ADVANCING BEHAVIORAL HEALTH PRIORITIES ACROSS COMMUNITIES

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Speakers

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ABOUT KHI

• Nonprofit, nonpartisan educational organization focusing on health policy and research.
• Established in 1995 with a multi-year grant by the Kansas Health Foundation and located directly across from Kansas Statehouse in downtown Topeka.
• Committed to convening meaningful conversations around tough topics related to health.
RESOURCES

• Both reports available at KHI.org
TODAY'S AGENDA

1. System profile
2. Capacity
3. CHA/CHNAs and behavioral health priorities
4. Promising strategies
MENTAL/BEHAVIORAL HEALTH

• Mental health
  • Emotional, psychological and social well-being
  • Biological factors, life experience and family history can contribute to mental health problems

• Behavioral health
  • Includes mental health, substance use disorders and addictions
KEY EVENTS IN KANSAS

1990: Kansas Mental Health Reform Act passed. Made CMHCs gatekeepers to access to hospitals and community resources.

1990: Kansas State Hospital beds: 1,003

1990: Kansas mental health expenditures
State hospitals: 82%
Community services: 18%

1996: Kansas community mental health caseloads increase by 222%.

1996: Kansas mental health expenditures
State hospitals: 49%
Community services: 51%

1997: Topeka State Mental Hospital Closes

2004: Kansas State Hospital beds: 340

2005: Kansas Consumer-run Organizations (CRO): 20

2008: Kansas CMHCs provide services to 35,040 adults with severe mental illness and children with serious emotional disturbance.

2013: Kansas mental health expenditures:
State Hospitals: 27%
Community Services: 73%

2013: Kansas 1115 waiver approved by CMS creating KanCare

2015: Kansas State Mental Hospital beds: 250

2016: Average wait times at Osawatomie State Hospital: 2.88 days

Pre-1987

1987: Rapp report: CMHCs and state hospitals disjointed. Funding streams/efforts are not aligned.

Source: KHI’s Understanding the Mental Health System in Kansas, 2017.
# CHANGE IN SETTINGS

*Figure 1. State Mental Health Expenditures by Care Setting, Select Fiscal Years 1990–2014*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State Hospitals - Inpatient</td>
<td>82%</td>
<td>49%</td>
<td>28%</td>
<td>25%</td>
<td>24%</td>
<td>25%</td>
</tr>
<tr>
<td>Community</td>
<td>18%</td>
<td>51%</td>
<td>68%</td>
<td>71%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Administration</td>
<td>n/a</td>
<td>n/a</td>
<td>4%</td>
<td>4%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Total State Mental Health Agency Expenditures</td>
<td>n/a</td>
<td>n/a</td>
<td>$321.7 million</td>
<td>$375.7 million</td>
<td>$385.0 million</td>
<td>$357.6 million</td>
</tr>
<tr>
<td>Per Capita State Mental Health Agency Expenditures</td>
<td>n/a</td>
<td>n/a</td>
<td>$115.63</td>
<td>$132.33</td>
<td>$134.49</td>
<td>$124.11</td>
</tr>
</tbody>
</table>

Note: Percentages may not add to 100 percent because of rounding. Values begin in 1990 to illustrate state expenditures pre-Kansas Mental Health Reform Act of 1991. For FY 2008-2014, “Community” includes ambulatory, community, and other 24-hour care, while “Administration” includes agency expenditures for research, training, administration, and other central or regional office expenditures.

## ANY MENTAL ILLNESS IN PAST YEAR

<table>
<thead>
<tr>
<th>State</th>
<th>Adults 18+</th>
<th>Adults 18-25</th>
<th>Adults 26+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas</td>
<td>17.5%</td>
<td>19.2%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Colorado</td>
<td>19.6%</td>
<td>24.3%</td>
<td>18.8%</td>
</tr>
<tr>
<td>Missouri</td>
<td>18.0%</td>
<td>21.0%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Nebraska</td>
<td>18.2%</td>
<td>20.0%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>19.2%</td>
<td>20.6%</td>
<td>18.9%</td>
</tr>
<tr>
<td>Total United States</td>
<td>18.0%</td>
<td>20.9%</td>
<td>17.5%</td>
</tr>
</tbody>
</table>

*Source: SAMHSA National Survey on Drug Use and Health (NSDUH), 2014-2015.*
FACILITY TYPES

- Consumer-run organizations
- Community mental health centers (CMHC)
- Community crisis centers
- State and private psychiatric hospitals
- Psychiatric residential treatment facilities
- Nursing facilities for mental health
- Residential care facilities

(Substance use treatment facilities also licensed)
# SERVICES BY SETTING, FY16

<table>
<thead>
<tr>
<th></th>
<th>Community Setting</th>
<th>State Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of People</strong></td>
<td>133,247</td>
<td>2,406</td>
</tr>
<tr>
<td><strong>Rate / 1,000</strong></td>
<td>45.8</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male, %</td>
<td>47.0%</td>
<td>66.3%</td>
</tr>
<tr>
<td>Female, %</td>
<td>52.2%</td>
<td>33.7%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–17</td>
<td>26.8%</td>
<td>0%</td>
</tr>
<tr>
<td>18–20</td>
<td>6.2%</td>
<td>5.7%</td>
</tr>
<tr>
<td>21–64</td>
<td>60.9%</td>
<td>90.9%</td>
</tr>
<tr>
<td>65+</td>
<td>5.3%</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

Note: Gender or age not reported for some consumers, so figures may not add to 100 percent.

# ACCESS METRICS

<table>
<thead>
<tr>
<th>Behavioral Health Metric</th>
<th>Kansas (Rank)</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with Any Mental Illness (AMI) who did not receive treatment</td>
<td>53.3% (20)</td>
<td>56.5%</td>
</tr>
<tr>
<td>Adults with AMI reporting unmet need</td>
<td>22.7% (38)</td>
<td>20.3%</td>
</tr>
<tr>
<td>Adults with AMI who are uninsured</td>
<td>17.4% (30)</td>
<td>17.0%</td>
</tr>
<tr>
<td>Adults with disability who could not see a doctor due to costs</td>
<td>19.6% (18)</td>
<td>22.9%</td>
</tr>
<tr>
<td>Youth with major depressive episode (MDE) who did not receive mental health services</td>
<td>56.6% (12)</td>
<td>64.1%</td>
</tr>
<tr>
<td>Youth with severe MDE who received some consistent treatment</td>
<td>29.6% (10)</td>
<td>21.7%</td>
</tr>
<tr>
<td>Children with private insurance that did not cover mental or emotional problems</td>
<td>5.9% (14)</td>
<td>7.9%</td>
</tr>
<tr>
<td>Students identified with emotional disturbance for an individualized education program</td>
<td>5.3% (39)</td>
<td>7.7%</td>
</tr>
<tr>
<td>Mental health workforce availability</td>
<td>550:1 (28)</td>
<td>529:1</td>
</tr>
</tbody>
</table>

*Source: Mental Health America, Mental Health in America-Access Care Data, 2014.*
GAPS/BARRIERS

- Waiting lists
- Financial/insurance
- Transportation
- Housing
- Cultural, language and attribution
POLLING QUESTION #1:

What do you see as the primary gap in your community’s mental health system?
A. Waiting lists/capacity
B. Financial/insurance
C. Transportation
D. Housing
E. Cultural, language and attribution
COMMUNITY HEALTH ASSESSMENTS AND BEHAVIORAL HEALTH

• KHI reviewed 78 CHAs, CHNAs and CHIPs developed in Kansas between 2009-2015
• Purpose: Understand the extent to which communities identified behavioral health as a priority area
• Method:
  1. Identify behavioral health-related issues that were included in CHA/CHNAs based on data assessment and community feedback
  2. Analyze issues that were or were not prioritized for further action and implementation
FINDINGS
All reviewed CHAs/CHNAs and CHIPs discussed or mentioned behavioral health-related issues.

One-half of the reports did not prioritize behavioral health issues for further action.

Community capacity – number one reason
Mental Health

- Access to health insurance coverage
- Provider shortages
- Access to comprehensive and integrated services
- Assessment of the need for mental health services in the community

Substance Use

- Use of tobacco products
- Access to comprehensive substance use treatment programs
- Use of smokeless tobacco
- Use of tobacco during pregnancy
- Use of alcohols products by adults and youth
- Alcohol-related traffic accidents
- Use of drugs (prescription drugs)
KEY FINDINGS

1. Access to mental health care
2. Provider shortages
3. Screening and prevention
4. Tobacco use
ACCESS TO MENTAL HEALTH CARE
ACCESS TO MENTAL HEALTH CARE: REASONS

• Financial barriers
• Lack of mental health professionals
• Mental health awareness
• Social stigma
ACCESS TO MENTAL HEALTH CARE: STRATEGIES

- Parity provisions
- Medicaid coverage
- Waiver of IMD exclusion
- Crisis stabilization services
- Patient navigator programs
- Cell phone-based support programs
- Telehealth
- Health insurance enrollment outreach and support
The University of Virginia Health System in Charlottesville

- Uses videoconferencing to link rural patients to the University's psychiatric fellows and residents

The University of Texas Medical Branch

- Working with community-based partners to provide remote mental health services to students and parents in the Galveston Independent School District

Statewide Partnership (The South Carolina Department of Mental Health, the University of South Carolina and 18 rural hospitals)

- Provides psychiatrists via teleconference to assess and treat patients with mental health issues
## STRATEGY: ENROLLMENT AND OUTREACH

<table>
<thead>
<tr>
<th>Overview</th>
<th>Outreach Activities</th>
<th>Potential Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health insurance enrollment outreach and support programs</td>
<td>Community health workers</td>
<td>Increase insurance coverage</td>
</tr>
<tr>
<td></td>
<td>Social media campaigns</td>
<td>Increase awareness of health insurance</td>
</tr>
<tr>
<td></td>
<td>Case management</td>
<td></td>
</tr>
</tbody>
</table>

### Offered by
- Government agencies
- Schools
- Community-based organizations
- Health care organizations

### Outreach Activities
- Community health workers
- Social media campaigns
- Case management

### Outreach Places
- Local events
- Hotlines
- Fixed locations (community centers)

* Funding: grants from federal agencies and private foundations
PROVIDER SHORTAGES
PROVIDER SHORTAGES: REASONS

• Increased awareness of mental health issues – more people are seeking treatment
• Lower reimbursement rates/salaries
• Aging workforce
PROVIDER SHORTAGES: STRATEGIES

• Higher education financial incentive for health professionals serving underserved areas
• Rural training programs
• Peer Support
## STRATEGY: PEER SUPPORT

<table>
<thead>
<tr>
<th>Overview</th>
<th>Services</th>
<th>Potential Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer-supporters are people who use their experience of recovery to support others in recovery</td>
<td>Provide information to consumers</td>
<td>Reduce symptoms and hospitalizations</td>
</tr>
<tr>
<td></td>
<td>Facilitate a dialogue – help consumers to be engaged in their treatment</td>
<td>Increase social support and participation in the community</td>
</tr>
<tr>
<td></td>
<td>Help consumers access resources</td>
<td>Decrease length of hospital stays and cost of services</td>
</tr>
<tr>
<td></td>
<td>Network consumers with other consumers</td>
<td>Improve well-being, self-esteem, and social functioning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage thorough and longer-lasting recoveries</td>
</tr>
</tbody>
</table>

### Qualifications
- Must be at least 18 years old (3 years older than a consumer under age 18)
- Receive certification
- Supervised by mental health professional
- Care-coordination

### Services
- Covered by Medicaid

### Funding
SCREENING AND PREVENTION
SCREENING AND PREVENTION

• Mental health training courses in schools and community centers
• Primary care providers ask questions about mental health
• Social determinants of health screening tool
• Integrated care models
<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last 12 months, did you ever eat less than you felt you should</td>
<td></td>
<td></td>
</tr>
<tr>
<td>because there wasn’t enough money for food?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>In the last 12 months, has your utility company shut off your service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for not paying your bills?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Are you worried that in the next 2 months, you may not have stable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>housing?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Do problems getting child care make it difficult for you to work or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>study? (leave blank if you do not have children)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>In the last 12 months, have you needed to see a doctor, but could not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>because of cost?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>In the last 12 months, have you ever had to go without health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>because you didn’t have a way to get there?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Do you ever need help reading hospital materials?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Are you afraid you might be hurt in your apartment building or house?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>If you checked YES to any boxes above, would you like to receive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>assistance with any of these needs?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Are any of your needs urgent?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For example: I don’t have food tonight, I don’t have a place to sleep</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

**FOR STAFF USE ONLY:**
- Place a patient sticker to the right
- Give this form to the patient with patient packet
## Overview
- Assess social needs
- Standard tool that can be adopted
- Connect to services

## Adapting the Screener
- Capacity to address specific needs
- Referral network
- Ease of use

## Activities
- Integrate with existing services/tools
- Conduct an inventory of community’s resources (e.g., 211 system, Healthify)
- Establish relationships with non-traditional partners (e.g., food banks)
- Conduct referrals and/or “warm hand-offs”

## Potential Impacts
- Growing evidence indicates potential to narrow gap between clinical services and community services
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.

Source: SAMHSA-HRSA Center for Integrated Health Solutions
WHY INTEGRATED CARE?

- **Diabetes**
  - Mental Illness: 7.9%
  - No Mental Illness: 6.6%

- **Obesity**
  - Mental Illness: 42%
  - No Mental Illness: 35%

- **Asthma**
  - Mental Illness: 15.7%
  - No Mental Illness: 10.6%

- **High Blood Pressure**
  - Mental Illness: 21.9%
  - No Mental Illness: 18.8%

- **Smoking**
  - Mental Illness: 36%
  - No Mental Illness: 21%

- **Heart Disease**
  - Mental Illness: 5.9%
  - No Mental Illness: 4.2%

*Source: SAMHSA-HRSA Center for Integrated Health Solutions*
TOBACCO: STRATEGIES

- Policy Work
  - Tobacco 21
  - E-cigarettes
  - Smoke-free parks, worksite grounds, playgrounds

Figure 1. Percent of People Potentially Affected by Statewide Tobacco 21 Policy in Kansas by Age, 2016

Note: Total Kansas population = 2,898,292.
POLLING QUESTION #2:

- In which of the following areas has your organization implemented efforts that focus on addressing behavioral health? (Choose all that apply)
  
  A. Mental health workforce
  B. Housing
  C. Transportation
  D. Employment
  E. Integrated care
  F. None
RESOURCES FOR COMMUNITIES

• Kansas Health Matters
  http://www.kansashealthmatters.org/

• County Health Rankings and Roadmaps
  http://www.countyhealthrankings.org/

• U.S. Preventive Services Task Force
  https://www.uspreventiveservicestaskforce.org/

• The Community Guide, CDC
  https://www.thecommunityguide.org/
TASK FORCE REPORT

- 11-member task force
- Reviewed reports from previous five+ years
- 26 priority recommendations
THANK YOU
Any questions?

You can connect with us at: kbruffett@khi.org and tlin@khi.org