Georgia ADA Settlement Update for Behavioral Health Department of Behavioral Health and Developmental Disabilities May 16, 2014

Terri Timberlake, Ph.D.
Director, Office of Adult Mental Health
DBHDD

Fiscal Year 13, Year 3 of ADA Settlement Agreement

“AT THE COMPLETION OF THE THIRD YEAR OF THE SETTLEMENT AGREEMENT, IT IS EVIDENT THAT THE BUILDING BLOCKS FOR A COMMUNITY-BASED SYSTEM OF MENTAL HEALTH CARE ARE LARGELY IN PLACE. THE DEPARTMENT HAS MADE IMPRESSIVE STRIDES IN IMPLEMENTING PEER SUPPORTS, SUPPORTED HOUSING, SUPPORTED EMPLOYMENT, CRISIS SERVICES, AND IN BUILDING ASSERTIVE COMMUNITY TREATMENT TEAMS. THE STATE, THROUGH ITS DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES, HAS MADE VERY SIGNIFICANT PROGRESS IN IMPLEMENTING THE BUILDING BLOCKS OF A RESPONSIVE, RECOVERY-ORIENTED MENTAL HEALTH SYSTEM. WITH A SINGLE EXCEPTION, THE REQUIREMENTS FOR NEW MENTAL HEALTH SERVICES HAVE BEEN MET OR HAVE BEEN EXCEEDED BY THE DEPARTMENT, OFTEN IN CONCERT WITH ITS SISTER AGENCIES, AND WITH FULL SUPPORT BY THE GOVERNOR AND THE GENERAL ASSEMBLY.”

SEPTEMBER 19 , 2013, ELIZABETH JONES, INDEPENDENT REVIEWER FOR THE ADA SETTLEMENT AGREEMENT

2013 Report by the DOJ Independent evaluator for ACT

Dr. Angela Rollins

“THE STATE OF GEORGIA IS IN COMPLIANCE WITH THE SETTLEMENT AGREEMENT REQUIREMENT TO ESTABLISH TWENTY-TWO ACT TEAMS BY JULY 1, 2013. AS OF THE END OF JUNE 2013, THE TWENTY-TWO TEAMS COLLECTIVELY WERE SERVING 1,263 CONSUMERS. THE STATE IS ALSO IN COMPLIANCE WITH REGARDS TO ADDITIONAL REQUIREMENTS RELATED TO THE COMPOSITION OF ACT TEAMS WITH MULTIDISCIPLINARY STAFF, INCLUDING A DEDICATED TEAM LEADER, AND THE RANGE OF SERVICES TO BE PROVIDED BY THE TEAM, INCLUDING THE AVAILABILITY OF 24/7 CRISIS SERVICES.”

AUGUST 12, 2013

Targets by service ; Assertive Community Treatment (ACT)

- ✓ **22 DBHDD contracted ACT teams**

Provider	Region
Avita Community Partners, Cobb Douglas CSB, Highland Rivers CSB	1
Advantage Behavioral Health System, American Work, River Edge Behavioral Health System	2
Fulton-Dekalb Grady Hospital (3) Viewpoint Health(2) Georgia Rehabilitation & Outreach (2)	3
Albany CSB, South Georgia Behavioral Health Services, Georgia Pines Community Services	4
American Work (2) , Gateway Behavioral Health Services	5
Pathways Center for Behavioral Health, McIntosh Trail CSB, American Work	6

DBHDD Strengths, Support and Sustainability Efforts

CLEARER STANDARDS FOR ACT, STREAMLINED REGULATORY DOCUMENTS AND CLEARER ACCOUNTABILITY STANDARDS FOR COMPLIANCE WITH THOSE STANDARDS

SOLID FIDELITY MONITORING SYSTEM

ENHANCED DATA COLLECTION

IMPROVEMENTS IN FUNDING AND AUTHORIZATION ALLOWANCES

HIGH QUALITY ACT TRAININGS AND TA

2013 Report by the DOJ Independent evaluator for SE David Lynde

“THE DATA PRESENTED FROM DBHDD AND THE INFORMATION CONFIRMED BY A VARIETY OF STAKEHOLDERS (INCLUDING PROVIDERS) THAT WERE INTERVIEWED DO INDICATE THAT DBHDD IS COMPLYING WITH THE SUPPORTED EMPLOYMENT PROVISIONS OF THE SETTLEMENT AGREEMENT. ACCORDING TO THE —FY 13 PROGRAMMATIC REPORT DATA: SUPPORTED EMPLOYMENT SERVICES, AS OF THE END OF MAY 2013, THERE WERE 706 INDIVIDUALS RECEIVING SUPPORTED EMPLOYMENT SERVICES UNDER THE SETTLEMENT AGREEMENT.”

AUGUST 12, 2013

The DOJ Settlement and Supported Employment

“ PURSUANT TO THE FOLLOWING SCHEDULE, THE STATE SHALL PROVIDE SUPPORTED EMPLOYMENT SERVICES TO 550 INDIVIDUALS WITH SPMI BY JULY 1, 2015.”

Targets by service: Supported Employment

2014 DOJ target :500 consumers enrolled in SE meeting ADA criteria Current enrollment of consumers meeting ADA criteria 930	2015 DOJ target:550 consumers enrolled in SE meeting ADA criteria	Current Total of 1093 consumers receiving SE Meeting ADA and non-ADA criteria

DBHDD contracted Supported Employment Providers

Provider	Region
Cobb Douglas CSB, Avita Community Partners, Lookout Mountain Community Services, Highland Rivers CSB, Briggs & Associates, Inc.	1
Advantage Behavioral Health System, American Work, Oconee CSB, River Edge Behavioral Health Services, Serenity Behavioral Health System	2
Community Friendship, Inc., Dekalb CSB, Viewpoint Health, Briggs & Associates, Inc.	3
American Work, G & B Works, Inc., South Georgia Behavioral Health Services	4
Gateway Behavioral Health Services, Pineland CSB, Unison CSB, American Work,	5
New Horizons CSB, Pathways Center for Behavioral Health, Middle Flint CSB, American Work, Briggs & Associates, Inc., McIntosh Trail CSB	6

DBHDD Strengths, Support and Sustainability Efforts

SOLID FIDELITY MONITORING SYSTEM

ENHANCED DATA COLLECTION

HIGH QUALITY SE TRAININGS AND TA

GA VOCATIONAL REHAB PARTNERSHIP

TASK ORIENTED REHABILITATION SERVICES (TORS)

DOJ Targets by service:
Case Management
Intensive Case Management

	FY 2014 DOJ target	FY 2015 DOJ target
Case Management	✓ 25	45
Intensive Case Management	✓ 8	14

Targets by service: Community Support Team (CST)

- ✓ **FY 2014 DOJ TARGET: 8 TEAMS**

Provider	Region
Highland Rivers CSB Avita Community Partners	1
Advantage Behavioral Health Systems Serenity Behavioral Health Systems	2
Albany CSB	4
Pineland CSB, CSB of Middle Georgia	5
Phoenix Center CSB	6

Targets by service: Peer Support Services

- ✓ **FY 2014 DOJ TARGET**
  PROVISION OF PEER SUPPORT SERVICES TO 835 PERSONS WITH SPMI

  CURRENTLY
  1,418 PERSONS MEETING ADA CRITERIA HAVE PARTICIPATED IN PEER SUPPORT SERVICES (PEER MENTORING, PEER RESPITE, AND\OR PEER SUPPORT WELLNESS & RESPITE CENTERS).

Targets by service: Crisis Services
Mobile Crisis Response (MCR)
Crisis Respite Apartments (CRA)
Crisis Stabilization Unit (CSU)
Behavioral Health Crisis Center (BHCC)

DOJ TARGETS

Service	FY 2014	FY 2015	Provider
Mobile Crisis Response	✓ 126 counties covered by mobile crisis response	159 counties covered by mobile crisis response	Benchmark 1,2,4,6 BHL 3,5
Crisis Respite Apartments	✓ Provision of 12	Provision of 18	No Gap (Cobb/Avita), Viewpoint, Albany CSB, GA Pines, BHS SGA, McIntosh Trail CSB
Crisis Stabilization Unit (CSU)	✓ Provision of 3 CSUs		
Crisis Service Center	✓ Provision of 3 CSCs	Provision of 6 CSCs	Albany CSB South GA BHS GA Pines CSB

Targets by service: Supported Housing

	FY 2014 DOJ Target	FY 2015 DOJ Target
Supported Housing	Provision of 1400 supported housing beds ✓ Currently providing 1450 supported housing beds	Provision of 2000 supported housing beds

The State of ADHD Care in Georgia: From Data to Action

Georgia Mental Health Forum

The Carter Center

May 16, 2014

Moderator: Ruth Perou, PhD

Panelists:

Susanna Visser, DrPH, MS

Monica Parker, MA, LPC

Ann DiGirolamo, PhD, MPH

Doris Greenberg, MD

Susanna Visser, DrPH: CDC, National Center on Birth Defects and Developmental Disabilities

United States and Georgia

THE EPIDEMIOLOGY OF ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

ADHD Symptoms

Diagnostic and Statistical Manual of Mental Disorders - 5 (2013)

- **A child with ADHD might:**
  - have a hard time paying attention
  - daydream a lot
  - not seem to listen
  - be easily distracted from schoolwork or play
  - forget things
  - be in constant motion or unable to stay seated
  - squirm or fidget
  - talk too much
  - not be able to play quietly
  - act and speak without thinking
  - have trouble taking turns
  - interrupt others

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders -5* Washington, DC: APA.

Attention-Deficit/Hyperactivity Disorder
Diagnostic Criteria

The Gold Standard: *Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5)*

- **Symptom Count (6 or more)**
  - Inattention and/or Hyperactivity
  - Presentations (subtypes): Inattentive, Hyperactive, Combined
- **Age of Onset (symptoms before age 12)**
- **Impairment (significant)**
- **Pervasiveness (multiple settings)**
- **Rule-Outs**

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders -5* Washington, DC: APA.

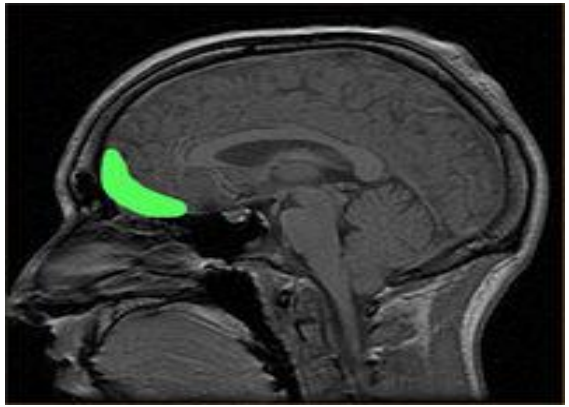
What May Cause the *Disorder* (ADHD)?

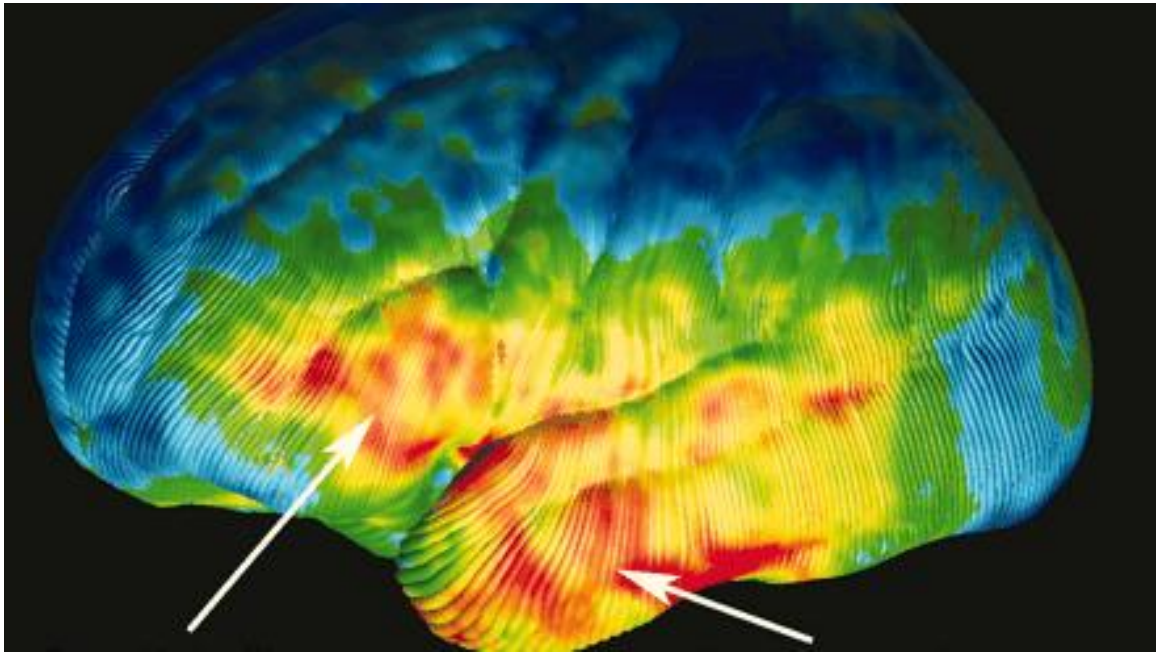
- We don't really know
- Multifactorial
  - Genetic contributors (Nature)
    - DRD4, DAT, SNAP-25
  - Environmental contributors (Nurture)
    - Environmental exposures, like lead, PCBs, and bromated flame retardants
    - Fetal alcohol exposure
    - Poor parenting practices (inconsistent parenting, neglect, harsh or inappropriate discipline, etc.)
    - Others

What Causes the *Symptoms* of ADHD?

- Anatomical Differences in the Brain

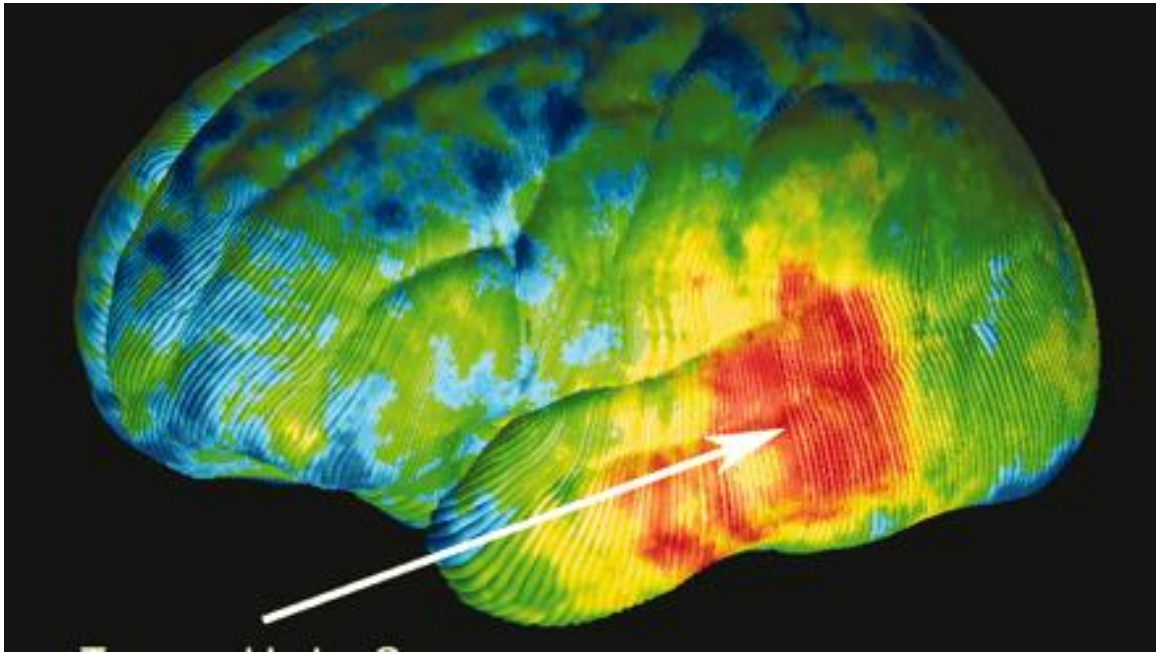
- Differences in Neurochemistry
  - Thoughts
  - Actions
  - Feelings
  - Motivation





Anatomical Differences in Youth with ADHD

Sowell, E. R., Thompson, P. M., Welcome, S. E., Henkenius, A. L., Toga, A. W., & Peterson, B. S. (2003). Cortical abnormalities in children and adolescents with attention-deficit hyperactivity disorder. *Lancet, 362*(9397), 1699-1707.



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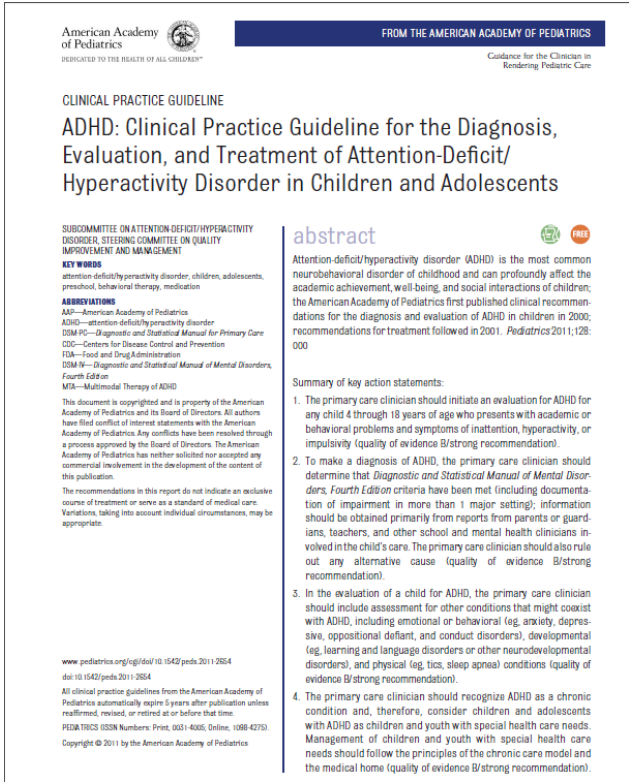
Practice Guidelines from Professional Academies

- AAP Diagnostic and Treatment Guidelines
  - Recommendations and special considerations, by age
- AACAP Diagnostic and Treatment Guidelines



American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Guidance for the Clinician in Rendering Pediatric Care

CLINICAL PRACTICE GUIDELINE

ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/ Hyperactivity Disorder in Children and Adolescents

SUBCOMMITTEE ON ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, STEERING COMMITTEE ON QUALITY IMPROVEMENT AND MANAGEMENT

KEY WORDS
attention-deficit/hyperactivity disorder, children, adolescents, preschool, behavioral therapy, medication

ABBREVIATIONS
AAP—American Academy of Pediatrics
ADHD—attention-deficit/hyperactivity disorder
DSM-PC—*Diagnostic and Statistical Manual for Primary Care*
CDC—Centers for Disease Control and Prevention
FDA—Food and Drug Administration
DSM-IV—*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*
MTA—Multimodal Therapy of ADHD

www.pediatrics.org/cgi/doi/10.1542/peds.2011-2654
doi:10.1542/peds.2011-2654

All clinical practice guidelines from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

abstract

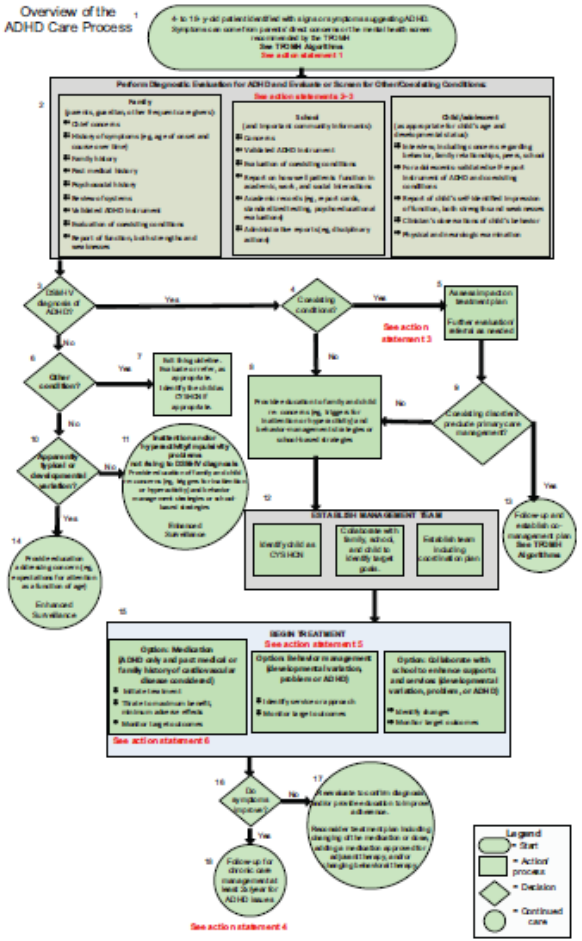
Attention-deficit/hyperactivity disorder (ADHD) is the most common neurobehavioral disorder of childhood and can profoundly affect the academic achievement, well-being, and social interactions of children; the American Academy of Pediatrics first published clinical recommendations for the diagnosis and evaluation of ADHD in children in 2000; recommendations for treatment followed in 2001. *Pediatrics* 2011;128:000

Summary of key action statements:

1. The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity (quality of evidence B/strong recommendation).
2. To make a diagnosis of ADHD, the primary care clinician should determine that *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria have been met (including documentation of impairment in more than 1 major setting); information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care. The primary care clinician should also rule out any alternative cause (quality of evidence B/strong recommendation).
3. In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral (eg, anxiety, depressive, oppositional defiant, and conduct disorders), developmental (eg, learning and language disorders or other neurodevelopmental disorders), and physical (eg, tics, sleep apnea) conditions (quality of evidence B/strong recommendation).
4. The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (quality of evidence B/strong recommendation).

ADHD Process of Care Algorithm

American Academy of Pediatrics, 2011



AAP Guidance on Diagnosis and Treatment

- Clinician should evaluate for ADHD any child 4-18 years who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity
- Clinician should determine that *DSM-IV* criteria have been met
  - Symptoms and impairment in more than 1 major setting
  - Information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care
  - Clinician should rule out any alternative cause
- Clinician should assess comorbidities
- Clinician should recognize ADHD as a *chronic* condition

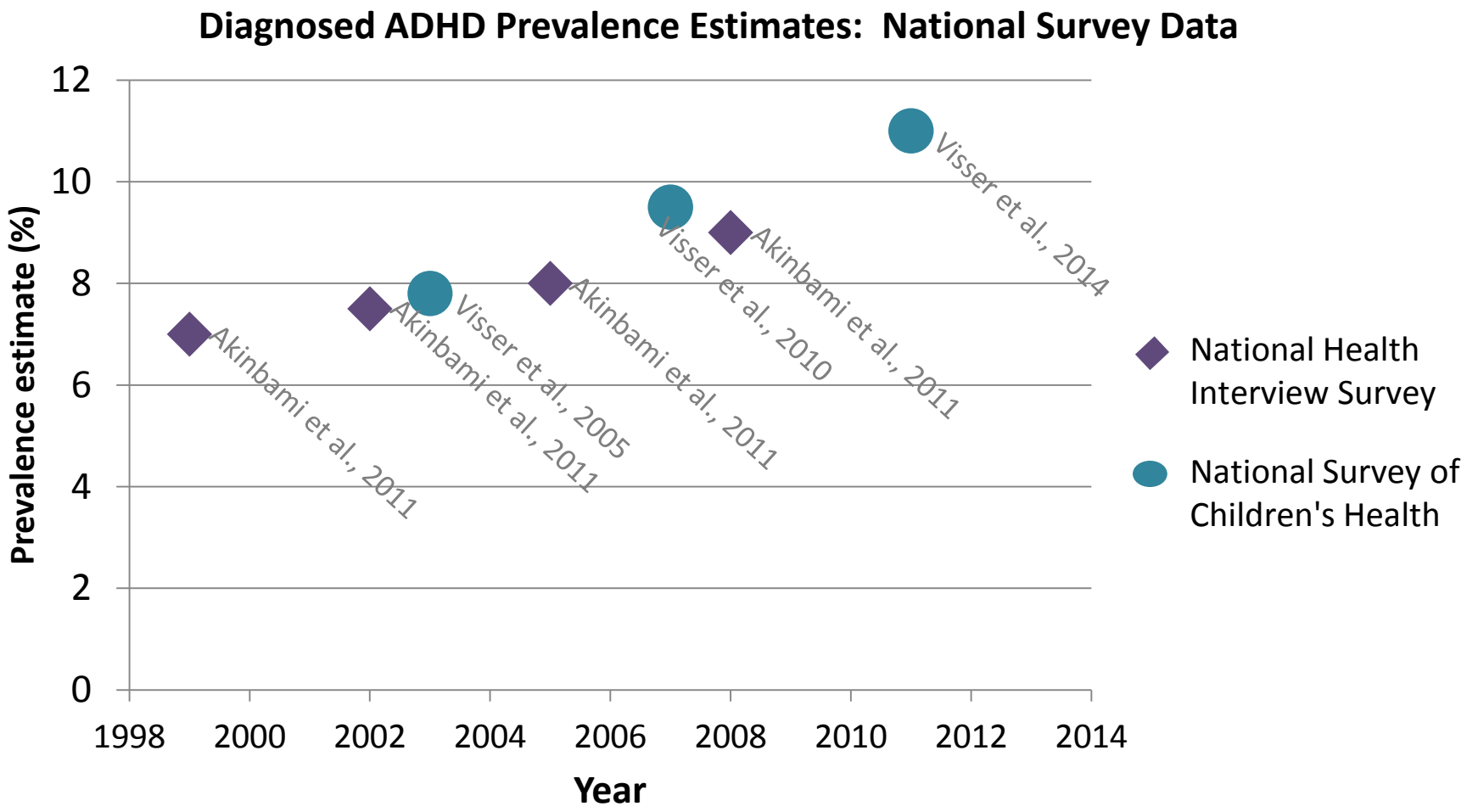
The Prevalence of Diagnosed ADHD

THE EPIDEMIOLOGY OF ADHD

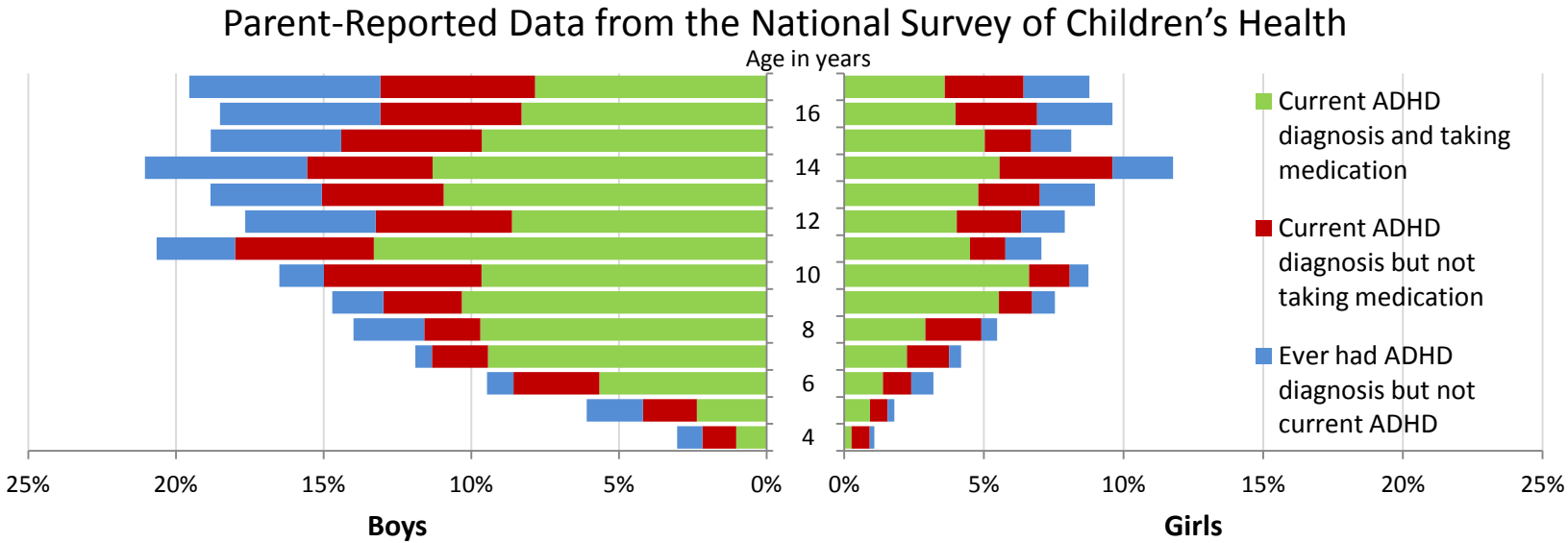
Prevalence of ADHD among School-Aged Youth

- **National Population Estimates**
  - 6.4 million youth 4-17 years diagnosed as of 2011-2012
    - 2 million more than in 2003
  - 5.1 million with a current ADHD diagnosis
- **National Prevalence Rate (%)**
  - 11% of youth 4-17 years of age ever diagnosed
    - Up from 7.8% in 2003-2004; a 42% increase
  - 8.8% with a current diagosis

Visser, S. N., Danielson, M. L., Bitsko, R. H., Holbrook, J. R., Kogan, M. D., Ghandour, R. M., . . . Blumberg, S. J. (2014). Trends in the Parent-Report of Health Care Provider-Diagnosed and Medicated Attention-Deficit/Hyperactivity Disorder: United States, 2003–2011. *Journal of the American Academy of Child and Adolescent Psychiatry, 53*(1), 34-46.e32.


Diagnosed ADHD Prevalence Estimates: National Survey Data
Prevalence estimate (%)
12
10
8
6
4
2
0
1998
2000
2002
2004
2006
2008
2010
2012
2014
Year
Akinbami et al., 2011
Akinbami et al., 2011
Visser et al., 2005
Akinbami et al., 2011
Visser et al., 2010
Akinbami et al., 2011
Visser et al., 2014
National Health Interview Survey
National Survey of Children's Health

Weighted Prevalence Estimates (%) of ADHD Diagnosis by a Health Care Provider among U.S. Children, by Age and Medication Status

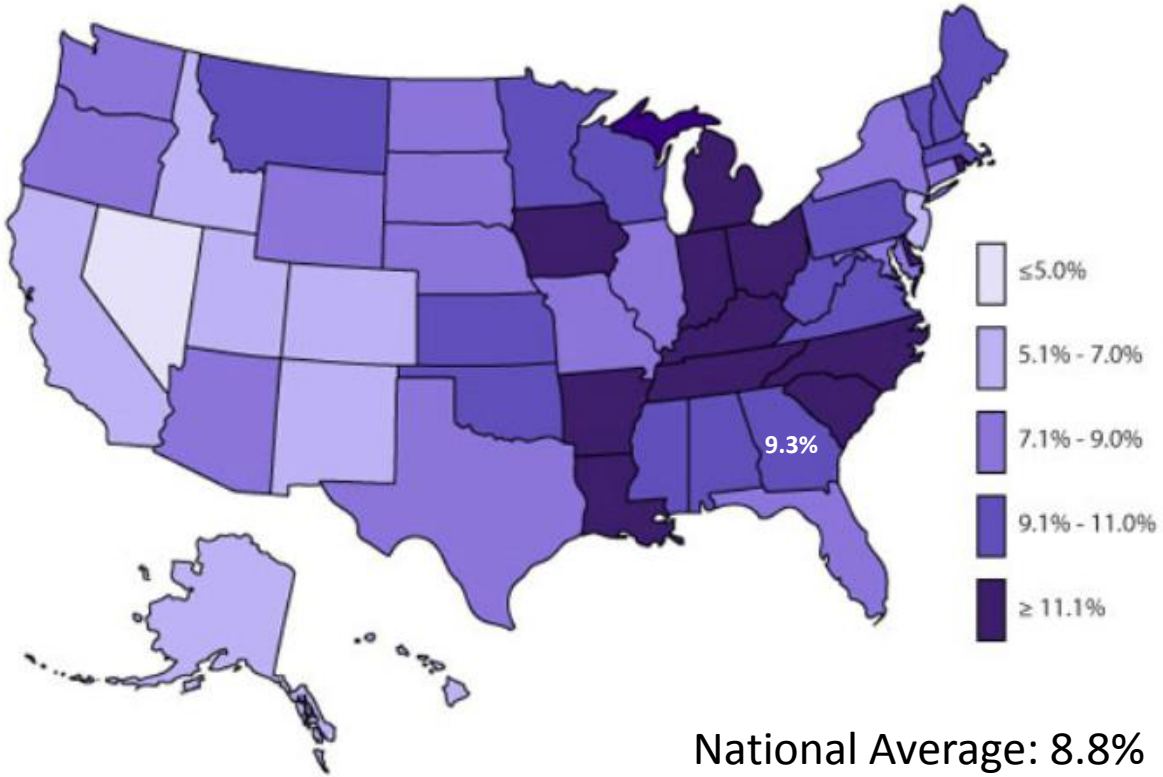


2011-2012

Visser, S. N., Danielson, M. L., Bitsko, R. H., Holbrook, J. R., Kogan, M. D., Ghandour, R. M., . . . Blumberg, S. J. (2014). Trends in the Parent-Report of Health Care Provider-Diagnosed and Medicated Attention-Deficit/Hyperactivity Disorder: United States, 2003–2011. *Journal of the American Academy of Child and Adolescent Psychiatry, 53*(1), 34-46.e32.

WHAT DO WE KNOW ABOUT ADHD DIAGNOSIS AND TREATMENT IN GA?

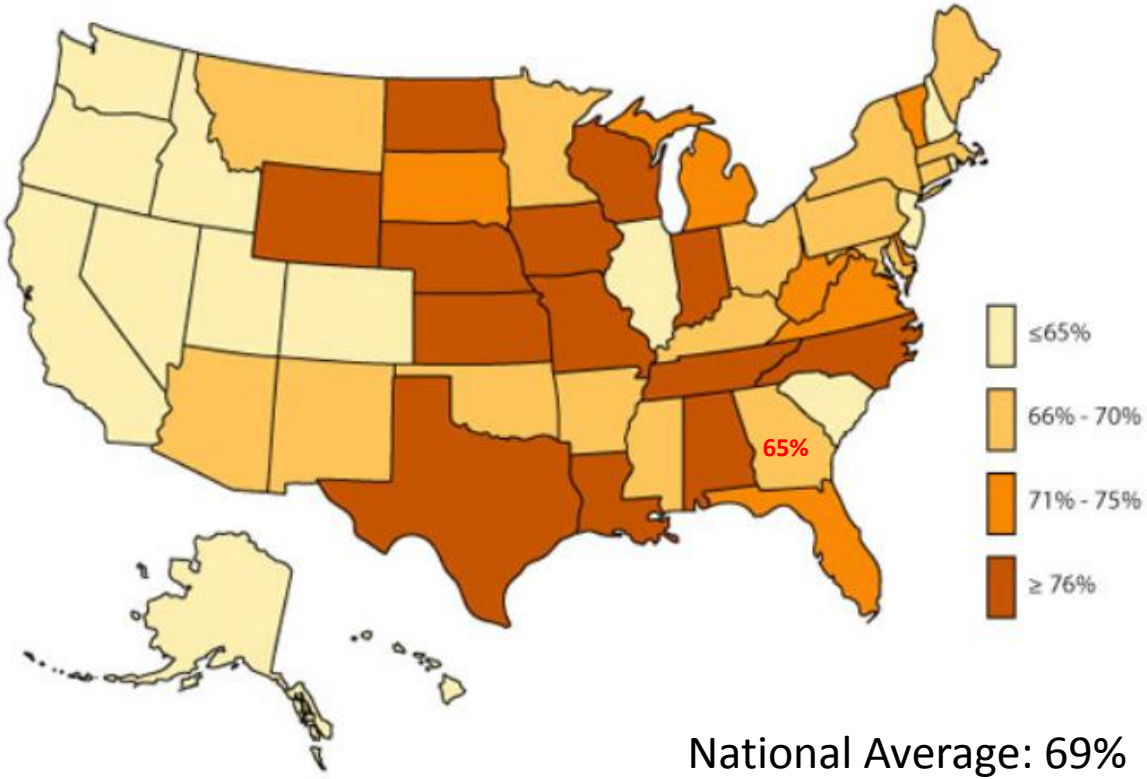
Current ADHD Diagnosis: NSCH. 2011-12



National Average: 8.8%

http://www.cdc.gov/ncbddd/adhd/prevalence.html

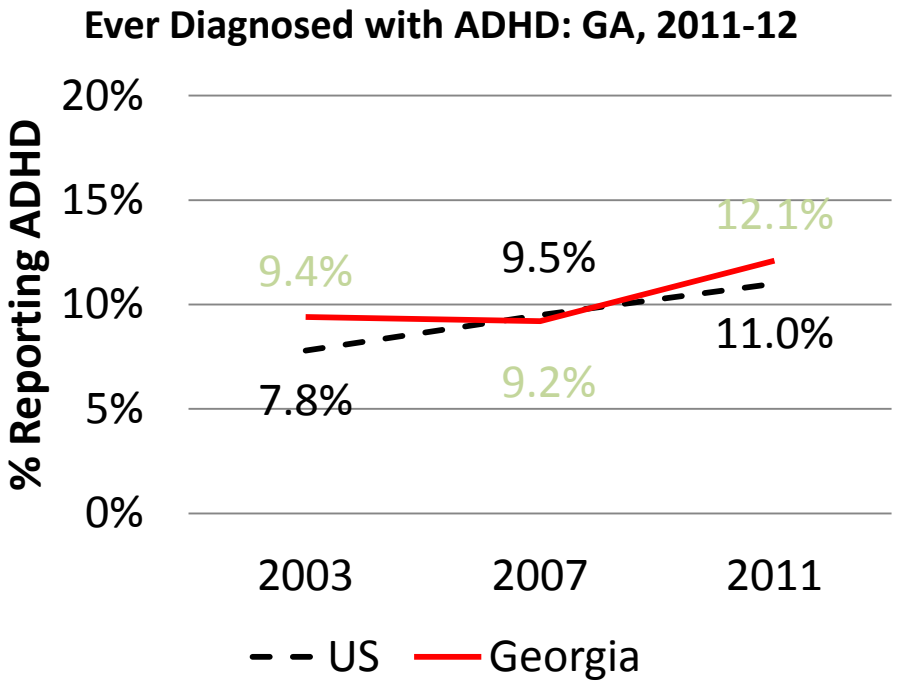
Current ADHD Medication Treatment: NSCH 2011-12



National Average: 69%

http://www.cdc.gov/ncbddd/adhd/medicated.html

Diagnosed and Medicated ADHD in GA



In 2011

- Current ADHD
  - 8.8% of US children
  - 9.3% of children in GA
  - Among all US states, GA ranked 25th highest.
- ADHD medication treatment
  - 6.1% of US children
  - 6.1% of children in GA
  - Among all US states, GA ranked 30th highest.

Monica Parker, MA, LPC: GA Department of Behavioral Health and Developmental Disabilities

Interagency Directors Team (IDT)

THE GA SYSTEM OF CARE COLLABORATION

Mission

- The IDT is a multi-agency system of care leadership collaborative that uses an integrated approach to address the needs of children and adolescents with behavioral health issues through macro level system planning.

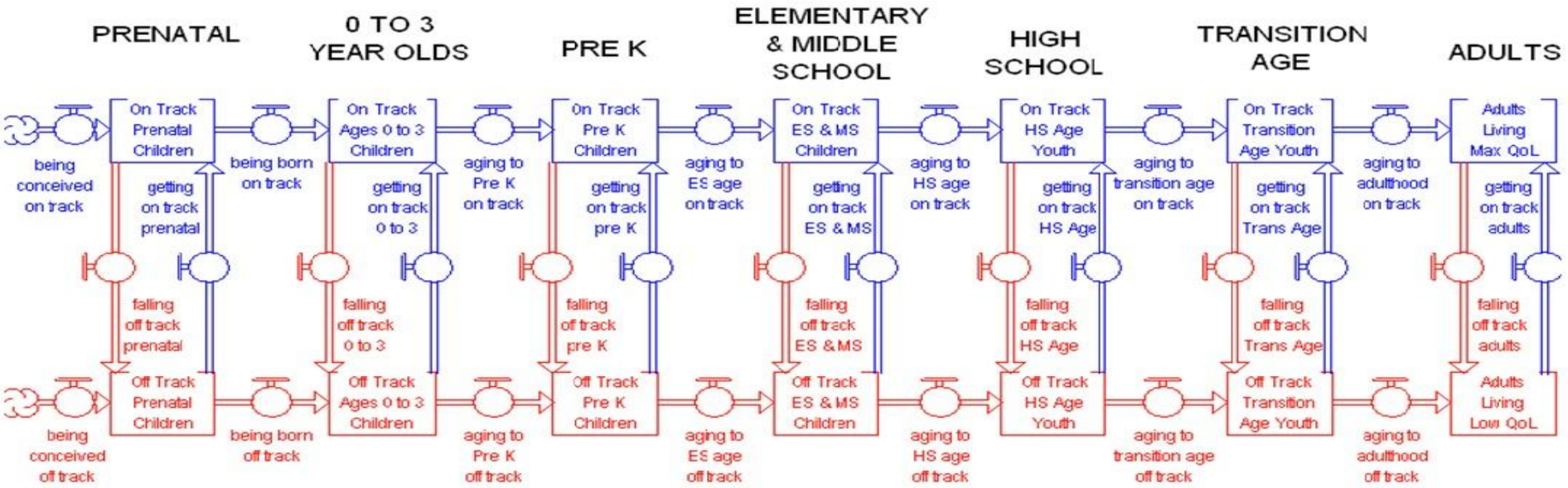
Key Guiding Principles

- Promotes Evidenced Based Practices
- Ensures equitable participation among partners
- Committed to a system driven by data that uses measurable outcomes for system design
- Respect the unique cultures and priorities of each agency

Team

- Department of Behavioral Health & Developmental Disabilities
- Department of Community Health
- Department of Human Services – DFCS
- Department of Juvenile Justice
- Department of Public Health
- Department of Education
- Georgia Parent Support Network
- The Carter Center
- Together Georgia
- The Center of Excellence
- **Federal Consultant – Centers for Disease Control and Prevention*

CHILDREN'S BEHAVIORAL HEALTH: COLLABORATIVE SYSTEMS MAP



Developed by the IDT
(Interagency Directors Team)

Strategic Goal

- Driven By Data Presented by CDC for ADHD
- Goal:
  - Build capacity to provide optimum practice for young children with behavioral disorders (ADHD, ODD, conduct disorders).

Action Steps

- **COE analyze Georgia Medicaid claims to learn more about ADHD treatment in GA & compare to national data**
- **Survey Practitioners in Georgia to identify trends in linkage to best practice treatment recommendations**
- **Disseminate best practices / recommended guidelines to workforce in Georgia**
  - GA AAP Conference: Pediatrics by the Sea – June 2014
  - IDT System of Care Conference – June 2014
  - Recorded webinar available through Center of Excellence

Ann DiGirolamo, PhD, MPH: Georgia State University

Georgia State University in partnership with the Department of Behavioral Health and Developmental Disabilities

COE Vision and Mission

- **Vision:** Children and families will have improved quality of life and a productive future as a result of systems that promote optimum behavioral health.

- **Mission:** To continually improve systems that promote optimum behavioral health by ensuring a community-based approach to youth-guided, family-driven care with a focus on shared outcomes, a competent workforce, and unbiased research.

Approach to our work

COE Activities

- **Workforce Development**—
  - Training (currently lay workforce)
  - Technical Assistance to provider groups includes QA/QI, using data for decision making, financing, sustainability
- **Evaluation** (process and outcome) **& Research** (most data focused on those with serious emotional disturbance)
  - Data Hub
  - Using data for decision making for QI and to impact policy

Data collected on:

- Fidelity and quality improvement data for various treatment modalities (e.g. PRTF, CSU, CME, Clubhouse)
- Outcomes
  - Family satisfaction with care, self-reported empowerment
  - Health/Mental health functioning
  - Time spent in or recidivism to out of home placements (DJJ*, PRTF, CSU, foster care placements*)
  - Working to get information from DOE on schooling*
- Medicaid/CHIP & State FFS claims data (other limited system data)
  - Cost (by payer)
  - Service utilization (movements to higher or lower levels of care)
  - Diagnosis
  - Foster care status
  - Demographics

*Need data sharing agreements for data outside EBP intervention window

COE and IDT

- **Administrative and data backbone to IDT**
  - Administrative
    - Meeting logistics; engagement of consultants
    - Helps ensure sustainability of the collaborative
    - IDT able to maximize resources and potential for braided funding through university collaboration
  - Data
    - Ensures IDT has necessary data to inform decisions
    - Data hub; helps develop data sharing agreements so collective data can be brought back to the group
    - Collaborates with IDT members on data analyses and dissemination
    - Assists in evaluation and report of annual progress of the collaborative

- **Work of the IDT also informs the ongoing work of the COE and enhances their ability to accomplish their goals**

Susanna Visser, DrPH: CDC, National Center on Birth Defects and Developmental Disabilities and the GA IDT

IDT Collaboration – GA Medicaid Data Analyses

IMPLEMENTING THE IDT STRATEGIC PLAN & UNPACKING THE GA DATA AMONG YOUNG CHILDREN IN GA

Age-specific ADHD Treatment Recommendations from AAP: Preschoolers

- **For those aged 4–5 years, evidence-based parent- and/or teacher-administered behavior therapy as the *first line of treatment***
- **May prescribe methylphenidate if behavior interventions do not provide significant improvement and moderate-to severe disturbance in the child's function continues**
- **If evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment**
- **The primary care clinician should titrate doses of medication**

American Academy of Pediatrics' Subcommittee on Attention-Deficit/Hyperactivity Disorder Steering Committee on Quality Improvement and Management, Wolraich M, Brown L, et al. ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics.* November 1, 2011 2011;128(5):1007-1022.

Medicaid Claims Data System: GA Dept of Community Health

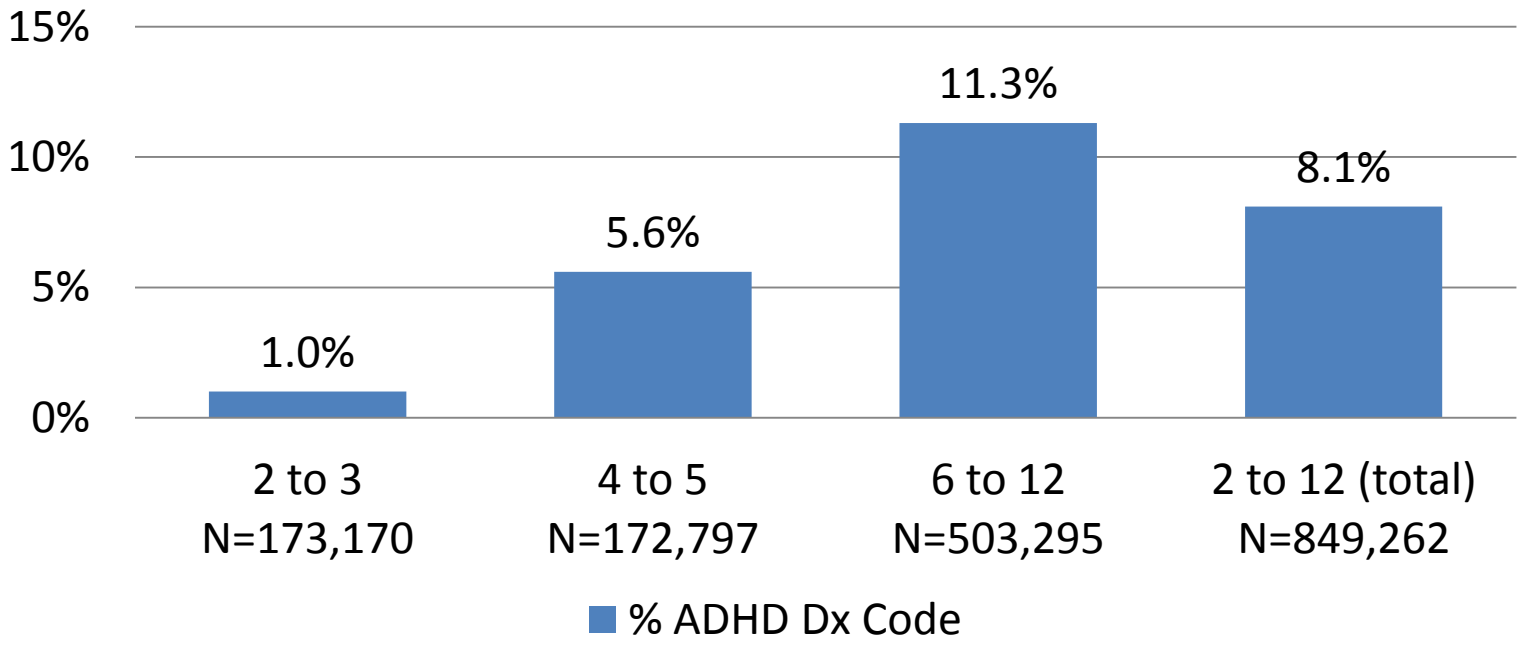
- Currently medically managed ADHD (2012)
  - # of GA children (2-12 years) enrolled in Medicaid with >= 2 ADHD Dx codes in 2012
  - % of children in Medicaid who had medically managed ADHD in 2012
- Currently medicated ADHD (2012)
  - # of GA children (2-12 years) enrolled in Medicaid with >= 1 ADHD Dx code and >= 1 ADHD medication claim, using National Drug Codes for medications FDA-approved for pediatric ADHD treatment*
  - % of children in Medicaid who were medicated for ADHD in 2012
- Behavioral Treatment
  - # of GA children (2-12 years) enrolled in Medicaid who have received behavioral treatment or psychological services in 2012
  - % of children in Medicaid receiving behavioral therapy for ADHD

* AAP. ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics.* 2011; 128(5):1007-1022.

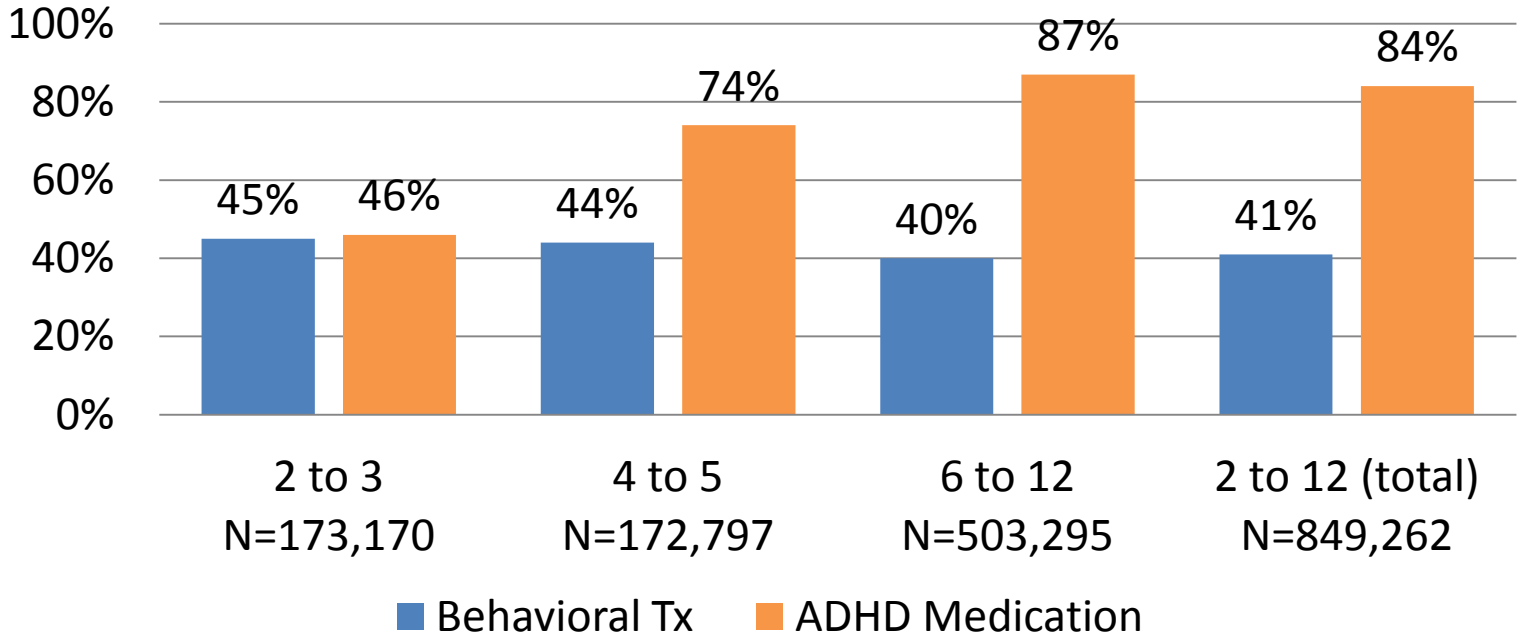
List of FDA-approved ADHD medications used in the abstraction of medication claims for ADHD among children in Medicaid

Medication	Drug Class
Adderall	Central nervous system stimulant (CNS Stimulant)
Atomoxetine	Selective norepinephrine reuptake inhibitor (SNRI)
Concerta	CNS Stimulant
Daytrana Patch	CNS Stimulant
Dexedrine	CNS Stimulant
Dextrostat	CNS Stimulant
Dextro-Amphetamine	CNS Stimulant
Dexmethylphenidate	CNS Stimulant
Focalin	CNS Stimulant
Guanfacine	Centrally acting alpha-adrenergic receptor agonist
Intuniv	Centrally acting alpha-adrenergic receptor agonist
Kapvay	Central alpha-2 agonist
Metadate	CNS Stimulant
Methylin	CNS Stimulant
Methylphidate	CNS Stimulant
Ritalin	CNS Stimulant
Strattera	SNRI
Tenex	Centrally acting alpha-adrenergic receptor agonist
Vyvanse	CNS Stimulant

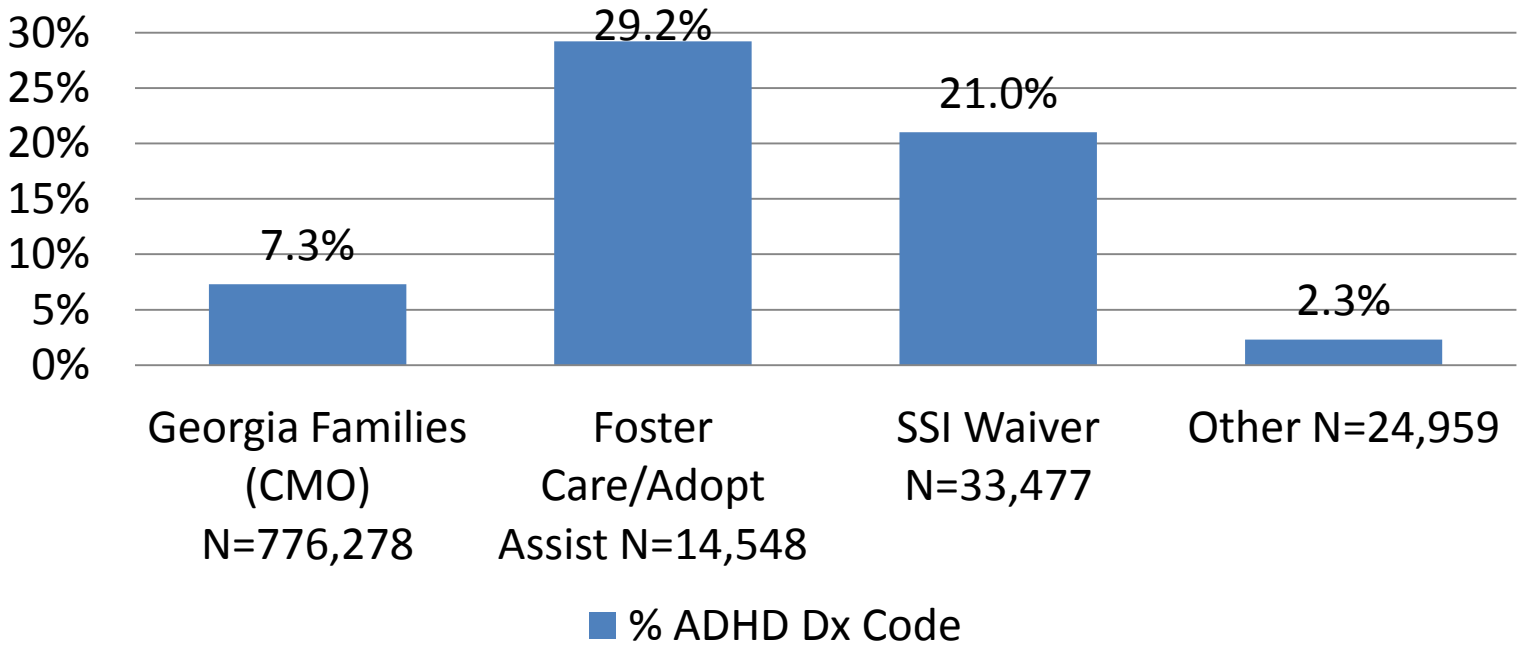
Percentage of GA Children in Medicaid with 2+ ADHD Diagnosis Codes (2012)



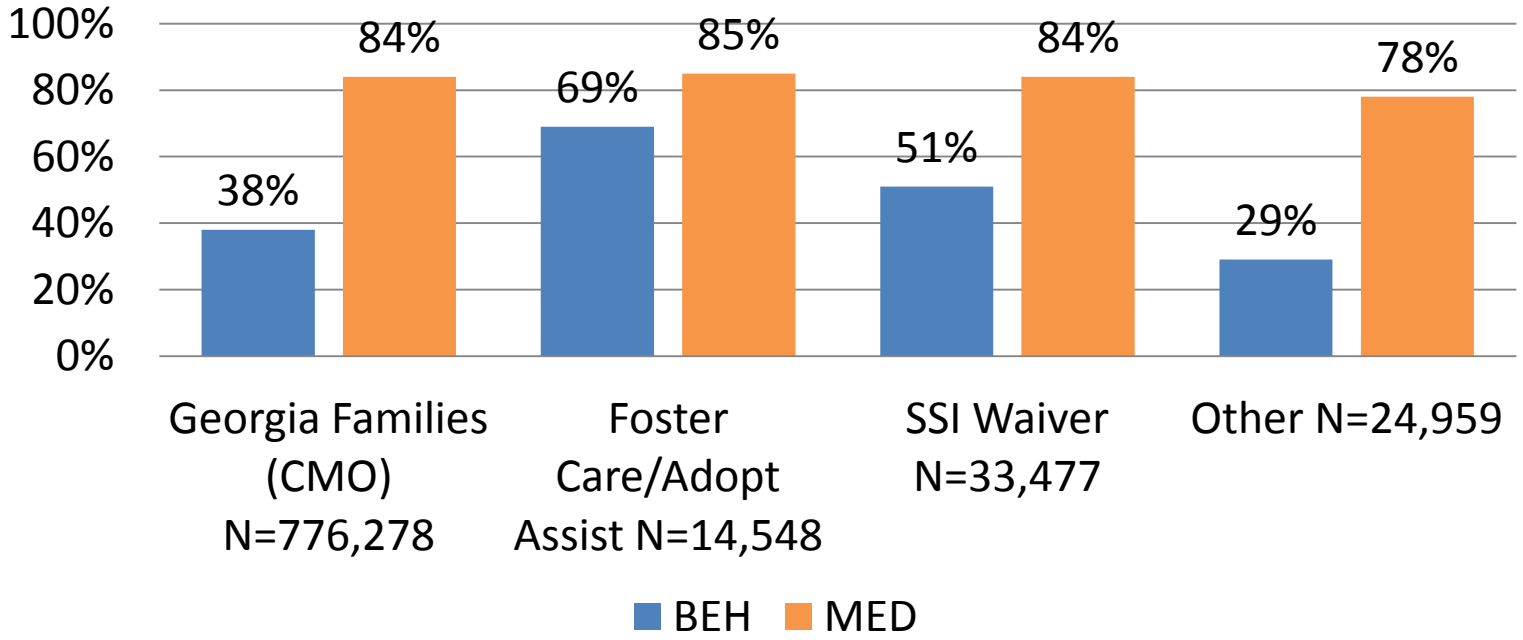
Treatment of GA Children in Medicaid with 2+ ADHD Diagnosis Codes (2012)



Percentage of Children in Medicaid with 2+ ADHD Diagnosis Codes (2012), by Eligibility Categories



Treatment of Children in Medicaid with 2+ ADHD Diagnosis Codes (2012), by Eligibility Categories



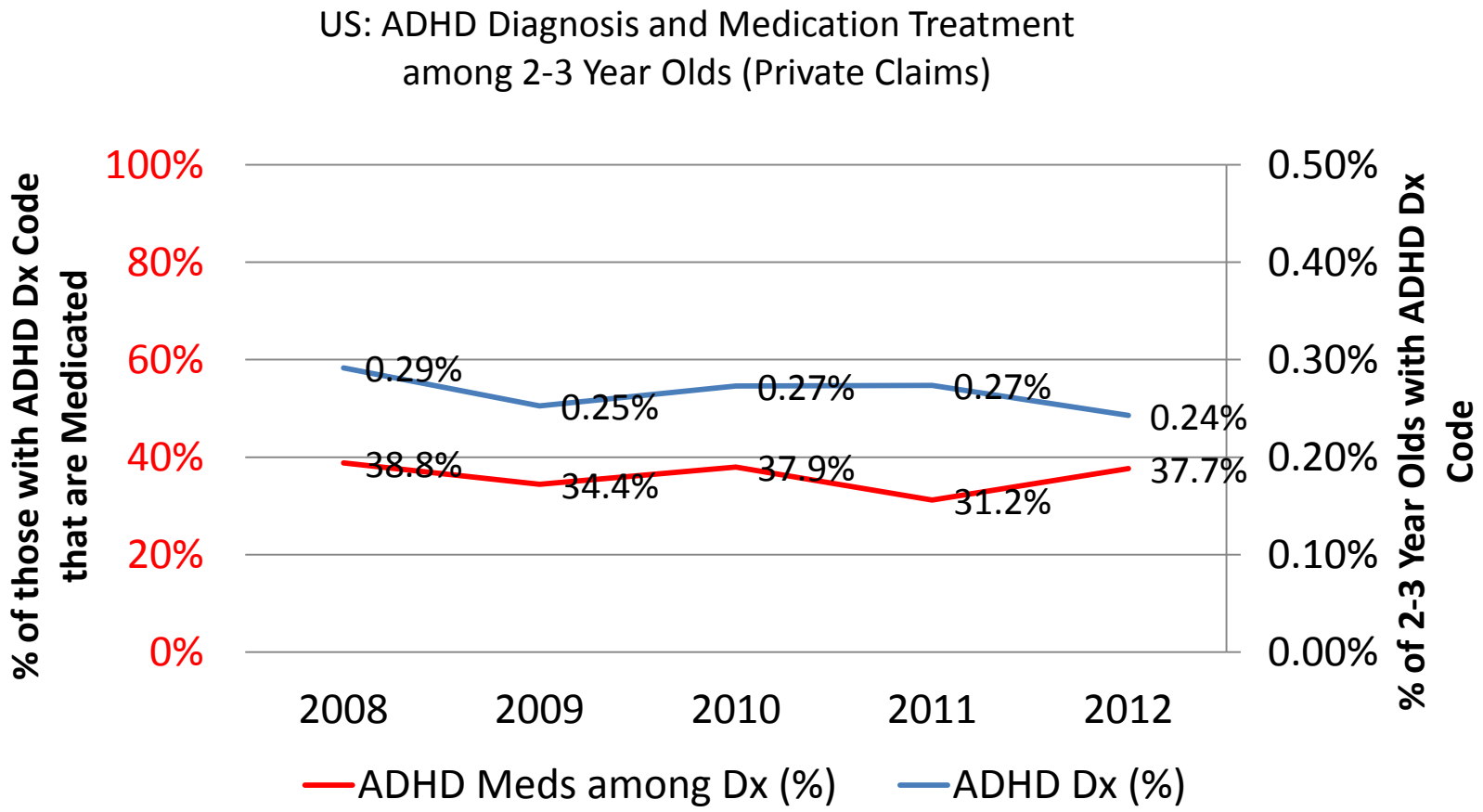
ADHD Treatment among GA Preschoolers

- AAP recommends that 4-5 year olds with ADHD should receive behavioral therapy first
  - In GA, about 5.6% of 4-5 year olds in Medicaid were medically managed for ADHD
  - 44% had a behavioral therapy claim, while 74% had an ADHD medication (FDA-approved) claim in 2012
  - The behavioral therapy rates are similar to older children, 6-12 years of age
  - 56% of preschoolers may not be receiving care consistent with AAP's best practices for ADHD treatment (behavioral therapy)

ADHD Treatment among GA Toddlers

- There are no current guidelines that guide the diagnosis and treatment of ADHD among children under 4 years of age
  - In GA, about 1% of 2-3 year olds in Medicaid were medically managed for ADHD
  - 45% had a behavioral therapy claim, while 46% had a medication claim in 2012
  - Only amphetamine and d-amphetamine is FDA-approved for ADHD treatment for children as young as 3 years
  - Valid diagnosis of ADHD in a toddler is not supported by evidence
- These medication treatment patterns are not unique to GA

National MarketScan Database: Pathways



* Among a MarketScan sample of 10,000,000 individuals

Conclusions

- In 2012, approximately 1,660 toddlers in GA were being medically managed for ADHD in GA and about 760 of these had a claim for ADHD medication (class II controlled substances)
- Only about 41% of all children 2-12 with 2+ ADHD Dx codes had a behavioral therapy/psych claim in 2012
- GA data suggest areas for quality improvement in GA and beyond, particularly among GA toddlers and preschoolers
- Additional research and investigation is needed
  - Education about AAP best practices
  - Investigation of coding practices
  - Investigation of the infrastructure for the provision of behavioral therapy

DISCUSSION POINTS

Evidence-Based Therapies for Preschoolers with ADHD

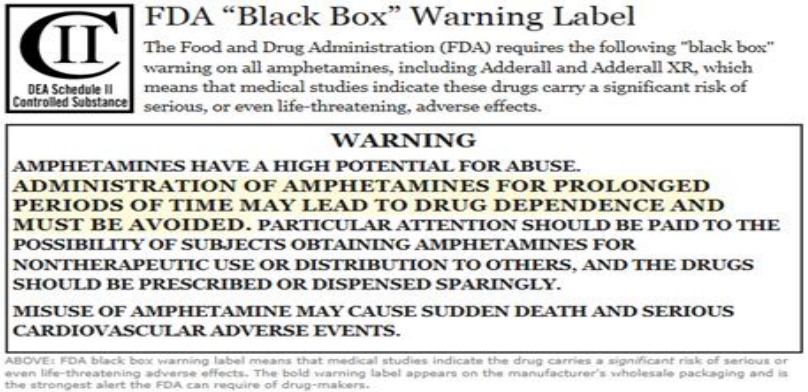
- **The Agency for Health Care Research and Quality (AHRQ) reviewed treatments for preschoolers with behavioral problems**
- **Recommended *parent behavioral interventions* as a good treatment option for preschoolers with ADHD, ADHD symptoms, and disruptive behavior in general**
  - Help parents develop a positive relationship with their child
  - Teach them about how children develop
  - Help them manage negative behavior with positive discipline
- **4 programs for parents of preschoolers with key components**
  - Triple P (Positive Parenting of Preschoolers program)
  - Incredible Years Parenting Program
  - Parent-Child Interaction Therapy (PCIT)
  - New Forest Parenting Programme

Gaynes B, Christian R, Saavedra L, Wines R, Jonas D, Viswanathan M, Ellis A, Woodell C, Carey T. Treatment in At-Risk Preschoolers; Long-Term Effectiveness in All Ages; and Variability in Prevalence, Diagnosis, and Treatment. Rockville (MD), 2012.

What are the *Short-term* Side Effects of ADHD Medications?

- Side Effects of Stimulants
  - **Black Box**
    - Should not be used by those who abuse drugs, alcohol or who have heart problems
  - Tics, tremors, jitters
  - Dilated pupils
  - Increased pulse rate
  - Increased blood pressure
  - Appetite suppression, nausea, stomach ache
  - Insomnia
  - Cardiovascular incident
  - Sudden death

- Side Effects of Strattera
  - **Black Box**
    - Suicidal ideation
  - Abdominal pain



What are the *Long-term* Side Effects of ADHD Medications?

- Stimulant medications have been used widely for over 70 years and have long been considered safe
- We don't completely understand the long-term effects
- What we know
  - Growth suppression
    - ~1 cm and ~1 kg
  - Paranoia or hallucinations
- Concerns and ongoing research
  - Damage to the developing brain
    - Particularly among the very young
  - Genetic toxicity
  - Later drug abuse/addiction
  - Cardiovascular incident and sudden death

Why are these unique findings?

- Difficult to have sufficient sample size to estimate prevalence and medication treatment among young children, using national survey data
- Dx prevalence is likely closer to lifetime prevalence in younger children
  - These claims data may be more valid for prevalence
- Claims data provide population counts, not estimates
  - Relevant for state-based quality improvement efforts

Next Steps

- Additional analyses
- Identification of barriers to best practices for ADHD
  - Survey
  - Key informant interviews
  - Policy analysis
- Workforce development opportunities
- Educational outreach about the AAP Diagnostic and Treatment Guidelines for ADHD
  - Clinicians
  - Parents
  - ADHD/CMH Stakeholders
- What more should be done?

Acknowledgements

Interagency Director's Team for Child and Adolescent Behavioral Health

Georgia Center of Excellence in Child and Adolescent Behavioral Health at Georgia State University

Mei Zhou

Angela Snyder, PhD

Department of Community Health

Thank you!

Susanna Visser, DrPH, MS

Follow me on Twitter @VisserCDC

svisser@cdc.gov

CDC ADHD Web-Site

www.cdc.gov/adhd/

CDC-funded National Resource Center for ADHD

www.help4adhd.org

For more information please contact Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333
Telephone, 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov Web: www.cdc.gov

The Physician Perspective: The Reality in Georgia

Doris M. Greenberg MD
Developmental-Behavioral Pediatrician

Realities

- Ideally, youngsters over 3, or at least 4, should be screened for ADHD as part of pediatric assessments. This is still rare in most practices.[1]
- Most Medicaid and Managed Medicaid and Peachcare recipients can receive behavioral therapy but few can receive testing first, preventing assessment of cognitive difficulties prior to designing therapy. Some companies won't fund testing at all.

- 1 Wigal, T., et al, JAACAP, 45 (11), 1294-1303, November, 2006

For the Under 6, Behavioral Therapy Recommended First

- No quality controls on what behavioral therapy is, how long it should continue, and when medication for ADHD should be considered (the non-responders).
- No clear outline as to what this therapy entails.

- Since only about half of the very young respond to medication mgt, the use of the methylphenidate class of stimulants ARE NOT ON LABEL , and pharmacy plans hide behind this, despite the PATS study which used methylphenidate for the very young.[1]

- 1 Vietello, B. et al, J Child and Adolescent Psychopharmacology, 17 (5), 595-603, Oct. 2007

Medication Frustrations

- Patients have unique metabolic profiles in handling the stimulant medications. One dosage regimen does not fit everyone.
- Pharmacy plans require unreasonable authorizations, appeals, re-appeals. Much productive time is wasted trying to obtain permission to treat appropriately.
- Shortages of medications due to DEA and FDA and Pharma
- Due to denials, patients are back to 30 year old regimens “the Ritalin for lunch bunch” with mostly immediate release meds.
- Unrealistic dosage recommendations when longer days need coverage
- Inferior generics (i.e. Concerta generics)

Provider Scarcity

- Many psychologists and therapists in our area have refused to take Medicaid or managed Medicaid due to the “hassle factor.”
- Medicaid and managed Medicaid patients are less likely to appear for appointments.

- Children in foster care system who have had parenting problems are often more needy, have more pathology, are less likely to have continuity of care—ie. new doctor with each new foster home.[1]

1Leslie, L, Child Abuse and Neglect, “Children in Foster Care,” 24(4) April 2004, 465-76

The Physician Gets Little Say

- Using our best expertise, we decide on a course of treatment only to find a clerk for a pharmacy plan rejecting it. It may take weeks to finally have a peer review the decision.
- Families who are expected to go through step edits to finally get the medication that should have been used first, may experience catastrophic problems in the “failure” phase of each medication trial.
- Why can’t we have more say and avoid unnecessary visits and medications that end up being thrown out?

Wasted Money

- School nurses charge Medicaid and managed care companies to administer short-acting medications at school. Use of long-acting medications may save money, yet they are not always allowed.
- Quantity limits may require several bottles of several strengths, just to avoid the limits. This adds extra expense to each month's prescriptions.

Not Taught Well in Hospital Setting

- A common disorder that should be taught to all medical students, and to residents in Pediatrics, Internal Medicine and Family Medicine.
- Behavioral Health is still treated like second class medicine.

Treating ADHD is Cost Effective

- Prevents future failures: in school, in home, in jobs, in marriages, in the justice system, in the world
- Reduces substance abuse disorders by a huge amount
- Reduces traumatic accidents
- Increases taxpayers[1]

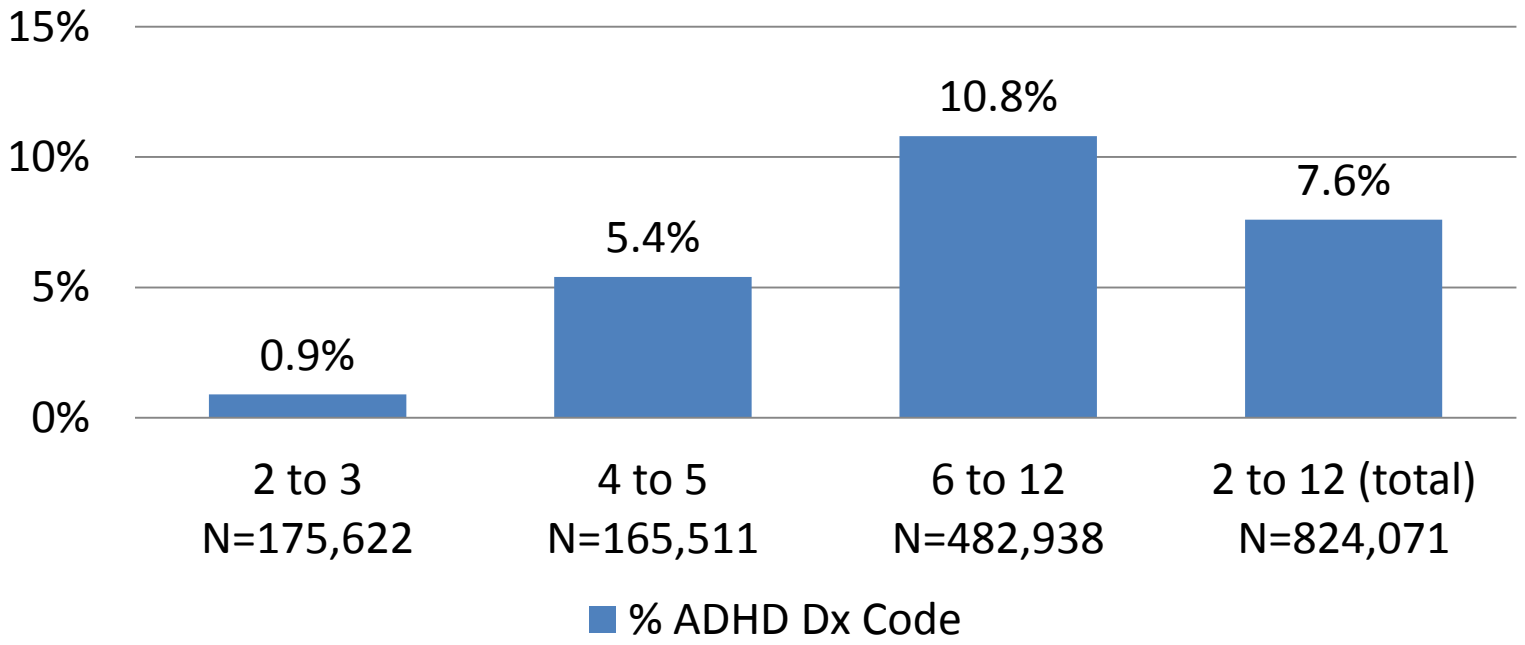
1 Barkley, R., ADHD in Adults, What the Science Says, Guilford Press, 2008

Ruth Perou, PhD – CDC's Mental Health Coordinator

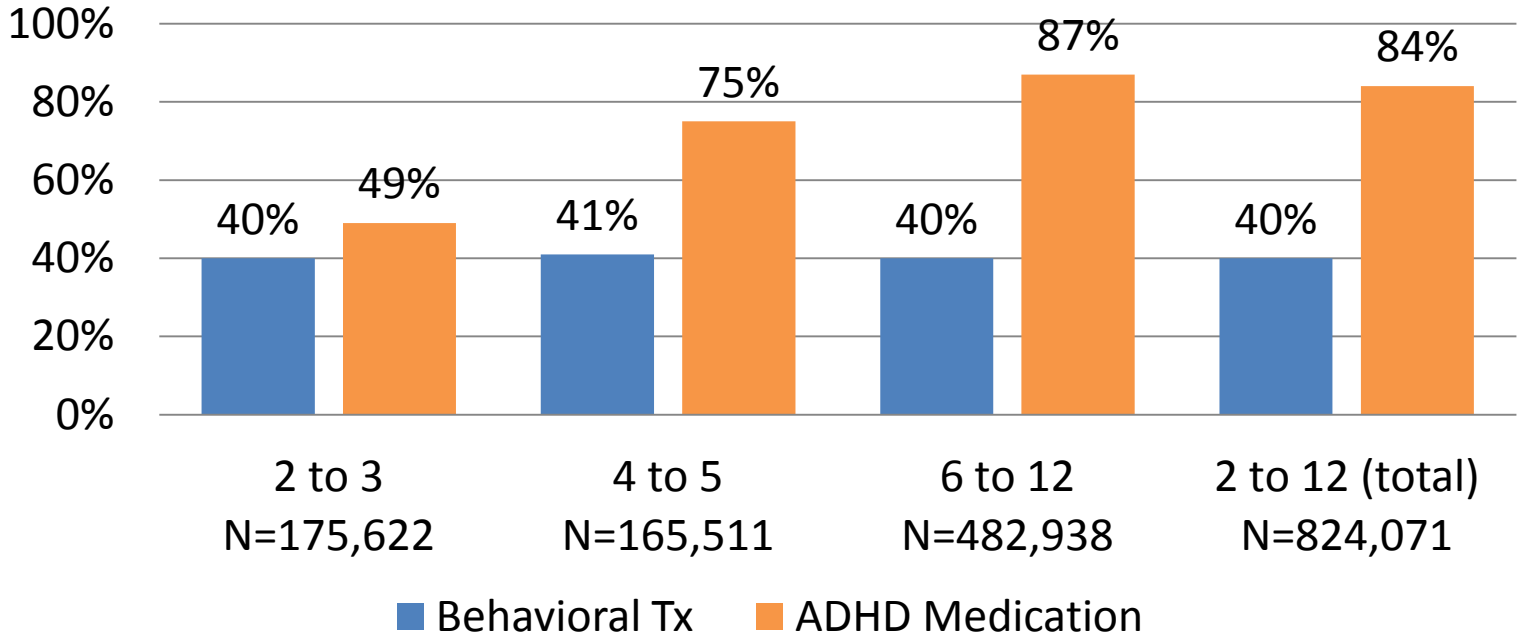
SUMMARY COMMENTS

2011 DATA

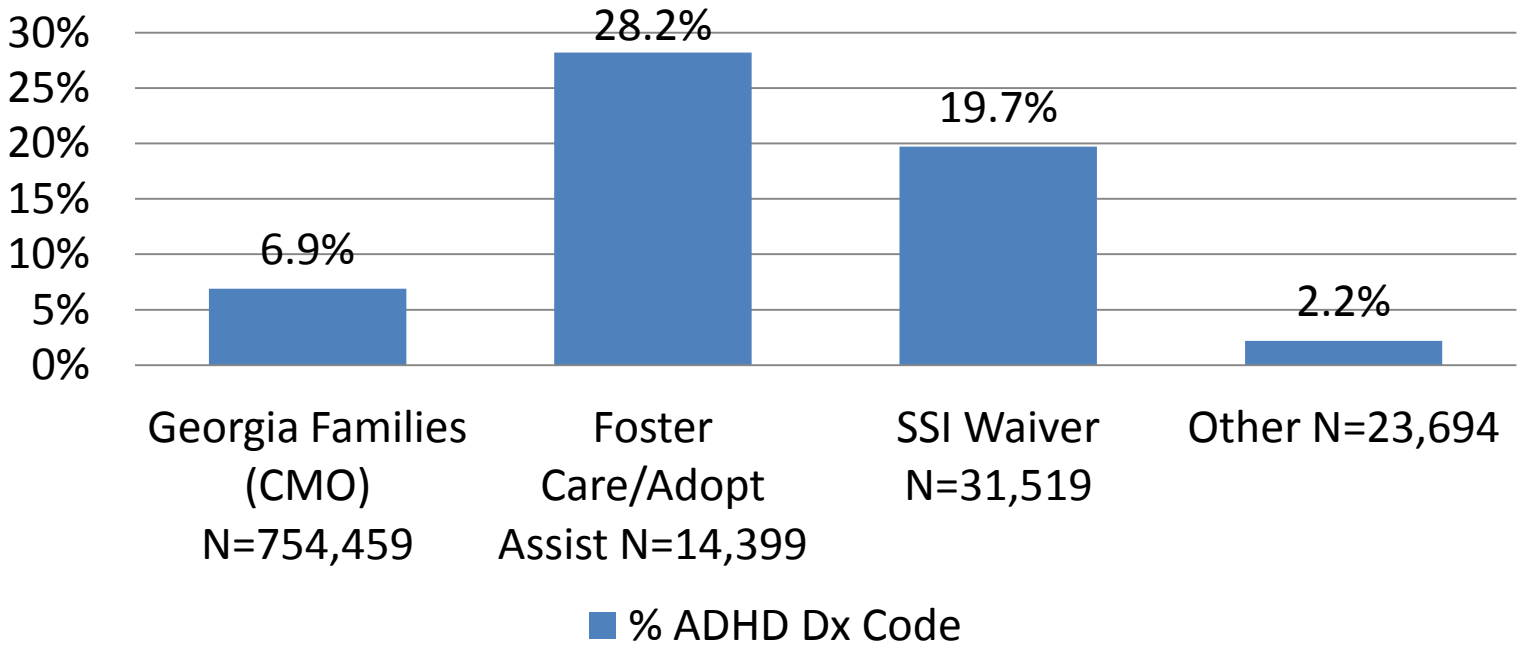
Percentage of GA Children in Medicaid with an ADHD Diagnosis Code (2011)



Treatment of GA Children in Medicaid with an ADHD Diagnosis Code (2011)



Percentage of Children in Medicaid with an ADHD Diagnosis Code (2011), by Eligibility Categories



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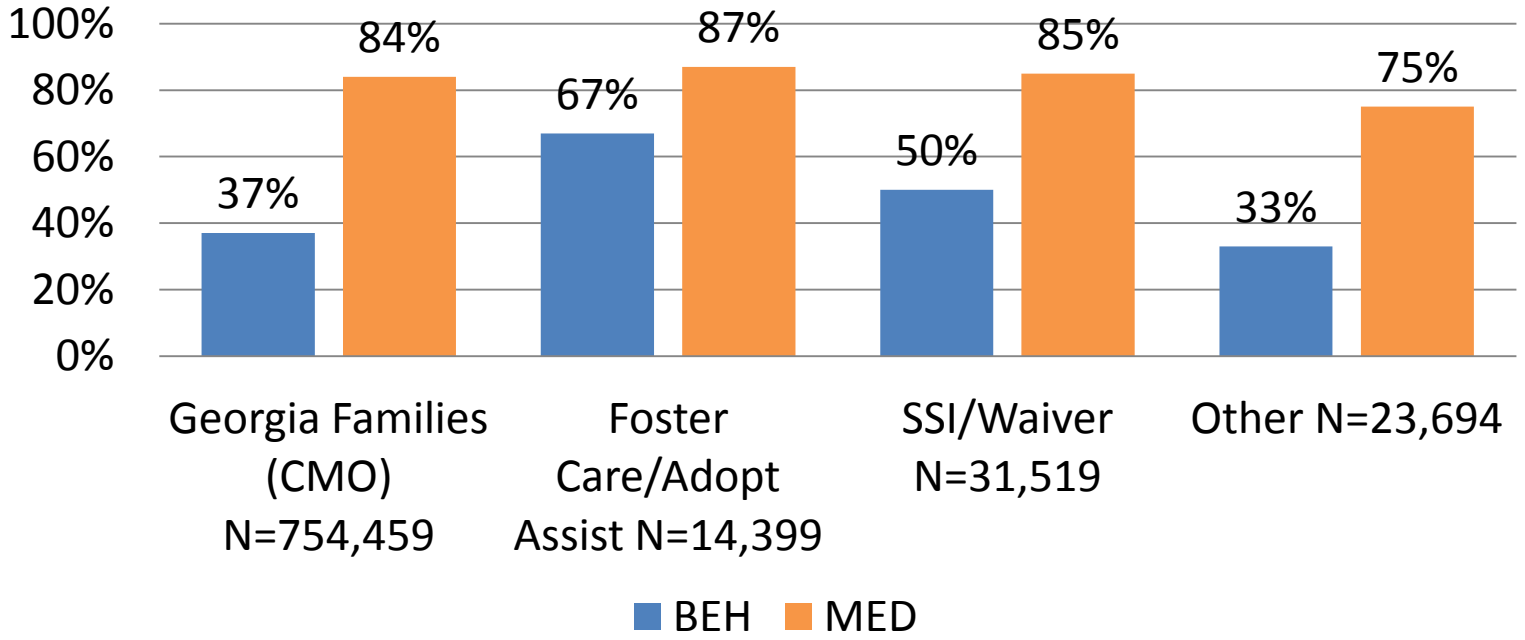


Addressing the Workforce Challenges in Advancing Behavioral Health Reform

John A. Morris, MSW
Executive Director,
The Annapolis Coalition on the Behavioral Health Workforce

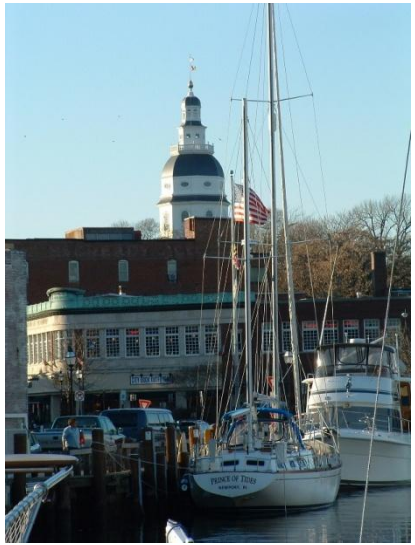
Georgia Mental Health Symposium

The Carter Center, May 16, 2014

What is The *Annapolis Coalition*?

- A small not-for-profit
- Large Coalition
- Neutral convener of stakeholders
- Source of information & technical assistance
- Vehicle for strategic planning, collective action, & public/private partnerships

www.annapoliscoalition.org



Four + Decades of Change in Behavioral Health Care (“Better But Not Well”…)

- Cultural competency
- Patient Safety/State Hospital Downsizing
- Performance/outcomes measurement
- Managed care and shifts in financing
- Consumerism
- Recovery & resilience
- Recognition of Co-occurring illnesses & medical co-morbidities
- Evidence-based practice &the rapidly expanding body of evidence
- And now the advent of the ACA

Response of the Field

Typically – slow, uneven and unfocused, inefficient and driven by tradition and anecdote

A universal problem irrespective of setting, discipline, or specialty

The workforce landscape—

how we think it ought to be....

How we more often experience it…

But what's the reality?

As usual, somewhere in between

- Workforce issues are complex, creating "wicked" challenges
- Issues of diversity (race/ethnicity/language and workplace culture) further complicate workforce development strategies
- Traditional methods have not always been sound…

Today's presentation-National trends—implications for Georgia

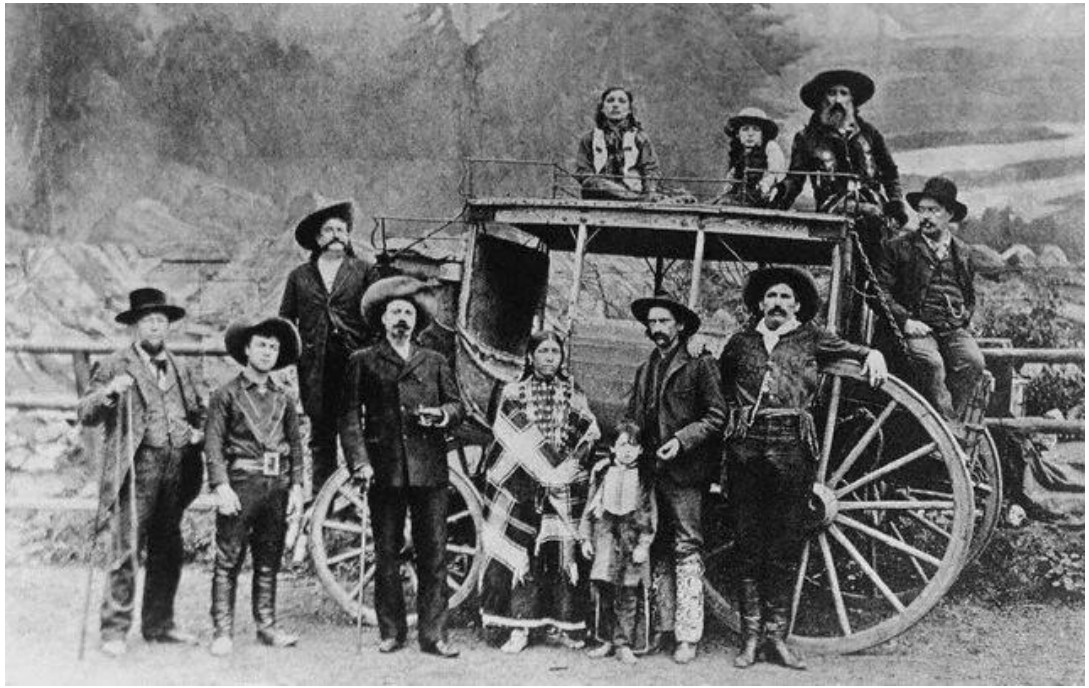
- First, a focus on workforce development in behavioral health specialty settings
- Second, a focus on behavioral health in integrated settings..one of the key developments of healthcare reform in the US and in Georgia's future
- Third, a focus on the direct support workforce in a variety of settings

Workforce development

- For decades we have underinvested, and worse, wasted resources we did invest in workforce development
- In the Annapolis Coalition Work, we refer to this collective phenomenon as

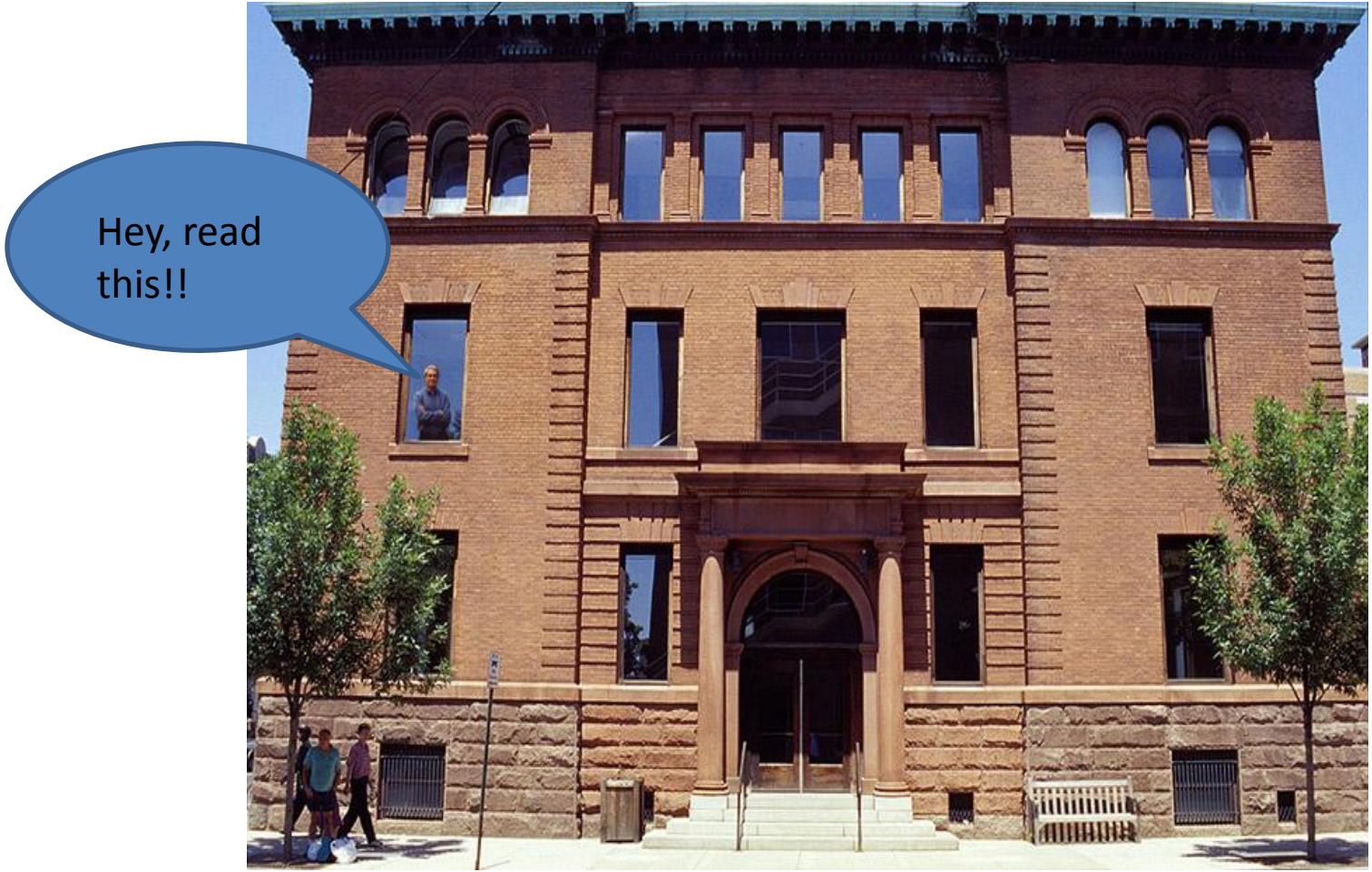
THE PARADOXES OF WORKFORCE DEVELOPMENT IN BEHAVIORAL HEALTH

Paradox 1: We train graduate behavioral health professionals for a world that no longer exists



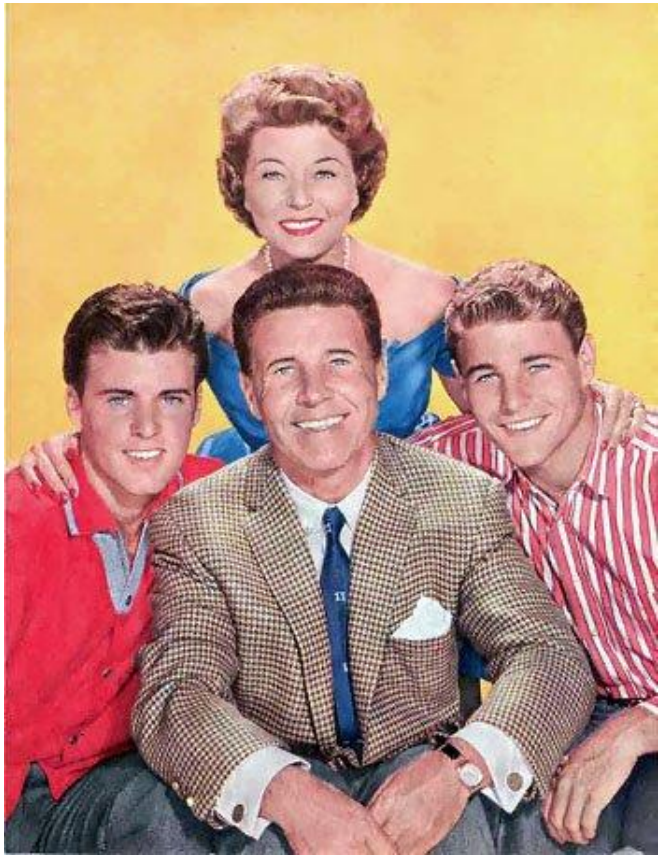
Paradox 2: Those who spend the most time with consumers receive the least training

Paradox 3: Continuing education and academic training programs persist in utilizing ineffective teaching strategies


Hey, read this!!

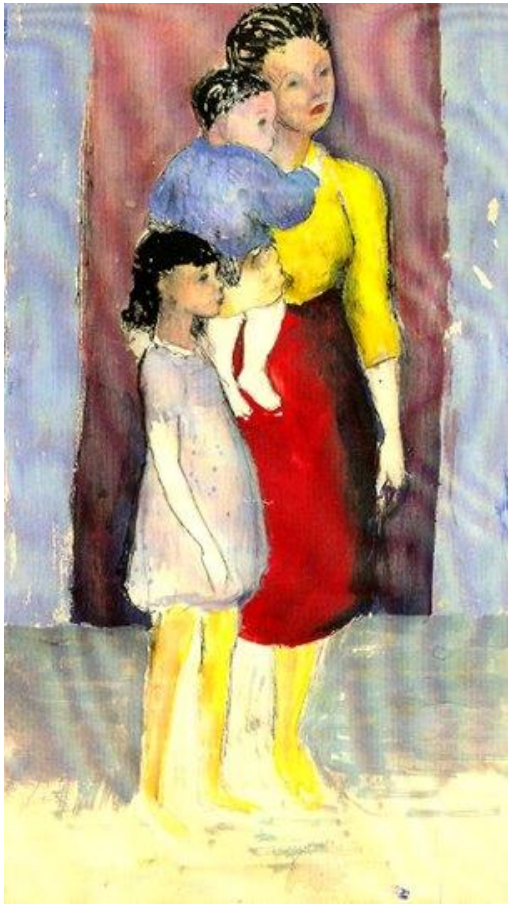
Paradox 4: We train only where willing crowds gather

Paradox 5: Consumers and families receive little educational support….



…(a contemporary “mo-occurring” family)

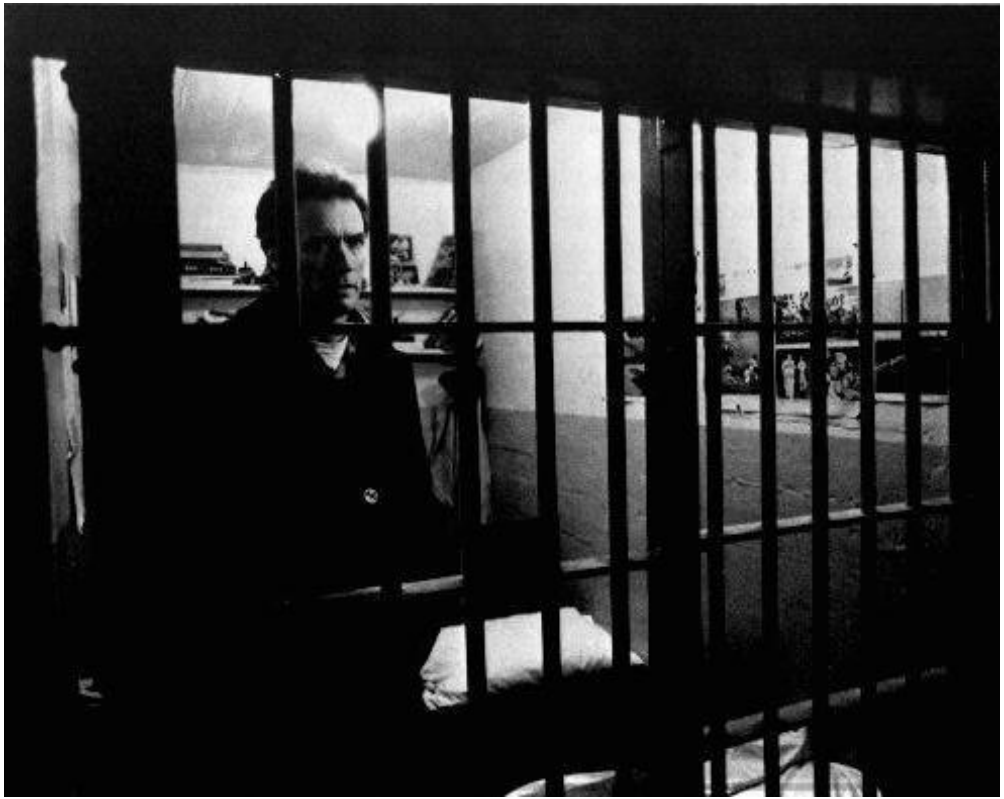
Paradox 5: Their Lived Experience Doesn't Inform the rest of the Workforce



Paradox 6: The diversity of the current workforce doesn't match the diversity of those served.

Paradox 6: The diversity of the current workforce doesn't match the diversity of those served.

Paradox 7: Students are rewarded for "doing time" in our educational systems

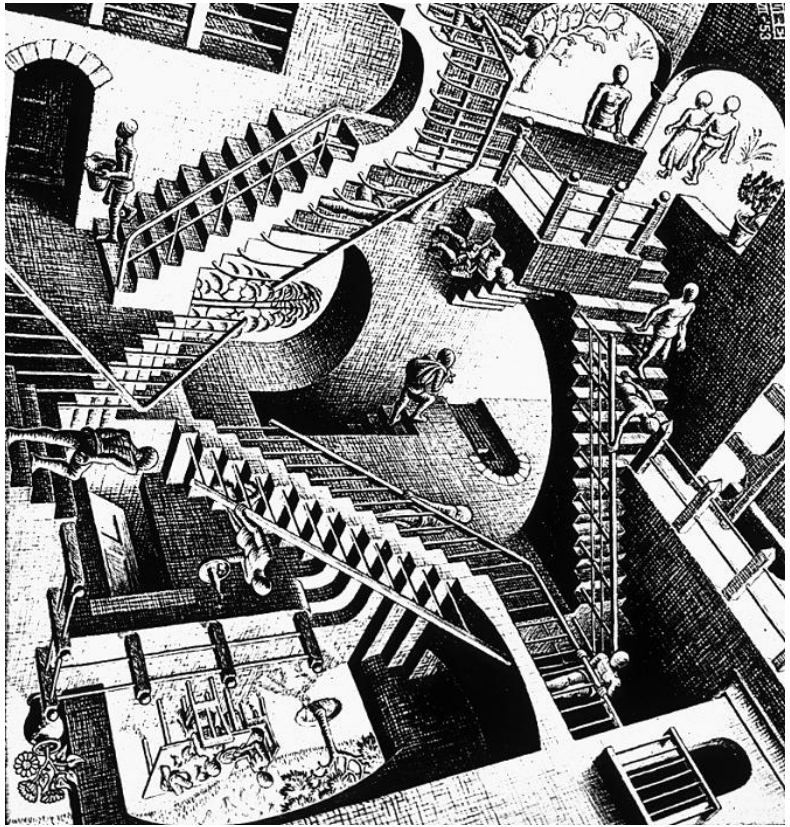


Paradox 8: We do not systematically retain or recruit staff

Paradox 9: Once hired, little supervision or mentoring is provided

Paradox 10: Career ladders and leadership development are haphazard

Paradox 11: Incompetent service systems thwart the competent performance of individuals



Some light at the end of the tunnel…

For behavioral health specialty settings: A national action plan—
with relevance for Georgia

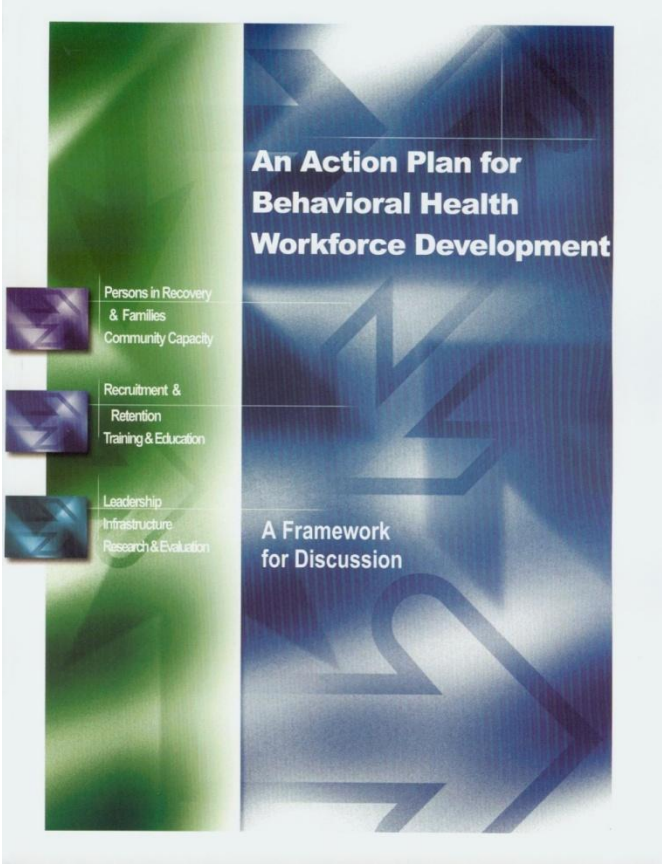
For integrated settings:

The Center for Integrated Health Solutions

For the high volume category of direct support workers:

DSW Resource Center, Hitachi/Annapolis

The Plan


An Action Plan for
Behavioral Health
Workforce Development
Persons in Recovery
& Families
Community Capacity
Recruitment &
Retention
Training & Education
Leadership
Infrastructure
Research & Evaluation
A Framework
for Discussion

Elements of the Plan

- General findings
- Seven strategic goals
- Objectives & Actions
- Preliminary implementation tables linked to recommended stakeholders
- Special topics
  - Relevance of core recommendations
  - Unique issues & recommendations

APPENDIX A: PRELIMINARY IMPLEMENTATION TABLES
GOAL 1

GOAL 1: Significantly expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.

Objectives, Actions, & Levers of Change	Stakeholders
Objective 1: Provide information and education to individuals in care or recovery and their families[17] to enable them to maximally participate in or direct their own care and to assist and support each other.	
Action 1: Identify and make available to people in care and their families a body of peer-reviewed, scientifically sound, culturally and linguistically relevant materials in a variety of formats (text, video) and languages, and make these materials accessible to people with different educational levels.	
a. Create or identify a central clearinghouse to which consumers and families could be directed to obtain materials on a range of conditions. The clearinghouse could provide the information directly or refer to existing sources (such as national or local advocacy organizations). Provisions will need to be made for individuals and families for whom computer access is problematic.	Consortium of National Organizations, supported by Federal Government
b. Initiate a grant program to foster the development of new educational materials to reflect current and emerging science and to respond to changing demographics, ensuring accuracy and cultural appropriateness.	Federal Government; Foundations
c. Identify or develop and widely disseminate curricula for educating professionals about optimal ways to communicate core information about mental health and substance use disorders. (This is a two-part intervention, as development and dissemination are distinct but interrelated tasks.)	Foundations; Advocates; Education & Training Programs

[17] *Individuals in care or recovery* is always intended to include both adults (including elders) and youth; the term *families* refers to primary caregivers (including foster parents or other parent surrogates) for minors as well as people who are actively involved in the treatment of another family member by invitation of the adult or young adult.

General Findings

- Widespread concerns about the current and future workforce
- High levels of dissatisfaction among
  - Persons in recovery & families
  - Workforce employers
- “We” are fragmented: disciplines, sectors, & effort
- Historically narrow foci, missing:
  - Life span issues (children & elders)
  - Culturally diverse populations
  - Rural America

General Findings

- Scarcity of data
- Doing what is easy or affordable - not what is effective
- A hunger for “tools”
- Pockets of innovation
- Difficulties with sustainability and dissemination
- A crisis that extends throughout health & human services settings.

Goals 1 & 2

Broadening the Concept of“Workforce”

Goal 1: Expand the roles of persons in recovery (Consumers/Patients) & families

Objectives:

- Increased educational supports
- Real shared-decision making
- Expand peer & family support
- Greater employment as paid staff
- *Formal* engagement as educators of the rest of the workforce

Goal 2: Enhance community capacity to support behavioral health and wellness

Objectives:

- Competency development with communities
- Competency development of the behavioral health workforce in community collaboration
- Strengthening connections between behavioral health organizations and their communities

Note: This recommendation preceded the

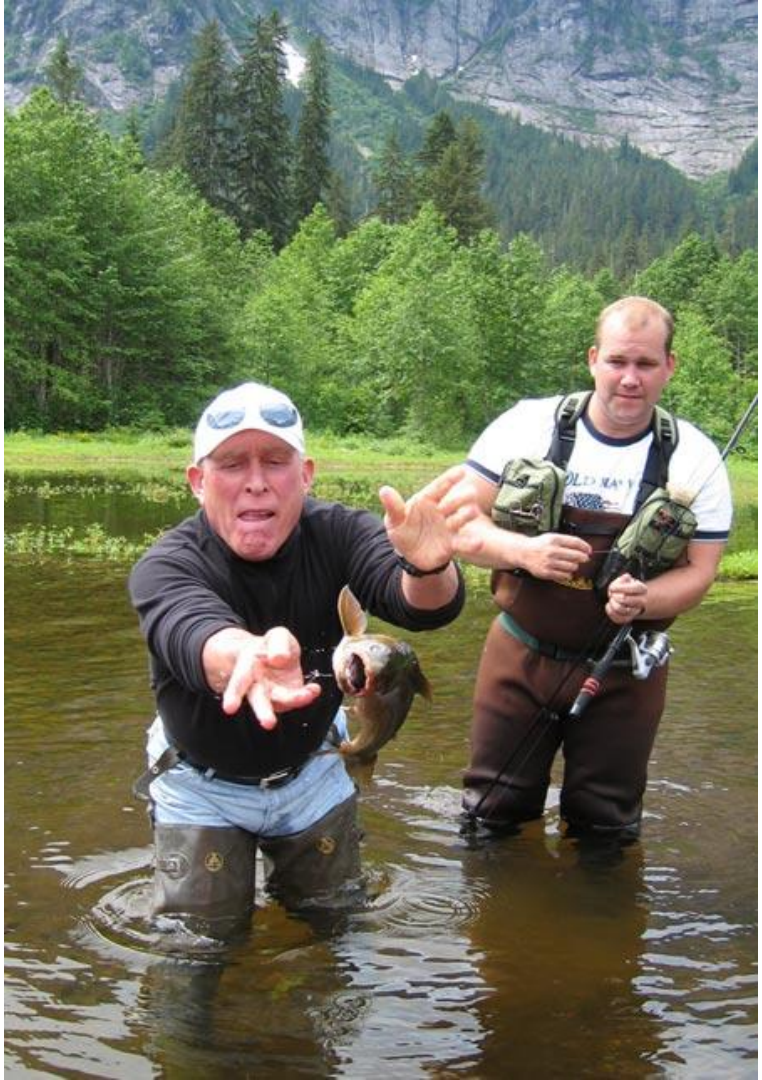
2009 IoM prevention report

Goals 3, 4, & 5

Strengthening the Workforce

Goal 3: Implement systematic retention & recruitment strategies

- Implement & evaluate interventions:
  - Salary, benefits, & financial incentives
  - Non-financial incentives & rewards
  - Job characteristics
  - Work environment
- Develop career ladders
- “Grow your own” workforce
- Cultural & linguistic competence
- Social marketing
- **Too often our approach might be closer to…**



Goal 4: Increase the relevance, effectiveness, & accessibility of training

Objectives:

- Competency development
- Curriculum development
- Evidence-based training methods
- Substantive training of direct care workers
- Technology-assisted instruction
- Addiction and co-occurring competencies

in every staff member

- Systematic support to sustain newly acquired skills

Effective Teaching Strategies

No magic bullets, but LOTS of tools.

- Interactive sessions
- Academic detailing / outreach visits
- Reminders
- Audit and feedback
- Opinion leaders
- Patient mediated interventions
- Social marketing

Telling ain’t training…

training ain’t performance

--Harold Stolovitch

Effective strategies

We ask ourselves this challenging question:

Is it training?

Or is it just…

Exposure?

Goal 5: Actively foster leadership development

Objectives:

- Identify leadership competencies tailored to behavioral health
- Use competency-based curricula
- Formalize succession planning
- **Implement formal, continuous leadership development in all sectors beginning with <u>supervision</u> (or is it “surveillance”?)**

Sister Surveillance is watching you

(#1 Draft pick this year from what state….?)

Behavioral Health Style

Goals 6 & 7

Structures to Support the Workforce

Goal 6: Enhance workforce development infrastructure

- **A workforce plan for every agency**
- Data-driven CQI on workforce issues
- Strengthen HR & training functions
- Improve IT support for training, workforce support, & tracking
- Decreased paperwork burden: variable, redundant or purposeless reporting


Espresso

Goal 7: Invest in research & evaluation of workforce Issues

Objectives:

- Federal and state inter-agency research collaboratives

- Technical assistance to field on evaluation of workforce practices – lots to be learned from our colleagues in the IDD and aging worlds.

Plan summary

- Strategic goals & objectives are a guide for assessment & planning
- State / organization plans must be unique and tailored
- Levers of change
  - Leadership
  - Competency assessment
  - Financing
  - Accreditation, licensure & certification
  - **Advocacy**
- Relevance to all health and human service professions

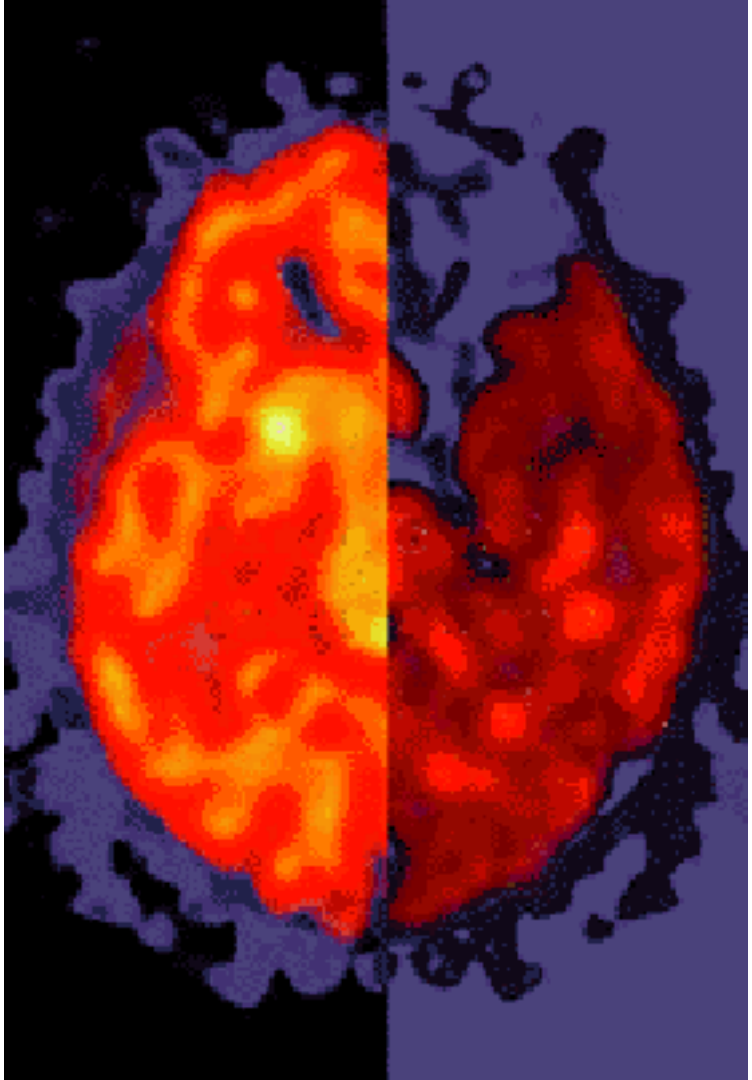
Observations on planning

- Potential for endless “process”
- 1000 points of “No”
- All solutions are flawed
  - Narrow: more effective, less overall impact
  - Broad: potential for greater overall impact, yet outcomes more uncertain
- **Pairing workforce development and organizational change strategies critical**
- Sustaining the workforce development effort and evaluating outcomes is tough

Levers of change to improve the workforce

- Leadership
- Advocacy
- Competency assessment
- Licensure & Certification
- Accreditation
- Financing & other incentives
- Performance monitoring

Workforce development is itself a lever for transformation….



Behavioral health/primary care integration

- Do we really know what this will mean?
- Are providers in either sector really prepared?
- What are the dynamics likely to be?

It kind of feels like this

Or maybe this…

Agreed: The stakes are high

The history of behavioral health integration in the US has some scary precedents…

- Reduced access and benefits
- Inappropriate limits on visits and medications
- Dramatically under-priced reimbursement rates
- Narrow definitions of medical necessity that negatively impacted using natural supports and peers; resistance to inclusion of substance use treatment in basic coverage
- Loss of recovery focus in care to medical management

On the other hand….

- Data on mortality and morbidity for people diagnosed with major mental illnesses, including comorbid substance use disorders = a scandal for our field.
- Life expectancy reductions of 20+ years cannot be allowed to continue.
- Integrated care must be part of our toolbox.

The way forward: Reasons for optimism

- Behavioral health actually has something to bring to the table (more on this later)
- Co-occurring disorders are increasingly recognized as the norm not an anomaly
- The new buzz word in US integration circles is “bidirectional”: **not** a foregone conclusion that the mergers or integration will all be from behavioral health into primary care.

Lessons from the rest of healthcare

- The history of how we arrived at the current general healthcare “system” is every bit as haphazard as ours.

- Atul Gawande, MD: Health care development was “path-dependent”, following the paths of least resistance.

Some tools and resources

- New resources
- Exemplary models


Center for Integrated Health Solutions - Windows Internet Explorer
http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions
hsa hrsa center for integrated health solutions
Favorites
Center for Integrated Health Solutions
Page
Safety
Tools
SAMHSA-HRSA
Center for Integrated Health Solutions
Making Integrated Care Work
NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE
SAMHSA
HRSA
Center for Integrated Health Solutions
Mental Health First Aid
National Council LIVE Webinars
Healthcare Reform Blog
Operations
Financing
Clinical
Wellness
Research
Training
Communities
About the Center
The SAMHSA-HRSA Center for Integrated Health Solutions, run by the National Council for Community Behavioral Healthcare under a cooperative agreement from the U.S. Department of Health and Human Services, is funded jointly by the Substance Abuse and Mental Health Services Administration and the Health Resources Services Administration. The CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings.
Peer Support Wellness Respite Centers
Free Webinar, Wednesday, March 30, 2011
1:00 pm - 2:30 pm eastern
CLICK HERE TO REGISTER *Space is Limited
ABOUT THE WEBINAR
Eight states currently fund Peer Support Wellness Respite Centers promoting mind-body wellness, whole health, and resiliency. Join us for this free webinar that will address how these innovative Centers are supporting wellness and demonstrating outcomes that include reduced hospitalization for people in recovery from addiction and mental illness.
This webinar will help Health Centers understand what Peer Support Centers are and how they support meeting the behavioral health care needs of their patients/consumers. Peer Support Centers also offer collaborative care for patients with behavioral health concerns and the resources and links to help primary care providers learn more about these Centers.
WEBINAR OBJECTIVES
Search For
Find a Provider in ...
Print Page | Email Page
Together WE WILL!
Learning Communities Login
Join your Learning Community to exchange ideas, information, and resources on integrating primary care and mental health addictions services.
start
John Morris ...
Facebook - ...
http://www....
Center for I...
Microsoft Po...
Advancing R...
4:58 PM

Just released

- Core competencies for providing integrated primary and behavioral health services
- Expert panel methodology
- Available at the SAMHSA-HRSA Center for Integrated Health Solutions

Consensus categories for ALL staff

- I. Interpersonal Communication
- II. Collaboration & Teamwork
- III. Screening & Assessment
- IV. Care Planning & Care Coordination
- V. Intervention
- VI. Cultural Competence & Adaptation
- VII. Systems Oriented Practice
- VIII. Practice Based Learning & Quality Improvement
- IX. Informatics

Navigating the competencies

Drill down detail

Using the core competencies

- Shaping Workforce Training
- Informing Job Descriptions
- Employee Recruitment
- A Guide to Orientation
- Performance Assessment

Focusing on the Direct Support Workforce

- Historically, in the US at least, very little attention paid to this group

- Demand for services has always out-stripped supply of graduate trained behavioral health professionals, worsened by geographic maldistribution

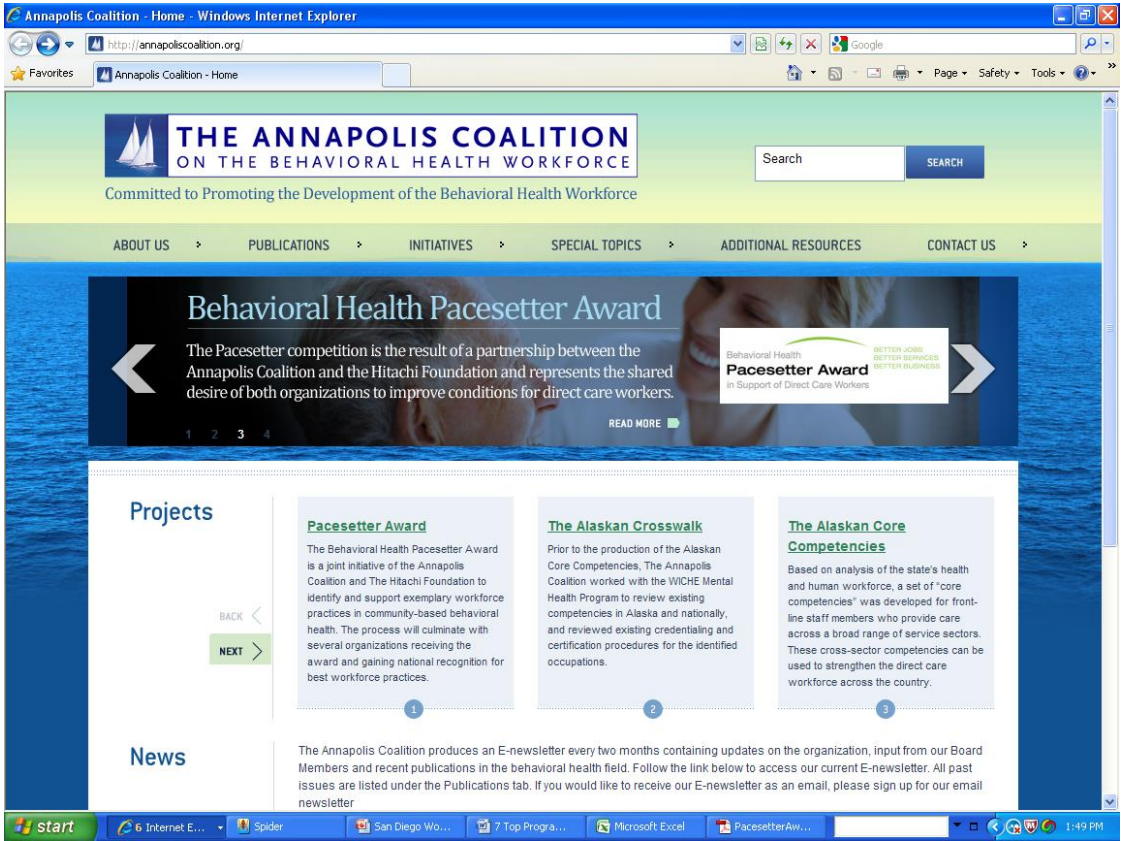
- Rise of recovery-peer and other peer specialists is helping to fill the gap

- Increased focus on DSW can also help fill that gap

The Pacesetter Awards

- A partnership between The Annapolis Coalition and The Hitachi Foundation
- Better Jobs, Better Services, Better Business
- 51 programs nominated
- 5 National Award Winners, 2 Programs of Merit

www.annapoliscoalition.org



Pacesetter Awards

- Criteria for finalists based on the Kennedy School Innovations in American Government Awards:
  - Novelty
  - Effectiveness
  - Significance
  - Transferability
  - Durability/sustainability

Key Improvements by Site

Program	Patient Satisfaction	Patient Outcomes	Revenues/ Reimburse	EBP Imple-mentation
Borinquen	✓	✓	✓	✓
Family Services of Western PA	✓	✓	✓	
Hartford Dispensary	✓	✓	✓	✓
SSTARR	✓	✓	✓	✓
Thresholds	✓	✓	✓	✓

✓ - Anecdotal or modest improvement ✓ - Significant measured improvement Blank – Insufficient data

Worker Outcomes by Site

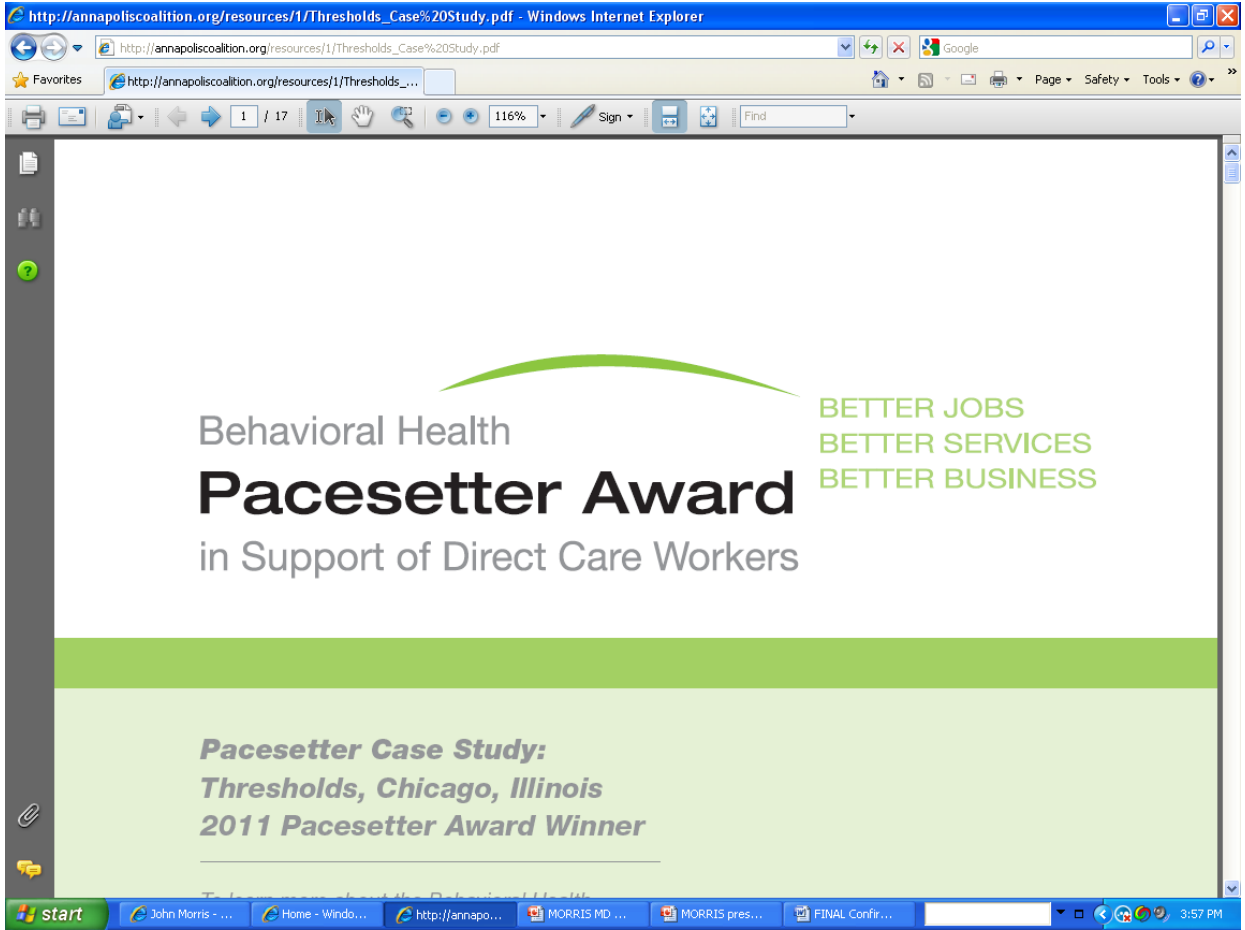
Case Study	Wage Gains	Benefits/ Credentials	Lower Turnover	Employee Satisfaction
Borinquen	✓	✓		✓
Family Services of Western PA	✓	✓	✓	✓
Hartford Dispensary	✓	✓	✓	✓
SSTARR	✓	✓		✓
Thresholds	✓	✓		✓

✓ - Anecdotal or modest improvement ✓ Significant measured improvement Blank – Insufficient data

Common strategies used by Pacesetter Award winning programs

- Supporting educational and career development
- Increasing wages and benefits
- Creating partnerships
- Using Evidence-Based Practices
- Strengthening supervision
- Employing People in Recovery

Case studies:
www.annapoliscoalition.org



In closing

- The **True North** of all healthcare has got to be improved over-all health outcomes for real people in the real world—which means people who have multiple health conditions.
- ACA will increase demand dramatically
- There can be no health without behavioral health.
- As Georgia faces a daunting transition period, the challenge is improving services for individuals already diagnosed, while decreasing demand via prevention.

Action is key

- Create or update a workforce plan
- Make workforce issues a central priority in all activities
- Make workforce core to quality improvement approaches
- Influence every element of preparation and support

of an effective workforce:

- pre-service education
- in-service training/continuing education,
- science-driven retention strategies,
- strategic recruitment, starting early

Use the Coalition's unofficial strategies

- Create demand, don't wait for invitations
- Use the "opportunistic infection" model
- Create the right amount of trouble

Coalition Motto:

I get up each day determined to change the world – *and* to have one hell of a good time.

Sometimes this makes planning the day difficult.

Adapted from
E.B. White

THANKS FOR LISTENING!

Keep in touch…

www.annapoliscoalition.org

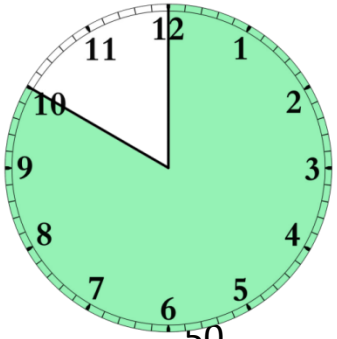
JAMAnnapolis@gmail.com

Georgia's public psychiatry workforce: framing the issues

Benjamin Druss MD, MPH
Georgia Forum
The Carter Center
May 16, 2014

Available Psychiatrist Time/Week

- What We Think Of



50 minutes

- United States: Urban

6 minutes

- United States: Rural

1.5 minutes

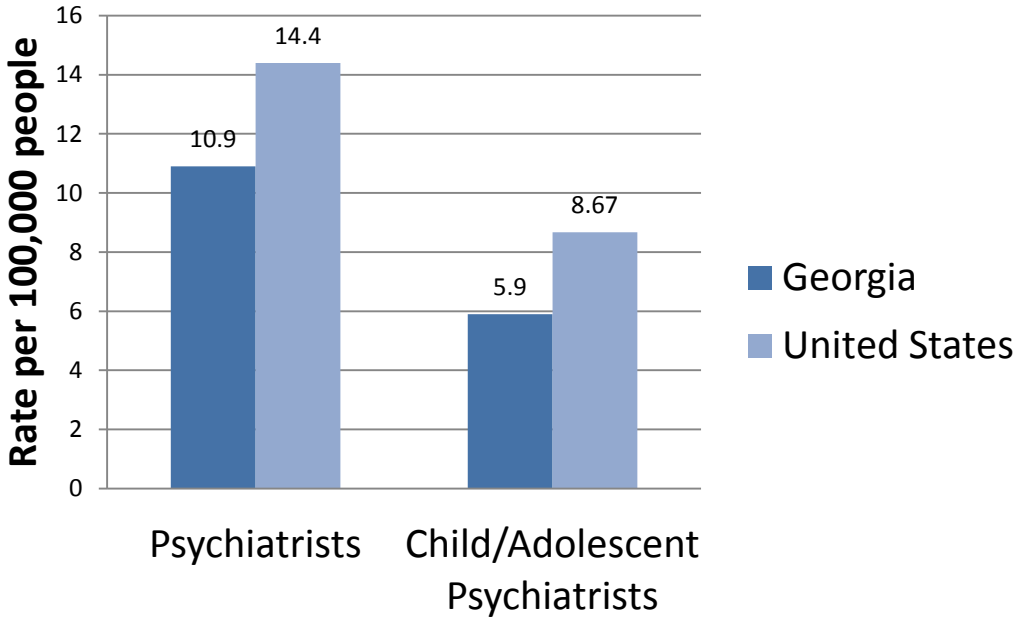
*Adapted from J. Unutzer 2014

It’s Not Just Numbers…

- It’s about location:
  - Psychiatrists, more than other MDs, tend to cluster in urban areas near where they trained
- It’s about insurance:
  - Nationwide, only 43% of psychiatrists vs. 73% of other MDs accept Medicaid
- It’s about competencies:
  - Few psychiatrists have skills/training to practice in community settings

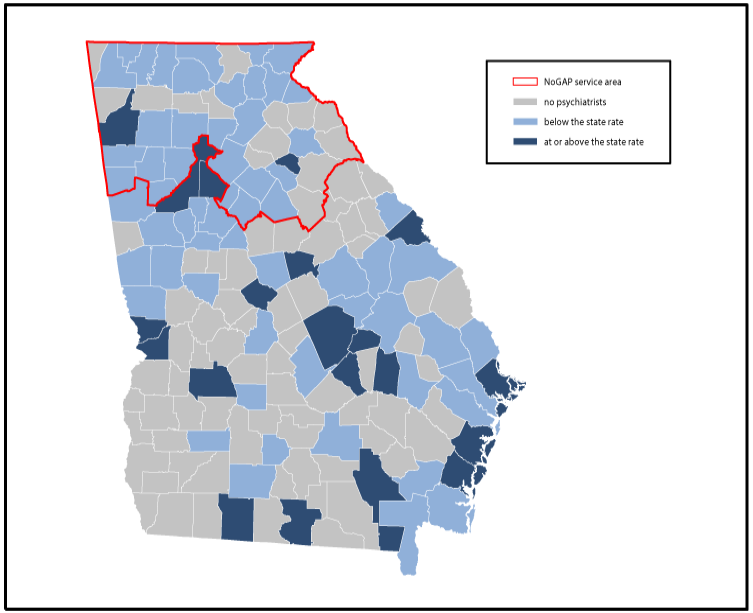
Psychiatr Serv. 2009 Oct;60(10):1323-8.
JAMA Psychiatry. 2014 Feb;71(2):176-81
Psychiatric Services July 2011

Psychiatrists in Georgia: The Numbers



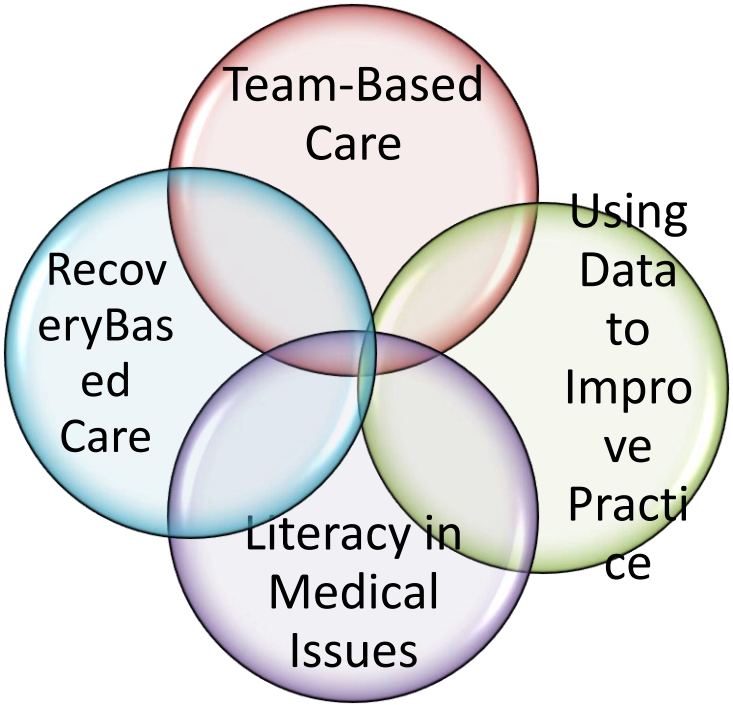
Distribution of Georgia's MD Workforce

- Almost half of GA counties have no psychiatrists
  - Particularly in rural areas
- 48% of GA psychiatrists are 55 or older



Psychiatric Services in press

Competencies for the Future Public Sector Workforce



Implications for Georgia's MH workforce moving forward

- Increase the pipeline: Increase the number of providers trained in core competencies for public sector practice during residency and fellowships
- Extend the reach: Use telehealth and technology, particularly for rural settings
- Work smarter: Stepped care and organized models to help support treatment in primary care and use psychiatrists for the most complex cases

Special Thanks

- DBHDD
  - Frank Berry, Commissioner
  - Judy Fitzgerald, Deputy Commissioner
- NoGAP
  - Jason Bearden, CEO, Highland Rivers Health
  - Tod Citron, Executive Director, Cobb/Douglas CSB
- Emory University
  - Liz Walker, PhD
  - Mark Rapaport, MD
  - William McDonald, MD
  - Edward Craighead, MD

Georgia Behavioral Health Workforce

Ben Robinson

May 16, 2014

Overall Concerns

- Challenges seen in the state system's ability to provide safe care has led to:
  - Federal scrutiny of state behavioral health care
  - Grave concerns regarding quality of care and safety of Georgians needing care from the state's mental health system
- A critical factor driving the problems seen in this system is shortages in the workforce

Behavioral Health Workforce Defined

- Demands placed on behavioral health systems are immense
  - According to DBHDD – estimated 350,000 adults, 91,000 children
  - SAMHSA corroborates this
- Actual need may be higher
  - An estimated 1 in 4 Americans ages 18+ suffer from a diagnosable mental disorder in any given year
- No data on prevalence of substance abuse and developmental disabilities
- Demands for these services growing
  - In part, a product of population size and demographics
    - Georgia population growing faster than the nation
    - This will result in a substantial increase in demand for services

Behavioral Health Workforce Defined

- Provision of behavioral health care is largely a public endeavor provided through multiple systems of care:
  - Dept. of Behavioral Health and Developmental Disabilities
  - Dept. of Corrections
  - Dept. of Juvenile Justice
  - Georgia schools
- As a result of public nature of behavioral healthcare,
  - Constraints of state budgeting process exist
  - Unwavering public expectations
  - Legal constraints
  - More difficult patients

Behavioral Health Workforce Defined

- Workforce is extensive and complex:
  - Consists of large array of professions:
    - Medicine – primary care physicians and psychiatrists
    - Nurses – registered nurses and Advanced Practice RNs
    - Psychologists
    - Social Workers
    - Licensed Professional Counselors
    - Marriage and Family Therapists
    - Numerous technical professions
    - Peer Support Specialists
    - Others
- Many of these professionals are not specific to behavioral health care

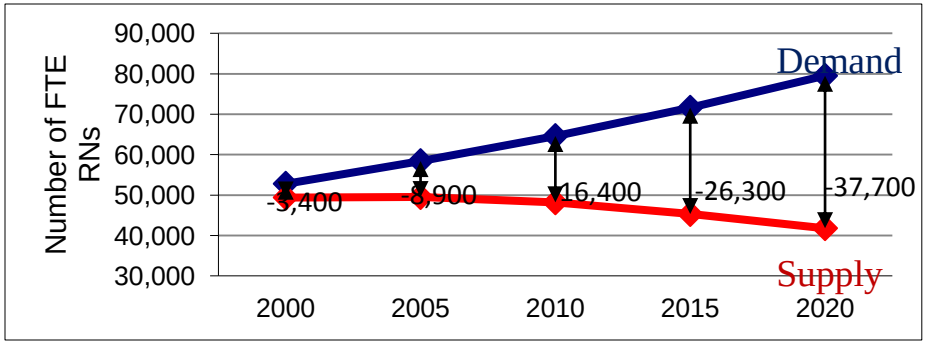
Concerns with Behavioral Health Workforce

- Looking at these professions, we see:
  - Overall workforce is already small
  - Demand for their services is growing
  - Education pipeline is constrained

Concerns with Behavioral Health Workforce

- Many professions in short supply in mental health workforce are in general short supply
  - Georgia typically ranks low when compared to other states
  - Rankings factor for population
  - Broadly used professions (e.g. medicine and Nursing) are particularly constrained
- Attracting them into the mental health workforce can be difficult

Ranking of per capita number of Behavioral Health Professionals in Georgia	
Counselors	28th
Marriage & Family Therapists	31st
Psychiatric APRNs	28th
Psychiatrists	30th
Psychologists	42nd
RNs	40th
Physicians	40th
Social Workers	41st



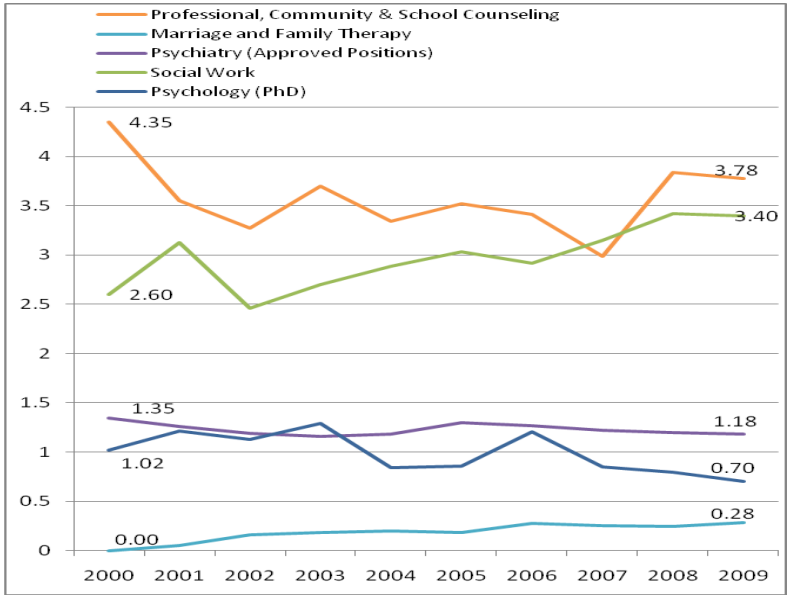
Concerns with Behavioral Health Workforce

- Employers Demonstrate growing need
  - Roughly 6,000 positions to be created in coming decade
  - Demand estimates likely conservative
    - Measure employer demand and not need
    - Does not include critical groups like family medicine, advanced practice RNs, physician assistants…

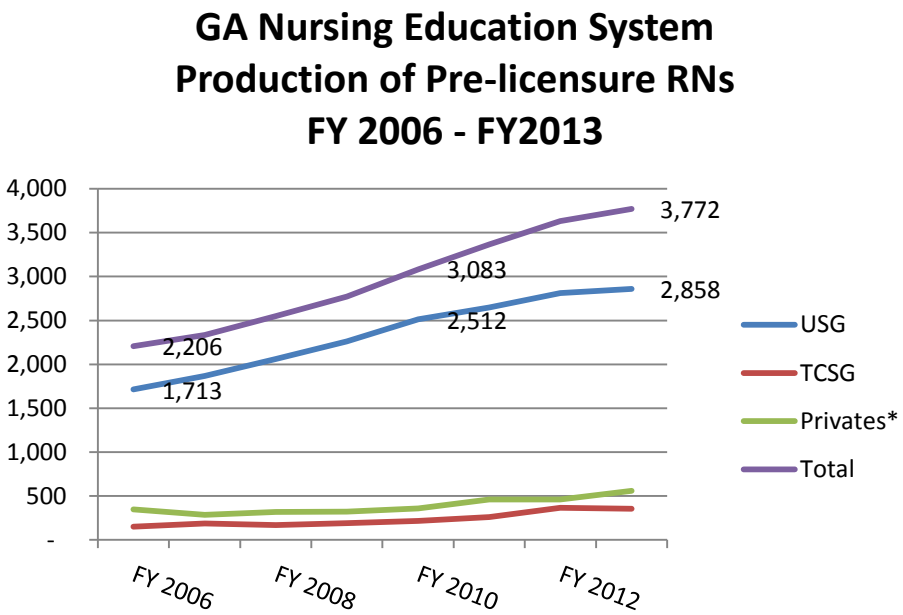
Long-Term Occupational Projections 2010 - 2020 Georgia Statewide							
	2010	2020	Total	Percent	Annual	Annual	
	Base	Projected	Change in	Change in	Openings	Openings	Annual
Occupation	Employment	Employment	Employment	Employment	from Growth	from Replmnts	Openings
Clinical, Counseling, and School Psychologists	2,760	3,290	530	19.5%	50	90	140
Substance Abuse and Behavioral Disorder Counselors	1,150	1,470	320	27.5%	30	30	60
Educational, Vocational, and School Counselors	6,890	8,130	1,240	18.0%	120	150	270
Marriage and Family Therapists	290	460	170	55.3%	20	10	30
Mental Health Counselors	2,030	2,870	840	41.3%	80	40	120
Child, Family, and School Social Workers	7,570	8,910	1,340	17.7%	130	180	310
Medical and Public Health Social Workers	4,560	5,700	1,140	25.1%	110	110	220
Mental Health and Substance Abuse Social Workers	970	1,260	290	29.7%	30	20	50
Dentists, General	3,740	4,580	840	22.5%	80	110	190
Psychiatrists	520	620	100	20.5%	10	10	20
Registered Nurses	69,190	90,020	20,830	30.1%	2,080	1,250	3,330
Licensed Practical and Licensed Vocational Nurses	26,400	31,470	5,070	19.2%	510	700	1,210

Constraints in Education Pipeline

- Change in graduate outputs is mixed
  - the impacts of the post-secondary education systems have not adjusted for many professions
  - This is the case even for the profession where graduate count has grown: counselors
  - Graduates in many fields can choose from multiple areas of practice and may not pursue a career in behavioral health



Constraints in Education Pipeline



- Some important changes may have positive impact over long term:
  - RN graduate count has risen sharply
  - New psychiatry programs emerging in GA
    - Tanner Health System
    - Redmond Regional (Possible)

Constraints in Education Pipeline

- Other enhancements to education pipeline emerging and probable, however ongoing scrutiny is warranted:
  - Impacts of healthcare reform
  - Changes in healthcare delivery
  - Changes in population dynamics
- Ultimately – solutions found in taking the broader view

Unique aspects of the Health Workforce

- Elements of health profession legal, academic and practice constructs can restrict access to these professionals
  - Licensure requirements
  - Practice constraints
  - Education
- However, these can also provide unique ways to connect

Goal for Behavioral Health Workforce

- The right professionals
- Doing the right job
- For the right people
- With the right needs

- This is **not** simply an HR/education pipeline problem
- Many issues at work
  - Employer concerns exist – benefits, salary
  - Sector problems Exist – Constraints of public sector and personnel shortages
  - Pipeline Problems exist
  - Peculiarities of healthcare personnel exist
  - Scope of Practice problems exist

Solutions

- Build internal DBHDD workforce knowledge
- Strengthen the education pipeline:
  - Create more education programs as needed (or enlarge existing ones)
  - Establish high quality clinical education experiences for students
  - Establish residency/internship/post doctoral programs/experiences for medicine, nursing, psychology and others
- Develop existing workers into needed professionals
  - Establish career pathways
  - Enhance supports (salary, stipend and supervisory) for students engaged in supervised clinical practice prior to full licensure

Solutions

- Increase appeal of work in the public sector
  - Appropriately reduce work burden placed on clinical professionals
  - Maximize appropriate substitutions of work/professionals across the system. Apply training and workforce education efforts to this endeavor as needed.
  - Establish systems that attract needed clinicians to public sector
- Improve the efficacy of the workforce
  - Properly align state law/rules governing workforce to align with public sector needs
  - Modernize knowledge and skills of existing clinical professionals through continuing education systems
  - Establish/enhance training pathways that target newer skills/professions that align with state of the art practices

Building Georgia's Primary Care Workforce

Thinking through the issues of capacity and capability

Georgia Health Policy Center

Create the RIGHT
environment to have
IMPORTANT
conversations

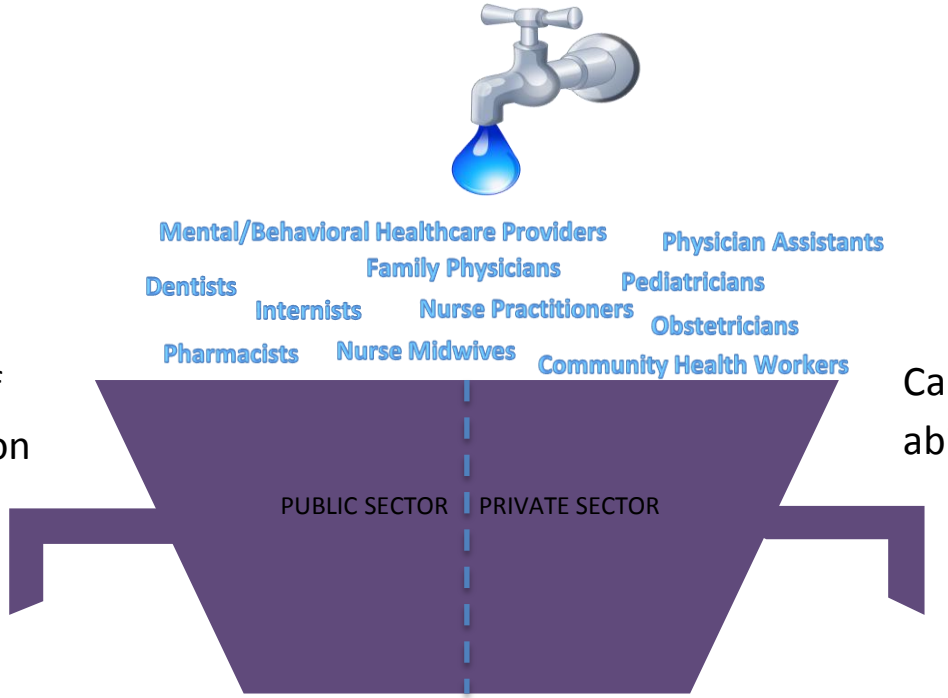
BUILD
and
VALUE
relationships

Bring in
relevant information
that is
integrated
translated, and
interpreted
from
primary and secondary research,
best practices, and
thought leaders

Georgia Primary Care Workforce Initiative

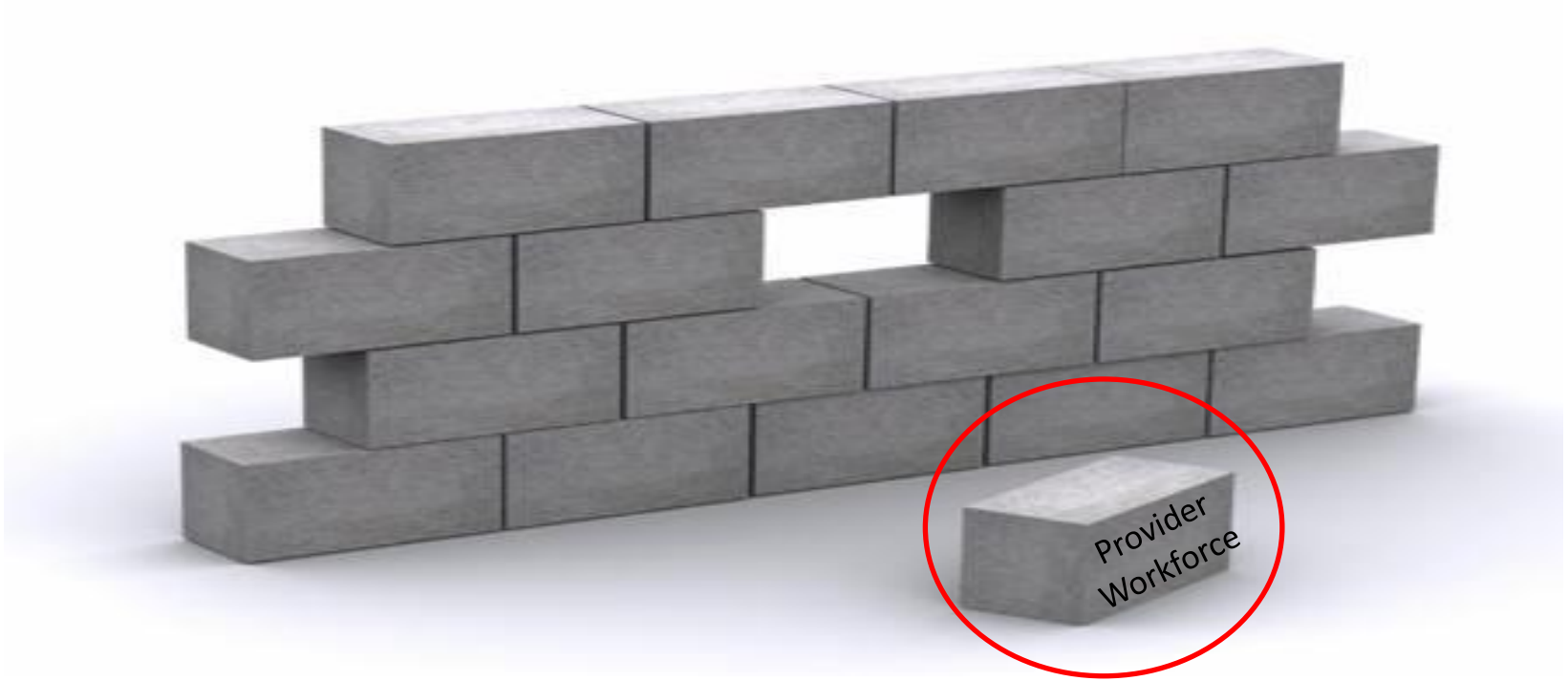
Primary Care Workforce

Capacity = Measure of volume and distribution

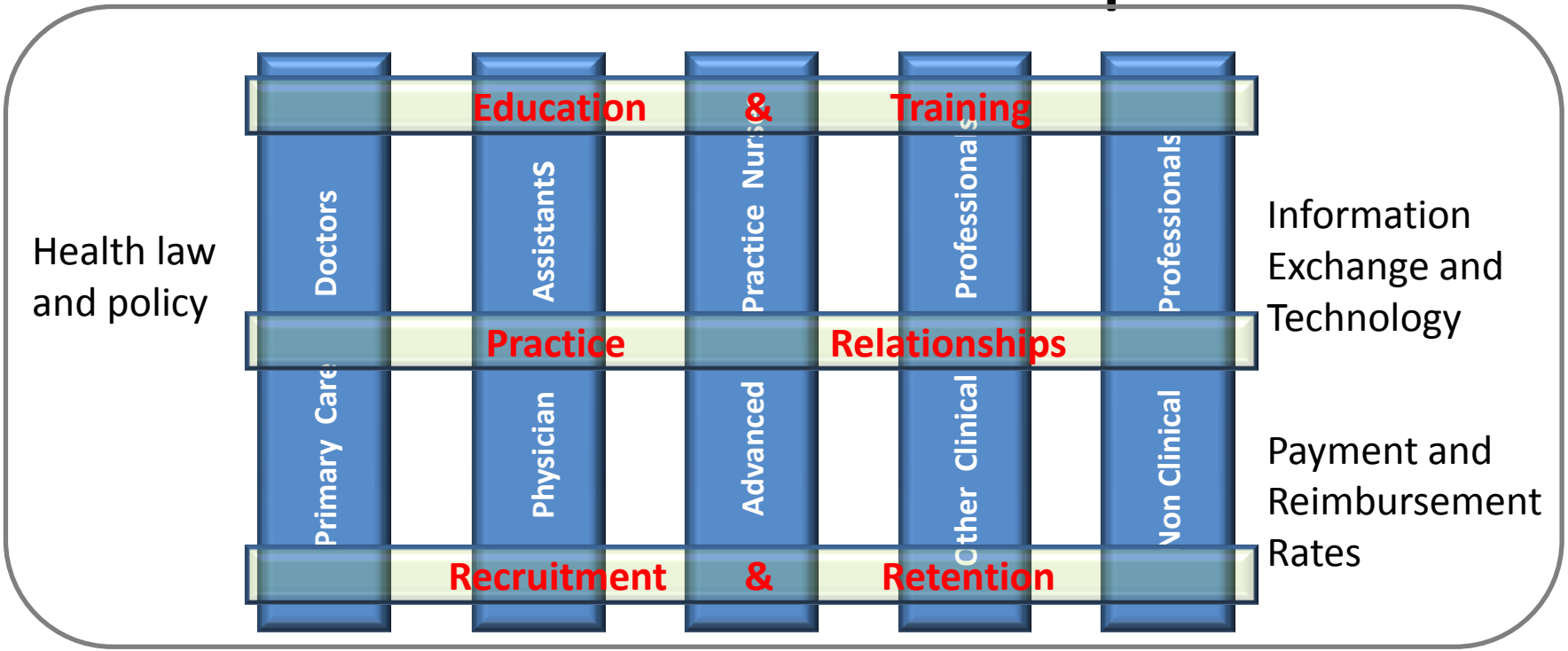


Capability = Measure of ability/functional integrity

Primary Care Delivery System



Provider Workforce Components



Conceptual Process

- Georgia State University as Engagers
  - School of Nursing
  - School of Policy Studies
    - Georgia Health Policy Center as facilitators
- Steering and Design Team as directors
  - Data and information
    - » gathering, modeling, translating
  - Meeting design and facilitation
    - » principles and outcomes
- Stakeholders as problem solvers
  - policies, programs, paradigm shifts?

Collaborative Modeling

Legislators/Policymakers

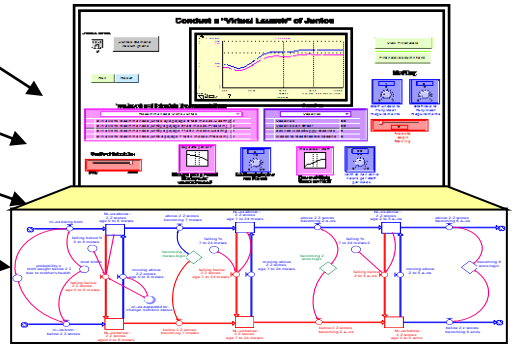
Providers

Patients/Clients

Insurers

Economists

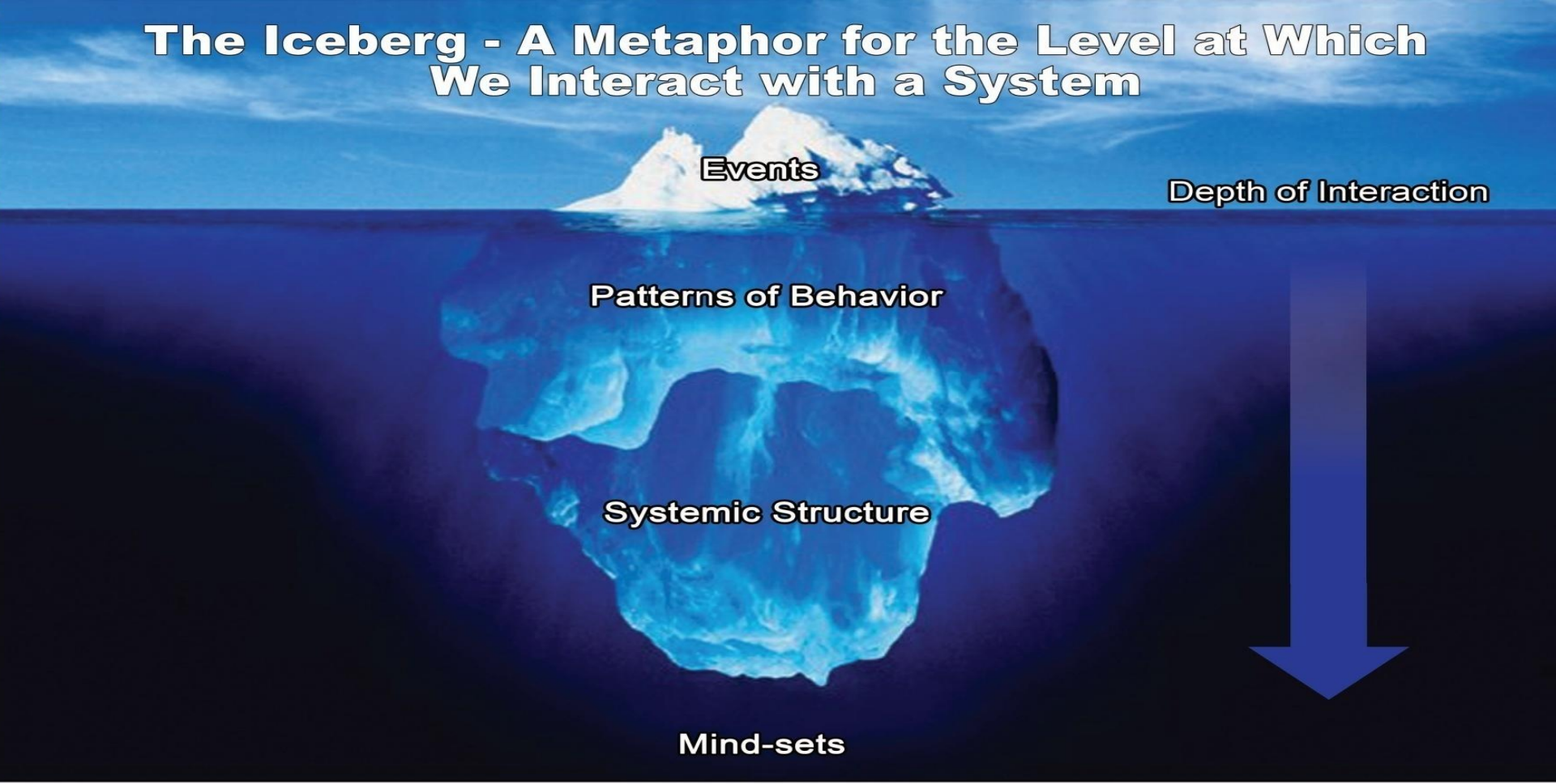
MODEL IS USED TO RIGOROUSLY TEST ASSUMPTIONS



PROCESS

- Develop Purpose
- Build/Revise Model
- Test Model
- Add/Revise Policies
- Test Policies
- Engage Policymakers

The Iceberg - A Metaphor for the Level at Which We Interact with a System



Source: Sustainability Institute, adapted from other versions from the organizational learning field

Georgia Health Policy Center

Questions/Comments

Mary Beth Walker
Dean, Andrew Young School of Policy Studies, Georgia State University

Margaret Wilmoth
Dean, Byrdine F Lewis School of Nursing, Georgia State University

Karen Minyard
Director, Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University

Christopher Parker
Associate Project Director, Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University
chrisparker@gsu.edu

Georgia Mental Health Consumer Network

Sherry Jenkins Tucker, MA, CPS, ITE
Executive Director

GEORGIA CPS PROJECT
MISSION STATEMENT

It is the mission of the Georgia Certified Peer Specialist Project to identify, train, certify and provide ongoing support and education to consumers of mental health services, to provide peer support as part of the Georgia mental health service system and to promote self-determination, personal responsibility and empowerment inherent in self-directed recovery.

Georgia CPS Project Origins and History:

Originated from 1999 Surgeon General's Report on the value of peer-to-peer support in the acquisition of real recovery.

Georgia CPS Project Origins and History:

- Originally funded through a federal grant from the Substance Abuse Mental Health Services Administration, Center for Mental Health Services.
- Grant was secured and administered by the Georgia Mental Health Consumer Network in collaboration with DBHDD
- Currently funded by DBHDD in collaboration with the Office of Recovery Transformation

Georgia CPS Project Origins and History:

December 2001 marked Georgia's first class of Certified Peer Specialists (CPSs).

Georgia CPS Project Origins and History:

CPSs now provide Medicaid reimbursable services throughout the state in ACT, CSI, PSR, Peer Supports working for public and private providers, and public/private hospitals

Georgia CPS Project
Origins and History:

Since 2001 the Georgia CPS Project has held 42 CPS trainings.

Georgia CPS Project
Origins and History: 42nd CPS Class

Georgia CPS Project Origins and History:

To date, 997 peers have achieved their CPS certifications in Georgia and 505 are working in the Behavioral Health System.

Where do we go from here?

The Georgia CPS Project: Moving Forward

Program Expansion:

Increased staff support to include q full-time CPS Training Coordinator and a full-time CPS Certification Coordinator.

The Georgia CPS Project: Moving Forward

Program Expansion:

5 CPS trainings annually across the state:
Macon, Augusta, Albany, Savannah, and Atlanta.

The Georgia CPS Project: Moving Forward

Program Expansion:

In 2014, Medicaid was expanded to include the CPS deliverable service of Peer Support Whole Health and Wellness Coaching.

The Georgia CPS Project: Moving Forward

Origins of Peer Whole Health Wellness Coaching:

Studies have found people with serious mental illness (SMI) die, on average, 25 years earlier than the general population.

The Georgia CPS Project: Moving Forward

Roles and Responsibilities of a Peer Wellness Coach

- Assist peers in choosing, obtaining, and keeping wellness and healthy lifestyle related goals.
- Help peers work through the process of identifying health and wellness related goals.
- Ask facilitative questions to help peers gain insight into their own personal situations.
- Empower peers to find solutions for health problems and concerns they are facing.
- Help peers find their own solutions by asking questions that give them insight into their wellness status.

The Georgia CPS Project: Moving Forward

Roles and Responsibilities of a Peer Wellness Coach (continued)

- Assist in identifying steps to take to achieve a health and wellness related goal
- Assist peers in strengthening their readiness to actively pursue health and wellness
- Use a variety of methods, tailored to the individual in setting and reaching health/wellness related goals
- Provide structure and support to promote personal progress and accountability.
- Compile and share wellness and healthy lifestyle resources for peers and other staff or supporters.

The Georgia CPS Project: Moving Forward

The Georgia Mental Health Consumer Network in partnership with DBHDD and Appalachian Consulting, Inc. has sponsored 8 Whole Health Action Management (WHAM) Trainings since September 2012.

The Georgia CPS Project: Moving Forward

As of April 2014, 297 CPSs have be certified as Peer Support Whole Health and Welllness Coaches.

The Georgia CPS Project: Moving Forward

The Georgia Mental Health Consumer Network and the Georgia CPS Project are dedicated to expanding peer-based services to support individuals in achieving and maintaining recovery.

The Georgia Mental Heath Consumer Network and the Georgia CPS Project

Future: We see a bright future for the trained peer workforce in Georgia. We belief the only wrong place for a CPS is no place. With this philosophy we see more and more venues opening up for CPSs in the future.

Thank you very much!

- Sherry Jenkins Tucker, MA, CPS, ITE
- Executive Director
- Georgia Mental Health Consumer Network
- 246 Sycamore Street, Suite 260
- Decatur, GA 30030
- 404-421-5683
- sjtucker@gmhcn.org
- www.gmhcn.org