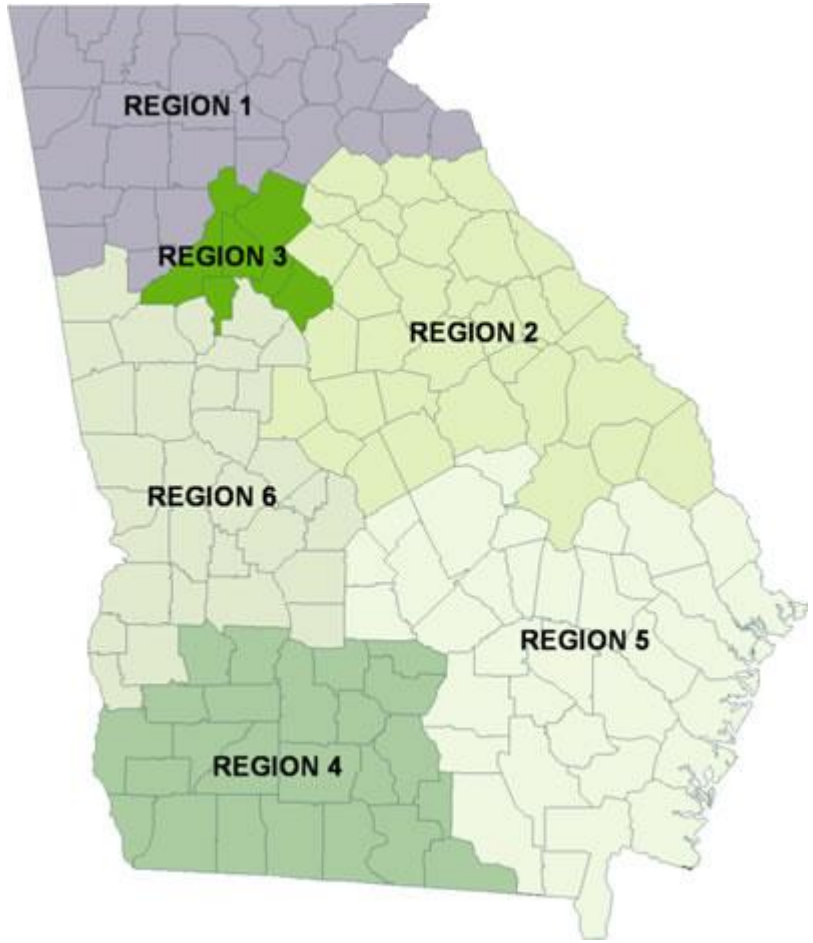
Georgia Department of Behavioral Health and Developmental Disability System of Care

Commissioner Judy Fitzgerald



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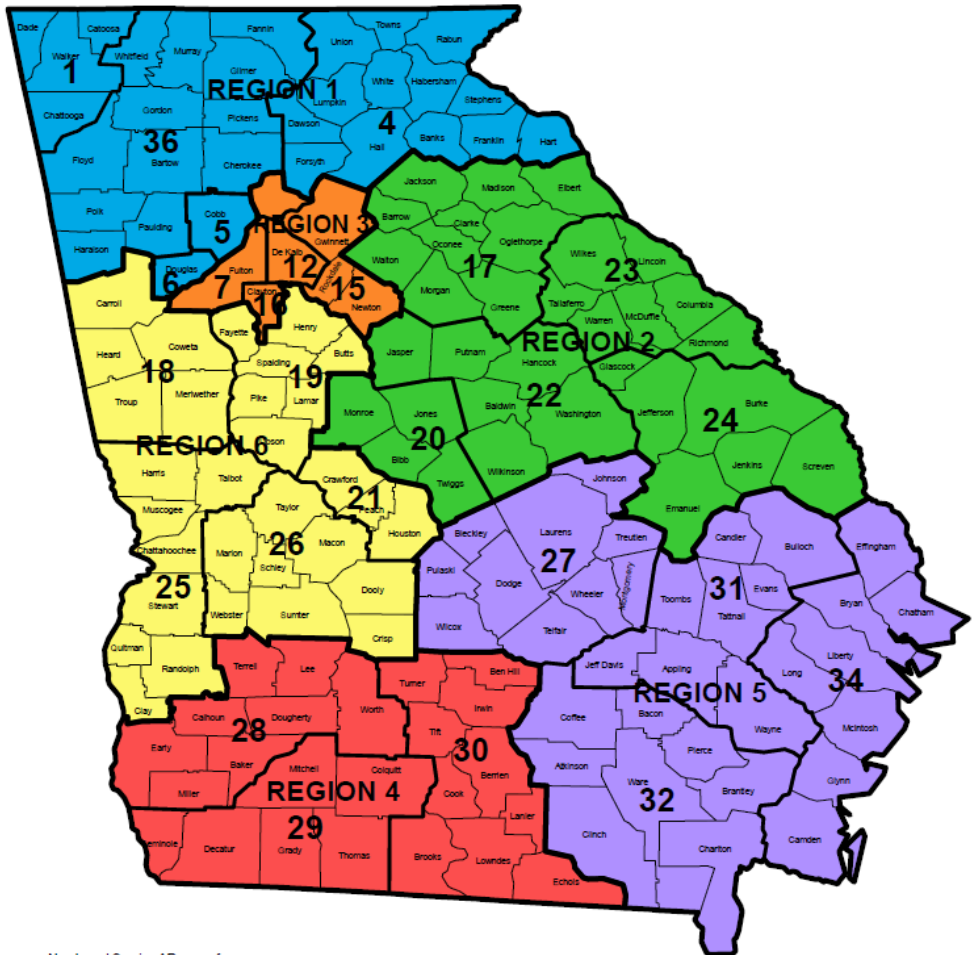
mygcal.com

If you or a loved one needs help dealing with a behavioral health crisis, the Georgia Crisis and Access Line (GCAL) offers free and confidential crisis intervention 24/7.

DBHDD

Georgia Department of Behavioral Health & Developmental Disabilities
Regional Map with Community Service Areas
Effective January 1, 2014



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BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITY SERVICES

Numbered Service ARes are for identification purposes only.

1 - Lookout Mountain Community Services
4 - Avita Community Partners
5 - Cobb Community Service Board
6 - Douglas Community Service Board
7 - Fulton County MHDDAD
12 - DeKalb Community Service Board
15 - View Point Health
16 - Clayton Community Service Board
17 - Advantage Behavioral Health Systems
18 - Pathways Center for BH and & Developmental Growth
19 - McIntosh Trail Community Service Board
20 - River Edge Behavioral Health Center
21 - Phoenix Center Behavioral Health Services
22 - Oconee Community Service Board
23 - Serenity Behavioral Health (CSB of East Central Ga)
24 - Ogeechee Behavioral Health Services
25 - New Horizons Community Service Board
26 - Middle Flint Behavioral Healthcare
27 - Community Service Board of Middle Georgia
28 - Aspire BH & DD Services (formerly Albany CSB)
29 - Georgia Pines Community MHMRSA Services
30 - Behavioral Health Services of South Georgia
31 - Pineland Area Community Service Board
32 - Unison Behavioral Health (formerly Satilla CSB)
34 - Gateway Community Service Board
36 - Highland Rivers Community Service Board

DBHDD, Office of Decision Support (rev. 2/1/2017)

GEORGIA ASSOCIATION of Community Service Boards, Inc.

- Georgia's Community Services Boards are the pre-eminent providers for children, youth and adults with serious mental illness, developmental disabilities, and addictive diseases. Recent surveys * indicate that:

- - Nearly two million Georgians suffered from mental illness and / or addictive disease in the past year
- - Over 320,000 experienced a serious mental illness in the past year
- - There are over 145,000 adults in Georgia with intellectual / developmental disability
- Of the SMI, the Community Service Boards served over 175,000 with high quality, cost effective care to Georgia's most vulnerable population.
- To learn more about the vital contributions of Georgia's Community Service Boards to help persons with these disabilities go to: www.gacsb.org
- *US Department of Health and Human Services and Bethesda Institute

VISION

Leading our communities toward

Health, Hope & Recovery!

MISSION STATEMENT

To offer Affordable, Accessible, and Quality Mental Health, Addictive Disease and Developmental Disability services by skilled professionals who are sensitive to the needs of individuals and families served.

Aspire Behavioral Health & Developmental Disability Services

Service Area

- Behavioral Health, Addictive Disease, and Developmental Disability Services
- Community Support Team (CST)
- Assertive Community Treatment Team (ACT)
- Treatment Court Services
- LIGHT – Early Treatment Program
- Child & Adolescent Clubhouses
- Developmental Disability Service Centers

8,182 Square Mile Service Area

Poverty Rate: 24.6% SW GA | 16.5% GA | 14.7% Entire US | 17.2% Rural US

ASPIRE – 2016 Out Patient Behavioral Health Services - SPMI

Unduplicated MH/AD Adult Clients	Unduplicated Child & Adolescent MH/AD Client	Total Unduplicated MH/AD Clients
5001	992	5993

- ASPIRE – 2017 Out Patient Behavioral Health Services - SPMI

Organization	Unduplicated Adult MH/AD Clients Served	Unduplicated Child & Adolescent MH/AD Clients Served	Total Unduplicated DD Clients Served
Aspire	6985	932	211

Community Collaborations

Collaborations with primary care providers and hospitals

Collaborations with schools

DFACS

Behavioral Health Coalition

Homeless Coalition

Community Conversations

Do Co Coroner's Office – Suicide Prevention

Council on Aging

Albany Transition Center/Daily Reporting Centers

Universities/colleges w/ internship opportunities for RNs, SW, LPCs, LPNs, etc.

Numerous local, state and national advocacy groups

Building Community Partnerships
Educating Community and Stakeholders

- Accountability Court Partnerships
- CIT Trainings in partnership with NAMI since 2004
- Law Enforcement/First Responders
- Jail Partnerships
- State of GA Community Supervision
- Homeless Coalition
- Community Coalitions

Children / Adolescents – At Risk Population

- Children who have not developed social/emotional skills by the time they enter school are at a disadvantage.
  Students with poor social skills are more likely to:
  experience difficulties in interpersonal relationships with teachers and peers; show signs of depression, aggression, or anxiety; demonstrate poor academic performance; and have a higher incidence of involvement in the criminal justice system as adults.

- Approximately 50 percent of students age 14 and older with a mental illness drop out of high school.
  This is the highest dropout rate of any disability group.

- Without adequate treatment, young adults in college with a mental illness are more likely to receive lower GPAs, drop out of college, or be unemployed than their peers who do not have a mental health challenge.

- 31% of college students have found it difficult to function due to depression in the past year,
  while more than 50 % have felt overwhelming anxiety, making it hard to succeed academically.

Behavioral Health is a Public Health Challenge!

- In Georgia, over 2.3 million face the challenge of living with mental illness; 1 in 3 will receive treatment.
  1 out of 4 adults will experience at least one behavioral health illness in their lifetime!
- In U.S. death by suicide happens every 16 minutes
- In Georgia, suicide is the 11th leading cause of death
- In U.S. 22.1 million with substance abuse and 17.9 million with alcohol dependence or abuse
- 41% of Georgians with addictive diseases report needing treatment but are not receiving
- One out of every 10 families are affected by intellectual disabilities
- 111,000 children in Georgia live with serious mental illness.
- Adults with a co-occurring ICD-9 mental health disorder (in addition to substance dependence) was 48% for 50- to 64-year-olds and 61% for those aged 65 and over.
- Opioid epidemic – increasing demand for addiction services – especially with elderly
- Robust Accountability Court services
- **Strong referral system to BH continuum of care for Individuals returning to community**

Severe and Persistent Mental Ill (SPMI) Morbidity and Mortality in People With Serious Mental Illness

National Association of State Mental Health Program Directors (NASMHPD) 2006 Report

- Individuals with Serious Mental Illness are dying approximately 25 years earlier than the general population **due to medical conditions**
  - **Average age of death is 53**
- *Substance Use Disorders and the Person-Centered Healthcare Home*, a 2010 report by Barbara Mauer, finds that those with co-occurring mental illness and substance use disorders were at greatest risk
  - **Average age of death is 45**

Severe and Persistent Mental Ill (SPMI) Morbidity and Mortality in People With Serious Mental Illness

National Association of State Mental Health Program Directors (NASMHPD) 2006 Report

- 60% of premature deaths are due to preventable medical conditions:
  - Metabolic and Cardiovascular Disease
  - Diabetes
  - Respiratory Disease
  - Infectious Disease
  - Cancer
  - Obesity

- Example: recent Johns Hopkins Medicine studies published
  - July 2012 *Psychiatric Services:* SMI are 2.6 times more likely to develop cancer
  - July 2012 *Injury Prevention*: SMI are nearly twice as likely to end up in ER suffering from an injury and 4.5 times more likely to die from their injuries.

Perceptions of Violence and Mental Illness

Criminal Justice Involvement

There are high rates of mental illnesses and substance abuse problems among people in the criminal justice system.

Approximately 70 % of jail inmates with mental illnesses are incarcerated for non-violent offenses.

56 % of state prisoners, 45 % of federal prisoners, and 64 % of jail inmates report a behavioral health diagnosis.

Sixty-seven to seventy % of youth in the juvenile justice system have a diagnosable mental disorder.

Individuals with mental illnesses only commit three to five % of violent acts every year.

People with mental illnesses are much more likely to be victims of crime than perpetrators.

Georgia Department of Corrections/Juvenile Justice

- 1 in 4 Georgians affected by MI (Mental Illness)
- 33-75% jail population with mental illness or addiction related offenses
- 15-16% GDC inmates with MI
- 75% of YDC population with MI or SED
- Georgia home to 4 of 50 largest US jails
  - DeKalb County, #30 (ADP – 3,117)
  - Fulton County, #32 (ADP – 2,970)
  - Gwinnet County, #36 (ADP – 2,716)
  - Cobb County, #42 (ADP – 2,510)

*ADP=Average Daily Population

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Behavioral Health Needs of a Community

<u>Early intervention- key to recovery</u>

- Easy access to services
- Affordable services
- Evidence based treatment – team approach
- Community based services (out of clinic)
- Stakeholder collaboration
- Positive outcomes

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Behavioral Health Recovery is built on:

Appropriate Level of Care with appropriate community support services.

Health—overcoming or managing one's disease(s) or symptoms – including abstinence if one has an addiction – and making informed, healthy choices that support physical and emotional wellbeing.

Home—a stable and safe place to live.

Purpose—meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society.

Community—relationships and social networks that provide support, friendship, love, and hope.

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BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITY SERVICES

Partnership Benefits

- Maximize available resources
- Capitalize on Expertise
- Collaborative Case Coordination to enhance recovery focused services
- Healthy and Safe Families and Communities

Helping one, changing all!

Behavioral Health Provider Challenges

- Stigma
- Confidentiality
- Limited awareness of mental health/substance abuse symptoms and treatment
- Isolation/Transportation
- Ability to pay for service- uninsured; Inability to pay for premiums and/or deductibles
- Homelessness
- Competent behavioral health workforce
- Behavioral Health Workforce shortage
- Co-occurring - complex cases – BH case management needs
- Employment support services

<u>Collaboration/Partnerships Matter</u>

Community/Agency Challenges
Access to Support, Services, Treatment and Stigma

- Not only can the attitudes and beliefs of the individual / Family in need prevent a person from seeking treatment, although research tells us that treatment is effective and people do recover.
- Health Profession, First Responders, community agencies - attitudes and beliefs are important!
- Only 38 percent of adults with diagnosable mental health conditions get treatment.
- Less than one in five adolescents get treatment for diagnosable mental health conditions.

Paying for Behavioral Health Care

Lack of ability to afford care is among the top reasons that people with unmet behavioral health needs do not seek treatment.

People with mental health and substance abuse problems have historically had high rates of being uninsured.

Mental health and substance abuse treatment spending has depended more on public payers than all health care, with public payers— such as Medicaid—accounting for approximately 60 percent of mental health spending.

Significant challenge in Southwest Georgia is the high rate of un-insured individuals.

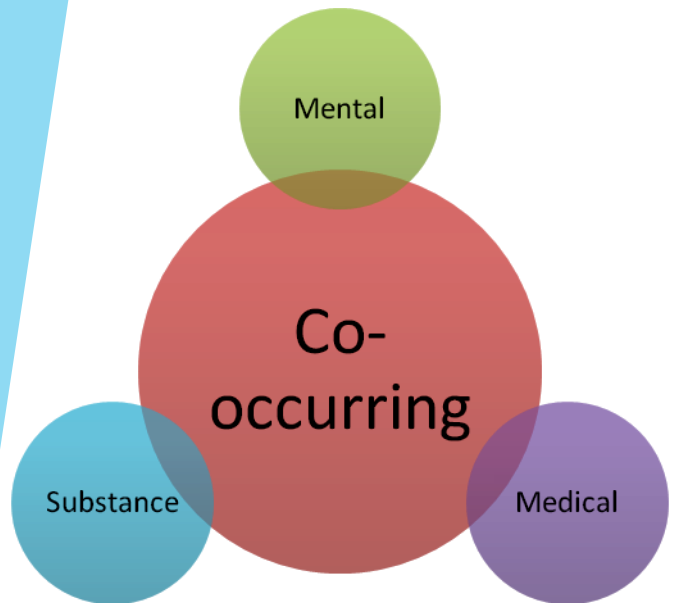
Georgia Health News states:

- "A map of exchange enrollment in GA in 2014 shows generally low participation rates in rural South Georgia, even though these counties have high percentages of uninsured residents."
- "For the current year, Southwest GA in particular had high premiums compared with other Georgia regions. In fact, it had among the highest premiums in the nation."

As a safety net provider in the DBHDD System of Care our agency - Aspire provides services for a large population that met BH service criteria and have no means to pay – utilizing FFS reimbursement thru DBHDD.

An integrated health and substance use disorder treatment system requires a diverse workforce…

- That includes, mental health counselors, physicians, nurses, mental health treatment providers, care managers, and recovery specialists.
- However, Medicare, restricts “billable” health care professionals to physicians (including psychiatrists), nurse practitioners and clinical nurse specialists, physician’s assistants, clinical psychologists, clinical social workers, and certain other specified practitioners.
- Medicare does not include as billable mental health counselors who are trained to provide services for substance use disorders.
- A 2015 *American Journal of Alcohol and Drug Abuse* article reports that rural substance abuse treatment centers, compared to urban centers, had a lower proportion of mental health clinicians.



Challenge of Behavioral Health Services

Examples of Co-occurring Disorders

- Mental disorders and medical disorders
- Mental disorders and substance use disorders
- Multiple mental disorders

Co-occurring Disorders

Risk factors for co-occurring mental disorders and substance use disorders include:

Difficulty in school, relationship, employment, community

History of trauma/loss

Legal history

Homelessness

Family history of substance use or mental illness

Examples of consequences include:

Not sticking with treatment

Problems with family

Frequent use of emergency rooms or acute care clinics

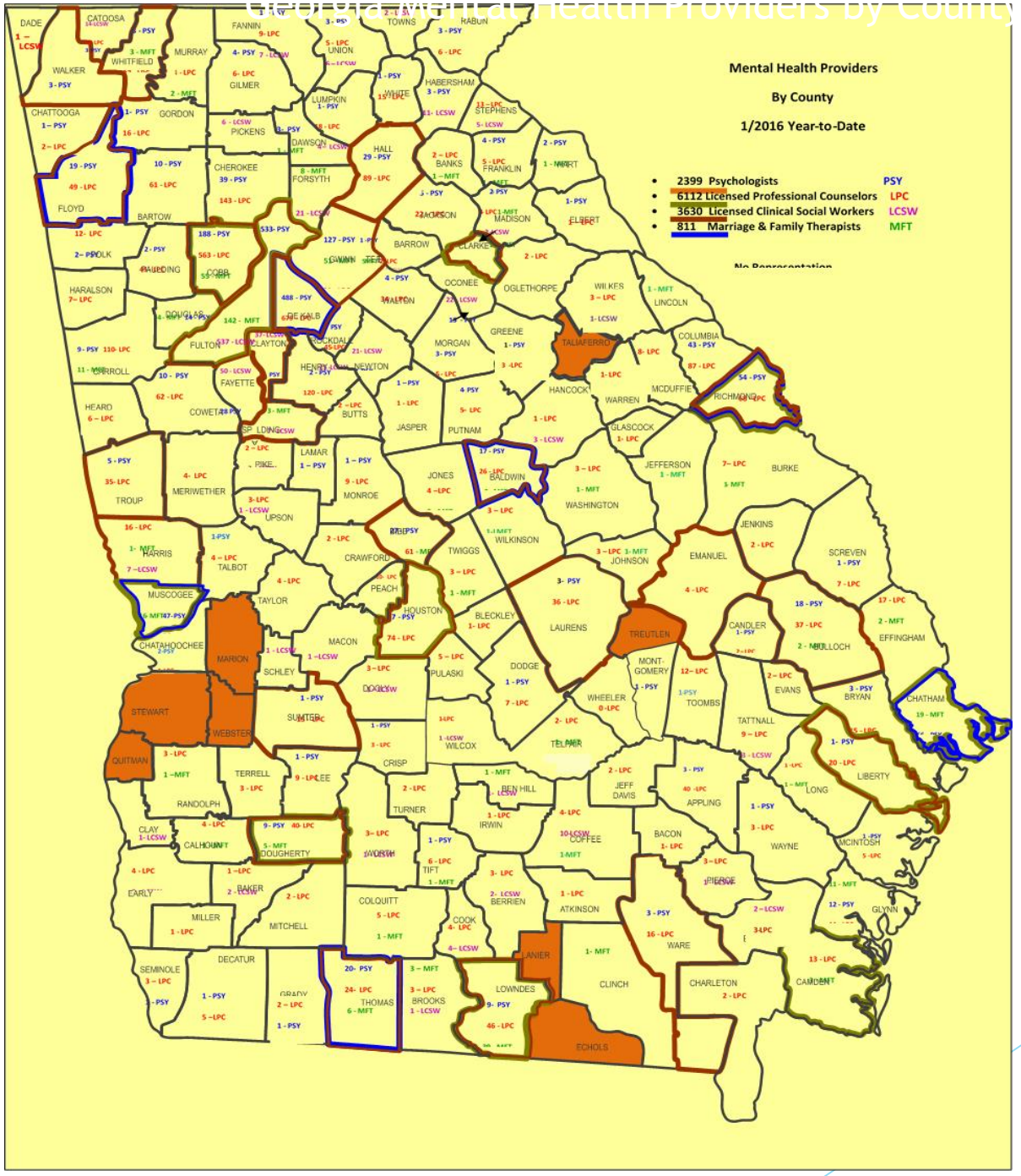
Behavioral Health Professional Workforce Shortage

- Uneven geographic distribution
- Recruitment challenges across the treatment field
- Fragmented system of provider silos that compete for limited workforce

Competent Behavioral Health Workforce:

- Community Support Staff
- PEERS/CARES/CPS credentialed staff
- Licensed Clinical Staff (LPC, LCSW, LMFT)
- LPNs, RNs, NPs, APRNs, PAs
- Primary Care Doctors, Psychiatrist

Georgia Mental Health Providers By County



What are your BH Challenges?
What are your solutions?

- Can you provide BH services with out collaborating with a BH provider?
- Can you provide BH community support services needed to promote long term recovery?
- Can you access BH funding that is available to CSB providers?

  (FFS/Specialty service funding)

NEEDS of SWGA:

- Easy access to BH services - Integration of behavioral health and primary care services.
- Case management services provided to coordinate bh/pc needs of individuals served.
- Access to child and adolescent services to increase school attendance, improvement in grades, decrease disruptive behaviors and law enforcement involvement.
- Access extended hours for behavioral health services to include early intervention, crisis behavioral health services, on-going community support services, group, individual, nurse and doctor services. Serve Calhoun, Baker, eastern Early, Southern Clay, Miller and Randolph and Terrell counties.
- Access to out-patient SA services.
- Access to shared Competent Behavioral Health Workforce
- Expansion of Touchstone Residential Recovery to male/female specific units with a recovery focused environment.

OUTCOMES To Consider

With easy access to services, competent BH staff, appropriate treatment and community support services:

- **Improvement in care coordination between medical office/hospital/BH staff**
- **Improvement in Treatment/Medication compliance**
- **Stabilization of co-occurring medical/behavioral health concerns**
- **Behavioral challenges decrease, school absence and suspension decrease**
- **Emergency room visits, hospital stays, and periods of incarceration reduced.**
- **High-risk and harmful substance use is decreased.**
- **Employment opportunities for staff and individuals served**

Behavioral Health ER Visits in SWGA January to July 2015

Hospital	CO Population	ER visits	C/A	Early Adult	Adult	Admissions	Insurance	Cost
Miller County	5,958	53 (40 ind)	8	3 (early 20s)	31	3	75%	227,164
Early County	10,491	93	14	5	54	5	75 %	397,537
Randolph	7,313	73	10	4	38	4	75 %	279,412

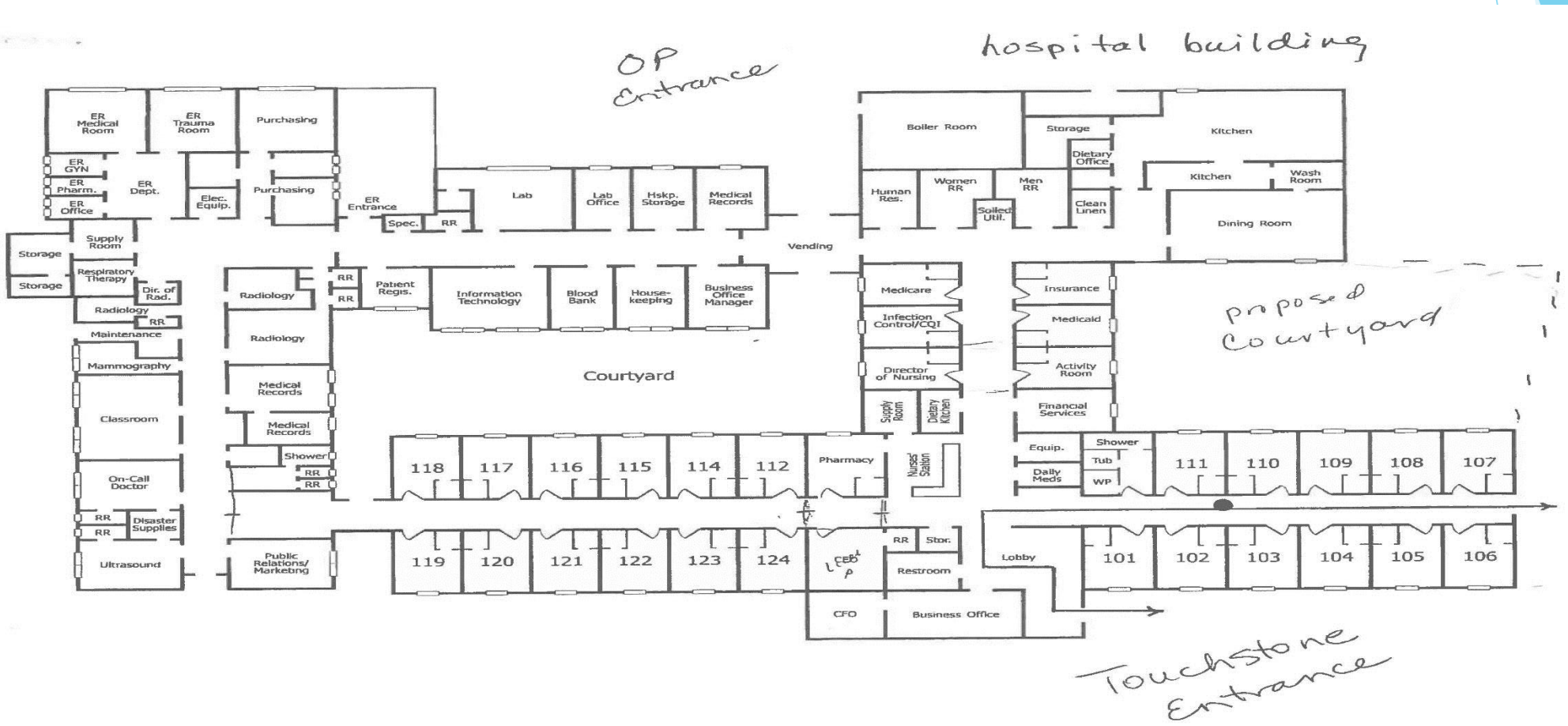
Miller County Behavioral Health Expansion

- Outpatient Behavioral Health Services offered close proximity to medical clinic and hospital.
- Expansion of wide array of outpatient behavioral health services
- Referrals, case management and outcomes
- Community supportive services to participants to insure engagement with services

Need: LongTerm Residential Recovery Treatment in SWGA

Recently closed Calhoun County Hospital (2013) was a 25 bed hospital. The hospital 70+ staff continue to live in a 30 mile radius of this facility. Facility repurposed to 12 month Long term residential treatment facility with 54 FTEs and growing.

Arlington Hospital



Touchstone Residential Recovery

- **Aspire's** 12 bed male intensive residential recovery program relocated to this facility.
- 28 beds are located on separate wings (N/S). This unit is easily separated and secured from other units housed in the building. ASPIRE's Touchstone Program for long-term SA recovery would be transitioned to this space.
- Hospital building provides a recovery focused environment with expanded green space, privacy and activity areas.
- The present 14 bed Touchstone program (male only) will be expanded to additional 14 female residents. Transitional beds will be available.
- 14 beds are presently DBHDD funded. Requesting additional funding from DBHDD for 14 beds. Additional beds will be available for other payor sources.
- As research supports, longer length of stay would extend treatment, provide stability and support recovery skill building as well as provide support with transitions of employment, housing and family restoration.

Aspire – Calhoun Behavioral Health Services

- Outpatient Behavioral Health Services will be offered on back hallway of building. Back entry way will have benches and trees/plants planted in large containers.
- Outpatient BH Service Staff will provide services in surrounding counties.

FTE – 46/54(new jobs)

Touchstone – **18** (techs, LPN, .25 RN, .25 Dr, licensed BH staff)
contract staff for woodworking, art, horticulture, landscaping, pottery (**2**)

Outpatient – **8** (community support, LPN, .75, .25 Dr, licensed BH staff)

CM Collaboration with MCH – **5** case managers

Administrative support staff (clerical, billing, UM) **5**

Support Services: Food Service, Housekeeping, Janitorial, Security, Transportation, yard maintenance – **10**

Additional Aspire administrative staff maybe transitioned to this site. (6)

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Aspire Miller BH Clinic FY 2017 – FY 2018

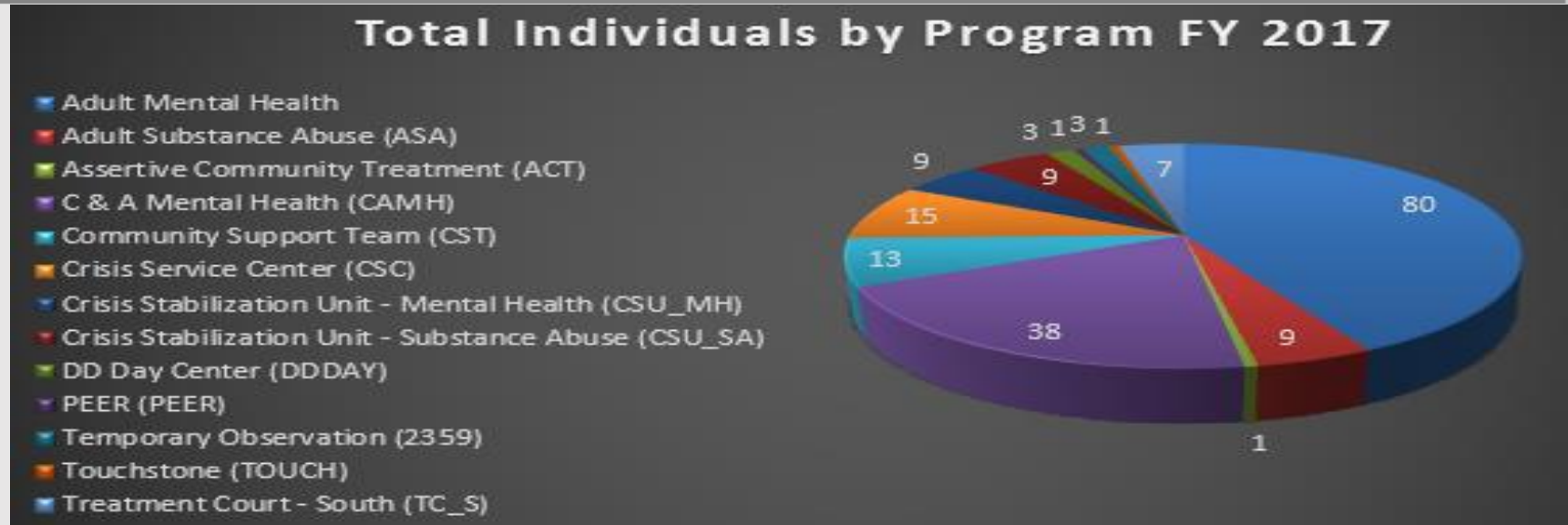
FY 2017 NUMBER OF INDIVIDUALS | FY 2018 NUMBER OF INDIVIDUALS | FY 2017 TOTAL APPOINTMENTS | FY 2018 TOTAL APPOINTMENTS

Total Individuals by Program FY 2017

Program	Total Individuals
Adult Mental Health	80
Adult Substance Abuse (ASA)	9
Assertive Community Treatment (ACT)	1
C & A Mental Health (CAMH)	38
Community Support Team (CST)	13
Crisis Service Center (CSC)	15
Crisis Stabilization Unit - Mental Health (CSU_MH)	9
Crisis Stabilization Unit - Substance Abuse (CSU_SA)	9
DD Day Center (DDDAY)	3
PEER (PEER)	1
Temporary Observation (2359)	3
Touchstone (TOUCH)	1
Treatment Court - South (TC_S)	7
	189

Total Appointments by Status FY 2017

Appointment Status	Total Appointments
Kept	12373
CBT	141
CBC	772
DNS	1663
	14949



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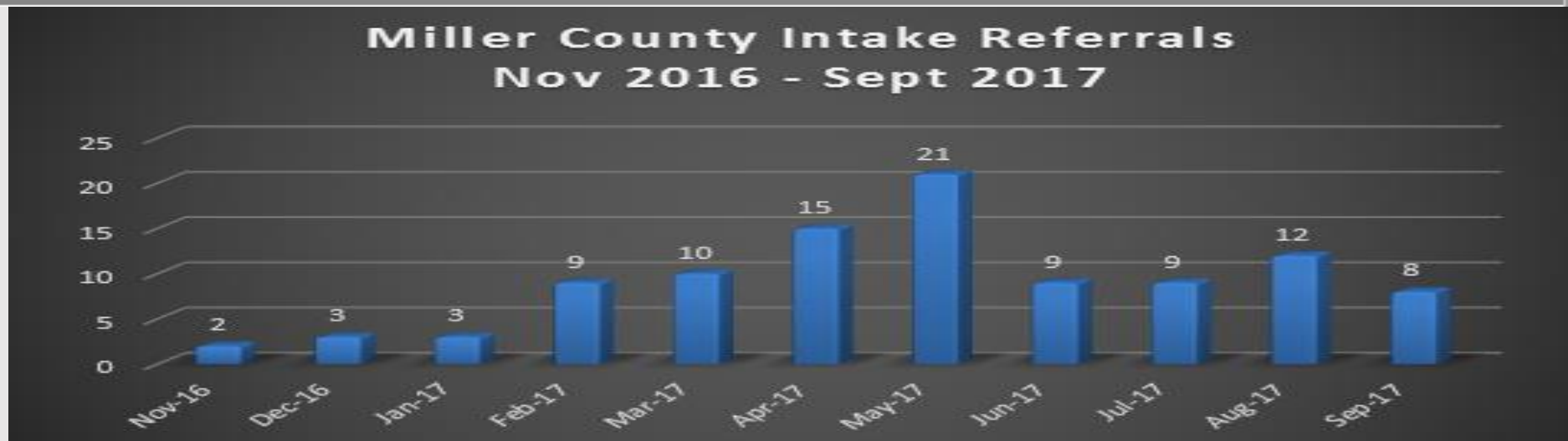
Aspire Miller BH Clinic FY 2017-FY 2018

INTAKE REFERRALS NOVEMBER 2016 – SEPTEMBER 2017

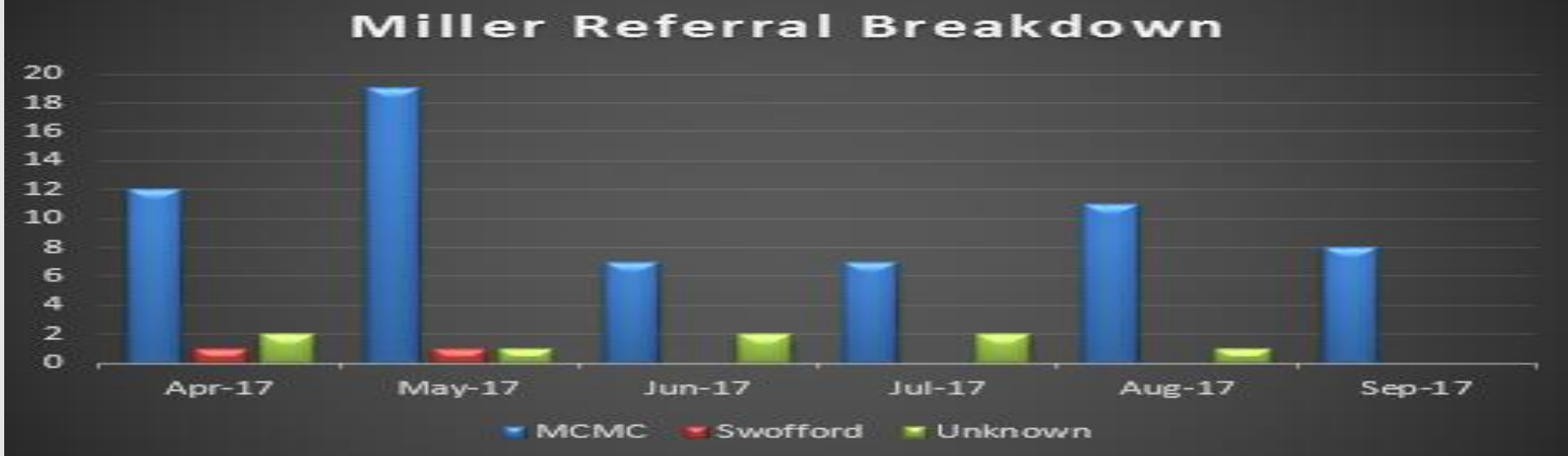
Intake Referrals Nov 2016 – Sept 2017

Date	Intake Referrals
Nov-16	2
Dec-16	3
Jan-17	3
Feb-17	9
Mar-17	10
Apr-17	15
May-17	21
Jun-17	9
Jul-17	9
Aug-17	12
Sep-17	8
	101



Miller Intake Referral Breakdown

Date	MCMC	Swofford	Unknown
Apr-17	12	1	2
May-17	19	1	1
Jun-17	7	0	2
Jul-17	7	0	2
Aug-17	11	0	1
Sep-17	8	0	0

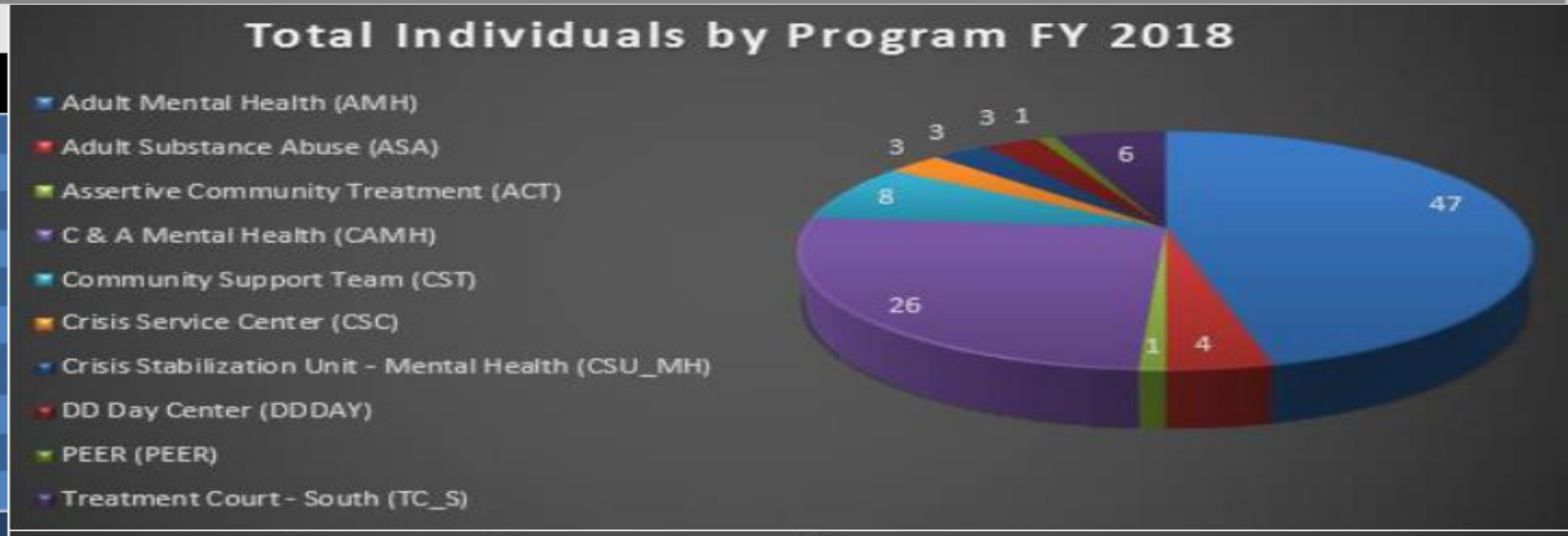


Aspire Miller BH Clinic FY 2017 – FY 2018

FY 2017 NUMBER OF INDIVIDUALS | FY 2018 NUMBER OF INDIVIDUALS | FY 2017 TOTAL APPOINTMENTS | FY 2018 TOTAL APPOINTMENTS

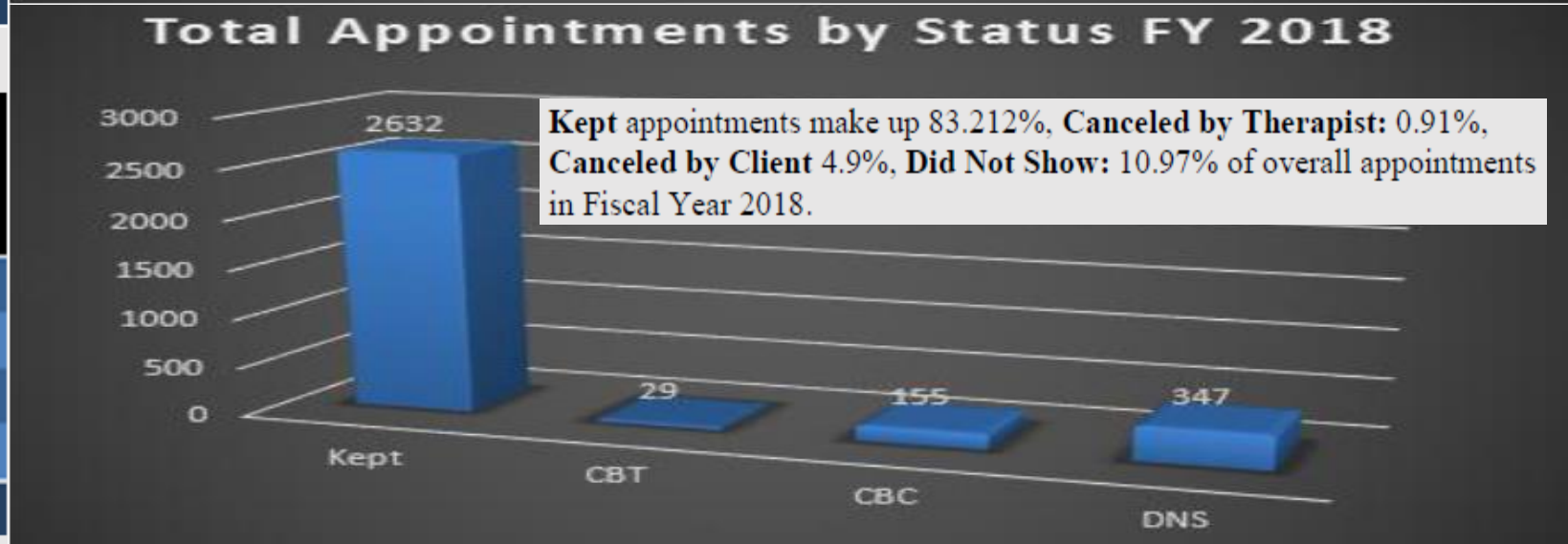
Total Individuals by Program FY 2018

Program	Total Individuals
Adult Mental Health (AMH)	47
Adult Substance Abuse (ASA)	4
Assertive Community Treatment (ACT)	1
C & A Mental Health (CAMH)	26
Community Support Team (CST)	8
Crisis Service Center (CSC)	3
Crisis Stabilization Unit - Mental Health (CSU_MH)	3
DD Day Center (DDDAY)	3
PEER (PEER)	1
Treatment Court - South (TC_S)	6
	102



Total Appointments by Status FY 2018

Appointment Status	Total Appointments
Kept	2632
CBT	29
CBC	155
DNS	347
	3163



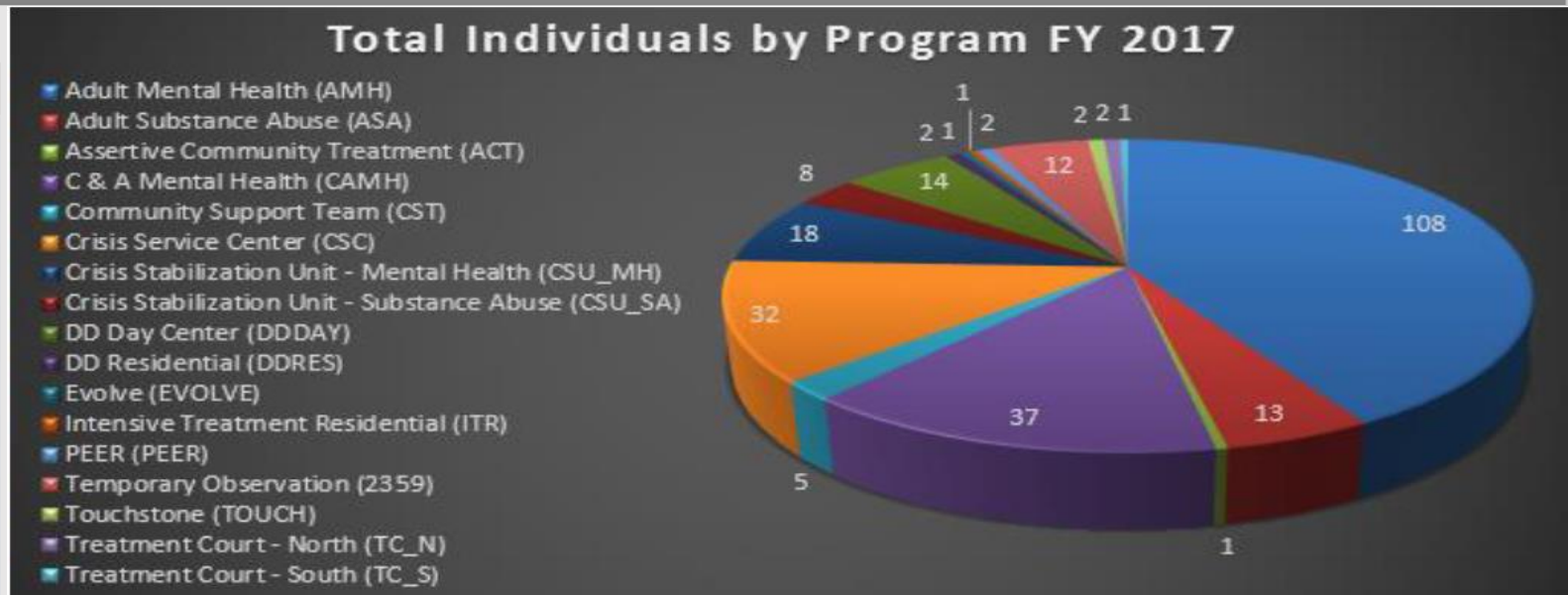
Kept appointments make up 83.212%, **Canceled by Therapist:** 0.91%, **Canceled by Client** 4.9%, **Did Not Show:** 10.97% of overall appointments in Fiscal Year 2018.

Aspire Calhoun BH Clinic FY 2017 – FY 2018

FY 2017 NUMBER OF INDIVIDUALS | FY 2018 NUMBER OF INDIVIDUALS | FY 2017 TOTAL APPOINTMENTS | FY 2018 TOTAL APPOINTMENTS

Total Individuals by Program FY 2017

Program	Total Individuals
Adult Mental Health (AMH)	108
Adult Substance Abuse (ASA)	13
Assertive Community Treatment (ACT)	1
C & A Mental Health (CAMH)	37
Community Support Team (CST)	5
Crisis Service Center (CSC)	32
Crisis Stabilization Unit - Mental Health (CSU_MH)	18
Crisis Stabilization Unit - Substance Abuse (CSU_SA)	8
DD Day Center (DDDAY)	14
DD Residential (DDRES)	2
Evolve (EVOLVE)	1
Intensive Treatment Residential (ITR)	1
PEER (PEER)	2
Temporary Observation (2359)	12
Touchstone (TOUCH)	2
Treatment Court - North (TC_N)	2
Treatment Court - South (TC_S)	1
	259



Total Appointments by Status FY 2017

Appointment Status	Total Appointments
Kept	17182
CBT	159
CBC	548
DNS	1837
	19726

Kept appointments make up 87.1033%, Canceled by Therapist: 0.806%, Canceled by Client: 2.778%, Did Not Show: 9.3126% of overall appointments for FY 2017.

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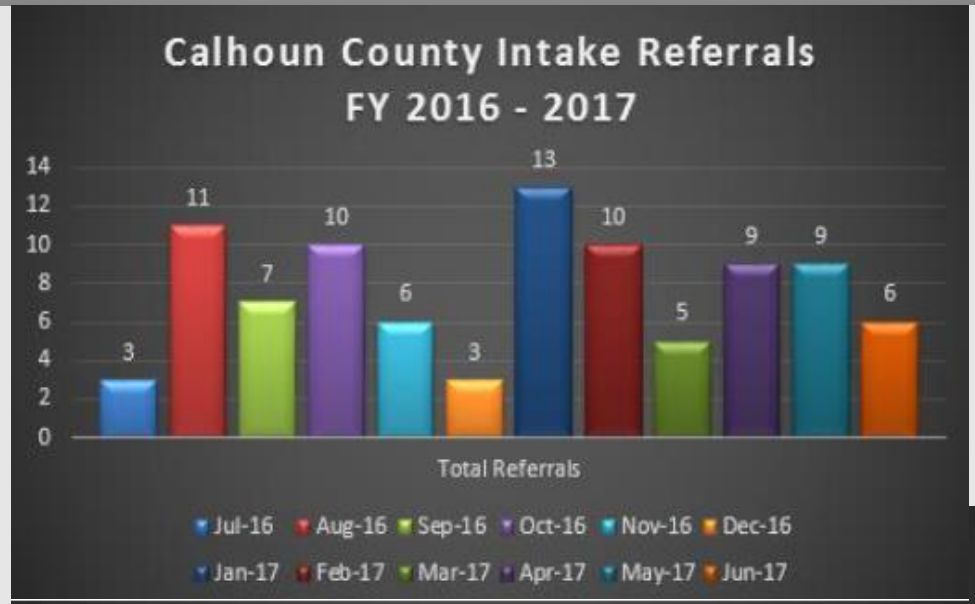
Aspire Calhoun BH Clinic FY 2017-FY 2018 Intake Referrals

INTAKE REFERRALS FY 2016 – 2017 | INTAKE REFERRALS FY 2017 – 2018

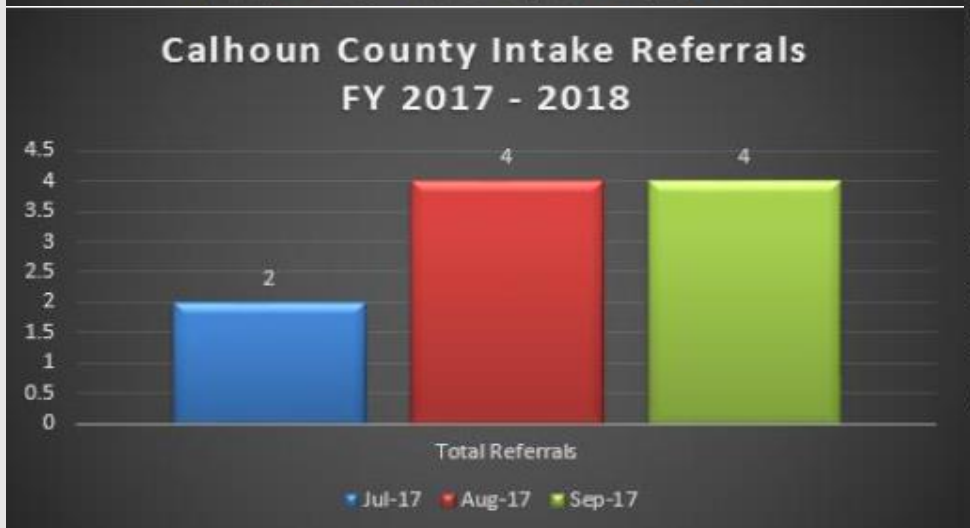
Intake Referrals FY 2016 - 2017

Date	Total Referrals
Jul-16	3
Aug-16	11
Sep-16	7
Oct-16	10
Nov-16	6
Dec-16	3
Jan-17	13
Feb-17	10
Mar-17	5
Apr-17	9
May-17	9
Jun-17	6



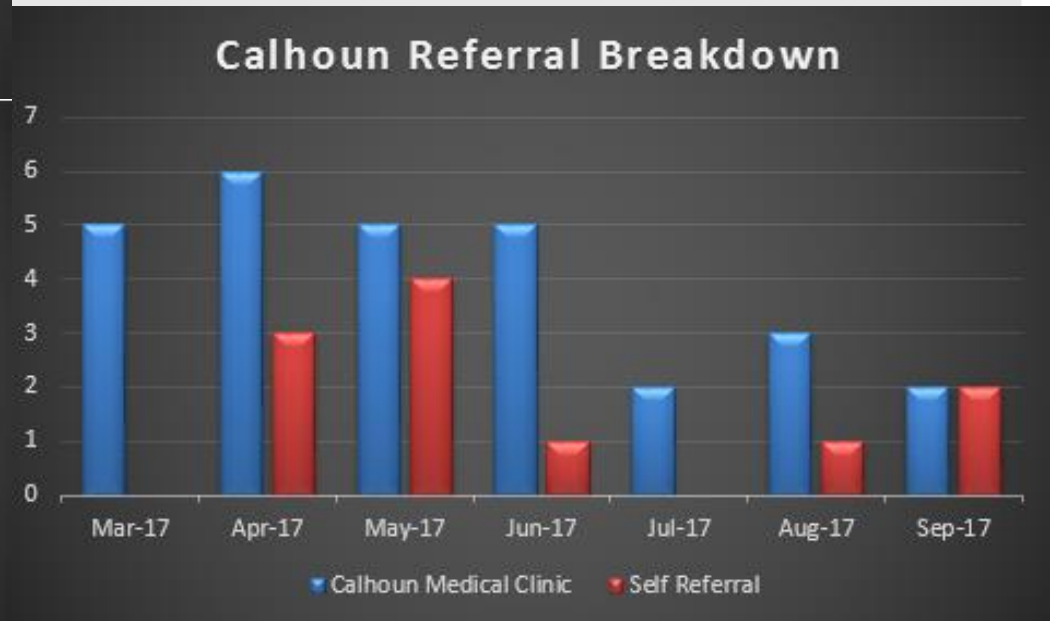
Intake Referrals FY 2017 - 2018

Date	Total Referrals
Jul-17	2
Aug-17	4
Sep-17	4



Calhoun Referral Breakdown

Date	Calhoun Medical Clinic	Self Referral
Mar-17	5	0
Apr-17	6	3
May-17	5	4
Jun-17	5	1
Jul-17	2	0
Aug-17	3	1
Sep-17	2	2



Aspire Calhoun BH Clinic FY 2017 – FY 2018

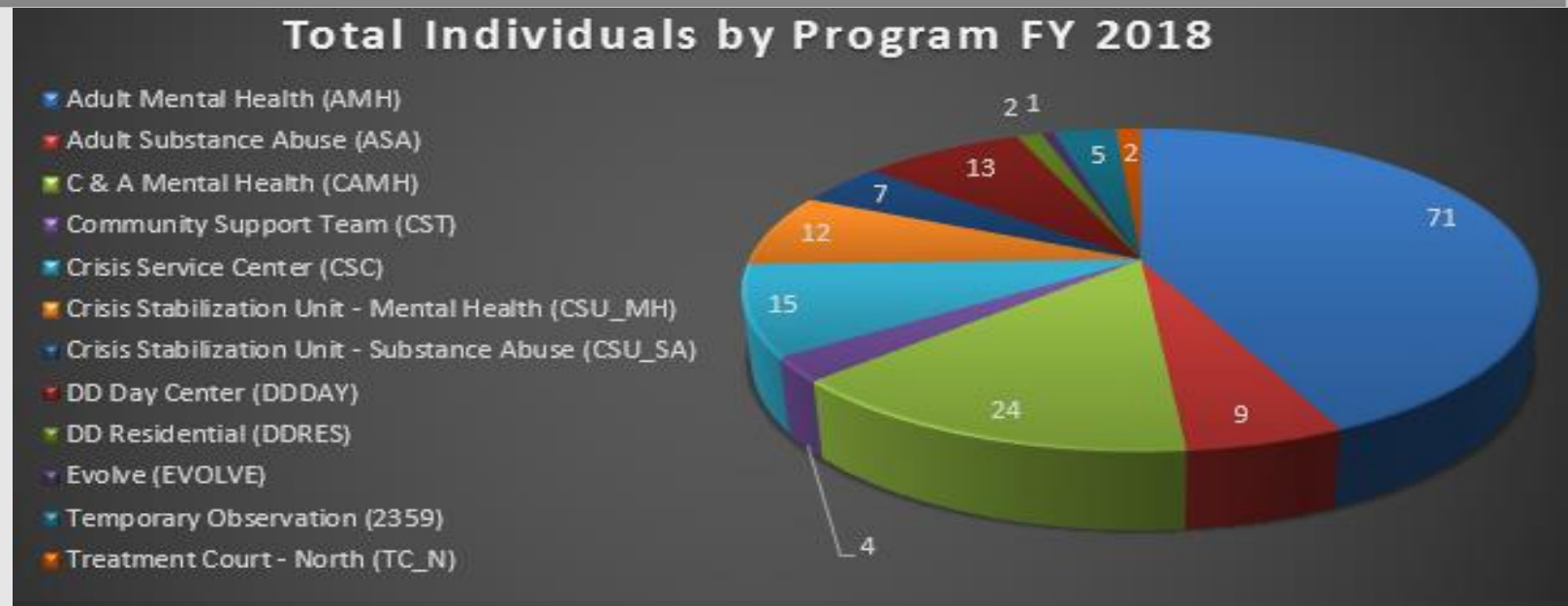
FY 2017 NUMBER OF INDIVIDUALS | FY 2018 NUMBER OF INDIVIDUALS | FY 2017 TOTAL APPOINTMENTS | FY 2018 TOTAL APPOINTMENTS

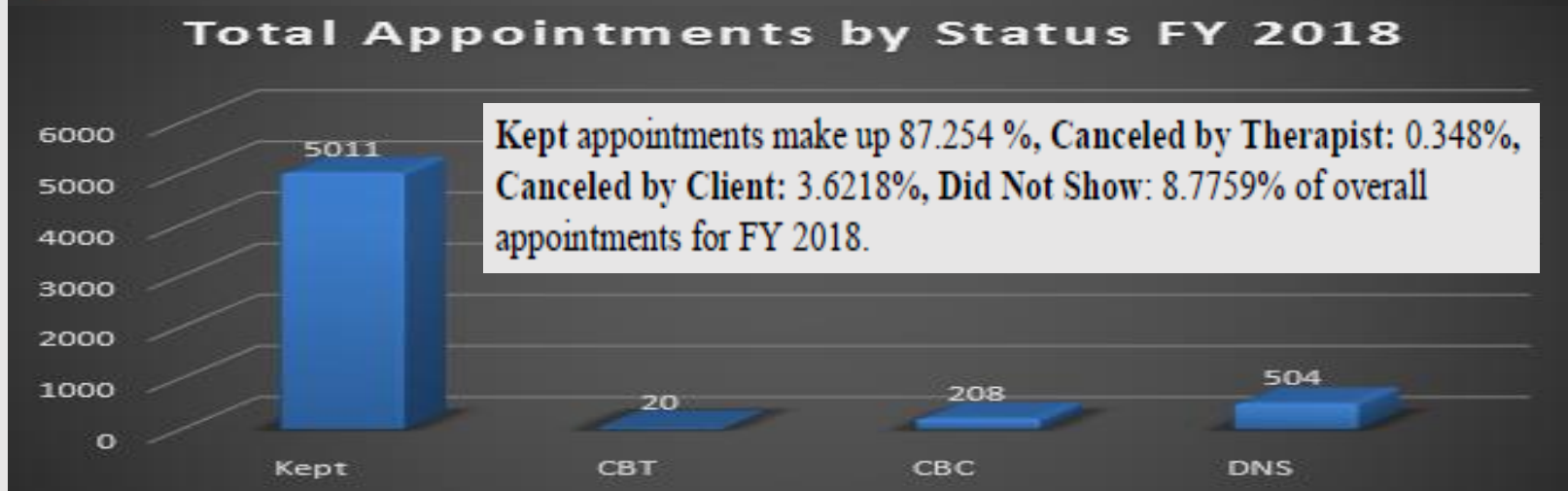
Total Individuals by Program FY 2018

Program	Total Individuals
Adult Mental Health (AMH)	71
Adult Substance Abuse (ASA)	9
C & A Mental Health (CAMH)	24
Community Support Team (CST)	4
Crisis Service Center (CSC)	15
Crisis Stabilization Unit - Mental Health (CSU_MH)	12
Crisis Stabilization Unit - Substance Abuse (CSU_SA)	7
DD Day Center (DDDAY)	13
DD Residential (DDRES)	2
Evolve (EVOLVE)	1
Temporary Observation (2359)	5
Treatment Court - North (TC_N)	2
	165

Total Appointments by Status FY 2018

Appointment Status	Total Appointments
Kept	5011
CBT	20
CBC	208
DNS	504
	5743





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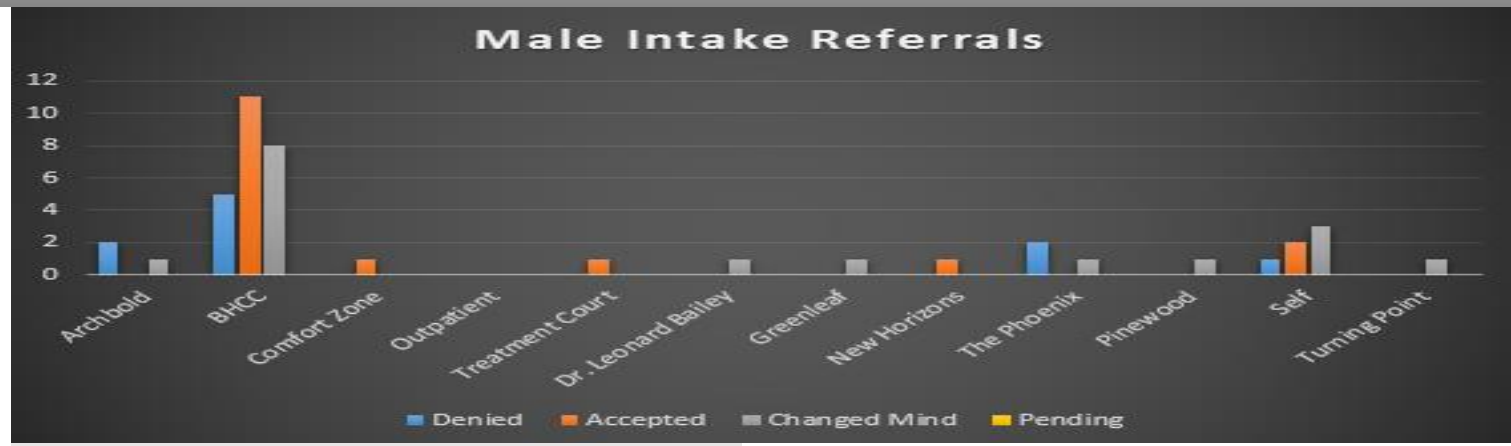
Touchstone Census / Intake Referrals

FEMALE INTAKE REFERRALS | MALE INTAKE REFERRALS

Male Intake Referrals

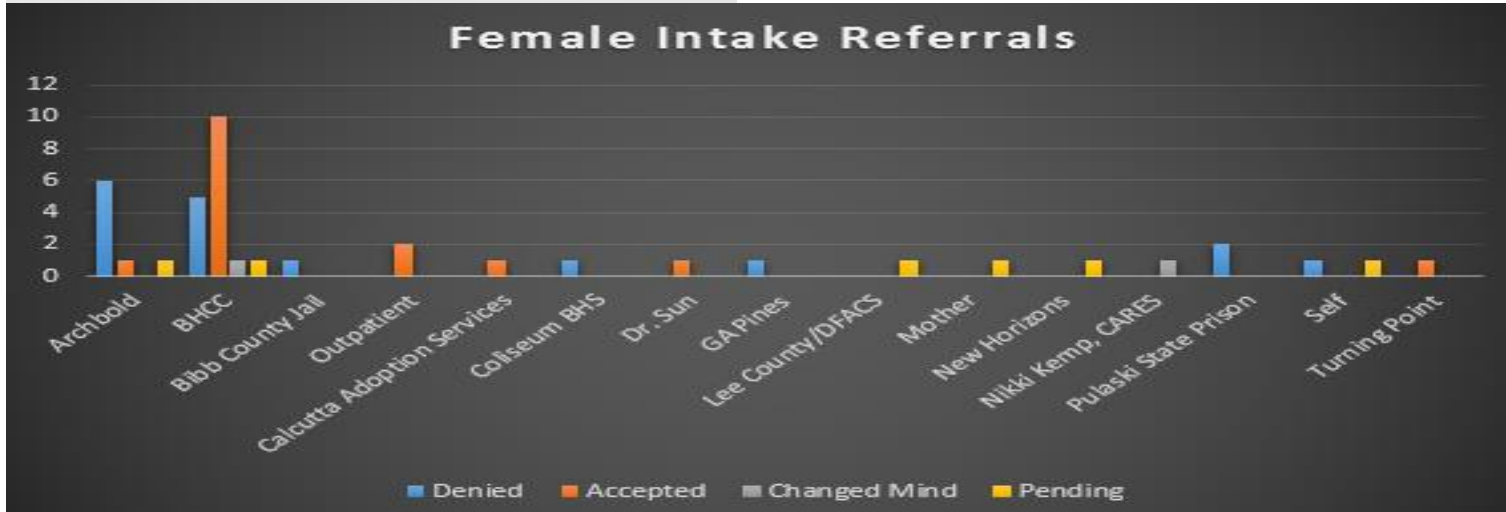
Referral Facility	Denied	Accepted	Changed Mind	Pending
Archbold	2	0	1	0
BHCC	5	11	8	0
Comfort Zone	0	1	0	0
Outpatient	0	0	0	0
Treatment Court	0	1	0	0
. Leonard Bailey	0	0	1	0
Greenleaf	0	0	1	0
New Horizons	0	1	0	0
The Phoenix	2	0	1	0
Pinewood	0	0	1	0
Self	1	2	3	0
Turning Point	0	0	1	0



Female Intake Referrals

Referral Facility	Denied	Accepted	Changed Mind	Pending
Archbold	6	1	0	1
BHCC	5	10	1	1
Bibb County Jail	1	0	0	0
Outpatient	0	2	0	0
Calcutta Adoption Services	0	1	0	0
Coliseum BHS	1	0	0	0
Dr. Sun	0	1	0	0
GA Pines	1	0	0	0
Lee County/DFACS	0	0	0	1
Mother	0	0	0	1
New Horizons	0	0	0	1
Nikki Kemp, CARES	0	0	1	0
Pulaski State Prison	2	0	0	0
Self	1	0	0	1
Turning Point	0	1	0	0

TOUCHSTONE CENSUS – 28 BEDS / FULL



ASPIRE Behavioral Health and Developmental Disability Services –

Kay Newberry Brooks, EdD, LPC
Aspire Executive Director

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kbrooks@albanycsb.org


It's
all about
building
Community

Resources:

Addressing Bullying http://www.stopbullying.gov

Appendix: Helpful Resources and Websites
(Note: These organizations, materials and links are offered for informational purposes only and should not be construed
as an endorsement of the referenced organization's programs or activities.)

Children's Mental Health Awareness Day http://www.samhsa.gov/children

Find Youth Info http://www.findyouthinfo.gov

Information About Mental Health • http://www.MentalHealth.gov

Additional information you could use to host a conversation in your community
http://www.CreatingCommunitySolutions.org

Resources

National Institute of Mental Health (NIMH) http://www.nimh.nih.gov

National Registry for Evidence-Based Programs and Practices • http://www.nrepp.samhsa.gov
National Center for Trauma-Informed Care http://www.samhsa.gov/nctic
Children's Mental Health Initiative Technical Assistance Center http://www.cmhnetwork.org

National Consumer Technical Assistance Centers • http://ncstac.org/index.php
Homeless Resource Center http://www.homeless.samhsa.gov
Shared Decision Making in Mental Health Tools http://162.99.3.211/shared.asp
College Drinking: Changing the Culture http://www.collegedrinkingprevention.gov

Million Hearts http://millionhearts.hhs.gov/index.html

Resource Center to Promote Acceptance, Dignity, and Social Inclusion •
http://promoteacceptance.samhsa.gov

Resources

SAMHSA-HRSA Center for Integrated Health Solutions: www.Integration.SAMHSA.gov

Substance Abuse and Mental Health Services Administration (SAMHSA) http://www.SAMHSA.gov

Suicide Prevention Resource Center • http://www.sprc.org

The Institute of Medicine's *Preventing Mental, Emotional and Behavioral Disorders Among Young People*: Progress and Possibilities

http://www.iom.edu/Reports/2009/Preventing-Mental-Emotionaland-Behavioral-Disorders-Among-Young-People-Progress-andPossibilities.aspx

Voice Awards http://www.samhsa.gov/voiceawards

YouTube videos

- *23 ½ Hours* by Dr. Mike Evans

Monitoring tools and educational materials

- CDC: www.cdc.gov
- American Heart Association: www.heart.org
- American Diabetes Association: www.diabetes.org