

**Mental Health Workgroup
Summary Notes
September 23, 2003**

I. Welcome and Introductions

Welcome by Evalyn Greb, Chief, Long Term Care Integration, Aging & Independence Services (AIS). Self-introductions by 23 stakeholders in attendance (see page 4).

II. Purpose of Meeting

The purpose of the meeting was to kick-off the new Mental Health Workgroup for the San Diego Long Term Care Integration Project (LTCIP) for the purposes facilitating a group discussion and educating professionals and consumers in the mental health community about LTCIP and mental health and substance abuse services. The goal of the LTCIP Mental Health Workgroup is to make a recommendation to the larger LTCIP Planning Committee regarding appropriate and adequate inclusion of mental health and substance abuse services in LTCIP. The projected time commitment will be limited to six months with three formal meetings of the entire group and interim ad hoc meetings to develop possible options for the inclusion of mental health and substance abuse services.

III. Overview of LTCIP – Evalyn Greb

The following bullets provide a summary of the LTCIP portion of the PowerPoint presentation; the full slideshow (including Dr. McCahill's presentation) can be viewed on the LTCIP web site; hard copies can also be mailed to any interested stakeholder:

- San Diego LTCIP is highly committed to its community planning process and established decision-making process.
- The vision of LTCIP is to develop a consumer-centered system of care shared by all providers that offers the full continuum of health, social and supportive services for San Diego's aged and disabled residents.
- After thorough examination of various service delivery models, in January 2001 by consensus decision, LTCIP stakeholders recommended exploring the feasibility of using San Diego County's existing geographic Medi-Cal managed care program, Healthy San Diego (HSD), because of its existing infrastructure, community stakeholder involvement and local influence over the program by its joint advisory body.
- HSD currently does not tailor the program for chronic care or aged or disabled persons, provide "wraparound services," receive adequate reimbursement for chronic care, or have much information on duals.
- In 2002, the Board of Supervisors reviewed and approved the recommendation to explore expansion of HSD, but also requested development of two additional options for integration.
- As a result, three strategies are currently being developed (Network of Care, Physician Strategy, Health Plan Pilots) that represent incremental approaches to long term care integration that will work alone and together to position San Diego to gain experience with providing resources to and managing the care of individuals with chronic care needs. While the physician plays a key role in managing care and improving outcomes for persons with chronic disease/conditions, LTCIP seeks to create a new paradigm of consumer-focused care that increases access to home and community based care (HCBC) and ultimately improves quality while reducing fragmentation and unnecessary duplication of time, effort, and resources across the continuum of care.

IV. Integration and Mental Health – Dr. Margaret McCahill, Workgroup Chair

Dr. McCahill presented the following story that describes the type of people she currently serve and who would greatly benefit from an integrated system like the one envisioned for LTCIP:

A married couple, “Mr. and Mrs. Worker,” 58 and 60 years of age, both worked full-time, and “just got by” financially. Mrs. Worker started having trouble getting to work because she felt poorly, but she had no health care access (her employer, as well as her husband’s, offered health coverage, but the Workers could not afford the premium). Mrs. Worker lost her job because of absenteeism; she became more ill and depressed because of her failing physical health and inability to work; Mr. Worker started taking time off to care for her; then he lost his job; they lost their home, and they arrived at St. Vincent de Paul Village - homeless for the first time in their lives. Mrs. Worker died a week later of complications of diabetes, hypertension, and kidney problems, all of which had developed insidiously, and none of which had been diagnosed earlier. If they had access to medical care when Mrs. Worker first noticed symptoms, her diabetes and blood pressure could have been diagnosed and controlled, the kidney problem probably could have been avoided, and they both would have kept their jobs and their home, in addition to having more years of productive life.

The situation that Mr. and Mrs. Worker faced is becoming more common. Dr. McCahill later pointed out during the group discussion that the 55+ age group is the fastest growing homeless population in San Diego. In the last 10 years, the percentage of homeless men and women 55 and over has increased from approximately 12% to 25%. The continued rising costs of health care will only exacerbate the problem in the future, which emphasizes the need for a better coordinated and integrated system of care for people with mental illness/conditions.

Other important points from Dr. McCahill’s presentation include:

- Integration is not new; a “White Paper on the Provision of Mental Health Services by Family Physicians” concluded that, “After replacing its managed care firm (i.e., carve-out model) with a collaborative mental health care model, a large health care delivery system reduced by 33% its overall medical and mental health costs, while retaining high consumer and provider satisfaction.”
- Well-coordinated multidisciplinary teams of providers are essential in any type of integrated system.
- It takes proper awareness of all three diagnostic axes to effectively treat the patient. Axis-I: What major mental illness does the patient have; Axis-II: What *kind* of patient has the illness? (Personality disorder (P.D.), developmental disorders, etc.); Axis-III: What general medical conditions does the patient have? For example, the personality-disordered patient will act out more if the major depression is not treated; the diabetic will be out of control if the personality disorder or psychosis is not managed; the psychosis will be worse if the asthma, diabetes, pneumonia, etc., is not treated.

V. Group Discussion - the following questions, comments and statements were made during the group discussion:

- The Mental Health Workgroup and smaller Working Committee must have broad and balanced representation of consumers, consumer advocates and professionals in health and social services in order to be successful.
- LTCIP staff will make efforts to recruit additional members, but all stakeholders are encouraged to recommend and/or recruit consumers and professional colleagues.
- LTCIP staff will help arrange transportation to meetings for any interested consumer.
- **Q:** *How is the work of this group related to what County Mental Health Services has done or is currently doing for this population?* **A:** Approximately 2% of the public mental health dollar goes to the elderly population, even though the elderly comprise about 15% of the population. Currently, mental health is a carve-out, but LTCIP stakeholders have made it clear that they do not want any

carve-outs. One possible solution would be to carve that 2% back in and include it in a consolidated fund that would cover the full continuum of health, mental health, social and supportive services for the aged and disabled.

- **Q:** *Who will make the decision about who gets what type of mental health service? How will eligibility be determined?* **A:** The focal point of the envisioned LTCIP system of care is individual care management where a qualified care manager facilitates communication between the consumer and the consumer's family, physician(s), and other care providers to determine level of need and provide appropriate services. Under LTCIP, aged and disabled persons eligible for Medi-Cal and/or Medicare will be able to receive any needed long term care service based on individual **need**; a consolidated long term care fund with a Medi-Cal capitation (and eventually a Medicare cap) will offer greater flexibility in spending and allow the consumer to receive all needed services.
- Aspects of the Regional Center's social case management model are relevant to LTCIP. The case manager works closely with the consumer and the consumer's family to develop an individualized care plan for needed social and supportive services. LTCIP envisions a similar type model, but one that would also integrate medical services.

VI. Next Steps

- Recruit additional members for Mental Health Workgroup and smaller Working Committee to ensure broad representation from the mental health community.
- LTCIP staff and Dr. McCahill will select approximately 15 stakeholders for smaller group, including a Committee Chair. All stakeholders may participate in Working Committee, but only the 15 selected members will have voting privileges for the purpose of consensus development. A formal invitation to participate in Working Committee will be sent to selected stakeholders by Oct. 10, 2003.
- First Working Committee meeting on October 21, 2003 from 2:30 – 4:00 PM at AIS.
- LTCIP staff and Committee present work-to-date to larger Mental Health Workgroup at Nov. 19, 2003 full Mental Health Workgroup meeting. Option discussion by full group; ideas for further option development referred back to staff and Working Committee; Committee meets again to modify recommendation; future meetings TBA.
- Consensus development at January MH Workgroup meeting; forward recommendation to LTCIP Planning Committee by February 2004.

VII. Adjourn - Save the Dates: October 21, 2003 and November 19, 2003

FIRST WORKING COMMITTEE MEETING:
Tuesday, October 21, 2003 from 2:30 to 4PM
Aging & Independence Services
9335 Hazard Way, Training Room
San Diego, CA 92123

NEXT FULL MENTAL HEALTH WORKGROUP :
Wednesday, Nov.19, 2003 from 4 to 5:30 PM
Point Loma Nazarene University - Mission
Valley, 4007 Camino Del Rio South, Room
204, San Diego, CA 92108

If you have questions or would like more information, please call (858) 495-5428 or email:
evalyn.greb@sdcounty.ca.gov or sara.barnett@sdcounty.ca.gov

Mental Health Workgroup Attendance List

September 23, 2003

Name	Agency
1. John Allen, M.D.	San Diego Psychiatric Society & SD Mental Health Board
2. Sara Barnett	Aging & Independence Services (AIS) LTCIP
3. Don Berk	Sharp Mesa Vista
4. Arlene Cawthorne	Palomar Pomerado Health
5. Alison Cook	Adult Protective Services, Inc.
6. Ruth Covell, M.D.	UCSD/ CHIP Mental Health Workgroup
7. Marlaine Cover	Bay Recovery Centers, Inc.
8. Catherine Eckl	University Community Medical Center
9. Laurie Edwards-Tate	At Your Home Services for the Aging & Disabled/Family Care
10. Charles Ertl	Sharp Mesa Vista
11. Teresa Graves	Sharp Healthcare
12. Evalyn Greb	AIS LTCIP
13. Kit Kerwick	VA Healthcare System
14. Abe Krems	AIS Advisory Board/ AARP/retired M.D.
15. Betty London	AARP volunteer/Consumer
16. Margaret McCahill, M.D.	UCSD/ St. Vincent De Paul's Village
17. Monica McCorkle	Alpine Special Treatment Center
18. Arnold Morales	Paradise Valley Hospital
19. Anne DeMeules-Myers	Consumer/St. Paul's Senior Homes & Services Board
20. Karenlee Robinson	Sharp Mesa Vista
21. Karen Ross	Sharp
22. Terry Rutherford	Sharp Senior Health Center
23. Judith Yates	Healthcare Association of San Diego & Imperial Counties