Evolution of Behavioral Health in the Public Sector

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Major Factors Shaping Policy and Delivery of Behavioral Health Care

- Social Attitudes
- Politics
- Funding
- Legal and Administrative Precedents

Approaches to Behavioral Health in the Public Sector

- History of mental illness—"Ship of Fools"
- Mentally Ill--part of the community or isolated and contained
- Focus on mental **illness** or mental **health** (including prevention)
- Social tolerance or neglect of the mentally ill
- Substance abuse social issue or medical illness or both
- Treatment of symptoms only or recovery, rehabilitation, and wellness

Origins of the Current Community Behavioral Health System in the United States

- State verses Federal responsibility for mental Health—Origin of State Hospital system
- Somatic treatments; eventual “warehousing” in state hospitals
- National Institute of Mental Health in 1948
- Joint Commission on Mental Illness and Health in 1955
- Community Mental Health Centers (CMHC) Act of 1963/1965—Pres. Kennedy and reform
- New Medications—Anti-psychotics and anti-depressants

CMHC Act 1963

- Immediate care for acutely disturbed patients
- Mental illness a core problem, focus of the mental health movement
- Fully staffed, full-time Mental Health clinics per 50,000 people—SF and SM almost did it!
- Smaller state hospitals (<1000 beds)
- Expanded aftercare and rehab services in the community

CMHC Amendments 1975 (I)

Top Priority: People most disturbing to the Community

- Serve children
- Serve aged
- Follow formerly institutionalized
- Screen before admissions
- Alcoholism services—for the first time
- Drug abuse services—for the first time
- Transitional housing

CMHC Amendments 1975 (II)

- Community Governing Board
- Quality assurance and utilization review
- Relationships with any local HMOs
- Servicing Medicare and Medicaid

Mental Health Systems Act 1980

•Minorities and underserved
•Serious mental illness
•Links with primary care providers
•Fund non-revenue services: consults, education, coordination, administration

Post 1980s Trends

- 1981—Act repealed by Pres. Reagan
- Financing shifts to states, local government
- Deinstitutionalization/changes in bed patterns
- Managed Care and HMOs/Gatekeepers and Carve-outs
- Rehabilitation and Recovery/Wellness
- Medication Revolution and costs
- Consumer participation
- Cultural Competency
- Substance Abuse treatments
- Criminalization of Mentally Ill

Principles of Public Psychiatry

- Population focus; proximate; immediate
- Prevention orientation and outreach
- Housing; stabilize living situation
- Community-based services; easy access
- Continuity of Care
- Evaluation and Outcomes
- Evidence Base practices
- Advocacy/Self-help/self-management
- Rehabilitation
- Wellness/Recovery/Resilience
- Cultural Competency

Newer Forces

- Least restrictive level of care—"Olmstead"
- Medication adherence and drug costs
- Evidence-based practices, including "brand names" like DBT, MST
- Reduced number of acute beds
- Community alternatives—Acute Diversion Units, Residential Services
- "Braided" Funding—weave funding streams to provide coordinated services
- Primary Care involvement
  - Medical home vs. specialty care?

California Model

- Counties responsible for Medi-Cal and indigent services (except State Hospitals and Corrections)
  - 1991 Realignment Funding (vehicle license fees; Bay Area favored)
  - Managed Care funding—cut then partially restored (for crisis; inpatient ; and medications)
- Carve-out model
- Systems of care/Clinical Services and Supports
- Rehabilitation Model (vs. Clinic Model)
- Consolidation of out- and in-patient Medi-Cal
- Role of Primary Care Providers—Medi-Cal "Medical Necessity" criteria (diagnosis; functionality; not manageable by Primary Care)
- Pharmacy Costs—local vs. Medi-Cal

San Mateo: Major Sources of Public Mental Health Funding

- Realignment (state GF tied to VLF)—restructured
- MH Medi-Cal: 65% (Short-Doyle)
- FQHC (Primary Care)
- EPSTD—children's services Medi-Cal (10% MATCH)
- Mental Health Services Act (Prop 63)--Realigned
- Local General Fund—Manager and Board of Supervisors driven
- SAMHSA Grants and other grants
- Healthy Families/Workers/Children/Kids—restructured
- Drug Medi-Cal—primarily Methadone
- AB 3632—mandate moved to school systems
- ACE, MCE, Medicare (CareAdvantage)
- Private Insurance

Mental Health Service Act (Prop 63)

- Passed in 2004; implemented 2006—1% tax on earning one $1 M
- Funding in several categories:
  - Clinical services and supports, including full service partnerships (ACT-type services);
  - Prevention;
  - Innovations;
  - Education, Training, and Workforce Development;
  - Housing (in collaboration CHA);
  - IT (time limited);
  - Infrastructure improvement for County-owned property
- Distribution formula favored Southern California

Dual Project: Medi-Medi

- Starting in Sept 2013, managed care for Medi-Cal/Medicare population
- Identify treatable conditions—primarily depression and substance abuse in population covered in active or not in active care
- Theoretically will save costs with coordinated, unduplicated care but difficult to know baseline costs since most Medicare provided in the private sector

Major Federal Public Sector Funding

- Medicaid
- Medicare
- VA
- Indian Health Services
- State Children's Health Insurance
- Military Health Care
- Federal Employee Health Benefits Program

Medicaid (Medi-Cal)

- Started 1965; partial state and federal
- Mean-tested, US citizens and permanent residents
- Certain low-income adults, their children
- Pregnant women
- Parents of eligible children
- People with certain disabilities
- Elderly needing nursing home care
- Will expand in 2014 to all under 133%
- Some counties already adding coverage
  - MCE in San Mateo with Substance Abuse

Medicare

- Started in 1965; fully federal
- Over 65 or permanent disability or congenital disability
- Funds residency programs
- Part A: Hospital
- Part B: Outpatient
- Part C: Special Plan
- Part D: Drug benefits

Supplemental Security Income (SSI)

- Created 1972; started 1974
- Low income aged (over 65), blind, or disabled
- Federal funds
- In California, now managed via a coordinated care approach

Social Security Disability Insurance (SSDI)

- Income supplements to people with physical or mental conditions that prevent engagement in any “substantial gainful activity”
- Temporary or permanent
- Payroll tax funded (need to have worked)
- Not income related

Policy and Challenges

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Complex Social Issues: Role of Behavioral Health

- Homelessness
- Housing
- Violence
- Poverty—role in foster care, BH
- Employment/education
- Health Inequities/Disparities
- Chronic inebriates
- Medical ERs,
- Stigma and discrimination
- Suicide prevention

Complex Service Delivery Issues

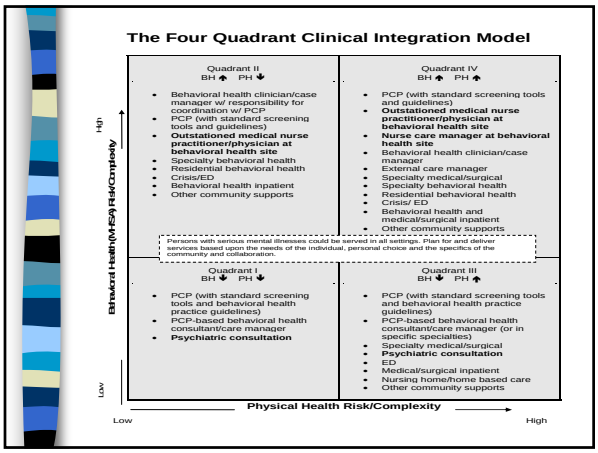
- Complex populations with limited BH awareness or desire to seek services
- Involuntary outpatient treatment—"Laura's Law" problems
- LPS /5150 criteria—need for reform
- Conservatorship and medications
- Drug Medi-Cal
- Evidenced based/practice based evidence
- Staffing: Workforce Development

Complex Service Delivery Issue: Health Care Reform

- January 2014
- "Triple Aim"
  - Better care for individuals
  - Better health for populations
  - Reducing per-capita costs
- San Mateo's Low Income Health Plan Waiver
- Community Service Areas

Complex Service Delivery Issue: Integration with Primary Care

- Bring care to the clients
- Integrated primary care and behavioral health care clinics
- Current Medical Home emphasis and shift from specialty BH care
- Medical Model verses Recovery Model
- Quadrant model of BH and PC needs



Complex Policy Issue: Criminal Justice

- Parole Realignment
  - Target population
  - Coordination with Probation
  - Treatment Approaches
  - Treatment Decisions
  - Sharing Information
- Individuals with Serious Mental Illness
  - Mentally Incompetent to Stand Trial
  - Balancing public safety and treatment
- Specialty Courts
  - (same list as Parole Realignment)
  - Juvenile Court-Incompetent to Stand Trial

Complex Policy Issue: Child Welfare/Child Trauma

- Emerging evidence based practices
- Changing legislative priorities
- Court Decisions
- Prevention Strategies
- Collaborative Service Delivery
  - Organizational Culture Differences
  - Funding
  - Case Decision Making

Challenges: Funding/Revenue

- Realignment
- Entitlement Demand
  - EPSDT
  - Drug Medi-Cal
- Underfunded Substance Use Services
- FQHC restrictions
- Medicare and rigid integrity standards
- MHSA--dedicated but at risk with State crisis
- Health Care Reform Matching Requirements

Challenges: Cost-of-Business Increases

- Labor, Insurance, Workmans Comp
- Rising pharmacy costs and polypharmacy
- State hospitals shifting costs:
- Shared clients:
  - Developmental disabilities--Regional Centers
  - Dementias and other "organic" states--primary care

Challenges (among others): Now and Ahead

- Preservation of Existing Revenue Sources
- Adequate Funding for Substance Use Services
- Retention, Recruitment and Training of Staff
- Effective Engagement/Services for Diverse Populations
- Safe and Affordable Housing
- Complex Client Needs
- Accountability and Performance Outcomes
- Alternatives to out patient commitment
- Recovery and Wellness Promotion
- Parity in terms of adequate service provision
- Stigma

BHRS Strategic Initiatives