Successful Treatment of SMI in New Health Care Systems

Integrating Primary Care, Behavioral Care, and Beyond

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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: JFK: 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 publicly financed systems.

Questions

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