mhca
Leaders in Community Health Solutions

mhca's e-Newsletter

Vol. 7, Issue 8
Published November 2022

There are no more lines

A Guest Article By Principal at Health Management Associates Josh Rubin

Ever since the 19th century when Dorothea Dix crusaded up and down the east coast encouraging state legislatures to fund state psychiatric hospitals, we have had separate systems for medical and mental health care. I mean Ms. Dix no disrespect, far from it; before her work we simply had no system of care for people with mental illnesses. Her contribution was immeasurable. In 1963 when President Kennedy signed the Community Mental Health Act, it was an acknowledgement that the 'out of sight, out of mind' warehousing of people with mental illnesses in large state psychiatric hospitals was inappropriate and had to end.

Those of us who remember the heady days of the 1960s rightly celebrate the advance it represented in recognizing the rights of people with mental illness to live in the community, and the opportunity it created for people with behavioral health conditions to build lives of dignity, productivity, and inclusion. And while we ought to celebrate that important advance, we must nonetheless acknowledge that it maintained a separation between the mental health system that was never funded like it needed to be, and a medical system that was significantly better funded. And thus, the community mental health system in America was built. It was designed to provide mental health care to the roughly 5% of the population that has a serious mental illness (SMI). In the nearly 60 years since then much has been done that community mental health providers should be proud of. We have transformed countless millions of people's lives (and those of their families), built new program models, identified and implemented new practices, and built a service delivery system that offers a comprehensive continuum of behavioral health care for people with SMI and significant substance use disorders (SUD).

All those accomplishments happened while we were quietly working on our own with a population nobody else wanted very much to take care of. We were left out of the healthcare delivery system. We were funded through

block grants with our own sets of regulations, regulators, payment methodologies and program models. Our funding was inadequate, but it was ours; we didn't have to compete for it. Many of us had catchment areas that served effectively as monopolies. The stigma of our clients' illnesses attached to us and our service system, so we were largely ignored by the healthcare delivery system and the people who funded and oversaw it.

While we have much to be proud of, we cannot ignore the impact of our segregation. Our clients continue to die much younger than their peers. BH-related hospitalizations continue to increase. Overdose deaths and completed suicides, the worst possible outcomes, keep climbing, leaving incalculable suffering in their wake. And the financial costs of BH conditions continue to escalate, falling hardest on the historically underserved and marginalized communities that can least afford them. When America establishes a separate system, we don't treat it equally; being ignored has consequences.

The good news? We are not being ignored any longer. The bad news? We are not being ignored any longer.

Healthcare policymakers have finally awakened to the reality that they will not be able to achieve their goals of better outcomes, lower costs, and improved customer service unless they address the BH needs of their populations. They are figuring out that everyone needs behavioral healthcare, and that a dichotomy that focuses BH care only on those with the most significant BH issues ill serves them. They are coming to understand that the skills, capabilities, and expertise of community BH providers has extraordinary value. It's nice to be acknowledged and invited to help.

But it's not all good news, because while being ignored left us underfunded and disrespected, it also protected us. Now that hospitals (which have been buying up outpatient practices at a remarkable pace) have started opening up BH services, we must compete with their deep pockets. And private equity (with even deeper pockets) has increased the pace at which they are acquiring BH providers, forcing additional competition on us. We are not even safe from our own phones. 10,000 mental health apps in the app store offer our clients a totally different paradigm for care. Much of it may lack an evidence base, but that makes it more dangerous for our clients, not less competitive for us.

This is happening against a backdrop of the bright lines that have historically divided the healthcare delivery system getting wiped away at an astonishing pace. Healthcare systems are growing their own managed care plans while managed care organizations expand their own delivery systems. Cross sector groups are opening Accountable Care Organizations (ACO) that now offer more than 10% of Americans comprehensive, coordinated, integrated and accountable care. ACOs, Independent Practice Associations (IPA), Management Services Organizations (MSO) and other platform entities are blurring the lines between different provider organizations. When one agency is clinically and financially integrated with another – sharing data, sharing clients, and sharing payments – the line between one and the other gets fuzzy.

At the governmental level, the lines are getting blurry too. Dozens of different agencies across states fund BH programs. Whether it's Veteran's Affairs funding suicide prevention, State Police funding BH response teams, or Gaming Authorities funding gambling addiction services, lots of government officials have discovered that BH is integral to the success of their portfolio. Likewise, the mental health and substance use disorder block grants and state general funds, which were once the primary sources of funding for BH services are now dwarfed by Medicaid's spending. And that spending will only grow as more than ½ the states expanded their Medicaid BH benefits in the last two years. Similarly, Medicaid agencies across the country are adding social services benefits – not at quite the same pace as BH, but nearly.

So, what should providers do? Should we try to build the walls around our system back up? Some are endeavoring to use the CCBHC initiative to do so. Protection is nice. Monopolies are comfortable. If we do that, however, not only will we wall our clients off from the integrated health care that will help them to live longer and healthier lives, but we will also deny access to the high quality behavioral health care we provide to millions of people with mild and moderate BH conditions.

I think providers should do just the opposite. Behavioral health is central to people's well-being. It is central to the holistic, comprehensive, coherent care model that we know works best. We should embrace the disappearing lines. We should celebrate that BH is finally being understood as an integral part of a healthy life. If service delivery

systems are coming together, we should urge them to come together around us. We are the providers who have spent decades with a foot in health care and a foot in social services; we speak the language of both systems.

If you look at the history of the BH system in America, from Dorothea Dix through today, you will see that the movement has been consistently in the same direction – inward. We have moved out of the hospitals in the countryside into the clinics in the neighborhood. We have slowly chiseled away at the barriers dividing mental health from substance use disorder services. We have patiently worked to integrate with our health care colleagues. Now things are accelerating, and the pace of change is scary, but we should embrace the opportunity. We have a once in a lifetime chance to build something new, better, more effective.

Like Rudolph the Red Nosed Reindeer, we have been ostracized for our differences (and the differences of our clients). Like Rudolph, those who have ostracized us suddenly realize how much they need us – because of the thing that has made us different. And now, like Rudolph, it's time for us to lead, to seize the opportunity presented by the changed circumstances and celebrate our differences. The only real question is whether we will take advantage of the opportunity. For the sake of the people we serve, I hope so.

A policy expert and deft administrator, Josh Rubin brings an impressive depth and breadth of mental hygiene services knowledge and expertise to HMA. He has shared his wisdom as a featured speaker during several **mhca** conference presentations over the years. His most recent presentation from our 2022 Fall Conference in Scottsdale, Arizona, *You Can't Color Inside the Lines if There Are No Lines*, is available to **mhca** members online at mhca.com (https://mhca.com/conference-presentations/2022-scottsdale-az?limit=20&limitstart=20)

Thrive as an organization
Results from the mhca Member survey
DOWNLOAD NOW
nextgen healthcare

Unsubscribe from Monthly Minute Newsletter

1876 Eider Court, Suite A

Tallahassee, FL 32308

mhca
1876 Eider Court, Suite A
Tallahassee, FL 32308

TEL: (850) 942-4900

If you don't want to get similar messages from us in the future, you can Unsubscribe or Opt-Out by clicking the following link:
https://mhca.com/index.php?option=com_civicrm&task=civicrm/mailing/unsubscribe&reset=1&jid=&qid=&h=fakehash