

Commonwealth North Health Care Action Coalition

**“Integration of Healthcare
Primary and Behavioral Health Care =
No Brainer”**

Now the Rest of the Story

Jerry A. Jenkins, M.Ed., MAC
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What's following?

- “Integration of Healthcare
- Primary and Behavioral Health Care =
 - No Brainer”
 - Now the Rest of the Story

- Quiz – Remember 6-17-25
- **Summary – What is in the future?**
 1. Behavioral Health Horizontal and Vertical Integration (linking of behavioral health services). (alliances; joint ventures; change of sponsorship; holding company; merger/acquisition/consolidation)(article re VBHCS staff working in several locations in one day)
 2. Health care integration – the Cherokee model or via service links
 3. Consolidation – moving services under one umbrella
 4. Centralized assessments and prescribed care
 5. Treat trauma/Adverse Events/Adverse Childhood Events

What got us here?

- **1955**—P.L. 84-182, the Mental Health Study Act, authorized NIMH to study and make recommendations on mental health and mental illness in the U.S. The act also authorized the creation of the Joint Commission on Mental Illness and Health.
- **1956**—P.L. 84-830, the Alaska Mental Health Enabling Act, provided for territorial treatment facilities for mentally ill individuals in Alaska.
- **1963**—P.L. 88-164, the Mental Retardation Facilities and Community Mental Health Centers Construction Act, provided for grants for assistance in the construction of community mental health centers nationwide.
- **1965**—P.L. 89-105, amendments to P.L. 88-164, provided for grants for the staffing of community mental health centers.
- **1966**—P.L. 89-793, Narcotic Addict Rehabilitation Act of 1966, launched a national program for long-term treatment and rehabilitation of narcotic addicts.

What got us here?

- **1967**—P.L. 90-31, Mental Health Amendments of 1967, separated NIMH from NIH and raised it to bureau status in PHS.
- **1968**— P.L. 90-574, The Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968, authorized funds for the construction and staffing of new facilities for the prevention of alcoholism and the treatment and rehabilitation of alcoholics.
- Note: During the 1960's, de-institutionalization of mental ill consumers began. De-institutionalization and re-institutionalization has accelerated since.

What got us here?

- **1970**—P.L. 92-211, Community Mental Health Centers Amendments of 1970, authorized construction and staffing of centers for 3 more years, with priority on poverty areas.
- P.L. 91-513, Comprehensive Drug Abuse Prevention and Control Act of 1970, expanded the national drug abuse program by extending the services of federally funded community treatment centers to non-narcotic drug abusers as well as addicts.
- P.L. 91-616, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act, authorized the establishment of a National Institute on Alcohol Abuse and Alcoholism within NIMH.
- **1972**—P.L. 92-255, Drug Abuse Office and Treatment Act of 1972, provided that a National Institute on Drug Abuse be established within NIMH.
- **1974**—P.L. 93-282, authorized the establishment of ADAMHA. (Alcohol, Drug Abuse and Mental Health Administration)
- Anchorage Community Mental Health Services, Inc. (ACMHS) was established on June 11, 1974 as a private nonprofit corporation. The purpose was to provide treatment for persons impacted by mental illness in what was called a catchment area, Anchorage and surrounding areas. The forming Board of Directors consisted of four directors: Jon Baker; John Beard; James Hotchkiss and James Smith. The governance of ACMHS developed in the 1970's and remains today as a board of directors consisting of fifteen (15) volunteers from the community. The company is operated by an Executive Director who is selected by the Board of Directors. (Akeela - 1974)

What got us here?

- **1978**—P.L. 95-622, the Community Mental Health Centers Extension Act of 1978.
- **1979**—P.L. 96-88, the Department of Education Organization Act, created the Department of Education and renamed HEW the Department of Health and Human Services (HHS).
- **1980**—P.L. 96-398, the Mental Health Systems Act, reauthorized the community mental health centers program.
- **1981**—P.L. 97-35, the Omnibus Reconciliation Act, repealed P.L. 96-398 and consolidated ADAMHA's treatment and rehabilitation programs into a single block grant that enabled each State to administer allocated funds.
- **1983** - The Clinch Mountain Regional Health Center Corporation (now Cherokee Health Systems in East Tennessee) was initiated as an amalgamation of Cherokee Guidance Center services and the Blaine Medical and Dental Board. (www.cherokeehealth.com/)
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- **1992**—P.L. 102-321, the ADAMHA Reorganization Act, abolished ADAMHA, created the Substance Abuse and Mental Health Services Administration.
- **1994** – Tennessee implemented TennCare – Medicaid population, uninsured and those turned down in a managed care risk based model. Funding streams were consolidated.

“TENNCARE represents a major initiative by the State of Tennessee to address the uncontrollable growth of costs in the Medicaid program. In the absence of this initiative, the current Medicaid program threatens the viability of Tennessee’s health care system and the financial stability of the entire state government.

TENNCARE is the alternative we have developed to maintain quality health care services while reducing the unacceptable growth in the cost of these services to federal, state and local governments. TENNCARE embodies many of the priorities and initiatives under consideration by the President’s Health Reform Task Force . . .” (Letter to Secretary of Health and Human Services Donna Shalala from Tennessee Governor Ned McWhorter dated 16 June 1993)

What got us here?

- 1990's – Mental health and substance abuse replaced with term behavioral health. Dual treatment capability became expected by payer sources. However, the funding remained categorical in many instances.
- 1990's – increase in number involved in criminal justice and correctional systems with history of mental illness, addictions or combination of both.
- 1990's – recovery movement accelerates
- Now, why this history?

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- Third, funding streams often shift based on grants, contracts and regulations. They are currently complicated and are often fraught with process audits. Diverse oversight infrastructures have evolved to administer the funding streams.
- Fourth, in parts of the US, behavioral health vertical and horizontal alignments/integration/consolidation resulted in order to better connect/streamline care and reduce costs. (Alaska began discussions with topic of regionalization.)

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- Third, funding streams often shift based on grants, contracts and regulations. They are currently complicated and are often fraught with process audits. Diverse oversight infrastructures have evolved to administer the funding streams.
- Fourth, in parts of the US, vertical and horizontal alignments resulted in order to better connect/streamline care and reduce costs.
- Fifth, key pieces impacting behavioral health care outcomes require either additional business lines or key social service/educational linkages. (Housing, clothing, food, employment or income source, meaningful activity, **health care**, etc.)

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- Might this reduce the cost of health care?

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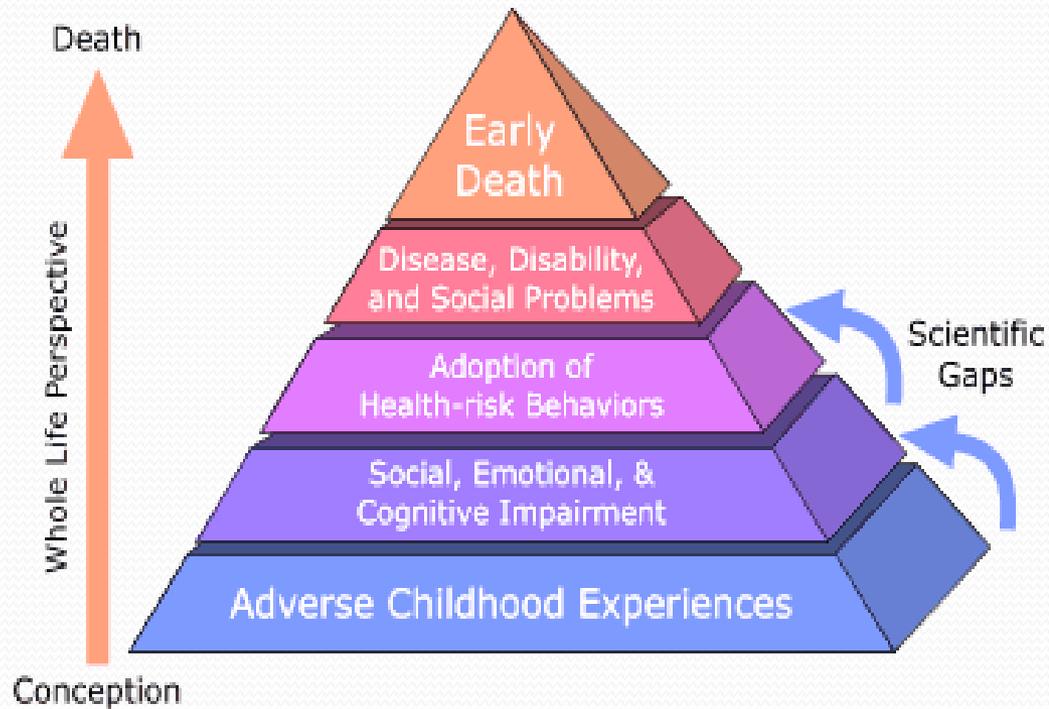
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- ACE – Adverse Childhood Experiences –
- Over 17,000 Kaiser patients participating in routine health screening volunteered to participate in The Study. Data resulting from their participation continues to be analyzed; it reveals staggering proof of the health, social, and economic risks that result from childhood trauma. (<http://acestudy.org/>)

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- Among the more notable findings were that compared to persons with an ACE score of 0, those with an ACE score of 4 or more were twice as likely to be smokers,
- 12 times more likely to have attempted suicide,
- 7 times more likely to be alcoholic, and
- 10 times more likely to have injected street drugs.
-
- In combination, the fallout from various forms of child abuse and household dysfunction is monumental, costing Americans untold sums of money because of the health risks such as the use of street drugs, tobacco, alcohol, overeating and sexual promiscuity. Not the least of these high-ticket medical costs is due to:
 - Cardiovascular disease,
 - cancer,
 - AIDS and other sexually transmitted diseases,
 - Unwanted and often-high-risk pregnancies,
 - Chronic obstructive pulmonary disease, . . .

Why is it past time?

- ACE – Adverse Childhood Experiences –



What's next?

- Remember three numbers
6-17-25
- 6 years - Half life of psychological knowledge
- 17 years - Science to Service Gap
- 25 years - Average loss in life expectancy for SMI
- **Relevance to the topic this morning? Can we speed up science to service gap and increase life expectancy for SMI and reduce overall cost of health care?**
- **Predictive Modeling:** Preliminary Results in Determining Probability of Clinical Improvement Based on Intake Demographics – Dennis Morris, Ph.D., CEO, Centerstone Research Institute presentation at MHCA Winter Meeting – 2010.
- Can we predict what treatments are likely to be most effective for this individual based solely on data available at intake?
- Model client outcomes as a function of baseline clinical and demographic characteristics and clinical interventions delivered (Medical, Therapy, Case Management, and combinations).
- Apply Bayesian Network Analysis to calculate a probability of positive treatment response given specific choice of interventions.
- Using only Intake information: Accurately predicts treatment response for more than 70% of clients.

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- Using only Intake information: Accurately predicts treatment response for more than 70% of clients.
- What IF this could be done when entering primary care?
- What is the savings if this is done once rather than 5 or more times? (PPER; API; CRC; Akeela; ACMHS)

Why not now?

- **Hurdles:**
- Expectations/Political will
- Funding – multiple sources and too many rules –
- What's in for me?

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- **Summary – What is in the future?**
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