RETHINKING CARE PROGRAM SPOTLIGHT

CHCS Center for Health Care Strategies, Inc.

Improving Medicaid Care Management for People with Serious Mental Illness in Pennsylvania

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About four years ago, Shervene, a 43-year-old grandmother of two, was diagnosed with Type 2 diabetes that had gone unmanaged.[1] *She already suffered from spinal disc degeneration and had difficulty walking. She fell into a severe depression, staying at home with her curtains drawn and not even bathing. Shervene, who receives Medicaid based on her disability and lives in Telford, Pa., was hospitalized half a dozen times over a short period. She says she felt overwhelmed in trying to navigate the complicated health care system.*

Her mental health therapist suggested she contact a new, county-sponsored demonstration program called HealthChoices HealthConnections (HCHC), begun in 2009. The goal of the program – a partnership between three southeast Pennsylvania counties, Magellan Behavioral Health, and Keystone Mercy Health Plan – was to better coordinate care while reducing costs for high-need, high-risk Medicaid beneficiaries with serious mental illness and chronic physical conditions. A similar demonstration, called Connected Care, was started in Allegheny County in southwest Pennsylvania around the same time. "I figured, why not give it a try," says Shervene.

Helping Patients with Mental Illness Navigate Complex Health Care Needs

Often meeting with Shervene at her home, Lori Marshall and her colleagues at the Penn Foundation community mental health center in Sellersville, Pa. worked with her to develop and update a wellness plan for her physical and mental health. Marshall, a registered nurse who serves as a "navigator" for Medicaid members in the program, accompanied her on medical and behavioral health visits, reviewing lab test results with her and helping her understand how to better control her cholesterol and blood sugar. Marshall's colleague, behavioral health navigator Angela Hackman, sometimes provided Shervene with therapy at home when she felt too depressed and couldn't get in to see her regular therapist.

Shervene recently needed a biopsy done and was nervous about it. Because she felt uncomfortable with the physician, Marshall arranged for a different doctor to do the test.

IN BRIEF

Through the *Rethinking Care Program*, the Center for Health Care Strategies partnered with four state pilots to test new strategies to improve health care quality and control spending for Medicaid's highest-need, highest-cost populations. This profile details the experiences of Pennsylvania's *Serious Mental Illness (SMI) Innovations Project*, which included two regional pilots designed to integrate physical and behavioral health care services for adult Medicaid beneficiaries with serious mental illness and co-occurring physical health conditions. For more information about the *Rethinking Care Program*, visit www.chcs.org.

[1] *To maintain privacy, Shervene's last name is not used for this article.*

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She held Shervene's hand and guided her through breathing relaxation techniques during the procedure. Fortunately, the biopsy was negative.

"Before I got into this program, I remember feeling so stressed and not wanting to interact," Shervene says. "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."

About the Serious Mental Illness Innovations Project

Pennsylvania is one of four states that launched Medicaid demonstrations for high-cost, high-need beneficiaries with support from the Center for Health Care Strategies' (CHCS) Rethinking Care Program. It chose to focus on beneficiaries with serious mental illness, including schizophrenia and bipolar disorder. Like many states, Pennsylvania Medicaid beneficiaries receive physical and behavioral health services from separate managed care plans. State officials recognized that partly as a result, services were often not well coordinated, costs were high, and outcomes were unsatisfactory.

So the state established two two-year regional demonstrations, called the *SMI (Serious Mental Illness) Innovations Project*, to better integrate care. It set overall process and performance measures. Officials invited counties, providers, and plans to participate – choosing Allegheny County, in the Pittsburgh area, for one project, and Montgomery, Bucks, and Delaware counties, near Philadelphia, for the second (see Exhibit 1). They let the local players flesh out the program details.

"The whole idea was to bring our physical and behavioral managed care plans together to better coordinate care so consumers with serious mental illness

Exhibit 1: **Southeast and Southwest Pennsylvania Pilot Overviews**

	HealthChoices HealthConnections	**Connected Care**
County	Bucks, Montgomery, and Delaware	Allegheny
Behavioral Health Plan	Magellan Behavioral Health	Community Care Behavioral Health
Physical Health Plan	Keystone Mercy Health Plan	UPMC *for You*
Program Model	Decentralized, community-based model	Centralized, plan-based model
Key Program Elements	▪ Member contact centered around a navigator employed by a behavioral health agency. ▪ Member health profile integrated key behavioral and physical health, pharmacy, and provider contact information. ▪ Case rounds with staff from both plans and the behavioral health navigator. ▪ Wellness planning goals identified with emphasis on self management strategies.	▪ Member contact centered around plan care managers (primarily by telephone) and providers (especially for high need members). ▪ Integrated care plan facilitates information exchange between health plans. ▪ Multidisciplinary case conferences inform care planning for complex cases.

would have their lives improved," says Dr. David Kelley, chief medical officer for the state Department of Public Welfare's Office of Medical Assistance Programs, who helped design the program.

In the HCHC demonstration in the southeast, about 900 Medicaid members with serious mental illness consented to enroll, while in the Connected Care demonstration in the southwest about 2,500 members participated. The SMI Innovations Project grew out of an earlier collaboration between CHCS and Kaiser Permanente to improve Medicaid disease management programs for people with multiple chronic conditions. That led to the four-state Rethinking Care Program involving Pennsylvania, New York, Colorado, and Washington, funded through Kaiser Permanente. Each state differed somewhat in the model it used and the beneficiary groups it focused on.

In Pennsylvania, after recruiting the counties, health plans, and providers in the two regions, Kelley and his colleagues created the program's guiding principles and metrics. The central features included: (1) consumer engagement; (2) establishment of a medical home integrating physical and behavioral health care; (3) full and timely access to member information; (4) aggressive follow-up after hospital discharges; (5) close medication management; (6) appropriate emergency department (ED) use for behavioral health treatment; and (7) coordination with alcohol and substance abuse treatment providers. The state also established a $500,000 a year incentive pool for each regional demonstration, to be shared among the partners if they met performance measures. For the first year, there were four process performance targets, including development of integrated care plans for at least 1,000 members and timely notification of hospital admissions at least 90 percent of the time. For the second year, the state added two outcomes measures – reduction in hospital admissions and emergency department visits.

Two Regional Variations Tested Medicaid Care Management Models

The HCHC demonstration was a partnership between the three southeast counties, Magellan, and Keystone Mercy, with each county developing its own somewhat different approach. The project established community mental health centers as the care homes for members, because these members generally had closer relationships with their behavioral health providers than with medical providers. Nurse navigators, working with behavioral health clinicians and wellness recovery coaches, were at the center of the model. They interacted with members and providers to develop individualized care plans and share information on member health status, medication use, specialist and ED visits, and hospitalizations.

A critical tool was the development of the member profile, updated monthly. Members had to give consent to let providers access relevant information from their providers, medical and behavioral diagnoses, lab test results, pharmacy utilization, hospital and ED use, and a risk assessment score. Obtaining member consent, then convincing plans and providers to share information, often was challenging and required close partnership and communication.

"It's a fantastic tool that didn't exist before," Marshall says, noting that the profile helps ensure that members hospitalized for medical reasons continue to get their psychiatric medications during the hospital stay.

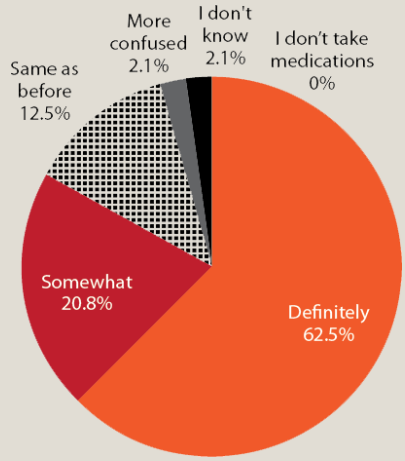
The Connected Care demonstration was a partnership across Allegheny County, UPMC *for You* (a Medicaid managed care plan), and Community Care Behavioral Health (a behavioral health plan). While both plans are owned by UPMC, the University of Pittsburgh's health care system, and headquartered in the same office complex, their prior care management collaborations had been primarily focused on individual case coordination, without planned data exchanges or structured collaborations, says John Lovelace, President of UPMC *for You* and President of Government Programs at the UPMC Insurance Services Division.

The project focused on better managing care for members with high ED or hospital use. Unlike the more community-based HCHC program, Connected Care relied mainly on care managers within the physical and behavioral health care plans working internally to better coordinate care, using weekly multidisciplinary case review conferences. The two plans created an integrated member record and care plan for each member, and decided which plan would take the lead role in managing the member's care.

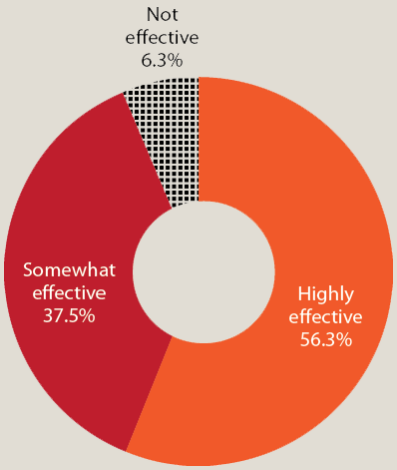
In addition to the internal coordination work, there was also direct care management work with some members. A number of primary care physician practices within the UPMC *for You* provider network previously had established a patient-centered medical home model with care managers on site; those care managers worked with members to develop individualized wellness plans and coordinate services.

Exhibit 2: **Consumer Feedback on Program Effectiveness**

Perhaps as important as any other outcome, consumer satisfaction among program participants is an important gauge of program effectiveness. Following are select results from a survey conducted to determine how program participants in Montgomery County view the nurse navigator service.



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.*



Please rate the effectiveness of this service on your quality of life. *Overall, nearly 94% felt this service was effective.*

SOURCE: HealthChoices, HealthConnections Report to the Community (Montgomery County, Pa. Published by Magellan Health Services.

As in the southeast region, leaders of the southwest regional project say the experience was positive. "Sharing key information with behavioral and physical health providers was very helpful in identifying issues, encouraging collaboration, and following through," says Dr. James Schuster, Chief Medical Officer of Community Care Behavioral Health. "It wasn't something providers routinely did before. Now the behavioral and physical health providers have formed partnerships that have persisted."

Lovelace and Schuster say both their plans intend to expand the coordinated-care program to more Pennsylvania counties they work in, and roll it out with other Medicaid plan partners as well. In addition, they are training case managers and other staff as navigators, following the example of HCHC's nurse-navigators in southeastern Pennsylvania and some testing of the navigator approach during the Connected Care pilot itself.

"Providers are often eager to work together, but people are busy and it doesn't always rise to the top of their list spontaneously," Schuster says. "With support from the plan, we can enhance that."

Measurable Improvements in Care Coordination for Medicaid Beneficiaries

Both regional demonstrations produced promising results. An evaluation by Mathematica Policy Research comparing participating Medicaid members with control groups found the two demonstrations achieved success at reducing ED use, hospital readmissions, and/or mental health hospitalizations. As a result, participating plans received bonus payments from a state incentive pool for meeting most of the performance targets. State Medicaid officials now are encouraging physical and behavioral health plans around the state to adopt and expand the coordinated-care model.

Both the southeast and southwest regional demonstration projects met most of the process and outcomes performance targets in both years of the program, including reductions in ED and inpatient utilization in the second year. The partners in each region received slightly more than $800,000 each in incentive bonuses for the two years.

The Mathematica Policy Research evaluation found that the HCHC study population showed a 5.7 percent decline in ED visits, while the comparison group showed a 10.5 percent increase. The Connected Care study population showed a 13.3 percent decline in ED visits, compared with only a 1.4 percent drop for the comparison group. Connected Care also produced declines in mental health hospitalizations and hospital readmissions within 30 days, while those measures rose for the comparison group.

Overall, the positive results were stronger for the Connected Care demonstration, even though it lacked HCHC's navigator feature, Kelley says. He speculates that the southwest region may have gotten better results because both the physical and behavioral health plans are owned by the same organization, enabling a more robust internal process of care management. In contrast, there were many independent organizations involved in the three southeast counties, and it took them longer to get the demonstration up and running effectively.

"We have some great measurable outcomes," Kelley says. "But there were also a lot of intangible benefits in the quality of care. The best was that our

The Power of Navigators to Steer through Complex Health Needs

Leaders of Pennsylvania's SMI Innovations Project say a key to the success of the demonstration program was the use of registered nurses as "navigators" to help Medicaid members develop integrated care plans and get the services they need. While nurse navigators were primarily used in the southeast regional demonstration, plans and providers in other parts of Pennsylvania say they also intend to employ navigators based on the promising demonstration experience.

LeeAnn Moyer, Montgomery County's deputy administrator of behavior health, recalls one navigator's struggle for weeks to meet with a member, who wouldn't leave her apartment. The navigator finally got her to meet downstairs in a coffee shop. It turned out that the member's mother had died of cancer and she feared she had cancer, too, but she hadn't sought medical care. The navigator got her to a doctor, and it turned out she did have cancer. But the disease was caught early and treatment was successful. The navigator stayed with the woman through the treatment.

"If not for the navigator developing that relationship, I don't know where that woman would be now," Moyer says. She notes that the navigators, based in behavioral health centers, have received extensive training in motivational interviewing, a crucial skill in engaging members.

Almost as difficult as engaging members was for navigators to develop a close working relationship with primary care physician practices. Moyer says some navigators held pizza parties to introduce themselves and the HealthChoices HealthConnections program. But what really got them in the door, she explains, was the help navigators provided in working with these often-challenging patients and coordinating with the behavioral health services, to which the doctors had little connection.

"There's been a very rich experience between navigators and consumers," he says. "The reduced ED and hospital utilization related to navigators should speak for itself."

Emergency department physicians and staff also found the navigators' help invaluable, particularly given the growing number of mentally ill patients going to EDs due to the shortage of mental health facilities. "We've had navigators show up in EDs to help triage cases," Moyer says.

Montgomery County convinced the state Medicaid program to make its navigator service a billable Medicaid service. Dr. David Kelley, chief medical officer for the state Department of Public Welfare's Office of Medical Assistance Programs, says he's a fan of navigators and would be open to making it a reimbursable service if the state budget allows. "There's been a very rich experience between navigators and consumers," he says. "The reduced ED and hospital utilization related to navigators should speak for itself."

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counties and plans rolled up their sleeves to work together and improve quality and access for these consumers. Those folks are now working more closely, they know each other and talk to each other."

Kelley thinks the demonstrations produced net Medicaid savings for the state from significant reductions in ED and inpatient utilization for the study population. "We feel we saved money but we haven't put a number on that yet," he says.

Medicaid Care Management Lessons for Pennsylvania and Beyond

Allison Hamblin, CHCS vice president, says the promising Pennsylvania results point the way for other states struggling with uncoordinated care and high costs for Medicaid beneficiaries with serious mental illness. "We're thrilled to see there are opportunities for savings in both the physical and mental health systems," she says.

Nurse-navigator Lori Marshall says that while she has found the coordination model exciting and fulfilling, she continues to face two big challenges in serving her clients – lack of access to medical specialists who take Medicaid patients, and inadequate Medicaid benefits for dental care. "Medicaid providers are few and far between when it comes to finding specialists in areas like neurology and pain management," she says. "We really struggle with that."

Kelley says the state is encouraging Medicaid physical and behavioral care plans to use their existing capitation payments to develop coordinated care models. The state also will build on its extensive chronic care management and patient-centered medical home initiatives in the private sector to disseminate these innovations into Medicaid managed care. "We're allowing practices and plans to develop models on their own without having to go through a state plan," he says.

For her part, Shervene is counting on continuing to work with Marshall and the HCHC program on her integrated wellness plan. Her latest goal is to participate in a yoga and physical fitness program. "I've made tremendous strides," she says. "I'm out of the house and my curtains aren't drawn. I'm very grateful."

Author Harris Meyer is a Washington State-based freelance journalist who has been writing about health care policy and delivery since 1986.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. In collaboration with state and federal agencies, health plans, providers, and consumer groups, CHCS pursues innovative and cost-effective strategies to better serve Medicaid beneficiaries.

This spotlight is a product of CHCS' *Rethinking Care Program*, which is developing and testing new strategies to improve health care quality and control spending for Medicaid's highest-need, highest-cost populations. It is made possible by Kaiser Permanente. For more information about the *Rethinking Care Program*, as well as tools for improving care management for Medicaid beneficiaries with complex needs, visit www.chcs.org.