Alzheimer's Disease and Related Disorders Advisory Committee
Discussion Topic: Access to Mental Health Services for Persons with Dementia
March 9, 2016

Overview

The Alzheimer's Disease and Related Disorders Advisory Committee (Committee) has been looking into issues of access to mental health services for persons with dementia. The Committee intends to continue to examine this topic to better understand the barriers that prevent persons with dementia from accessing and receiving appropriate mental health services that would potentially alleviate some of their symptoms. The intent of this document is to summarize the issue and provide additional context for further Committee discussions. While the problems underpinning this issue are complex and multifaceted, this document is likely not to characterize the entirety of the problem.

Background

It is estimated that one-third to one-half of persons with dementia also exhibit psychiatric symptoms or behavioral disturbances and disorders,[1] only a small percentage of these reach a level that warrants access to crisis mental health services. Moreover, older adults have among the highest rates of depression in the general population, and the prevalence of these problems is unlikely to change in the future. As the baby boomer generation grows older, the number of seniors with mental health disorders will likely increase and the mental health system will need to be prepared to address this rising tide. This presents a particular challenge for individuals with dementia as the primary risk factor for Alzheimer's disease, the most common form of dementia, is older age. The Alzheimer's Association reports that over 600,000 Californians 55 and over are living with Alzheimer's disease—that is one-tenth of the nation's Alzheimer's patients reside in this state.[2]

Summary of Presentations

To date the Committee has met with the California Department of Health Care Services, the California Department of Managed Health Care, and the California Mental Health Planning Council. The Committee intends to engage other Departments and experts, who are knowledgeable about these issues, to further assess the problem and to identify lessons learned and best practices.

California Department of Health Care Services[3]

At the December 10, 2015 Committee meeting, Brenda Grealish, Assistant Deputy Director of the Mental Health and Substance Use Disorder Services Division at the Department of Health Care Services (DHCS), presented on the Division's role in the delivery of public mental health services. Ms. Grealish provided background and noted that prior to the Affordable Care Act, mental health services in California were primarily carved-out and provided through county Mental Health Plans under the California 1915 (b) Specialty Mental Health Services Waiver. In 2013, California adopted an optional benefit expansion, which expanded services available to beneficiaries in their local Medi-Cal Managed Care Plan. In 2014, eligible Medi-Cal beneficiaries began to receive

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[1] *Improving Access to Mental Health Services for Persons with Alzheimer's Disease and Related Disorders*. California Health and Human Services Agency. 2003.
[2] *California Alzheimer's Disease Data Report.* Alzheimer's Association. 2015.
[3] DHCS PowerPoint Presentation, Alzheimer's Disease and Related Disorders Advisory Committee. 2015.

mental health benefits through Medi-Cal Managed Care Plans. These services continue to be offered as fee-for-service benefits for eligible beneficiaries that are not enrolled in a Medi-Cal Managed Care Plans. Table 1 provides an overview of mental health services responsibilities between the Medi-Cal Managed Care Plans and the county Mental Health Plans.

Table 1: Mental Health Services Responsibilities

Medi-Cal Managed Care Plan	County Mental Health Plan Outpatient	County Mental Health Plan Inpatient
Mental health services when provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their licenses: • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient laboratory, medications, supplies, and supplements • Psychiatric consultation	Medi-Cal Specialty Mental Health Services outpatient responsibilities includes: • Mental Health Services (Assessment, Plan Development, Therapy, Rehabilitation, Collateral); • Medication Support Services • Day Treatment Intensive • Day Rehabilitation • Crisis Residential • Adult Crisis Residential • Crisis Intervention • Crisis Stabilization • Targeted Case Management	Medi-Cal Specialty Mental Health Services inpatient responsibilities includes: • Acute psychiatric inpatient hospital services • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service hospital

California Department of Managed Health Care[4]

At the December 10, 2015 Committee meeting, Mary Watanabe, Deputy Director for Health Policy and Stakeholder Relations, and Liz Spring, Attorney in the Office of Plan Licensing at the California Department of Managed Health Care, provided the Committee with an overview of the roles and functions of the Department as it relates to the commercial market. Ms. Spring provided the Committee with an overview of Departmental efforts to ensure parity in health coverage for mental health and substance use disorders. Ms. Spring also discussed the federal Mental Health Parity and Abdication Equity Act (MHPAEA) and the Department's role in the implementation of the law. The Department's oversight of mental health parity is specific to the commercial market and focused on products sold by Health Maintenance Organizations and Preferred Provider Organizations to individuals, small groups, and large groups. The Department's oversight does not include Medi-Cal or Medicare. The Department is in the process of conducting a MHPAEA compliance review of the participating commercial health plans and will complete an onsite survey in 2016, which will look to ensure that plans are charging correct cost-sharing and are not distributing to enrollees inaccurate information about mental health and substance use disorder benefits.

California Mental Health Planning Council[5]

At the December 10, 2015 Committee meeting, Jane Adock, Executive Officer of the California Mental Health Planning Council gave a presentation on the role and purpose of the Council. Ms. Adock provided an overview of the federal and state mandates that

[4] DMHC PowerPoint Presentation, Alzheimer's Disease and Related Disorders Advisory Committee. 2015.
[5] CMHPC PowerPoint Presentation, Alzheimer's Disease and Related Disorders Advisory Committee. 2015.

govern the functions of the Council and outlined areas of focus, which includes programs that prevent individuals from having to be institutionalized; programs that divert individuals form locked facilities; and programs that re-integrate individuals into the community. The Council is working toward developing a mental health system that makes it possible for individuals to lead full and productive lives, while incorporating public and private resources to offer community-based services that embrace recovery and wellness.

Problem Synopsis

There seem to be a number of broad factors that contribute to the lack of access to mental health services particularly for person with dementia: 1) a lack of current expertise in the system to address the mental health needs of older adults, and demented elders in particular; 2) the scarcity of professionals being trained in geropsychiatry in medicine, social work, and nursing; and 3) the lack of awareness of community partners to which appropriate referrals could be made to help reduce the burden on the county system.

Historically, there have been additional factors that contributed to the lack of access to mental health services for persons with dementia. This may include:

- Funding divisions between the medical/health field and the mental health field;
- Belief amongst mental health providers that Medi-Cal and Medicare will not reimburse on mental health claims if the patient has dementia;
- Budget short falls leading to reducing funding for caring for persons with dementia;
- Lack of training in how to help a person with dementia and mental health needs;
- Belief that mental health interventions will not be effective in people with dementia;
- Lack of awareness regarding the health and medical benefits by caregivers and family members; and
- Continued stigmatization of people living with Alzheimer's disease and their families.

There is some evidence from mental health clinicians that persons with a dementia diagnosis and a co-morbid mental health-related diagnosis are routinely excluded from accessing mental health services. For example, a person with Alzheimer's or a related dementia who also has a co-occurring psychiatric condition such as depression does not receive services for the co-occurring illness simply because s/he also has dementia. It is the Committee's understanding that the co-occurring illness would only be covered if the treating professional could determine that the psychiatric illness was unrelated to the dementing disorder. Confusion often exists about the term "primary diagnosis" and "principal diagnosis." In order to be reimbursed for mental health services, the patient must have a principal diagnosis of mental illness, other than the dementia. Ultimately, it is difficult and burdensome for treating professionals to differentiate co-occurring psychiatric diagnoses from a primary diagnosis of Alzheimer's or a related dementia, and there is little incentive to do so.

There are a number of additional factors that have contributed to this problem:

- Mental health providers may not be aware that a person with a "dementia-plus-a-mental-health-related diagnosis" is eligible to receive services;
- Mental health providers may not have adequate training to diagnostically differentiate dementia from psychiatric illnesses and understand the co-existence of mental health diagnoses with dementia;
- The diagnostic categories used in the Diagnostic and Statistical Manual IV combine both dementia and psychiatric diagnoses (e.g., Alzheimer's disease with depression), often creating confusion regarding eligibility; and
- Mental health providers may use any dementia diagnosis to exclude patients because the system is already overburdened and under-funded, and the dementia diagnosis provides a convenient way to exclude a class of patients who they have historically not served, or have been reluctant to serve.

The lack of access to mental health services can lead to additional problems:

- Persons with Alzheimer's disease and related disorders do not receive the medication, psychotherapy, mental health case management, psychiatric hospitalization, and emergency response they could benefit from. This contributes to excess human suffering, including depression, anxiety, agitation, psychosis, etc., in both the dementia patient and their caregivers.
- Persons with Alzheimer's disease and related disorders functioning declines due to exacerbation of their mental illness leading to decline in functioning, increase in behavioral disturbances, quickened caregiver burn-out, increase in use of hospitalization, emergency room use, and skilled nursing facility placement. This in turn leads to increased expense for the larger institutional systems.

Discussion Questions

1. What are the gaps in care for persons with a dementia diagnosis and a mental health-related diagnosis?
2. What are the key barriers in accessing timely and appropriate dementia care and behavioral or mental health services?
3. Are there examples of persons with a dementia diagnosis and a mental health-related diagnosis who are not getting access to appropriate services?
4. What data can be leveraged to better understand the complexity and magnitude of the problem?
5. How does access to mental health services differ between private and public health insurance coverage?
6. What are the access barriers for individuals with dementia and mental illness who have public health insurance coverage?
7. Are there areas of the state or are there coverage categories where there are no access issues?
8. Are there lessons learned or best practices that can be shared more broadly across the state?
9. Do other states have similar problems? If so, how are they addressing the problem?
10. Who are the key stakeholders and what other groups/organizations should the Committee engage on this issue?