

ADAMHS Board Needs Analysis

*Presented
by*

The Center for Health
Affairs

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Preface

This point in time is a critical one for the ADAMHS Board to closely examine the needs of its community members. Many things have changed over the past few years, mostly related to the Affordable Care Act and Medicaid Extension in Ohio. Who the Board serves, and how it serves them, is changing rapidly. And more changes are likely to come.

Coincident with that, also due to the Affordable Care Act, is an improved understanding within the medical and general social service community of the importance of behavioral health as it impacts the overall health of our community members. That is, the medical community, in partnership with the social service provider community, have increased their focus on behavioral health. As shown in all of the Community Health Needs Assessments of the University Hospitals in Cuyahoga County published in 2015, about four in five adults are hospitalized with conditions brought on by lifestyle choices. Thus, the medical community is changing its view on the importance of behavioral health.

The ADAMHS Board is about to have access to greatly improved data on the delivery of its funded services in the county, which is aptly timed as the populations' needs and the provider community will need to be closely understood in order to maximize the use and impact of the Board's limited resources.

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Summary: Supply vs. Demand Gaps

	Mental Health	Addiction
Non-Medicaid Beneficiaries or Services	Based on the prevalence estimates of severe mental illness and addiction services needs, in 2016 we can estimate that all of those who are not Medicaid beneficiaries who require <i>and</i> seek care are receiving at least <i>some care</i> . That is, the gap here is not in people who need care being completely turned away; instead the gap is in the availability (both community capacity and financial resources) for the <i>best types</i> of care which are required based on the individual need for each client; that gap in services for many is clear: there is not a sufficient level of either community capacity or financial resources to pay for the number of clients who require <u>residential care</u>. There is also no/limited funding for post-recovery supports which would improve outcomes.	
	Estimated Funding Shortfall: Residential: \$7,000,000-\$13,000,000 Employment**: \$1,900,000 Housing***: \$10,550,000 Total <u>Minimum</u> Gap: \$19.45M to \$25.45M	Estimated CURRENT Funding Shortfall: Detoxification**: \$2,000,000 Sober Housing**: \$1,000,000 Residential Treatment: \$1,800,000-\$2,200,000 Total <u>Minimum</u> Gap: \$4.8M to \$5.2M
Medicaid Beneficiaries	The number of Medicaid beneficiaries far exceeds the number of non-beneficiaries among the low-income residents of Cuyahoga County. Hence, the number of people requiring mental health or addiction services is far greater also. We did learn in our inquiries that there is a capacity shortage in our total community of service providers who accept Medicaid; however, ADAMHS Board funded agencies do accept Medicaid.	
	The gap for Medicaid beneficiaries who require care relates to those whose outcome would be improved if they had access to key services which Medicaid does not cover. We cannot determine what percentage of clients fall in this category as it is not captured by either the ADAMHS Board or the service providers. We do know what the key needed services are however: housing, employment services, inpatient detoxification.	

*Clinicians interviewed estimate that one-third to one-half of those who would benefit from residential care do not obtain it.

**Assumes a 100% increase in 2016 funding levels.

***This specifically would serve the 1/5th of the chronically homeless in the County who have not yet been placed in Supportive Housing. Most of these clients require both Mental Health and Addiction services.

Summary: Other Major Findings

- The ADAMHS Board is the safety net for critical Mental Health and Addiction services needed by those who are uninsured (for the services needed). In 2015, most of the Board's funding was provided by local sources (mostly county levies, 61.3%). Most of the remainder of the funding was split among federal (23.7%) and state (10.3%) sources.
- Almost all of the expenses of the ADAMHS Board in 2015 were to mental health and/or addiction services providers (91.8% of expenses).
- Medicaid extension in Ohio accounted for an increase of 107,820 Medicaid beneficiaries in Cuyahoga County from 2011 to 2016. We can estimate there were 76,000 adults in the County who remained without healthcare coverage in 2016. Because of the expanded number of those with healthcare coverage, the ADAMHSCC funding served fewer clients in 2015 than in 2013 (29%). However, the total number of episodes of care for the population served by ADAMHS Board funding did not decline at the same pace (16% for Mental Health services and 26% for Addiction services); that is, the smaller pool of clients were able to receive a slightly larger volume of care, on average. This is a positive trend for the well-being of those who depend on ADAMHS Board funding.
 - Despite the improved access to care for low-income residents in Cuyahoga County because of improved access to healthcare coverage, there remain a number of gaps which continue to negatively impact the well-being of those low-income residents in our County dependent on ADAMHS Board funded services. Those are critical treatment/recovery services deemed necessary by mental health, addiction and medical professionals which are not covered by Medicaid and some private insurers. Herein lies the growing key role for the ADAMHS Board in filling those gaps. **In sum, policy changes at the state and federal level led to a shift in who is served and how they are served; hence, the ADAMHS Board is being called upon to fund an evolving set of services as these policy changes play out.**

Summary: Other Major Findings

Services Provided:

- In terms of expenditures, about one-third (34%) were for Addiction Services and two-thirds for Mental Health Services in 2015.
- The **mix of services** provided to clients evolved from '13 to '15. Overall, the proportion of services related to *treatment* decreased from 57% of all expenditures to providers in 2013 to 50% in 2015. That is, the proportion of services not defined as treatment (crisis care/intervention, prevention services, psychiatric services, justice related services, detoxification, peer support, employment services, coordination/evaluation services, sober beds, adult and family services and 'other' services) all inched up as a proportion of all expenditures.
- In addition, of the treatment expenditures, residential treatment/housing increased as a proportion of all treatment from 44% in 2013 to 60% in 2015.

The Population Served:

- Cuyahoga County has not seen significant recent changes in its population demography. The overall population of the County is decreasing slowly (down by 1.7% from 2010 to 2015), and the economic conditions have remained somewhat stable. The biggest demographic change in Cuyahoga County at this point in time is the proportion of residents who are senior citizens. By 2020, the proportion of those in their teen years will have decreased by 12% (compared to 2015) and the proportion of those aged 65+ will have increased by 9%. This will have a dramatic impact on the social services and healthcare delivery systems, not only via increased demand for the services, but via the smaller population which will make up the unskilled and skilled workforce.
- The demographic profile of the ADAMHS Board client base has changed little from 2013 to 2015. The adults served by funding provided by the Board are predominantly unmarried (8 in 10), male (59%) and non-White (45% African American and 6% Hispanic/Latino in 2015).

Summary: Other Major Findings

The Population Served (continued):

- The median age of those who received mental health services was 34 in 2015, and 33 for those who received addiction services. However, the distributions of the ages of those two client populations were quite different. The ages of those who received mental health services is fairly evenly distributed among all adult age groups under age 60, with the greatest proportion aged 13 to 18 or aged 53 to 57. In sharp contrast, those who received addiction services cluster in the age 20 to 35 range. That being said, 40% of those who received addiction services in 2015 were over age 35.

Services Provided:

- Although alcohol is more common within the general population than is illicit drug abuse, drug dependence was three times more common among clients served by ADAMHS Board funding than was alcohol dependence.
- For mental illness services, most clients had a primary diagnosis of a severe chronic mental illness (affective psychoses or schizophrenic disorders) (59%).
- The great majority of services for clients were provided in an outpatient setting. Note, however, that community stakeholders reported a great shortage of inpatient treatment options.
- The dozens of service providers funded by the ADAMHS Board are dispersed throughout Cuyahoga County, with somewhat of a concentration in the City of Cleveland. In both Cleveland proper and especially within the outskirts of Cuyahoga County there are neighborhoods and larger geographic areas which lack any ADAMHS Board supported mental health and/or addiction services provider. This is likely more due to the community's overall lack of providers as opposed to those which are supported by the ADAMHS Board. This reflects an unmet need in terms of access overall. Stakeholders reported that lack of transportation was a barrier to care; this issue is also a commonly cited problem in relation to access to medical care.

Summary: Other Major Findings

Specific Barriers to Care:

Policy issues:

- The IMD (Medicaid Institutions for Mental Diseases) exclusion limits capacity for inpatient treatment tremendously;
- These key services, which improve client outcomes, are not reimbursable: client engagement activities, inpatient care for detoxification periods (medically necessary); and most residential services (Mental Health and Addiction). The latter was cited by stakeholders as the most impactful gap in our mental health/addiction services community.
- Other covered issues which lead to denial of needed care include: Medication Assisted Therapy for addiction; some acute intensive services; some outpatient services; some intensive support services; prevention; and, post-recovery support (in particular housing, employment and mentoring/coaching).

Infrastructure:

- The following are shortages in the **infrastructure**: detoxification beds; inpatient beds in local hospitals for psychiatric patients; inpatient beds in local hospitals for medical stabilization of mental health and addiction clients; intensive outpatient care capacity for addicts (for Medicaid patients); Medically Assisted Therapy capacity [community providers are not adequately aligned with providers who can manage MAT]; sober beds/sober housing; and psychiatrists who accept Medicaid. There are simply not enough of any of these to provide care for those who require it, even if additional funding were suddenly available.
- **Other challenges** facing the provider community which are barriers to their ability to optimize care are: high turnover of personnel; lack of housing for clients during and/or after receiving care; clients' unmet basic needs (food, clothing, etc.); non-English/non-Spanish speaking personnel; failure of clients to sustain Medicaid coverage; and, a lack of data integration and information sharing among providers.

Summary: Other Major Findings

Specific Barriers to Care (continued):

Overall Funding:

- The estimated incidence of mental health and/or addiction issues within the Medicaid covered population in Cuyahoga County in comparison to the number of people who received care suggest that, *at a bare minimum*, those who needed care received it in 2015. This is not to suggest that clients received the type of care which is best for them or that all of the care, or supportive services, they needed was covered by insurance.
- Stakeholders stressed the extreme shortage of funding for services which are not covered by Medicaid yet which are needed. Details on the type and volume of funding needed are described previously (page 4).

Other Findings Related to Needs Assessment:

- The provider community urged the ADAMHS Board to take a larger leadership role in terms of:
 - Behavioral Health Transformation: Many are in a 'wait and see' mode and most are unclear on what it will mean for their ability to serve (7 of 11 providers interviewed).
 - The provider community is disconnected and not unified (3 of 11 providers interviewed; 13 of 22 other stakeholders interviewed; 6 of 6 clients/family members of clients interviewed).
- The chronic under-funding of behavioral health and addiction services has resulted in a shortage of licensed professionals. Psychiatrists are in particularly short supply. (10 of 11 providers interviewed)
- About one-fourth of the mental health and one-third of the addiction services clients account for 80% of the service expenditures for the ADAMHS Board. A focus on and management of those high-need clients could open up resources for other uses.

Summary: Other Major Findings

- The ADAMHSCC is not alone in Cuyahoga County in its being impacted by the Affordable Care Act. Many components of the Affordable Care Act have resulted in a greater emphasis on the management of chronic disease outside of the traditional healthcare institutions. There is a growing emphasis on prevention and population health management, and a much greater appreciation for the linkages between mental and physical health. The current goal is an integrated healthcare system, where providers of all types are joined in a coordinated effort to support patients and clients who need it. Current data systems rely on a 'retrospective' annual review of information; to properly manage population health, 'real-time,' integrated systems will be needed in order to match clients with the care and services they need, when they need it. The ADAMHSCC, as a vital component of the overall system, should expect and prepare for a client data management system. This certainly will not occur overnight, but data integration efforts throughout the healthcare community were underway in 2016.
- **Perhaps the most pressing issue facing our community related to behavioral health is the very rapid increase in the number of fentanyl-related overdose deaths.** Our county's capacity to provide treatment for low-income residents faced with heroin addiction was seen as inadequate by almost all involved in this study. Naloxone distribution among first responders, including law enforcement, has increased tremendously in the County during the past few years but needs to increase even further. More medically-assisted treatment for opioid/heroin addictions is also needed, along with the array of services that are not covered by Medicaid but are often the necessary course for those addicted (crisis intervention, detoxification, inpatient care, sober living).
 - Prior financial estimates (page 4) to meet the needs of the community in regards to addiction services should be considered minimums.

Introduction: Background & Purpose

The mission of the Alcohol, Mental Health and Addiction Services Board of Cuyahoga County (ADAMHS Board) is to promote and enhance the quality of life for residents of our community through a commitment to excellence in mental health, alcohol, drug, and other addiction services.

The ADAMHS Board does not provide any direct services. Instead, it accomplishes this mission through the planning, funding and evaluating services provided by a large network of community-based organizations. These service providers* comprise the safety net for residents of Cuyahoga County when faced with the need for mental health and/or addiction treatment services but who do not have health insurance or cannot otherwise pay for those services.

The ADAMHS Board is funded through local sources (\$39,363,656 in 2015) and state and federal sources (6,633,703 and \$15,197,066, respectively, in 2015).

The local funds which support the ADAMHS board activities come through two property tax levies: 1) the 8-year renewal Cuyahoga County Health & Human Services 4.7-mill property tax levy approved by voters in March of 2016; 2) the 5-year replacement 3.9-mill tax levy approved by voters in November of 2013.

Methods

This report accomplishes a comprehensive review of the ADAHMHs Board activities and current capacity to provide services and contrasts those with the needs of the community.

The ADAMHS Board **activities and capacity levels** are understood through:

- A review of the Board's **revenue sources and expenditures** (describes what the board is charged with doing, via the goals of the funding sources, and what they are doing, via the distribution of dollars to various services).
- Qualitative descriptions, via ADAMHS Board personnel, of **services funded**;
- Qualitative interviews of **service delivery agency personnel** in the community.

The community needs are understood through an examination of:

- The **demographic make-up** of the community, and if/how the community demography is changing. The types and levels of services needed by community members are highly related to the demographic make-up of the community, in particular age, income levels (and subsequent access to health insurance), geographic location and gender.
- **Policies** already in place to meet community's members' needs. This relates most specifically to reimbursement policies for various services.
- **Providers** of services in the community. Those on the 'front lines' are charged with impacting the well-being of our community members and are closest to the reasons behind any failures to meet that goal.
- **Clients** of services in the community also provide valuable insight into what they need to see change to better meet their needs.
- Other **stakeholders or community partners**, who can also lend insight into where the gaps in services are.

Qualitative Efforts

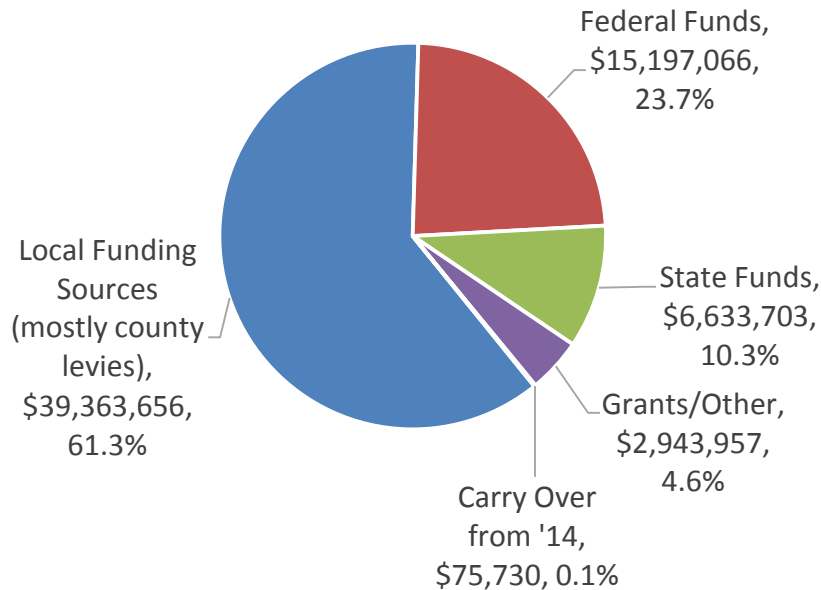
- Qualitative data were collected from three different sources for this project:
 - Employees of the ADAMHS board, via a mostly qualitative online survey
 - Executive (telephonic) interviews with 33 members of the community providers. Six of them were with Addiction Services providers leadership, and five of them were with Mental Health Services providers. In addition, we completed 22 interviews with other stakeholders who are part of the network of care in this population and who often interact with service providers. Interviewees included:
 - Hospital-based physicians (emergency departments) (4)
 - Private practice psychiatrists/psychologists (3)
 - Family-practice specialists; other medical professionals (physicians and APRNs) (3)
 - First responders (police, EMTs) (3)
 - State of Ohio government healthcare administrators (2)
 - Cuyahoga County government healthcare administrators (2)
 - Advocacy group leadership (1)
 - Justice department (coordinators) (1)
 - Social workers/case managers (1)
 - Education professionals (2)
 - A series of focus groups completed in 2015. Because the findings of those focus groups so closely mirrored the findings of the interviews of the individuals we completed in 2016, we use the findings of them, despite having been completed in 2015, in this analysis.
 - Personal interviews with 6 clients or family members of ADAMHS board funded local community providers (Two clients of Addiction Services; Two clients, one as an adult, one as an adolescent, of Mental Health Services; one family member each of a recent client of Addiction Services and Mental Health services).

ADAMHS Board – Introduction

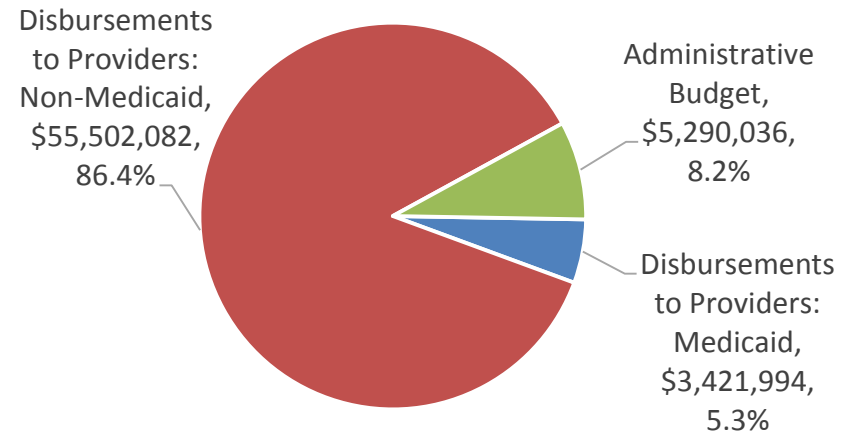
Introduction: Funding & Expenditures

Understanding where the ADAMHS Board funding comes from and then also how the dollars are spent help us understand its role in the community.

Revenue Categories, 2015



Major Expense Categories, 2015



The majority of funds which support ADAMHS Board activities come from locally (county) derived tax revenue. Federally sourced dollars are just over two times that of state-provided funds.

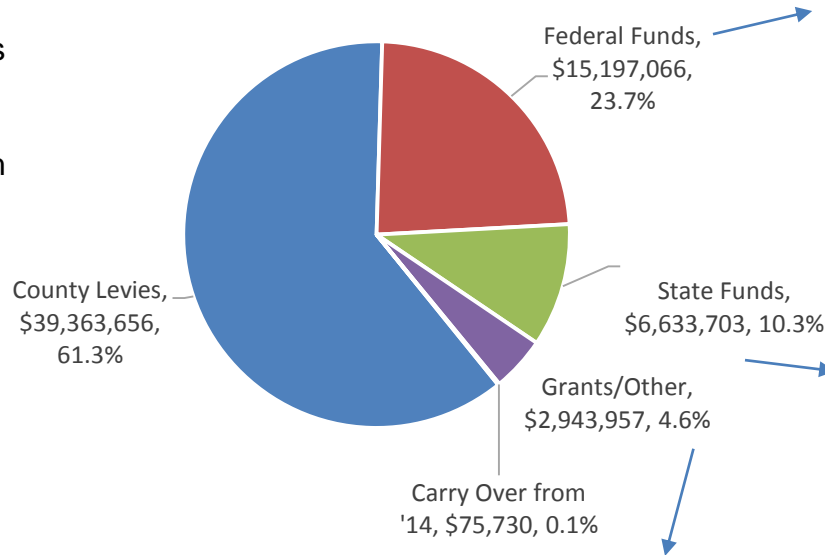
The ADAMHS board is the safety net for critical services needed by those who are uninsured. The bulk of the Board's disbursements go to providers serving those who are uninsured but do not qualify for Medicaid (86.4% of the disbursements in 2015). Some dollars fund services provided to Medicaid eligible clients, yet are for services not covered by Medicaid.

Introduction: Funding & Expenditures

Revenue from the county levies is essentially unconstrained dollars – that is, it can be used to provide services which match the needs in the community.

The dollars from state and federal sources are much more tied to a specific treatment or support need, or a specific population in need.

Revenue Categories, 2015



- Medicaid Waiver Program
- Substance Abuse Prevention and Treatment Program, & Pass-Through)
- Title XX
- Projects Assistance Transition from Homelessness (PATH)
- Mental Health Block Grant (& Housing)
- Early Childhood Mental Health Consultation
- 1 Time: Respite Care & Reentry Coalition
- CABHI Demonstration
- Opportunities for Ohioans with Disabilities (OOD)

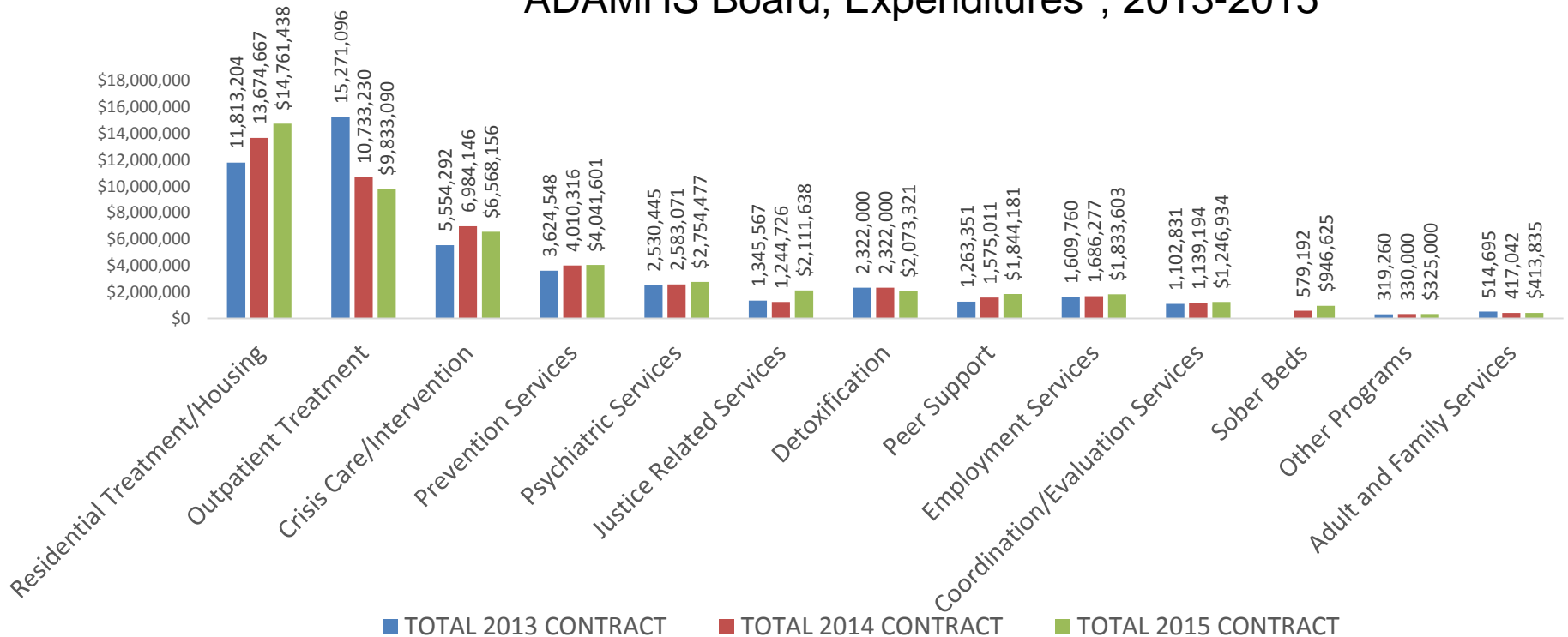
- Continuum of Care – Community Investments
- Mental Health System of Care
- Behavioral Health Juvenile Justice
- ODRC Transitional Assertive Community Treatment (ACT)
- Early Childhood Mental Health Counseling
- Addiction Treatment Program
- Forensic Monitoring
- AOD Per Capital Treatment/Prevention
- AOD Pass Through Funding
- Casino Gambling Treatment & Prevention

- Corrections Planning Board
- Invest in Children
- Family Children First Council
- Private grants; rent income

Introduction: Funding & Expenditures

- Below we describe the general categories of expenditures from 2013 to 2015. The mix of services evolved from '13 to '15. Overall, the proportion of services related to *treatment* decreased from 57% of all expenditures to providers in 2013 to 50% in 2015. Also, of the treatment expenditures, residential treatment/housing increased as a proportion of all treatment from 44% in 2013 to 60% in 2016.

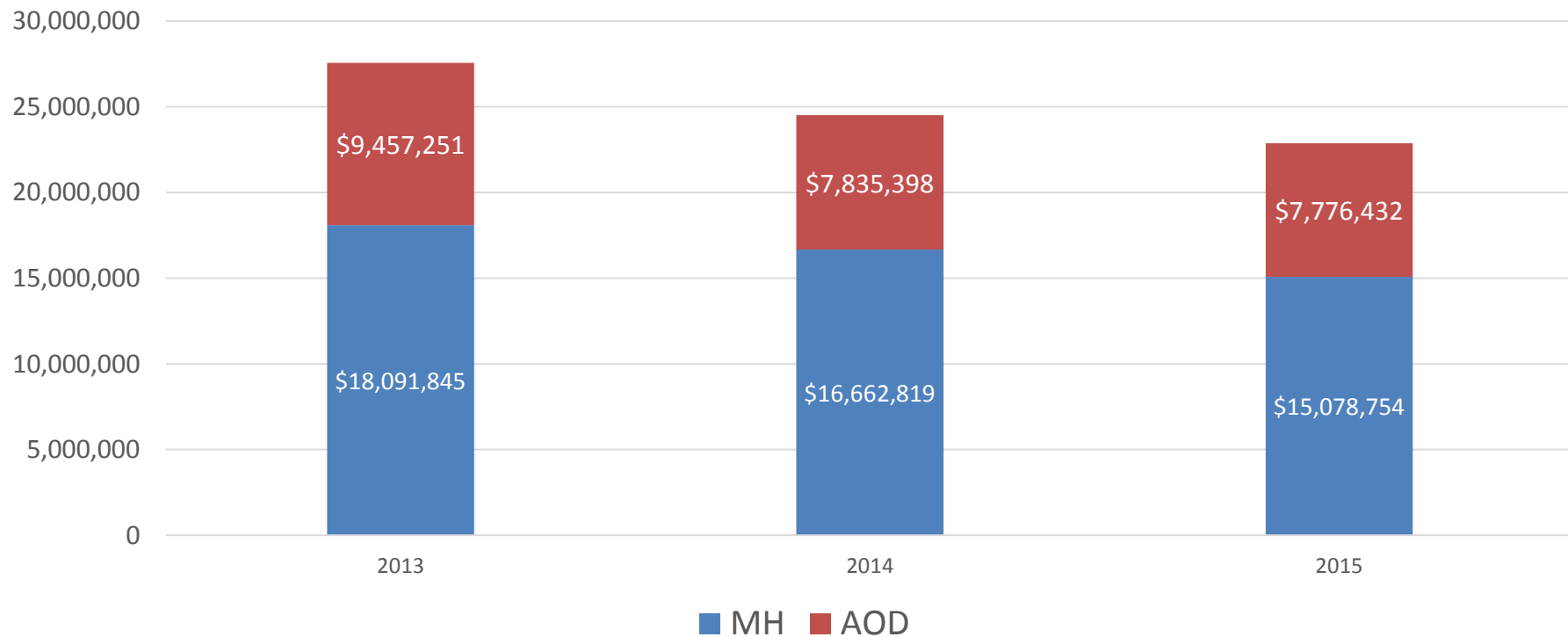
ADAMHS Board, Expenditures*, 2013-2015



*Does not include Board Administration, Medicaid Waiver expenditures, or Pass Through Contracts

Service Levels

Sum of Dollars Spent



#1. Cuyahoga County Population Demography

Community Profile

	Cuyahoga County*		
	2010	2015	Percent Change
Total Population	1,278,172	1,255,921	-1.7%
By Gender			
Males	47.4%	47.6%	+0.2%
Females	52.6%	52.4%	-0.2%
By Age Group			
0-18	22.7%	21.4%	-.7%
65+	15.5%	16.8%	+1.3%
By Race			
White	63.6%	63.2%	-.4%
Black or African American	29.7%	29.7%	No change
Hispanic/Latino (any race)	4.8%	5.6%	No change
Asian	2.6%	3.1%	+.5%

- In the first five years of this decade, Cuyahoga County's overall population decreased by 1.7%. The biggest demographic shift in the population was the proportion of senior citizens (+1.3%). The racial composition of the County did not significantly change during this period.

*Source: U.S. Census Bureau

Community Profile

	Cuyahoga County*		
	2010	2015	Percent Change
Total Households	534,653	532,702	-0.4%
Less than \$10,000	10.2%	9.9%	-.3%
\$10,000 to \$14,999	6.5%	6.6%	+.1%
\$15,000 to \$24,999	12.1%	12.1%	No change
\$25,000 to \$34,999	11.2%	11.4%	+.4%
\$35,000 to \$49,999	14.3%	13.7%	-.6%
\$50,000 to \$74,999	16.9%	16.8%	-.1%
\$75,000 to \$99,999	10.9%	11.1%	+.2%
\$100,000 to \$149,999	10.8%	10.3%	-.5%
\$150,000 to \$199,999	3.6%	4.0%	-.4%
\$200,000 or more	3.6%	4.2%	+.6%
Median household income (dollars)	\$45,184	\$45,297	+.25%
Mean household income (dollars)	\$64,552	\$66,336	+2.8%

- There was little change in the economic conditions of Cuyahoga County residents overall from 2010 to 2015. The most significant (but still not large) difference was the slightly higher mean household income.

*Source: U.S. Census Bureau

Community Profile

	Cuyahoga County*		
	2010	2015	Percent Change
Total Households	534,653	532,752	-0.4%
Percent of households with Social Security	29.0%	31.8%	+1.4%
Percent with cash public assistance income	3.7%	3.3%	-0.6%
Mean cash public assistance income (dollars)	\$3,142	\$2,506	-20.2%
With Food Stamp/SNAP benefits in the past 12 months	14.5%	18.4%	+3.9%

- Reflective of the aging population in the County, a greater proportion of residents have social security income in 2015 than in 2010. Likewise, the proportion of those receiving cash public assistance income decreased slightly by 2015, as did the average cash assistance dollar benefit (from \$3,142 to \$2,506). The proportion of those receiving Food Stamp/SNAP benefits increased, however.

*Source: U.S. Census Bureau

Community Profile

	Cuyahoga County*		
	2010	2015	% Change
Total Households	534,653	532,752	-0.4%
Percent of families under the poverty line	13.1%	13.9%	+0.8%
Percent of households with related children under 18 years under the poverty line	21.2%	23.0%	+1.8%
Percent of households with related children under 5 years (no older children) under the poverty line	21.5%	22.6%	+1.1%
Percent of married couple families with related children under 18 years under the poverty line	5.6%	6.9%	+1.3%
Percent of married couple families with related children under 5 years (no older children) under the poverty line	4.5%	5.0%	+0.5%
Percent of families with female householder, no husband present, with related children under 18 years, under the poverty line	43.2%	43.9%	+0.7%
Percent of families with female householder, no husband present, with related children under 5 years (no older children), under the poverty line	46.7%	46.8%	+0.1%
Percent of all people in the county under the poverty line:	17.3%	18.2%	+0.9%
Of those with related children under 18 years	25.8%	25.0%	-0.8%
Of those with related children under 5 years	30.4%	28.0%	-2.4%
Of those with related children 5 to 17 years	24.2%	25.0%	+0.8%
Living under the poverty line, by age:			
Of those under 18 years	26.1%	26.0%	-0.1%
Of those 18 years and older	14.6%	16.0%	+1.4%
18 to 64 years	15.6%	17.6%	+2.0%
65 years and over	10.8%	10.0%	-0.8%

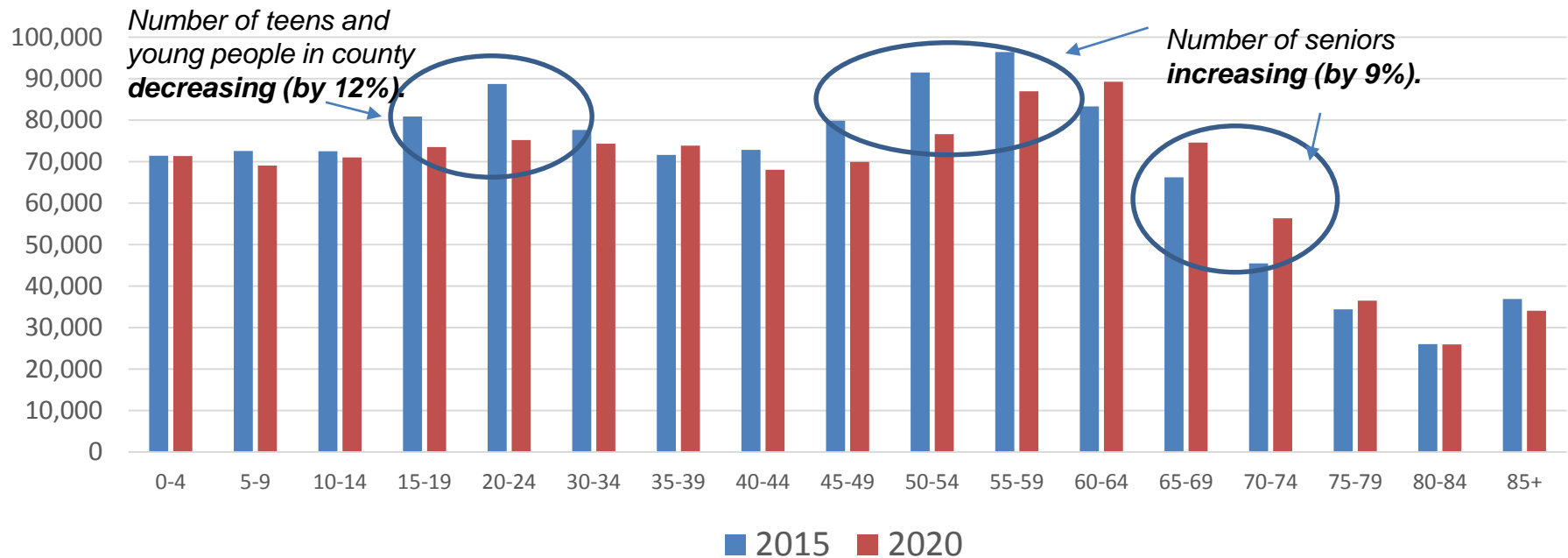
- Families with children were the most likely to see a higher likelihood of living under the poverty line.

- Non-senior citizen adults most likely to increased poverty levels.

*Source: U.S. Census Bureau

Population Profile

Age of Cuyahoga County Total Population, 2015 Projected to 2020



- Here we show the age progression of Cuyahoga County's population from 2015 to 2020. The number of teenagers/young adults will decrease by 12% and the number of senior citizens will increase by 9%.
- This is important for two reasons:
 - The total resident pool which the ADAMHS Board serves will shift slightly to older adults (assuming there is no increase in the incidence of mental health or addiction issues among younger county residents);
 - The medical healthcare system will be heavily stressed by a rapid increase in demand for all types of services (acute care, sub-acute care, skilled nursing, and long term care).

Summary: Cuyahoga County Demographic Trends

- There have not been significant changes in the demographic profile of Cuyahoga County residents in the past five years; certainly no change which is significant enough alone to drive a change in the types of services the ADAMHS Board should support.
- The aging of the population is expected to accelerate within the next 5-10 years, and that will have an impact on the ADAMHS Board in that the medical healthcare system will be stressed in order to respond to the much larger demand for services that the older population will generate.

2. Who the ADAMHS Board Serves: Profile of Clients

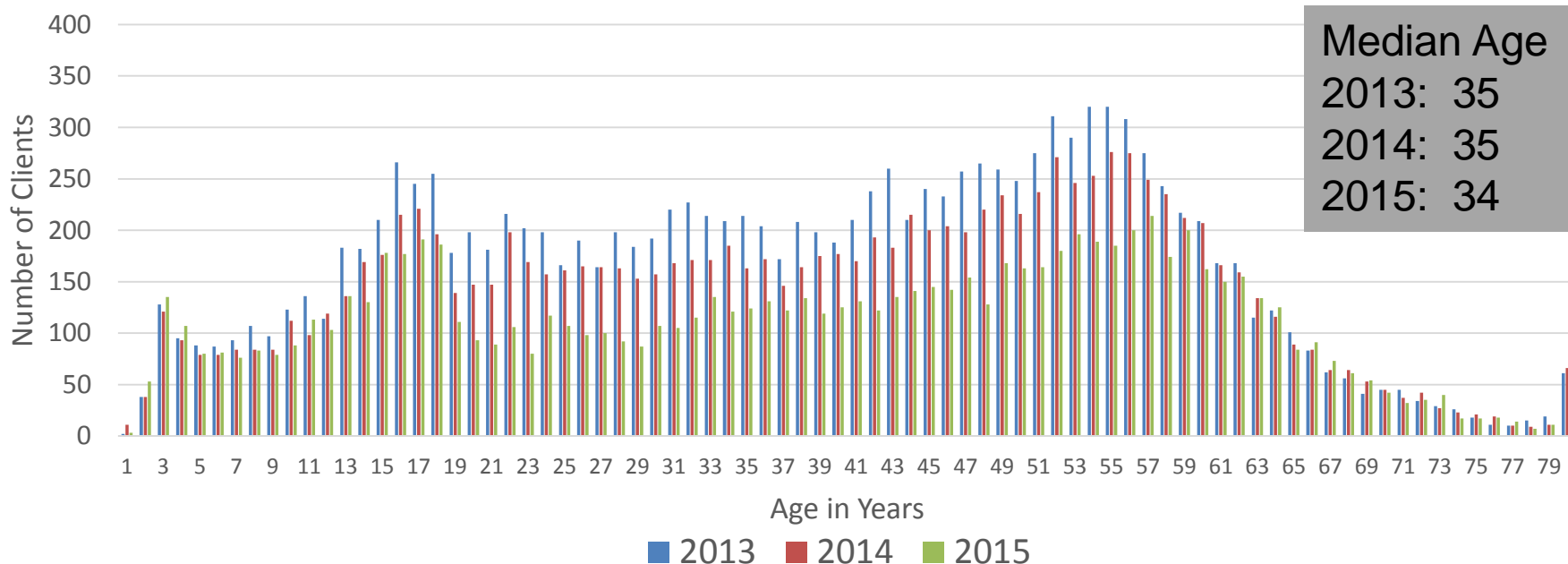
Profile of Clients

	2013	2014	2015
Marital Status			
Single	78.4%	78.5%	79.0%
Divorced	10.2%	10.4%	9.8%
Married	8.4%	8.1%	7.8%
Widowed	1.7%	1.6%	1.7%
Other	0.2%	0.1%	0.1%
Unknown	1.2%	1.4%	1.6%
Gender			
Female	43.1%	42.6%	41.3%
Male	56.9%	57.4%	58.7%
Race			
African American	46.5%	45.7%	44.5%
White	42.5%	43.2%	44.1%
Hispanic/Latino/Latina	5.2%	4.9%	6.1%

- The marital status and racial composition of the clients served by the ADAMHS Board has changed little from 2013 to 2015, and neither has the general population.

Profile of Clients

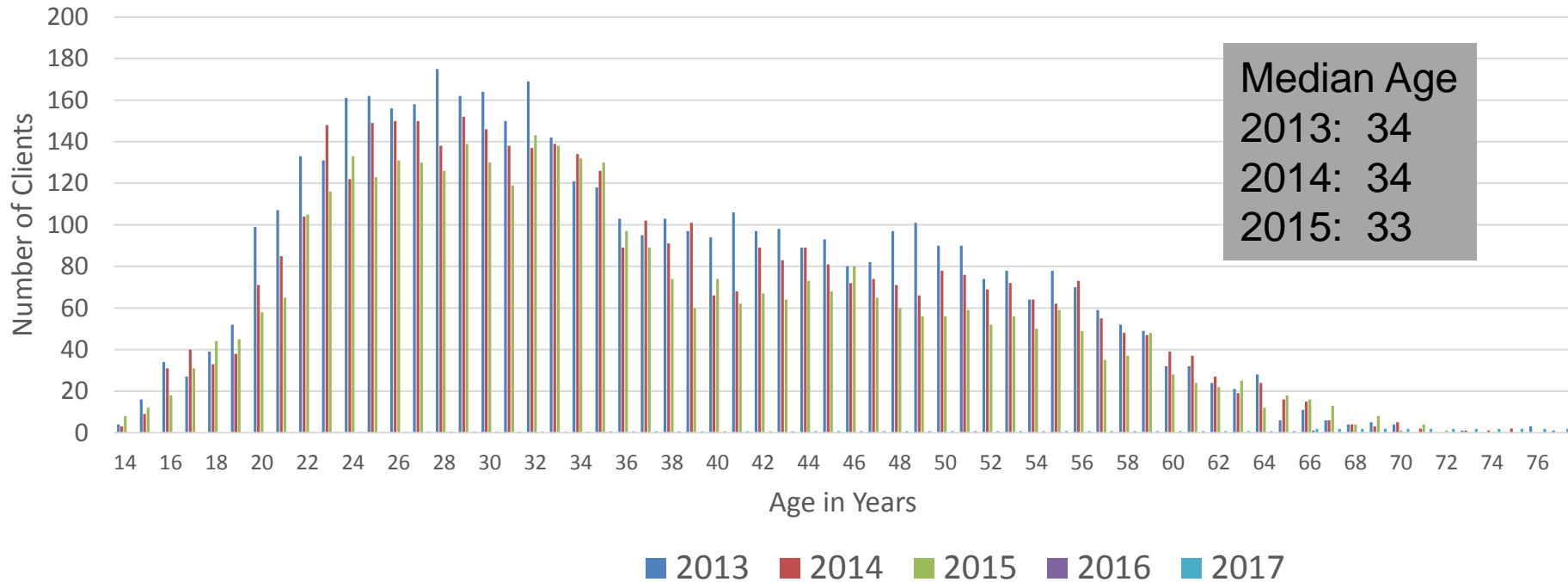
Age of Consumers, FY 2015, Mental Health Services Consumers



- Mental Health Services clients range in age from infancy to over age 80.
- Average age (median) is 34-35 years. Clients are somewhat evenly distributed among all adult ages; however, there is an increase in the frequency of clients in the age 13 to 18 and again from ages 53 to 57.
- The distribution of the age groups from 2013 to 2015 does not vary, however, we see a slight decrease in average age (35 to 34) by 2015.

Profile of Clients

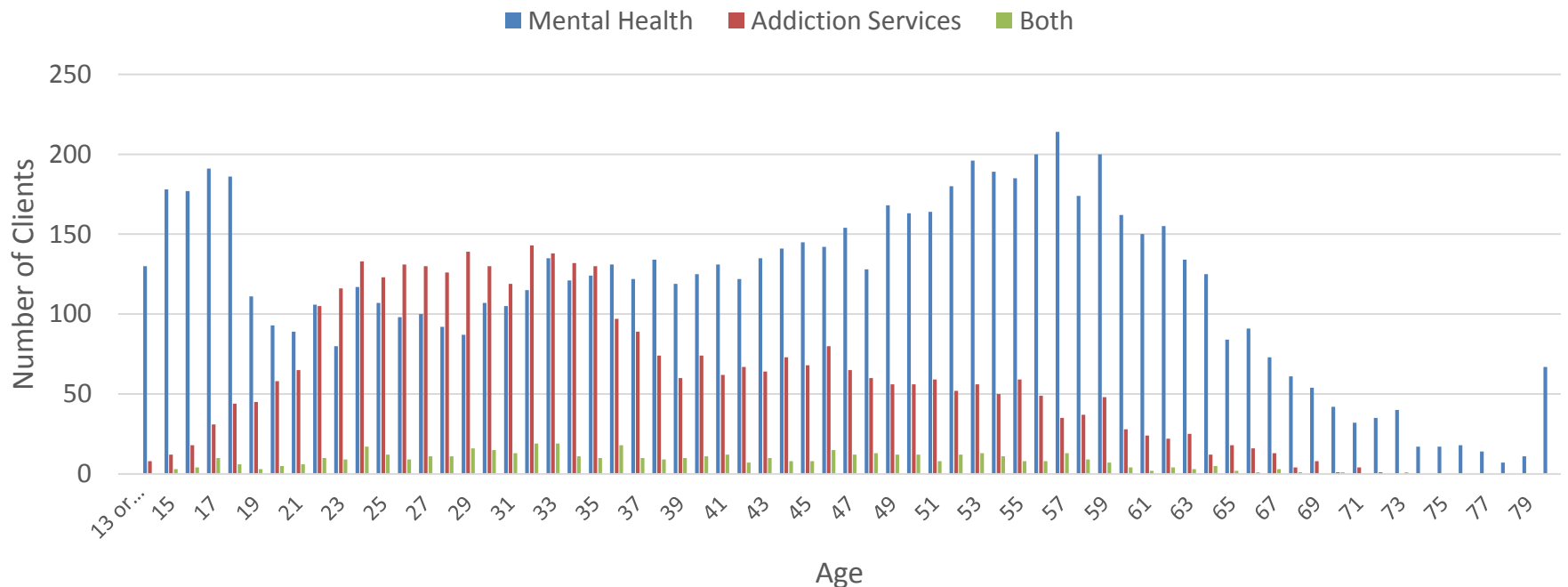
Age of Consumers, FY 2015, **Addiction Services Clients**



- Addiction Services clients range in age from 14 to over age 75.
- Average age (median) is 33-34 years. Clients' ages tend to cluster in the age 20 to 35 range.
- The distribution of the age groups from 2013 to 2015 does not vary, however, we see a slight decrease in average age (34 to 33) by 2015.

Profile of Clients

Age Distribution of FY 2015 Only, Addiction Services, Mental Health, or Clients of Both Service Types

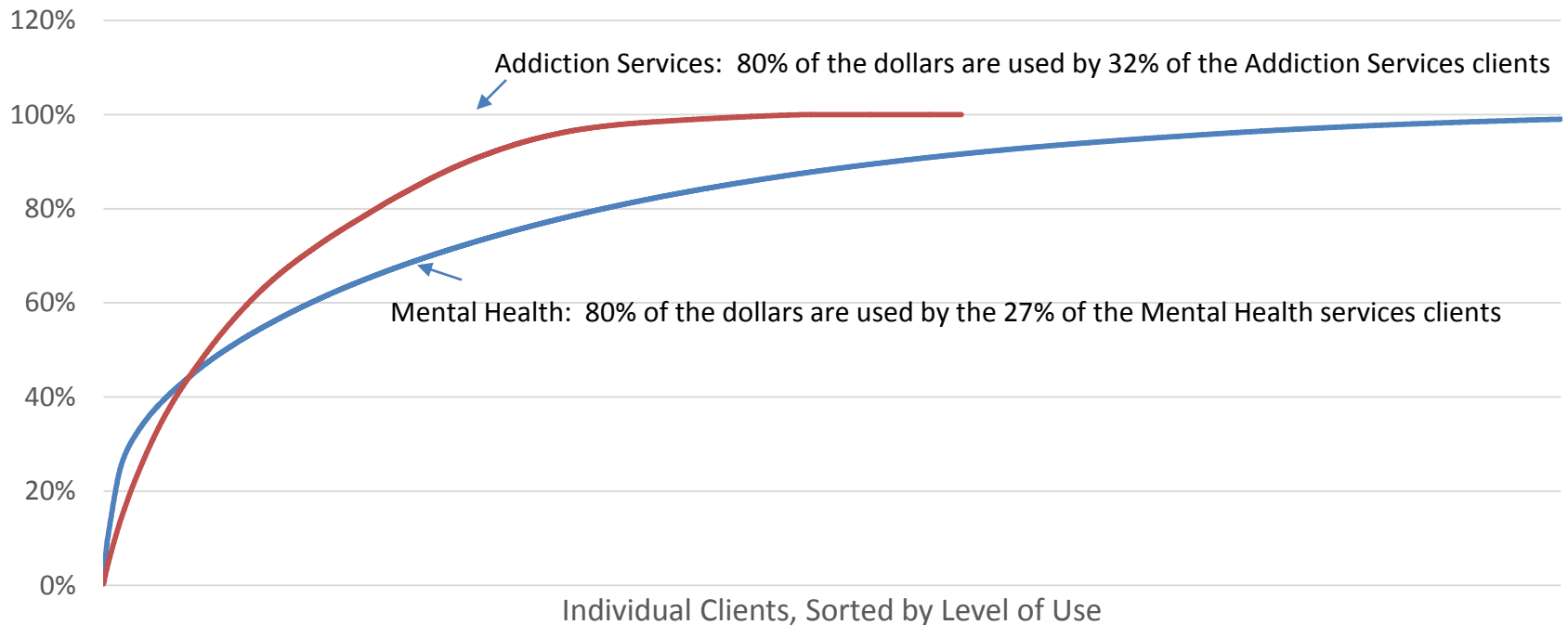


- The age distribution of Addiction Services (red) and Mental Health (blue) clients is somewhat different. Mental Health clients are distributed fairly evenly among all ages, while Addiction Services clients tend to be clustered between the ages of 21 and 35.

Service levels

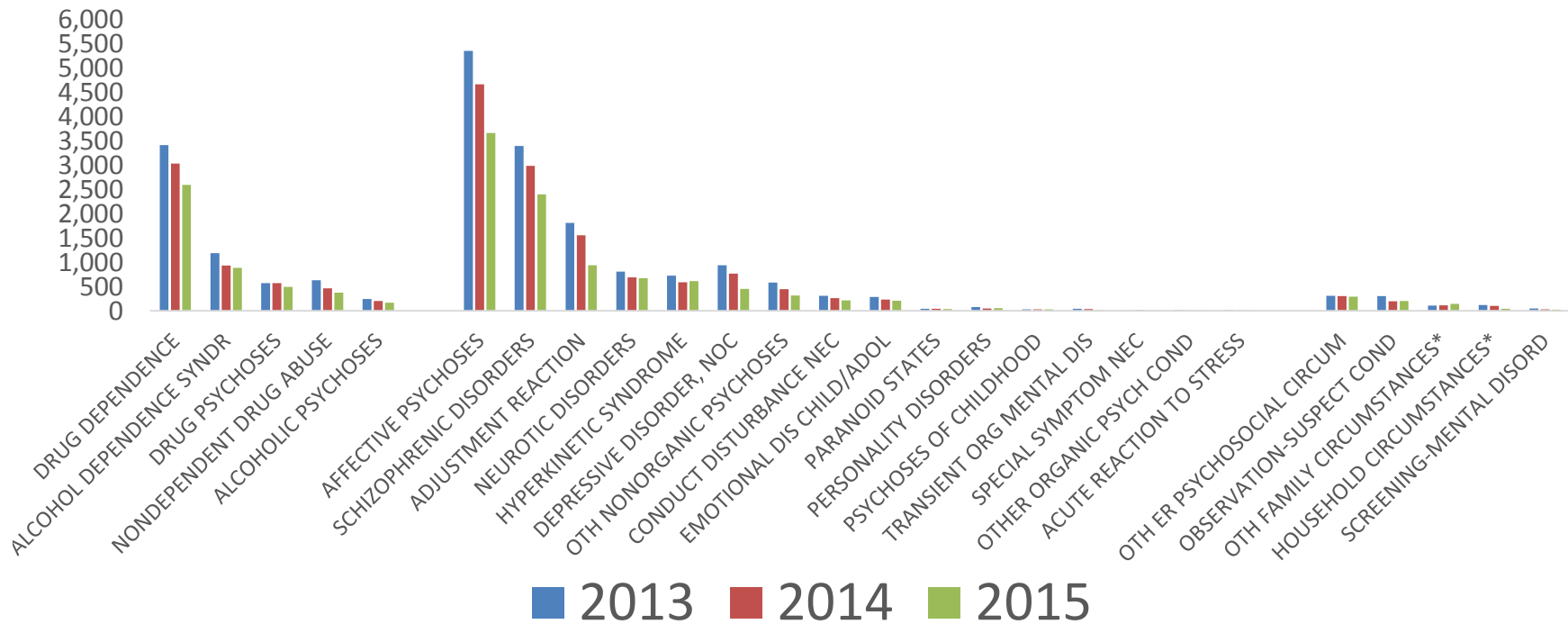
- A small proportion of consumers use a disproportionate amount of service (in terms of dollars). This is slightly more acute within Mental Health services.

Cumulative Dollars Spent, By Service Type; Non-Medicaid Only



Client Disorders

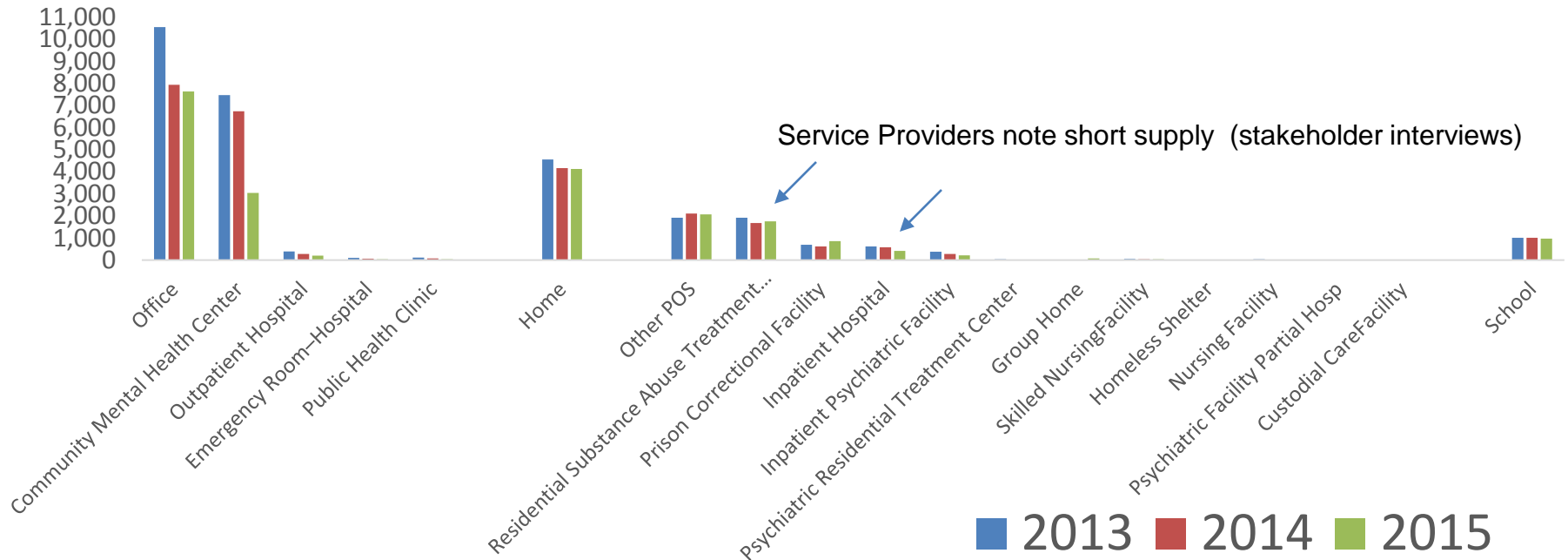
Number of Clients, With Diagnosis (Primary), 2013-2015



- Although alcohol addiction is more common than illicit drug abuse in the adult population than other drug abuse, drug dependence is the more common diagnosis.

Service Locations

Treatment Locations, Number of Clients, 2013-2015



- Clients reported (in focus groups and interviews) that treatments in the home are more beneficial; however, they are only moderately used. This is likely a resource issue.
- Qualitative findings stressed the dire need for more residential treatment for addiction clients.

#3: Who is and is not covered by health insurance: The Affordable Care Act and Medicaid Extension in Ohio

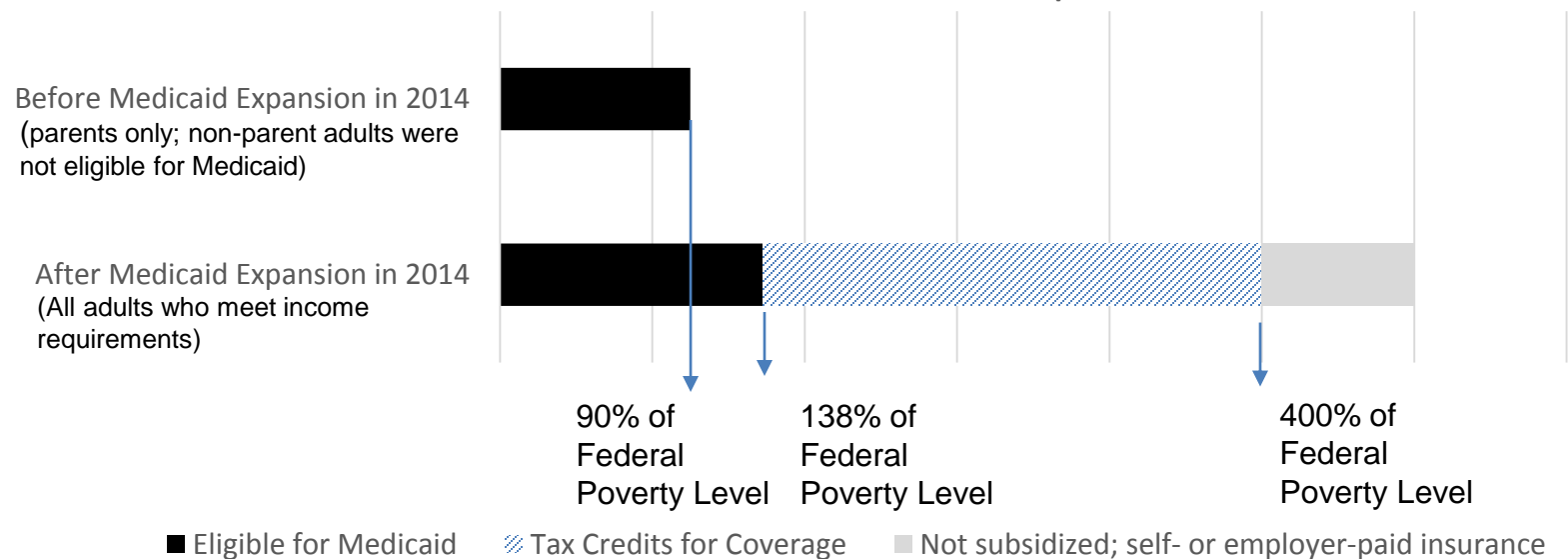
Policy & Impact on the Uninsured and the Non-Covered Needs

The Affordable Care Act was expected to benefit people with mental illness and substance use disorders in three ways:

- A. Expanding access to health insurance coverage through **Medicaid extension** (to include mainly more low-income childless adults);
- B. **Improved access to private insurance plans** purchased on the Health Insurance Marketplace for those not eligible for Medicaid; and,
- C. **Mandatory inclusion** of a package of Essential Health Benefits to Ohioans.

A: Medicaid Extension

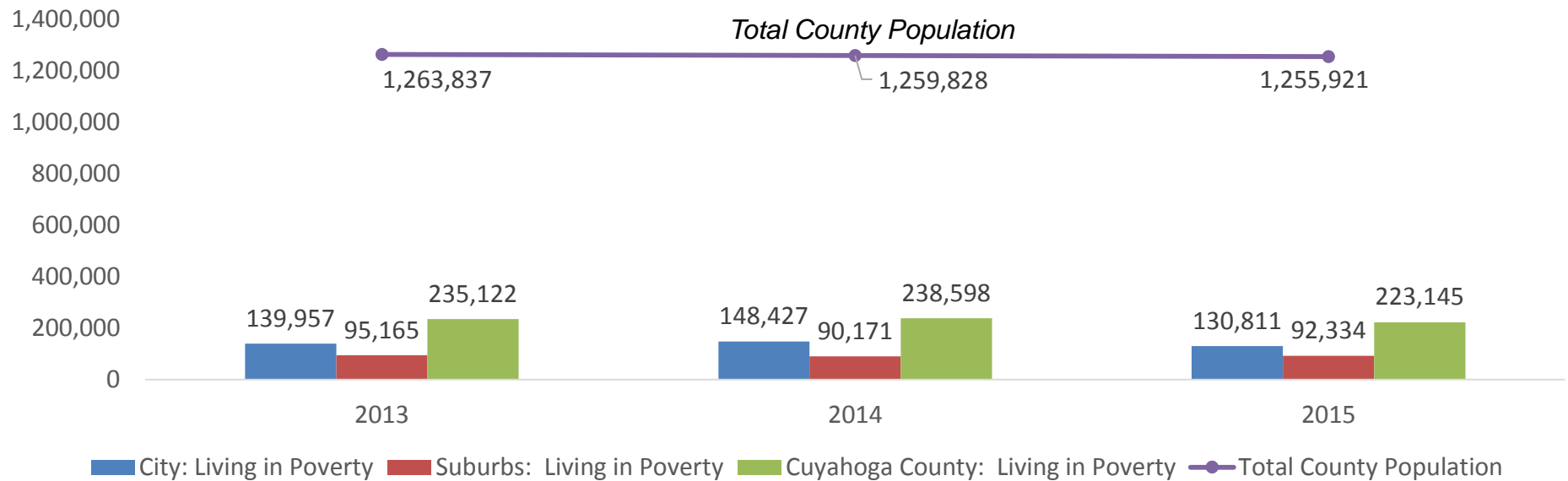
Most Impactful Change in Number of Cuyahoga County Residents With Medicaid After Expansion



- Medicaid Expansion allowed for coverage for childless low-income adults, most of which previously were not eligible for coverage, regardless of income levels.

A. Demography: Poverty Levels & Trends*

Number of Residents in Poverty, Cleveland & Surrounding Suburbs – Cuyahoga County, 2013-2015



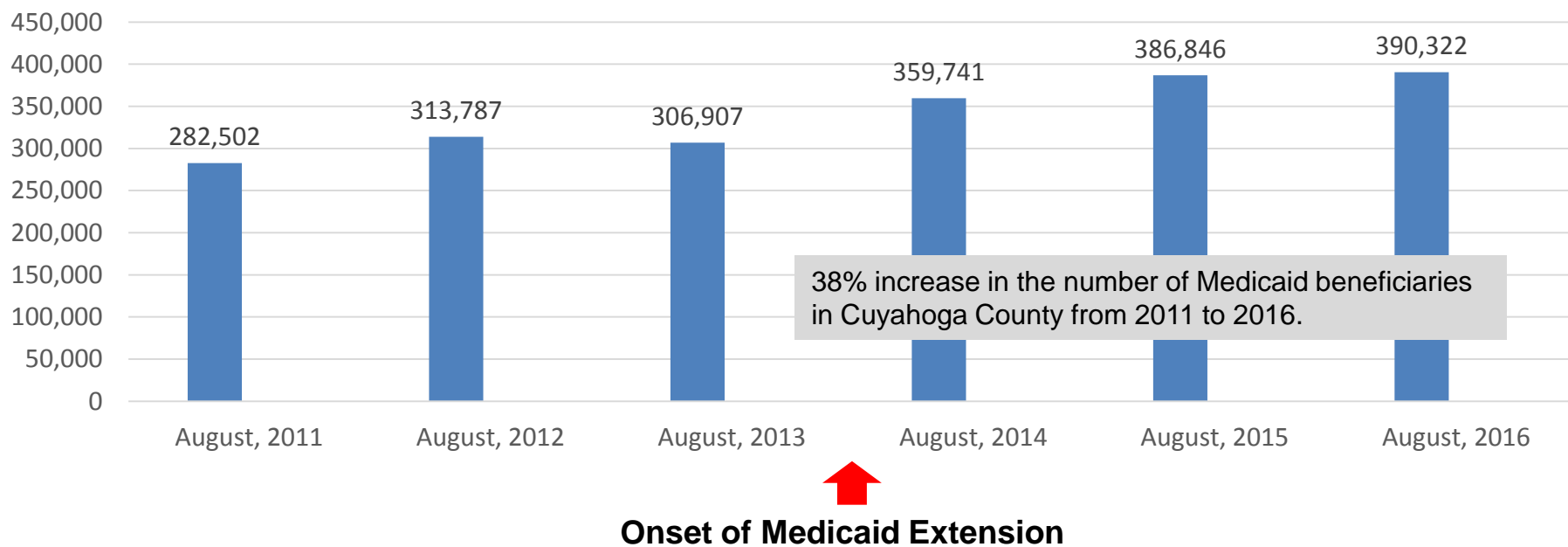
- The number of County residents living in poverty **has not changed dramatically** during the period of Medicaid Extension in Ohio (2013-2015) but we do see a slight decrease of the numbers living in poverty in the County overall (5%).

*Source: US Census

Service levels

- The state estimates an increase of 107,820 Medicaid beneficiaries from 2011 to 2016.

Number of Medicaid Beneficiaries, Cuyahoga County
2011-2016 (August)



- Medicaid Expansion accounted for an increase of 107,820 Medicaid beneficiaries from 2011 to 2016. These are mainly low-income childless adults who were previously not eligible for Medicaid.

B. Number of Insured

- While poverty levels decreased slightly over the period of Medicaid Extension in Ohio, the U.S. Census Bureau estimates only an additional 61,425 people with health insurance by mid 2015, ostensibly due mainly to the Affordable Care Act and Medicaid Extension.

	2010	July, 2015	Percent Change
Percent with health insurance coverage	88.2%	93.9%	+5.7%
Percent with private health insurance	67.6%	64.6%	-3.0%
Percent with public coverage	32.9%	41.6%	+8.5%
Percent with no health insurance coverage	11.8%	6.1%	-5.7%
Under age 18 with no health insurance coverage	3.5%	2.5%	-1.0%
Employed adults:	600,202	596,277	
With health insurance coverage	86.5%	92.4%	+5.9%
With private health insurance	80.6%	80.1%	-.5%
With public health coverage	7.8%	14.5%	+6.7%
No health coverage	13.5%	7.6%	-6.1%
Unemployed adults:	71,993	54,793	
With health insurance coverage	59.1%	78.3%	+19.2%
With private health insurance	33.3%	29.6%	-3.7%
With public health coverage	28.9%	51.1%	+22.2%
No health coverage	40.9%	21.7%	-19.2%
Not in labor force, adults:	173,675	181,732	
With health insurance coverage	80.5%	91.3%	+10.8%
With private health insurance	46.6%	43.1%	-3.5%
With public health coverage	40.1%	53.8%	+13.7%
No health coverage	19.5%	8.7%	-10.8%

Impact of Affordable Care Act and Medicaid Extension on Cuyahoga County Residents' Health Insurance Coverage by July, 2015:

+3,173 Under age 18

+31,785 adults

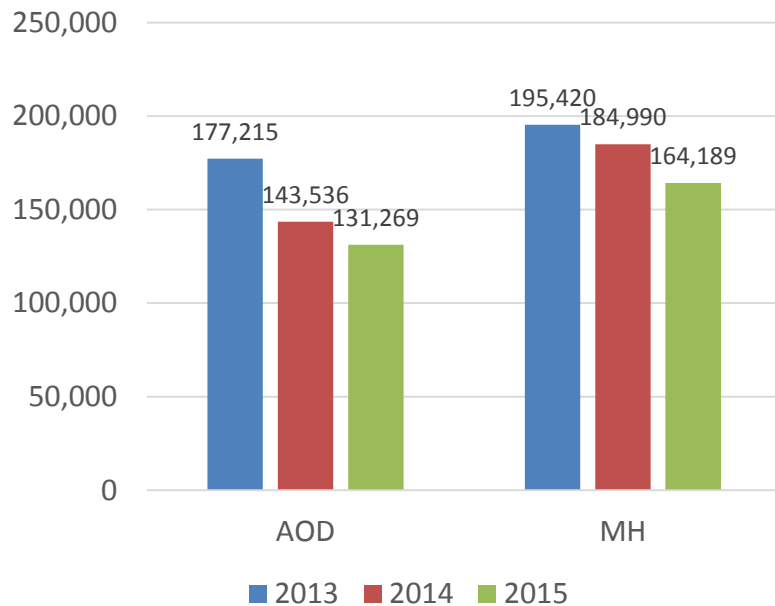
+355 adults

+26,112 adults

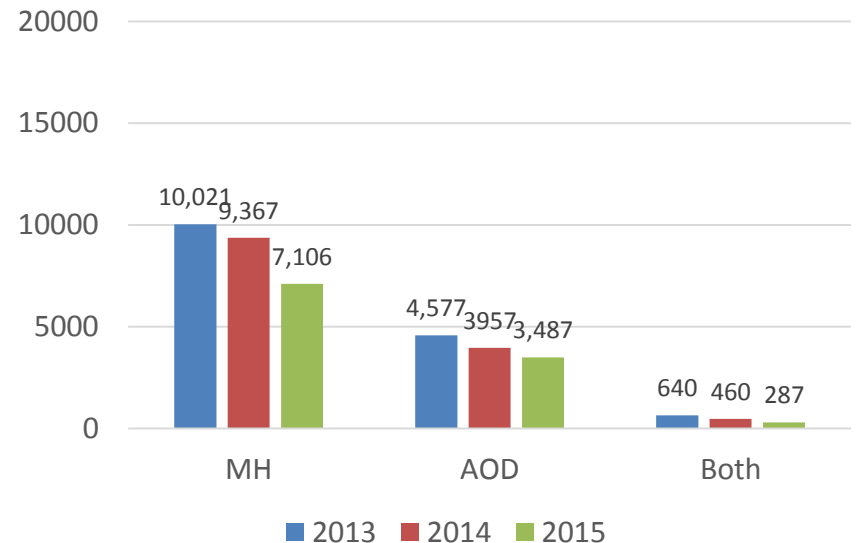
Net Increase of: 61,425 with health coverage

ADAMHSCC Service levels

**Episodes of Care, 2013 - 2015,
by General Treatment Category
Non-Medicaid**



**Number of Clients, By General
Treatment Category (Addiction or
Mental Health), 2013-2015
Non-Medicaid**



- As Medicaid Expansion created more beneficiaries from 2014 to 2015, the ADAMHS Board served fewer clients.

C. Policy Impacting Coverage Levels

- Despite the passage of the Mental Health Parity and Addiction Equity Act (2008) and the Affordable Care Act (2010), there are a number of mental health and addiction treatment/recovery services deemed necessary by medical professionals and service providers which are *not* covered by many health insurance plans and Medicaid.
- **Therefore, the need very much remains for the ADAMHS Board to support services for those clients who are covered by Medicaid but who require services which are not covered by Medicaid.**

Policy: Qualitative Findings

Funding Policies Which Are Barriers to Care

- ✓ Engagement efforts are necessary for this population of clients. Agencies are not reimbursed for that, yet it is critical to ensure good client outcomes.
- ✓ IMD exclusion limits capacity tremendously.
- ✓ Insurance companies will only pay for outpatient detoxification, but, inpatient care is medically called for.

Summary and Conclusion:

- As expected, The Affordable Care and the resultant extension of Medicaid benefits to more of Cuyahoga County residents has decreased the proportion of the uninsured substantially. In 2016, there is an estimated 51,000 – 77,000 Cuyahoga County residents without health insurance coverage, the vast majority of which are adults between the ages of 19-64.
- The newly mandated coverage for mental health and addiction services, while impactful on those covered and hence the service provider community overall, is not expected to have a large impact on the population that ADAMHSCC have traditionally served (non-Medicaid clients) *per se*.
- Overall, policy changes have resulted in a shift in who is served and how they are served; if carried to its complete conclusion (all are covered by health insurance), the ADAMHS Board will be funding a dramatically different (but just as necessary) set of services than it did in 2013.

#4: What is not covered by Medicaid and its impact on the demand for ADAMHSCC-supported services.

What Medicaid does NOT Cover

- A cross examination between what is considered a full and robust mental health and addictions services community*, where all necessary and appropriate modalities and types of care are accessible to beneficiaries, and what Medicaid does and does not cover (or covers with restrictions), highlights where the ADAMHS Board needs to provide some support. Those necessary services, not fully covered by Medicaid, include:
 - ✓ Most residential services (MH & AOD), including substance detoxification
 - ✓ Some Medication Services (Medication Assisted Therapy for addiction)
 - ✓ Some acute intensive services
 - ✓ Some outpatient services
 - ✓ Some intensive support services
 - ✓ Prevention
 - ✓ Post-recovery support (in particular, housing, employment, and mentoring/coaching)

Source: *U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)

Gaps in Services

From the interviews with stakeholders and ADAMHSCC employees, as well as focus groups with clients and their families, we uncovered the following on-going acute gaps in services, both in terms of general availability and coverage by Medicaid (and non-coverage by Medicaid impacts the level of supply negatively).

Consensus that there is a lack of access to:

- ✓ Detoxification Beds
- ✓ Inpatient beds in local hospitals for psychiatric patients
- ✓ Inpatient beds in local hospitals for medical stabilization of mental health and addiction clients
- ✓ Intensive outpatient care for addicts (for Medicaid patients)
- ✓ Medical Assisted Therapy [community programs are not adequately attached to providers who can manage MAT].
- ✓ Sober beds/Sober Housing

Many of those seeking addiction services need immediate care. Heroin users need to be safely detoxed and will continue to use heroin while waiting for availability of services. This increases the chances of overdosing.

AOD Service Provider

Please emphasize – biggest need is resources to address opioid substance abuse.

Hospital Stakeholder

Detox. We have got to wrap our heads around this substance use issue. Shouldn't be publicizing on the crisis line as having the answers when we have no additional resources. People call in desperation because they believe Frontline can help...but they are being scheduled 3 weeks out.

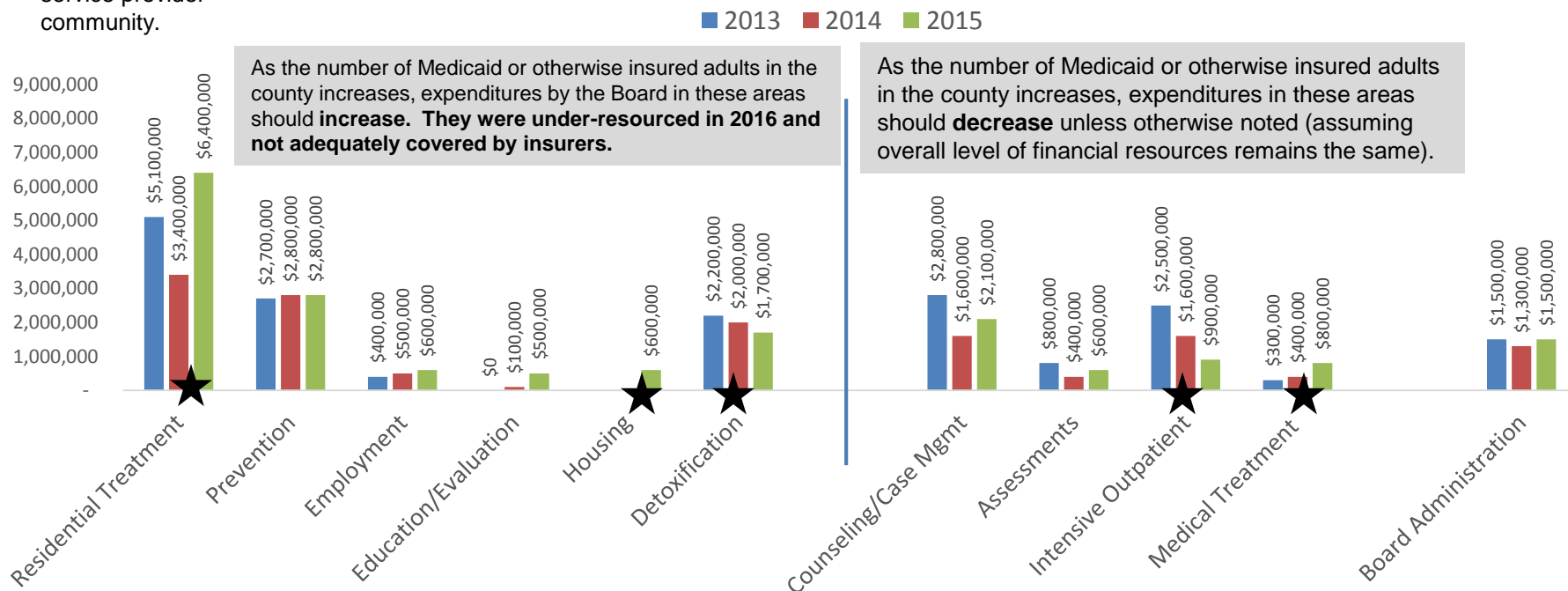
Mental Health Stakeholder

GAP ANALYSIS: Addiction Services

- Below we isolate the service areas, by level of coverage by Medicaid; service areas which are fully or mostly covered by Medicaid should be decreasing as the number of Medicaid beneficiaries increase. As those funds are released, ADAMHSCC was then able to allocate resources to those service areas which are not covered by Medicaid and for which the ADAMHSCC is the payer-of-last-resort.

★ = seen as severely under-resourced by service provider community.

ADAMHS Board, Addiction Total Expenditures, 2013-2015



Source: ADAMHSCC Annual Reports, 2013-2015

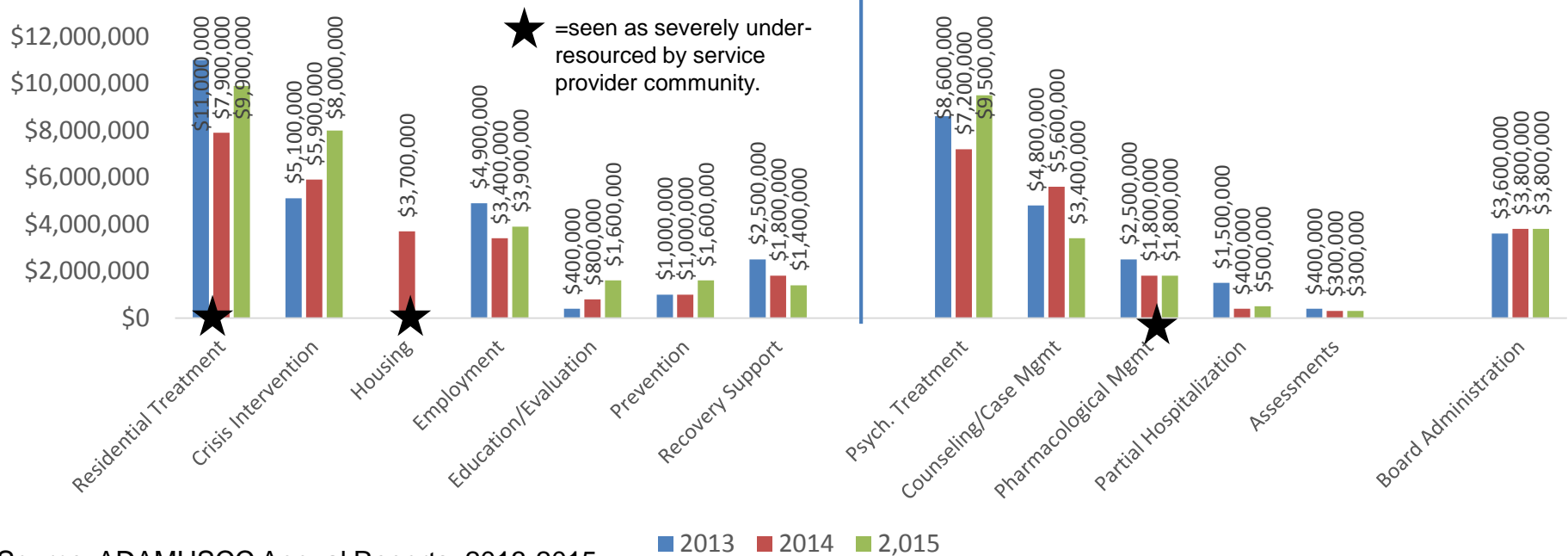
GAP ANALYSIS: Mental Health Services

...Continued

ADAMHS Board, Mental Health Services Total Expenditures

As the number of Medicaid or otherwise insured adults in the county increases, expenditures in these areas should **increase**. They were **under-resourced in 2016 and not adequately covered by insurers**.

As the number of Medicaid or otherwise insured adults in the county increases, expenditures in these areas should **decrease** (assuming overall level of financial resources remains the same).



Source: ADAMHSCC Annual Reports, 2013-2015

Qualitative Findings

We don't have in this county robust outpatient commitment like they do in other places in Ohio and in the U.S. That results in a lot of misuses of services. If folks were mandated to outpatient that helps them get the care they need.

Community-Based Psychiatrist

Getting someone into detox, rapidly into treatment, is darned-near impossible.

AOD Service Provider

Agency-to-agency communication is still very difficult.

Mental Health Service Provider

Ability to access information in terms of what would be considered HIPAA info is just terrible. Right hand doesn't know what the left is doing and it is a huge barrier for appropriate care.

Hospital-Based Physician

The hoops you have to jump through (to arrange for inpatient care for the very sick or violent)! The state hospital is supposed to be available to those patients who need longer term care. The process remains unclear to us. So we call the medical director there and they accept the patient, but the Board has to OK it. But the Board then tells us you don't have to call us....we go back and forth all the time. The relationship between the board and access to the programs is very problematic. What is their role? Why do we always get such inconsistent answers?

Hospital-Based Physician

Qualitative Findings

Persistent Issues Which Impact Quality of Care (mentioned by a significant number of stakeholders interviewed)

- ✓ Turnover of personnel
- ✓ Housing for clients during and/or after receiving care (especially sober living settings).
- ✓ Client's unmet basic needs (food, clothing, etc.)
- ✓ Agencies not able to share info on patients impacts patients too – they have to provide info over and over again.

Qualitative Findings

Other Gaps in Services

- ✓ Assistance for non-English/non-Spanish speaking personnel.
- ✓ Many psychiatrists don't take Medicaid. Many are 'cash only.'
- ✓ Medicaid is allowed to lapse for many.

4: Summary: What is not covered, and the resultant gaps

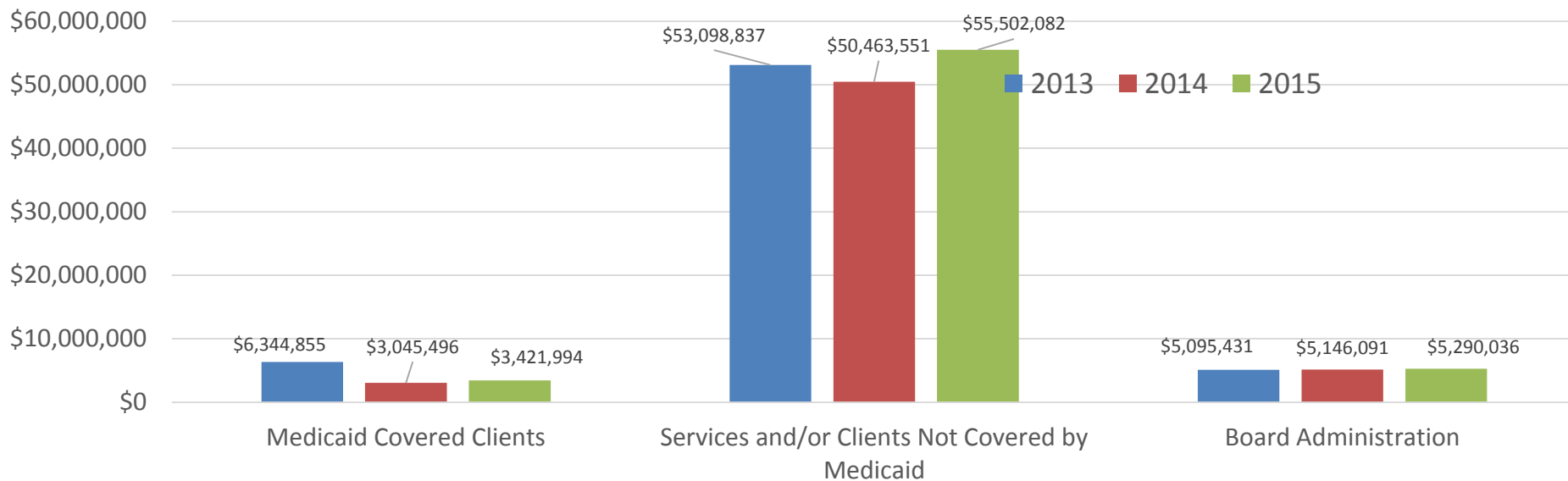
Identified Need	Current level of Funding by ADAMHS Board
Detoxification Beds	“Detox” is currently funded by ADAMHS Board (4.3% of total expenditures).
Inpatient beds in local hospitals for psychiatric patients	Some level of funding by ADAMHS, but low level of supply in community.
Inpatient beds in local hospitals for medical stabilization of mental health and addiction clients	Not funded by insurance; somewhat funded by ADAMHS but low level of supply in community.
Intensive outpatient care for addicts (for Medicaid patients)	Variable levels of funding; low level of supply in community.
Medical Assisted Therapy	Low levels of supply in community. [community programs are not adequately attached to providers who can managed MAT].
Sober beds/Sober Housing	Not covered by insurance and funded by ADAMHS Board at low levels (1.9% of expenditures)
Housing	Not covered; funded by ADAMHS Board at a relatively low level.
Transportation	Not covered or consistently funded by ADAMHS.

#5. Demand for Services: Number of People Who Need Care

Annual Expenditures

- Although the number of low income Cuyahoga County residents without healthcare insurance coverage has decreased substantially from 2013 to 2015, the relative proportion of dollars spent on those patients has not changed significantly. We would expect dollars spent on Medicaid covered clients to increase as the number of insured increases. This suggests that the limited resources of the Board continued to be needed by those still not covered by Medicaid or other insurance, even in 2015. See following pages for further explanation.

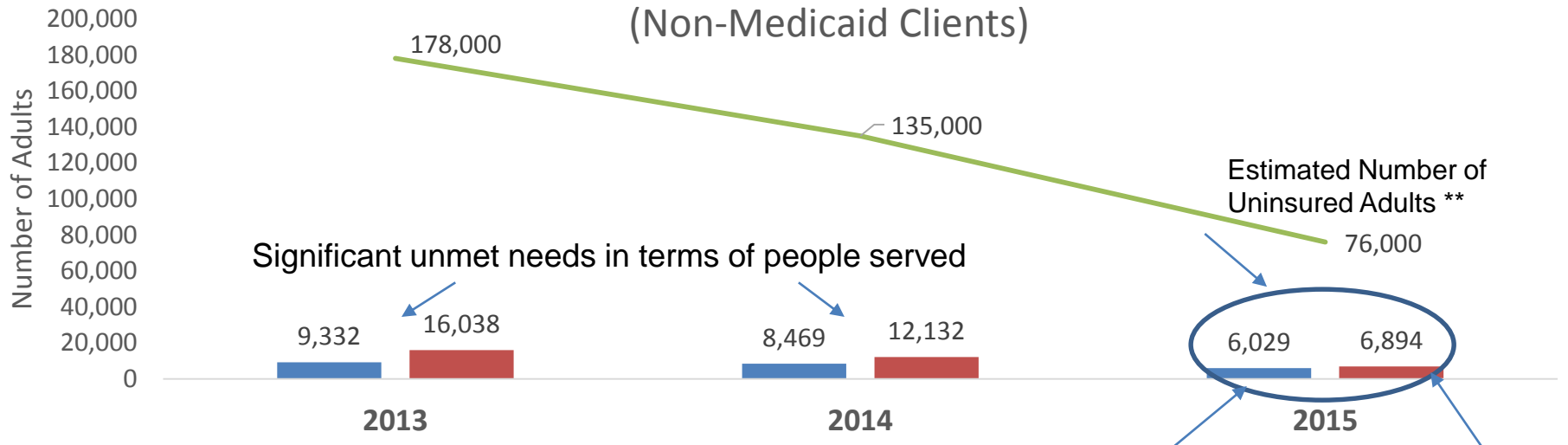
ADAMHS Board, Total Expenditures, 2013-2015



*Source, ADAMHSCC Annual Reports

Impact of Medicaid Expansion in OH

Cuyahoga County: Trends in Demand for **Adult Mental Health Services** (Non-Medicaid Clients)



- Prior to 2015, the number of clients served by the ADAMHS Board (for mental illness) was far lower than the number who needed services (prevalence of those with severe mental illness within the past 12 months). In 2013, 9,332 county residents were served yet the estimated minimum number who needed services was 16,038. However, by 2015 because of Medicaid Expansion, the number of uninsured adults in Cuyahoga County decreased and hence so did the number of those who require services from the ADAMHS Board (the last-resort for funding care). By 2015, the demand for services (in terms of number of clients) was just above the amount the Board was able to serve with existing resources. Hence, the amount of 'non-Medicaid' spending by the Board has not decreased by 2015 (because the demand still exceeds the supply of resources).

Number of Mental Health Clients served by ADAMHSCC agencies ("Non-Medicaid Clients")

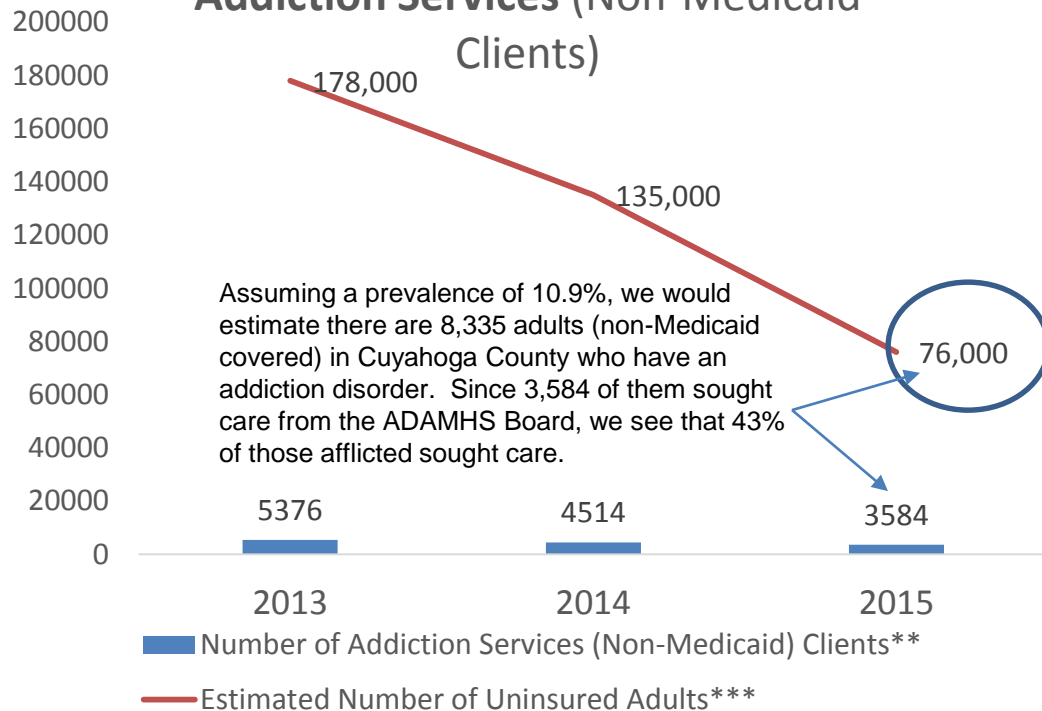
Estimated Number of Uninsured Adults Requiring Mental Health Services*

*Based on incidence of severe mental illness/mental illness which requires treatment within past year of 9%, which is adjusted to account for a 37% increase in incidence among those with incomes between 138% and 220% FPL. SAMHSA, 2016 .

**A rougher estimate from the U.S. Census 2015 of 776,159 adults between the ages of 19 and 64, inclusive, and an uninsured rate of 6.1% suggests this is 47,000.

Impact of Medicaid Expansion in OH

Cuyahoga County: Trends in Demand for Addiction Services (Non-Medicaid Clients)



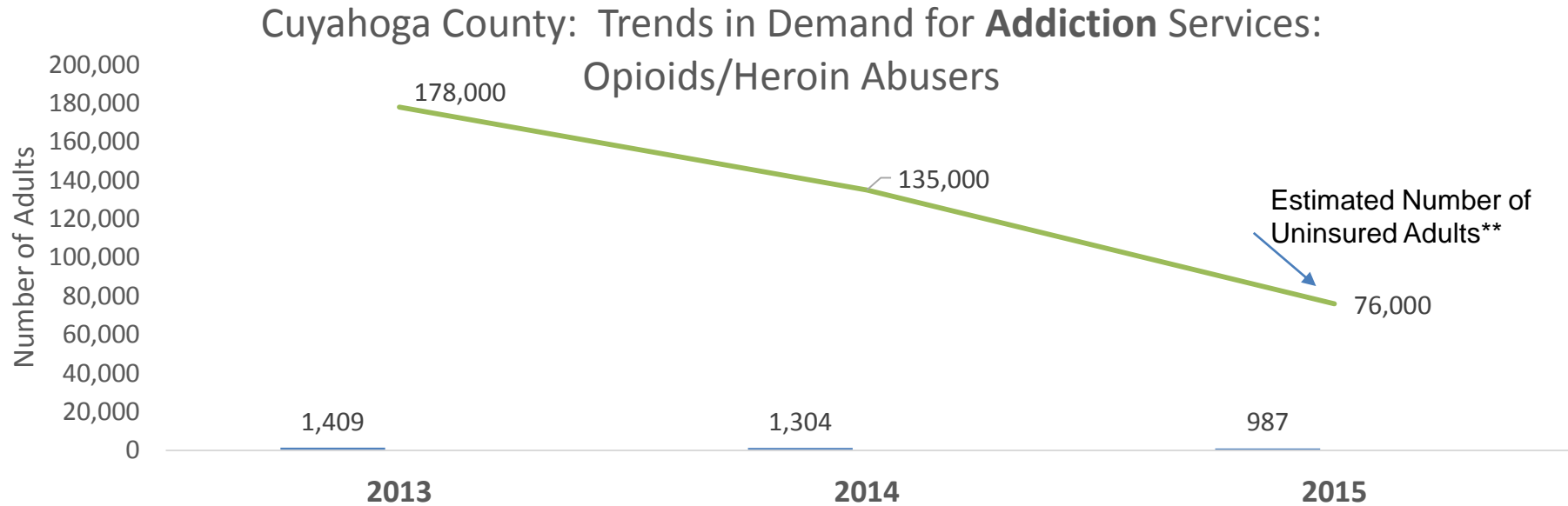
- In the previous page we showed the trend in the difference between the number of patients who should receive mental health services and those who did receive mental health services. To do this, we used prevalence data for serious mental health disorders and used this as a minimum measure of the amount of demand for services.
- Estimating the demand for addiction services is a very different matter. Not all those who have addiction disorders (estimated to be about 11%* of the adult population), seek care or would receive care even if offered to them. However, within the ADAMHS Board's service population (non-Medicaid) we see that about 43% of those with addiction disorders sought care (and they received it). We do not know if this could be higher if more services were available.

*Based on incidence of dependent or abuse of illicit drugs or alcohol in past year or 10.9% (note this is for those aged 12+, not adults); SAMHSA, 2016 .

**ADAMHS Board

***A rougher estimate from the U.S. Census 2015 of 776,159 adults between the ages of 19 and 64, inclusive, and an uninsured rate of 6.1% suggests this is 47,000.

Impact of Medicaid Expansion in OH



- Here we show the number of clients obtaining addiction services who had a diagnosis related to **opioid abuse** from 2013 to 2015. The number of clients served decreased by 30% over that time frame. However, the number of uninsured adults in the county decreased by 57% during that period. This suggests that a higher proportion of those afflicted received care over time. We cannot determine if *all* of those who sought or wanted care received it. However, some addiction services providers reported waiting lists for outpatient services (of varying lengths and wait times), suggesting some unmet demand for outpatient services. **What was clear from the interviews with addiction service providers is that many clients would benefit most from residential treatment or supervised inpatient detoxification, which is not accessible to this population of country residents and/or the community has very little capacity.**

*Based on incidence of dependent or abuse of illicit drugs or alcohol in past year or 10.9% (note this is for those aged 12+, not adults); SAMHSA, 2016 .

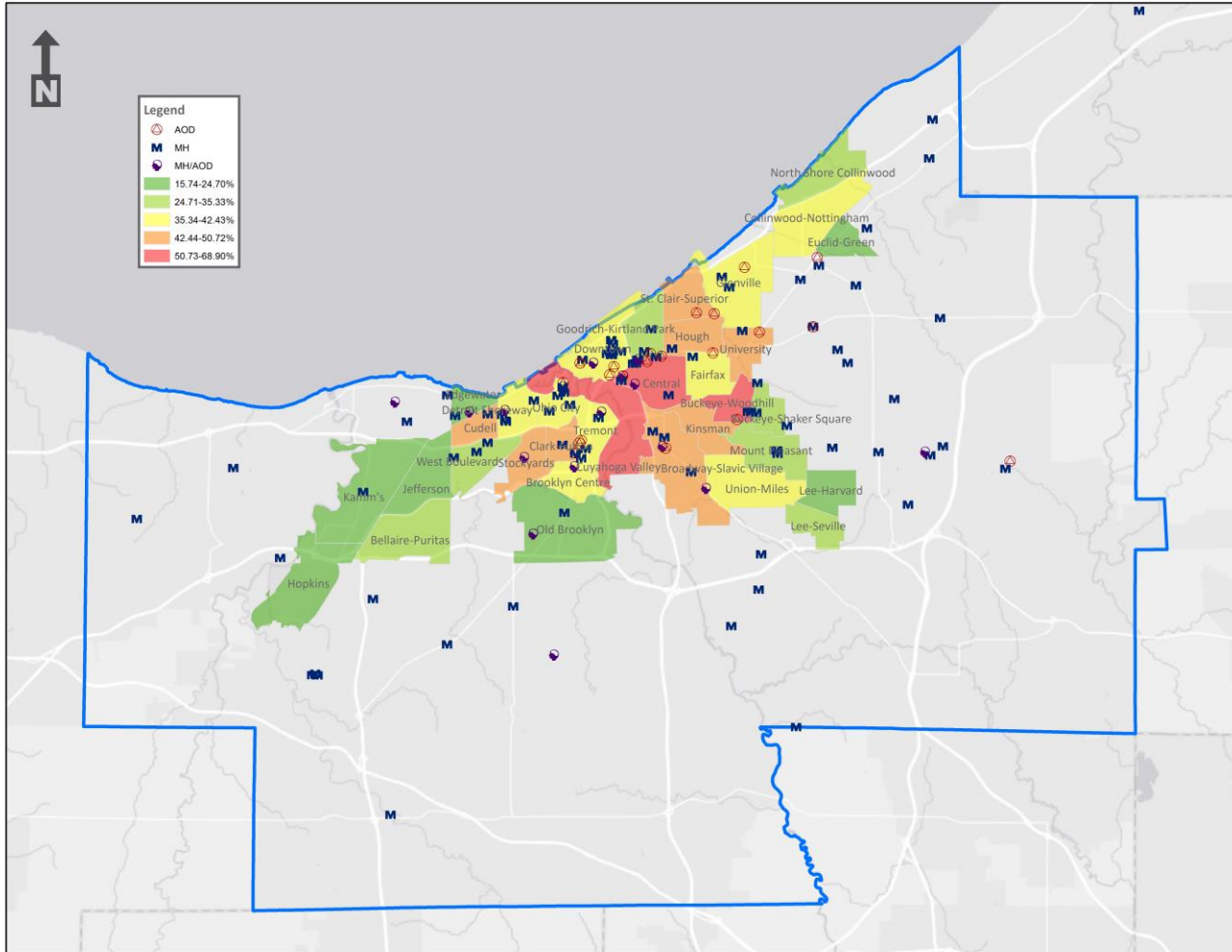
**A rougher estimate from the U.S. Census 2015 of 776,159 adults between the ages of 19 and 64, inclusive, and an uninsured rate of 6.1% suggests this is 47,000.

Summary: #4. Demand for Services: Number of People Who Need Care

Type of Service	Conclusion on gap between demand and supply
Mental Health	<ul style="list-style-type: none">The number of mental health clients which the ADAMHS Board is able to support appears to just about meet demand (given historic types of services supported). However, for Medicaid clients (support of non-covered services), demand for services far exceeds supply of support and capacity in the community.
Addiction Services	<ul style="list-style-type: none">Difficult to determine the true level of demand. Anecdotal evidence from service providers reports a dire undercapacity of key services: detoxification beds (and financial support for them); sober living opportunities; and, medical management of addictions.

#6. Provider Community

Provider Profile



- This figure shows the location of community-based mental health and addiction services providers in Cuyahoga County.
- The neighborhoods within the City of Cleveland are also shown.
- Here we can see that several neighborhoods lack an Addiction Service Provider and/or a Mental Health Provider. Many outlying communities also lack a service provider, but also likely have much lower levels of poverty and/or non-insured rates.

Community Profile

Specific Cleveland Neighborhood Characteristics, 2015*

	Bellaire Puritas	Broadway Slavic Vill.	Brooklyn Centre	Buckeye-Shaker Sq	Buckeye-Woodhill	Central	Clark Fulton	Collinwood-Nottingham	Cudell	Cuyahoga Valley	Detroit Shoreway	Down-town
Total Pop	14,273	21,429	9,224	11,853	6,967	10,980	7,451	11,323	8,929	1,106	10,303	10,303
< 18	3,225	6,232	2,561	2,380	2,279	4,631	1,901	2,736	2,600	490	2,261	422
18-64	9,274	13,365	5,916	7,502	3,966	5,687	4,804	6,903	5,659	593	6,990	9,488
% Black	24.0	51.1	21.7	78.1	94.3	90.7	18.5	85.2	32.6	70.2	24.4	33.8
% Hispanic	17.2	5.9	31.6	2.6	2.9	1.6	48.1	0.9	28.1	6.2	22.8	3.8
% Poverty	28.7	72.4	67.0	58.0	80.6	89.1	72.4	70.7	74.9	65.6	65.6	50.7

	Edgewater	Euclid-Green	Fairfax	Glenville	Goodrich-Kirtland Pk.	Hopkins	Hough	Jefferson	Kamm's	Kinsman	Lee-Harvard	Lee-Seville
Total Pop	6,227	5,271	6,180	26,701	4,233	288	11,733	16,117	25,898	6,782	10,329	4,641
< 18	796	1,099	1,636	7,092	667	63	2,917	3,926	4,928	2,104	1,975	1,044
18-64	4,797	3,318	3,428	15,571	2,976	186	7,022	10,432	17,245	3,830	5,845	2,707
% Black	26.1	92.2	93.6	94.9	23.6	15.1	92.1	19.9	7.8	95.9	95.8	95.8
% Hispanic	5.0	0.1	1.0	0.6	9.0	12.6	1.7	17.1	6.8	1.0	0.5	1.8
% Poverty	46.0	52.2	66.0	69.6	55.5	43.9	68.6	48.8	33.2	72.4	51.0	61.0

	Mt. Pleasant	N. Shore Collinwood	Ohio City	Old Brooklyn	St. Clair-Superior	Stockyards	Tremont	Union-Miles	University	West Boulevard
Total Pop	15,540	16,051	8,889	33,948	6,115	9,195	7,861	19,438	7,620	18,907
< 18	3,371	3,488	1,764	7,439	1,569	2,381	1,604	5,121	504	4,987
18-64	9,741	10,109	6,410	22,185	3,952	5,862	5,777	11,096	6,071	12,425
% Black	97.0	68.4	54.0	8.2	80.5	21.7	18.8	95.0	26.0	26.7
% Hispanic	0.6	1.4	12.2	15.9	3.7	32.0	19.9	0.9	4.5	27.3
% Poverty	64.3	56.7	62.0	44.1	76.7	79.4	59.0	69.5	67.9	65.0

• Multiple neighborhoods within the City of Cleveland have a majority of households under the poverty line.

Impacts on Quality of Care: Workforce

- Focus groups and interviews with clients and their families show perceived inconsistencies in the quality of care in terms of the professionalism of those providing mental health and/or addiction services. In that same light, many felt that high turnover rates impacted their quality of care.
- Some feel Clients receiving care who are not privately insured have no choice on providers.
- Clients are not always knowledgeable about the “big picture” of things available to them. “No one guides patients through the system.”
- Some clients perceive that agency personnel can be disrespectful. Others are wonderful and supportive and experts at providing care.
 - Frequent concern that appointments are too quick and difficult to build rapport.
 - Yet stakeholders felt that it was the quality of the individual practitioner, not the model or program being implemented, which most impacted outcomes for clients.
 - At the same time, the system lacks enough well-trained practitioners.
- High quality people often seek opportunities elsewhere when reimbursement rates are too low.
- Home-based service is viewed by many clients as more effective, but difficult to find.

Qualitative Findings: Medicaid Expansion

Consequence of Medicaid Expansion:

Because of Medicaid expansion, hospitals have seen a 20% increase in volume for psych issues. Many are violent. Many have been incarcerated so hospitals need to increase security.

Hospital Physician

EDs have boarders 100% of the time. CCF's beds are always full. UH's beds are always full.

Emergency Medical Technician

When non-Medicaid dollars decrease, we find that people have been directed to us. People have found a way to circumvent the system. They don't need primary care, but are sent to us, told to ask for primary care, then in first visit it is obvious they have a behavioral health need. They should be in the community mental health system (which can't handle them).

Hospital Physician

The amount of untreated mental illness has led to vast increases in violence within agency's walls.

Mental Health Service Provider

#7. Other Issues/Barriers to Care

Qualitative Findings

Mental Health Care Professional Shortages

The behavioral health sector in our county has suffered from many years of being underfunded. Agencies compete aggressively for dollars and many admit to “chasing the money.” This has exacerbated gaps in services because services are often offered only because there is a funding source for them, not because the clients need only those things. Agencies, with their mission of improving the well-being of their clients, therefore have to juggle resources in order to ensure their clients have what they need to succeed (regardless of whether or not it is directly funded). This stresses all agencies in terms of overall management and efficient allocation of resources and creates weaknesses in terms of human resources. Well-educated and trained professionals do not thrive in an environment where their future is uncertain; hence, turnover within agencies tends to be very high (especially for the lower level positions). This impacts the quality of care for clients as they greatly benefit from continuity of care by the same addiction or mental health professional.

In addition....

- There is a severe shortage of psychiatrists (especially child specialists)
- Generally a shortage of all licensed mental health professionals

While the age distribution of RNs is generally balanced in NE Ohio, for RNs within behavioral health, it is not. More than one-third (35.8%) of RNs who work in a behavioral health setting are over age 55. In contrast, the youngest cohort to work in behavioral health setting (age 35 and younger) is only 18.7% of all RNs working in mental health. That is, as the older nurses working in mental health settings retire, there will not be enough choosing that setting to replace them.

Source: Center for Health Affairs analysis of licensed RNs, 2015.

#8. Leadership opportunities for the ADAMHS Board

Qualitative Findings: Leadership

Leadership Opportunities In County (as described by stakeholders):

- ✓ Agencies work in 'silos.' They are familiar only with their own line of service delivery and only somewhat with the services which feed clients to them, and to which they feed clients. Many feel that the ADAMHS Board should find ways to foster collaboration among the agencies to prevent duplication of efforts and to find synergies among the various agencies. Some went so far to say that the ADAMHS Board discourages collaboration because of its funding approaches.
- ✓ Many agencies' leadership expressed concern over their ability to weather the storm of the state's Behavior Health Transformation. They would like to see the ADAMHS Board take the lead in assisting the agencies understand what the changes will mean and also assist an agency temporarily which needs time to adjust.

Qualitative Findings

Antiquated Connections Among Providers

- Service providers do not have a consistent level of understanding of the 'big picture' of the service network in the County. Placing clients into a care situation is time consuming and labor intensive, and providers tend to use only a few go to places because of this. They are often unfamiliar with and unaware of agencies which may have availability.
- In that same light, there are major 'inter-operability' issues among agencies in terms of their patient data systems and other data-exchange systems. This prevents collaborations (because different organizations don't use compatible systems), continuity of care for patients who shift among agencies, and difficulties in combining any data system-wide.

Because of lack of funding for so long....we never want to put money into things which doesn't immediately and directly assist our clients.....our computer systems are horribly antiquated. We don't have the ability to look at management data like we should. Everyone inside the agency approaches their own data as if it didn't have to be used by anyone else in the agency, and most of that hasn't changed in years.

Mental Health service provider

We (community providers) still function in silos. As as we continue to do that, we won't be able to do the best job.

A.O.D. service provider

Leadership Opportunities In County

There is a great deal of waste in the system – there are so many small agencies and they all have an executive director, a finance person, etc. And they are all fighting for funding from the same sources.

Addiction Services stakeholder

The ADAMHS Board hasn't been involved in facilitating the relationship between the hospitals and the community mental health agencies. We've had to figure that out on our own. They could do a better job of getting that [link mental health agencies with hospitals] to happen and supporting the community mental health centers.

Hospital Stakeholder

The ADAMHS Board simply funds the community programs, and that is appreciated, but they are not providing leadership. They are not creating linkages; they are not learning from one entity and sharing it with the others to everyone's benefit.

Mental Health Services Stakeholder

Medicaid expansion has led to a number of individuals who see the hospital as the best place for them to be at any particular point in time. They see it as their best option for shelter/housing. They'll go from ER to ER.

Hospital Stakeholder

The state, in funding mental health care through Medicaid, views their job as done....so in some ways they feel that abdicates their responsibility towards community mental health and providing them with the other things they need.

Mental Health Services Stakeholder

Need leadership around safety. Not preventing violence but the safety of staff and other patients. The ADAMHS Board should step up when it comes to things like that.

Hospital-Based Physician

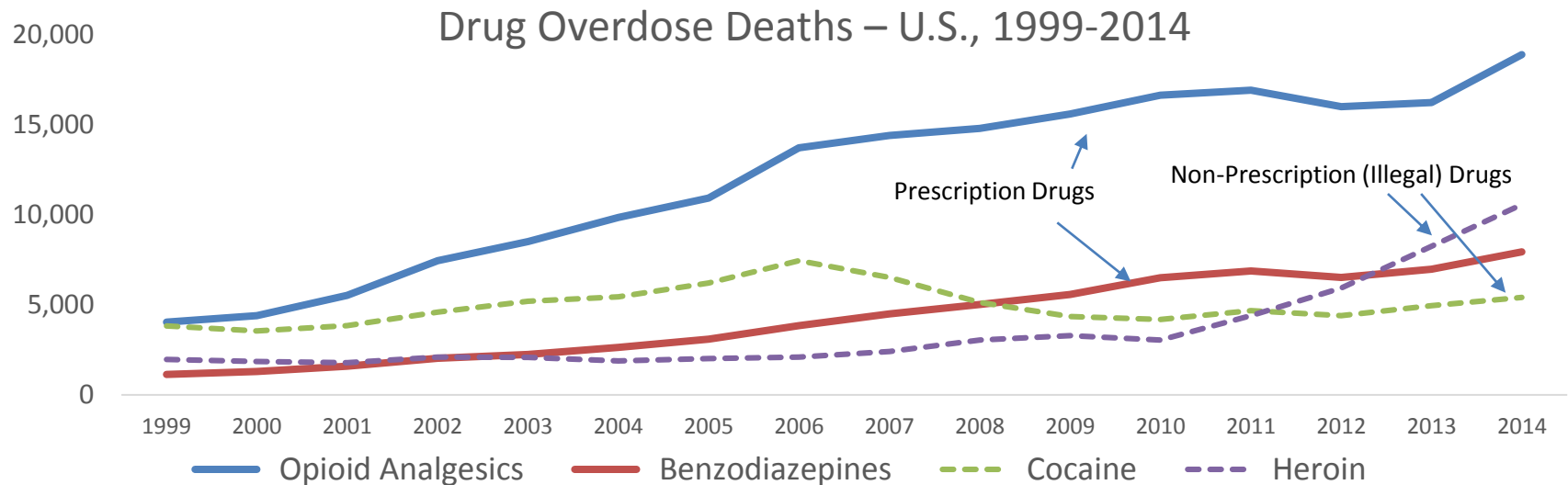
The ADAMHS Board "gets it" and we appreciate that.

AOD Service Provider

#9. Of Immediate and Great Concern: The Opioid Epidemic and Overdose Deaths

The Drug Overdose Epidemic

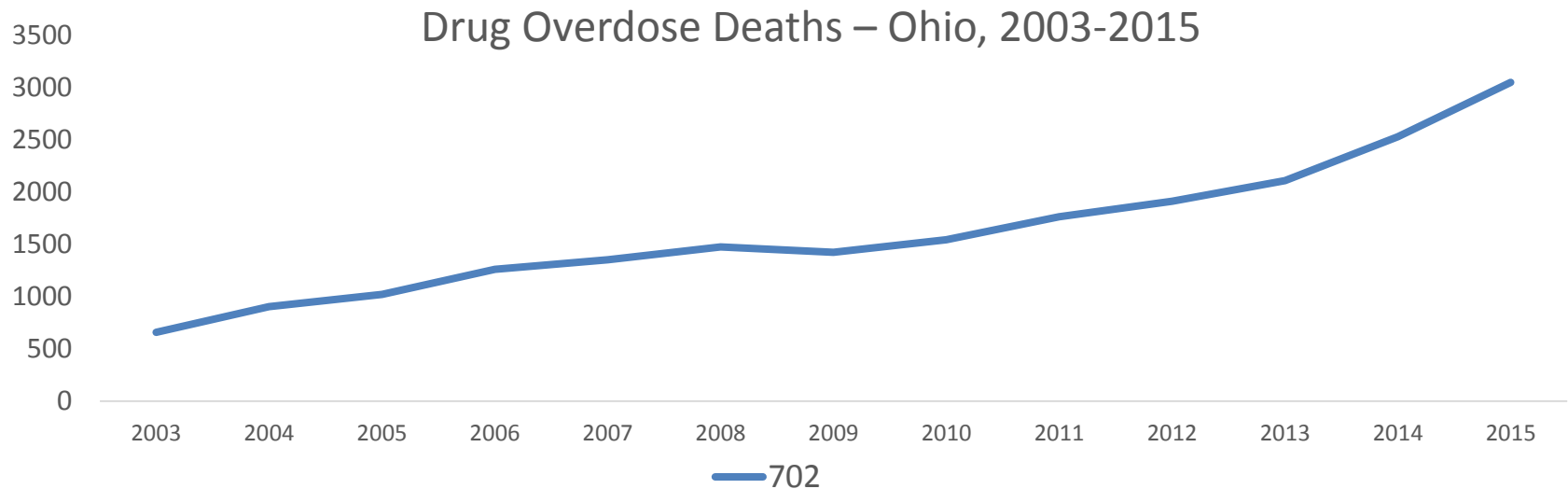
Although the U.S. adult population grew by about one-third from 2000 to 2014, the incidence of drug overdoses increased by 328% during that time period. During these 15 years, overdose due to misuse or abuse of prescription drugs has been higher than that due to illegal drugs. For prescription drug overdoses, opioid analgesics were the most common substance. While historically cocaine overdoses were far more common than those related to heroin, that began to change in 2010. By 2014, nationally, heroin overdoses far exceeded those due to cocaine*. Drug overdoses are on the rise, and prescription opioid and heroin overdoses have shown an alarming increase most recently.



*Source: National Institute of Drug Abuse, 2016.

The Drug Overdose Epidemic in Ohio

Ohio has shared in this national trend. Although the Ohio adult population grew by only about 2% from 2003 to 2015, the incidence of drug overdoses increased by 335% during that time period.

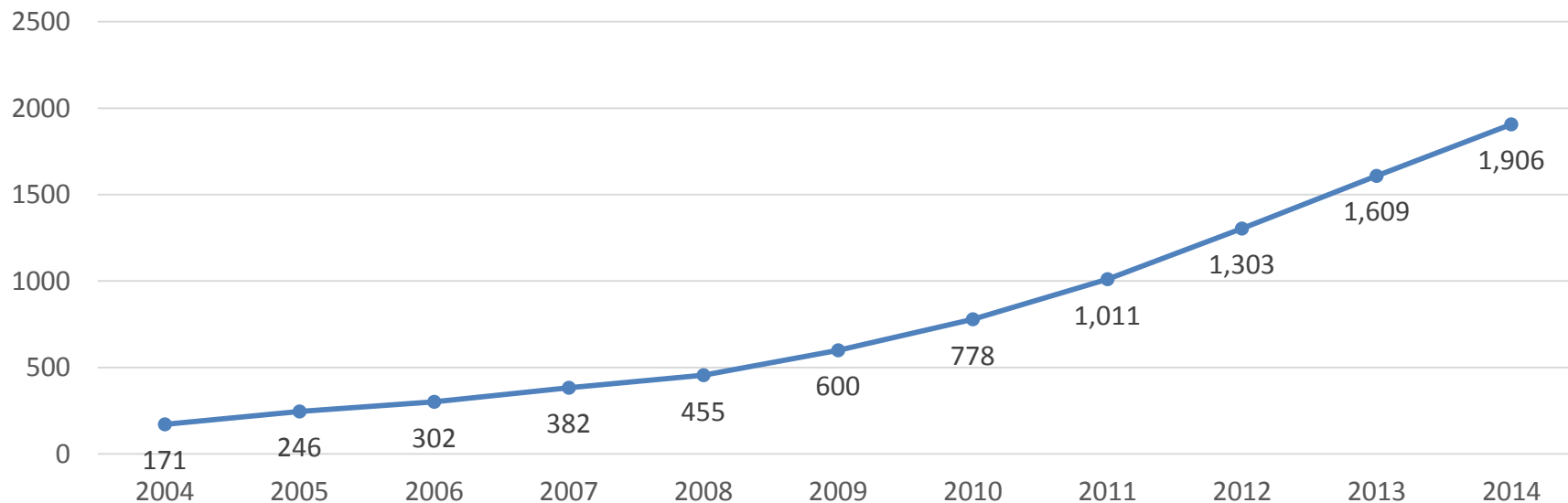


*Source: Ohio Department of Health

Ohio Maternal Opioid Abuse/Dependence

Like in the U.S. overall, opioid abuse has shown the greatest increase during the past decade. All demographic groups have shown increases in opioid use. From 2004 to 2014, there was even a dramatic statewide increase in the number of women who, at the time they were delivering their babies, were abusing or dependent on opioids.

Maternal Opioid Abuse and Dependence Diagnoses at Time of Delivery: Ohio, 2004-2014



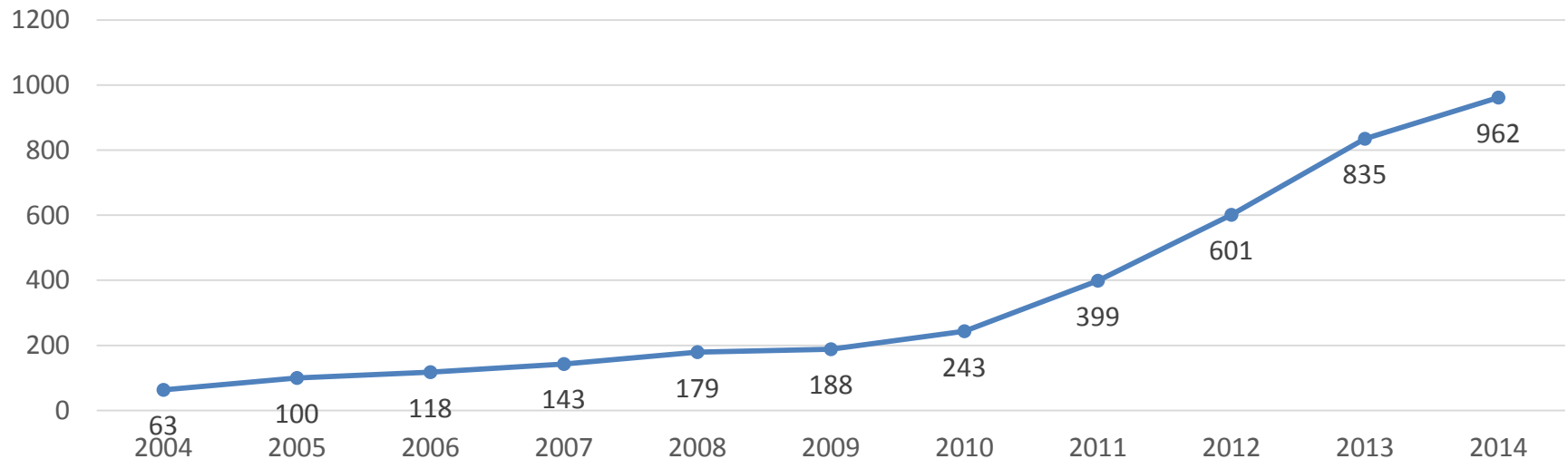
Source: Ohio Department of Health Violence and Injury Prevention Program. "Neonatal Abstinence Syndrome (NAS) in Ohio: 2004-2014 Report."

Ohio Infant Exposure to Opioids

There has also been a substantial increase over the last decade in the number of infant hospitalizations statewide associated with exposure to opioids through the placenta or breast milk. Just from 2009 to 2014, there was a more than 400% increase.

Hospitalizations of Children Under Age 1* Associated with Exposure to Opioids through the Placenta or Breast Milk: Ohio, 2004-2014

*May not reflect unique individuals



Opioids, Heroin and Fentanyl

Fentanyl is a synthetic opioid which is 50-100 times more potent than morphine and approved for the management of surgical/postoperative pain, severe chronic pain, and other intractable pain. In 2015, the federal Drug Enforcement Administration and the Centers for Disease Control issued nationwide alerts identifying fentanyl as a threat to public health and safety*. Fentanyl is a controlled pharmaceutical; however, it can be unlawfully manufactured and distributed in illegal drug markets. Fentanyl is often combined with or sold as heroin. **The increased supply of illicitly manufactured fentanyl is suspected to be driving the sharp recent increase in opioid-related deaths as opposed to increased abuse of prescription opioids:**

- The number of law enforcement submissions (confiscation) of drug contraband containing fentanyl increased by 526% from 2013 to 2014 in 14 of Ohio's largest counties.
- During that same short period, fentanyl deaths increased by 526%**.

*Source: Centers for Disease Control

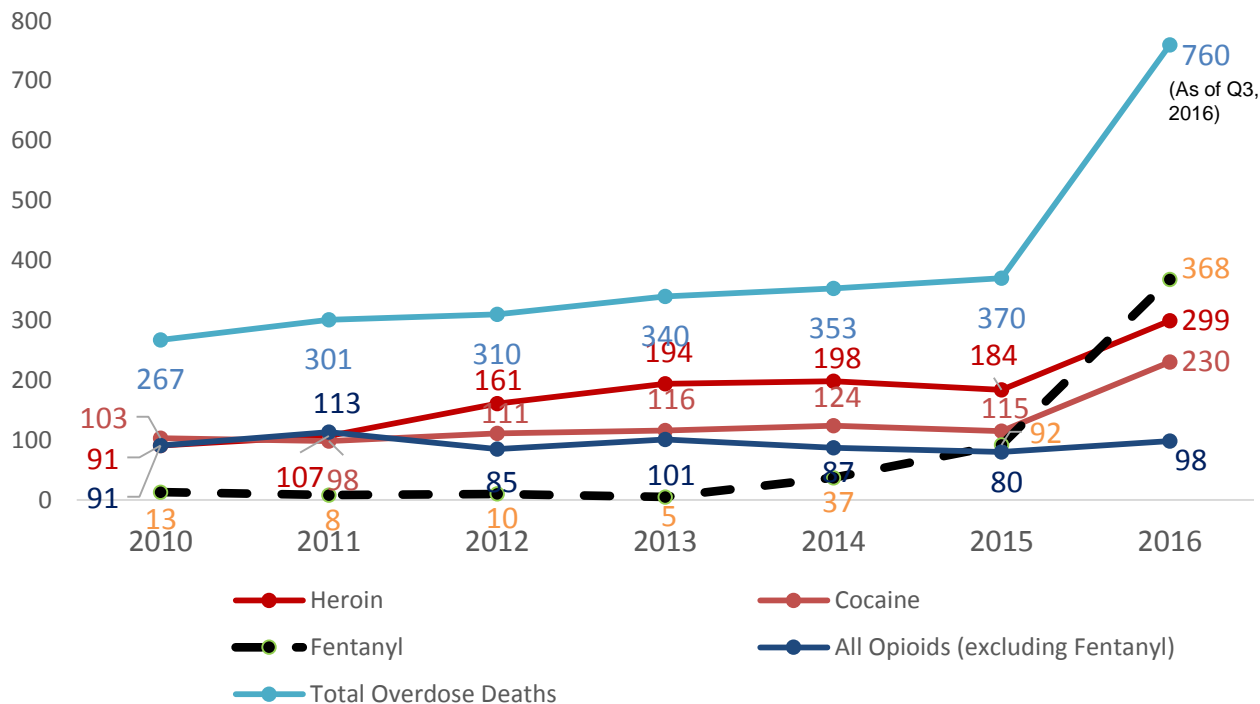
**Source: Increases in Fentanyl-Related Overdose Deaths — Florida and Ohio, 2013–2015. *Weekly* / August 26, 2016 / 65(33);844–849

Overdose Deaths: Cuyahoga County

Cuyahoga County Overdose Deaths: 2006-2016*

Most Common Drugs

(*2016 projected based on ruled cases as of Sept. 30)



In contrast with the decline in opioid prescriptions, the overdose rate has moved steadily upward. A sharp increase in opioid-related deaths occurred in Cuyahoga County between 2015 and 2016.

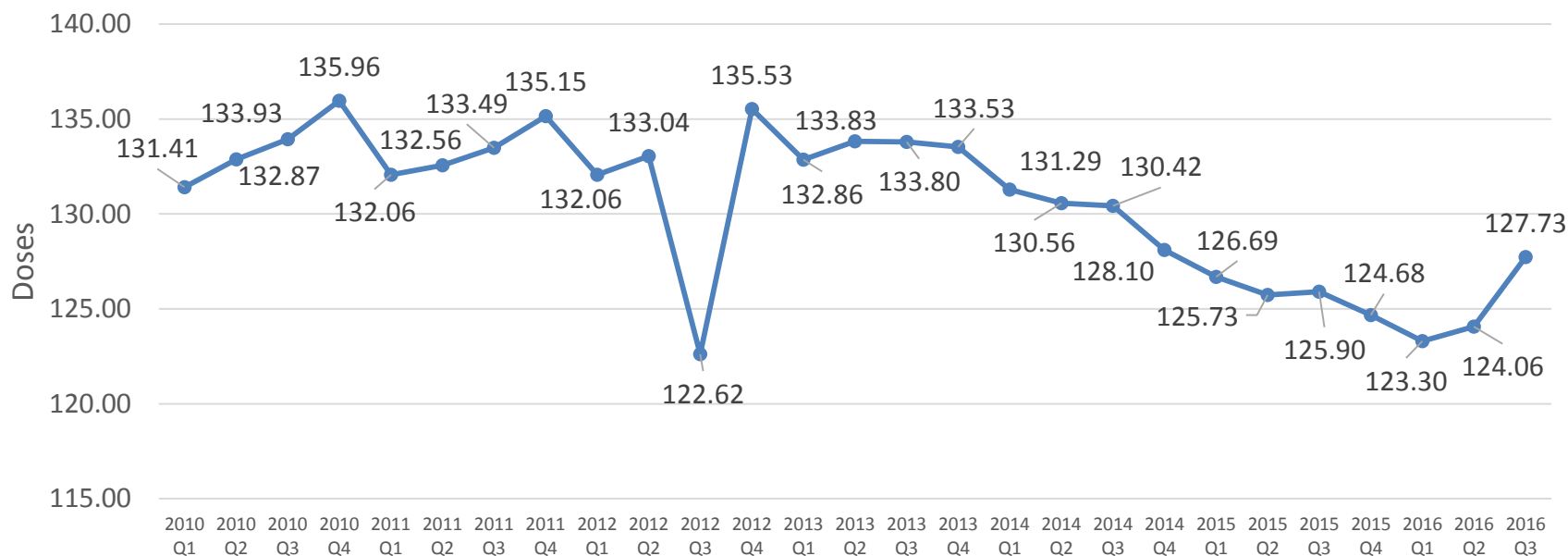
The largest increase is attributable to Fentanyl.

Fentanyl-related deaths rose from 92 in 2015 to 368 in the first nine months of 2016 – a 300% increase.

Source: Cuyahoga County Medical Examiner's Office. "Heroin & Fentanyl Related Deaths in Cuyahoga County." Nov. 7, 2016.

Opioids Dispensed: Cuyahoga County

Opioid Doses Dispensed Per Cuyahoga County Patient, by Quarter

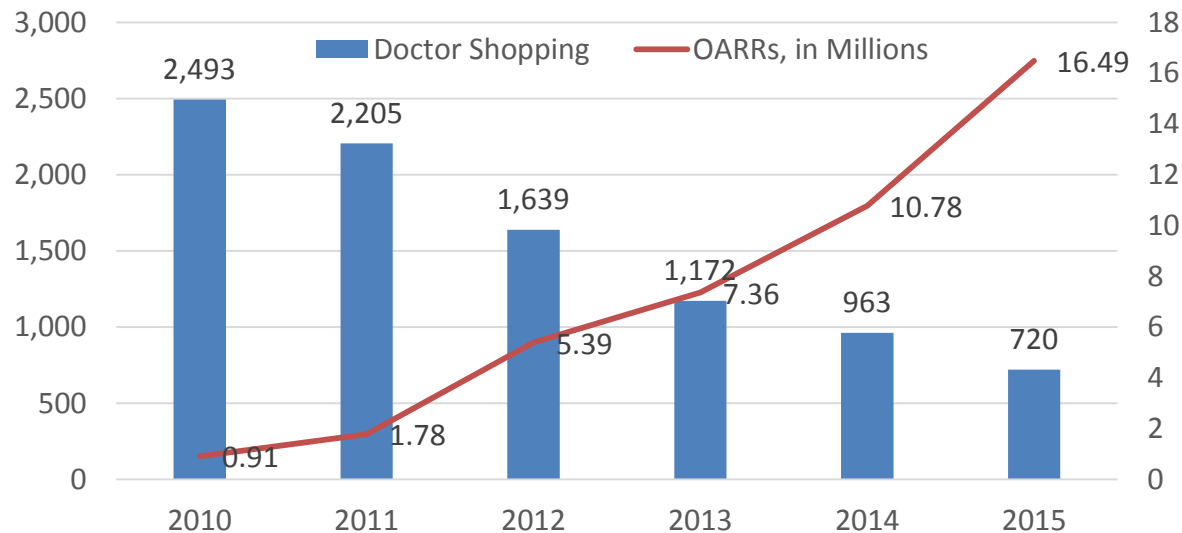


Until the second quarter of 2016, opioid prescriptions in Cuyahoga County had been declining steadily over the last four years.

Source: Ohio Automated Rx Reporting System

OARRS Queries Increase & “Doctor Shopping”

Ohio OARRs Queries By Physicians¹ and Patient “Doctor Shopping”^{2, 3}



The number of provider queries in the Ohio Automated Rx Reporting System (OARRS) has increased from 512,598 in 2009 to 16,490,221 in 2015, an increase of more than 3,100%. Providers are more carefully self-monitoring their prescription of opioids.

Likewise, the number of individuals who see multiple prescribers in order to procure controlled substances declined steadily from 2010 through 2015. “Doctor shoppers” are defined here as individuals receiving a prescription from five or more prescribers in one calendar month.

Conclusion: Research has shown that past misuse of prescription opioids is the strongest risk factor for heroin initiation and use.⁴ However, the *recent rapid rise* in fentanyl deaths appears to be more related to an increase in illicitly manufactured fentanyl and not increased prescription opioid abuse. The improved limitations on prescription opioids has not slowed the increase in opioid deaths.

¹Source: Ohio Automated Rx Reporting System, 2015 Report

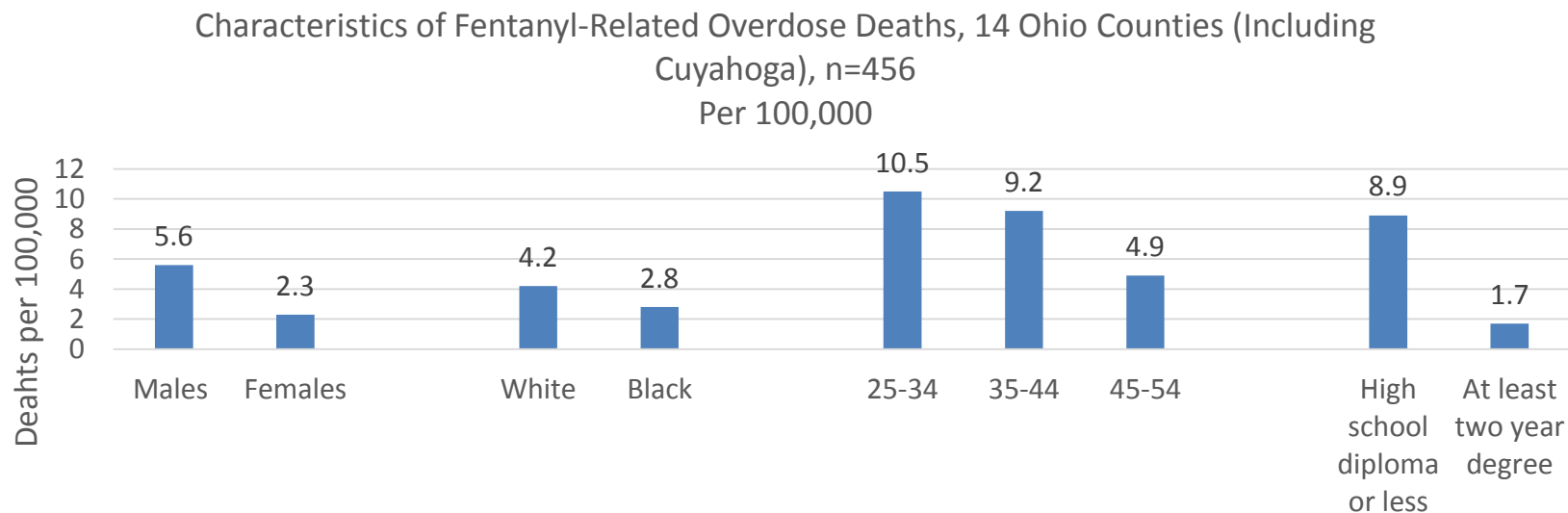
²Source: Ohio Automated Rx Reporting System, 2015 Report

³Doctor Shopping is defined as individuals receiving prescriptions from five or more prescribers in one calendar month.

⁴DJones, C.M., Loan J., Gladd, R.M., Bohm, M.K.. Vital signs: demographic and substance use trends among heroin users – U.S., 2002-2013. MMWR Morb Mortal Weekly Report, 2015; 64; 719-25.

Opioids, Heroin and Fentanyl

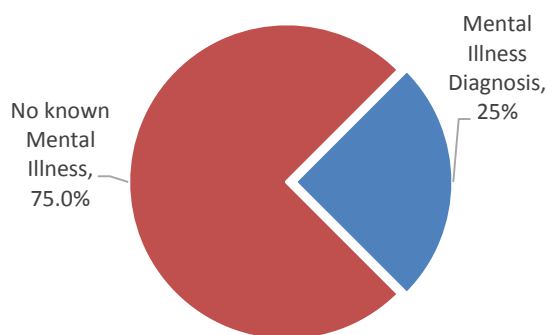
Understanding what lies beneath the increase in opioid overdoses is important because heroin and prescription opioid overdoses impact somewhat different groups of people. U.S. death rates involving prescription opioids are highest among persons aged 45-54 years. In contrast, heroin overdoses are more associated with younger people (aged 25-44). An examination** of 2014 overdoses in 14 Ohio counties shows that males, whites, those aged 25-34, and those without a college degree (2-year+) have been most impacted by fentanyl overdoses.



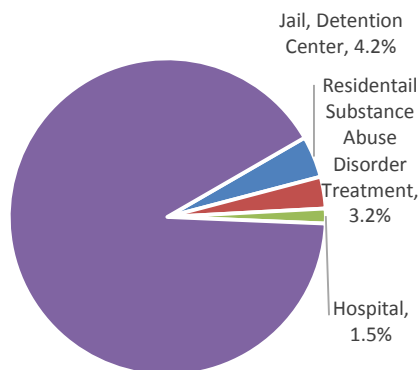
Source: Increases in Fentanyl-Related Overdose Deaths — Florida and Ohio, 2013–2015. *Weekly* / August 26, 2016 / 65(33);844–849

The Opioid Death Epidemic, and Fentanyl's Role

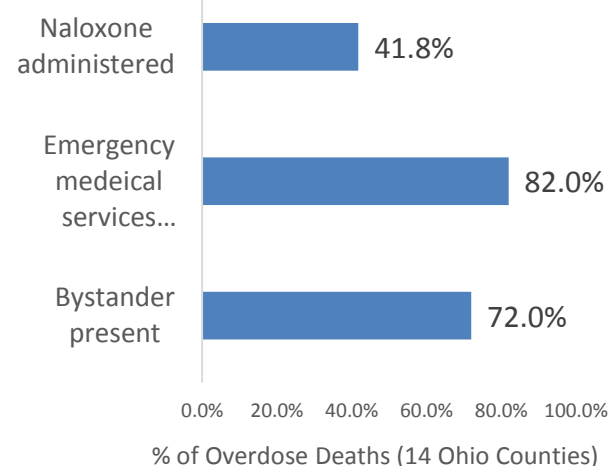
Incidence of Mental Illness Among Ohio (14 Counties) Fentanyl-Related Overdose Deaths, 2014



Circumstances Around Fentanyl Related Overdose Deaths Recent Released From:



Immediate Circumstances Around Fentanyl Related Overdose Deaths



In that same study of Ohio fentanyl overdose deaths in 2014*, researchers showed that one-in-four were those with a mental illness diagnosis. Also, one-in-ten were recently incarcerated, in residential treatment or hospitalized. Typically fentanyl overdose deaths in Ohio occurred with a bystander present (72%). Emergency medical services did respond in most cases, also (82%). However, naloxone was administered only in 42% of the cases.

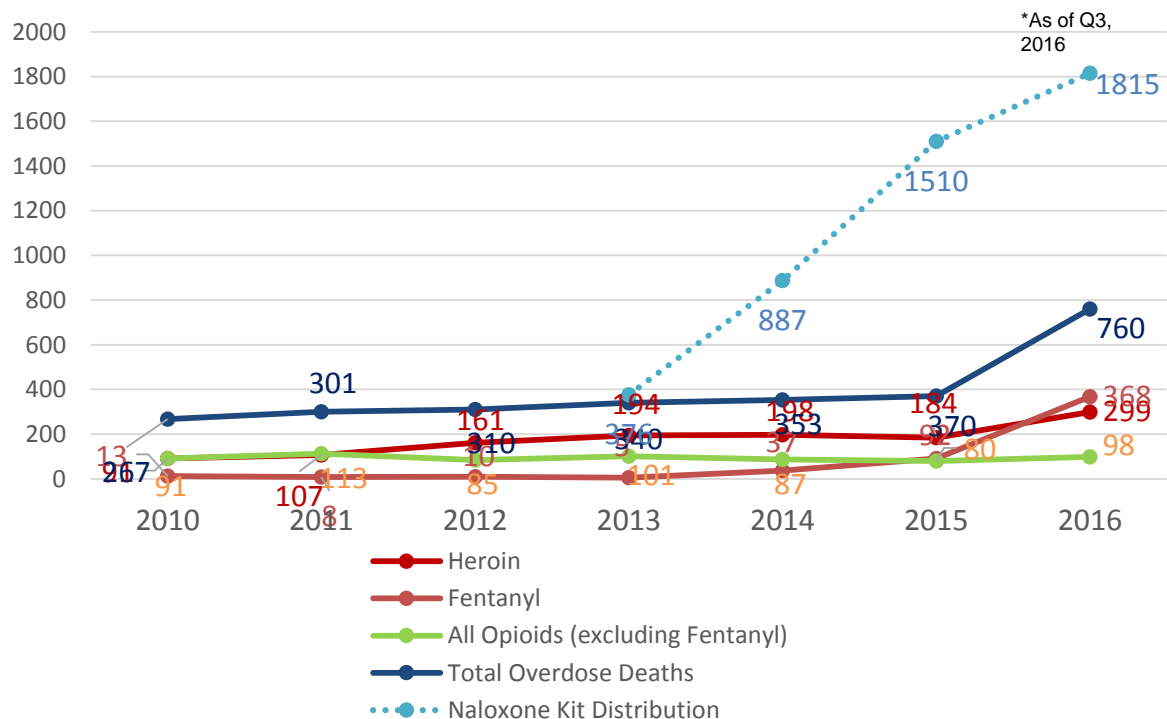
Source: Increases in Fentanyl-Related Overdose Deaths — Florida and Ohio, 2013–2015. *Weekly* / August 26, 2016 / 65(33);844–849

Overdose Deaths: Cuyahoga County

Cuyahoga County Overdose Deaths: 2006-2016*

Most Common Drugs

(*2016 projected based on ruled cases as of Sept. 30)



Source: Cuyahoga County Medical Examiner's Office. "Heroin & Fentanyl Related Deaths in Cuyahoga County." Nov. 7, 2016.

Here we revisit the trends in Cuyahoga County overdoses to demonstrate that the distribution and use of naloxone has not been sufficient to prevent the rise in deaths.

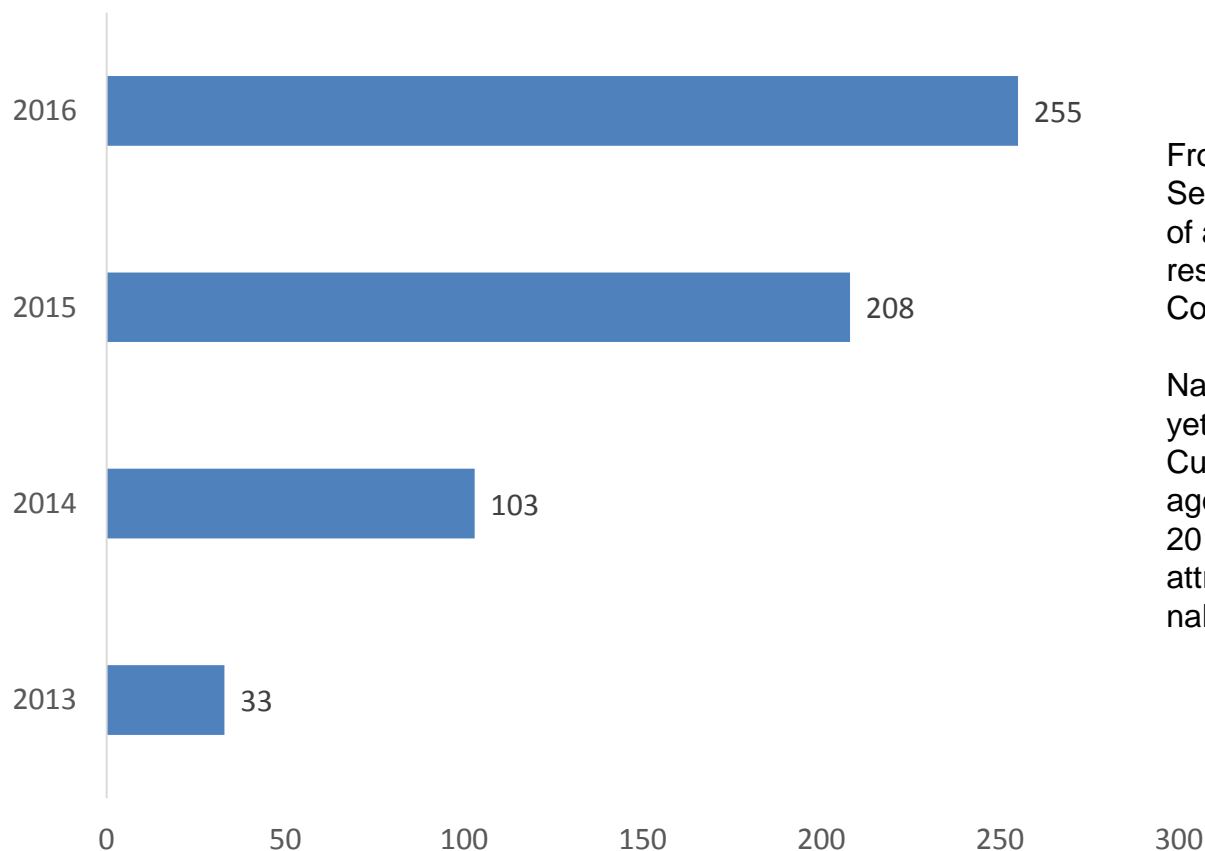
In 2015, Cuyahoga County Project DAWN distributed over 1,500 naloxone kits, quadrupling distribution from its inaugural year in 2013.

During 2016, kit distribution has risen each quarter.

While we have seen a steady increase in the distribution of naloxone kits, we have also seen the coincident increase in the number heroin and fentanyl related deaths. However, many deaths were likely prevented by the distribution of naloxone, as shown on the following page.

Cuyahoga County Project DAWN Naloxone Rescues

Project DAWN Naloxone Rescues: 3/2013 - 9/2016



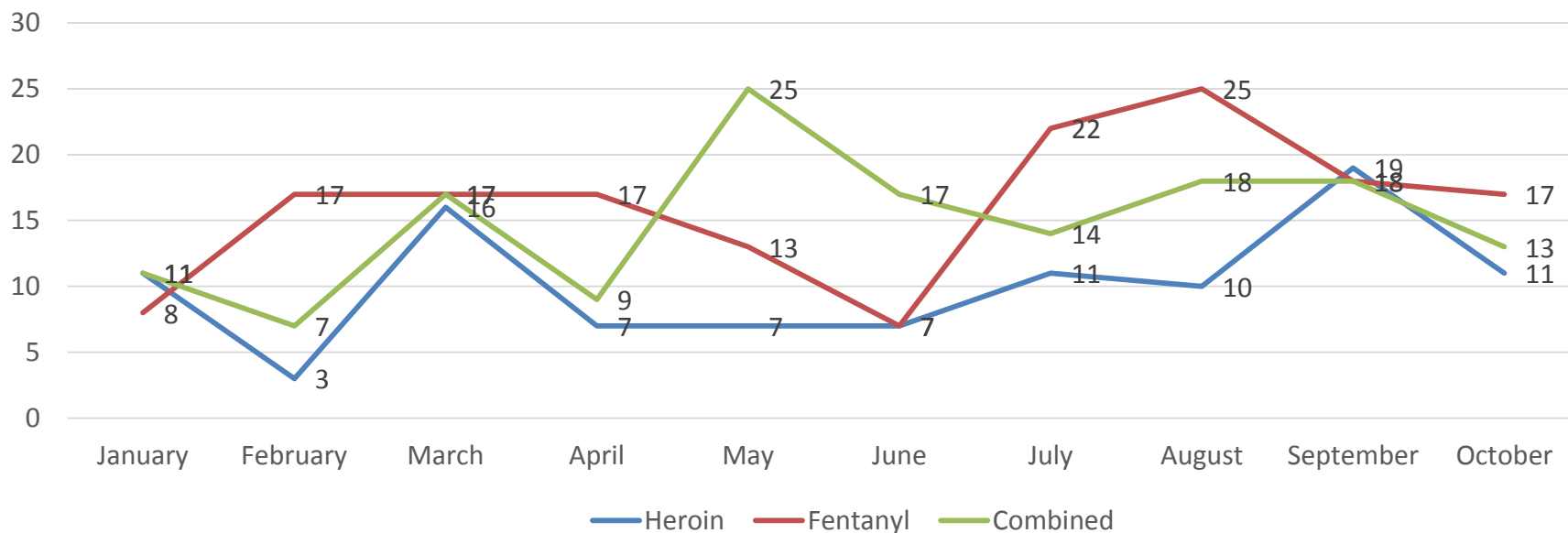
From March 2013 through September 2016, there were reports of at least 647 opioid overdose rescues with the use of a Cuyahoga County Project DAWN kit.

Naloxone distribution and use is not yet complete. Only 47 of 58 Cuyahoga County law enforcement agencies carry naloxone. From 2014 to 2016, 199 saves have been attributed to law enforcement use of naloxone.

Source: Cuyahoga County MetroHealth Project DAWN Reversal & Distribution Data Brief

2016 Heroin & Fentanyl Deaths: Cuyahoga County

Heroin- & Fentanyl-Related Deaths, Cuyahoga County, 2016



Our most recent data on heroin and fentanyl related death is not encouraging. Through October, there have been a total of 102 heroin-related, 161 fentanyl-related, and 149 heroin/fentanyl combined deaths in Cuyahoga County in 2016.

Source: Cuyahoga County Medical Examiner's Office. "Heroin & Fentanyl Related Deaths in Cuyahoga County." Nov. 7, 2016.

Summary: Opioid Overdose Deaths

- Opioid overdose deaths have been on the dramatic rise since 2010. In 2014 Ohio had more opioid-related deaths than any other state – about the same number as California despite having less than one-third the population.
- Cuyahoga County has had a sharp increase in fentanyl-related deaths in just the last two years.
- It appears that illicitly manufactured fentanyl plays the largest roles in deaths; while the number of prescribed opioids is decreasing, opioid-related deaths are increasing as is the incidence of law enforcement confiscation of illicitly manufactured fentanyl. The vastly improved focus by the medical community on limiting the overuse of prescription pain medications has not resulted in a reduction in this problem.
- Naloxone has helped, but its use is not routine. **Distribution and awareness of its benefits needs to be increased further.**
- Recall that a common theme that surfaced during many of the interviews with community leaders for this study was an inadequate supply of treatment programs – especially residential – for individuals with chemical dependency. Lengthy waits for such services were mentioned repeatedly. The increasing levels of overdose deaths is a symptom of the insufficient capacity for these services for addicts.
- Other recommendations to address this crisis come from national studies:
 1. Focus on communicating the dangers of fentanyl-laced heroin to those being released from prison, residential addiction treatments and hospitals.
 2. Increase the availability of medication-assisted treatment, especially after the release from prison, residential addiction treatment and hospitals.
 3. Increase the community's capacity and funding for appropriate care for addicts. Too few of those who need intense care (detoxification, residential inpatient care, sober housing) are receiving it.

Certified AoD Residential Providers: Cuyahoga County

Facility	Certification Type	Bed Type	# of Beds
Bellefaire Jewish Children's Bureau	Residential	Residential	30
Catholic Charities – Matt Talbot Recovery for Men	Residential	Residential	14
Catholic Charities – Matt Talbot for Women	Residential	Residential	16
Catholic Charities – Matt Talbot for Women II	Residential	Residential	14
Catholic Charities – Parmadale	Residential	Residential	34
Community Action Against Addiction	Residential	Residential	8
Community Assessment and Treatment Services	Halfway House	Residential	75
Community Assessment and Treatment Services	Residential	Residential	75
Highland Hills Hospital	Residential	Detoxification Acute	8
Highland Hills Hospital	Residential	Detoxification Sub-Acute	16
Highland Hills Hospital	Residential	Residential	24
New Direction	Residential	Residential	15
New Direction	Residential	Residential	12
New Direction	Residential	Residential	18
Roberto Flores SAMI Residential Treatment Facility	Halfway House	Residential Halfway House	8

Stakeholders described the level of residential beds for addiction services *and* mental illness as being inadequate. There are a total of 367 beds in the county; 83 are halfway house, 8 are acute detox, 16 are sub-acute detox.

Appendix

Use of Hospital-Based Emergency Mental Health Services

Hospital ED

Patient Visits to St. Vincent Charity Medical Center's Psychiatric Emergency Department, 2014 to 2015

Psychiatric ED Visits	2014		2015	
	Number	Percent	Number	Percent
Inpatient	1,096	28.1%	1,225	31.3%
Outpatient	2,799	71.9%	2,695	68.8%
Total	3,895	100.0%	3,920	100.0%

- These are duplicated counts of patients seen the psychiatric emergency department at St. Vincent Medical Center.

50% of those in ED who should be admitted are turned away
ED Physician

Hospital ED

Diagnostic Category for Patient Visits to St. Vincent Charity Medical Center's Psychiatric Emergency Department, 2014 to 2015

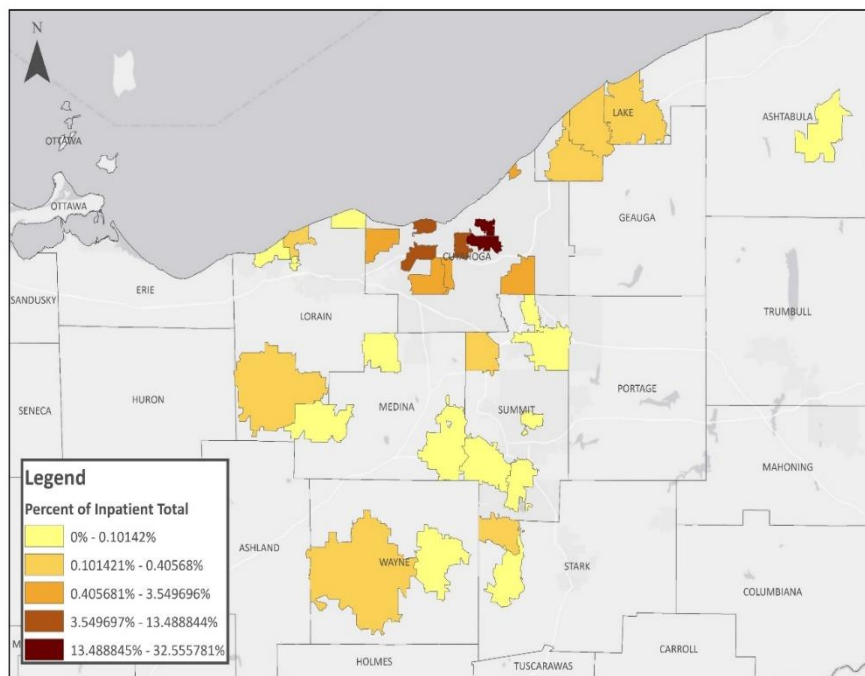
Diagnosis	Inpatient		Outpatient	
	2014	2015	2014	2015
Schizophrenia/Affective Psychoses	68.2%	53.3%	25.4%	21.8%
Depression/Mood Disorders	10.1%	7.8%	13.7%	9.9%
Bipolar Disorders	10.8%	7.3%	8.3%	5.5%
All Others	0.6%	25.3%	26.9%	29.8%
Chronic Mental Illness (Subtotal)	89.7%	93.7%	60.7%	67.0%
Substance Abuse	3.2%	2.2%	19.0%	15.6%
Adjustment Disorder – all types	0.7%	0.7%	14.2%	12.2%
Acute, Transient Episode	0.3%	0.1%	3.0%	2.5%
Developmental (Dementia, etc.)	2.7%	1.7%	0.7%	1.2%
Poisoning (psychotropic drugs)	0.5%	0.2%	0.1%	0.1%
Non-Psychiatric Issue	2.9%	1.3%	2.4%	1.3%
Total	100.0%	100.0%	100.0%	100.0%

- Proportionately these relate closely to the diagnoses of the ADAMHS Board mental illness clients. Note that very few substance abuse patients were seen as inpatients at the hospital. Also note that the majority of outpatients were classified as mentally ill as opposed to having an addiction disorder (especially for inpatients).

Hospital ED

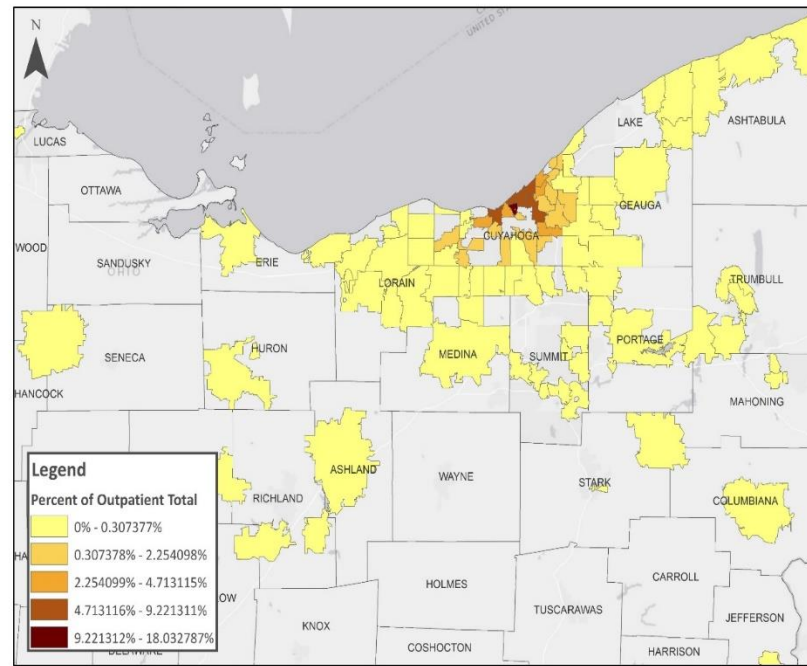
Home Zip Code for St. Vincent Charity Medical Center's Psychiatric Emergency Department Patients, 2015 -

INPATIENT



Prepared By: The Center for Health Affairs, September 2016

OUTPATIENT



Prepared By: The Center for Health Affairs, September 2016

- The only psychiatric emergency department in Cuyahoga County treats patients from all over Northeast Ohio.