CHCS Webinar: Integrating Physical and Behavioral Health Services: Lessons from Pennsylvania

Monday, October 1, 2:30-4 PM ET

- For audio, dial: 1-888-245-0920; Passcode: 783030
- You may also listen to this event online via streaming audio.
- A video archive will be posted on www.chcs.org following the event.
Center for Health Care Strategies

A non-profit health policy resource center dedicated to improving health care quality for low-income Americans.

► Focuses on: (1) enhancing access to coverage and services; (2) improving quality and reducing racial and ethnic disparities; (3) integrating care for people with complex needs; and (4) building Medicaid leadership capacity.

► Provides technical assistance for Medicaid stakeholders, including states, health plans, and providers; informs federal policymakers regarding high-quality and cost-effective Medicaid delivery systems.

► Disseminates information on how to improve the organizing, financing, and delivery of Medicaid services at www.chcs.org.
Rethinking Care Program

- Supported by Kaiser Permanente, the Aetna Foundation, the Robert Wood Johnson Foundation, and the New York State and Colorado Health Foundations

- Objectives:
  - Improve care for Medicaid’s highest-cost, highest-need patients with the greatest potential to benefit from improved care management
  - Design and test methods to integrate physical and behavioral health care
  - Include rigorous external evaluations to identify effective models worthy of replication

- 4 multi-year pilots -- in CO, NY, PA, WA -- tested innovative approaches to transform care delivery
Prevalence of Behavioral Health Needs Among Medicaid-Only Beneficiaries with Disabilities

- Hypertension: 35% No BH Dx, 65% BH Dx
- Diabetes: 35% No BH Dx, 65% BH Dx
- Coronary Heart Disease: 31% No BH Dx, 69% BH Dx
- Congestive Heart Failure: 36% No BH Dx, 64% BH Dx
- Asthma and/or COPD: 28% No BH Dx, 72% BH Dx

Impact on Cost and Hospitalization

Per Capita Cost Per Year

Per Capita Hospitalization Per Year

Beneficiaries with Diabetes

- Diabetes Only
- Diabetes + MI
- Diabetes + SUD
- Diabetes + MI + SUD

National Context

• Increasing recognition of integration imperative
• Heightened attention on high-need, high-cost populations
• New opportunities to encourage care coordination
• Hunger for information on “what works”
The PA Example:
Integration At All System Levels

- Policy
- Management and Financing
- Care Delivery
Susan Fleischman, MD

Vice President
Medicaid, CHIP, and Charitable Care
Kaiser Foundation Health Plan, Inc.
Establishing Accountable Physical/Behavioral Health Care Homes: Pennsylvania’s Innovations Pilots

CHCS Webinar
October 1, 2012

David K. Kelley MD, MPA
Chief Medical Officer
Office of Medical Assistance Programs
Pennsylvania Department of Public Welfare
Agenda

1) Pilot Rationale and Goals

2) Framing the Pilot: Intervention Pillars

3) Performance Incentive Approach and Evaluation
Unique Opportunity for Pennsylvania

PH – BH systemic coordination: long-standing challenge

Claims review highlighted “SMI” population as costly group

Tight budget climate increased motivation

Complex SMI care needs only addressed with effective coordination

High yield potential – efficiency and quality
Serious Mental Illness is a Predictor of Poor Health Outcomes

- *SMI reduces life expectancy by 25 years --- many risk factors are preventable*

<table>
<thead>
<tr>
<th>High BP</th>
<th>Diabetes</th>
<th>Cardiovascular Disease</th>
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</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>Poor Nutrition</td>
<td>Smoking</td>
</tr>
<tr>
<td>Low Physical Activity</td>
<td>Substance Abuse</td>
<td>Side Effects of Psychotropic Medications</td>
</tr>
<tr>
<td>Poor Access to Primary Care Services</td>
<td>Stigma</td>
<td>Lack of Cross-Discipline Training</td>
</tr>
</tbody>
</table>
Expected Pennsylvania Pay Offs

Better Program Administration
Stronger connections between PH & BH systems at all levels
  • DPW staff
  • Health Plans
  • Providers

Better Health Care
  • Fewer Hospitalizations
  • Appropriate use of ER
  • Connection to medical home
  • Coordinated care delivery (PH/BH)

Satisfied Consumers
  • Empowered
  • Engaged
  • Self-sufficient
Defining the Target Population

• Adults (18+) residing in selected counties and members of participating physical health plans

• Diagnosis of Serious Mental Illness (SMI) using the diagnostic criteria from the Federal SMI definition:
  – schizophrenia, major mood disorder, psychotic disorder NOS, or borderline personality disorder
    (DSM-III-R diagnostic codes 295.xx, 296.xx or 301.83).

• Stratified on PH & BH risk indicators
Framing the Pilot: The Pillars

- Provider engagement and medical home
- Consumer engagement
- Data management and information exchange
- Coordination of hospital discharge and appropriate follow-up
- Pharmacy management
- Appropriate ED use for behavioral health treatment
- Alcohol and substance abuse treatment/care coordination
- Co-location of resources
Innovations in Pennsylvania

Southwest
Connected Care
UPMC for You, Allegheny County, Community Care Behavioral Health

Southeast
HEALTHCHOICES
HealthConnections
Keystone Mercy Health Plan, Bucks, Montgomery, Delaware Co & Magellan Health Services

Pittsburgh
Philadelphia
Shared Incentives Pool

PA established joint PH-BH incentives pool

• Defined performance measures
• PH managed care plan and BH counties “rise and fall” together
• State funds not contingent on realized savings
Performance Measures

Year One – Process Measures

1) Member stratification
2) Development of integrated care plan
3) Real time notification of hospital and ER admission
4) Identification of medication gaps

Year Two – Add Outcome Measures

1) Reduced hospital admissions
2) Reduced ER utilization
Implementation Issues

• The “consent” challenge
• Provider engagement
• State contracting
• Auditing of performance
• Systems changes
Looking Ahead

- Rigorous external evaluation at end of 2-year pilot
- Qualitative & quantitative analyses
- Identify best practices
- Dissemination to other regions
III. Evaluation Highlights

October 2012

Dominick Esposito • Jung Kim • Tricia Higgins
Agenda

- Summary of Key Findings
- Evaluation Design
- Pilot Findings
- Lessons from the SMI Innovations Project
- Limitations and Final Thoughts
Both models of integration hold promise to improve consumer outcomes

- Emergency department (ED), mental health hospitalization, and all-cause readmission rates were estimated to be 9 to 14 percent lower than projected trends for these outcomes in the absence of the intervention

The pilots were able to take advantage of the previous work of the partners to improve coordination and consumer-centered care

States’ early efforts at integration are likely to face implementation challenges which might delay measurable impacts on outcomes
Evaluation Design

- Quantitative analysis of changes in outcomes
  - Emergency department visits
  - Hospitalizations – separately for physical health, mental health, and alcohol/other drug-related
  - All-cause readmissions (30, 60, and 90 days)
  - Regression adjusted analysis (difference-in-differences approach)

- Qualitative assessment of planning process and implementation through site visits, key informant interviews, and focus groups
Quantitative Outcomes Analysis

- **Primary analysis:** population-based (includes all members who met eligibility criteria)

- **Secondary analyses**
  - Southeast: By county, for invited, and for consented
  - Southwest: By date of eligibility and for consented
  - Analysis by six-month intervals to account for potential implementation delays
Context for the Evaluation

- Impacts might be difficult to identify in the short-term because of the potential for:
  - Implementation delays
  - Low participation rate among eligible population
  - Time required to gain buy-in among providers

- Comparison groups offer value by helping to identify regression to the mean in outcomes among the aggregate population
Southeast Pilot – Background

Comparison Group: Members of AmeriHealth, Gateway, or Unison physical health plans in Lehigh and Northampton counties

Study Group: Members of Keystone Mercy (physical health plan) and Magellan Behavioral Health in Bucks, Montgomery, and Delaware counties
A County/Community-Based Model

- Separate plans had little/no prior collaboration
- Each suburban county developed own program
- Navigators, employed by BH agencies, at core of the Southeast model
  - RNs, BH clinicians, or case managers
  - Engaged consumers who consent to share health information and providers in person and via telephone
  - Prioritized consumers seen in large primary care practices (or in case management in Bucks County)
Integrated Care Planning

- Plans jointly created member health profiles and hosted case rounds

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<th>Care Providers</th>
<th>Behavioral Health Navigator</th>
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<td>Case Mgmt Engaged?:</td>
<td>Last CTT/SCOT DOS:</td>
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<tr>
<td>Date of Engagement:</td>
<td>CTT/SCOT Provider:</td>
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<td>Case Manager:</td>
<td>Last ICM DOS:</td>
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<td>Last ICM Provider:</td>
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<td>Behavioral Health SMI Qualified</td>
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<td>295.xx Diagnosed</td>
<td>2nd Diagnosis Most Used:</td>
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<td>296.xx Diagnosed</td>
<td>3rd Diagnosis Most Used:</td>
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<td>301.xx Diagnosed</td>
<td>4th Diagnosis Most Used:</td>
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<table>
<thead>
<tr>
<th>Behavioral Health Mental Health Utilization</th>
<th>Behavioral Health Outpatient Utilization</th>
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<td>Behavioral Health Inpatient Utilization</td>
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<td>Number of Days:</td>
<td>Last Discharge:</td>
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<td>Last Discharge:</td>
<td>Last Provider:</td>
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<td>Number of Admits:</td>
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<td>Number of Admits:</td>
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MATHENTIC A
Policy Research
Southeast: Eligible Population

Baseline period

Intervention period

Eligible members identified

Number eligible: 4,788
Number consented:

Members invited

Selected by case managers or based on a combination of members’ BH providers and PCPs

Those who agree to share all of his/her health information across providers

Number consented: 857

Number invited: 1,955
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<th>All Counties</th>
<th>Montgomery County*</th>
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<tr>
<td>Hospitalizations – Physical Health</td>
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<td>-</td>
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<td>Alcohol/Other Drug</td>
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<tr>
<td>Readmissions within 30 days</td>
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<tr>
<td>60 days</td>
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<td>-</td>
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<tr>
<td>90 days</td>
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<tr>
<td>ED Visits</td>
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</tr>
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*Only county with statistically significant findings.
Compared with the projected trend without the program, the rate of ED visits was an estimated 9 percent lower for the three counties combined and an estimated 14 percent lower in Montgomery County.
Southeast: Stakeholder Findings

- Flexibility in program design fostered local buy-in and sustainability
- Identifying funding for start-up costs and establishing long-term financing take time
- Member health profile, although challenging to implement, demonstrates the ability of two separate systems to collaborate effectively
- Counties might have benefited from having more standard tools for assessment and monitoring

Programs implemented across multiple regions and systems benefit from both flexibility and structure, and need ample time for planning and consensus building
Southeast: Stakeholder Findings

- BH provider-focused model (BH agency and navigator) takes advantage of natural synergies
- Nurse navigators enhanced the BH-centric care team
- Nurse outreach to primary care offices was time-intensive but effective in building relationships

> Adding nurses to locally based, BH-centric care team holds promise for improving integration of care for individuals with SMI
Southwest Pilot – Background

**Study Group:** UPMC (physical health plan) and Community Care Behavioral Health members in Allegheny County

**Comparison Group:** Members of other physical health plans in Allegheny County
A Centralized Plan Model

- Both plans owned by UPMC in Allegheny County

- MCO care managers engaged consumers primarily by telephone focusing on consumers with frequent ED use or recent hospitalization
  - A small number of UPMC nurse care managers placed in primary care practices engaged consumers in person

- Plans engaged network PCPs and select BH agencies

- Plans exchanged information through integrated care plans and multidisciplinary case reviews
Southwest: Eligible Population

- **Baseline period**: 2007 July to 2008 July
- **Intervention period**: 2008 July to 2011 July

- **8,633 Eligible members**

- **Early cohort identified**: 5,425 Members identified before the intervention start

- **Late cohort identified**: 3,208 Members identified throughout the intervention period
## Southwest: Statistically Significant Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>All Members</th>
<th>Early Cohort</th>
<th>Late Cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalizations – Physical Health</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mental Health</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>Alcohol/Other Drug</td>
<td>-</td>
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</tr>
<tr>
<td>Readmissions within 30 days</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
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<tr>
<td>60 days</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>90 days</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>ED Visits</td>
<td>-</td>
<td>-</td>
<td>✓</td>
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</table>
Southwest: Mental Health Hospitalizations

Compared with projected trends without the program, MH hospitalization rate was an estimated 12 percent lower for the full study group and an estimated 40 percent lower for the late cohort.
All-cause readmissions dropped 20 percent for the late cohort and increased 2 percent in the comparison group.
Southwest: ED Use, Late Cohort

The rate of ED visits for the late cohort was an estimated 12 percent lower than projected in the absence of the program, based on the comparison group’s experience.
Existing initiatives at each plan contributed to an organizational environment supporting integration.

Relationships with providers and UPMC’s integrated delivery system facilitated implementation.

Developing a shared information tool across two sister companies was still challenging.

Existing resources, infrastructure, and context can facilitate integration… to a point. Integration efforts are likely to encounter common challenges but can still contribute to reducing excessive utilization.
Lessons for Program Planning

- A balance of state leadership and local ownership fostered buy-in and sustainability
- Establishing formal venues and methods for deliberate collaboration at multiple levels was important for a new Medicaid integration program
- Privacy issues and information exchange were critical for the state and partners to address early
- Joint care planning and real-time hospital notification measures encouraged information sharing and a more holistic approach to care
Consumer-Level Lessons

- Key consumer engagement strategies for both pilot programs included
  - Comprehensive member assessments
  - Education about appropriate ED use
  - Follow-up after hospitalizations

- Targeted education and support to a large number of members at risk of readmission or additional ED visit holds promise for improving health care utilization
Behavioral health system might be a natural point of provider and consumer engagement and care coordination for individuals with SMI

Resources to support integrated care and the size of the SMI population relative to the overall practice affected partners’ ability to engage PCPs

PCPs valued receiving previously unavailable clinical support and information about members from navigators and care managers
Program design and implementation requires balancing flexibility with standardization but is challenging in practice.

Exchanging BH and PH information was critical for a holistic approach to care.

Nurses and pharmacists were particularly important members of the multidisciplinary care teams.
Limitations

- Comparison groups are not perfect matches, but regression analysis helps adjust for baseline differences.

- Other important outcomes were not measured (for example, costs, office visits, prescription drug use).

- Interviews with program staff revealed a lot about how the programs were implemented, but program features that contribute to improved outcomes need to be better defined.

- Opportunities exist to collect data systematically on implementation of those features.
Final Thoughts

- Two models of integration hold promise to improve outcomes, although more research is needed on program details, such as types and frequency of member contacts.

- Favorable outcomes suggest the pilot programs were able to take advantage of the previous work of the partners to improve coordination and consumer-centered care.

- Early integration efforts are likely to encounter implementation challenges which might delay measurable impacts on outcomes.
Acknowledgements

- Special thanks to the partners and DPW for their time and assistance setting up and participating in our site visits and telephone interviews and providing data for the evaluation

- And contributions by Mathematica staff: Mark Flick, Angela Gerolamo, Randy Brown, Beth Stevens, Jonathan Brown, Shinu Verghese, Carol Razafindrakoto, and Dina Belloff
Additional Slides
Study and comparison groups were similar in age and gender

More study group members were black (26 versus 7 percent); much fewer were Hispanic (4 versus 45 percent)

More study group members had physical health conditions

Study group had lower rate of ED visits
## Southeast Population by County

<table>
<thead>
<tr>
<th></th>
<th>Study Group</th>
<th>Comparison Group</th>
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<tbody>
<tr>
<td></td>
<td>Bucks</td>
<td>Delaware</td>
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<tr>
<td>Number of Eligible Members</td>
<td>1,312</td>
<td>2,163</td>
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<tr>
<td>Number Invited</td>
<td>614</td>
<td>631</td>
</tr>
<tr>
<td>Percent Invited of Eligible</td>
<td>46.8</td>
<td>29.2</td>
</tr>
<tr>
<td>Number who Consented</td>
<td>282</td>
<td>297</td>
</tr>
<tr>
<td>Percent Consented of Eligible</td>
<td>21.5</td>
<td>13.7</td>
</tr>
<tr>
<td>Percent Consented of Invited</td>
<td>45.9</td>
<td>47.1</td>
</tr>
<tr>
<td>Enrollment, Average (months)</td>
<td>20.8</td>
<td>21.0</td>
</tr>
<tr>
<td>Percent Enrolled 18-24 Months</td>
<td>77.9</td>
<td>79.5</td>
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Southeast: Reduction in ED Visits

<table>
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<tr>
<th></th>
<th>All Counties</th>
<th>Montgomery County</th>
<th>Comparison Group</th>
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<tr>
<td>Number of Members</td>
<td>4,788</td>
<td>1,313</td>
<td>7,093</td>
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<td>Pre-Intervention Period Rate</td>
<td>148.1</td>
<td>166.4</td>
<td>183.8</td>
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<tr>
<td>per 1,000 Member Months</td>
<td></td>
<td></td>
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<tr>
<td>Intervention Period Rate</td>
<td>142.4</td>
<td>151.5</td>
<td>194.4</td>
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<tr>
<td>per 1,000 Member Months</td>
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<td>p-Value</td>
<td>0.036</td>
<td>0.049</td>
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Southwest Baseline Characteristics

- Study and comparison groups had similar demographic characteristics
- Slightly higher percentages of study group members had physical health conditions
- Inpatient use was higher for the study group than for the comparison group
- Early cohort had higher proportions of BH and PH conditions and inpatient and ED use than late cohort
## Southwest Eligible Population

<table>
<thead>
<tr>
<th></th>
<th>Study</th>
<th>Comparison</th>
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<tbody>
<tr>
<td>County</td>
<td>Allegheny</td>
<td>Allegheny</td>
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<td>Behavioral Health Managed Care</td>
<td>Community Care</td>
<td>Community Care</td>
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<td>Organization</td>
<td></td>
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<tr>
<td>Physical Health Plan</td>
<td>UPMC</td>
<td>Gateway or Unison</td>
</tr>
<tr>
<td>Number of Eligible Members</td>
<td>8,633</td>
<td>10,514</td>
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<tr>
<td>Enrollment, Average (months)</td>
<td>18.3</td>
<td>15.9</td>
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<tr>
<td>Percent Enrolled 18-24 Months</td>
<td>59.0</td>
<td>49.6</td>
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### Southwest Population by Cohort

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<tr>
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<th>Study</th>
<th>Comparison</th>
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<tbody>
<tr>
<td></td>
<td>Early Cohort</td>
<td>Late Cohort</td>
</tr>
<tr>
<td>Number of Eligible Members</td>
<td>5,425</td>
<td>3,208</td>
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<td>Number who Consented(^a)</td>
<td>778</td>
<td>92</td>
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<td>Percent Consented of Eligible</td>
<td>14.3</td>
<td>2.9</td>
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<tr>
<td>Enrollment, Average (months)</td>
<td>20.3</td>
<td>15.1</td>
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<tr>
<td>Percent Enrolled 18-24 Months</td>
<td>74.8</td>
<td>32.3</td>
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Early cohort includes all members eligible before the start of the intervention (July 1, 2009); late cohort includes those eligible after the start.

\(^a\)Connected Care leaders estimated they engaged approximately 2,500 members (those who agreed to work with a care manager).
Southwest: Mental Health Hospitalization Rates

<table>
<thead>
<tr>
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<th>Late Cohort</th>
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<td>8,633</td>
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<td>Pre-Intervention Rate</td>
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<td>25.8</td>
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<tr>
<td>per 1,000 Member Months</td>
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<td>39.6</td>
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<td>43.3</td>
<td>45.1</td>
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<td>p-Value</td>
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<td>&lt;0.01</td>
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## Southwest: All-Cause Readmissions

<table>
<thead>
<tr>
<th>Percent with a Readmission Within 30 Days of Hospital Discharge</th>
<th>All Members</th>
<th>Late Cohort</th>
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<tbody>
<tr>
<td></td>
<td>Study</td>
<td>Comparison</td>
</tr>
<tr>
<td>Pre-Intervention</td>
<td>43.1</td>
<td>39.5</td>
</tr>
<tr>
<td>Intervention Period</td>
<td>38.9</td>
<td>39.7</td>
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<td>Difference</td>
<td>-4.2</td>
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<td>Difference in Differences</td>
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<tr>
<td>$p$-Value</td>
<td>&lt;0.01</td>
<td></td>
</tr>
</tbody>
</table>
Southwest: Rates of ED Use

<table>
<thead>
<tr>
<th></th>
<th>Full Two-Year Period</th>
<th>By Six-Month Calendar Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Intervention Rate, Study</td>
<td>184.4</td>
<td>206.6</td>
</tr>
<tr>
<td>Intervention Rate, Study</td>
<td>190.0</td>
<td>250.4</td>
</tr>
<tr>
<td>Pre-Intervention, Comparison</td>
<td>167.1</td>
<td>182.4</td>
</tr>
<tr>
<td>Intervention, Comparison</td>
<td>195.6</td>
<td>232.6</td>
</tr>
<tr>
<td>Difference in Differences</td>
<td>-22.9</td>
<td>-6.3</td>
</tr>
<tr>
<td>p-Value</td>
<td>0.052</td>
<td>0.808</td>
</tr>
</tbody>
</table>

All rates are per 1,000 member months
Frontline Perspectives Panelists

- John Lovelace, CEO, UPMC for You
- LeeAnn Moyer, Deputy Administrator, Montgomery County Department of Behavioral Health and Developmental Disabilities
- Fazlu Rahman, MD, Medical Director, Keystone Mercy Health Plan
- James Schuster, MD, Chief Medical Officer, Community Care Behavioral Health
- Sandy Zebrowski, MD, Medical Director, Magellan Behavioral Health
Questions?

To submit a question please click the question mark icon located in the toolbar at the top of your screen.

Your questions will be viewable only to CHCS staff and the panelists.

Answers to questions that cannot be addressed due to time constraints will be posted online after the webinar.
Meet Shervene

► 43-year-old grandmother of two
► Spinal disc degeneration with associated difficulty walking; diagnosed with Type 2 diabetes four years ago, but totally unmanaged
► Hospitalized 6 times in past few months
► Overwhelmed with health care needs; severe depression leaving her homebound with complete lack of motivation, curtains drawn, not even bathing
Connecting Shervene to Stability, Better Health

► Shervene enrolled in the Southeast pilot, where she was connected to a navigator team who:
  ► Conducted home visits
  ► Helped her develop a personal wellness plan
  ► Helped her address severe depression and gave her confidence to get out of the house
  ► Accompanied her on medical and behavioral health visits, including a biopsy test that she was fearful of
  ► Reviewed lab tests and helped her understand how to control cholesterol and blood sugar levels
► Shervene continues to work on her integrated wellness plan and is joining a Yoga and physical fitness program
“I’ve made tremendous strides . . . “

“Before I got into this program, I remember feeling so stressed and not wanting to interact. Now I’ve become much more aware of the importance of doing what it takes for my health. I get choked up, I’m so lucky. I feel they saved my life.”

-- Interview with Shervene, August 2012
Consumer Health Outcomes: Self Report

- Behavioral Symptoms: 29.03%
- Strength: 38.71%
- Provider Relationship: 33.30%
- Work-School Participation: 22.58%
- Emotional Health: 58.06%
- Physical Health: 54.84%

Legend:
- % of HCHC Members Reporting Progress
- % of All Magellan Public Sector Members Reporting Progress
Do you have a better understanding of the medications you take as a result of using this service?

Overall, nearly 84% had a better understanding of their medications.
Consumer Satisfaction: Quality of Life

Overall, nearly 94% felt this service was effective.

Please rate the effectiveness of this service on your quality of life.
For More Information

Visit www.chcs.org for:

• SMI Innovations Pilot Evaluation
• Regional Pilot Case Studies
• Project Spotlight about the SMI Innovations Project
• Slides and an archived recording of today’s presentation