DMH Innovation Project Ideas

1. **Develop health neighborhoods in targeted areas across the county, testing different service and support models and focusing on specific under-served populations, including**:

    - Underrepresented ethnic populations
    - Homeless mentally ill individuals
    - Older adults

    Introduction

    Older adults with serious mental illness present with complex issues and face multiple challenges, including medical health conditions, decline in cognitive functioning, substance and alcohol abuse, isolation and psychosocial issues related to poverty and aging. Currently, limited resources are available and provided by public and community agencies to address the multiple and complex needs of older adults. Nonetheless, there is a lack of structured neighborhood collaboratives charged with coordinating care specifically for older adults. Additionally, older adults often do not know where to find needed services due to lack of information, or have problems accessing services due to barriers associated with stigma, physical and mental impairments, transportation, and mobility constraints.

    The Model

    The Senior Health Neighborhood model is established on a wide array of "Person-Centered" and "Consumer-Driven" services and resources that are supported by a continuum of mental health, health, substance abuse, and adjunct resources. The program model focuses on developing geographic collaboratives that improves access to services; and promotes care coordination for older adults who present with health, mental health, and substance abuse conditions. The program objectives include:

    a. Develop a seamless referral and linkage system that promotes expeditious access, reduces risks of seniors falling through the cracks due to "wrong-door" syndrome, service siloes, or system fragmentation
    b. Enhance the skill set of older adult workforce through cross-training, consultation, and in-service opportunities that are open to; and shared by all members of the network of providers
    c. Coordinate an in person or virtual / electronic referral and linkage system
    d. Promote healthy lifestyles, increase independence and aging in place through interventions offered by the provider network

Proposed Service Provider Network

1. Mental health
2. Health
3. Substance abuse treatment
4. Senior centers
5. Social services
6. Parks and recreation sites
7. Employment / vocational development / volunteerism
8. Libraries
9. Senior housing
10. In-Home Supportive Services (IHSS)
11. Community Based Adult Services (CBAS)
12. Faith based organizations
13. Legal / advocacy
14. Adult Protective Services (APS)

Learning

1. What are the effective strategies that will sustain a successful collaboration and partnership within the Health Neighborhood structure for older adults?
2. Does the Senior Health Neighborhood model increase timely access to services, improve quality of life, and improve treatment compliance?

2. Behavioral assessment and treatment of cognitive disorder and traumatic brain injury

Proposal

Develop, implement, and compile outcomes for an innovative program that delivers behavioral assessment and treatment services to currently un-served and underserved populations with cognitive disorders such as dementia and traumatic brain injury, fully integrated with physical healthcare services. This proposal is based upon the following rationale:

a. Judicial and legislative decisions will likely greatly increase the Department's involvement in service provision to cognitively impaired individuals within the next few years, including requirements to provide long term health and rehabilitative services.
b. The population of individuals with cognitive impairment is expected to rise steeply within the next few years.
c. Underserved populations are disproportionately affected by cognitive disorders as a result of multiple social and environmental factors, yet have less access to associated treatment.
d. Healthcare reform requires greatly increased integration of health services for individuals with co-occurring physical and mental health disorders, including the development of an interdisciplinary care plan and interdisciplinary care team.
e. Few models currently exist for integrated health/mental health programs for cognitive impairment for underserved populations, and there is almost no data on outcomes for such programs.

f. The development of a program for these purposes, accompanied by measured outcomes, would be almost unprecedented in systems that serve safety-net and publically insured populations, and would therefore provide critically needed services now, and would be of extraordinary value for shaping healthcare systems across the state and nation.
g. Possible populations would include returning vets or incarcerated individuals with the above conditions.

3. **Test out specific outpatient service approaches to reduce recidivism of mentally ill individuals with incarceration histories in Los Angeles County Jail's mental health units**, focusing on males with co-occurring mental health and substance use conditions (COD) using interventions targeting the dynamic criminogenic factors (antisocial, pro-criminal attitudes, values and beliefs, pro-criminal associates, temperament and personality factors, low levels of educational, vocational and financial achievement) and women with COD and trauma histories using trauma-informed interventions.

4. **Integrated Telemental Health Services**

Proposal

The development of an Integrated Telemental Health Services Program will allow primary care patients seen in small FQHCs increased access to mental health services. This is especially true for underserved ethnic minority groups in LAC. In addition, the ITHS program will promote collaboration and efficiencies in service coordination between primary care and mental health. ITHS reduces the barriers to accessing mental health services for primary care patients who would rather be seen in their physical health care setting and might reside in a geographically isolated location. ITHS also provides an alternative solution to co-location of mental health staff and mitigates the challenge of recruiting clinicians to work in undesirable locations in large metropolitan areas. Moreover, ITHS also enhances cultural competency by electronically linking non-English speaking clients with clinicians who are linguistically matched, regardless of their physical location. The extant literature also supports improvements in overall health status when primary care patients with emotional problems are treated for their mental health issues. As a result, the ITHS program will likely lead to a reduction in health care costs.

Services to be provided by the proposer:

a. Ability to become Medi-Cal certified to provide specified specialty mental health services to both Medi-Cal and uninsured patients in at least 35 FQHCs with an active caseload of 25 unique clients per site (see below) at any given time.
b. Ability to provide mental health services consistent with the Mental Health Integration with Primary Care (MHIP) model; this would include Initial Assessments, Evidence-Based Psychotherapies such as Problem Solving Therapy, Seeking Safety and Cognitive Behavioral Therapy from appropriately licensed clinicians, along with case consultation by California licensed psychiatrists (primarily Indirect Consultation).

c. Ability to provide these Assessments and Evidence-Based Psychotherapies demonstrating efforts at linguistic matching in an effort to maximize cultural competency.
d. Equip participating FQHCs with suitable video teleconferencing equipment (both hardware and software) for high definition visual and real-time audio capture; provide training on the use of the equipment, as well as initial and ongoing IT support.
e. Coordinate with high speed Internet carriers in order to supply participating FQHC sites with sufficient bandwidth to support video teleconferencing.
f. Coordinate with LAC DMH in order to ensure that FQHC patients warranting specialty mental health services are appropriately referred to a traditional mental health setting.

Learning

1. Will patients being treated in primary care settings accept mental health services when it is offered to them utilizing a computerized, Internet-based format?
2. Will there be a difference in the rate of acceptance of the video teleconferencing format for mental health service delivery by different population groups treated in primary care?
3. Will primary care patients who receive their mental health services via video teleconferencing endorse the same degree of satisfaction with the format as is cited in other studies of Telemental Health Service delivery?
4. As a corollary to #3, any differences in patient satisfaction among different population groups?
5. Will access to mental health care improve for patients seen in small FQHCs without mental health in scope?
6. Will the quality of life improve for primary care patients who receive mental health services through the ITHS program? Differences among different population groups?
7. Will the overall health status, as evidenced by the stabilization or reductions in both health care and mental health care treatment targets, improve in patients treated through the ITHS? Differences among different population groups?
8. Will the ITHS program result in a reduction in the number of referrals to specialty mental health settings by FQHCs?
9. Is delivering mental health services via video teleconferencing to patients in primary care settings cost-effective?
10. Can a contracted mental health business enterprise successfully collaborate with both the LAC DMH and the LAC DHS primary care provider network to streamline care coordination, referral and linkage?

Evaluation

The Integrated Telemental Health Program will be evaluated for effectiveness and feasibility across four domains: (1) Service Level/Access, (2) Care Coordination, (3) Quality of Care/Patient Satisfaction, and (4) Cost. These four domains will be assessed using established qualitative and quantitative tools for evaluation of progress towards goals as well as for ongoing process evaluation which informs quality improvement. With meaningful involvement from diverse community stakeholders, the information from ongoing assessment will later inform the recommendation and possible dissemination of this new mental health practice into the County's existing systems and services.

Funding Requested

1000 estimated patients at each FQHC (estimated 35 total lacking MH in scope); need for MH services is estimated at 10% and factoring in 25% acceptance of MH referral = 25 patients per site. 25 patients x $2,000 per patient per fiscal year = $1,700,000 total, per fiscal year for three years.

5. **Life style interventions that positively impact physical health indicators, possibly using personal health mentors**.

Introduction

Current Innovation projects are demonstrating less success in impacting physical health indicators such as weight, Body Mass Index (BMI), a1c levels and blood pressure.

Proposal

Develop and train a team of peers and nurses to function as personal health mentors to assist clients in achieving better health outcomes.

6. **Specialized Treatment Team to the LGBT Communities**

Introduction

Stigma, as well as the fear of accessing traditional mental health service systems, are significant barriers to the older adult 60+ lesbian, gay, bisexual and transgender (LGBT) population within Los Angeles County. This is problematic and makes the challenge of accessing care more difficult in general, than for other underserved or inappropriately served populations. According to the L.A. Gay and Lesbian Center, there are approximately 65,000 LGBT older adults residing in Los Angeles County and two-third of this population live alone. This number may be understated due to the stigma, fear and apprehension related to sharing this information outside of the LGBT community. There are limited outreach and engagement services aimed at connecting and sustaining this underserved population in mental health treatment; furthermore, traditional mental health professionals may not possess specific culturally relevant training and experience to be effective. Lastly, this community has faced trauma, discrimination, grief and loss issues and multiple levels of stigma which is not readily addressed in traditional mental health settings.

Model

The Older Adult System of Care Bureau proposes to develop and implement an innovative OA Specialized Care Team, to provide the full array of mental health services to the LGBT unserved or underserved community. This specialized treatment team would provide intensive case management and the full range of outpatient mental health services, enabling a broad spectrum of older adults who meet Medi-Cal necessity to be served. Initially this will be done by establishing relationships with gatekeepers in the LGBT community specifically those that have experience in working with the senior population. A multi-disciplinary team composed of mental health, health, and substance abuse staff will conduct outreach and engagement services and provide clinically appropriate care. These services may be field based, and offered in the home, at community agencies and at a mental health clinic. A network of community providers will be established to provide ancillary services such as housing, food, transportation, and recreational activities. This model is field-based so that the services can occur in the community and offer a high degree of flexibility in terms of service location.

Service Spectrum

This intensive outreach and engagement and treatment program would provide intensive care management, centered around connection to culturally sensitive and relevant community resources, housing, healthcare, substance use treatment, legal services and other natural supports. The team would also provide the full range of mental health services, including psychotherapy and medication management. Multiple evidenced based practices would be employed including the following: Cognitive Behavior Therapy (CBT), Interpersonal Psychotherapy (IPT), and Crisis Oriented Recovery Services (CORS). Strong collaborative relationships with organizations that have demonstrated expertise in providing services to this underserved population are an essential element in building the trust necessary to access this population.

What Makes This Project Unique and Innovative

The target population, along with the required collaboration with LGBT gatekeepers, make this project innovative. Currently, there is not a strong working and trusting partnership between the DMH Older Adult System of Care Bureau and LGBT community centers in Los Angeles County. Yet, this unique population has a myriad of needs and service gaps that could be facilitated through DMH and its partner agencies. While more services focus upon the LGBT TAY population, there are very few programs that aim to outreach and engage the older adult population and provide the full spectrum of mental health and other supportive services. The development and cross training of LGBT organizations and mental health providers, would be key to fostering welcoming environments in which to offer mental health care.

Peer support would enhance the program as well as provide a venue for LGBT older adults to actively participate in a meaningful venture. Enlisting LGBT peers to serve as liaisons to their community would enhance treatment engagement as well as provide insight to the mental health providers on needs within the program. The

reduction of stigma, isolation and fear, should result in an increase in quality of life factors and better mental health, health and substance use access and outcomes.

Learning

1. Will field-based mental health services increase the sense of safety and increase access to mental health, substance use and health services?
2. Will intensive Outreach and Engagement strategies followed by field-based services be an effective mechanism to build trust and then link this underserved community to site-based services?
3. What are some of the mental health needs of this community and what interventions are the most effective?
4. What aspects engender acceptance by a mental health provider and what is the best way to communicate this information?
5. What is the best array of services to address the uniqueness of this community?

7. Older Adult Wellness and Technology Centers

Introduction

The number of older adults in Los Angeles County is growing dramatically, due to advances in access to health care. Given the fact that older adults are living longer and with multiple health, social and mental health needs, there is a need to modify the service array available within the Los Angeles County Department of Mental Health (LAC DMH), to effectively serve older adults.

The current system of Senior Centers has not been effective in engaging older adults with mental health needs due to the stigma associated with accessing care. Furthermore, the Senior and Community Centers within Los Angeles County do not have adequate private space to facilitate mental health services.

Los Angeles County Department of Mental Health (LAC DMH) currently operates or contracts with approximately 65 Adult Wellness Centers throughout the County; however, these programs do not provide services that are tailored to the unique and specialized needs of the older adult population. The needs of older adults age 60+ are quite different from the needs and interest of adults 18-59. For example, older adults are often managing multiple medical problems, loss of role(s), death and dying issues, retirement and cognitive changes. None of these issues are generally the focus of an Adult Wellness Center.

Model

The Older Adult System of Care Bureau (OASOC) is proposing the development and implementation of three (3) Older Adult Wellness and Technology Centers throughout Los Angeles County to address the unique needs of older adults. These programs would be implemented in a community setting and be culturally informed and developed based upon the targeted older adult under-represented population. The three (3) centers would each focus or highlight a different under represented cultural group. The spectrum of services developed and offered in each community would be

culturally sensitive and appropriate for the community in which the center would be located. Therefore, each center's activities, programs and community partners would vary, depending on the needs of the older adults within that community.

The Older Adult Wellness and Technology Center would offer the full range of out-patient mental health services, while also providing health screening and education and substance use treatment. The Center would offer both site based and field based services based upon the needs and preferences of the older adults. As health issues impinge upon an older adult's ability to access site based services, the continuity of care would be preserved through technology informed services such as telephonic psycho-educational groups, connection to social media and continued interaction with family and other support systems through technology.

Technology would be employed to make wellness activities accessible to frail older adults who have difficulty leaving their homes. Interventions that use computers to encourage social contact and reduce isolation would be critical. In addition, telephone psycho-educational groups would add an important and innovative component to this project. An older adult's ability to establish and remain connected to a supportive community which includes family, friends, neighbors and other social contacts, plays a vital role in reducing isolation and improve mental wellbeing.

Community partnerships would include a broad array of social and human services agencies. Potential partnerships would include the following:

- Senior Centers
- Faith Based Organizations
- Food Banks
- Health Centers
- Parks and Recreation Centers
- Department of Public Social Services
- Home Delivered Meals
- Public Libraries
- Senior Classes and Special Interest Groups
- Neighborhood Councils
- Community Senior Services
- Legal/Advocacy Services
- L.A. Gay and Lesbian Centers (Long Beach and Hollywood)

<u>Service Spectrum</u>

The Center would offer the full range array of mental health services via an older adult specific interdisciplinary treatment team. This team would consist of mental health clinicians, registered nurse (RN), substance abuse counselor, service extenders, psychiatrist and a case manager. The core services provided include the following:

- Mental Health Outpatient Services
- Substance Use Services
- Health Screening, Referral to Primary Care and Linkage.

- Psycho-educational Services
- Group Therapy: Bereavement Groups, Depression and Healthy Living
- Housing
- Peer Run Activities
- Employment/Vocational
- Computer and Technology Literacy Classes
- Social and Recreational Opportunities
- Grandparents as Parents Support Groups
- Mentoring and Coaching
- Exercise
- Nutrition Planning
- Transportation

What Makes This Project Unique and Innovative

Los Angeles County DMH does not currently offer any older adult Wellness Centers. There are no other counties within California that have the quantity as well as diversity of older adults that reside within Los Angeles County. This model expands the traditional site based Wellness Center model and adds an innovative technology component. As mental or health status changes, older adults can continue to remain linked to the same team (County of Care) while receiving site or field based services.

Learning

1. Do older adult Wellness Centers increase access to mental health, health and substance use services for older adults between the ages of 60-75?
2. Are Wellness Services provided via technology sustainable and effective?
3. Will this model be effective in terms of serving the mental health population that traditionally does not access senior centers?
4. Will older adults be receptive to utilizing Technology to participate in home-based wellness/mental health services?
5. Will older adult telephonic psychosocial and/or psycho-educational groups be an effective interview technique?
6. Will this model improve mental health, substance use and health outcomes?