

# Challenges Facing Adult Providers of Behavioral Health Services: A Recovery Perspective

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# 3 Major Challenges Facing Providers

- The Integration of Behavioral Healthcare and Physical Healthcare
- The Increasing and Expanding Relationship between Behavioral Health Services and Law Enforcement
- The Growing Influence of Managed Care and its Effects on How We Provide Services (and How We Get Paid)

# Recent SAMHSA Definition of Recovery

## Four Domains

- **Health:** overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;
- **Home:** a stable and safe place to live;
- **Purpose:** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- **Community:** relationships and social networks that provide support, friendship, love, and hope.

# A Few Caveats

- MHALA is a provider of services to people with severe and persistent mental illnesses only.
    - To the extent that an agency serves a “less disabled” population, some of these comments may not apply.
  - MHALA provides services exclusively in Los Angeles County.
    - L.A. County is extremely urban and densely populated and to the extent that an agency operates in a more rural, less densely populated county, some of these comments may not apply.
  - In referring to “adult” services, I mean people 18 years of age and older.
    - Transition Age Youth (18-25) and Older Adults (60+) may have special considerations and needs that go beyond or are different from those in the 26 to 59 age group.
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# Challenges as we approach Physical Health and Behavioral Health Integration

- Per Capita spending for healthcare (excluding mental health) in 2006: \$2,631.64 (94.6%)
- Per Capita spending for mental healthcare in 2006: \$148.56 (5.4%)
- Drug spending accounts for 26% of health care spending but 51% of mental health care spending
- Inpatient mental health care accounted for 16% of total mental health care spending

**Richard G. Frank, Howard H. Goldman and Thomas G. McGuire.  
Trends In Mental Health Cost Growth: An Expanded Role For  
Management? Health Affairs, 2009, Vol 28, 649-659.**

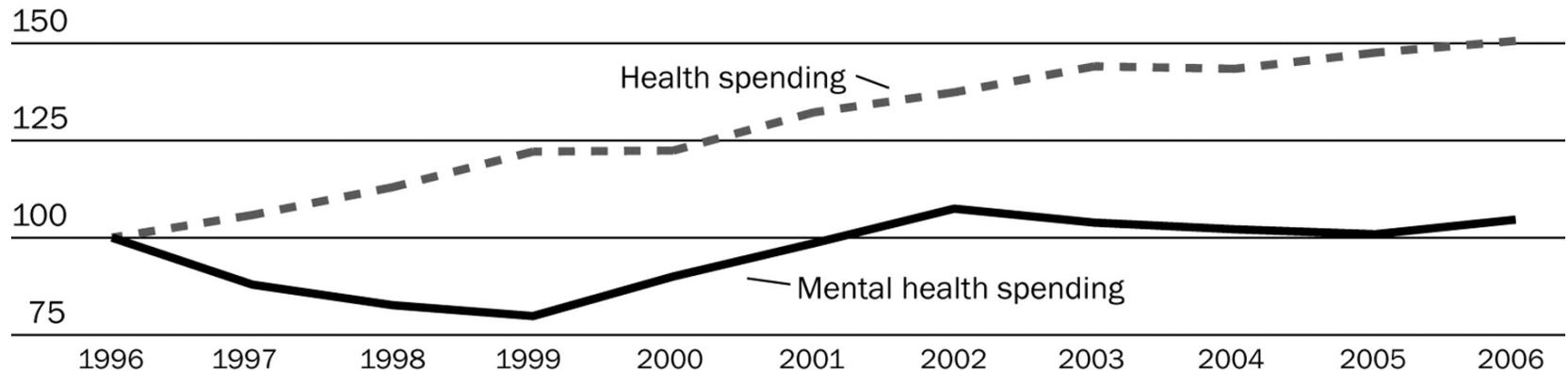
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# Growth In U.S. Health And Mental Health Spending (Indexed To 1996) In Medicaid, 1996–2006.

## EXHIBIT 5

### Growth In U.S. Health And Mental Health Spending (Indexed To 1996) In Medicaid, 1996–2006

Spending index



**SOURCE:** Medical Expenditure Panel Surveys, 1996–2006.

**NOTES:** Spending index constructed through regression analysis, available in the online appendix at <http://content.healthaffairs.org/cgi/content/full/28/3/649/DC1>. 100 represents mean spending in 1996 for each group. For regression details, see Exhibit 3 notes.

Frank R G et al. Health Aff 2009;28:649-659

HealthAffairs

# Who are the new members we will serve under the Medicaid Expansion?

- They are unlikely to be determined to be psychiatrically disabled (No SSI or they would have gotten this already)
- Many of them will have a severe and persistent mental illness (and/or substance use disorder) that results in moderate to severe impairment in functioning
- Many of them will require extensive care coordination services to help them meet their “non-behavioral healthcare” needs
  - Co-occurring physical health conditions/disorders
  - Poverty
  - Low levels of employment / education

How will we ensure that our members' behavioral health (and care coordination) needs are met? Some possibilities

- Co-locating our behavioral health staff within primary healthcare clinics (FQHCs)
- Demonstrate how a behavioral healthcare home is the most effective means of providing integrated healthcare for the SMI population
  - “re-invent” ourselves as “dynamic care coordinators” for the newly-insured Medicaid population
- Provide physical healthcare services in our own facilities either through collaboration or becoming an FQHC ourselves

# The Intersection of Behavioral Healthcare and Law Enforcement

- Coming soon to a county near you: Laura's Law
  - The unavoidable conflict between our role as advocate and our role as service provider
  - What compromises in our recovery principles will we be required to make if we choose to provide these services?

## On the Evidence for Compulsory Treatment Orders...

We looked at two groups of similarly ill people in the British healthcare system who'd been judged by their psychiatrists to need CTOs [Community Treatment Orders]. One group received CTOs and one not, and we found that there was absolutely no difference in the outcome, with or without compulsory treatment. About a third of both groups relapsed and required hospitalization over the following 12 months.

I was depressed by those results. I worked for more than 20 years to get the CTO law passed. I thought such laws were going to make a difference, but they don't.

Interview with Psychiatrist Tom Burns by L.A. Times Columnist Pat Morrison (July 22, 2014)

# On the Evidence for Compulsory Treatment Orders...

We know what does keep patients well, and our experience is that adding compulsion does not appear to make it work better. Care is better than no care; it doesn't say care with compulsion is better than care.

## **What does work? (Pat Morrison)**

The long-term treatment of very severely mentally ill people — consistent, steady, low-grade outreach which is flexible and which goes on for months and years and which is based on ensuring the person gets their medicine, ensuring their social life is stabilized as best we can — that reduces the rate of relapse substantially. We've now tried to add compulsion to it and it hasn't improved the outcome. So I think the effort should go into making sure that everybody gets access to basic treatment.

<http://www.latimes.com/opinion/op-ed/la-oe-morrison-burns-20140723-column.html#page=1>

# The Devil is in the Details...Considerations for Implementation

- How do we minimize the coercive elements of this program?
- The importance of evaluation – Can we eliminate court orders in the future?
- The unintended consequences – Will we be compensated for the likely increased costs of serving this population?
  - The underlying assumption of AOT is that these members will be no more expensive than our current FSP eligible clients

# The Paradox Inherent in our Work: “Family” vs. “Flow”



## Needed: A rational, objective means of determining level of care

- Our current fee-for-service is likely to be replaced by some form of capitated or case-rated payment system.
- Things to watch out for as we move toward managed care...
  - How do we define recovery? Is “success” defined solely as lowering costs (hospitalization) or as improvement in quality of life (employment)?
  - What role will people with lived experience play in the delivery of services?

# The Problem

- More and more high-need consumers, particularly from prisons/jails and locked facilities are flooding into the system
- Full Service Partnerships are filling up and creating a bottleneck
- Clients are funded by “silo” (FSP, FCCS, Wellness Center)
  - Moving clients from one funding silo to another is an enormous administrative burden.
  - Providers are hesitant to move clients to a lower level of care for fear they will need to come back.

# Rationale and Goals for the FSP Integration Pilot

- To Create a more seamless service continuum
    - Resolve the “Bucket Problem”
    - Ability to provide the appropriate level of care to meet client needs
  - FCCS used as an FSP-Step Down with funding limitations.
    - FCCS clients often very similar to FSP clients but funding structures don’t always support the level of service needed
    - Test out fiscal and programmatic models that are likely to be used under Healthcare Reform.
  - Specify service expectations, outcomes and available funding
  - Increase service area capacity
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# The L.A. County DMH System of Care

- Level 4 - Full Service Partnerships (FSP)
  - ACT Teams serving highest need clients
- Level 3 - Field Capable Clinical Services (FCCS)
  - ACT “Lite” (Intensive Case Management)
- Level 2 - Standard Outpatient Clinics and Wellness Centers
- Level 1 - Consumer-Run Centers

# The FSP Integration Pilot

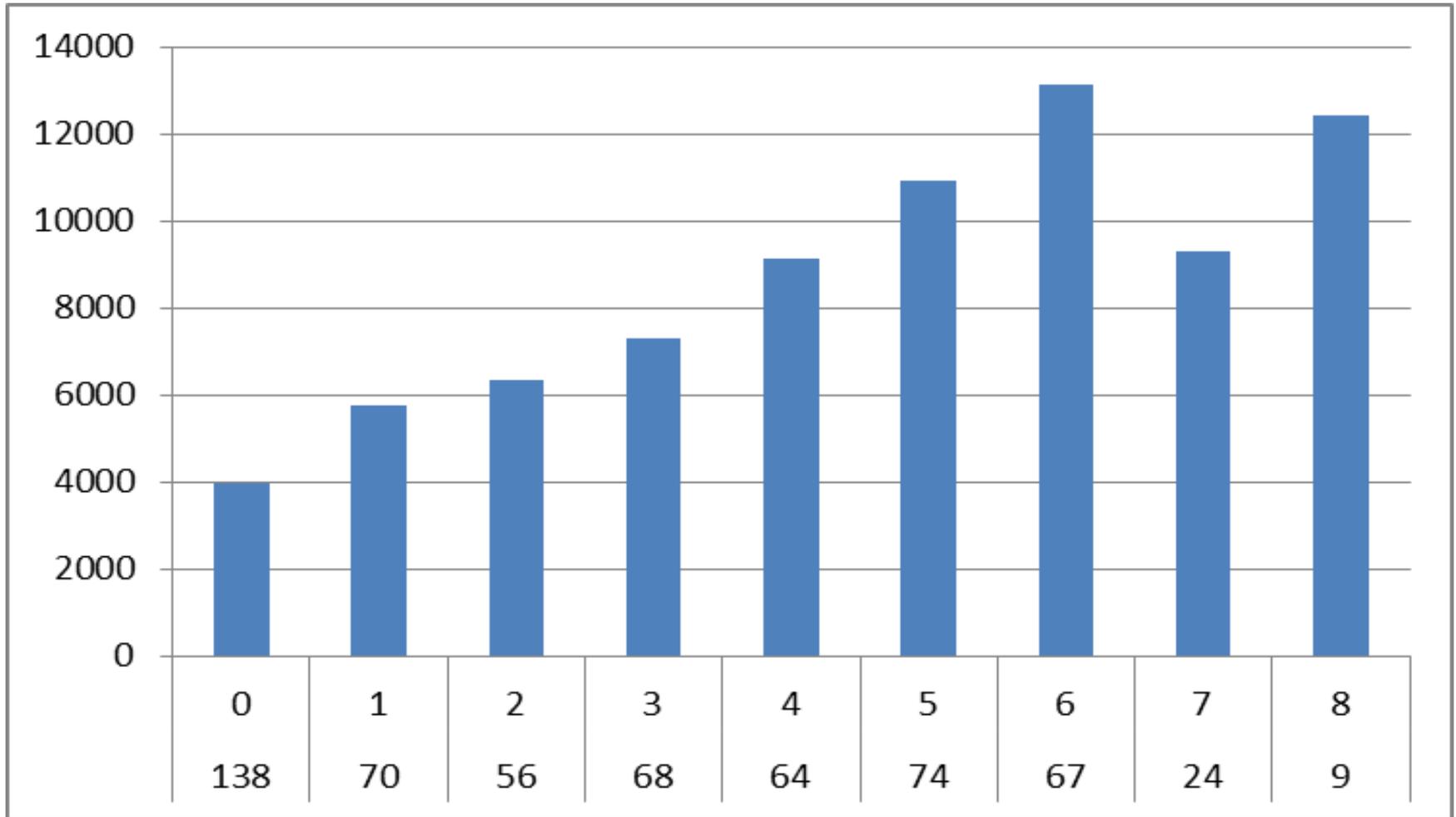
- Six Provider agencies are given permission to “merge” all their FSP and FCCS clients into a single funding silo.
  - Former FSP clients are now “FSP Level 4”
  - Former FCCS clients are now “FSP Level 3”

# Determinants of Level of Care

- Does the client...
  - ...require support to manage his/her own financial resources?
  - ...require support to coordinate his/her own transportation needs?
  - ...require formal or informal assistance with 2 or more ADLs?
  - ...require at least once per week contact with staff to coordinate his/her care?
  - ...require support to manage his/her medication?
  - ...require support to manage community relations and minimize disruptive behaviors?
  - ...show less than 6 months stability at his/her current level of recovery?
  - ...require CSS (Flex) funds to meet basic needs (housing and food)?

LEVEL OF CARE	RULE PARAMETERS
<p style="text-align: center;"><b>5</b></p> <p>Residential / inpatient services for people who are gravely disabled or are currently a danger to self or others</p>	<p>If MORS score is a 1 <u>then</u> LEVEL OF CARE is a 5</p>
<p style="text-align: center;"><b>4</b></p> <p style="text-align: center;"><b>High Intensity Community Based OP</b></p>	<p>If MORS score is a 2 or 3, <u>then</u> LEVEL OF CARE is a 4 and/or</p> <p>If sum of determinants equals 5 or more, <u>then</u> LEVEL OF CARE is a 4 and/or</p> <p>If sum of determinants equals a 3 or 4 and one of those determinants is required weekly care coordination, <u>then</u> LEVEL OF CARE is a 4</p>
<p style="text-align: center;"><b>3</b></p> <p style="text-align: center;"><b>Moderate Intensity Community Based OP</b></p>	<p>If sum of determinants equals a 3 or 4 and required weekly care coordination <u>IS NOT</u> one of those determinants, <u>then</u> LEVEL OF CARE is a 3 and/or</p> <p>If sum of determinants is 2 or less and MORS score is 4 or 5, <u>then</u> LEVEL OF CARE is a 3 and/or</p> <p>If sum of determinants is 2 or less and MORS score is 6 or 7 and the client has been stable at the current MORS score for less than 6 months, <u>then</u> LEVEL OF CARE is a 3</p>
<p style="text-align: center;"><b>2</b></p> <p style="text-align: center;"><b>Wellness Services</b></p>	<p>To be determined: All other clients not meeting above rules will be assigned to LEVEL OF CARE 1 OR 2.</p>
<p style="text-align: center;"><b>1</b></p> <p style="text-align: center;"><b>Recovery Maintenance</b></p>	<p>To be determined: All other clients not meeting above rules will be assigned to LEVEL OF CARE 1 OR 2.</p>

# Average Total Cost per Client (April, 2013 – Sept. 2013) by Number of Determinants



# MHA Village FSP Integration Pilot Member Flow Summary

## December, 2013 – April, 2014

December Level	April Level	Number	Percent	-2	-1	0	1	2
2	2	25	8.09%			25		
2	3	8	2.59%		8			
2	4	3	0.97%	3				
3	2	36	11.65%				36	
3	3	25	8.09%			25		
3	4	40	12.94%		40			
4	2	28	9.06%					28
4	3	11	3.56%				11	
4	4	123	39.81%			123		
4	5	4	1.29%		4			
5	4	2	0.65%				2	
5	5	4	1.29%			4		
		309		3	52	177	49	28
				0.97%	16.83%	57.28%	15.86%	9.06%
				17.80%			24.92%	
						7.12%		

# Some Lessons Learned

- Both members and staff experience a significant resistance to the idea of “flow” from higher to lower levels of care
- The determinants have significant clinical utility in that they create the ability for managers to ask the question: “What does this member need to move on?”

Managed Care is Coming. We can fear it and resist it...



...Or we can embrace it **on our terms** and make it a tool to serve the recovery of our members.



# Thoughts?