The Los Angeles County Department of Mental Health: Our Journey Toward Integrated Care

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Robin Kay, Ph.D.
Chief Deputy Director

Overview

- Steps Toward Integrated Care
  - The Last Decades: Efforts to Integrate Care
  - MHSA Community Services & Supports Plan
  - MHSA Prevention & Early Intervention
  - The 1115 Waiver Opportunity: LIPH
  - MHSA Innovations Plan
  - Models for the Future

Steps Toward Integrated Care

- The Last Decades: Efforts to Integrate Care
  - Special Programs
    - Older Adults: GENESIS Team
      - Team pairs social worker and nurse
      - Geriatrician as team member
    - Adults with Serious Mental Illness
      - Santa Monica Continuum of Care Project
      - Project 50
      - Selected Partnerships with FQHCs

Steps Toward Integrated Care

- The Last Decade: Efforts to Integrate Care
  - Training and Workforce Development
    - Substance Abuse Issues
      - Hiring of Substance Abuse Specialists
      - Assessment for Co-Occurring Disorders as required component of Adult and Child Initial Assessments
      - STATS COD Measure
      - Development of joint treatment guidelines with SAPC
    - Medical Issues
      - Practice Parameters such as OMD – Parameters for General Health-related Monitoring and Interventions in Adults

Steps Toward Integrated Care

- Mental Health Services Act (MHSA)
  - Community Services & Supports Plan
    - Older Adult Field Capable Clinical Services:
      - IMPACT Model
      - Efforts to Co-locate or Integrate with Primary Care
    - Wellness Centers
      - Nurse Practitioners provide leadership
      - Wellness Activities (e.g., Smoking Cessation)
    - Integration of Substance Abuse Programs in Mental Health Urgent Care Centers
    - System Navigators

Steps Toward Integrated Care

- Mental Health Services Act
  - Prevention & Early Intervention
    - Program-based Project: Primary Care and Behavioral Health
      - MHIP/IMPACT
      - Prevention & Early Treatment of Depression in Primary Care

Steps Toward Integrated Care

- The 1115 Waiver Opportunity: Low Income Health Program (LIHP)
  - Tier I Services
    - Individuals with serious and persistent mental illness and high level of need and risk
    - Delivered through existing network of specialty mental health providers
    - Services include full array of mental health rehabilitation programs

Steps Toward Integrated Care

- The 1115 Waiver Opportunity: Low Income Health Program (LIHP)
  - Tier II Services
    - Individuals with an acute mental health issue and moderate level of need and risk
    - Medical necessity criteria for specialty mental health services
    - Clients identified in primary care settings
    - Ability to benefit from limited focused evidence-based intervention

Steps Toward Integrated Care

- The 1115 Waiver Opportunity: The Low Income Health Plan (LIHP)
  - Tier II services
    - Building the Foundation: Structural Models
      - Co-location of DMH staff in DHS Comprehensive Health Centers
      - Contracting with Community Partners/FQHCs
      - Partnering Legal Entities and Community Partners

Steps Toward Integrated Care

- The 1115 Waiver Opportunity: The Low Income Health Plan (LIHP)
  - Tier II Services
    - Clinical Model for Integrated Care: Mental Health Integration Program (MHIP)
      - Primary Care Screening
      - Referral of those Screening Positive
      - Stepped Model of Care
      - Behavioral Activation and Problem-solving Therapy
      - Registry to Monitor Progress and Outcomes

Steps Toward Integrated Care

- The 1115 Waiver Opportunity: The Low Income Health Plan (LIHP)
  - Tier II Services
    - Fostering integration
    - Developing relationships among agencies and providers through selective partnering
    - Communication: referral forms and exchange of information
    - Training in integration model(s)
    - Professional development and role modification
    - Developing networks of care

Steps Toward Integrated Care

- Innovations Plan: Testing 4 Models
  - Integrated Mobile Health Team
  - Integrated Clinic Model
  - Community-Designed Integrated Service Management Model (ISM)
  - Integrated Peer-Run Model

Steps Toward Integrated Care

- Innovations Plan: Testing 4 Models
  - Integrated Mobile Health Team
    - Using a Housing First model to provide permanent housing to homeless clients and families, combined with a comprehensive single-team approach to providing primary care, mental health and substance abuse services

Steps Toward Integrated Care

- Innovations Plan: Testing 4 Models
  - Integrated Clinic Model
    - A single team approach to providing integrated services in a primary care setting and in a mental health setting
    - Embeds mental health and substance abuse services in physical health clinic sites or embeds physical health services at mental health sites

Steps Toward Integrated Care

- Innovations Plan: Testing 4 Models
  - Community-Designed Integrated Service Management Model (ISM)
    - Utilizing non-traditional healing approaches and culturally-sensitive approaches to care
    - Focus on individual integrated service approaches for Under-Represented Ethnic Populations (UREP) communities:
      - The African/African American
      - Latino
      - Asian Pacific Islander
      - American Indian and
      - Middle Eastern/Eastern European

Steps Toward Integrated Care

- Innovations Plan: Testing 4 Models
  - Integrated Peer-Run Model
    - Residential short term Respite Care services combined with active linkages to health, primary care and substance abuse services.

Steps Toward Integrated Care

- Behavioral Health Home Workgroup
  - Convened by DMH in April, 2011
  - Goals:
    - Define essential and desirable elements of a behavioral health home for Los Angeles County
    - Identify opportunities for pilot programs
  - Proposed Essential Elements

Steps Toward Integrated Care

- Behavioral Health Home Workgroup
  - Proposed Essential Elements
    - Client and Patient-centered, driven by wellness and recovery philosophy
    - Focus on "quadrant 2 and 4" clients – i.e., those with serious risk related to mental health and substance abuse, some with serious medical problems (4)
    - Mental Health and/or substance abuse agencies as leads
    - An identified principal integrated care coordinator

Steps Toward Integrated Care

- Behavioral Health Home Workgroup
  - Proposed Essential Elements
    - A team approach to integrated service delivery including mental health, health, substance abuse and social service specialists
    - Evidence-based and standardized screening of all three domains (physical health, mental health, substance abuse)
    - Development of a collaborative care plan
    - Supportive services such as housing, education, employment

Steps Toward Integrated Care

- Behavioral Health Home Workgroup
  - Proposed Essential Elements
    - Emphasis on outcomes and tracking
    - System capacity and capability for linguistic and cultural appropriateness

Steps Toward Integrated Care

- Additional Projects
  - Information Sharing
    - EMPI, Electronic Health Record
  - Technology
    - Telemental health and consultation

Steps Toward Integrated Care

- For questions or more information, please contact:
  - Robin Kay, Ph.D., Chief Deputy Director
    - (213) 738-4108 Email: rkay@dmh.lacounty.gov
  - Roderick Shaner, M.D., Medical Director
    - (213) 738-4603 Email: rshaner@dmh.lacounty.gov
  - Lisa Wicker, District Chief
    - (213) 738-2297 Email: lawicker@dmh.lacounty.gov
  - Kathleen Kerrigan, District Chief
    - (213) 738-3111 Email: kkerrigan@dmh.lacounty.gov