MI/DD
COLLABORATIVE TEAMS

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Objectives

• Ohio’s Coordinating Center of Excellence in Mental Illness/Intellectual Disability

• Ohio’s Telepsychiatry Project for Intellectual Disability
Ohio’s CCOE in Mental Illness/Intellectual Disability

- Coordinating Center of Excellence in Mental Illness/Intellectual Disability
- Initiated in 2004
- Grant Funded Project:
  - Ohio Dept. of Developmental Disabilities
  - Ohio Department of Mental Health and Addiction Services
  - Ohio Developmental Disabilities Council
Ohio’s Coordinating Center of Excellence in Mental Illness/Intellectual Disability

• Educational Programming

• Assessment/Clinical Capacity

• County Team Collaboration
County Collaboration - WHY?

• Aimed at raising awareness of need, resolving issues, and increasing each teams’ capacity to provide services through the collaborative efforts of local systems and agencies such as the County Board of DD, county community mental health or ADAMH board, provider agencies, hospitals, schools, law enforcement, residential agencies, advocates, families, etc.
County Collaboration Efforts

• Suburban County
• Urban County
• Rural County
Obstacles

- Punt Responsibility
- Insurance/Managed Care (length and frequency of appointments)
- Complex Needs
- Misperceptions
- Communication Issues
- Residential/Employment Concerns
- Both systems needed for success
- Workforce Issues
Local Approaches

- Top Down
- Bottom Up
- Pool Resources
- Be Creative and Resourceful
- Network
- Communicate
- Meet
County Collaboration

• Are you speaking the same language? Verbiage: Schedule appointment for individual with Down syndrome? Residential/work placement?

• Best Practices: Psychotherapy; Poly-pharmacy; No Off Label; Inter-class and Intra-class prescribing, BPSD Formulation; Multidisc Teams
County Collaboration: Cost Effective

Case Manager Versus SSA

• CM: personal growth/success; identifying add’l need for services; communicating with all team members; achieving personal independence; monitor index behaviors; review of coping skills and bet. counseling appt; attending CBDD meetings; collateral data collection; CMS; services r/t ISP
County Collaboration

• Don’t focus on what you don’t have; every county has leaders, talent and strengths (and individuals in need)
• Who are your movers/shakers?
• Knowledge is Power: Communication and Training
• Key to Success: Building Relationships
<table>
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<tr>
<th>Community Development</th>
<th>Education</th>
<th>Assessment and Consultation</th>
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<tbody>
<tr>
<td>→ 32 Collaborative Teams developed</td>
<td>→ 26,877 education attendees</td>
<td>→ 973 provided ongoing psychiatric care</td>
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<tr>
<td>→ 53 counties represented by Collaborative Teams</td>
<td>→ 63,624 education contact hours</td>
<td>→ &gt;100 new assessments annually</td>
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<td>→ &gt;Statewide List Serv for networking purposes</td>
<td>→ 457 programs directly sponsored, co-sponsored, and/or with CCOE partners providing educational programming</td>
<td>→ Regional assessments performed for all 88 Ohio Counties (available by web cam if needed)</td>
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<tr>
<td>→ $465,646 mini grants awarded to local communities</td>
<td>*Use of Speaker’s Bureau including professionals around the state on various topics</td>
<td>*Access Ohio Mental Health Center of Excellence...Columbus, Ohio/Dayton, Ohio</td>
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<tr>
<td></td>
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<td>*Nisonger Center (The Ohio State University).........Columbus, Ohio</td>
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Ohio’s Telepsychiatry Project for Intellectual Disability

• **Prototype** from 2005-2011 treating 90 individuals from 23 counties
• **Telepsychiatry project initiated** 2012
• **Prioritize individuals from Developmental Centers and State Psychiatric Hospitals**
Telemedicine

- Telemedicine uses communication networks for delivery of health care services and medical education from one geographical location to another. It is deployed to overcome issues like uneven distribution and shortage of infrastructural and human resources.
Leigh et al 2009

- Eighteen month period: 7,523 telepsychiatry appointments and 115,148 conventional

- No shows: 8% telepsychiatry vs 13%

- Cancellation rate: 4.2% telepsychiatry versus 7.8%
Why consider Telepsychiatry?

- In rural communities ~50% of mental health care is provided by primary care physicians.
- Patients may have to travel long distances or forgo such services altogether.
- Telemedicine helps disseminate skill set to PCPs.
- Many patients prefer to go to a PCP clinic for appointments (or other location of their choice) as opposed to a MH clinic (decreased stigma).
- Increasing data shows reliability/validity are similar to face to face interaction.
Telepsychiatry

• Simms et al 2011
• Research shows alliance is not compromised by use of videoconferencing
• Medium made some patients feel less embarrassed and more able to express difficult feelings (Fragile X; Autism)
• Clinicians length of time in the field affected their openness to the new technology
Telepsychiatry

- Reduction in travel time, costs, ER visits and hospitalizations
- Not necessary to be ‘tech savvy’
- Established programs use ‘buffet menu’ (phone, email, MD-MD, MD-patient, etc) (Nursing facility)
Ohio’s Telepsychiatry Project for Intellectual Disability

- **Virtual software** which abides by patient privacy guidelines (**HIPAA compliant**)
- Required Criteria for Individuals Referred
- Child or adult with co-occurring mental illness/intellectual disability
- Medicaid Enrolled
- **Top 13 most populated counties can only refer children/adolescents**
Ohio’s Telepsychiatry Project

• Expectations of County Developmental Disabilities Board

• Arrange staffing/computer equipment

• Accept lead role in coordinating access to emergency services as deemed necessary, to include hospitalization.

• Develop a collaborative relationship with local MH Board (as available and at your discretion) in order to best support the person’s full range of MH needs.
Lessons Learned

• One contact person for each patient
• Define what you CAN and CANNOT do
• Intake in person (or web cam)
• RN interface/AIMS/MMM/Vitals
• Psychotherapy (LOS longer)
• Specific psychiatric pathology (IOR)
Lessons Learned

• On call strategy
• Increased labs, imaging, PCP collaboration
• SSA/CM
• Identify strong counties and request input and advice from them (CMS regulations most often cited)
Telepsychiatry Project Preliminary Results

- For the first 120 individuals engaged in the program, emergency room visits decreased from 195 to 8 and hospitalizations decreased from 74 to 10 (comparisons are 12 months prior to telepsychiatry use to 12 months post treatment).

- A number of the individuals were discharged from state operated institutions; none of the 120 involved in the project were admitted or readmitted to state operated institutions. This saves the state approximately $80,000 per person per year in support costs (currently 92 patients in this category).

- Travel costs were reduced in some cases by 78% by not having to travel distances for specialty psychiatric care.
**Telepsychiatry Project**

**Preliminary Results**

- As of December 2016, >950 individuals from 62 counties engaged in the project
- **EOY stats for > 950 patients:**
  - Hospitalizations/6 months: 19
  - ER Visits/12 months: 21
  - DC Admission: (3)
  - Discharged from DCs/BHOs: 92
- No wait list, no referrals denied
CCOE Assessments Utilizing Telepsychiatry

- Second Opinion Assessments
- Available to all ages in all 88 counties
- Comprehensive Psychiatric Assessments
- Face to Face or Web Cam
- ~100 annually
- Diagnostic dilemmas, metabolic monitoring, poly-pharmacy, Best Practices, EBM, undiagnosed medical conditions, etc.
# Psychotherapy for ID

<table>
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<th>Flexible sessions</th>
<th>Length of therapy sessions should match the individual’s attention span. For some patients, this may be no longer than 30 minutes.</th>
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<tbody>
<tr>
<td>Simplification of interventions</td>
<td>Break down intervention into smaller segments and reduce the complexity of the techniques being utilized.</td>
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<td>Adjust language</td>
<td>Reduce level of vocabulary, sentence structure and length of thought to match the cognitive ability of the patient.</td>
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<td>Augment interventions with activities</td>
<td>Use of activities can help to deepen change and learning and may include the use of drawing, therapeutic games, role play and homework assignments.</td>
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<td>Involve caregivers</td>
<td>Important source of collateral information necessary to ascertain progress between sessions.</td>
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<td>Increased length of care</td>
<td>Most research indicates that a longer length of treatment (1 to 2 years) is a best practice with this population. This allows the psychotherapy to move at a slower pace so that the clinician can spend additional time on each intervention utilized, ensuring that the skills being taught are internalized. It also allows for the inclusion of additional treatment stages which may be necessary.</td>
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How to get started

• Next steps.....
• No MH? Consider Telepsychiatry
• Can manage most individuals well but need help for a small number?
• Identify your community resources
• Top down? Bottom up?
• Meetings: start with a ‘doer’ or start with an individual
Summary

• County Board of Developmental Disabilities collaborative efforts are essential
• You are the natural leaders in this effort
• Be cognizant of the individual strengths of your geographic area and your community
Summary

- Individualize your local team efforts to fit your county and your individuals in need
- Utilize your local resources
- Utilize your statewide resources: Ohio Department of DD; Regional Liaison, CCOE in MIDD, Telepsychiatry for ID, Trauma Informed Care, Grant Opportunities, RFPs, Networking, etc.
- Assessment of Needs/Strategic Plan/Move
Summary

• ID does not protect one from developing mental illness; over- and underdiagnosis
• Telemedicine is a vehicle to connect individuals with MI/ID to specialized resources and clinicians (if local resources do not exist)
• Myth that patients with ID can’t benefit from mental health services including trauma informed care, psychotherapies and state of the art medication regimens
Referrals for Telepsychiatry Project or CCOE Assessments

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