About MHPA Center for Best Practices

The Medicaid Health Plans of America (MHPA) Center for Best Practices is a 501(c)(3) affiliate organization created to support MHPA’s mission: to provide efficient health care services and improve quality and access to care for Medicaid beneficiaries. The Center serves as a convener of Medicaid health plans on research, quality improvement and dissemination of health plan best practices in both clinical and operational domains. With guidance from the leadership of premier health plans serving Medicaid populations and expert stakeholders, the Center uses data, information and knowledge transfer to disseminate innovative solutions to caring for underserved populations.
Best Practices Compendium for Serious Mental Illness
By Liza Greenberg, RN, MPH, MHPA Senior Consultant, Clinical Initiatives
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The MHPA Center for Best Practices thanks the members of the Serious Mental Illness Advisory Panel for their guidance and insights on MHPA’s Serious Mental Illness initiative and publication. Special thanks to members who reviewed drafts of this document. MHPA also greatly appreciates the many member plans who submitted best practice examples for this publication. Best practices were self-selected and submitted voluntarily by member organizations. Any errors in this Compendium are the responsibility of MHPA, not the Advisory Panel or member plans.

Funded by Johnson & Johnson Health Care Systems, Inc.

President’s Letter
A Message from Thomas L. Johnson, MHPA President & CEO

Dear Colleagues:
On behalf of the Medicaid Health Plans of America Center for Best Practices, I am pleased to bring you this Best Practices Compendium for Serious Mental Illness. The Medicaid program is the largest payer of mental health services in the United States, typically through fee-for-service arrangements. Yet care for people with serious mental illness (SMI) remains less than optimal, regardless of insurance status. Some of the challenges lie in the mental health services system itself — complex eligibility requirements, poorly coordinated systems of health and social services offered by county, state and private providers, and siloed mental health and physical health systems. But some challenges are specific to health care delivery — lack of integrated care, underuse of preventive health services, inconsistent patient adherence to medications and over-reliance on emergency care.

Medicaid health plans are part of the solution for improving quality of care for people with serious mental illness. As an increasing number people receive their health care coverage from the Medicaid program, insurance-related access barriers to mental health services will be diminished. And, with Medicaid health plans emerging as the leading solution for States to implement managed care expansions, more attention will focus on health plan capabilities to reach and effectively serve individuals with serious mental illness. This Best Practices Compendium highlights some challenges in delivering mental health services, outlines important treatment recommendations, and identifies examples of cutting-edge approaches used by Medicaid health plans to address the needs of people with SMI.

Health plan approaches featured in this Compendium include: using technology to expand access to psychiatric and other mental health treatment providers; developing peer support and culturally appropriate intake and care management programs; increasing screening for depression, substance use and co-morbid conditions of SMI; and other innovations. Health plans are able to use sophisticated data systems coupled with trained care management staff to improve medication adherence — a critical factor in successful treatment of SMI. Medicaid health plans’ diverse strategies include collaborating with communities, expanding their own programs, and working with specialized behavioral health organizations.

The MHPA Center for Best Practices is very pleased to highlight the Best Practice examples in this publication, featuring both Medicaid health plans and their behavioral health partners. We thank our sponsor Johnson & Johnson for supporting this effort. MHPA and its member plans look forward to helping the nation move towards an integrated, coordinated mental health, physical health and social services system that effectively promotes recovery for people with serious mental illness.

Sincerely,

Thomas L. Johnson
President & CEO, Medicaid Health Plans of America
President, MHPA Center for Best Practices
PART I: An Introduction

Serious mental illness — schizophrenia, major depressive disorder and bipolar disorder — impacts a large number of Americans. Yet despite the prevalence, treatment for serious mental illness (SMI) falls short of need. Treatment is often unavailable, incomplete and un-coordinated with other health and social services.

The Medicaid program covers over 51 million people located in every state. In this Best Practices Compendium, we look at the environment for delivering services to people with serious mental illness, key treatment recommendations and offer best practice case studies of Medicaid health plan programs to improve care.

Prevalence of Mental Health Conditions

The National Institutes of Health reports that 25 percent of people have a diagnosable mental health condition. About 25% of adults have bipolar disorder, about 1% of the population has schizophrenia, and 7% have a major depressive disorder. (See Sidebar 1 at right for brief descriptions of these conditions.) These conditions can be treated but may be chronic. Symptoms can be very severe, and impact the relationships, ability to work and economic wellbeing of individuals who have them.

Unfortunately, serious mental illnesses are often accompanied by abuse of alcohol and other drugs. According to Substance Abuse and Mental Health Services Administration (SAMHSA), “Approximately 8.9 million adults have co-occurring disorders; that is they have both a mental and substance use disorder. Only 7.4% of individuals receive treatment for both conditions with 55.8% receiving no treatment at all.” SAMHSA estimates that 10.6 million adults have unmet needs for mental health care.

Within the Medicaid program, the prevalence of mental health disorders is particularly high, and a large number of Medicaid beneficiaries have a co-morbid chronic medical condition in addition to a mental health diagnosis. For example, an analysis by The Lewin Group for The State of Missouri Medicaid found that 5.4% of beneficiaries incurred 53% of program costs. Three common factors were associated with the highest cost patients: multiple inpatient admissions; large numbers of emergency room visits; and “highly aberrant” prescription drug use.

Sidebar 1: Serious Mental Illness

Schizophrenia: Schizophrenia is a chronic, severe and disabling brain disorder that affects about 1 percent of Americans. People with the disorder may hear voices other people don’t hear. They may believe other people are reading their minds, controlling their thoughts or plotting to harm them. This can terrify people with the illness and make them withdrawn or extremely agitated. Families and society are affected by schizophrenia too. Many people with schizophrenia have difficulty holding a job or caring for themselves, so they rely on others for help. Treatment helps relieve many symptoms of schizophrenia, but most people who have the disorder cope with symptoms throughout their lives. However, many people with schizophrenia can lead rewarding and meaningful lives in their communities. Researchers are developing more effective medications and using new research tools to understand the causes of schizophrenia.


Bipolar Disorder: Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels and the ability to carry out day-to-day tasks. Symptoms of bipolar disorder are severe. Bipolar disorder often develops in a person’s late teens or early adult years. At least half of all cases start before age 25. Bipolar disorder is not easy to spot when it starts. The symptoms may seem like separate problems, not recognized as parts of a large problem. Bipolar disorder symptoms can result in damaged relationships, poor job or school performance, and even suicide. But bipolar disorder can be treated, and people with this illness can lead full and productive lives. Some people suffer for years before they are properly diagnosed and treated. Like diabetes or heart disease, bipolar disorder is a long-term illness that must be carefully managed throughout a person’s life.


Major Depressive Disorder: Depression is a common but serious illness. There are several forms of depressive disorders. Major depressive disorder, or major depression, is characterized by a combination of symptoms that interfere with a person’s ability to work, sleep, study, eat and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. Some people may experience only a single episode within their lifetime, but more often a person may have multiple episodes. Other illnesses may come on before depression, cause it, or be a consequence of it. Depression and other illnesses interact differently in different people. In any case, co-occurring illnesses need to be diagnosed and treated. Medications, psychotherapies and other methods can effectively treat people with depression.

Of note, 85% of the high cost members had a mental health diagnosis. Similarly, a Center for Health Care Strategies (CHCS) report on adults with disabilities enrolled in fee-for-service Medicaid found that that 60% of the highest cost beneficiaries had chronic disease and mental health co-morbidities. Sixty percent of Medicaid spending for this group was attributable to 5% of beneficiaries.

About Medicaid and Mental Health

The Medicaid program is the largest public funder of mental health services in the U.S. Medicaid is jointly funded and implemented by states and the federal government, and is overseen at the federal level by the Centers for Medicare and Medicaid Services (CMS). CMS determines the minimum eligibility for individuals to access the Medicaid program. States have the option to add additional categories. Individuals eligible for Medicaid include low-income pregnant women, low-income children, foster children, individuals with disability, the “aged, blind and disabled,” and individuals with Supplemental Security Income (SSI). States and counties also have important roles in funding and delivering mental health services. Sidebar 2 below describes some of the mental health funding sources, and additional graphics on the topic can be found in Part 3.

People with SMI can become eligible for Medicaid because they are disabled with a mental health disorder, or they may be eligible for Medicaid in other categories and coincidentally have a mental health condition. People with SMI may also be uninsured or have coverage from commercial insurance, Medicare or other public insurance.

Medicaid health services are delivered either through fee-for-service arrangements, primary care case management or through Medicaid health plans. States often have distinct delivery arrangements for different eligibility categories of Medicaid. A state may use managed care arrangements for some categories of eligible beneficiaries, while other beneficiaries are in fee-for-service, uncoordinated care. People with SMI may be in both fee-for-service and managed care due to “carve outs.”

“Carve out” services are those for which separate entities are statutorily or contractually accountable for health and mental health services. For example, health plans may be contracted to provide overall health services, while the state pays for mental health services on a fee-for-service basis. Carve out arrangements for Medicaid mental health services impact the flow of information and funding. See page 61 for a table of state use of mental health and pharmacy carve outs for Medicaid. Partial carve outs may be created for selected services or therapies such as medications. Under a pharmacy carve out, the health plan pays for treatment services but not pharmaceuticals. [Note: Health plans commonly use specialized vendors to manage pharmacy services or behavioral health services. MHPA distinguishes these from state-mandated carve outs, in which services and information are not coordinated with the health plan. When health plans contract with specialized vendors for selected services, the plans and the behavioral health vendors work collaboratively to manage the member’s mental health and medical care along with other needed services.]

Key Treatment Recommendations

Advocates and clinicians agree that the treatment goal of mental health services is “recovery,” a concept that includes more than stabilization of health indicators. Recovery also “refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.”

SAMHSA, the federal agency charged with leading improvements in mental health and substance abuse has proposed that services for people with mental illness be available along a continuum that includes health and social assistance. The continuum includes:

- Health Homes
- Prevention and Wellness Services
- Engagement Services
- Outpatient and Medication Assisted Treatment
- Community Supports and Recovery Services
- Intensive Support Services
- Other Living Supports
- Out-of-Home Residential Services
- Acute-Intensive Services

Although the specific elements of treatment needed for patients with SMI depend on the patient’s diagnosis and support system, many common treatment elements to promote recovery can be identified. These include:

- Prevention and Wellness
- Medication
- Psychotherapy
- Psychosocial support
- Crisis Intervention

Psychosocial interventions are critical to recovery, and often must be accessed through effective coordination between health care providers and specialized, multidisciplinary providers and community organizations. Elements of psychosocial treatment identified by the National Alliance on Mental Illness include Assertive Community Treatment (ACT), Cognitive Behavioral Therapy, Dual Diagnosis and Integrated Treatment of Mental Illness and Addictions, Family Psycho-education and Support, Peer Services and Supports, Housing, Jail Diversion and Employment.

Sidebar 2: About Mental Health Services

Payment for and treatment of mental health conditions is widely recognized to be fragmented and overly complex. The Substance Abuse and Mental Health Services Administration (SAMHSA) says, “In the public sector, individuals/families/youth with complex mental and substance use disorders receive services funded by federal, state, county and local funds. These multiple funding sources often result in a maze of eligibility, program and reporting specifications that create funding silos featuring complicated administrative requirements.”

Many people with SMI cycle between types of coverage (or no coverage), often adversely impacting their access to treatment and medications. Fragmentation of services also impacts quality of care, since a changing array plans and providers disrupts treatment and the flow of information needed to fully coordinate and effectively treat physical and mental health conditions.

States also offer mental health services funded under the Community Mental Health Services Block Grant (MHSBG), administered through State Mental Health Agencies. MHSBG funds may cover prevention, treatment, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private insurance. A priority is serving people not eligible for Medicaid or other insurance. One of the challenges to providing effective care for individuals with SMI is accessing and coordinating health and social services available from diverse community and governmental agencies.

* See www.samhsa.gov
Treatment needs of individuals with SMI cut across general health, mental health, substance use treatment and social services. There is emerging consensus that integration of treatment services would improve care for people with SMI. Currently, mental health and medical care typically use distinct reimbursement systems, provider types and information management systems. Integrating mental health and medical services provides significant operational and data management challenges. While many practitioners embrace the concept, few practices have undergone the transformation needed to provide and integrate comprehensive mental, physical, and social care.

The Best Practice case study from MDwise of Indiana illustrates how health plans can support and collaborate with local stakeholders to develop viable integrated models of health and mental health services. Additional resources for information on integrated care can be found in Section 4, including information on a model developed by the State of Missouri which advocates believe holds promise for improving quality of care for people with SMI.

The Burden of Serious Mental Illness and Health Care Quality Gaps

Experts repeatedly find that the mental health system is desperately in need of improvements. For example, the 2004 The President’s New Freedom Commission Report on Mental Health noted, “The mental health delivery system is fragmented and in disarray … leading to unnecessary and costly disability, homelessness, school failure and incarceration.” The report described the extent of unmet needs and barriers to care, including:

- Fragmentation and gaps in care for children;
- Fragmentation and gaps in care for adults with serious mental illnesses;
- High unemployment and disability for people with serious mental illnesses;
- Lack of care for older adults with mental illnesses; and
- Lack of national priority for mental health and suicide prevention.

In spite of these findings and the passage of Mental Health Parity and Addiction Equity Act of 2008, there is little evidence that the system has been transformed or that the burden of mental illness has been reduced. Gaps in mental health care services can be measured not only by treatment lapses, but also by rates of preventable hospitalization, homelessness, unemployment, disrupted families, poverty, and incarceration for people with SMI.

The Impact on People

People with serious mental illness face difficulties in their work and home lives attributable to illness. The burden on individuals is quite high. People with a serious mental illness have an expected life span over average 25 years less than people without SMI. Ninety percent of people who commit suicide have a serious mental illness. Forty percent of homeless people report mental health problems, and 20-25% have an SMI. Mental health conditions are treatable, but often are characterized by episodes of illness and relapses. For that reason, treatment approaches to SMI address not only physical care, but also psychosocial issues including relationships, jobs and housing.
The Impact on Society

The cost of serious mental illness lies both in direct treatment expenses and in non-health costs. Mental illness may exacerbate the impact of other health conditions if people have difficulty complying with behavioral or treatment recommendations. On the indirect side, people with SMI have more difficulty retaining employment, and their families may experience financial and productivity costs caring for them.

One detailed examination of the U.S. 2002 cost of schizophrenia broke out the following categories:

- Total cost was estimated to be $62.7 billion, with $22.7 billion excess direct health care cost ($7.0 billion outpatient, $5.0 billion drugs, $2.8 billion inpatient, $8.0 billion long-term care).
- The total indirect excess costs were estimated to be $32.4 billion. This includes unemployment, reduced workplace productivity, premature mortality from suicide, and family caregiving. Non-health costs include law enforcement, homeless shelters, disability payments and other items.

Mental illnesses also add to the costs of chronic diseases. It costs $50 more per month to care for a person with depression plus a chronic disease than it does just for the chronic disease. The important takeaway about cost is not that it is so high, but that it is evidence of so much lost opportunity for good health and productivity. And, cost reflects missed prevention opportunities.

Quality Gaps

Specific gaps have been documented in clinical areas. Some clinical gaps identified in the research literature and by national quality organizations include:

- **Lower Quality Medical Care**: In spite of frequent contact with the health care system, health care for people with SMI is commonly of lower quality than that of people without. Closely related to this is underuse of preventive services. Preventive care is especially important as individuals with SMI have higher rates of smoking, obesity and substance abuse problems.

- **Underuse and Overuse of Services**: People with SMI are likely to underuse important services such as preventive health care. One-third of people with mental illness and substance use problems do not receive needed immunizations, cancer screenings and counseling on tobacco use. These are key preventive services recommended for all adults and essential for the high-risk SMI population. People with SMI may have access barriers that result in underuse of needed care, including psychiatric services. On the other side, people with SMI have higher rates of emergency services use for both mental health and medical care. Many emergency visits are thought to be preventable through more effective psychiatric and psychosocial care.

- **Lack of Medication Adherence**: Non-adherence to medication is a pervasive problem in treatment of individuals with SMI; between 40-50% of schizophrenic patients do not adhere to prescribed medications. Non-adherence is associated with increased rehospitalization, more hospital days, and higher hospital costs reflecting millions of dollars of preventable hospital expenditures. Racial and ethnic minority populations may be at greatest risk of non-adherence: a recent study of Medicare patients with major depressive disorder found that the odds of adhering to a new anti-depression treatment medication were 40% lower for African Americans than Caucasians. Use of “second generation” antipsychotics and longer acting medications is associated with lower rates of non-adherence.

- **Co-morbid conditions**: A large number of people with SMI have co-morbid substance use or physical health conditions. Diabetes and heart disease are more prevalent in SMI populations. Some factors, such as substance abuse, impact treatment adherence and increase the patient’s risk of hospitalization. Studies have shown that people with SMI already having more risk factors for chronic diseases, many medications used to treat SMI also increase risk of diabetes. Failure to identify co-morbid conditions through preventive care or to treat them exacerbates the severity and often the cost of these co-morbid conditions.

- **Disparities in Outcomes**: Studies have shown racial and ethnic differences in adherence to medications, which can have an important impact on outcomes. Rates of hospitalization for psychiatric conditions are 44% higher for people in poor communities than in non-poor communities, and twice as high for poor people with schizophrenia. Some stakeholders have recommended that SMI populations themselves be considered a “disparity population,” for the reasons that people with SMI as a group have shorter lifespans and higher risk of morbidity and disability.

Medicaid Health Plans and Treatment for Serious Mental Illness

Medicaid health plans enroll over 50% of Medicaid beneficiaries. With passage of the Affordable Care Act, more people will be covered under Medicaid. Medicaid populations currently in the fee-for-service system, particularly Medicare and Medicaid “dual eligible” populations, are being moved into managed care arrangements. States turn to managed care with the goal of better coordinating care, improving access and managing costs.

Much of the information we have about quality of care for people with SMI comes from the fee-for-service Medicaid program. Health plans see an opportunity to improve care for members with SMI by applying information management to identify opportunities for quality improvement or systems efficiency, and by using care coordinators to help individuals get better care.

MHPA believes that health plans offer a higher level of accountability for quality. Medicaid health plans are accountable to states and beneficiaries for the cost and quality of care delivered to enrolled beneficiaries. Unlike fee-for-service providers, Medicaid health plans:

- Link members with behavioral health and primary care practitioners;
- Coordinate access to specialists;
- Have care coordinators and case managers on staff to help people with serious mental illness and other complex health problems;
- Offer enhanced enrollee benefits such as peer support and diabetes education;
- Facilitate access to care by providing language interpretation services and transportation;
- Are responsible for care of all enrolled members and for ensuring services;
- Track cost, quality and health care use of patients in order to know where preventive or more efficient services could be provided;
- Report publicly on cost, quality and access using standard definitions;
- Survey members about their satisfaction;
- Carry out fraud detection and prevention activities; and
- Are accountable to states and members for improvements in care.

*SMI Best Practices Compendium* productiviy. And, cost reflects missed prevention opportunities. about cost is not that it is so high, but that it is evidence of so much lost opportunity for good health and
Health plans report on their performance to state Medicaid agencies. Most Medicaid health plans also report HEDIS performance measures that include many metrics related to mental health care and common co-morbidities of mental illness. Standardized HEDIS measures include:

- Antidepressant Medication Management
- Follow-Up Care for Children Prescribed ADHD Medication
- Follow-Up After Hospitalization for Mental Illness
- Annual Monitoring for Patients on Persistent Medications
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Inpatient utilization
- Mental health utilization
- Body Mass Index (weight) screening
- Cancer screening
- Diabetes care

In the future, health plans and Medicaid programs may be positioned to produce more detailed standardized performance information on care of beneficiaries with SMI. The National Committee for Quality Assurance (NCQA), a national organization that establishes accreditation standards and develops the HEDIS measures, is working on a set of measures specifically addressing services for Medicaid members with schizophrenia. The schizophrenia measure set is designed to be reported by State Medicaid Agencies. The measures — currently in draft — address quality of health care, specifically related to medication adherence, preventive services, coordinated care and use of emergency services.

As the best practices highlighted in this Compendium show, health plans are working to close the clinical quality gaps impacting the lives of people with SMI. Some of the strategies health plans are using to close gaps in care include:

- **Quality Care**: Plans are proactively reaching out to members to increase uptake of preventive services, testing new models for integration of services and implementing programs that alert physicians and other providers when patients need services.
- **Underuse and Overuse**: Plans are using care management programs to improve access to under-used services such as psychiatry and preventive care. They are also using care managers to address patient needs and thus help patients avoid using emergency care for non-emergent situations.
- **Medication Adherence**: Health plans are working to increase medication adherence by training care managers and enhancing patient education, as well as by tracking use of medications to identify gaps in refills that signal non-adherence.
- **Reducing the Impact of Co-morbid Health Conditions**: Health plans are collaborating on demonstration programs to integrate health and mental health services. Where services are not integrated, plans are implementing programs to increase coordination between primary care and mental health, and to increase screening for health and mental health problems.
- **Reducing Disparities**: Health plans are deploying peer counselors, measuring and reporting on performance, and using trained care managers to work with the highest needs, highest risk populations.

Health plan strategies emphasize use of data to identify members in need, use of trained care management staff, coordinating with community services, and preventing exacerbations through better medication and health care services adherence. For example:

- **OptumHealth Behavioral Solutions** developed the Behavioral Health Transition Coach program to increase follow up for members post-hospitalization, address co-morbid conditions, link to peer support and reduce rehospitalizations.
- **AmeriHealth Mercy’s PerformCare** uses an Enhanced Care Management Program to identify high-risk members, increase services and link to community services.
- **Keystone Mercy Health Plan** collaborated with multiple stakeholders to pilot test innovative care coordination approaches to improving services for members in a “carve out” delivery system.
- **WellPoint State Sponsored Business’ CommunityConnect program** uses a case management team to and is increasing its collaboration with a local community services organization to increase face to face services and meet members on their own terms.
- **Beacon Health Strategies** is bringing face-to-face care coordination to a high-risk, high-need population of people with mental illness, partnering with the state of New York and a health plan;
- **Centene Health Strategies** is bringing culturally competent, peer-lead access point for health and mental health services.

These and other Best Practices highlighted in Section 2 of this Compendium illustrate some innovative health plan approaches to improving access to care, reducing disparities, and improving treatment adherence.

Effective health services can positively influence patients’ ability to function in work and home life. As more beneficiaries are enrolled in Medicaid managed health care plans, plans will increasingly be called upon to offer solutions that work for people with serious mental illness. MHPA commends its member plans for developing solutions and partnerships to improve health and health care for people with serious mental illness, and encourages ongoing collaboration with stakeholders to raise the bar to promote recovery.
PART 2: Best Practice Case Studies

WellPoint State Sponsored Business (SSB) - Indiana
Behavioral Health Follow-Up after Hospitalization

**DESCRIPTION:** The goal of this Indiana program is to improve community tenure and overall psychosocial functioning of members with psychiatric needs by addressing the barriers to engaging in outpatient treatment. The WellPoint SSB Behavioral Health (BH) Team employs multiple strategies including Utilization Management/Intensive Case Management/Outreach Care Specialists, Transition Sessions, Measures of Success Facility Feedback Program and Provider Education. The goal of these efforts is to engage members in effective follow-up care after an acute psychiatric admission. Longer-term goals include the development of core coping skills, improving medication compliance and increasing overall functioning and community tenure.

**KEY OBJECTIVES:**
- To increase appropriate treatment for Severe Mental Illness (SMI)
- To improve long-term medication adherence
- To reduce mental health-related preventable hospital admissions
- To improve the health of the population
- To enhance the patient experience of care (including quality, access and reliability)
- To control or reduce the per capita cost of care or increase efficiency

**ACTIONS TAKEN:** The WellPoint SSB Behavioral Health (BH) Team employs multiple strategies to engage members in effective follow-up care after an acute psychiatric admission. Effective outpatient care is the key to addressing the underlying reasons for hospitalization, the prevention of readmissions, development of a plan for emergencies and triggers of relapse for behavioral health and substance abuse issues. Longer-term goals include the development of core coping skills, improving medication compliance and increasing overall functioning and community tenure.

Key WellPoint initiatives include:
- Utilization Management/Intensive Case Management/Outreach Care Specialists
- Transition Session
- Measures of Success Facility Feedback Program
- Provider Education

**Utilization Management/Intensive Case Management/Outreach Care Specialists**
The engagement process starts at the time the member is admitted for an inpatient psychiatric stay. The BH Utilization Management (UM) team begins discussions with the hospital utilization review staff regarding discharge planning. The hospital staff is encouraged to communicate the inpatient admission to the outpatient provider and to plan an outpatient discharge appointment for the member within seven days of discharge from the acute hospital setting. At the time of discharge, the hospital is asked to provide the UM team the name of the clinician the member will be seeing and the date for the follow-up appointment.

Once the member is discharged, the UM manager sends the case to a team of Outreach Care Specialists (OCS). The OCS reaches out to the member telephonically within two business days of discharge. The goal of the outreach call is to educate the member on the importance of following the discharge plan and of attending any scheduled follow up appointments. The OCS is also available to assist the member in locating an outpatient provider should the member request assistance.

* Several states have modified their approaches to delivering Medicaid managed care services since 2010. Please contact MHPA for the latest information.

**SOURCE:** KCMU/HMA Survey of Medicaid Managed Care, September 2011.
Additionally, the OCS calls the provider within one to two business days of the appointment to confirm attendance at the follow-up appointment. This information provides real-time feedback regarding appointment compliance. If the member did not attend the appointment, the OCS makes an additional outreach call to help identify barriers and encourage the member to reschedule a follow-up appointment. These members are referred to case management services where a master level case manager reaches out to the member to further address complex barriers to medication adherence and outpatient follow-up care.

**Transition Sessions**

The “Transition Session” was created to provide an intermediary step between the inpatient stay and engagement with a community provider. Members who are being discharged from an acute psychiatric setting that experience significant barriers and cannot see a mental health provider within seven days can be seen by an independently licensed clinician on the day of discharge for a transition session.

The Transition Session is a WellPoint affiliated health plan reimbursed service which has the goal of providing a seamless transition from inpatient to outpatient care. During this session, the clinician:

- Reviews and ascertains the member’s understanding of their discharge plan
- Identifies and addresses anxieties related to discharge
- Discusses a plan for medication adherence
- Identifies barriers which might prevent medication adherence and/or follow-up with outpatient care and develops a plan to address them
- Identifies and explains symptoms which might prompt a readmission and develops an emergency plan to address those symptoms.

Following the Transition Session, clinicians complete a summary of the session and forward it to the health facility feedback program called the Facilities Measures of Success (FMOS). This program provides feedback to health facilities sending members to WellPoint-affiliated health plans. The feedback is based on their performance in providing a seamless transition from inpatient to outpatient care. The transition session was implemented for the Healthy Indiana Plan (HIP) on January 1, 2011. An assessment in rate changes for HIP will occur after the release of 2012 HEDIS® rates.

Several enhancements are in the planning stages for the Measure of Success Program. Enhancements will include expanding the reporting of the follow-up percentage based on payer type (Commercial, Medicare, and Medicaid), determining facility case mix, and expansion into Virginia SSB lines of business. In addition to the Measures of Success program enhancements, expansion of the transition program into Virginia SSB is being considered. Further opportunities are also being explored to expand education to outpatient providers about the importance of member follow-up within seven days of discharge from an acute psychiatric setting and effective engagement in outpatient treatment.

**Geographic Location:** The case study program was conducted in Indiana.

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Behavioral Health Transition Coach

**DESCRIPTION:** A small number of OptumHealth Behavioral Solutions-contracted psychiatric hospitals in Tennessee experience 30-day readmission rates higher than 10% with some having 30-day readmission rates well over 15%. Additionally, seven-day follow-up after hospitalization (FUH) rates for some of those providers falls below 30 days. In order to increase post-psychiatric hospitalization follow-up appointment adherence, address potential physical health co-morbidities, facilitate linkage with peer support, and affect a decrease in readmission rates, OptumHealth will pilot a Behavioral Health Transition Coach program.

OptumHealth’s Behavioral Health Field Care Advocates (FCA) will meet with identified members in a pre-discharge interview to discuss outpatient follow-up treatment and barriers to attending post-discharge behavioral health appointment(s) (at least within seven days), barriers to obtaining medications/medication adherence, and identification of possible physical health treatment issues. The FCA will also send to the member a post-discharge treatment reminder letter, as well as attend the post-discharge appointment(s) to offer the member a familiar contact in that treatment setting.

**KEY OBJECTIVES:**
- To increase appropriate treatment for Severe Mental Illness (SMI)
- To increase appropriate treatment for serious co-morbidities associated with SMI
- To reduce preventable mental-health-related hospital admissions
- To implement and measure the effectiveness of appropriate patient education
- To enhance care coordination by using peers and other non-physician providers

**ACTIONS TAKEN:** This initiative is currently in the planning phase with a target implementation date of February 15, 2012. Senior Management staff has discussed and agreed upon the need for the program, and have scheduled other management meetings to work out the details and logistics of implementation.

**OUTCOMES:** The primary outcome measures will be the follow-up after hospitalization (FUH) for behavioral aftercare services, readmission rate for participating members and level of member satisfaction with the program. Additional measures may include prescription medication utilization and physical health appointment adherence.

**GEOGRAPHIC LOCATION:** Study was conducted in the cities of Memphis, Nashville and Knoxville, Tennessee.

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OptumHealth Behavioral Solutions, Public Sector, Tennessee

Child and Adolescent Residential Treatment Center Diversion

**DESCRIPTION:** In order to make more informed medical necessity decisions for children and adolescents referred to residential treatment and to ensure those children and adolescents do not experience needless residential treatment admissions, OptumHealth developed the Child and Adolescent Residential Treatment Center Diversion (C&A RTC) diversion program. The aim is to help ensure children and adolescents are not needlessly being sent to residential treatment facilities when the best and most appropriate level of care is intensive in-home and/or outpatient services.

**KEY OBJECTIVES:**
- To increase appropriate treatment for Serious Emotional Disturbance (SED) (evidence shows in-home services to be the most effective venue for C&A treatment versus residential)
- To decrease inappropriate C&A RTC utilization

**ACTIONS TAKEN:** OptumHealth contracted with two C&A Behavioral Health service providers who have a statewide presence as well as extensive clinical experience with respect to whether or not a child should receive services at home or in a residential facility. Beginning in May 2009, for every C&A RTC request, one of those service providers is dispatched to perform a face-to-face assessment of both the child and family. The provider then gives the OptumHealth utilization manager the assessment and a recommendation as to the level of service believed to be most appropriate (i.e., RTC or intensive in-home services). That information augments the clinical information provided by the requesting RTC and informs the UM’s and MD’s decision. Should the MD decide to deny the RTC request, intensive in-home services are authorized for the child and family, and are set up to begin within 24 hours.

**OUTCOMES:** As of November 2011, the program reviewed over 1,400 C&A RTC requests. Over 500 (36%) of those children and adolescents were diverted to intensive in-home or other outpatient services. Only a small number (approximately 4-6%) of children and adolescents who were initially diverted from RTC ended up in a residential setting. This was due to several reasons, including increasing symptomatology that required a more intensive and structured level of treatment, or because of involvement with the State Child Welfare system, which would usually place children and adolescents in RTCs in order to keep them out of custody.

**GEOGRAPHIC LOCATION:** The case study program was conducted in the State of Tennessee.

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Optum Health Behavioral Solutions
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UPMC Health Plan
Connected Care™

DESCRIPTION: Connected Care™ is an initiative to improve the connection and coordination of care for those with serious mental illness (SMI) among health plans, personal care physicians (PCP), and behavioral health providers in outpatient, inpatient and emergency department (ED) care settings. Behavioral health is a carve-out for the mandatory Medicaid managed care program in Pennsylvania, thus members would have a different managed care plan for behavioral and physical health care. Members qualify for Connected Care if they are a member of UPMC for You and Community Care (Behavioral Health MCO), age 18 or older, live in Allegheny County and are identified as having SMI which has been defined as individuals with schizophrenic disorders, episodic mood disorders, or borderline personality disorder.

Historically, there is a coordination gap between physical health (PH) and behavioral health (BH) providers, similar to gaps between other specialists and PCPs. This occurs regardless of financing mechanism. Coordination is a challenge posed by confidentiality provisions.

People with SMI die at age 51, on average, compared to age 76 for Americans overall. Their odds of dying from the following causes, compared to the general population are:

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Increased morbidity and mortality associated with SMI result in high rates of premature death. Those with SMI die 25 to 32 years younger than the general population. This trend has accelerated in recent decades. Most deaths (60% to 70%) result from physical conditions with treatable risk factors, such as metabolic disorders, cardiovascular disease, diabetes and modifiable risk factors such as obesity and smoking.

UPMC for You’s population has a high rate of BH and PH admissions and readmission and emergency room utilization. Baseline data for this program is located in section 5, titled “Outcomes.”

KEY OBJECTIVES: There are three overall goals of this project and consistent with IHI’s Triple Aim: (1) improve the health of this population; (2) enhance the consumer’s experience; and (3) to reduce or at least minimize the cost of care. The measurements for these goals are described below:

- To decrease PH and BH admission/1000
- To decrease PH and BH readmission/1000
- To increase average number of community days between each PH or BH admission
- To decrease average length of stay
- To decrease ED visits/1000
- To increase the percent of members with at least 3 atypical antipsychotics filled with a glucose screen
- To increase the percent of members with at least 3 atypical antipsychotics filled with an annual glucose screen or HbA1c

The program addresses the following MHPA Best Practice priorities:

- To improve the health of the population
- To enhance the patient experience of care (including quality, access, and reliability)
- To control or reduce the per capita cost of care or increase efficiency
- To reduce disparities in care of racial and ethnic minorities
- To demonstrate accountability of Medicaid health plans, including fraud and abuse

ACTIONS TAKEN: New processes were implemented to facilitate care coordination among the physical health and behavioral health care management staff and the identification of members who had an inpatient admission or emergency room visit. The care managers were jointly trained on the program and to help the staff from each organization understand the differences in their approach to care management. An integrated care plan was developed that was viewable by staff from both organizations. Data from the two discrete care management systems was merged to create a common view. This helped staff to identify who the member was seeing the care managers involve with the member, key barriers and a text field for case notes. As members were identified for the program, the care managers discussed the case and determined, based on the member’s existing relationships, the staff member that would take the lead in managing the member. Weekly integrated care team meetings were implemented were the most complex members were discussed. The meeting included medical directors from both organizations, care managers and pharmacists. Information that had been obtained from the member or their providers was discussed along with the review of the member use of services and medication profile. A care plan was developed based on the team’s input. The responsible care manager then facilitated the implementation of the care plan with the member and applicable providers.

To help the member and their providers manage acute episodes of care, daily processes were implemented to identify when a Connected Care member was admitted to a physical or behavioral health inpatient facility or had an emergency room visit. This information was shared with the care managers from both organizations and faxed to the member’s behavioral health provider and PCP. The care managers would assist with discharge planning and contact the member upon discharge or after the emergency room visit to provide education and care coordination.

A monthly process was implemented to notify the prescribing provider and PCP of gaps in filling antipsychotic medications or other medication that are used to treat chronic conditions. In addition to this information, the providers were informed if recommended laboratory tests that help to monitor specific conditions were not done. This include an annual glucose screening for members on antipsychotics.

Other activities that were implemented to support the program are provided below:

- Consumer group meetings to obtain input on program design and materials.
- Using BH providers to help obtain consents.
- In 2009 provided a $25 gift card incentive to 4,400 members who had a visit with their PCP. In 2010 the incentive was changed to a $25 gift card for completing the consent form and enrolling in the program.
- Access to a 24-hour/day phone line managed by Community Care to answer member questions.

The following summarizes activities done to promote provider engagement:

- Mailing sent to PCPs and BH providers explaining the Connected Care program.
- UPMC Health Plan and Community Care clinical leadership conducted joint on site visits to high volume PCP offices and BH providers to explain Connected Care and shared materials consumers would be receiving.
- In the first quarter 2010 Community Care met with the BH providers and shared the list of their members so that they could assist in informing them of the program and help in obtaining consents resulting in increased consents.
OUTCOMES:

Number of unique members with PH admission
- Baseline – 685 (13.8%)
- First Year – 1062 (15.8%)

Average number of community days between each PH admission
- Baseline – 52.93 days
- First Year – 66.66 days *(statistically significant over baseline)

Average length of stay
- Baseline – 17.47 days
- First Year – 19.63 days *(statistically significant over baseline)

Number of unique members with PH and BH admission
- Baseline – 208 (4.2%)
- First Year – 196 (3.9%) *(statistically significant over baseline)

Number of unique members with BH admission
- Baseline – 950 (19.4%)
- First Year – 862 (12.8%) *(statistically significant over baseline)

Number of unique members with BH readmission
- Baseline – 146 (2.9%)
- First Year – 187 (2.8%)

Number of unique members with PH readmission
- Baseline – 62.06
- First Year – 57.02

Number of unique members with BH readmission
- Baseline – 177 (3.6%)
- First Year – 169 (3.1%) *(statistically significant over baseline)

Percent of members with at least 3 atypical antipsychotics filled with glucose screen
- Baseline – 54.8%
- First Year – 53.7%

Percent of unique members with PH/BH admission
- Baseline – 835 (16.5%)
- First Year – 759 (11.0%) *(statistically significant over baseline)

Percent of unique members with at least 3 atypical antipsychotics filled with glucose screen or HbA1c
- Baseline – 65.26% (1286)
- First Year – 68.86% (1650) *(statistically significant over baseline)

Number of unique members with PH and BH admission
- Baseline – 208 (4.2%)
- First Year – 196 (3.9%) *(statistically significant over baseline)

Average number of community days between each PH or BH admission
- Baseline – 52.09 days
- First Year – 66.66 days *(statistically significant over baseline)

Average length of stay
- Baseline – 17.47 days
- First Year – 19.63 days *(statistically significant over baseline)

ED visits/1000
- Baseline – 1963.1
- First Year – 1961.14

Percent of unique members with ED visits
- Baseline – 54.8%
- First Year – 53.7%

Percent of unique members with at least 3 atypical antipsychotics filled with glucose screen
- Baseline – 64.35% (1267)
- First Year – 67.45% (1616) *(statistically significant over baseline)

Percent of members with at least 3 atypical antipsychotics filled with glucose screen or HbA1c
- Baseline – 65.26% (1286)
- First Year – 68.86% (1650) *(statistically significant over baseline)

Contact: Debra Smyers
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WellPoint State Sponsored Business
Development of Mental Health Resources for Rural Residing Medicaid Patients

DESCRIPTION: WellPoint State Sponsored Business (SSB) is the only private health plan in California to develop, manage and comprehensively support a statewide Telemedicine program to improve access to care. Following a quality improvement initiative, the plan was able to increase access to specialty services for members in rural areas. This intervention was of particular importance to members in need of psychiatric care, the specialty service most in demand through telemedicine services. SSB’s Telemedicine Program in California has allowed patients to receive consultations from medical specialists throughout the state. Telemedicine can be used by local primary care providers to obtain second opinions on difficult cases to avoid misdiagnosis and to help prevent them from prescribing ineffective medications.

KEY OBJECTIVES:
- To increase appropriate treatment for Severe Mental Illness (SMI)
- To reduce mental health-related preventable hospital admissions
- To address cultural and ethnic disparities in behavioral health care

ACTIONS TAKEN: WellPoint’s SSB Telemedicine program offers coverage in 24 of the 58 counties in the state. The program offers access to approximately 25 specialties. The five most commonly used specialties are Psychiatry, Dermatology, Endocrinology, Neurology and Pediatrics. An appropriate and adequate selection of specialists is critical to the success of a telemedicine network. It can be difficult to recruit specialists who participate in programs that cover uninsured, underinsured, or Medicaid patients.

SSB provides Presenting Sites with access to an appropriate specialist network. Reimbursement comes from billing payers, not from grant funds. This intervention was designed to address unmet utilization of the telemedicine program, which resulted in limited access to specialty services, including psychiatric care. Through marketing, negotiations, and selective support, telemedicine specialists contracted with SSB have been encouraged to contract with Medicare, Medicaid, CHIP and as many other health plans as possible.

The strategies listed below, were used to develop and maintain a robust network of specialists providing services, regardless of the patients’ payer source:
- Recruiting private provider groups not affiliated with the severely impacted University of California Telehealth programs
- Providing site fee reimbursement for specialty centers
- Providing small incentives to encourage targeted providers to serve Medicaid patients
- Contracting FQHCs that have comprehensive behavioral health specialists, which seek out Medicaid patients (due to their reimbursement model, and which are usually very financially stable)
- Recruiting semi-retired physicians and specialty groups with excess capacity and an affinity for technology

These efforts have helped specialists to realize the primary care practices in “Presentation Sites” are necessary customers. If the specialist is not contracted with a majority of payers, the specialist becomes an out-of-network provider for some patients and cannot provide services. The Site Coordinator for Presentation Sites will do business first with specialists who accept the most insurance plans.
Background - Specialty Contracting for the Medicaid Population

The SSB Telemedicine Program has 59 Presentation Sites, locations where the patient is presented to a remote specialist via telecommunications technology, diagnostic equipment, and computers and 19 Specialty Centers (the specialist’s location). SSB supplies the equipment, software and maintenance; conducts the trainings; provides marketing materials; and disseminates information on how to apply for grant funding and discounted phone services. All of these services are offered with the hope of easing the financial burdens incurred by the site to access specialty care, and to ensure program sustainability and longevity.

In 2006, WellPoint’s SSB began a process of evaluating the impact of the Telemedicine Network, with the goal of improving access for members in need of specialty consultations. Despite operation for almost eight years (1999–2006), the team had been disappointed in the utilization of the SSB Telemedicine Network. A survey or Presentation Sites (primary care facilities) revealed the following issues:

1. 95% of the Presenting Sites were Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) with, on average, above 75% of the patient population on Medicaid.
2. The majority of available specialists either refused to see Medicaid patients, demanded block time payment for seeing Medicaid patients, or were booked up for many months.
3. Greatest specialty demand was for Behavioral Health providers (Psychiatrists) and the supply was minimal.

California has the fourth lowest Medicaid (Medi-Cal) payment rate in the nation, averaging 56 percent of federal Medicare rates,1 and pays out less in benefits per enrollee than any other state.2 These low payment rates are making it increasingly difficult for physicians to treat Medi-Cal patients, while staying financially viable. This is illustrated by the fact that only 57 percent of physicians were able to accept new Medi-Cal patients in 2008.3

SSB discourages the practice of Presenting Sites purchasing specialist block time with grants because we believe that model is not sustainable. For instance, grants are short-term and unpredictable, with added administrative burdens on the Presenting Sites. Normalizing the reimbursement process for both the Presenting Site and the specialist through contracts with health plans allows both entities to be concerned only with their own claims and billing activities. If reasonable rates are negotiated, both parties are in service to members for the long term.

OUTCOMES: Since it was implemented in 2008, the recruiting strategy has resulted in rapid utilization growth. The data shows a marked increase in mental health and other telemedicine encounters since the model became operational. As broadly contracted specialty providers became available to the Presenting Sites, utilization grew at a fast pace. In 2007, 1312 of the 2927 clinical consultations were psychiatric consultations. In 2010, 3515 of the 6740 clinical encounters were psychiatric consultations. Contracting efforts became more focused on the specific specialties that Site Coordinators identified as being in short supply.

NurseWise®/Nurse Response™ (A Centene Company)

Diabetes Education for SMI

**DESCRIPTION:** NurseWise of Arizona has developed a diabetes education program for persons with Serious Mental Illness (SMI) which is delivered in conjunction with a community behavioral health services provider. Through the combined health and behavioral health program, NurseWise is able to provide integrated care services for people with SMI, and to enhance screening for diabetes. As part of the program the community provider identifies and invites members to participate in a weekly support group that addresses mental, physical, and social health issues. An RN with both diabetes education and psychiatric nursing experience leads the group and tailors materials and interventions to the unique needs of this population. Members meet weekly, keep their own workbooks and the group activities are documented in their medical record. Members learn how to manage their diabetes and how to communicate their needs and progress to their behavioral and medical providers.

**KEY OBJECTIVES:**
- To increase appropriate treatment for serious co-morbidities associated with SMI
- To improve long-term medication adherence
- To use and measure the effectiveness of appropriate patient education
- To improve coordination of care for persons with SMI when services are carved out

**ACTIONS TAKEN:** Key initiative taken to meet the program objectives include:
- Development of referral and admission criteria for the diabetes education group with the behavioral health agency.
- Engaging persons with SMI in self-management of their diabetes through structured group meetings, activities and feedback mechanisms (blood sugar checks, as an example)
- Integration of medical and physical care within a single point of care. The SMI participants are able to attend diabetes education at the same clinic setting where they receive psychosocial therapies and medication management. Education group records are available for the behavioral health prescriber and therapist in the participant’s medical record.
- Our RN educator has developed the diabetes education program activities for this group and tailors modules according to their functional level.

**OUTCOMES:** This program began in 2010, and allows the agency prescriber to order labs directly or obtain records from the PCP with release from the participant. The program is carried out at one site, and the number of group participants varies over time from four to eight. The intended measures from this program include the engagement of participants as measured by weekly groups, as well as HbA1c measures as provided by behavioral health agency records.

**GEOGRAPHIC LOCATION:** Case study program was conducted in Pinal County, Arizona.

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PerformCare (Part of the AmeriHealth Mercy Family of Companies)

Enhanced Care Management for High-Risk Members

**DESCRIPTION:** The Enhanced Care Management Program was implemented in 2007 by PerformCare, a managed behavioral health and human services company providing services to Medicaid beneficiaries in Pennsylvania. Through this program, PerformCare identifies high-risk members, including those with serious mental illness (SMI) and provides increased care management services to ensure these members have access to community services, experience coordinated mental health treatment, connect with supportive providers and receive outreach as needed. In Pennsylvania Medicaid, the counties are the primary contractors for the Behavioral Health program. These county stakeholders meet monthly to brainstorm supportive initiatives for each member. Regular outreach and contact occurs between the clinical care manager and these members to assess ongoing needs, provide support and encourage members’ recovery efforts.

**KEY OBJECTIVES:**
- To improve identification of members with SMI
- To increase appropriate treatment for SMI
- To increase appropriate treatment for serious co-morbidities associated with SMI
- To reduce mental health-related emergency room utilization
- To reduce mental health-related preventable hospital admissions
- To enhance care coordination by using peers and other non-physician providers

**ACTIONS TAKEN:** Through the Enhanced Care Management for High-Risk Members initiative in 2007, PerformCare developed a forum for community stakeholders to discuss and brainstorm solutions for SMI members identified as High Risk. Over the past four years the program has grown to include activities that incorporate outreach calls to SMI members identified as high risk, and activities to evaluate needs, coordinate care and connect members with services. The program encourages members to contact the clinical care manager for assistance during high-need time periods. The program also includes treatment team meetings, outreach phone calls and monthly meetings to ensure member’s treatment teams coordinate care.

Enhanced care management:
1. Diverts mental health inpatient admissions when appropriate through outreach to members, member’s treatment team and other invested parties.
2. Works with the providers to facilitate discussion with and explanation for the member to arrange an assessment for and referral to community case management services.
3. Calls members to discuss their perspective on service needs and potential assessment for services. With member consent, a conference call will immediately be made to the provider to ensure connection with services.
4. Contacts the member’s providers to determine if they are actively providing services with the member and encourage development of a wellness recovery plan.
5. If treatment protocols are not effective or previous attempts to engage the member are unsuccessful, arranges a service plan team meeting. The clinical care manager coordinates a meeting to assist in determining alternative treatment, assure that all steps are in place, and facilitate the follow-through on recommendations.
6. Facilitates service planning and recovery plans. The service plan and/or recovery plan is either reviewed or developed at the service planning team meeting, ensuring that recovery principles are followed and it includes the following areas: a focus on strengths, self-help and self-management, peer support, proactive crisis planning and effective hospital alternatives, an emphasis on rights and informed consent, and effective treatment approaches.
OUTCOMES: The Enhanced Care Management Program has successfully increased communication contacts with members that facilitate care and reduce preventable admissions and inpatient stays. The data below indicates that in calendar year 2011 there have been 1,077 unique contacts with SMI members meeting the high risk criteria. On average, each month 76.5 members are contacted by the clinical care manager to coordinate care, connect members with community services and to assess their needs. This averages out to between 1.5 and 2.5 contacts with each SMI member each month.

Additionally, the clinical care managers’ activities to support this population resulted in a significant decrease in the number of mental health inpatient admissions, total mental health inpatient days and average length of mental health inpatient stay for SMI members determined to meet the high-risk criteria. Sixteen SMI members could be tracked with 12 months of data prior to engagement and 12 months post engagement; these are represented in the below graph. Prior to entering into the Enhanced Care Management Program, these members experienced 54 mental health inpatient admissions totalling 510 days. Each member’s engagement in the program is then broken into a first and second half. Mental health inpatient admissions decreased to 36 in the first half of engagement and 12 in the second half of engagement. Days on a mental health inpatient unit decreased to 471 days in the first half of treatment and 117 in the second half of treatment. Finally, for an entire year following discharge from the Enhanced Care Management Program, these 16 members experienced only 12 mental health inpatient admissions and 67 days on a mental health inpatient unit. This represents a decrease of over 76 percent for mental health inpatient admissions and nearly 87 percent for total mental health inpatient days.

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**Grand Total** 1,077

**Number of Admits:**

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<td>67</td>
<td>6</td>
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<td></td>
<td>15.0</td>
<td>12.9</td>
<td>0.6</td>
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**Number of Days:**

<table>
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<tr>
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<th>Before 1st Half</th>
<th>1st Half</th>
<th>2nd Half</th>
<th>Before 2nd Half</th>
<th>2nd Half</th>
<th>After</th>
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<tbody>
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<td></td>
<td>16</td>
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<tr>
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<td>117</td>
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**Avg Length of Stay:**

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<tr>
<th>MHP</th>
<th>Before 1st Half</th>
<th>1st Half</th>
<th>2nd Half</th>
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<td>12.9</td>
<td>0.6</td>
<td>6.9</td>
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</tbody>
</table>

**Key:**

- “Before” indicates the period 12 months prior to High Risk Designation
- “1st Half” / “2nd Half” indicates the period from 12 months prior to 12 months post High Risk Designation
- “1st Half of the High Risk Period has been summarized for MHP Admits and MHP Days
- “After” indicates the period 12 months following the enddate of the High Risk Designation

**Geographic Location:** Case study program was conducted in Pennsylvania.

**Contact:**

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MDwise Hoosier Alliance (Part of the AmeriHealth Mercy Family of Companies)

Four-Quadrant Model of Care Management

DESCRIPTION: MDwise Hoosier Alliance implemented a four-quadrant model of care management in October 2011. The program has integrated behavioral and physical health for Medicaid members with serious mental illness (SMI) in the complex care management program. The four-quadrant program uses a thorough health assessment to identify physical and mental health needs of a member and to assign the member to a care management category based on health risk. Rather than assigning two care managers to members with co-morbid behavioral health (BH) and physical health (PH) conditions, one care manager is assigned to manage all the member’s conditions. A four-quadrant approach is used to identify the behavioral and physical health needs of the member and to assign a care manager with an appropriate skill set. The care manager coordinates multi-disciplinary services using regular integrated case conferences.

KEY OBJECTIVES:
- To improve identification of members with SMI
- To increase appropriate treatment for SMI
- To increase appropriate treatment for serious co-morbidities associated with SMI
- To improve long-term medication adherence
- To reduce mental health-related emergency room utilization
- To reduce mental health-related preventable hospital admissions

ACTIONS TAKEN: Due to the high level of co-morbidities between SMI and physical health conditions as well as for chronic medical conditions, depression and the poorer outcomes for this population, the MDwise Hoosier Alliance care management department has integrated behavioral health and physical health support so that members with co-morbid BH and PH conditions are assigned one complex care manager to work with the member and address both BH and PH conditions. This model replaces the traditional co-management model where two care managers, one BH and one PH, are assigned to the member and co-manage the case. MDwise Hoosier Alliance identifies at-risk members through multiple avenues, including referrals from Utilization Management, data mining and provider referrals. Once identified as at-risk, the member is assessed for both behavioral and physical health issues. Members are assigned to a quadrant depending on their behavioral and physical health needs.

- Quadrant I members have low behavioral and physical health needs and are provided low-level care management supports primarily by care management technicians.
- Quadrant II members have high behavioral health and low physical health needs. Quadrant II members are served by complex care managers with a strong behavioral health background.
- Quadrant III members have high physical health and low behavioral health needs. Quadrant III members are served by complex care managers with a strong physical health background.
- Quadrant IV members have high behavioral and physical health needs. Quadrant IV members are served by a super care manager who has experience in both BH and PH.

The care managers receive intensive training in managing all conditions which is supplemented with support from a psychiatrist and physician advisors. Integrated case conferences occur at least monthly. Staff presents cases that are discussed in a group setting with oversight from the physician advisors. This program was implemented October 3, 2011.

OUTCOMES: The outcome measures which have been identified are for members who are fully engaged in care management. The outcome measures currently identified are as follows:
1. Inpatient admissions
2. ER admissions
3. Medication adherence
4. Visit adherence

This program was implemented during 2011. Currently, MDwise Hoosier Alliance is finalizing baseline measurements. The plan anticipates the first measurement report to be provided in January 2012. Outliers will be identified as three standard deviations. Additional planned measurements include:
- Percent of members transitioning between quadrants
- Percent of members disenrolled and reason for disenrollment

GEOGRAPHIC LOCATION: Case study program was conducted in Indiana.

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Keystone Mercy Health Plan (Part of the AmeriHealth Mercy Family of Companies)

Health Choices/Health Connections

DESCRIPTION: This project was part of the larger Rethinking Care program of the Center for HealthCare Strategies. HealthChoices/Health Connections was the southeast Pennsylvania entry in a two-year collaborative demonstration project designed to improve coordination of care for individuals with serious mental illness (SMI). This project was aimed at Medicaid beneficiaries only. The initiative was sponsored by the Pennsylvania Department of Public Welfare (DPW) and the Center for Health Care Strategies. Program partners were Keystone Mercy Health Plan (KMHCP), the Behavioral Health (BH) leadership of Bucks, Delaware, and Montgomery counties and Magellan Behavioral Health of Pennsylvania (MBH, the administrative partner of the counties). The goal of the project was to design, implement and assess strategies for improving coordination of physical and behavioral health. The strategy was to define and implement specific performance goals, linked to a shared savings pool for each year. Program evaluation is being performed by Independent Pharmaceutical Research Organization (IPRO), responsible for collection and scoring of the partner’s performance against established targets, and Mathematics Policy Research (responsible for evaluation of overall project, including process effectiveness and member impact).

KEY OBJECTIVE:

- To improve coordination of care for SMI when services are carved out.

ACTIONS TAKEN: The program partners, including Keystone Mercy Health Plan:

1. Established a Navigator model, utilizing existing staff from the counties’ BH staff, as the primary member contact, as well as the contact on the member’s behalf for the physical health (PH) and BH managed care organizations (MCOs), primary care provider, BH provider and, as indicated, specialty care provider.
2. Created a specific member consent, designed to facilitate communication between designated stakeholders in the member’s care.
3. Targeted members either already receiving care in the BH system, or members that would most likely benefit from engagement.
4. Fully engaged ONLY those members completing a project consent form (in order to protect the privacy of the members involved).
5. Established multidisciplinary case conferences, both intraplant and between all project partners (including member Navigator) for complex cases.

In year one, DPW established four performance goals for the project. Each performance goal reflects aspects of care important to improving coordination for members with SMI. Partners needed to develop quality improvement strategies that improve care for members in order to improve performance on program metrics. Each goal counted for 25 percent of the available shared savings pool:

- Member Stratification and Re-stratification: The partners needed to demonstrate the ability to provide an initial stratification level, as well as track and document any movement within stratification levels, from both the PH and BH perspectives. The performance targets for this measure were:
  - Documentation of the stratification and re-stratification process.
  - Demonstration that 90 percent of all project-eligible members received an initial stratification within 60 days of program launch, and that 90 percent of new members identified receive stratification within 60 days of identification.
  - Documentation of member movement within stratification levels at least annually.

- Integrated Care Plan: Creation of a communication tool, referred to as the Member Health Profile, which summarizes and integrates selected PH and BH utilization information over a rolling 15-month period. The profile includes a rolling 12-month review of pharmacy utilization. The performance target for this measure was the creation of 1,000 integrated member profiles by the end of the first year (June 30, 2010).

- Hospital Notification Process: The PH and BH MCOs will track information and notify each other about inpatient utilization activity of identified members. To achieve this performance target, plans were required to document successful hospital notification of the project partner within one business day of when plans were notified at a 90 percent success rate. Additionally, the plans needed to provide evidence for active post-discharge care coordination.

- Pharmacy Utilization: Focused attention on member adherence with atypical antipsychotic medications. To achieve this performance target, the plan needed to identify members as non-adherent or defined as having a medication possession ratio of < 0.8 and communicate this fact with prescribing providers for 90 percent of these members.

In year two: In addition to the four performance measures from year one (which account together for 50 percent of the year two score) the following measures were included, each accounting for 25 percent of the Shared Savings pool:

- Reduction of emergency room (ER) utilization: Target = decrease of > 3.0 ER visits per 1,000 members
- Reduction of inpatient utilization: Target = combined decrease of > 3.0 discharges per 1,000 members
  - Physical Health Rates
  - Mental Health Rates

OUTCOMES: Qualitatively, through the project KMHCP case managers gained greater knowledge of how BH issues are managed: what programs exist, the program contacts and how the programs work, etc. We were also able to help our BH partners gain a better understanding of the care management processes and issues on the PH side, how benefits are administered, and how to ensure members gain access to required services/equipment, etc. Part of the final project evaluation from MPR will focus on these aspects of the project.

Year 1 Performance Measures

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>HCHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stratification of at least 90 percent of members into risk groups</td>
<td>✔</td>
</tr>
<tr>
<td>Patient-centered care plans for 1,000 members during year one</td>
<td>✔</td>
</tr>
<tr>
<td>Notification of at least 90 percent of admissions within one business day of responsible entity learning of admission</td>
<td>✔</td>
</tr>
<tr>
<td>Prescriber notification of at least 90 percent of medication refill gaps for atypical antipsychotics leading to a medication possession ratio of &lt; 0.8</td>
<td>✔</td>
</tr>
</tbody>
</table>
In year one, IPRO determined that HealthChoices/Health Connections successfully met requirements for three-of-the-four DPW performance measures. Mathematica Policy Research (MPR) implemented their evaluation model. Although there were differences in population baseline characteristics, all trends in outcome measures were reported as consistent. There was no demonstrated program impact on aggregate rates of ER visits or hospitalizations. The program did improve access to multidisciplinary care through rounds/case conferences and PH-BH navigator/care manager teams.

In year two, evaluations by both IPRO and MPR are ongoing. It is not clear at this time when we might expect IPRO’s review for year two. It is anticipated that MPR’s final overall program evaluation will be available sometime in the second quarter of 2012. The project ended as of June 2011. The counties fully intend to try to continue and expand the Navigator model to other members under their care. Medicaid (including KMHP members, and members under other payors), Commercial and Medicare. DPW would like to see this type of care coordination continued and expanded. A key outstanding question is how to facilitate sharing of PHI between the BH and PH plans to facilitate effective care coordination without running the risk of violating strict Pennsylvania statutes.

**GEOGRAPHIC LOCATION:** Case study program was conducted in Southeast Pennsylvania in the Philadelphia area.

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Physician Advisor, Medical Director, Keystone Mercy Health Plan  
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**NurseWise®/Nurse Response™ (A Centene Company)**

**Health Risk Assessment (HRA) for SMI**

**DESCRIPTION:** This program was developed to increase screening with a health risk assessment for patients identified with a Serious Mental Illness (SMI). Communication and coordination of care is vital in bridging the gap between behavioral health and medical providers to promote the improvement of quality of care for persons receiving services from both systems. NurseWise successfully accomplishes this communication and coordination by telephonic contacting persons with SMI to complete Health Risk Assessments (HRA), which are then saved in a secure system for both behavioral health and medical providers to access. The regional behavioral health authority provides the call lists based on enrollment and identification of SMI status.

**KEY OBJECTIVES:**
- To increase appropriate treatment for Serious Mental Illness (SMI)
- To increase appropriate treatment for serious co-morbidities associated with SMI
- To improve coordination of care for persons with SMI when services are carved out
- To enhance care coordination by using peers and other non-physical providers

**ACTIONS TAKEN:** Key initiatives taken to meet the program objectives include:
- Persons identified as having a Serious Mental Illness are contacted to complete a HRA. When appropriate, behavioral health providers are contacted and asked to assist the person in making an appointment with their PCP.
- The HRA tool is initiated through a behavioral health managed care system and focuses on physical conditions in order to facilitate coordinated care needs. The tool is specific to the SMI population.
- Handoffs to the treating behavioral health provider agency are conducted as a coordination of care call to the agency if the participant responds that they have not seen a PCP in over a year or have a complex medical condition. The agency point of contact follows up with the participant to coordinate an appointment with their PCP.
- Behavioral health and medical documents are stored in a secure database. All providers can access and update information as needed.
- NurseWise® uses Peer Support partners, self-identified as receiving mental health services, to conduct outreach. They are trained in application of the HRA tool and in the medical terms used. These are employees of NurseWise and provide other telephonic services to persons with SMI as well.

**OUTCOMES:** Outcomes to be measured:
- Completion rate of HRA’s over an annual period, calculated by the number of HRA’s completed divided by the total of SMI enrollees per county
- Number of PCP appointments scheduled for SMI enrollees

**GEOGRAPHIC LOCATION:** Case study program was conducted in Yuma, Pinal, Gila, Cochise and Santa Cruz counties in Arizona.

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Manager, Call Center Operations, NurseWise/Nurse Response  
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Value Behavioral Health of PA, Inc.

Improving Access to Care in a Rural Community

DESCRIPTION: ValueOptions developed this pilot project to increase access to behavioral health services in a rural underserved area of Florida. ValueOptions, an independent behavioral health and wellness company partnered with a community mental health/substance abuse provider (David Lawrence Center) and Verizon. The project is proving that communications technology can bring doctors and patients together virtually to increase accessibility, improve care and reduce costs. The target population was the Haitian community that had migrated to Immokalee, Florida. The technology was used for children and adults. Cultural competency and transportation challenges locally were preventing them from accessing needed behavioral health services. The telepsychiatry was useful for the entire population, with a satisfaction rate of over 99% for the members and the physicians alike. This pilot worked so well because ValueOptions wrapped case management around these members to assist them in getting care.

KEY OBJECTIVES:

- To increase appropriate treatment for Serious Mental Illness (SMI).
- To improve long-term medication adherence
- To reduce mental health-related preventable hospital admissions
- To improve identification of members with SMI
- To reduce mental health-related Emergency Room utilization
- To address cultural and ethnic disparities in behavioral health care
- To enhance care coordination by using peers and other non-physician providers

ACTIONS TAKEN:

A doctor typically needs to “see” the patient, read body language, see facial expressions and catch the nuances in voice for an effective behavioral health visit. Replication of the in-person experience is the key factor in tele-psychiatry. “When you are seeing someone for mental health service, it is very critical for it to be as close to a real face-to-face visit as possible. There can be no lag in sound or picture quality,” says Dr. J. David Moore, DLFAPA, Medical Director, ValueOptions Tampa Regional Service Center. To extend psychiatric care to members living in remote areas, ValueOptions decided to bring psychiatric evaluations to them virtually.

To accomplish the goal of increasing access to psychiatric evaluations while preserving the important doctor/patient relationship, ValueOptions determined that they would need superior communications technology performance. Through a partnership with Verizon, ValueOptions provided the safest, high-quality, real time technology available. The video units are so easy to use that there was very little training of the doctors or staff at the remote site. Training revolved around how to handle medications and getting prescribed medications to the members.

ValueOptions implemented the pilot project with Medicaid members and physicians in Immokalee over the past year. In both Immokalee and Naples, a monitor with a camera sat on desks. The member sat in front of the one in Immokalee while the physician sat in front of the one in Naples. These units were more than sufficient to allow engagement of the member with the physician. Based on the success of the pilot, ValueOptions has recently expanded efforts to encompass up to 15 additional mental health centers. Staff of these centers will be trained in appropriate care scenarios involving both tele-psychiatry and tele-behavioral health during the next two-to-three months.

OUTCOMES: This technology based solution enables better use of limited physician resources, improving access to care and prevention for rural and remote members while helping control delivery costs. The anecdotal evidence of success is backed up by the numbers: for a 14-week period from June 28 to October 1, 2010, the service had a 62 percent increase of care delivery to clients over the same period the previous year. That equates to a jump from serving 95 clients and providing 645 services during the June to October timeframe in 2009, to 157 clients served and 1,223 services provided during the same period in 2010. The pilot project experienced over 90% satisfaction from the members and the physicians.

ValueOptions has been thrilled with results at the David Lawrence Center and is looking to expand in other areas with tele-psychiatry. With the advent of 4G wireless technology, ValueOptions is eager to explore a mobile solution in which case managers meet members in homes, community centers and other locations. And with the success of their pilot program, ValueOptions is proving that with the right communications technology and clinical expertise, barriers to access will continue to fall and quality of care will continue to rise. Dr. Moore continues to monitor the use of tele-mental health to improve access to needed services for ValueOptions members.

GEOGRAPHIC LOCATION: Case study program was conducted in Immokalee, Florida and Naples, Florida

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Health Partners of Philadelphia, Inc.

Improving Coordination of Care for Our Young Members with Emotional Health Needs/Medications

DESCRIPTION: Health Partners of Philadelphia, Inc. is a non-profit, hospital-owned physical health MCO serving more than 170,000 members in the Philadelphia region. Behavioral Health services for children and adults are carved-out in Pennsylvania. Health Partners is accountable for physical care services and all pharmacy services, including behavioral health medications. Health Partners recognizes that emotional health and physical health are intricately linked and must be addressed together to improve health outcomes. This is especially true of the child population, which includes treating and educating the entire care support system in addition to the child. Through an analysis of pharmacy claims, the plan identified a high number of children who were prescribed at least one of the classes of psychotherapeutic medications. The plan developed a best practice to improve documented coordination of care between our PCPs and contracted behavioral health services providers. The initiative is designed to improve coordination of primary and behavioral care, improve patient/family/care-giver education, and improve clinical monitoring for side effects of psychotherapeutic medications.

KEY OBJECTIVES:

- To improve coordination of care for Serious Mental Illness (SMI) when services are carved out
- To increase appropriate treatment for serious co-morbidities associated with SMI
- To address cultural and ethnic disparities in behavioral health care
- To improve identification of members with SMI
- To increase appropriate treatment for SMI
- To improve long-term medication adherence
- To reduce mental health-related Emergency Room utilization
- To reduce mental health-related preventable hospital admissions
- To use and measure the effectiveness of appropriate patient/parent education
- To enhance care coordination by using peers and other non-physician providers

ACTIONS TAKEN: In 2008, Health Partners began using pharmacy claims data to develop a baseline for documenting coordination of care between the member’s primary care provider (PCP) and his/her behavioral health specialist. (At times, this PCP provider is independently prescribing BH needs without a BH provider). These members were identified as those having more than one prescription for a medication classified as a behavioral health drug. As a best practice, patient children and/or their parents on these medications need to have education on the behavioral health condition and medication, regular evaluations for side effects, laboratory testing, and coordination with behavioral health providers. Through extensive medical record review, the plan found that compliance/coordination of care by the PCP was low. The plan developed a comprehensive initiative designed to:

- Educate providers (including how to identify new, young patients with emotional/behavioral health needs and maintain good documentation in the member’s medical record)
- Enhance communication between plan PCPs and behavioral health specialists
- Increase patient medication compliance
- Raise awareness of Health Partners’ Special Needs Unit as a key provider and member resource
- Enhance overall “big picture” synchronization of young members’ physical and mental health

Health Partners spent the first year educating providers about the importance of communication, documentation and follow up on the patient’s behavioral health needs in the primary care setting. Health Partners also used quarterly physical health and behavioral health collaboration meetings as a forum for further discussion and follow up. PCP education was accomplished through network management consultants and QM Nurse visits to MCO provider offices to offer education, review of findings and a tool to facilitate better documentation. Providers were selected for a visit determined by their baseline rates of performance in chart review. The collaborative meetings offered a multidisciplinary forum for physical and behavioral health care givers to discuss opportunities to improve coordination of care.

Health Partners then established a focus group of plan PCPs to work with the Quality Management Committee to review documentation tools for use by our network providers and BH providers. Through these meetings, we created a quick-to-complete follow-up checklist that is kept in the PCPs member chart and updated as needed at each visit. Through the checklist and educational efforts, Health Partners encourages use of our behavioral health guidelines to monitor the patient’s behavioral health status and offer counseling in areas like lifestyle (drugs, smoking and sexual activity), as well as medication compliance and education regarding side effects. The plan communicates with provider through a quarterly provider newsletter, the provider section of the website, and other provider communications vehicles.

Health Partners’ Special Needs Unit (SNU) is always available to assist providers and members with resources regarding children and teens’ behavioral health needs. Each quarter, the SNU meets with our behavioral health contractors/providers to discuss the most complicated scenarios and responses. In addition, plan outreach includes member education, such as regular articles in our Member Newsletter informing parents and caregivers of the importance of getting care whenever mental health medications were being used.

OUTCOMES: Overall, the results are encouraging, demonstrating compliance over time in a tremendously challenging area of care. As noted in the attached graph, we continue to monitor coordination of care by PCPs including:

- BH medications confirmed
- Compliance documented
- Side effects reviewed
- Coordination of care (psychiatric and physical)
- Parental education
- Laboratory work

This best practice includes review of all PCPs who have eligible members with one or more prescriptions for a medication classified as a behavioral health drug. We continue to focus on additional communication or education which would further improve coordination of care.

GEOGRAPHIC LOCATION: Case study program was conducted in Philadelphia, Pennsylvania and the surrounding four counties.

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MDwise
Integrated Healthcare in Indiana

DESCRIPTION: MDwise and the State of Indiana are collaborating with three multi-site clinic providers in the MDwise Behavioral Health and Medical Networks to develop integrated healthcare models for members with mental health and medical care needs. These initiatives were begun by the three clinics in 2008, 2009 and 2010 respectively. The first two are funded by MDwise and the third by the State of Indiana. Each clinic is working towards the goal of improving access to care, improving patient outcomes, increasing appropriate care for co-morbid medical conditions and to reducing hospital admissions. Each clinic developed its own model for co-locating or coordinating services, increasing screening for mental health and other needs, facilitating access to practitioners, and improving office operations to facilitate integrated care. The impact of the projects is measured through health plan data on use of health services, emergency care and hospital admissions as well as patient and provider satisfaction. Federal agencies including HRSA, SAMHSA and CMS are supporting the initiative with technical assistance.

KEY OBJECTIVES:
- To increase appropriate treatment for Severe Mental Illness (SMI)
- To increase appropriate treatment for serious co-morbidities associated with SMI
- To reduce preventable mental-health-related hospital admissions

ACTIONS TAKEN: MDwise is working with three clinics to integrate behavioral health and medical services, with a particular emphasis on members with serious mental illness. The overall program goals include:
- Healthier, more satisfied patients
- Decreased readmissions to Hospital/ER
- Increased productivity, more revenue, more services provided in clinics
- Practitioners functioning in ideal roles: prescribing, counseling, social work, case management, with coordination between multidisciplinary services.
- Cost savings to Medicaid

While each clinic has designed its own model, common integration features of the programs include:
- Co-located services
- Use of patient navigators to help patients move through the clinic visits, and “warm” handoffs between medical and behavioral programs to ensure patients have needed follow through
- Increased screening using validated tools
- Emphasis on brief solution therapy
- Utilization of outside agencies when appropriate
- Direct patients to most appropriate level of care
- Work with PCPs to treat complex medical cases

OUTCOMES: MDwise uses health plan data and member surveys to evaluate the impact of the program. Surveys of clinic staff show satisfaction with clinician’s ability to coordinate and manage care and decreased access barriers for patients. In addition, the plan is beginning to see trends in the reduction of hospital admission and access to appropriate medical care. The longer a patient is in integrated healthcare, the greater the reduction in cost as the patient is receiving the appropriate care at the right time, in the right place.

GEOPGRAPHIC LOCATION: Case study program was conducted in Indianapolis, Indiana and Lake County, Indiana.

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| MidTown and North Shore Members with at least one month of eligibility prior to and after initial integration visit. |
| Inpatient Claims PMPM | Prior to Integration | Post Integration |
| $115 | $90 |
| Outpatient Claims PMPM | $62 | $58 |
| Professional Claims PMPM | $120 | $93 |

| MidTown and North Shore Members with 6+ months of eligibility prior to 9+ months after initial integration visit. |
| Inpatient Claims PMPM | Prior to Integration | Post Integration |
| $415 | $274 |
| Outpatient Claims PMPM | $196 | $83 |
| Professional Claims PMPM | $430 | $164 |
Value Behavioral Health of PA, Inc.

Monitoring for Risk of Metabolic Syndrome in Persons Prescribed Second Generation Atypical Antipsychotic Medications

**DESCRIPTION:** Value Behavioral Health of Pennsylvania (VBH-PA) implemented an intervention in 2006 to increase the monitoring of Medicaid patients for risk factors for metabolic syndrome. The initiative addresses psychiatrists prescribing Second Generation Atypical Antipsychotic Medications (SGAs), and seeks to increase the coordination of care with primary care physicians. SGAs are used appropriately for treatment of serious mental illness, but come with an increased risk to the patient of developing metabolic syndrome or diabetes related to weight gain. SGA prescribing and monitoring practices have been studied from 2006-2011 in 16 large mental health outpatient provider practices, with the goal of increasing evidence based monitoring for side effects of SGAs. Annual feedback and self-monitoring tools have been provided by the VBH-PA Quality Department. The quality of monitoring and coordination of clinical services with primary care providers has increased steadily during the intervention period.

**KEY OBJECTIVES:**
- To increase appropriate treatment for serious co-morbidities associated with SMI
- To improve coordination of care for SMI when services are carved out

**ACTIONS TAKEN:** Value Behavioral Health-PA developed an intervention to improve care for patients prescribed one of the following SGAs: Abilify, Clozaril, Zyprexa, Seroquel, Risperdal, Risperdal Consta, Geodon, or Invega Sustenna. The company developed a screening tool based on the recommendations of the Consensus Statement on Antipsychotic Drugs and Obesity and Diabetes, a white paper published by the American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and North American Association for the Study of Obesity. That document outlines clinical monitoring necessary for early identification and management of metabolic syndrome or diabetes. Chart audits were conducted annually from 2006-2011.

The Consensus Statement was sent to the providers with the request for charts to carry out a baseline measurement. Each year since 2006, the providers have received the results of the study and their individual results. VBH-PA also developed and sent to providers a monitoring tool they could use or adapt to aid them in increasing their monitoring practices. Providers scoring less than 80% were asked to develop corrective action plans to increase monitoring practices.

**OUTCOMES:** The primary outcome measures will be the follow-up after hospitalization rate (FUH) for behavioral aftercare services, readmission rate for participating members, and level of member satisfaction with the program. Additional measures may include prescription medication utilization and physical health appointment adherence.

**In 2009, VBH-PA began tracking the number of individuals identified as having, or at risk of developing, metabolic syndrome, the rate that providers referred to supportive services, and the number of individuals who followed up with these services. This year, 35 individuals were identified as either having, or at risk for developing metabolic syndrome. Twenty-two of these individuals were given a referral to a supportive service. All of these were to the individual’s primary care physician (PCP).**

**Table 1 outlines the annual monitoring rate of each indicator. All 16 indicators showed some improvement.**

The increases in total percentages over the past year ranged from five percent to 100 percent.

### Table 1: Percentage of Monitoring Documentation

<table>
<thead>
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<th>RISK FACTOR MONITORED</th>
<th>2006</th>
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<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal history of diabetes</td>
<td>19%</td>
<td>25%</td>
<td>59%</td>
<td>60%</td>
<td>70%</td>
<td>79%</td>
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<td>43%</td>
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<tr>
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<td>21%</td>
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<td>81%</td>
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<td>86%</td>
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<td>69%</td>
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### Table 2: Rate of Integrating Care

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<th>Measure</th>
<th>2009</th>
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<th>2011</th>
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<tr>
<td>At risk or diagnosed with metabolic syndrome</td>
<td>21%</td>
<td>80%</td>
<td>59%</td>
</tr>
<tr>
<td>Referred to PCP</td>
<td>27%</td>
<td>28%</td>
<td>63%</td>
</tr>
<tr>
<td>Followed up with PCP</td>
<td>59%</td>
<td>63%</td>
<td>55%</td>
</tr>
</tbody>
</table>
The fifth annual re-measure of provider monitoring practices for metabolic syndrome shows continued improvement since this quality improvement intervention and study began in 2006. Completion of personal and family histories increased by 16 percent over last year, while completion of physicals and laboratory tests improved by 25 percent. Eighty percent of providers are now utilizing a template or incorporating monitoring prompts on existing forms. Only two of the providers utilizing such a form scored less than 80 percent. Finally, providers are demonstrating commitment to integrated care, as individuals with elevated risk factors are referred to their PCPs 125 percent more than they were last year.

**Discussion**

The fifth annual re-measure of provider monitoring practices for metabolic syndrome shows continued improvement since this quality improvement intervention and study began in 2006. Completion of personal and family histories increased by 16 percent over last year, while completion of physicals and laboratory tests improved by 25 percent. Eighty percent of providers are now utilizing a template or incorporating monitoring prompts on existing forms. Only two of the providers utilizing such a form scored less than 80 percent. Finally, providers are demonstrating commitment to integrated care, as individuals with elevated risk factors are referred to their PCPs 125 percent more than they were last year.

**Geographic Location:** Case study program was conducted in nine counties in Southwestern Pennsylvania.

**Contact:** Leigh Gardner
Director of Quality Management, Value Behavioral Health of PA
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**Figure 2: Provider Scores Based on Use of Monitoring Tools**

**OptumHealth Pierce Regional Support Network and Recovery Innovations, Inc.**

**Peer Bridger Program**

**Description:** OptumHealth Pierce Regional Support Network and Recovery Innovations provides services to uninsured and Medicaid beneficiaries in Tacoma, Washington. OptumHealth Pierce Regional Support Network utilizes “Peer Bridgers” to provide in-home and community support to program members. In addition to helping to bridge community services for Medicaid members, the program supports non-Medicaid individuals transitioning from an inpatient setting to the community and supports them in applying for Medicaid. Peer Bridgers have a lived experience of mental health conditions and recovery, and can uniquely relate to many of the challenges individuals may be experiencing. Peer Bridgers link participants to community, recovery and wellness supports in an effort to increase self-empowerment and hope, improve personal success and adjustment to the community, assist eligible individuals in obtaining benefits, and reduce the need to return to inpatient services.

**Key Objectives:**
- To reduce mental health-related preventable hospital admissions
- To enhance care coordination by using peers and other non-physician providers

**Actions Taken:** Peer Bridgers receive special recovery model training which provide them with tools to help themselves and others on their recovery journey. The Peer Bridger helps to foster hope and serves as an advocate, role model and mentor assisting individuals coming out of inpatient services in becoming engaged in a broad range of community-based and natural supports. As a result of their shared experiences, Peer Bridgers and individuals are able to create a mutually supportive relationship based on trust and respect. Through this special relationship, individuals feel understood and empowered to express their needs and drive their own person-centered recovery plan. Peer Bridgers assist individuals by teaching and role modeling wellness management skills, coping skills, independent living skills and social skills. Peer Bridgers engage individuals during hospitalization and discuss with the participant what the immediate needs are to successfully manage their recovery. The Peer Bridger also assists individuals in accessing available resources for an average of 14 days post-discharge. These resources include but are not limited to temporary/permanent housing, accessing primary care services and needed medications, recovery and social support groups, shopping for groceries, etc. The Peer Bridger program relies on the peer-to-peer relationship to increase a person’s sense of connectedness to their community. Services empower and educate individuals to allow each person to move forward in their recovery, while providing a safety net should they feel like they need additional supports to successfully adjust and remain in the community.

**Outcomes:** We have served 113 individuals since July 2010 and those unique individuals had 137 hospitalizations from July 2009 to prior to entering the Peer Bridger Program. Since entering the program, those unique individuals have had only 21 hospital admissions to-date.

**Geographic Location:** Case study program was conducted in Tacoma, Washington.

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OptumHealth Behavioral Solutions, Public Sector, Tennessee
Regional Mental Health Institute Subacute Member Initiative

DESCRIPTION: When OptumHealth started to manage the behavioral services of the Medicaid Health plan in Middle Tennessee in February 2007, West Tennessee in September 2008 and East Tennessee in January 2009, we noticed that the respective Regional Mental Health Institutes (RMHIs) held several members who were authorized at the subacute level of care. Many of those members had lived at an RMHI for years, with one member having tenure of over 20 years and another over 50. There were many reasons for this: the most prominent including a lack of step-down treatment placement and resources, as well as a deeply held belief by hospital staff that those members could not successfully live outside of a hospital environment. Additionally, there was a significant number of members who had co-morbid Behavioral Health and Physical Health issues that were not serious enough to require a nursing facility, but too severe for them to live alone or with family.

OptumHealth’s initiative uses a team approach between Utilization Management (UM), Field Care Advocates (FCA), and contracting – all working together to move applicable long-term subacute members out of the RMHIs into more appropriate community treatment settings.

The initiative began in May 2008 in Middle Tennessee and March 2009 for West and East Tennessee.

KEY OBJECTIVES:
- To find the most appropriate, least restrictive and least costly level of care for long-term subacute members at RMHIs
- To decrease inappropriate hospital utilization (the cost for subacute admission at an RMHI was the same as for acute)
- To partner with hospital staff, who felt very protective of members, to assure them that OptumHealth had the member’s best interest in mind, and to help them better understand the principles of recovery and resiliency

ACTIONS TAKEN: Both Utilization Management (UM) and Field Care Advocates (FCA) teamed together to examine closely whether or not long-term subacute members met medical necessity for their current level of care. The FCA performed face-to-face assessments with each member, attended treatment team meetings, met with families, conservators, and Powers of Attorney (POAs), and worked to identify appropriate step-down treatment options. Additionally, Senior Management worked with contracting to create co-morbid Supported Housing sites where subacute members with co-morbid Behavioral Health and Physical Health issues could live in the community and receive treatment.

OUTCOMES: Within a year of the program’s inception, over 100 subacute members were discharged to community-based services and continue to live successfully outside of the hospital. Several of these discharged members had been in an institute for five or more years, one had a tenure of over 20 years, and another over 50 years.

There were less than a handful of denials of continued subacute care by the OHBS MDs overall, and no denials whatsoever in Middle TN.

GEOGRAPHIC LOCATION: Case study program was conducted in all five Regional Mental Health Institutes located throughout Tennessee.

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Executive Director, TennCare HC Delivery Systems
Optum Health Behavioral Solutions
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Select Health of South Carolina (Part of the AmeriHealth Mercy Family of Companies)
Screening Brief Intervention and Referral to Treatment (SBIRT)

DESCRIPTION: Select Health of South Carolina is implementing an evidenced-based approach to applying the SBIRT model in pregnant women enrolled in the Medicaid health plan. Select Health is participating in a state-lead initiative by engaging network providers and members. The goal of the SBIRT program is to identify problematic substance use and to reduce and prevent substance abuse and dependency, as well as screen for mental health needs in pregnant Medicaid enrollee. South Carolina’s revised SBIRT tool screens for mental health issues and all types of substance use and provides information and assistance that is tailored to the individual patient and their needs. The model focuses on risk and targets individuals who might be at risk of developing or having a mental health and/or substance use disorder. This project will focus specifically on members who are seen at a primary care physician’s (PCP’s) office or an OB/GYN to capture pregnant women who are at risk for substance use or currently acknowledge substance use. All high-risk mothers will have this screening currently through the comprehensive behavioral health assessment.

KEY OBJECTIVES:
- To improve identification of members with serious mental illness (SMI)
- To reduce mental health-related emergency room utilization
- To reduce preventable mental health-related hospital admissions
- To improve coordination of care for SMI when services are curtailed out
- To reduce health care costs, decrease the frequency and severity of drug and alcohol use, reduce the risk of trauma, increase the percentage of members who enter specialized mental health and substance abuse treatment and improve health delivery.

ACTIONS TAKEN: This project is in the planning stage. South Carolina has decided to pilot this program with the pregnant Medicaid population and the managed care organizations (MCOs). South Carolina statistics show that 30% of Medicaid births are to women with a history of tobacco or substance use during pregnancy and experienced complications during pregnancy and delivery. Of that 30 percent, 58 percent were births with single diagnosis of tobacco disorder, 3 percent with opioid dependence and 11.6 percent of women of childbearing age reported binge drinking in the past month. The program was modeled after the SBIRT in Washington State. Select Health is focusing on the pregnant population to go hand in hand with a state initiative to improve birth outcomes. Two staff members have been trained in SBIRT to provide direct training to identified PCPs and OB/GYNs who have been identified for the pilot. Select Health will send monthly reports to the state and the state will employ an agency to compile the information for the program as a whole. The state agency will keep the information separated by plan participant. Case managers will be involved with ongoing education of the involved providers to ensure that we are capturing all pregnant members seen at the pilot offices.

OUTCOMES: Select Health has identified the following metrics to evaluate the impact of the SBIRT program:
- Total number of members identified through a PCP or OB/GYN referral who received treatment
- Total number of members who reported healthy delivery after substance abuse and treatment. Total number of members who were seen in the emergency room and cost out of the total identified for mental health (MH)/substance abuse (SA) treatment.

The official start date is January 1, 2012, and the initiative will be rolled out to 15 providers statewide at first. The state will solicit feedback from providers before rolling out SBIRT statewide.

GEOGRAPHIC LOCATION: South Carolina targeted pregnant population in this case study.

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WellPoint State Sponsored Business (SSB)
Teaming with Community Advocacy Organizations to Help Improve MCO Behavioral Health Case Management for Medicaid Members

DESCRIPTION: The CommunityConnect Health Plan’s Behavioral Health Case Management team serving Milwaukee, Wisconsin and the surrounding counties has formed a unique collaboration with a local community service organization, Community Advocates, to increase the depth of involvement with its Medicaid members with mental illness and to add value to its existing programs and services. By combining traditional MCO case management techniques with face-to-face outreach that meets the member on their terms, in their environment, and, when possible, in their native language, the program has opened the door to new solutions.

KEY OBJECTIVES:
- To increase appropriate treatment for Severe Mental Illness (SMI)
- To improve long-term medication adherence
- To reduce mental health-related preventable hospital admissions
- To enhance care coordination by using peers and other non-physician providers
- To improve the health of the population
- To enhance the patient experience of care (including quality, access, and reliability)
- To control or reduce the per capita cost of care or increase efficiency

ACTIONS TAKEN: Case Management of the MCO Behavioral Health Medicaid population is essential to improving medication compliance, follow-up care, efficiency of treatment delivery, empowerment of the consumer and controlling the cost of care. The usual and customary methods for Behavioral Health Case Management have centered on contact with providers and members using telephonic outreach, written outreach, automated appointment reminder calls to members, and efforts to improve provider collaboration throughout the continuum of care. Community Connect Healthplan and Community Advocates case management teams have enhanced member outreach beyond the traditional interventions to include more intensive outreach including face-to-face interventions to target service delivery to those members who are difficult to reach through more traditional methods, members with multiple barriers to securing and following up with treatment, and members who are hesitant to engage in case management programs.

Members targeted for enrollment in the program are not limited to a specific diagnostic category, but include members with serious and chronic mental health and substance abuse conditions, members with co-morbid medical and mental health difficulties, members with multiple hospitalizations over a six month period, members at serious risk for re-admission, and members targeted through Community Connect’s utilization and case management programs requiring enhanced community-based interventions.

To initiate face-to-face outreach, CommunityConnect’s Behavioral Health case managers identify members for referral based on proactive, reactive and event-driven triggers. A referral summarizing who the member is and what type of assistance is requested is sent to the staff of Community Advocates. A Community Advocates case manager then responds directly to the CommunityConnect case manager to further discuss case details. Frequent communication and case coordination between CommunityConnect and Community Advocates takes place throughout the process until the member’s goals are met. Due to this ongoing communication, Community Advocates has been able to identify previously unknown areas of need for members.

This approach can result in greater follow-through for the member as the outreach becomes much more personal and the member experiences a greater sense of being cared for. In some instances, the team has been able to access and provide information to members suspected to be victims of domestic abuse. Without direct contact in this type of situation, it would be difficult to know whether or not members utilize the resources offered to them. By having Community Advocates initiate that personal face-to-face contact, the members are able to receive the information confidentially and in the presence of a trustworthy source.

OUTCOMES:

<table>
<thead>
<tr>
<th>Outcomes Community Connect and Community Advocates Summary for YTD 2011*</th>
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<tr>
<td># of Cases Triaged and Evaluated for Intensive Case Management:</td>
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<tr>
<td># of Cases Enrolled in Community Connect and Community Advocates Program</td>
</tr>
<tr>
<td>% of Cases with identified goals completed and/or in ongoing Case Management:</td>
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</table>

*The Community Connect and Community Advocates partnership has been operational and assisting members for one year. Outcome measurement is ongoing and will focus on the number of members where identified goals have been completed, nature and type of barriers identified to obtaining necessary services and treatment, improved processes for contacting difficult to reach members, and outcome measures associated with efficiency and cost of care for members enrolled in the program.

GEOGRAPHIC LOCATION: Case study program was conducted in Wisconsin.

CONTACT: Joseph Garten, PhD
Director of State Sponsored Behavioral Health Services, WellPoint State Sponsored Business
(317) 287-2920, joseph.garten@wellpoint.com
NurseWise®/Nurse Response™ (A Centene Company)  
Tribal Warm Line

DESCRIPTION: The NurseWise Tribal Warm Line program was developed in 2010 to improve access to behavioral health care for Native communities in Arizona. The program goal is to implement a service model that will impact existing disparities in health care by establishing points of contact within the tribes. Historically in Arizona, the Native American population has had the lowest penetration rate into enrolled behavioral health services of all reported ethnic groups. Data from Indian Health Service indicates a serious discrepancy between the overall health of American Indian and Alaska Natives and the general population (NIH, 2008). Staffing for the tribal warm line is provided by members of the tribe who live and work amongst their callers. The tribal warm line offers a powerful, technologically enhanced service delivery model for tribal members to connect with others who share the same culture and belief system which will reduce high-cost crisis interventions and services. The tribal warm line provides a caring knowledgeable contact who can assist the caller in accessing needed care through referrals for services available within their community.

KEY OBJECTIVES:
- To address cultural and ethnic disparities in behavioral health care
- To improve coordination of care for Serious Mental Illness (SMI) when services are carved out
- To enhance care coordination by using peers and other non-physician providers

ACTIONS TAKEN: Key initiatives taken to meet the program objectives include:
- A Native American Peer Line was established initially for support, then once engaged, tribal members could benefit from referrals for needed behavioral health and medical services.
- Leverage expansive network and technological capacity of NurseWise to assure the isolation of tribal communities and provide economic opportunities.
- Espouse cultural ideology support using progressive telehealth measures, by employing tribal members at the NurseWise Tribal Warm Line.
- Provide tribal employees call center training with additional curriculum regarding the warm line program, services available in and near the tribal communities, and identification of potential behavioral health emergencies.
- Provide peer services through the warm line that provides linkages for screening and intakes for behavioral health and medical services.

OUTCOMES: In the first month of operations the NurseWise Tribal Warm Line has received 14 calls from the community. This is significant as standard mass marketing efforts have been side-stepped in favor of grassroots efforts including small meetings with stakeholders, participation in local community events, and an email campaign initiated by Indian Health Services. Initiatives will be local, community-driven and represent a novel way of delivering behavioral health care to tribal communities. Outcomes will continue to be measured around these initiatives. Outcomes to be measured include:
- Percentage increase in utilization of the warm line by tribal members
- Increase in subsequent engagement in treatment through measuring penetration amongst tribes in behavioral health services enrollment

GEOGRAPHIC LOCATION: Case study program was conducted in Native communities in Arizona.

CONTACT: Kim Drexel  
Manager, Call Center Operations, NurseWise®/Nurse Response™  
(480) 317-2141 ext 26609; kdrexel@centene.com

Beacon Health Strategies  
Westchester Cares Action Program (WCAP) Chronic Illness Demonstration Project

DESCRIPTION: Beacon Health Strategies and Hudson Health Plan developed a comprehensive care coordination program in conjunction with the New York State Department of Health for a cohort of Medicaid Fee-For-Service recipients who have multiple chronic conditions, including serious mental illnesses. This brings a managed care approach to this population. An integrated team conducts field-based assessments and formulates individualized treatment plans to facilitate access to primary medical care, behavioral health treatment and related support services. The WCAP collaboration has achieved reductions in inpatient claims while improving quality metrics in its first year of operations. Hudson is a Managed Care Plan that provides health insurance to over 100,000 people eligible for Medicaid, Family Health Plus and Child Health Plus in six New York counties. Beacon is a leading managed behavioral health organization serving over six million individuals in multiple states.

KEY OBJECTIVES:
- To increase appropriate treatment for serious co-morbidities associated with Serious Mental Illness (SMI)
- To reduce mental health-related preventable hospital admissions
- To reduce mental health-related Emergency Room utilization
- To improve long-term medication adherence
- To improve coordination of care for SMI
- To enhance care coordination by using peers and other non-physician providers

ACTIONS TAKEN: WCAP is comprised of an interdisciplinary team who conduct field-based enrollment, assessment and care coordination activities. The team consists of a two RN Care Coordinators, a licensed Master-level Social Work Care Coordinator, two Integrated Care Coordinators, and a Peer Support Specialist. The team is supervised by a RN. Each WCAP member is assigned one primary Case Manager who is responsible for addressing medical and behavioral health issues without interdisciplinary “handoffs.” Validated assessment tools are used to determine treatment planning priorities and to chart progress through reassessments at six month intervals.

The DOH furnishes a roster of potential candidates on a quarterly basis. This roster contains basic demographic information and the last address and phone number known to the DOH. WCAP must locate the candidates, inform them about the services available through WCAP, and encourage them to voluntarily join the program. WCAP has developed a network of 29 community-based organizations who have signed confidentiality agreements known as Memoranda of Understanding (MOU) that permits an exchange of information. Establishing a community presence and earning the respect of community-based organizations has been essential to support our enrollment and engagement activities. Beacon developed a proprietary system to document comprehensive assessments and to construct patient-centered care plans. Along with a complete assessment, members get an individualized treatment plan and a written crisis response plan. Members are provided weekly telephonic coaching using motivational interviewing to promote treatment plan adherence, along with face-to-face appointments at least every three months. Establishing a medical home for clients receiving fragmented care is central to care planning efforts. WCAP also makes referrals to mental health clinics, chemical dependency treatment centers and other specialties as needed. Care coordination and safe transitions of care from different treatment settings is facilitated through communication with the medical home and client education and coaching to promote treatment plan adherence.
OUTCOMES: WCAP commenced enrollment operations on August 3, 2009. Over 400 members have been enrolled since implementation. A comparison of utilization data for 83 clients who have six months of continuous enrollment indicates a 10% reduction in inpatient service utilization over that period. For those with one year of enrollment in the program, there has also been a statistically significant reduction in acuity scores. Additionally for these enrollees, SF-12 scores indicate a significant improvement in their perception of their ability to manage their chronic conditions. A comprehensive review of the program’s impact will be conducted by an independent third party after the conclusion of the program on March 30, 2012.

GEOGRAPHIC LOCATION: Case study program was conducted in Westchester County, New York.

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Chief Medical Officer, Beacon Health Strategies, LLC
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PART 3: Statistical Data and Additional Information

Distribution of Mental Health and Substance Abuse Inpatient Stays 2008

Distribution of Mental Health Expenditures by Service (2003)

- Specialty Hospitals: 12%
- Physicians and Other Professionals: 22%
- General Hospitals, Non-specialty Units: 9%
- General Hospitals, Specialty Units: 7%
- Insurance Administration: 7%
- Nursing Homes and Home Health: 7%
- Multi-service Mental Health Organizations: 13%
- Retail Drugs: 23%

Mental Health = $100 billion in 2003

Data courtesy of SAMHSA

Distribution of Mental Health Expenditures by Public Payer (2003)

- Public: 58%
- Medicare: 13%
- Medicaid: 45%
- Other Federal: 6%
- Other State and Local: 36%

All Public = $58 billion in 2003

Data courtesy of SAMHSA
Data & Statistics

SAMHSA’s National Survey on Drug Use and Health (NSDUH) also found in 2008 that just over half (58.7 percent) of adults in the United States with a serious mental illness (SMI) received treatment for a mental health problem. Treatment rates for SMI differed across age groups, and the most common types of treatment were outpatient services and prescription medication.

### State Mental Health Budgets FY2011-FY2012

<table>
<thead>
<tr>
<th>State</th>
<th>FY2011 (Millions)</th>
<th>FY2012 (Millions)</th>
<th>Change (Millions)</th>
<th>Percent Change</th>
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<td>Vermont**</td>
<td>$306.6</td>
<td>$158.6</td>
<td>$148.0</td>
<td>-48.5%</td>
</tr>
<tr>
<td>Colorado</td>
<td>$116.9</td>
<td>$115.0</td>
<td>-$1.9</td>
<td>-1.6%</td>
</tr>
<tr>
<td>Delaware</td>
<td>$76.2</td>
<td>$76.0</td>
<td>$0.2</td>
<td>0.3%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>$173.9</td>
<td>$174.0</td>
<td>$0.1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Virginia</td>
<td>$385.8</td>
<td>$386.0</td>
<td>$0.2</td>
<td>0.3%</td>
</tr>
<tr>
<td>Missouri</td>
<td>$288.4</td>
<td>$289.5</td>
<td>$1.1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Utah</td>
<td>$90.70</td>
<td>$90.62</td>
<td>$0.08</td>
<td>0.1%</td>
</tr>
<tr>
<td>Florida</td>
<td>$574.5</td>
<td>$580.9</td>
<td>$6.4</td>
<td>1.1%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>$621.3</td>
<td>$629.8</td>
<td>$8.5</td>
<td>1.4%</td>
</tr>
<tr>
<td>Alaska</td>
<td>$65.2</td>
<td>$64.7</td>
<td>-$0.5</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Nevada</td>
<td>$188.5</td>
<td>$172.7</td>
<td>-$15.8</td>
<td>-8.2%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>$403.8</td>
<td>$414.1</td>
<td>$10.3</td>
<td>2.6%</td>
</tr>
<tr>
<td>Maine</td>
<td>$76.0</td>
<td>$80.9</td>
<td>$4.9</td>
<td>6.4%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>$695.4</td>
<td>$717.2</td>
<td>$21.8</td>
<td>3.2%</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>$84.0</td>
<td>$97.0</td>
<td>$13.0</td>
<td>15.6%</td>
</tr>
<tr>
<td>Mississippi**</td>
<td>$424.6</td>
<td>$438.4</td>
<td>$13.8</td>
<td>3.3%</td>
</tr>
<tr>
<td>New Mexico</td>
<td>$101.3</td>
<td>$104.8</td>
<td>$3.5</td>
<td>3.5%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>$152.4</td>
<td>$159.3</td>
<td>$6.9</td>
<td>4.5%</td>
</tr>
<tr>
<td>Ohio</td>
<td>$484.8</td>
<td>$485.9</td>
<td>$1.1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Kansas</td>
<td>$90.5</td>
<td>$101.1</td>
<td>$10.6</td>
<td>11.7%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>$223.9</td>
<td>$235.3</td>
<td>$11.4</td>
<td>5.1%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>$805.2</td>
<td>$849.0</td>
<td>$43.8</td>
<td>5.4%</td>
</tr>
<tr>
<td>Utah</td>
<td>$80.9</td>
<td>$85.5</td>
<td>$4.6</td>
<td>5.4%</td>
</tr>
<tr>
<td>Maryland</td>
<td>$627.2</td>
<td>$665.1</td>
<td>$37.9</td>
<td>6.0%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>$672.5</td>
<td>$716.5</td>
<td>$44.0</td>
<td>6.5%</td>
</tr>
<tr>
<td>Oregon</td>
<td>$340.7</td>
<td>$346.6</td>
<td>$5.9</td>
<td>1.7%</td>
</tr>
<tr>
<td>Georgia</td>
<td>$448.9</td>
<td>$480.0</td>
<td>$31.1</td>
<td>7.0%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>$55.2</td>
<td>$102.7</td>
<td>$47.5</td>
<td>86.3%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>$51.1</td>
<td>$57.4</td>
<td>$6.3</td>
<td>12.4%</td>
</tr>
<tr>
<td>Michigan</td>
<td>$1,074.5</td>
<td>$1,222.9</td>
<td>$148.4</td>
<td>13.9%</td>
</tr>
<tr>
<td>Washington</td>
<td>$352.2</td>
<td>$443.1</td>
<td>$90.9</td>
<td>26.0%</td>
</tr>
<tr>
<td>Arizona</td>
<td>$436.7</td>
<td>$520.0</td>
<td>$83.3</td>
<td>19.2%</td>
</tr>
<tr>
<td>North Dakota</td>
<td>$50.5</td>
<td>$73.9</td>
<td>$23.4</td>
<td>46.6%</td>
</tr>
<tr>
<td>Iowa</td>
<td>$153.6</td>
<td>$208.2</td>
<td>$54.6</td>
<td>35.5%</td>
</tr>
</tbody>
</table>

*Medicaid funds moved from state mental health authority to separate Medicaid Agency.
**Total Funds, including state, county, federal, grant and other revenue sources.

Source: National Alliance on Mental Illness
Inpatient Discharges for MH and SA Conditions by Payer

**Distribution of Discharges by Primary Payer and MHSA Diagnosis,* 2008**

* Based on principal CCS diagnosis.
** Includes other payers such as Workers’ Compensation, TRICARE, CHAMPUS, CHAMPVA, Title V and other government programs.
*** Includes discharges classified as self-pay or no charge.

Source: AHRQ HCUP 2008

**MCO Acute-Care Benefit Carve-Outs, by State**

Note: 36 states contract with MCOs. Not all states responded to this question.

Source: KCMU/HMA Survey of Medicaid Managed Care, September 2011
PART 4: Resources

This section highlights selected organizations representing stakeholders in mental health services delivery and support. Listings were selected for their resources that can be applied to understanding and improving health and other services for people with SMI and are not all inclusive. Listings are excerpted from the organizations' websites. Organizations are classified according to key target audiences and services, but many offer resources for multiple stakeholders. This section does not include all providers or organizations.

Provider and Insurer Organizations

AMERICAN PSYCHIATRIC ASSOCIATION (APA)

www.psych.org

The American Psychiatric Association is the world’s largest psychiatric organization. It is a medical specialty society representing more than 36,000 psychiatric physicians from the United States and around the world. Its member physicians work together to ensure humane care and effective treatment for all persons with mental disorders, including intellectual developmental disorders and substance use disorders. APA Members are primarily medical specialists who are psychiatrists.

AMERICAN PSYCHOLOGICAL ASSOCIATION (APA)

www.apa.org

The APA is a scientific and professional organization that represents psychology in the United States. With more than 154,000 members, APA is the largest association of psychologists worldwide. The mission of the APA is to advance the creation, communication and application of psychological knowledge to benefit society and improve people’s lives.

THE ASSOCIATION FOR BEHAVIORAL HEALTH AND WELLNESS (ABHW)

www.abhw.org

ABHW is an association of the nation’s leading behavioral health and wellness companies. These companies provide an array of services related to mental health, substance use, employee assistance, disease management, and other health and wellness programs to over 110 million people in both the public and private sectors.

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE (NCCBH)

www.thenationalcouncil.org

NCCBH is the unifying voice of America’s behavioral health organizations. With 1,950 member organizations, NCCBH members serve more than 6 million adults and children with mental illnesses and addiction disorders. NCCBH members are committed to providing comprehensive, quality care that affords every opportunity for recovery and inclusion in all aspects of community life. The National Council advocates for public policies in mental and behavioral health that ensure that people who are ill can access comprehensive healthcare services. It also offers state-of-the-science education and practice improvement resources.

U.S. PSYCHIATRIC REHABILITATION ASSOCIATION (USPRA)

www.uspra.org

USPRA’s mission is to advance the availability and practice of psychiatric rehabilitation so that all individuals with a serious mental illness have access to the supports they need to recover. With 1,400 members, USPRA is the preeminent association advancing the practice of psychiatric rehabilitation and recovery. Psychiatric rehabilitation promotes recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person-directed and individualized.

Advocacy Organizations

NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

www.nami.org

NAMI is the nation’s largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need. NAMI also offers mental health information and resource linkages for people with mental illness and their families.

NATIONAL COALITION ON MENTAL HEALTH RECOVERY (NCMHR)

www.ncmhr.org

NCMHR works to ensure that consumer/survivors have a major voice in the development and implementation of health care, mental health, and social policies at the state and national levels, empowering people to recover and lead a full life in the community.

NATIONAL EMPOWERMENT CENTER (NEC)

www.power2u.org/index.html

The mission of NEC is to carry a message of recovery, empowerment, hope and healing to people with lived experience with mental health issues, trauma and extreme states. NEC is a consumer/survivor/ex-patient-run organization and each one living a personal journey of recovery and empowerment. NEC has a toll-free information and referral line and information about topics such as advance directives, shock treatment, meditation and self-help techniques, coping with depression schizophrenia, along with local self-help groups and legal services.

MENTAL HEALTH AMERICA (MHA)

www.mentalhealthamerica.net/go/home

MHA (formerly known as the National Mental Health Association) is the country’s leading nonprofit dedicated to helping all people live mentally healthier lives. With more than 320 affiliates nationwide, MHA represents patients, providers and families who promote mental wellness for the health and well-being of the nation.
Integrated Care Resources

CENTER FOR INTEGRATED HEALTH SOLUTIONS (CIHS)
www.integration.samhsa.gov/
Center for Integrated Health Solutions (CIHS) is hosted by NCCBH for a SAMSHA collaboration with the Health Resources and Services Administration (HRSA). CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings.

INTEGRATED CARE RESOURCE CENTER
www.integratedcareresourcecenter.com/
The Integrated Care Resource Center was established to help States learn about best practices for delivering coordinated health care to Medicaid’s high-need, high-cost beneficiaries. The resource center is assisting the CMS Medicare-Medicaid Coordination Office and the Center for Medicaid, CHIP, and Survey & Certification in working with States to design and implement new programs that better serve beneficiaries, improve quality and reduce costs.

MISSOURI HEALTHNET INTEGRATED CARE INITIATIVE
One model for integrating mental health and clinical care services is under development through a partnership between the Missouri Medicaid Agency (MO HealthNet), the state Mental Health Agency, and Community Mental Health Centers. An initial report on this promising initiative (linked above) was developed by the Commonwealth Fund.

State and Local Governmental Organizations

NATIONAL ASSOCIATION OF COUNTY BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITY DIRECTORS (NACBHD)
http://nachbhd.org/index.cfm
NACBHD is the voice for county and local behavioral health and developmental disability authorities in Washington, D.C. NACBHD offers education, policy analysis, and advocacy, and promotes national policies that recognize and support the critical role counties play in caring for people affected by mental illness, addiction, and developmental disabilities. NACBHD is also an active partner in efforts to improve access to, funding for, and quality of behavioral health services, especially those that serve the most vulnerable in our communities.

THE NATIONAL ASSOCIATION OF MEDICAID DIRECTORS (NAMD)
http://medicaiddirectors.org/
NAMD is a bipartisan, professional, nonprofit organization of representatives of state Medicaid agencies (including the District of Columbia and the territories). NAMD is committed to providing a focused, coordinated voice for the Medicaid program in national policy discussion and to effectively meet the needs of its member states now and in the future. The website includes a listing of state Medicaid agencies.

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS (NASMHPD)
www.nasmhpd.org
NASMHPD represents state executives responsible for the $36.7 billion public mental health service delivery system serving 6.8 million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD has also developed a series of technical papers including “Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities” that can be found here: www.nasmhpd.org/general_files/publications/ned_directors_pubs_FINAL%20Technical%20Report%20on%20Primary%20Care%20Behavioral%20Integration_final.pdf

Federal Government Organizations (Sources for Data and Patient Information and Additional Links)

THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)
www.ahrq.gov/research/mentalix.htm
AHRQ hosts a resource center for quality improvement in mental health services. The agency conducted a Patient Outcomes Research Team (PORT) project on improved care for schizophrenia that developed a series of treatment recommendations. The PORT recommendations have not been recently updated. AHRQ also hosts the National Guideline Clearinghouse, a repository of clinical practice guidelines including those for treatment of serious mental illness at www.guideline.gov

CENTERS FOR DISEASE CONTROL AND PREVENTION
www.cdc.gov/mentalhealth/
The CDC Mental Health website offers basic public health information on mental health. The site aims to foster collaboration and advancement in the field of mental health in support of CDC’s public health mission.

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)
www.nimh.nih.gov/health/index.shtml
The mission of NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. The NIMH website offers patients and providers up to date research, data, and treatment information.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)
www.samhsa.gov/about/
SAMHSA’s goal is to effectively target substance abuse and mental health services to the people most in need and to translate research in these areas more effectively and more rapidly into the general health care system. SAMHSA administers a combination of competitive, formula, and block grant programs and data collection activities. SAMHSA offers a wide variety of reports and data on mental health and substance use, including segment of the SAMHSA website dedicated to co-morbid conditions and integrating mental health and substance abuse services.
**Notes & References**

1. Mental illness can be manifested in many ways with varying levels of severity. In this publication we use the term SMI consistently with the President’s New Freedom Commission report on Mental Health. That report defines SMI as a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet specified diagnostic criteria that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities.


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**Reports and Publications**


**Sponsored Links**

**QUALITYSOLUTIONS 360** [www.qualitysolutions360.com](http://www.qualitysolutions360.com).

**Notes: Access is password controlled. Contact your Johnson & Johnson account representative for access.**

This non-branded website is intended for medical directors and other healthcare managers of member populations or employee populations. It includes health information and tools on a wide variety of topics, including mental health. The site offers information, web resources and case studies on evidence based medicine practice.


22 Miller, B., Paschall, C.B., Svendsen, D., Mortality and Medical Co-Morbidity in Patients with Serious Mental Illness, Psychiatric Services (October 2006), vol. 57, no. 10, pp 1482-1487.


28 The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. HEDIS is owned and maintained by the National Committee for Quality Assurance. http://www.ncqa.org/tabid/99/default.aspx
