The Importance of Preserving California’s County Operated Mental Health Carve Out of Specialty Mental Health Services for Higher Needs Clients

Association of Community Human Service Agencies
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What Is a Mental Health “Carve Out”? 

A “carve out” is defined as “a service not covered in a health insurance contract. It is usually reimbursed according to a different arrangement or rate formula than those specified under the contract umbrella.”¹ In a mental health “carve out,” mental health services are delivered by a separate set of qualified providers who provide mental health benefits that are “carved out” from the basic set of benefits provided by a health insurance plan.

Over the past several years, there has been a shift away from carve-outs by specialty (e.g., behavioral health, cancer treatment, pharmaceuticals) to carve-outs by consumer type (e.g., persons with serious mental illness). Today, two delivery systems are emerging as states seek to improve care coordination for complex consumers: 1) specialty coordinated care systems for high-cost complex consumers; and 2) primary care directed models for the rest of the population.²

It is important to note that while historically most mental health carve outs have been operated by for profit behavioral health managed care companies, in California specialty mental health services have been managed by the counties. This distinction is critical to remember when analyzing California’s mental health carve out, which is both government operated and focused on the highest need segment of the State’s mental health population.

Background on California’s Mental Health Carve Out

From 1995 through 1998, the State of California consolidated its Fee-for-Service and Short-Doyle Medi-Cal programs into one “carved out” specialty mental health managed care program operated by the counties, under a Medicaid 1915(b) Freedom of Choice waiver. Under Medi-Cal Consolidation, counties were given the right of first refusal for taking on the new responsibility of managing specialty mental health care, under which all Medi-Cal beneficiaries must receive their specialty mental health services through the county Mental Health Plan (MHP) and the counties assume the entitlement risk.³

“Specialty mental health services” are provided to children and adults with moderate/severe mental illness with significant functional impairment. Today these

¹ The Free Dictionary – Medical Dictionary.
² “Update on Behavioral Health Carve-Outs From Medicaid MCOs,” Morgan, Laura, OPEN MINDS, June 20, 2014.
³ California Mental Health Directors’ Association Overview of California Community Mental Health Funding.
specialty mental health services continue to be managed by the counties, while non-specialty mental health services for Medi-Cal beneficiaries are the responsibility of Medi-Cal Managed Care plans and non-specialty Fee-for-Service providers.

According to the California Department of Health Care Services (DHCS), when deciding on the Medi-Cal Consolidation the State considered research which “demonstrated that a single integrated system of care is critical for successful treatment of persistent mental illness and emotional disturbance and that the needs of persons with mental illness are not always paid adequate attention to in an all inclusive health care managed care system.” (Emphasis added.) As a result, “the decision was made to ‘carve out’ specialty mental health services from the rest of Medi-Cal managed care,” with “a distinction [being] made between specialty mental health care (those services requiring the services of a specialist in mental health) and general mental health care needs (those needs which could be met by a general health care practitioner).”

Further according to DHCS, “the decision to provide specialty mental services in California through a single plan in each county logically followed the decision to carve out specialty mental health services and to consolidate the two mental health delivery systems,” necessitating a Medicaid Freedom of Choice waiver. “The selection of county mental health departments to be the single managed care plan for consolidated specialty mental health was a natural outgrowth of the extensive experience counties have had in serving the mental health needs of communities.” (Emphasis added.)

California’s Mental Health Carve Out Decision Proves to Be A Wise One
While California made the decision to invest its managed care responsibilities for specialty mental health in the counties during the initial push for behavioral health managed care programs in the 1990s, the majority of other states decided to use a model run by for profit managed care companies. California’s decision proved to be a wise and prudent one, as the counties were able to re-invest savings from managing care for this high needs population, most particularly from a shift from inpatient services to enhanced community-based services. These savings were re-invested back into the State’s mental health service delivery system rather than being siphoned off as profits for private managed care companies.

Los Angeles County Mental Health Network of Care:  A Shining Example of California’s County Operated Mental Health Carve Out for Specialty Mental Health Services
The vision of the Los Angeles County Mental Health Network of Care (Network), which includes both nonprofit community mental health agencies and County operated programs, under the management of the Los Angeles County Department of Mental Health, is that all County residents in need should receive client-driven integrated

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4 “MCMHP Consolidation and Managed Care,” California Department of Health Care Services, DHCS.CA.GOV Website, September 15, 2014.
5 Ibid.
6 See Appendix A – “The Los Angeles County Mental Health Network of Care: The Provider of Choice for Mental Health Services in the Era of Health Reform.”
behavioral health services that include high quality evidence-based mental health, substance use, and supportive social services. The Network is responsible for the care of persons with significant functional impairment qualifying for specialty mental health services. These persons receive community-based services rooted in the principles of resiliency for children and recovery for adults, which for children focus on integrated systems of care and for adults focus on a psychosocial rehabilitation model of care.

The advantages of the Los Angeles County Department of Mental Health’s Network are many, and include: 1) it provides a comprehensive, full continuum of mental health services, including screening and assessment, prevention and early intervention, case management, counseling and psychotherapy, rehabilitation services, employment and housing support, peer supports, and crisis response and stabilization; 2) it consists of experts providing the highest quality care in the most cost effective manner for individuals with complex needs, demonstrating highly successful outcomes; 3) it offers behavioral health services integrated with primary care using a variety of strategies; 4) it is known for delivering unparalleled culturally competent, specialty mental health services; 5) it is nationally known for its prevention and early intervention services delivered through an array of evidence-based practices; and 6) it has a well trained, multilingual workforce with unique skills and experience in delivering community-based services to children and adults with significant mental illness.

Not only are services provided by the Network delivered in collaboration with other County Departments and educational institutions, but these services are provided in locations often preferred by clients and families, including homes, preschools, schools, health centers, domestic violence shelters, senior centers, and libraries. Additionally, the Network’s emphasis on field-based services allows it to reach those who are in desperate need of services but face challenges in accessing care.

These Network characteristics, and the Network’s extensive nature and highly developed service delivery system which took many years to develop, cannot be replicated and would be lost without the current county operated mental health carve out, as primary healthcare systems and private managed care companies simply do not deliver services in this manner. Also not to be forgotten are the millions of privately fund raised dollars that the County’s nonprofit agencies today donate annually to the public service delivery system to enhance care for significantly mentally ill adults and children and their families.

In terms of successful outcomes, for children with serious emotional disturbances in intensive Full Service Partnership programs in Los Angeles County in FY 2012-13, there was a 35% reduction in the number of children psychiatrically hospitalized and a 40% reduction in the number of days children were psychiatrically hospitalized. For transition age youth in Full Service Partnership programs during that period, there was a 60% decrease in the number of youth sent to Juvenile Hall and a 59% decrease in the number of days of incarceration in Juvenile Hall. For adults in Full Service Partnership programs
during that period, there was a 50% decrease in the number of days incarcerated and an enormous 71% decrease in the number of days homeless.\(^7\)

**Reports and Analysis of Managed Care and Mental Health Provide Information Which Reinforces the Need for Continued Utilization of Government Operated Mental Health Carve Outs for Specialty Mental Health Services**

A number of problems have been identified that may arise in using managed care particularly in public mental health systems, including: an incentive in a risk-based contract to under serve/under treat people with serious disorders, an undue focus on acute care and neglect of rehabilitation and other services with significant long-term payoff in improved functioning, and difficulties in consistently ensuring quality and outcomes. Accordingly, while many states initially looked to large managed behavioral health care companies when care for persons with serious mental illnesses first began to be carved out from other managed health care services, since then there has been an increasing assumption by states of their own managed care, increasing reliance on traditional safety-net providers, and increasing use by states of county-based systems.\(^8\)

“The debate over the use of private for-profit companies [was] compounded by rhetoric that [had] exaggerated the potential of managed care to solve problems. To enter this market, many plans oversold their abilities.”\(^9\) “States that have chosen…to operate their own managed care programs…have been responding in part to concerns that the for-profit vendors do not have the skills to run complex public mental health systems, which cater to those with the most severe mental illnesses.”\(^10\) At the same time, states and counties themselves have worked to develop managed care systems to maximize the use of their limited public dollars. **Outcomes have been impressive.**

According to a 2003 State Department of Mental Health Report to the California Legislature, intensive community mental health services provided to high risk individuals diagnosed with serious mental illness in three California counties, including Los Angeles, revealed significant reductions in days of incarceration, homelessness, and hospitalization. Days incarcerated dropped 72 percent, the number of days spent homeless dropped 67 percent, and the number of hospital days dropped 67 percent.\(^11\)

According to a survey of all California counties in 2011, there were dramatic reductions in the number of very high cost individuals in intensive Full Service Partnership programs who experienced homelessness, hospitalization, or incarceration. There were also dramatic reductions in the duration of their days homeless, in hospitals, or in jails. There was a 66% reduction in days homeless and a 58% reduction in people homeless; a

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\(^7\) Mental Health Services Act Three Year Program & Expenditure Plan Fiscal Years 2014-15 Through 2016-17, Los Angeles County Department of Mental Health, July 15, 2014.

\(^8\) “Effective Public Management of Mental Health Care: Views from States on Medicaid Reforms That Enhance Service Integration and Accountability,” Bazelon Center for Mental Health Law, May 2000.

\(^9\) Ibid.

\(^10\) Ibid.

\(^11\) “Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness: A Report to the Legislature,” California Department of Mental Health, Mayberg, 2003.
35% reduction in days hospitalized and a 39% reduction in people hospitalized; a 48% reduction in days in jail and a 47% decrease in people jailed. Given that these individuals are among the hardest to serve, this success is even more noteworthy.\(^\text{12}\)

In sum, it is clear that cost effective, comprehensive, community-based psychosocial rehabilitation model services have proven extremely effective in reducing very costly inpatient and emergency services. According to a cost analysis of FY 2009-10 Full Service Partnership Programs by the University of California, Los Angeles, which compared per-client program expenditures with cost savings realized throughout the program, there were over $50 million in cost savings for over 4,500 new adult enrollees.\(^\text{13}\)

So what about children’s mental health services? The answer is that a carve out for children with significant mental illness has allowed families to maintain established networks of providers and access to specialists and services that managed care discourages. Moreover, the focus of treatment is not just on the individual child but on his/her family as well, which is critical to success. Thousands of children are treated annually in an effective wraparound model of care and in Full Service Partnerships, and the Los Angeles County Department of Mental Health has been working to supplement its long established systems of care model with the development of Health Neighborhoods. The bottom line is that these types of program models are simply outside the scope and purview of private managed care companies.

It has taken many years for the county to successfully develop its systems of care model and for county operated children’s programs to develop critical ties to their local communities and community resources, along with vitally important school-based programs and in-home mental health services for children. Nonprofit agencies, which deliver a significant portion of these services, are governed by community-based boards of directors which reinforce those community ties. In addition, the children’s system of care has made a huge investment of resources in developing expertise in the utilization of evidence based practices, which have proven very effective in delivering care.

According to an important study published by the National Technical Assistance Center for Children’s Mental Health in partnership with SAMHSA, the children’s mental health system of care approach, which “involves collaboration across agencies, providers, and families to improve access and expand the array of high-quality services and supports that are home and community-based…,” “has gained broad acceptance over the past 25 years as states and communities have recognized that traditional service delivery structures and practices are not successful, particularly for children and youth with serious and complex disorders who are involved with multiple child serving systems.”\(^\text{14}\)


\(^{13}\) Ibid.

Further, “[r]esearch and evaluation results from the Children’s Mental Health Initiative over the past 15 years have consistently found that the implementation of the system of care approach results in positive outcomes for children and their families, such as improvements in clinical and functional outcomes, increases in behavioral and emotional strengths, reduction in suicide attempts, improvement in school performance and attendance, fewer contacts with law enforcement, reductions in reliance on inpatient care, and more stable living situations.”15 (Emphasis added.)

**Conclusion**

There are two main arguments made in support of the carve out concept. The first is that “a specialty organization is helpful in managing costs and the quality and appropriateness of mental health care” and the second is that a carve-out “protects or sets aside a designated level of funding for MH/SA services.”16 While some may try to argue that a carved-out mental health system managed by the counties might not seem ideal for providing integrated physical and mental health care, it is important to recognize that there are other better ways to integrate care besides a single method of payment in a carved in system, which would eliminate the significant benefits of a carved out specialty mental health system, outlined above. Even with the mental health carve-out, integrated care can occur through the development of integrated service delivery models, which the Los Angeles County Department of Mental Health has pursued aggressively over the past couple of years.17

To quote from the children’s system of care study done in partnership with SAMHSA, “Although health reform is seen as an opportunity to better integrate physical health and behavioral health care, a concern is that research on managed care has found that when physical and behavioral health are integrated into one organization (perhaps like an ACO), behavioral health services lose focus, particularly when specific resources are not designated for those services. ‘Carving out’ behavioral health has tended to result in greater expertise, resources, and better behavioral health outcomes, without necessarily sacrificing coordination with physical health services.”18 (Emphasis added.)

“National experience suggests that carve-in systems are strictly a financial arrangement that has no bearing on whether or not care is coordinated. Most MCOs ‘downstream risk’ their mental health services to yet another managed care organization. These arrangements create barriers to care and siphon off needed dollars from care to administrative overhead or profit margins.”19

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15 Ibid.
17 See Appendix B – “Los Angeles County Mental Health Programs Promoting Integrated Care.”
At the same time, even mental health advocates acknowledge today that “cost management is a legitimate and ethically necessary target for health care policy.”

Given the lack of unlimited public resources to treat our most seriously ill clients, there is a need to ensure that the limited funds we are given are utilized most cost effectively to ensure that we best maximize our resources in support of those clients that rely on the public safety net. The real question is not whether care should be managed, and limited public resources most effectively utilized, but rather who should manage that care and how should it be managed.

Common sense dictates that it is better to have public entities adopt, utilize, and refine managed care techniques to ensure the maximization of limited public mental health funds rather than paying private managed care companies that have incentives to limit care to maximize profits with those limited funds. The current California system of care for specialty mental health services, managed by county mental health plans with services delivered by county networks that include both county and community-based providers, insures that providing the best possible quality client care with those limited public resources, rather than maximizing managed care company profits, continues to be the highest priority.

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20 “Effective Public Management of Mental Health Care,” Bazelon Center for Mental Health Law.
COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

The Los Angeles County Mental Health Network of Care: The Provider of Choice for Mental Health Services in the Era of Health Reform

**Our Vision:** All Los Angeles County residents in need should receive client-driven integrated behavioral health services that include high quality evidence-based mental health, substance use, and supportive social services. These services should be delivered by specialty behavioral health practitioners, integrated with primary care through care coordinators equipped to navigate all systems touched by our clients.

The Los Angeles County Department of Mental Health is ideally suited to be the public sector behavioral health provider network in the world of health reform. We are a willing and able partner in helping Los Angeles County to deliver on health reform's "triple aim" of improving clients’ experience with health care, enhancing the health of county residents, and reducing overall costs.

**Our Advantages:** Our provider network is ready for the challenge of health reform as:

- We maintain the most comprehensive mental health system in the United States.
- We are experts in providing the highest quality care in the most cost effective manner for individuals with complex needs, demonstrating highly successful outcomes.
- We offer behavioral health services integrated with primary care using a variety of strategies.
- We are known for delivering unparalleled, culturally competent, specialty mental health services.
- We take pride in supporting the County's mission by delivering integrated services that are delivered by no other mental health entity.
- We are nationally known for our prevention and early intervention services delivered through an array of evidence-based practices.
- We have the best practice knowledge and trained and skilled workforce necessary to deliver behavioral health services in 2014 and thereafter.

We believe that the Los Angeles County Department of Mental Health and our community agency partners are the best qualified mental health provider network for 2014 and beyond. No other system can match the scope of our network or the expertise and cultural diversity of our workforce. We offer a complete continuum of care for all age groups with proven outcomes.
COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

White Paper: The Los Angeles County Mental Health Network of Care: The Provider of Choice for Mental Health Services in the Era of Health Reform

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The Los Angeles County Department of Mental Health is ideally suited to be the public sector behavioral health provider network in the world of health reform. We are a willing and able partner in helping Los Angeles County to deliver on health reform’s “triple aim” of improving clients’ experience of health care, enhancing the health of county residents, and reducing overall costs.

Our Advantages: Our provider network is ready for the challenge of health reform for all of the reasons delineated below.

1. We maintain the most comprehensive mental health system in the United States.

With an annual budget of $1.9 billion, the Los Angeles County Department of Mental Health (LAC-DMH) is the largest public sector mental health system in the United States. Each year, 250,000 children, adolescents, adults and older adults are successfully served through an extensive network of over 120 provider agencies and 35 directly operated county outpatient clinics. Our clinical staff includes, but is not limited to: psychiatrists; nurses; psychologists; social workers; MFTs; medical case workers; and specialists in supportive housing, education and employment. Increasingly, consumers and family members augment our interdisciplinary teams and provide sensitive care coordination through their lived experience, knowledge of the needs of individuals with mental illness, and familiarity with the community in which they live. Our network of services is geographically dispersed, as residents of Los Angeles County can access services for all age groups in all eight Service Planning Areas (SPAs) and all five Supervisiorial Districts.

A distinguishing component of our comprehensive system of care is the extent to which mental health services are delivered in collaboration with other County Departments, health centers and educational institutions. We provide services in locations preferred by our clients and families, including homes, preschools, schools, health centers, domestic violence...
shelters, senior centers, libraries, and Wellness Centers. Our emphasis on field-based services enables us to reach those who are in desperate need of services but face challenges in accessing care. Our capacity to deliver field-based services ensures that best practices for treating vulnerable children, transition age youth and older adults are the standard of care.

The extensive nature of this highly developed service delivery system cannot be replicated. Moreover, the system's comprehensive continuum of services for all age groups enables us to maintain continuity of care for children, adolescents, adults and older adults as individuals' mental health needs may vary in intensity over time, and as they face transitions throughout their lifetimes.

2. **We are experts in providing the highest quality care in the most cost effective manner possible for individuals with complex needs, demonstrating highly successful outcomes.**

From the inception of California's 1915b waiver and the development of the specialty mental health carve-out, LAC-DMH has become the preeminent provider of services for individuals with serious mental illness and co-occurring disorders. In 2010-2011, the Department delivered intensive Full Service Partnership (FSP) services to 3,180 children and 1,620 adolescents with serious emotional disturbances as well as 4,672 adults and 406 older adults with serious and persistent mental illness. The priority populations for FSPs include those who are homeless, who have co-occurring substance abuse disorders and who are unable or unwilling to come to traditional mental health facilities to receive services. Our success has resulted in decreased hospital costs, lowered rates of incarceration for youth and adults, and a dramatic decrease in homelessness for all age groups, with a corresponding increase in the ability of clients to live independently.

**Services for Children and Youth**

The highly successful Children's System of Care served as the precursor for the design of Full Service Partnership services (funded by Mental Health Services Act) for children and youth. The focus of these intensive treatment programs is to increase the resiliency of children and youth by building protective factors (improved family cohesion, academic success, ability to enjoy peer relationships) in order to achieve the goal of enhanced emotional and social well-being. Current data substantiates the success of this approach. For example:

- For children in Full Service Partnership Programs there was a 31% decrease in the number of clients that were hospitalized with a 24% decrease in the number of days spent in the hospital after treatment compared with the year prior to receiving intensive care
- For adolescents in Full Service Partnership Programs, there was a 63% decrease in the number of youth sent to juvenile hall and a 49% decrease in the number of days of incarceration in juvenile hall after initiation of treatment compared with the year prior to enrollment in a full service partnership program
Services for Adults and Older Adults
The following characterizes the approach of LAC-DMH directly operated and community partner agencies with regard to high need/high risk populations: 1) integrated assessment and treatment of co-occurring disorders as a basic standard of care; 2) endorsement of the recovery model in all programs; 3) consumer involvement to drive service delivery and individual care including the development of career pathways for clients in recovery; 4) involvement of family members through collaboration with NAMI, development of career opportunities for parent partners and family members (service extenders) who participate in interdisciplinary treatment teams; 5) expertise in rehabilitative technologies required for recovery, including supportive housing, supported employment, supported education; 6) outreach and engagement for hard-to-reach individuals, including delivery of services in non-traditional settings when necessary; 7) well-developed multi-disciplinary team approach; and 8) specially trained psychiatrists accustomed to complex psychotropic medication management.

Achieved outcomes support the effectiveness of our approach. For example:

* For adults: 22% decrease in the number of clients that were incarcerated and a 45% decrease in the number of days in jail for enrolled individuals
* For older adults: a 41% decrease in the number of clients that were homeless and a 67% decrease in the number of days clients were homeless in the year following enrollment compared with the prior year

3. **We offer behavioral health services integrated with primary care using a variety of strategies.**

The Department of Mental Health currently delivers integrated behavioral health services in collaboration with primary care through:

* Delivery of evidence-based behavioral health services in federally qualified health centers
* Co-location of primary care service delivery teams in specialty mental health settings including residential treatment programs
* Partnerships between primary care clinics and outpatient mental health providers through strategic alignment in all areas of Los Angeles County
* Implementation of Innovative Integrated treatment programs including:
  * 5 Integrated Mobile Health Teams that deliver integrated primary care and mental health services to homeless individuals. These teams collaborate with permanent supportive housing developers to place individuals in housing and deliver on-site behavioral health services once clients are in residence
  * 14 Integrated Service Models that explore cultural adaptations of integrated primary care-behavioral health teams for individuals in Latino, Asian-Pacific Islander, Eastern European, and African American communities
  * 5 Integrated Clinic Models that deliver holistic treatment services through an integrated primary care-mental health team through two structural alternatives:
Providing mental health services for those with serious medical problems has been shown to improve health outcomes, drive down costs and improve the quality of life for both patients and their families.

4. **We are known for delivering unparalleled, culturally competent, specialty mental health services.**

The County mental health system is highly responsive to the disproportionate need for mental health services experienced by public beneficiaries, who have a higher need for mental health services compared to the general public. This need is represented by high rates of poverty, exposure to violence, unemployment, transitory housing and homelessness; poor chronic disease management (cardiovascular, diabetes, pulmonary, etc.); and early disruption in positive attachment to one’s primary caregiver (due to parental mental illness, substance dependency, and/or incarceration; out-of-home placement; and/or abuse or neglect).

The services delivered by the Los Angeles County Department of Mental Health’s network of providers are linguistically and culturally competent. Services are delivered in languages preferred by clients and families including: Spanish, Arabic, Cambodian, Cantonese, Farsi, Korean, Mandarin, Russian, Tagalog and Vietnamese. Treatment interventions are focused on meeting the needs of our diverse community. For example, a highlight of our Mental Health Services Innovation Program is the Integrated Services Model, offering specific cultural adaptations for integrated primary care-behavioral health teams. These Innovations teams ensure culturally appropriate outreach and engagement of those who have historically remained underserved.

5. **We take pride in supporting the County’s mission by delivering integrated services that are delivered by no other mental health entity.**

The Department of Mental Health takes ownership of the importance of delivering the highest quality services to those who are the responsibility of the County. DMH collaborates with the Department of Children and Family Services, Probation Department, Los Angeles Sheriff’s Department, and the Department of Health Services in delivering specialty services for children in foster care, youth in probation halls and camps, adults and older adults incarcerated in County jails and those who require public health services. We deliver these services using specialized approaches that are initiated in institutional settings, continue as clients transition to the community and are ultimately provided in non-traditional settings such as schools and homes.

6. **We are nationally known for our prevention and early intervention services delivered through an array of evidence-based practices.**
Each year, DMH spends approximately $30 million dollars for services intended to reduce stigma, prevent suicide and intervene early with those at risk of developing lifelong mental health problems. We have trained over 3,000 individuals to deliver evidence-based practices with demonstrated effectiveness in:

- Decreasing parental stress in order to preserve families
- Improving the ability of youth to make positive choices, including avoiding substance use and risky behaviors
- Decreasing anxiety and depression in children so they are able to meet their educational goals
- Assisting those who have experienced a serious trauma or life crisis, enabling them to return to important roles and activities
- Addressing bullying in schools in order to ensure that all children are safe as they learn
- Enhancing parents’ skills and interactions with their children to build stronger families.

7. **We have the best practice knowledge and trained and skilled workforce necessary to deliver mental health services in 2014 and thereafter.**

Delivery of integrated behavioral care rests on three key factors: 1) expertise in care coordination and care transitions; 2) use of evidence-based practices specifically targeted to integrated care programs; and 3) development of an enhanced workforce to meet the expanded needs of the MediCaid expansion. The Los Angeles County Department of Mental Health and our community partners have the capacity, the knowledge, and the skills to meet the challenges that lie ahead as leaders in all three of these areas.

- Care coordination. In order to effectively respond to the multiple and complex challenges faced by our clients, we have developed expertise in care coordination. We have developed a system of peer bridgers and system navigators who support clients through transitions from higher levels of care, often in inpatient settings, to the community thereby ensuring successful reintegration and prevention of recidivism.

- Evidence-based practices targeted to integrated primary care/mental health programs. LAC-DMH has invested heavily in training and implementing specific evidence-based practices including the Mental Health Integration Program (MHIP) and PEARLS, developed by the University of Washington. Over 200 professionals have been trained to deliver these services with more being trained on a regular basis. Crisis-oriented treatment and cognitive-behavioral interventions are also used routinely to reduce depression, anxiety and address trauma for those we serve.

- Enhanced workforce. LAC-DMH has adopted several strategies for developing the enhanced workforce that will be critical to meet the demands anticipated under the Medicaid expansion. We have implemented the following programs:
  - Community Health Worker Program, a collaboration between SEIU, DHS and DMH. Workers are trained to work in both mental health and health settings, allowing them to assist clients identified in one setting that require assistance from the other.
○ Promotoras Programs. LAC-DMH has collaborated with 3 contract agencies and one directly operated program to develop mental health promotoras: culturally sensitive natural helpers who can serve as coaches and navigators while relying on their connection to and knowledge of their own communities.

○ Health Navigators. A collaboration between USC and Pacific Care, the health navigator program trains individuals in recovery to work in integrated mental health-primary care settings. An internship program ensures that skills are applied in real-life settings.

In summary, we believe that the Los Angeles County Department of Mental Health and its community agency partners should be the mental health provider network for 2014 and beyond. No other entity can match the scope of our network or the expertise and cultural diversity of our workforce. We offer a complete continuum of care for all age groups with proven outcomes.
COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

Los Angeles County Mental Health Programs Promoting Integrated Care

A review of carved out mental health programs in Los Angeles County is incomplete without highlighting examples of successful integration of health – mental health – and substance use disorder treatment that have been implemented by the Los Angeles County Department of Mental Health (DMH) over the past decade without an integrated payment system. These fall within three major models of service integration for high risk clients:

- Integrated Cross-Agency Teams
- Integration of Specialty Mental Health into Primary Care or Other Non-Specialty Settings
- Integration of Primary Care into Specialty Mental Health Settings

Examples of each model follow.

Integrated Teams Composed of Health, Mental Health and Substance Use Treatment Providers

Integrated cross-agency teams enable providers to contribute their unique expertise to a project that serves an identified group of clients. While one agency typically assumes leadership for the purpose of organizing the work of the team, all providers participate in regular meetings and develop a shared care plan for all clients. Additional entities, including the Department of Public Social Services (DPSS) and housing developers, are often integral members of the team to ensure establishment of benefits and housing services and supports. Examples of successful Integrated Team programs include:

- Project 50: Fifty individuals at highest risk of dying on the streets of skid row were identified and engaged by an outreach team composed of DMH, the Los Angeles Homeless Services Administration (LAHSA), DPSS, and the Veterans Administration. Ongoing services are provided by DMH or its contract providers, Public Health Substance Abuse Prevention and Control providers, health agencies (typically Federally Qualified Health Centers, or FQHCs), DPSS, and housing developers. In addition to improved health and mental health status, P-50 demonstrated significant savings. Cost of hospital inpatient stays decreased from $677,000 in the year prior to program inception to $185,000 for enrolled clients in the year after enrollment. Cost of days in jail decreased from $79,000 to $15,000 prior to and after enrollment respectively.
- Mental Health Services Act Innovations Programs: Three Innovations models are currently in operation, including:
  - Integrated Clinic Model: Teams are composed of mental health providers, FQHCs and substance abuse providers. In some instances mental health services are embedded within medical
clinics, with the medical clinics providing administrative leadership for the teams, while in other cases mental health agencies take the lead, providing daily care planning meetings and organizing the work of the team.

- **Integrated Mobile Health Team:** Focuses on the needs of individuals who are chronically homeless at the time of admission. Teams outreach to and engage homeless clients and assist in moving them into housing by working with housing developers. Supportive services are provided on-site and in community locations.

- **Integrated Services Management for Underserved Ethnic Populations:** Services are delivered by agencies with special expertise in working with African American, Latino, Asian Pacific Islander, Native American and Middle Eastern/Eastern European clients. Culturally relevant outreach and service strategies are interwoven with health, mental health, and substance use disorder services delivered by an integrated cross-agency team.

While the outcome studies of the Innovation Programs are still being conducted, initial data analysis supports the success of these programs. More specifically, clients enrolled in all three models have reported improvements in overall health, enhanced ability to manage their illnesses, and decreases in illicit drug use. Homelessness and psychiatric hospital admissions have also decreased for some of the models.

**Integration of Specialty Mental Health into Primary Care or Other Non-Specialty Settings**

Beginning with the Low Income Health Plan, DMH introduced mental health teams into primary care settings, such as the Los Angeles County Department of Health Services (DHS) and various FQHCs that served as contractors of DHS for Healthy Way LA. This arrangement has allowed individuals who meet the criteria for specialty mental health care to be successfully treated in a familiar primary care setting by those trained to address their specialty needs.

This option is often preferred when clients cannot come to a free-standing mental health specialty clinic and/or when they do not require a full array of rehabilitation services. Outcomes have been very positive, with adults treated by specialty providers in primary care settings demonstrating significant decreases in depression and anxiety. Additional examples include: the delivery of DMH specialty mental health services for children and youth in school health centers that have FQHCs as anchor tenants; and the GENESIS program, which delivers services to frail older adults in field based settings such as senior centers and homes through teams composed of nurses, social workers, a geriatric psychiatrist, and a gerontologist.
Integration of Primary Care into Specialty Mental Health Settings

Recent surveys of adults with serious and persistent mental illness in DMH directly operated programs have identified the desire of the majority of individuals to receive basic medical screening and primary care services within the mental health clinic where they receive their mental health care – i.e., in a “behavioral health home.” Examples of successful behavioral health home programs include:

- Mobile primary care teams offered by FQHCs that establish “mini-clinics” within mental health agencies at specified times each week. For example, JWCH delivers primary care services in exam rooms established at contract provider LAMP and will soon do so at a directly operated clinic.
- A health provider, stationed at a primary care clinic, visits a specialty mental health agency to conduct health screenings, transitioning those in need of additional care to the health clinic. A nurse practitioner from DHS visits Augustus F. Hawkins.
- Individuals with dual training provide health screening and prevention services within mental health programs. Psychiatric nurse practitioners work in DMH Wellness Centers conducting health screenings, lead smoking cessation classes, and provide health education on matters such as nutrition, weight control, and exercise.

In summary, services delivered to high risk mental health clients can be, and are in fact today, delivered through a variety of innovative integrated but highly specialized arrangements, without the need for a single integrated payment system. These arrangements are responsive to the unique and very challenging needs of specialty mental health clients who present significant challenges when seen in non-specialty settings or programs.