Whole Person Care- Los Angeles Policy Brief

August 2021

Whole Person Care-Los Angeles Residential and Bridging Care Program Decreased Acute Care Use and Increased Primary Care Use for Patients with Serious Mental Illness

SUMMARY: The Whole Person Care-Los Angeles (WPC-LA) Residential and Bridging Care (RBC) Program is administered through the Los Angeles County Department of Mental Health (LAC-DMH) to provide discharge planning and linkage to community-based resources to patients with serious mental illness (SMI). The program is provided within high-acuity behavioral health facilities to promote the flow of patients to their next level of care to facilitate care continuity and patient stabilization. Patients in the RBC program have seen a 15% reduction in psychiatric inpatient admissions, a 14% reduction in medical inpatient admissions, and a 9% increase in primary care use.

PROBLEM: High Rate of Serious Mental Illness (SMI) and Lack of Mental Health Treatment

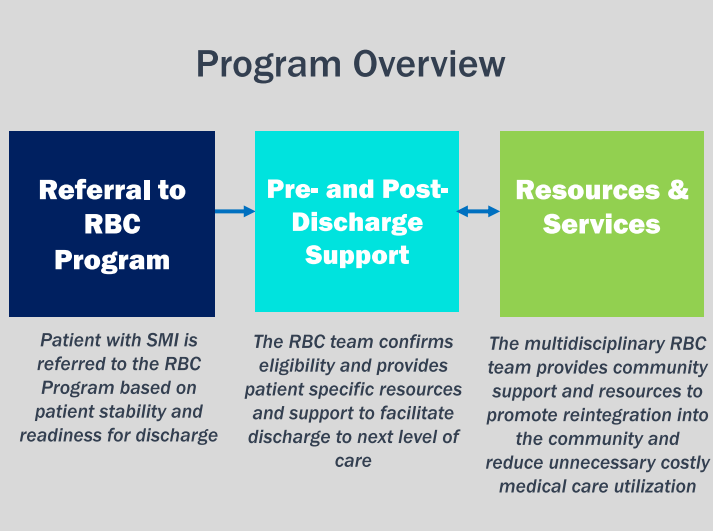
Within Los Angeles County, 5% of the population is diagnosed with serious mental illness (SMI), defined as "a mental, behavioral, or emotional disorder resulting in serious functional impairment that substantially interferes with major life activities."[1,2] Among individuals experiencing homelessness in Los Angeles County, the rate of SMI is exceptionally higher at 25%.[3] Patients with SMI are also likely to have a co-occurring chronic physical illnesses, such as cardiovascular disease, which leads to health disparities and a 25-year mortality gap as compared to patients without SMI.[4] Co-occurring chronic physical illnesses alongside SMI, compounded by substance use, homelessness, socioeconomic disparities, and social isolation, lead to increased medical care utilization and poor health outcomes.

The backlog of high-acuity behavioral health beds in Los Angeles County leaves patients with SMI unable to obtain needed care. Moreover, lack of discharge planning services has led to psychiatric inpatient readmissions rates of 37.8%, which are significantly higher than the national rate (20%).[3] Increased movement and support of patients with SMI within high-acuity psychiatric facilities to the next level of care could drastically free-up inpatient beds, decrease overall medical care utilization, and improve mental health services within Los Angeles County.

SOLUTION: The Residential and Bridging Care (RBC) Program

Administered by Whole Person Care- Los Angeles (WPC-LA) through the Los Angeles County Department of Mental Health (DMH), the Residential and Bridging Care (RBC) program provides discharge planning and linkage to community-based resources to patients with SMI within high-acuity behavioral health facilities to promote the flow of patients to their next level of care. Facilitating the discharge of patients who are clinically ready for step-down care frees up limited and costly acute-care beds. Patients are provided with a myriad of services that foster community re-integration.

The RBC team comprises 25-30 multi-disciplinary professionals, including Mental Health Clinical Supervisors, Psychiatric Social Workers, Mental Health Clinicians, Medical Case Workers, and Peer Community Health Workers. The RBC team works throughout behavioral health centers within Los Angeles County to facilitate discharges, provide comprehensive and patient-specific support for community re-integration, reduce unnecessary costly medical care utilization, and improve patient health.



Program Eligibility

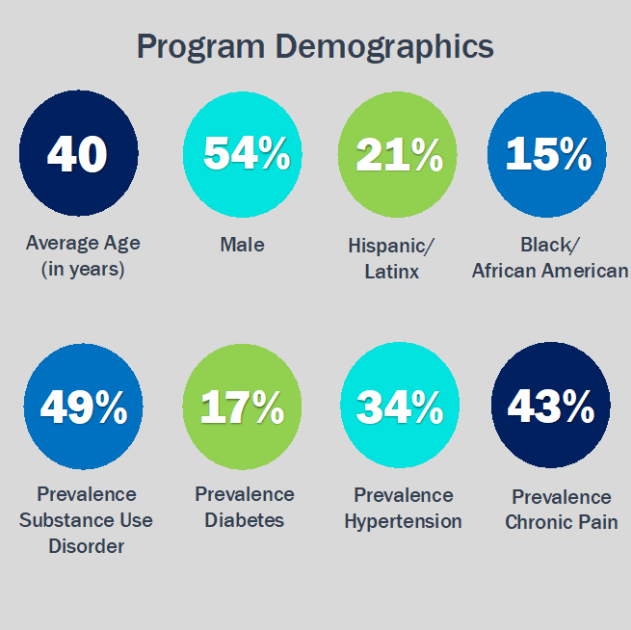
The Residential and Bridging Care (RBC) program targets patients with SMI currently admitted at high-acuity behavioral health centers such as County hospitals, subacute centers (Institution of Mental Diseases), and Enriched Residential Services (ERS). Patients that have the potential to be effectively returned to non-institutional settings with appropriate services and supports are

eligible. Eligible patients must meet the criteria for functional independence on screening using the Multnomah Community Ability Scale (MCAS), which scores several different aspects of functional independence.

Program Services

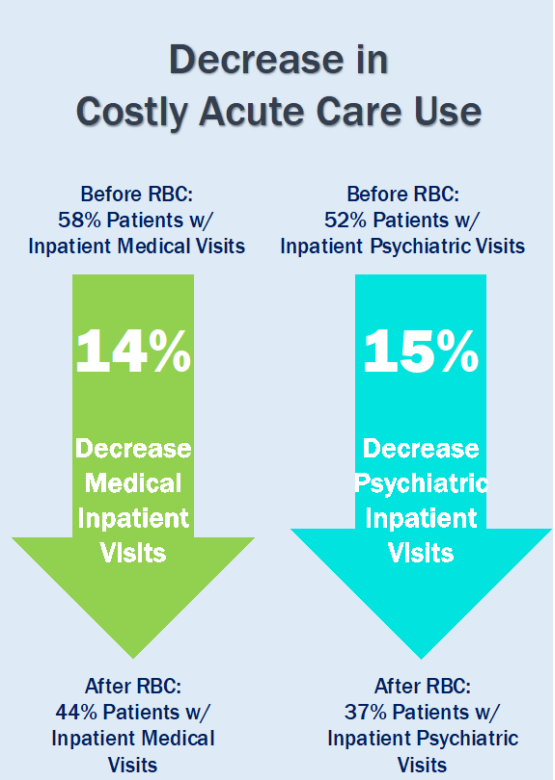
The RBC team provides comprehensive pre- and post- discharge services based on each specific patient's needs. Services that aim to provide continuity of medical and behavioral health care include: coordination and communication between high-acuity patient care teams and community-based providers, benefits establishment, and linkages to the community based resources, residential treatment, physical health and substance use providers. Services that assist patients with reintegration into the community include: peer support and support of family involvement, assistance with life skills and vocational support, and navigation to housing and legal services. The average time that patients receive services is 6 months. Patients exit the program when they are successfully discharged and/or linked to their next level of care.

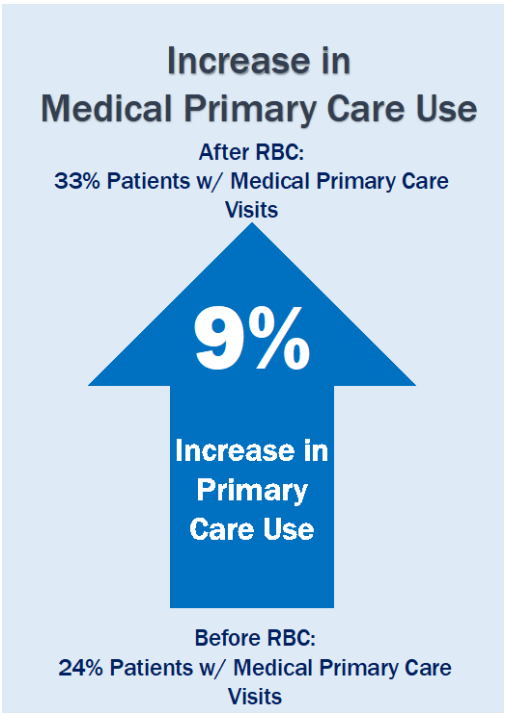
OUTCOMES: Reduction in High-Cost Care and Increase in Primary Care



From January 2017 to June 2020, 6,364 patients were enrolled in the RBC program, and their average age was 40. Approximately half of the patients were male (54%). Their races/ethnicities included Hispanic/Latino/a/x (21%), Black or African American (15%), and White (14%). Patients had a myriad of comorbid conditions, and there was a high prevalence of substance use disorder (49%).

The RBC program reduced costly medical care utilization while concurrently increasing primary care utilization. In the year after RBC enrollment, as compared to the year prior to enrollment, RBC patients had an absolute reduction in medical and psychiatric inpatient admissions (14% and 15%, respectively) and an absolute reduction in medical and psychiatric ED visits (17% and 21%, respectively). Further, RBC patients had an absolute increase in medical primary care utilization of 9% and absolute increase in psychiatric outpatient visits of 15% (defined as an outpatient visit with a mental health/substance use disorder as the primary diagnosis).





Program Strengths

- *WPC Increases Program's Capacity to Serve More SMI Patients:* WPC funding has significantly expanded the RBC program's ability to serve patients with SMI. Specifically,

increased employment of multidisciplinary professionals has increased the program's ability to identify eligible patients, provide patient-specific services, increase the number of discharge plans and discharged, and improve overall patient care.

- *Multidisciplinary RBC Team Members Present at Multiple Levels of Care:* Multidisciplinary RBC team members (providers, social services, case management) are present at multiple behavioral health facilities with varying levels of care throughout the County. Having team members who work with patients at multiple levels of care increases interdisciplinary communication, continuity, and care coordination as patients move from one level of care to the next.

- *Increased Lower-Acuity Board and Care Beds:* WPC funding has increased reimbursement rates for providers at board and care facilities, which has resulted in these facilities taking more patients. This has vastly improved the flow of discharges of patients in high-acuity centers who are ready for the next level of care.

- *Improved Engagement with Patient Social Support (i.e., family, caretakers):* Due to the increased number of RBC team members located throughout the behavioral health system, communication and engagement with patient's social support (i.e., family members, caretakers, etc.) has increased. Being able to speak and work with patient support systems improves patient re-integration into the community and long-term recovery.

Program Challenges

- *Inadequate Access to Substance Use Disorder (SUD) Programs:* The limited number of SUD programs within the County restricts RBC patient access to SUD services. Further, since SUD programs are contracted and not integrated into DMH, patient SUD records cannot be viewed by DMH staff. This combination of limited access and impaired data sharing limits services that are imperative to SMI patient community re-integration.

- *Soiled-Systems Reduce the Quality of Care:* Patients with SMI have numerous behavioral, social, and medical health needs, resulting in a complex web of care with systems and services that do not talk to each other. Increased clinical support is needed to ensure that as patients transition from one level of care to the next, all their health needs are met, including prescription refills and primary care appointments.

- *Lack of Shared Electronic Health Record (EHR) Fragments Care Coordination:* Throughout the mental health system, various EHRs are used, with no central database to access information on the treatment given at different facilities. A shared EHR, including with medical care, would significantly streamline and improve patient care.

- *Shortage of Step-Down Beds*: Despite the RBC program's ability to facilitate and increase discharges to the next level of care, the limited number of step-down beds prohibits optimal functionality of the program. Increasing the number of step-down beds would further increase the number of patients discharged, and in doing so, would also make available high-acuity beds for patients who need them (as patients from higher levels of care step-down).

Policy Recommendations

- *Support Sustainable Funding for the Residential and Bridging Care Program to Increase Mental Healthcare for All:* The RBC program provides invaluable continuous services to patients with SMI who are ready to be placed in their next level of care. This not only improves patient care and decreases acute care medical utilization across the board, but also frees up behavioral health beds for patients who need them. The ongoing COVID-19 pandemic has only worsened the ongoing behavioral health crisis, and now more than ever we must invest in programs such as RBC.

- *Promote Access to SUD Programs:* Currently, the limited number of SUD programs within the County restricts access to SUD services. This is particularly problematic considering the high rate of SUDs among RBC patients. Further, patient records outlining treatment plans within SUD programs are unavailable to DMH facilities, fragmenting care. Increasing the number of SUD facilities and improving data sharing will increase access to services and improve patient quality of care.

- *Support a Shared EHR and Data Sharing:* Currently, behavioral health facilities across the county all use independent EHRs, which fragments care. Creating a universal EHR across the county will improve patient care and decrease healthcare costs by streamlining medication/treatment regimens that have been shown to work and reducing duplicated tests/imaging.

- *Support Community Based Organizations (CBOs)*: CBOs, which represent mental health centers such as Board and Care facilities, provide step-down beds for patients with SMI who are ready for their next level of care. Unfortunately, complicated licensing, certification, and reporting processes limits the number of available Board and Care facilities within the County. Providing financial and logistical support, in tandem with incentives to start CBO Board and Care facilities, would increase the number of step-down beds and improve the flow of discharges from high-acuity behavioral health centers.

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Data and Methodology

Demographic data for patients enrolled from January 2017 to June 2020 are pulled from CHAMP, the database used to document demographic information on WPC-LA Residential and Bridging Care (RBC) patients. Outcomes for patients with any psychiatric inpatient, medical inpatient, and ED visits for patients enrolled from January 2017 to June 2020 are preliminary. Data are pulled from enrollment, utilization, and diagnosis files from Los Angeles County Department of Health Services, Department of Mental Health, LA Care, and Health Net.

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