Successful Treatment of SMI in New Health Care Systems

Integrating Primary Care, Behavioral Care, and Beyond

Roderick Shaner, MD
Medical Director

Los Angeles County Department of Mental Health

The Sea Change in Behavioral Health Treatment: Integration

* The most important health systems challenge facing mental health care is proper integration of health and behavioral health care.
* At stake is a remarkable opportunity to improve medical and social outcomes for those with severe mental illness.

300 years of MH carve-out and reintegration (part 1):

* *1700s:* *Almshouses, jails, homelessness*
* *1800s:* *Benjamin Rush: alienation, moral treatment, and farms.*
* *1900s:* *Adolph Meyer (Johns Hopkins): from farm to hospital & community*
* *1960s:* *JKF: Carving out community MH*
* *1970s:* *SD Medi-Cal: Focus on SMI*

What Community MH Became: A Fragmented System

* MH was last carved out of general health 45 years ago
* Response to perceived insufficient allocation of resources for MH treatment
* Advocates created a better system, with independent funding, more humane care, patient empowerment, and a much broader range of rehabilitative resources.
* Great strides in treatment of mental illness were made, but this carved out system came at terrible cost for those with SMI.

What was Wrong with the Carve-out?

* Biological tx of MI was substandard.
* Integration of psychopharmacologic tx of MH and general medical conditions, which often co-occur, was almost non-existent. (e.g., geriatric medicine).
* Access to addiction medicine tx for co-occurring substance abuse, was very limited.
* MH patients with co-occurring physical illness or addiction were ostracized from primary care and substance abuse tx.

300 years of MH carve-out and reintegration (part 2):

* *1990s:* *Recovery, reintegration, and dynamic tension*
* *2005:* *Steinberg: CA MHSA vs. hospital-based tx*
* *2010:* *Berwick: Large scale redesign with integration of health systems as goal*
* *2014:* *AHRQ: Patient-centered medical homes and the ascendancy of primary care*

ACA and Fresh Start

* In service of the triple aim (lower cost, better population health, better experience of care), health services are reorganizing with patient-centered health homes as primary care hubs.
* Properly done, this eliminates silos and offers a fresh way to integrate behavioral health.
* But there are challenges.

What We Must Develop: Structure to Integrate Primary Care and BH

* Primary care homes with the capacity to manage reasonably stabilized patients with MH challenges, including MH consultation and management of psychopharmacologic needs.
* Behavioral health homes with a broader range of disciplines to permit routine psychopharmacologic management to be delivered in the most cost-effective manner.
* Proper range of rehabilitative services in both settings

California's 2010 1115 Waiver: The Bridge to Healthcare Reform

- Extended Medi-Cal coverage to a large part of the formerly uninsured population.
- Developed medical homes for Medi-Cal population through Medi-cal Physical Health Plans.
- Preserved a substance abuse services carve-out and a specialty mental health carve-out.
- Created projects to test healthcare integration.
- Highlighted the remarkable challenges to providing integrated healthcare to a population with many needs.

California's 2015 1115 Waiver Renewal: Medi-Cal 2020

- Continues the specialty mental health carve-out
- Predicated on greatly enhanced drug Medi-Cal benefit (DMC-ODS Pilots).
- Provides the option of Whole Person Care Pilots

Whole Person Care Target Populations

- With repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement;
- With two or more chronic conditions;
- With mental health and/or substance use disorders;
- Who are currently experiencing homelessness; and/or
- Individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, IMD, county jail, state prisons, or other).

Whole Person Care

- Provides $300 m/yr federal funds ($3 b/5y) for program infrastructure to better integrate, health, behavioral health, and community supports.
- Must be composed of coalitions of agencies and stakeholders, including Health Plan.
- "Medically necessary housing" via "county housing pools"
- Individualized designs

Lessons about SMI Tx after 3 centuries

* Unique health structures [e.g., health homes] are necessary for SMI care, including those that empower and resist stigma
* Integrated dx and tx for general medical conditions, mental illness, and substance abuse are also necessary
* Infrastructure for housing and other social and non-medical services may positively impact other publically financed systems.

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Questions

Roderick Shaner, MD
Rshaner@dmh.lacounty.gov

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