Blog by Rusty Selix

Growing Washington Bipartisanship on Many Issues Gives Hope for Healthcare Future, But Everything Is Still at Risk.

Last week, the Senate began hearings on a bipartisan effort to provide greater short-term or moderate-term stability to the health benefit exchanges. These exchanges depend upon federal subsidies to provide affordable health insurance to individuals who do not qualify for Medicaid or employer insurance. They also depend on the mandate that everyone must pay at least part of their health insurance if they have above Medicaid incomes. It is the single part of the Affordable Care Act the Republicans most strongly campaigned to eliminate.

The fact a significant number of Republicans are now accepting (at least for the short term) this mandate will remain, and are open to negotiations with Democrats to stabilize these health benefit exchanges, is obviously a very encouraging sign that could extend to other related issues, especially in light of other similar developments.

- In a well-publicized action, last week, the president chose a proposal from Congressional Democratic Leaders over proposals from Republican Leaders-- on how to give immediate aid for areas damaged by hurricane Harvey in Texas and to raise the federal debt ceiling.
- Less well-publicized is the fact there is a bipartisan group in the House of Representatives, now meeting to consider healthcare market stabilization.
- Also, not so widely reported is the fact Congressional Budget Committees rejected the Trump Administration's proposal to reduce the Community Mental Health Block Grant by 25 precent, a relatively small grant. The administration's proposal would have meant a $12 million reduction for California. The overall dollars are not significant but preventing reduction is a strong signal of federal support for mental health.
- Not coincidentally, a moderate group of House Republicans known as the Republican Main Street Partnership and the "Problem Solvers Caucus" is reported to be growing.

These are all very hopeful signs. Nonetheless, we can't lose sight that congressional leaders are still very attached to the idea of making significant cuts in Medicaid, which could become a major part of discussion in developing the federal budget or tax reform – both of which are likely to be taken up in the next few weeks.

Workplace Mental Health Summit Meeting Brings This Key Component of a Comprehensive Prevention and Early Intervention System Out in The Open.

In 2014, I wrote a **white paper** on Prevention and Early Intervention (PEI), identifying four pillars or core programs around which most of our PEI efforts should be focused. These four

components consist of school (at all levels from preschool through college), primary care, and other healthcare entry points such as emergency rooms, the internet, and workplace. I also identified early psychosis programs as an additional essential component.

Since then, there have been discussions and effort about the need for bidirectional integration and coordination of physical healthcare and behavioral health care. The best model for this was incorporated into the Coordinated Care Initiative, a program for people with both Medi-Cal and Medicare. The same concept was made part of the proposed 2015 Medicaid waiver submitted to CMS with shared savings between counties, the state, and health plans, but it did not receive federal approval.

There are many successful local programs built around this concept and it will be a public policy priority for us in 2018.We believe it should produce net state savings even without federal financial participation.

Similarly, there been many advances in school mental health. Legislative approvals to start programs for community colleges and MHSOAC approval for a K-12 pilot program is expected to expand and complement hundreds of County PEI funded school efforts.

The use of the Internet and smart phone-based technology applications such as "7 cups" continue to grow. There is significant interest in partnerships between technology companies, county, and state leaders reflected in the success of AB 1315 (Mullin) which created an entity to receive private matching funds which have been promised by several Silicon Valley companies.

Early Psychosis Programs Now in Operation or Development in Nearly Every County. But the One Area in Which We Have Not Seen Any Significant Activity Is the Workplace.

As I wrote in 2014, the median age for onset of schizophrenia and bipolar disorder is 22 or 23 years old, an age at which most people are in the workplace. Moreover, it has been well documented for decades that untreated depression costs California employers' tens of billions of dollars annually in lost productivity, absenteeism, and disability.

It always seemed to me someone in the workplace should be able to recognize when something is not right. Employers need to be able to steer workers to getting the help they need. It would also seem these types of programs should eventually pay for themselves by reducing other employer costs.

There was a three-year program (Wellness Works!) funded by CalMHSA, under which Mental Health America of California (MHAC) sought to establish workplace programs built on a model developed in Canada. The CalMHSA program was part of its stigma reduction efforts with an emphasis on providing support for people with mental illness in the workplace.

As the program ended, Sutter Health (a large healthcare system in Northern and Central California which includes 29 hospitals in 16 counties) decided to promote workplace mental health for its system, led by John Boyd, CEO of Sutter System Mental Health Services. Boyd also

serves as a commissioner at Mental Health Services Oversight and Accountability Commission, as well as the Board of Directors at Steinberg Institute.

These three organizations are participating in a summit on workplace mental health being hosted by the Staglin family winery in Napa Valley. The two-day meeting, bringing together experts from across the country and many participating corporations, would appear to be the boost that this subject area needs to gain attention and statewide interest the other core programs have already received.

For now, it appears each of these four core programs is being developed as an innovation with pilot testing of concepts, or small grant funded programs not designed as sustainable system reforms.

I am hoping the day will come soon when we will know enough about the key approaches in each of these areas, so counties can build comprehensive PEI systems around these core programs. A necessity if our PEI programs are going to achieve their primary purpose –to make early identification and treatment of behavioral health problems the norm. In doing so, we should have the financial success we need in reducing the number of people who reached a level of very expensive long-term service needs, often required when a mental health or substance use disorder is untreated and allowed to worsen for several years. This is often the case under our current fail-first models that have existed for decades.

I also note since 2014, another emerging core program like early psychosis programs should be youth centers. A drop-in place where young people ages 12 to 30 can go for any type of health or behavioral health problem. Since we know this population is the least likely to use the health care system, the most vulnerable, and most important to reach for PEI.

The model was first developed as “Headspace” in Australia, where there are now 100 centers and replicated as “Jigsaw” in Ireland, and as “Foundry” in British Columbia, Canada; and is soon to be an innovation program in Santa Clara County. These efforts have been led by Stanford Professor Steve Adelsheim, who has written extensively through a Robert Wood Johnson grant on how to adopt this program for the United States. Here, there are challenges with our several different ways of financing behavioral health care and physical healthcare to make them available in the same place for people with both public and private insurance.

Over the next several years, we will see expansion in these areas with promising evidence that most of them only require one time investments of new money, and expectations they can be sustained over time due to the savings they generate across health care education in the workplace.