Webinar Questions – Integrating Medicaid Physical and Behavioral Health Services: Lessons from Pennsylvania, October 1, 2012

Allison Hamblin, CHCS Vice President for Strategic Planning

1. **This project focused on recipients living with SMI. Was there consideration to also look at recipients living with Substance Use Disorder (SUD)?**
   State officials elected to focus on individuals with SMI early in the process. That said, because SUD is often co-occurring among individuals with SMI, there was a concerted effort to address and coordinate the SUD treatment needs of enrolled members, particularly in the Southeast pilot. In the Southeast, individuals could only enroll in the program if they were willing to share information on any SUD treatment needs with participating providers.

2. **Did the state provide any parameters to the managed care organizations or did they instead provide only outcome measures and targets?**
   The project partners were encouraged to address the eight intervention “pillars” defined by the state. These included: (1) provider engagement and medical home, (2) consumer engagement, (3) data management and information exchange, (4) coordination of hospital discharge and appropriate follow-up, (5) pharmacy management, (6) appropriate ED use for behavioral health treatment, (7) alcohol and substance abuse treatment/care coordination, and (8) co-location of resources. As suggested, the process and outcome measures associated with Shared Incentives Pool provided further guidance to the partners on activities to focus on.

3. **Many states pursuing health homes took on an ambitious # of quality measures. Any comments about the ease or difficulty of tracking measures at the system or provider level?**
   All partners would agree that the performance measures involved a fair degree of difficulty in their implementation and tracking – particularly given the audit requirements associated with each. Please see Appendix D in the Evaluation Report for a detailed explanation of these challenges and associated recommendations for organizations looking to implement similar measures.

4. **Was this implementation via Waiver, State Plan Amendment or a Pilot study?**
   No additional federal authority was obtained for this project. Both the physical and behavioral health systems in PA currently operate under managed care waivers, through which these projects were implemented. In certain regions, project partners received state approval to use behavioral health reinvestment funds to support the cost of certain project-related services. In one region, state approval was also received around the designation of a new supplemental service associated with navigator activities.

5. **In our state of Arizona, we have addressed the differences between co-location and integration through licensing. How did the parties in the pilot address these dynamics from a regulatory standpoint? One license for the entire facility? Two licenses one for the medical? one for behavioral health?**
   Although the project partners were encouraged to explore co-location opportunities, co-location itself was not a focus of this project. Some partners did include previously developed co-location sites among the core providers involved in the project. The coordination/navigation services that were the focus of the project did not involve direct delivery of primary care services in mental health settings or vice versa. Therefore, licensing issues did not arise.

6. **Can the panelists describe the process for identifying eligible members, and then how those members were then identified to be invited?**
   In the Southeast, all three counties first identified potential participants using medical claims and plan enrollment data. From the initial lists of eligible members, Montgomery and Delaware counties identified members served by their largest behavioral health providers, analyzed which primary care providers (PCPs) were connected to these members, selected a subset of core PCPs, and sent invitations to eligible members assigned to those PCPs. The counties chose this strategy to help with relationship-building and program participation from the outset. Because Bucks County did not have
large primary care practices, it took a different approach, sending an informational packet to behavioral health providers for case managers to distribute to members. In the Southwest, project partners similarly used claims and enrollment data to identify members with SMI. To identify members with the greatest needs, the partners then classified each eligible member on a monthly basis into one of three tiers based on their risk for adverse behavioral or physical health events. The first tier included members with high physical health risk. Tier 2 included members with high behavioral/low physical health risk, and Tier 3 included members with low behavioral/low physical health risk. After engaging Tier 1 members, care managers focused on engaging members with a recent hospitalization or ED visit (regardless of risk/tier), and then engaged Tier 2 members.

7. What was the role of the local county governments and mental health entities in this project? In PA, Medicaid behavioral health services are organized and operated at a county level. Each of the four participating counties contracts with a behavioral health managed care organization (BH-MCO) to administer these services, and the project leadership in both pilot regions included senior officials from counties as well as the BH-MCOs. Collectively, these entities played key roles in all aspects of program design and implementation. In the Southeast, care coordination services were provided in the community by navigators employed by community mental health agencies, with support from care managers at the BH-MCO as well as the “physical health” MCO. In the Southwest, care coordination services were primarily provided by care managers at the BH-MCO and MCO levels, and the BH-MCO engaged community behavioral health providers. County governments also played key roles in engaging consumer input in the program design, and in assessing consumer satisfaction among enrollees. In the Southwest, the county convened and facilitated a consumer and family advisory committee.

8. Is the MCO part of the Medical Home or are the Medical Home and MCO two different entities? Efforts at the plan and provider levels were separate but complementary. In the Southeast, care coordination services were delivered by navigators located within the community mental health agencies, which served as the “medical homes” for the enrolled population. These navigators were further supported by care management staff and information resources at the MCO and BH-MCO partners. In the Southwest, care coordination services were principally provided by the MCO and BH-MCO care management staff. In some cases, these staff were located onsite at a number of primary care practices who were part of the MCO’s medical home initiative.

9. Were electronic records used and were there any record elements that were not shared among providers? The project itself did not include implementation of an electronic health record at the practice level. In the Southeast, claims-based information was provided to navigators in the mental health agencies monthly in the form of PDF “member health profile” files. Enrollees had to consent to share all of their health information (including mental health and substance abuse-related) in order to participate in the Southeast program. In the Southwest, the MCO and BH-MCO care managers used a shared electronic care plan to communicate enrollee needs across the two organizations. Mental health and substance use information was included only if a member provided explicit consent to share behavioral health information, and the care plans were shared only between MCO and BH MCO staff.

10. How did you address privacy rules under 42 CFR Part 2 related to SUDs when sharing info with PCPs? As part of this project, state officials provide Guidance on Health Care Information Sharing to the project partners to outline how patient data can be shared under federal and state privacy rules. In the Southeast, eligible individuals could only participate in the project if they agreed to share this information with their PCPs and other identified project partners. In the Southwest, the MCO and BH MCO did not share any SUD-related information with PCPs.

11. What is the difference between “navigators” and care managers? What is the role of each? In the Southeast, care coordination services were delivered by navigators employed by and located within the community mental health agencies. Each of the three participating counties determined the educational background and training required for its navigators and included bachelor’s prepared
case managers, registered nurses, and master’s prepared behavioral health professionals. These navigators were further supported by care management staff within the MCO and BH-MCO partners. For example, navigators participated in joint case rounds, with MCO and BH MCO medical directors and care managers, during which participants discussed diagnostic clarifications, how to access specialty consultations and follow-up appointments for members, and how to help the navigators access needed information. In the Southwest, care coordination services were principally provided by the MCO and BH-MCO care management staff, who were registered nurses or licensed behavioral health professionals. A number of these nurse care managers were located onsite at primary care practices as part of the MCO’s medical home initiative.

12. **Is there additional analysis planned (i.e. community tenure, physical disease management compliance, preventative PCP visits kept, etc.)?**
   
   No additional analyses are planned at this time. Community tenure was included among the outcomes reported in this study. See the [Southwest Case Study](#) (pages 13-14) for more information. Community tenure was not significantly impacted in the Southeast project.

James Schuster, MD, Chief Medical Officer, Community Care Behavioral Health

13. **What specific community resources were utilized as part of this pilot?**
   
   Both physical health and behavioral health providers were valuable community resources. They were engaged to help explain the benefits of the Connected Care program to members, assisted members with completing the necessary consents and often assisted in coordination of treatment. Additional resources included additional human service programs and members’ natural supports.

14. **Was there a related program to secure or find housing as part of the intervention? It seems homelessness and Substance Abuse are significant problems - how does all this navigation result in safe housing for these people?**
   
   Housing was not a specific part of the Connected Care program. However, if homelessness or substance abuse treatment was identified as an unmet need through the integrated care planning process, UPMC for You and Community Care staff would coordinate with community providers to address these concerns.

15. **How did these models of care impact substance use of the members?**
   
   The efforts to coordinate care led to identification of substance use by many members and coordinated efforts by physical and behavioral health providers to address it, with additional referrals when indicated.

16. **How did you fund startup activities? How do you plan on funding care coordination and wellness activities moving forward?**
   
   Start up was primarily funded by Community Care and UPMC for You which have committed substantial personnel and development resources to multiple care coordination and wellness activities. Additional sources of funding for care coordination activities have included funding from Allegheny County, grant funding from other sources, and Medicaid reinvestment funds from the Pennsylvania Department of Public Welfare.

Sandy Zebrowski, MD, Medical Director, Magellan Behavioral Health

17. **What were the risk factors that were used to determine the member stratification?**
   
   The physical health stratification was done by our partners at Keystone Mercy based on a DxCG® score, which includes member demographics and utilization patterns to calculate a risk score. A threshold score of 240 was used to identify high risk. Behavioral health stratification was based on utilization (top 20% utilization accounted for highest risk group. We used a four-quadrant model for behavioral health/physical health risk (e.g., assigning each member as high or low risk from both a
physical and behavioral health perspective). Both Keystone Mercy and Magellan re-applied their risk stratification methodology on consented members at least quarterly.

John Lovelace, CEO, UPMC for You

18. **What does an "integrated care plan" look like in practical terms - i.e., is it part of an EMR, a free-standing record, something created for this pilot, etc?**
   The ICP was created specifically for Connected Care. It’s housed on a Sharepoint site that UPMC for You and Community Care staff can access and it auto-populates by pulling information from both HealthPlaNET (the UPMC for You clinical database) and PsychConsult (the Community Care clinical database). The form is readily accessible to both sets of care managers. We have implemented community-based teams that use this new care plan format. This template has been well received by the providers. The care manager completes the care plan and then helps the member make an appointment with their PCP and attends that visit with the member. The care manager reviews the care plan with the provider and then helps the member arrange for any follow-up treatments. Community Care has hired a staff person who does work with the health plan’s community team nurses and social workers. They can then work with the BH providers and contribute what they know from their care management system.

   The content of this care plan includes a summary of physical health and BH issues, which providers the member is seeing, use of inpatient and ER, gaps in care, the member’s goals and any recommendations for ancillary services or referrals for community based services. We also include a summary of the medications we know the member is taking. This tool is very useful to staff. We are now looking to get this in an electronic format in our care management tracking system.

19. **What would you do to get even better results?**
   We are doing a few things to potentially improve results:
   - Being clearer with the PCP as to what we would like them to do with the information we send them (e.g., if we send them information that a patient stopped or started an atypical antipsychotic, what would we like the provider to do with that information).
   - We are focused more on those PCP practices in which we have embedded care managers of our own, as that gives us more “control” over the outreach and education efforts toward the consumer and family, when appropriate.
   - We are implementing some additional clinical sites in which PCP clinicians are physically seeing patients in the mental health center.

   The community based team is an example of how we plan on getting better results. We have also been working with Value Options, another managed behavioral health organization, to expand the program into two more counties.

20. **Can you describe how you worked with the hospitals and the ER physician groups?**
   We primarily worked with hospitals and ER physicians to secure timely information on who was admitted. In a couple high volume EDs, we work with the ED staff to have a plan of care along the “advance directive” line, e.g., standing orders for when John Doe comes in complaining of pain, for example. We fax reports to the PCP and BH providers when we know that a member has been seen in the ER and the care manager provides more details about what is going on with the member.

21. **Was there any attempt to embed CM in the ER's or to incentive ER MD's to help with coordination?**
   We do have one ED, pretty high volume, in which we support a care navigator in the ED; her job is to “redirect” non urgent care to more appropriate settings. The ED has enhanced BH clinicians as well, who provide clinical services more like a mental health outpatient clinic (they have a big walk-in business of SMI folks). This hospital also has tele-med capabilities with the local mental health center, that they have tried to use in supporting discharge planning, so the consumer can “telemeet” their outpatient clinician before they leave the hospital. This is a hospital that historically has very
high behavioral health readmission rates. We were operating a CMS ED Diversion grant at the same time, so we synchronized these activities.

22. **Any change in payments to ER’s, ER MD’s or hospitals?**

No, not yet.

23. **What were the risk factors that were used to determine the member stratification?**

Using medical and behavioral health claims data we stratified members into three tiers: Tier 1 is high BH/PH and high BH/low PH; Tier 2 is High BH/low PH; and Tier 3 is low BH/low PH. Definitions for the high-risk categories are as follows:

**High PH:**

1. Three or more ED visits in the past three months; or
2. Three or more inpatient visits in the past six months.

**High BH:**

1. Discharged from, history of being served, or diverted from state mental hospital;
2. Five or more admissions to most restrictive level of care, or readmitted within 30 days;
3. Four or more admissions to most restrictive level of care and inpatient or RTF or CTT admission;
4. Three or more admissions to the most restrictive level of care and inpatient or two admissions to most restrictive level of care and inpatient and an open authorization for certain services.

Fazlu Rahman, MD, Medical Director, Keystone Mercy Health Plan

24. **What would you do to get even better results?**

Following are three potential strategies: (1) On the physical health side, we would have had better success if we’d worked in a more concerted, targeted and focused fashion with our network providers. Many providers, when contacted by the Navigators, stated they were not familiar with the project. There were providers that indicated that they would have been more likely to actively participate if they received direct incentives from the plan for currently non-billable items such as telephone consultations, both directly with members, and with their behavioral health counterparts. Some providers expressed an unfamiliarity on how to arrange referral for behavioral health services; (2) we also would have done a better job if we invested more time in detailing the providers on the Member Health Profile, and ensuring their distribution; and (3) going forward, we would expand accessibility of the project to members who were not already familiar/receiving behavioral health services.

LeeAnn Moyer, Deputy Administrator, Montgomery County Department of Behavioral Health and Developmental Disabilities

25. **What were the obstacles to member engagement and what was done to address them?**

Navigators were trained in motivational interviewing to enhance their ability of engagement and developing a therapeutic relationship. Many clients were difficult to connect with initially. Some had sporadic attendance or a high no-show rate within the agency where they were receiving one or more outpatient services.

To connect with clients for the first or second time, navigator teams shared these action steps:

- Get to know the client – review psychosocial and medical history, check appointment adherence, use electronic data system.
- Collaborate internally to see whether person is connected with agency treatment supports (therapist, recovery coach, IOP, peer specialist).
- Identify the person’s main concern and use that information to highlight how you can help.
- Arrange meeting with recovery coach or other staff and find out from them the best way to engage (warm transfer).
Introduce self in waiting room while client is waiting for appointment. Give business card and program information/brochure.

Plan to first meet with client at the beginning or end of a therapy session/medication check.

Focus on relationship building and trust. Use listening skills and team approach.

Have an open door policy and/or standing appointments, drop-ins, come in during scheduled appointments.

Allow client to talk freely about any problem.

Be willing to meet client in the home or community based on client's desire or need.

**For cold calling during the Early Phase:**

- Ask peer specialist the best way to engage.
- Explain how you got the person's name.
- Let person know (if applicable) that you spoke with recovery coach or other support staff.
- Sell the program with focus on providing person with best care (focus on improving communication between MD/psychiatrist and other health care providers, increased awareness of medication interactions with a collaborative approach).
- Invite the person to share his/her health care concerns. Offer help and frame in a way that you have the knowledge/experience to do so.
- Meet in non-traditional ways.
- Give your name and contact number if they refuse to consider program at time of call.
- Ask permission to meet when coming in for another appointment and/or to follow-up with a phone call.

**For those bumps in the road:**

- Keep calling monthly.
- Attempt outreach.
- Communicate with recovery coach/therapist/peer specialist.
- Keep a non-judgmental stance – open conversation.
- Make it clear to clients that navigators can be used at anytime.
- Unconditional regard.
- Re-evaluate and affirm what client feels would be helpful when he/she experiences those bumps in the road.

**What helps to bring the client back:**

- Send letter
- Arrange home visit.
- Use recovery coach support if unable to reach and everything has been tried. Wait for a need to arise.
- When re-connection occurs, ask what would go better next time.

26. **What specific community resources were utilized as part of this pilot?**

It is important to note that Montgomery County has a recovery-oriented system of care offering many evidence-based practices including the use of peer specialists throughout many treatment services and community supports.

Navigators were surveyed during the pilot program for feedback on the specific community resources that they used to support each client's recovery and move toward self-management. **Resources cited included:** Gift of Sight/Lenscrafter Program, YMCA, Food Cupboard, Vocational Consulting-NHS, Recovery Coaching (aka, intensive case management), PA State Quit Line, MC Office of Probation/Prison System, AA/NA Support Group, Take 5-Program (peer respite), Spiritual Communities, Montgomery Hospital Smoking Cessation Program, Montgomery Hospital Diabetes Education Program, Mercy Suburban Diabetes Education Program, Norristown Legal Aid, ACLAMO (bilingual community service center), support groups for various medical conditions (CPAP, acromegaly, MS etc.), referral to IOP's vocational consultant, SEPTA Learn-to-Ride Program, PCPs, Dental, Comfort Keepers, GED support, soup kitchens, pharmacies, landlords, case managers at
KMHP, Transnet Reduced Fare Card, Gym, Church, Montgomery County Community College, Bipolar Support Group, Peer-Run Hope Market- food, clothing, home items.

27. How often did Navigators contact their patients? Was it based on stratification?
Frequency of navigator contact was based upon each person’s level of need further determined by an initial behavioral health and medical assessment regardless of their risk stratification. The service was designed to be time-limited varying in length and intensity of interventions.

28. Did the Navigators do any outreach calls on consumers before consumers actually needed service?
Navigators did do outreach calls to explain the benefits of the program and build a rapport with the person. Once a person agreed to enrollment in the program, the relationship between navigator and the person was ongoing with specific person-centered goals identified.

29. Was there a proportion of client participants who were homeless and if so, what extraordinary coordination occurred with this population?
Yes, there were participants who were homeless. Navigators would outreach to shelters and coordinate with staff, meet the person on location to assess behavioral health and medical healthcare needs and connect with intensive treatment supports to find housing and provide other needed services. Homeless resources supported by county and other public funds include: Homeless Outreach Center with shelter beds, Critical Time Intervention (evidence-based service) teams of specialized case managers, Housing Plan to support Housing First options.

30. What type of training was offered to navigators?
In Montgomery County, navigators participated in the six-month UMASS certification program in Primary Care Behavioral Health and they attended Motivational Interviewing skills training. In addition, they received ongoing education on topics such as metabolic disorder, obesity, diabetes, smoking cessation and they were kept informed of all nationally based webinars to enhance their skills in BH/PH and co-occurring disorders.

31. Were the wellness and fitness classes paid for from state funds?
No, navigators were able to either find charities, negotiate discount rates, and many free community support groups offered through hospital organizations and local colleges.

32. Was the state able to make additional in Home Support Service available?
Through the State’s HealthChoices Program, MA Managed Care with Behavioral Health Carve-out, “supplemental services” may be developed with approval by state for reimbursement under HealthChoices. The Wellness Recovery Teams of Navigators is one example of an approved in Home Mobile service funded by HealthChoices. Other examples include: Mobile Psych Rehab and Peer Specialist. Additionally, the MC Physical Health Plan coordinated with the Navigators to offer and fund in home services and supports, if needed.

33. How did you define to the clients the six categories for rating the effect on them (reference to the CHI results)?
Participants were informed of the usefulness of the CHI as an individual outcome measure so they could measure their progress over time within six domains: Emotional Health, Physical Health, Behavioral Symptoms, Strengths, Provider Relationships and Work-School Participation. The CHI was found to be helpful to both the participant and navigator for developing the Integrated Wellness Plan in which specific goals were targeted.
Jung Kim, Researcher, Mathematica Policy Research

34. *Did you use Propensity Score Matching to define the comparison groups (east and west)? If not, how did you put the comparison groups together?*

   No, we did not use propensity score matching to determine the comparability of the study and comparison groups. Rather, we used a population-based approach to select the study and comparison groups: everyone who met the study group eligibility criteria (age, SMI diagnosis, enrollment in the appropriate health plan and behavioral health plan, county of residence) in the comparison group were included in the analysis. To examine the comparability of the study and comparison groups over time, we identified cohorts of eligible members three years before the intervention began and examined trends in their hospital and emergency department use in the two years prior to the intervention period. We found that these trends across the study and comparison groups were similar before the intervention began, indicating that the two groups were comparable without having to match members via propensity score methods.

35. *Did the evaluators observe any difference in the effectiveness of telephonic vs. in-person case management?*

   The evaluation did not examine the effectiveness of different types or levels of intensity of care/case management. All we can confirm is that the intervention had an effect on mental hospitalizations and readmissions in the Southwest pilot, which targeted a larger number of individuals using primarily telephone contact. Likewise, ED use was reduced in the Southeast pilot, particularly Montgomery County, where nurse/behavioral health clinical navigator teams engaged individuals both in person and by telephone. However, because these approaches were not tested against one another in one of the pilot regions, we cannot comment on whether telephonic or in-person case management was more effective.

36. *Do you think that the results with the most complex situations would have been improved with the use of more in person contacts as opposed to the use of telephone contacts? Doesn’t this population need more than phone contact to be engaged?*

   We cannot answer this question without additional data and further study. If “the most complex situations” refer to individuals with greater health and psychosocial needs, this hypothesis is plausible, but we do not have data on the types or intensity of contact for specific individuals and could not test this hypothesis.

37. *Would you expand on areas of future research identified in the pilots?*

   Future areas of research might include examining: (1) the association of outcomes to the types and intensity of contact among different types of individuals (for example, diagnostic and utilization history/risk/acuity level or among those with/without a usual source of behavioral and primary care); (2) effects on program costs and potential cost savings; (3) readmissions by type of facility to better understand from where the potential for cost savings exist from reduced readmissions; (4) the association of readmissions to outpatient use/office visits, particularly after a hospital discharge or ED visit; and (5) medication use among the SMI population to examine its association to other outcomes such as ED visits and hospitalizations.