

Massachusetts Health Policy Student Forum

January 8, 2014

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Commissioner

Massachusetts Department of Mental Health



DMH Statutory Mandate

DMH operates pursuant to Massachusetts state statute, Mass. Gen. L. ch. 19, ch 123 and DMH regulations CMR 104

DMH's statutory mandate: provide treatment and services to citizens with long-term or serious mental illness(es) and research into causes of mental illness

DMH

- Provides or arranges for DMH services for adults and children for whom services authorized,
- Establishes standards and policies to ensure effective and culturally competent care that promotes recovery and self-determination and protects human rights, and
- Supports mental health training and research



DMH Mission and Vision

MISSION

The Department of Mental Health, as the State Mental Health Authority, assures and provides access to services and supports to meet the mental health needs of individuals of all ages, enabling them to live, work and participate in their communities. Recognizing that mental health is an essential part of healthcare, the Department establishes standards to ensure effective and culturally competent care to promote recovery. The Department sets policy, promotes self-determination, protects human rights and supports mental health training and research. This critical mission is accomplished by working in partnership with other state agencies, individuals, families, providers and communities.

VISION

Mental health care is an essential part of health care. The Massachusetts Department of Mental Health, as the State Mental Health Authority, promotes mental health through early intervention, treatment, education, policy and regulation so that all residents of the Commonwealth may live full and productive lives.



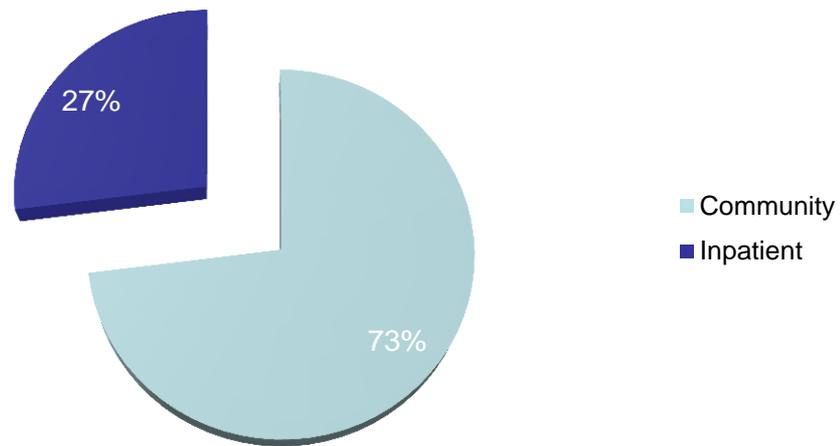
Community First

DMH is committed to its Community First vision and serving clients, staff and the community at large effectively and safely. Community First embraces the values of recovery, choice and self-determination and is guided by these principles:

- Empowering individuals with mental illness to live with dignity and independence in the community;
- Providing access to a full range of quality services and supports to meet their mental health needs;
- Enabling individuals to live, work and participate in their communities; and
- Implementing a consumer-centered, recovery-oriented system of mental health care.

DMH Allocation of Funds: Majority for Community-based Services

2010 DMH BUDGET ALLOCATIONS





DMH Services

Community-based Services include:

- Community Based Flexible Supports (CBFS)
- Program of Assertive Community Treatment (PACT)
- Clubhouses
- Case Management
- Recovery Learning Communities
- Forensic - Court Clinic, Jail Diversion and Re-entry Services
- Respite Services
- Homeless Support Services
- Child and Adolescent Residential Services
- Child and Adolescent Flexible Supports

DMH Private Facility Licensure

Facility Licensure:

- DMH oversees the licensure of approximately 2407 beds in 65 private psychiatric facilities:
 - private acute psychiatric hospitals and behavioral health units in general hospitals
 - intensive residential treatment programs for children
- DMH ensures that licensed hospitals are in compliance with regulatory requirements based on bi-annual licensing survey

DMH Research Centers of Excellence

1. UMASS: Center for Mental Health Services Research
 2. BIDMC: Commonwealth Research Center for clinical neuroscience and psychopharmacological research
- DMH Guiding Priorities for Research:
 - Culturally competent research and evidence-based practices
 - Consumer Involvement in Research
 - Dissemination of Research Finding to Accelerate the adoption of evidence-based practices



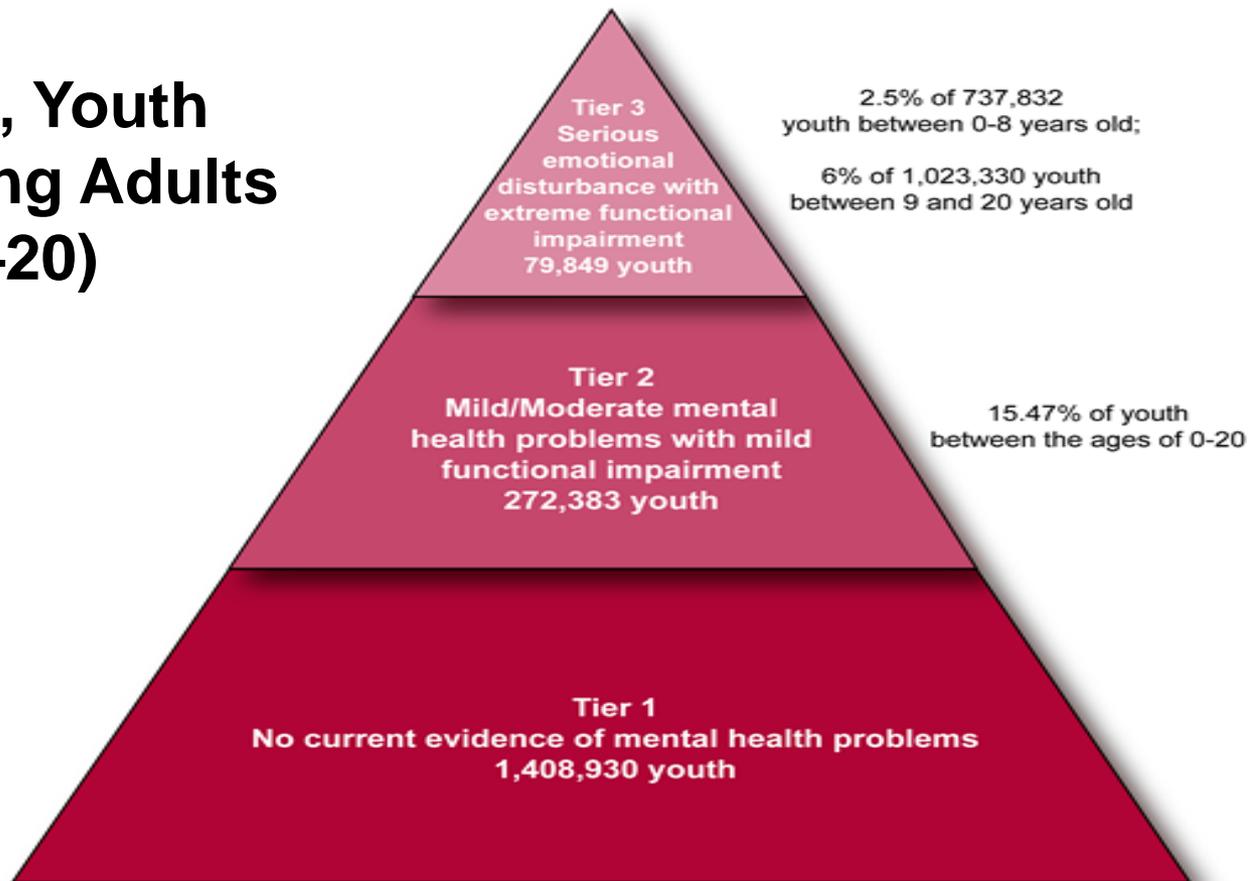
DMH Service Authorization

- DMH provides services for approximately 29,000 individuals
- Determining whether to authorize DMH services for an individual depends on an assessment of whether:
 - Individual meets the clinical criteria for DMH services;
 - Individual requires DMH services and has no other means for obtaining them;
 - DMH has available capacity.



Who are the patients with mental health disorders?

Children, Youth and Young Adults (Ages 0–20)

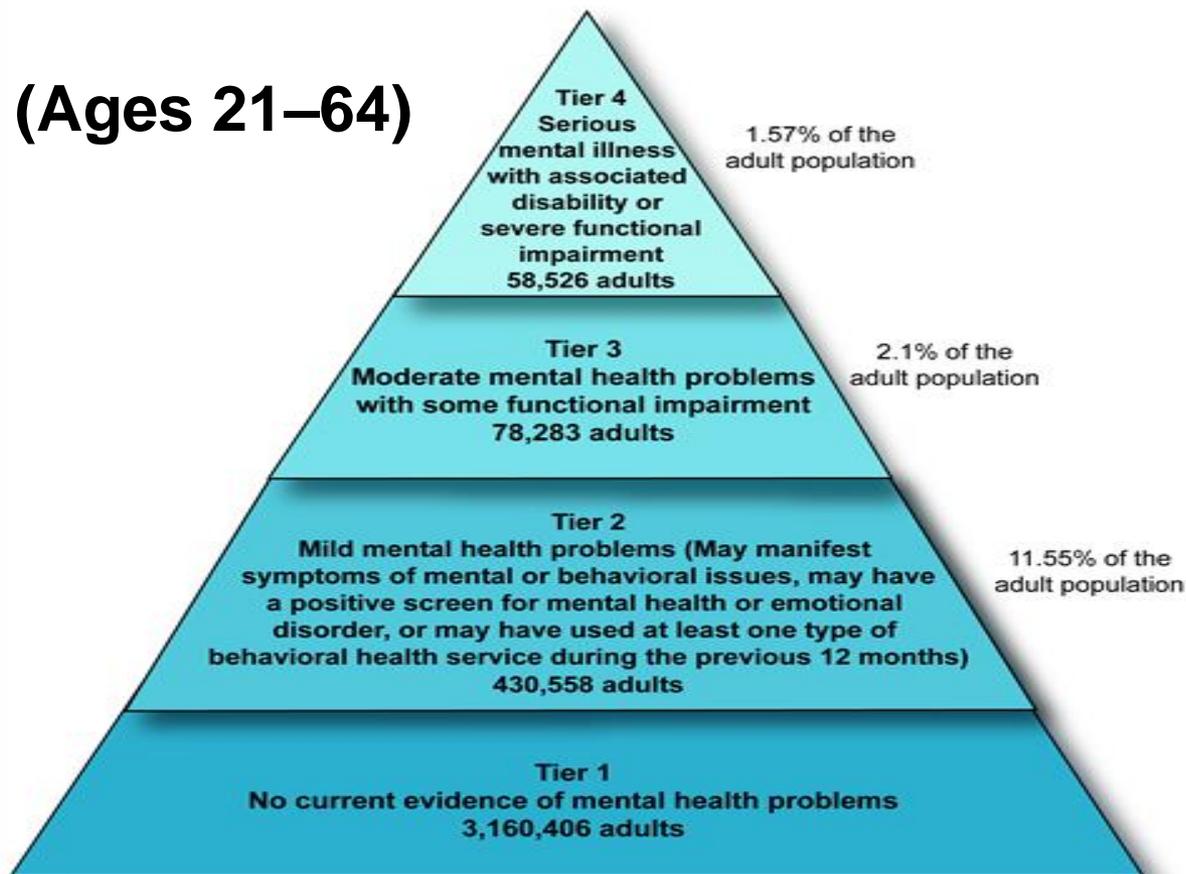


An estimated 1,761,162 youth between the ages of 0 and 20 are living in Massachusetts (27.7% of the total population). Tiers 3 and 2 represent 20% of the youth in Massachusetts based on the Surgeon General's report of any diagnosable mental disorder during childhood and adolescence.



Who are the patients with mental health disorders?

Adults (Ages 21–64)

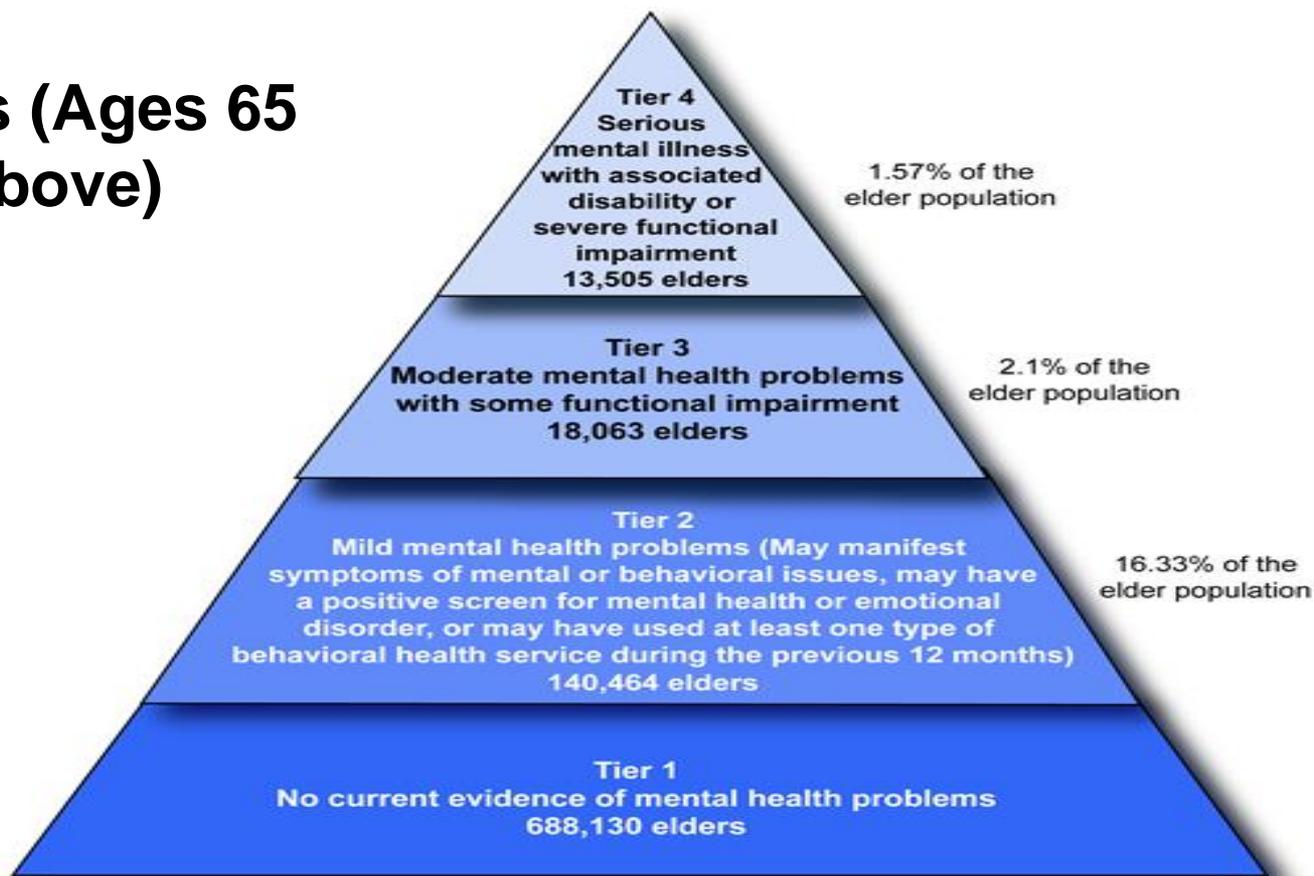


An estimated 3,727,773 individuals between the ages of 21 and 64 are living in Massachusetts (58.7% of the total population); 567,367 are potentially living with a mental illness (15.22% of individuals based on DMH prevalence estimates of adults with a diagnosable mental illness).



Who are the patients with mental health disorders?

Elders (Ages 65 and Above)



An estimated 860,162 elders live in Massachusetts (13.5% of the total population); 172,032 are potentially living with mental illness (20% of elders based on the Surgeon General's estimates for individuals aged 55 and over who will experience mental disorders that are not part of normal aging).



Who cares for patients with behavioral health disorders?

- 90 percent of patients with behavioral health disorders (mental health and substance use) are cared for in the primary care setting.¹
- Massachusetts has the largest rate of primary care physicians per 100,000 population than any other state.²
 - 132 per 100,000 compared to a median of 91 per 100,000
- Remaining 10 percent of patients may receive care through an outpatient behavioral health provider or not at all.

1. Kathol, Roger et al. "General medical and pharmacy claims expenditures in users of behavioral health services." *Journal of General Internal Medicine*. 2005, 160-167.

2. 2011 State Physician Workforce Data Book. *Association of American Medical Colleges*



Statute Overview

- The Behavioral Health Integration Task Force was created under Section 275 of Chapter 224 of the Acts of 2012.
- **Overall Goal:** To develop clear standards for integration of behavioral health and primary care for adults, children and their families, within context of ongoing delivery system and payment reform efforts across payers.
- Legislative report due by July 1, 2013
 - To include recommendations for integration, including statutory and/or regulatory changes needed to implement



Task Force Charge (1 of 3)

- Review the most effective and appropriate approach to including behavioral, substance use and mental health disorder services in the array of services provided by provider organizations
 - Provider organizations include risk-bearing providers and patient-centered medical homes
 - Services to include transition planning and maintaining continuity of care
- Review how current prevailing reimbursement methods and covered behavioral, substance use and mental health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral, substance use and mental health outcomes



Task Force Charge (2 of 3)

- Review the extent to which and how payment for behavioral health services should be included under alternative payment methodologies, including:
 - how mental health parity and patient choice of providers and services could be achieved
 - the design and use of medical necessity criteria and protocols

- Review how best to educate all providers to recognize behavioral, substance use and mental health conditions and make appropriate decisions regarding referral to behavioral health services



Task Force Charge (3 of 3)

- Review how best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness
- Review the unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperable electronic health records



Task Force Focus

- How best to integrate behavioral health and primary care, wherever primary care is provided.
- Focus is at the intersection of payment reform and integration. How can integration be included in the existing and evolving payment reform models?
 - Focus is not on reimbursement rates of behavioral health services within health care system.
- Recommendations to resolve health system factors that prevent behavioral health integration.



Why Is This So Important and What Are the Opportunities?

- 21% of children and adolescents in the US meet diagnostic criteria for MH disorder with impaired functioning
- 50% of adults in US with MH disorders had symptoms by the age of 14
- Children with chronic medical conditions have more than 2x the likelihood of having a MH disorder
- We know that people recover from mental illness



Epidemic of Premature Death

In the US the average life expectancy has increased steadily to 77.9 years

The average life span for SPMI is 53 years

25-30 year shorter life span than the general public

Declining over the past 30 years

Disproportionate risk of death from preventable cardio metabolic risk factors, common chronic illnesses and cardiovascular disease

The average loss of life expectancy of all cancers combined is 15 years

Next Steps

- Payment Reform
- Comprehensive Care Coordination
- Workforce/Peers