Engaging Ourselves & Our Communities

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I am delighted to be here.
I bring greetings to all of you from our county directors, our rural colleagues, and the Coalition for Whole Health.
Now, let’s shift gears....
Times have changed....
2017 was a very, very difficult year!
Congressional Bills in 2017

- American Health Care Act
- Better Care Reconciliation Act
- “Skinny” Act
- Graham–Cassidy Act

Each of these efforts failed to elicit sufficient votes in the US Senate.

Each would have been a tragedy for behavioral health.
These bills would have removed $4 trillion from Medicaid over 10 years, and they would have done great harm to the Affordable Care Act.
They also would have Block Granted Medicaid

- **Concerns:** Financial implications for the states and coverage for those insured by Medicaid.
- **Understand:** Fixed amount per state?; Per person covered? With what baseline: Now? Other?
- **Avoid:** Flexibility is simply a code word for increasing state responsibility and decreasing federal responsibility.
We were able to defeat these bills because the entire healthcare field came together to oppose them. The cooperation across all health fields was literally unprecedented.
We must remain very vigilant going forward. 2018 will be easy—all House members and 1/3 of Senators are running for office. Depending on the outcome of the fall elections, 2019 could be another very difficult year.
Some Positives in 2018

- Omnibus Budget Act—PASSED:
  - $2+ billion increase for the opioid crisis
  - $160 Million increase for the MH Block Grant
  - $100 Million increase for the CCBHC Program
  - $52 million for workforce development
  - $301 million increase for EBPs
  - $40 million increase for MH PRNS
  - $51 million increase for SUDT PRNS
  - $25 million increase for SUDP PRNS
  - $6 million increase for Children’ MH Services
Some Positives in 2018

- Stop School Violence Act—PASSED:
  - $50 million for training of teachers, counselors.

- Reducing the IMD Prohibition—IN PROCESS

- CARA 2.0—IN PROCESS

- CMMI Demonstration on EHRs for Behavioral Health—IN PROCESS
OUR KEY MISSION

Promoting Social Justice in Our Communities

“The dream lives on. The work will never die”
Ted Kennedy
Let’s shift gears again....
We have changed....
The Issue

- 25% of adults have a behavioral health condition each year.
- 5% have a very serious condition.

- 20% of children have a behavioral health condition each year.
- 7–13% have a very serious condition, depending on state.
The Issue

- **45,000** suicides occur each year; 997 in California (one every 8 hours).

- **64,000** drug deaths occur each year; 4,628 in California (one every 2 hours).

- **42,000** opioid deaths occur each year; 2,024 in California (one every 4 hours).
Our Model is Changing–1

Old Model:
- **Disease** is a *personal* characteristic
- Role is to treat disease
- Goal is to restore functioning

Focus:
- **Clinical** intervention
- Care system management
- Care policy
Our Model is Changing–2

New Model
- Disease is a principally a community characteristic
- Role is to change communities
- Goal is to improve community functioning

Focus:
- Community intervention
- Community management
- Community policy
Our current task is to blend the old and new models to achieve the Triple Aim:

- Better population health, i.e. **better wellbeing**
- Better quality care
- Reduced care costs

- And some would add a fourth:
  - Better provider health and satisfaction
How?

- Population Health Management: *Wellness for all.*

- Integrated Care Systems that bring together mental health, substance use, and primary care services AND incorporate disease prevention and health promotion strategies AND incorporate essential social services.
POPULATION HEALTH MANAGEMENT
“You’ve got a rare condition called ‘good health’. Frankly, we’re not sure how to treat it.”
Illness and Well-being -- 1981

- **Very Good Wellbeing**
- **Very Poor Wellbeing**
- **No Disease**
- **Severe Disease**
**Viewed as Population Health**

- **VERY GOOD WELLBEING**
  - Pop 1
  - NO DISEASE
  - Pop 3
  - VERY POOR WELLBEING

- **SEVERE DISEASE**
  - Pop 2
  - SEVERE DISEASE
  - Pop 4
Adding the Third Dimension

C O M ILLNESS - M B - ILLNESS
W E L U E U I N I N G T Y
Today’s Wellness Model

- Recovery and Health: Yes -> Wellness
- Self-Help, Social Support, Changes in Unhealthy Lifestyle
- Illness: Yes

- Biopsychosocial Interventions: Yes
- High Morbidity and Mortality, Little Self-Help or Hope
- No
How would this model change if we added community services to address the social and physical determinants of health?
Let’s shift gears again....
Our context has changed....
Pervasive National Concerns in Behavioral Health

- Move to Integrated Care Services
- Developing better/effective linkages with social services
- Incarceration of persons with mental and substance use conditions
- Linkage with public health

All are intended to promote wellness
INTEGRATION OF CARE
Models of Integration

- Treat–Refer
- Bidirectional Integration (Co–Location)
- Full Integration
## Integrated Care Services

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Discrete and non-overlapping medical and BH provider groups &amp; treatment settings; frequent delays</td>
<td>Non-network cross disciplinary providers at primary service delivery site; selective access</td>
<td>Integrated medical and BH network providers uniformly present in service locations; ready access</td>
</tr>
<tr>
<td>Integrated Care Delivery</td>
<td>Clinician documentation information firewalls; crisis dictated communication and care coordination; non-existent continuity</td>
<td>Site specific cross disciplinary information access, communication, and care coordination; partial continuity</td>
<td>Full integrated medical and BH network provider information access, communication, care coordination, and continuity</td>
</tr>
<tr>
<td>Payment</td>
<td>Separate medical and BH benefits, claims adjudication procedures, and coding and billing rules</td>
<td>Separate medical and BH benefits, claims adjudication procedures, and coding and billing rules; subsidized cross disciplinary services</td>
<td>Consolidated medical and BH benefit set, claims adjudication procedures, and coding and billing rules</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Discipline-specific clinical and cost/saving accountability</td>
<td>Discipline-specific clinical and cross disciplinary cost/saving accountability</td>
<td>Medical and BH clinical and cost/saving accountability</td>
</tr>
</tbody>
</table>
Payment Systems – 1

- Grants
- Encounter-Based
- Case Rates
- Capitation Rates

- Each could be performance adjusted
Payment Systems – 2

- Prepayment
- Risk Corridors
- Reinsurance
Outcomes

Full Model: Effects at each level
- Social Determinants
- Trauma (Resilience)
- Prevention and Promotion Interventions
- Disease Onset/Delay
- Treatment – Symptoms
- Rehabilitation – Functioning
- Recovery – Wellness and Wellbeing
ADDING SOCIAL SERVICES
Importance of Social Services

SOCIAL ILLS?
How states’ social services and public health spending compare to the Medicare and Medicaid spending on their residents. State with higher ratios achieve better health.

High to Low
Social and public health to medical spending

SOURCE: Bradley, et al., Health Affairs 2016
Alejandra Gonzalez, USA TODAY
HOW?
THE INCARCERATION CRISIS
# The Incarceration Crisis

## USA. Adult incarceration.

<table>
<thead>
<tr>
<th>Inmates in custody</th>
<th>2000</th>
<th>2012</th>
<th>2013</th>
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<tbody>
<tr>
<td><strong>Total</strong></td>
<td>1,938,500</td>
<td>2,228,400</td>
<td>2,217,000</td>
</tr>
<tr>
<td>Federal prisoners(^{a})</td>
<td>140,100</td>
<td>216,900</td>
<td>215,000</td>
</tr>
<tr>
<td>Prisons</td>
<td>133,900</td>
<td>208,000</td>
<td>205,700</td>
</tr>
<tr>
<td>Federal facilities</td>
<td>124,500</td>
<td>176,500</td>
<td>173,800</td>
</tr>
<tr>
<td>Privately operated facilities</td>
<td>9,400</td>
<td>31,500</td>
<td>31,900</td>
</tr>
<tr>
<td>Community corrections centers(^{b})</td>
<td>6,100</td>
<td>8,900</td>
<td>9,300</td>
</tr>
<tr>
<td><strong>State prisoners</strong></td>
<td>1,177,200</td>
<td>1,267,000</td>
<td>1,270,800</td>
</tr>
<tr>
<td>State facilities</td>
<td>1,101,200</td>
<td>1,170,200</td>
<td>1,178,700</td>
</tr>
<tr>
<td>Privately operated facilities</td>
<td>76,100</td>
<td>96,800</td>
<td>92,100</td>
</tr>
<tr>
<td>Local jails</td>
<td>621,100</td>
<td>744,500</td>
<td>731,200</td>
</tr>
<tr>
<td><strong>Incarceration rate(^{c})</strong></td>
<td>680</td>
<td>710</td>
<td>700</td>
</tr>
<tr>
<td>Adult incarceration rate(^{d})</td>
<td>920</td>
<td>920</td>
<td>910</td>
</tr>
</tbody>
</table>
Tonight: City and County Jails

- About 730,000 persons in these jails:
  - 182,500 (25%) with mental illness
  - 365,000 (50%) with substance use disorder
  - 73,000 (10%) with I/DD
  - Major co-morbidity between the three groups

- The three groups (620,500) actually exceed the total number in state mental hospitals in 1955 just before deinstitutionalization started (559,922).
National Initiatives

- NACo Stepping Up Initiative
- NACBHDD Decarceration Pilot
- Are you involved?
LINKAGE WITH COUNTY PUBLIC HEALTH PROGRAMS
American Public Health Association is taking on this issue.

Public Health 3.0 seeks to incorporate behavioral health into public health interventions.

SAMHSA seeks to incorporate public health into behavioral health interventions.
Linkage with Public Health: 1,943 County Public Health Departments
How will we respond?

LIFE is either a daring adventure or nothing.

- Helen Keller
Commentaries Available at Behavioral Healthcare Executive

- My commentaries on all of these issues are available at www.behavioral.net.
Contact Information

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