



Communities taking action to improve depression care in Los Angeles

February 25, 2015

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Dear Carol:

Thank you very much for the opportunity to submit our responses to the key questions for stakeholders surrounding the reorganization and potential realignment of the Los Angeles County health services agencies under a central authority. During our February 4, 2015 CPIC Council meeting, we voted to provide you with a report of the council's responses to the reorganization. As you know, a brief report and set of notes was sent as requested on February 13. We decided to prepare a fuller report both for your office and also to provide support and potential guidance to the three LAC Health Agencies as they move forward under any structure.

Please find the report outlining the key questions for stakeholders with additional recommendations from the CPIC Council. In addition, we are happy to assist the County moving forward with planning, particularly around community engagement and evidence-based strategies for improving services for individuals living in Los Angeles with behavioral health conditions or at risk for these conditions.

We thank you for your time to review our responses and for the opportunity to contribute our recommendations to the reorganization and realignment.

Sincerely,

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On behalf of the CPIC Council, CPIC Team Science Awardees, and invited stakeholders, and with information provided by county agency representatives who attended (please see Report Appendix for complete list).

cc.

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Report to Los Angeles County Executive Office and Health Agencies
Key Questions for Stakeholders:
Community Partners in Care (CPIC) Council Responses
February 2015

The Community Partners in Care Council has been asked to provide responses to the Los Angeles County Executive Office concerning reorganization and potential realignment of Los Angeles County health services agencies under a central health authority. A brief report from stakeholder meetings was provided on 2-13-2015. This is a fuller report to assist in the planning process, structured around the questions the Executive Office posed to guide input.

1) What are or could be the advantages to integration of the current three health departments (DMH, DPH and DHS) under a single umbrella agency?

Advantages:

- Improved coordination and integration of services
- Improved services access through “multiple ports of entry”
- Increased integration of all care services leading to a “system of care,” rather than three distinct systems of care
- Potential for one electronic health record system as opposed to separate data collection systems
- Consolidation of administrative functions such as human resources, data infrastructure, billing/financing, and operations

Potential overarching strategic mission for merger:

A public health system attending to the “culture of health” spanning prevention and attending to social determinants of health (e.g. poverty, environmental, social factors) through enhanced community and patient engagement/outreach (DPH) with healthcare agencies (DMH/DHS).

This option would require mapping the populations served by and functions provided by each agency as there are distinct differences in agency services, populations served and missions/procedures. For example, whereas DHS primarily focuses on health services, DPH and DMH have additional missions, such as addressing disaster preparedness and public health education and outreach; and through the Mental Health Services Act, DMH addresses stigma reduction, suicide prevention and other issues. Any integration or realignment should take into account the unique and combined missions of these agencies, which are quite broad and in an integrated system could be even broader. For example, the reach of a public health framework could be expanded to new areas of health.

Policy context:

When covering behavioral health services, Medicaid is subject to parity rules under the Federal Parity Act, thus integrated solutions must attend to implications of

parity of coverage terms for requirements of services capacities and access.¹ Currently access/capacity for substance abuse services have been limited, for example, owing to lack of parity requirements historically.

2) What disadvantages would you want the Board of Supervisors to be aware of related to the proposed integration? How can these be mitigated?

- a) *Integration history:* Community stakeholders are concerned that there has been a limited history in California of successful integration of behavioral health services. Integration creates specific implications for individuals having or at risk for behavioral health conditions, particularly for severe persistent mental illness, as well as severe alcohol and substance dependence. States and areas implementing integrated care have struggled with achieving integrated behavioral health care in primary care for more prevalent, less severe behavioral health conditions.²⁻⁶ Less is known about how to integrate behavioral care for more severe mental illness, as well as alcohol/substance dependence into primary care in a way that improves health outcomes.⁷
- b) *Input/authority:* Community stakeholders do not feel that they have a meaningful place “at the table” due to the rather rushed and short time frame for planning. The sense that their input may not be meaningful in this short timeframe is quite concerning since the community stakeholders feel that the future health and safety of our communities rely on the successful integration of DPH, DMH, and DHS in a way that meets communities’ needs.
- c) *Behavioral health client needs:* There is a concern that patients with severe behavioral health conditions may be overlooked within an integrated system seated in primary care. Research studies have also shown that medical needs may be missed in specialty care when primary care is not present.^{2,8,9} Other reports note that patients’ medical and behavioral health needs may be inadequately served in primary care relative to patients/clients without severe behavioral health needs.¹⁰ For example, there is nearly a 20 year disparity in mortality for individuals with schizophrenia compared to others primarily due to cardiovascular disease and risk factors related to medication side effects and/or inappropriate or delayed care for medical comorbidities.
- d) *System knowledge/capacity:* There is a risk in healthcare for poor understanding and knowledge of issues related to behavioral health clients. These issues may be apparent in how patients report substance abuse or dependence, how depression is recognized in primary care, and how improvements in behavioral health conditions are tracked.¹¹ For example, persons with substance abuse and dependence often do not disclose these problems. In our current system, most alcohol and substance abuse/dependence services are court-ordered. Persons with behavioral health conditions such as depression are often not recognized in primary care. Even in primary care settings where depression screening is successfully implemented, patient care and outcomes may not improve if

care is not provided or adjusted with failure to improve or with a decline.^{2,3} There are evidence-based models of primary care/behavioral health integration shown to improve health outcomes that emphasize comprehensive management programs through an active, educated role for primary care clinicians, trained care managers, behavioral health specialist partners, and data systems to track outcomes and adjust treatment in relation to outcomes.^{2,12-14}

- e) *Advocacy*: Persons with behavioral health disorders may have cognitive limitations or other issues limiting self-advocacy or have alienated or exhausted family members so that appropriate care requires a stronger orientation towards advocacy in the healthcare system.
- f) *Broader services*: Behavioral health conditions often must be integrated with social and rehabilitation services, especially for low-income populations. Behavioral health conditions can cause a “social drift.” This drift increases the likelihood of people with more severe disorders to become impoverished, and to seek a myriad of health, mental health, substance abuse, and social services in safety-net systems.
- g) *System cultures*: Community stakeholders are concerned about different “cultures” that apply in DHS, DMH and DPH which make integration more challenging. Historically, these different cultures have been partly attributable to different provider orientations, partnering service delivery agencies/providers, and payment structures across agencies, as well as differences in patient populations. For example, a “recovery orientation” toward rehabilitation, quality of life, and shared decision making for persons with severe mental illness is a feature emphasized under the Mental Health Services Act in specialty mental health care, but is a more unfamiliar concept in primary care services.
- h) *Organizational diversity*: Significant diversity exists within the services delivery structure for DPH, DMH, and DHS. Each agency may contract or manage services differently. With the exception of some monitoring and prevention services, the bulk of alcohol and substance abuse services overseen by DPH are contracted out. In contrast, DHS manages directly county hospitals and some outpatient centers but also contracts out. DMH has both directly operated and contracted out services. In particular, integration should be mindful of how restructuring may impact different types of contracts and agencies, as well as patient/client trust and engagement to overcome given with addressing behavioral health needs in LA County.
- i) *Plan responsibilities*: In LA County, DMH works directly with other healthcare entities, and they have also historically provided health plan functions for mental health services, including for privately operated Medicaid mental health services. For this reason, the scope of DMH functions do not fully align with the scope of physical health services managed through DHS, either for Medicaid or for other populations as well. In that respect, the scope of services provided by DHS and DMH cannot be fully integrated. Medicaid reimbursement is changing. Expanded Medicaid

resulted in reimbursement for mild-to-moderate mental health services through Medi-Cal managed care plans (L.A. Care, Health Net, and plan partners). County services and plan services should be considered with the same regard as service agencies.

- j) *MHSA*: The Mental Health Services Act Funding to LA County DMH has resulted in access to evidence-based mental health services, especially for children and families. Examples of such services include dialectical behavioral therapy for adolescent/adult suicide and self-harm; Parent-child Interactional therapy for reducing risk of abuse in children below the age of 8; Multi-systemic therapy for reducing recidivism for adolescents with mental health need; cognitive behavioral therapy for children, adolescents, and adults for anxiety, depression PTSD; and Assertive Community Treatment for adults with schizophrenia and bipolar disorder. The array and accessibility of these mental health services are unusual for any healthcare system. Most private and public healthcare systems do not provide routine access to these high quality treatments that are shown to improve outcomes. It is important to preserve this excellence in evidence-based care.¹⁵ These models are not within the scope of practice for other healthcare providers outside of specialty mental health currently.
- k) *Waivers*: LA County will have a substantial voice in deciding how the upcoming Medicaid waivers will be negotiated between the State of California and CMS. Both Substance Abuse and Mental Health will need a vigorous voice in all of the waiver discussions so that hospital financing concerns do not dominate every aspect of the decision-making processes. One approach over the long-term for matching financing with integration between DMH, DHS, and DPH may be to “carve-in” specialty mental health and substance abuse services into physical health care services. Another approach is to carve-in primary care services into specialty settings when that may result in better overall care for a population. Since the waiver must be budget neutral, and reimbursement under Medicaid for some services may decline, there is potential for greater reliance on capitation and increased capitated payment for enrolled individuals overall by taking dollars currently allocated for specialty mental health and substance abuse together with physical health payments. But there are challenges determining which vulnerable populations who are eligible may enroll and how funds will be managed by the system as a whole while taking into consideration the needs of vulnerable patients with behavioral health conditions. Recent informal discussions with colleagues involved with the Medicaid waiver in New York State suggest patients with behavioral health conditions may not initially enroll in Medicaid or have delays in acceptance of assignment to medical homes. The result can be poor outcomes during a transition period, during which the system does not actually have the assigned capitation rate for unenrolled patients as they are getting sicker. Colleagues in New York indicate that this can create challenges for individuals with cognitive impairments, unstable social/financial situations

(e.g. housing, changing of addresses and phone numbers – leading to poor outcomes over time and payment delays).

2a) How can these factors best be mitigated?

Community accountability and Centers of Excellence: Our community stakeholders do not feel that a top-down approach to accountability will lead to successful integration in a county as large and diverse as Los Angeles. We recommend the creation of an overall community council and local councils that have a meaningful role in supporting and monitoring the accountability of an integrated health authority. The responsibilities of this group should go well beyond an advisory capacity with real decision-making power. In addition, transparency and trust in services may be increased through establishing community centers of excellence to provide information on health, health services, and support for advocacy in diverse communities.^{16,17}

Advocacy groups and stakeholders representing particularly vulnerable populations should have a role in these councils and centers to attend to the special needs of individuals with various challenges, including behavioral health needs.

Key principles of community accountability:

- Two-way knowledge exchange: Communities have expertise in their needs and the assets in the community that may affect health and well-being of members. Two-way exchange between health agencies and community leaders/members is needed to improve health overall;
- Respect, trust and co-leadership: Community trust requires a process of respectful exchange and co-leadership over matters affecting the welfare and well-being of community members and the community as a whole;¹⁸
- Transparency: What is planned; how will it be accomplished; how are services delivered; who is eligible; and how will information be exchanged- these are all examples of key questions to consider when assessing transparency in health outcomes and healthcare services.

Behavioral health capacity building: There should be a meaningful effort to build capacity for the separate and/or integrated systems to address behavioral health needs through evidence-based models that are appropriate for different levels and types of need. Activities that may be required include: training workforces not traditionally involved in healthcare (e.g. community-based agencies), as well as training traditional healthcare providers, tracking and identifying gaps in availability of services, and developing strategic plans to build capacity in known areas of challenge, such as addictions and severe mental illness .

Key principles of health capacity building:

- Support for evidence-based models in under-resourced communities, including behavioral health where historically capacity has been limited;

- Capacity building for providers, community leaders and consumer stakeholders: a healthy system approach requires all to have the orientation and knowledge needed to support an integrated system.

Community health homes fit to communities and populations: Community health homes that span all healthcare sectors, as well as provide leadership and portals of entry that are appropriate for populations should be developed. Input and/or co-leadership of neighborhood health councils and advocacy groups are recommended for these health homes. Since one model is unlikely to fit all populations, it is important to consider what has been learned in implementing previous models, locally and nationally. Vulnerable groups that have not traditionally fared well under certain models should be taken into consideration when designing these community health homes. Some groups may be better served through bringing primary care into addiction or mental health centers.¹¹ Some of these models are currently being piloted in Los Angeles and elsewhere for identifying lessons learned, feasibility and potential outcomes.

Key principles for health homes:

- Support for access through multiple “ports of entry” that include locations of historical trust in the community with adequate knowledge and resources at those entry points;
- Fit health homes to characteristics of communities and assets to support access and quality services.

Models of integrated services for behavioral health clients: There are evidence-based models of services delivery utilizing integrated care systems for behavioral health clients.^{2,12,13} These should be prioritized for implementation. For example, there are collaborative care models for depression and anxiety, some of which have been implemented in LAC either in public or private sectors or both, that are known to improve outcomes. These have been limited in their implementation to co-located clinics. There are also evidence-based models of collaborative care for severe mental illness implemented with primary care and integrated into specialty settings or specialty care integrated into FQHCs. There are also important psychosocial interventions for bipolar disorder, schizophrenia and other psychotic disorders, such as family psycho-education and full-service partnerships. Determining how these types of services will be developed within an integrated care system requires careful consideration. Further, child services are often delivered for behavioral health conditions in school-based settings, where strong relationships exist between LAC and DMH. For example, school-based services for children exposed to community violence are evidence-based and improve both child outcomes and grades.^{19,20} It is important to consider how, for different age groups including children, to integrate services in evidence-based ways. Services integration must consider whether services are delivered in diverse healthcare settings, county services, FQHCS, schools or other settings. Each system should support a range of evidence-based models appropriate for age, clinical and community context.

Key principles for inclusion of evidence-based, behavioral health models:

- Access the range of relevant major behavioral health conditions;
- Identify existing, evidence-based models that are feasible for implementation and acceptable to stakeholders or build capacity to increase acceptability;
- Integrate within existing system supports and, as needed, modify systems to permit evidence-based models that align with health home principles and community accountability principles.

The CPIC Council Approach: Community Partners in Care (CPIC) is a more than decade long effort to develop a community health home model for depression in Los Angeles through combining the principles above.²¹⁻²⁴ This effort culminated in a large randomized trial of community-engaged services for depression compared to a model based on technical assistance to agencies. In both models, a full spectrum of health, mental health, substance abuse, and community-based agencies and social services were included and clients with depression screened across all agencies and followed for initially a year, and recently for three years. The intervention models were based on evidence-based quality improvement programs and treatment approaches for depression, modified in implementation with community input.^{25,26} The evaluation was community co-led in all respects as a community learning enterprise, as recommended above.²⁷ Key agencies in each community supported the collaboration principles, similar to the concept of centers of excellence above. The evaluation findings demonstrated that the collaborative or community-engaged model of implementation, led to greater improvements in mental health-related quality of life, reduced behavioral health hospitalizations by 50%, reduced chronic homelessness and risk factors for chronic homelessness, increased physical activity, and shifted outpatient services somewhat away from specialty medication management toward primary care, faith-based and park and recreation/ community-based depression support services. Thus, the CPIC approach, supported by the CPIC Council, has demonstrated that an integrated system that supports community accountability can lead to substantial health improvements, as well as reductions in indicators of intensive services such as hospitalizations.^{28,29} This effort was accomplished with the collaboration and full support of county services agencies including DMH, DPH and DHS.

Accountability and evaluation: Meaningful indicators of progress and success should be developed overall for integrated services and in particular for vulnerable populations with behavioral health conditions. Documented challenges in meeting needs, limitations in access and quality should be reviewed by healthcare and community stakeholders to modify implementation plans for community health homes. This requires a meaningful data and evaluation strategy, community input, and time to set up this infrastructure.

Key principles for accountability and evaluation:

- Develop meaningful indicators tracking key outcomes for communities and measures of progress of integration;
- Include indicators that might indicate the system is working and to determine areas where it may not be working or where people are falling into gaps in the system, unmet need;
- Think creatively about available data sources across all agencies, at levels of community, system, providers, and clients;
- Partner with evaluators to ensure that the data can be appropriately interpreted;
- Partner with communities to ensure that the successes and needs for improvement are transparent and understood and available in communities.

3) Other than a model of an agency director and three distinct reporting departments, what additional models should be considered?

As noted above, community stakeholders recommend community centers of excellence and meaningful council coalitions with shared authority and monitoring responsibility for local and public services.

Services versus plan function integration: The main model being considered, as we understand it, focuses on integrated services. Some plan of integration or coordination may be needed for insurance plan functions given DMH's plan scope for Medicaid and DPH's plan scope for substance abuse services. That aspect may not integrate into a central authority focusing on services when the services agencies otherwise do not have a plan function.

4) What could be considered as a centralized administrative agency functions and along what timeline?

What can be centralized likely depends on how centralization occurs. In particular, centralized functions would need to take into account the full range of functions of the three agencies, which currently have many distinct features, and whether any of those functions would be redistributed in an integrated or coordinated agency.

For example, the community assessment and planning functions of DPH are a major activity mandated by CDC/HHS, while there are more limited outreach activities of DHS (e.g., recently community health workers) and to some extent, DMH (e.g., prevention, early intervention, consumer development, and anti-discrimination/suicide-prevention activities). Moreover, some of those community functions are related to distinct funding authorities (such as MHSA or CDC) and thus not easily combined in authorities that do not currently respond to those funding entities. Planning is needed to anticipate how a reorganized agency relationship can strengthen other agencies and what the implications are for lines of funding and responsibility.

Nominations of agencies for the functions that they believe could be centralized would be an important activity for identifying an overall consolidation strategy.

5) What should not be centralized administrative agency functions?

It is possible that administrative functions related to distinct authorities may be difficult to centralize; such as the distinct funding of the DPH preparedness division by CDC, or the MHSA authority of DMH and Medicaid plan functions.

6) Are there some service-related functions that currently occur in all three departments that should be combined, for example Housing?

The functional elements of different agencies would have to be clarified for community partners. Our community agencies, for example, are not aware that a housing function is common across DHS, DMH and DPH or how those functions relate to other agencies, such as counting housing authority or social services. Information is needed for community stakeholders on the range of functions by department to comment meaningfully on implications for functional alignment.

7) Please share your thoughts on implementation timeline and process.

One of the most common themes for our community partners is that given the importance of successfully handling this transition, the planning seems rushed. This haste is of particular concern for the consumer advocacy groups. It is important to get this right.

Other comments:

- *Address disparities in services access, quality, and outcomes specific to local communities.*

Los Angeles is a highly diverse set of communities. There are multiple disparities in services availability, quality, capacities for evidence-based programs, and outcomes within and across communities; this is widely known through indicators such as rates of avoidable (ambulatory-sensitive) hospitalizations.³⁰ It is imperative in planning for an integrated system to attend to the needs of different cultural, gender, and socioeconomic groups to minimize and reduce disparities in access, quality, and outcomes.³¹ Many of the principles for community accountability noted above are also central recommendations for existing national groups and for efforts to reduce such disparities (e.g., recommendations for participatory co-leadership with communities). It is imperative to learn from these lessons and to set an example of an excellent system of care that can match community needs and strength with community engagement, education, co-leadership, and excellence in services, including for clients and community members with behavioral health conditions.¹⁷

- *We are there to help:*

The CPIC Council and its stakeholders, which is expanding through partnering with the Los Angeles County Health Neighborhood Initiatives, appreciates that implementing the scope of our recommendations requires considerable effort,

particularly around areas of community engagement and translation of community input into system-level quality improvement initiatives, and a clinical and business plan. The Council can assist with community engagement, establishing structures, matching community engagement and community input to evidence-based strategies, and working with business plan considerations, all of which we had to do on a smaller scale to design and implement the CPIC initiative described above.^{21,22}

CPIC Council, CPIC Team Science Awardees, and invited stakeholders framed the report, and county agency representatives attended to provide information:

Alex Li	Janet Perkins	Nicolle Perras
Ana Ramos	Jean Marrie Harris	Nygabingi Kuti
Andrea Jones	Jeanne Miranda	Paul Arns
Andrea Welsing	Jeffrey Guzenhauser	Paul Kogel
Anish Mahajan	Jeffrey Ring	Paul Simon
Audrey Fell	Jennifer Tang	Pluscedia Williams
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Beatriz Soliz	Jill Rotenberg	Reverend Stone
Beryl Brooks	Jim Gilmore	Richard Van Horn
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