HEALTHCHOICES HEALTHCONNECTIONS

Report to the Community

Montgomery County, Pennsylvania

The Integration of Health Care

The Montgomery County Department of Behavioral Health and Developmental Disabilities and Magellan Behavioral Health of Pennsylvania, Inc., have recognized the important role of integrating both behavioral health services and primary medical care for the members we serve. Public mental health systems across the County serve more than 3.1 million people each year *(U.S. Social Security Administration, 2006).* Montgomery County is responsible for 58,810 covered lives *(Magellan Utilization Management report, 2010).*

Studies have shown that those individuals with a serious mental illness die an average of 25 years earlier than the general population *(NASMHPD, 2006).* Such premature deaths often are linked to treatable or preventable chronic health conditions, such as cardiovascular, pulmonary and infectious diseases. Decreased mortality rates often are associated with controllable lifestyle factors such as smoking, obesity, diet and nutrition, lack of exercise and substance abuse. Oftentimes, individuals with serious mental illness have difficulty accessing medical care and find there is a lack of coordination between behavioral and physical health providers.

Montgomery County and Magellan are committed to focusing on promising solutions to remedy the disparity of a shortened life compromised by physical illnesses. In collaboration with Montgomery, Bucks and Delaware Counties; the Department of Public Welfare; Keystone Mercy Health Plan; the Center for Health Care Strategies; and the Office of Mental Health and Substance Abuse Services (OMHSAS), the innovative *HealthChoices HealthConnections* (HCHC) program was initiated as a pilot program by OMHSAS in June 2009 to facilitate quality health care in an integrative and holistic manner—**focused on recovery of the "whole person."**

All members referenced and pictured in this report have provided written consent to share their stories and their images. In some cases, members gave us permission to use their real names.

A visionary team, consisting of representatives of each partner agency, was formed to execute the administrative, operational and clinical aspects of the program. The vision team met for several months to work out all of the details involved in this multifaceted project. This type of collaboration between behavioral health care providers and physical health care providers was unprecedented.

The Vision Team

Each County was at liberty to implement the plan in different ways. Some Counties chose to enhance their case management to include the essential components of HCHC. Montgomery County, under the leadership of LeeAnn Moyer, Deputy Administrator for HealthChoices, worked diligently with core providers and invested substantial time and funding into making sure that this project would be beneficial to the members we serve and sustainable as a business strategy for the providers involved. LeeAnn Moyer became a "champion" of the team concept in which a registered nurse and a behavioral health professional *together* formed a Wellness Recovery Team to jointly provide integrative services to each member enrolled in HCHC. She worked with Magellan to develop a service description that was submitted to and approved by OMHSAS. Her commitment to this project has contributed to its success, and she has been invited to present this model at several conferences.

With *HealthChoices HealthConnections,* Magellan and its partners helped to improve communication among all health care providers, which resulted in positive outcomes for a sample of our members. The original pilot ended in June 2011; however, Montgomery County and Magellan are committed to continuing this initiative. The plan is to expand this model of integrated care to other physical health plan providers and additional HealthChoices individuals living in Montgomery County.

The impact on quality of life as reported by participants is remarkable. From its inception, the program was designed with key concepts of **recovery**—to give participants *hope, strength and empowerment.* With this in mind, successful outcomes could only be achieved by closing gaps in care, improving communication across health care providers and delivering services in "non-traditional" ways. The expertise of both a registered nurse and behavioral health professional working together on a Wellness Recovery Team provides optimal health care so that an individual's physical health and behavioral health needs can be met in a holistic manner with focus on the "whole person." With this approach, teams credit their success to the trusting relationships they strive to form with every individual served, in addition to the ongoing contacts with primary care physicians, specialists, treatment supports, family members, Certified Peer Specialists and other community resources.

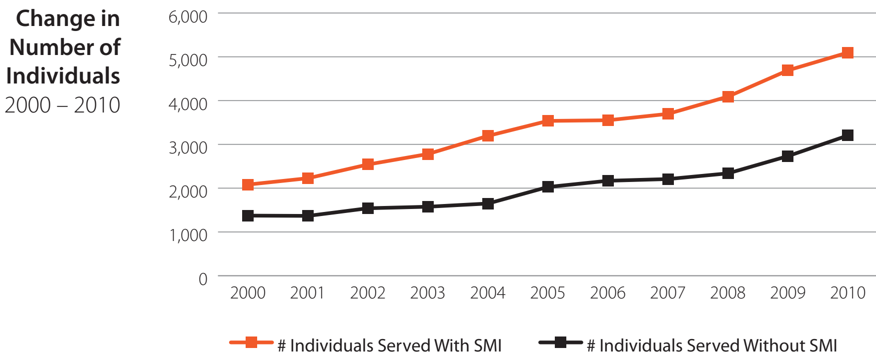
Purpose of Report

This report provides an overview of positive outcomes and highlights of the unique model developed for *HealthChoices HealthConnections* within Montgomery County. We have included utilization data, health data (as available), Consumer Health Inventory (CHI) outcomes, individual satisfaction reports, individual stories and quotations. It is intended that all of the information reported herein will demonstrate the value of such a program, not just in terms of return on investment, but also on the quality of life for members.

Demographics

For this initiative, OMHSAS identified specific diagnostic categories as representative of serious mental illness (SMI). Diagnoses included are schizophrenia, mood disorders (including bipolar disorder and major depressive disorder) and borderline personality disorder. Adults ages 18 and over with one of these SMI diagnoses are eligible for the HCHC program.

A steady increase is seen in the number of individuals in the Montgomery County HealthChoices program identified as having a serious mental illness since 2000, from 2,082 people in 2000 to 5,097 people in 2010. This is a rise of 145 percent in 10 years. An increase also is seen for individuals not identified as having a serious mental illness; however, the rate of increase of 133 percent was not as fast as with the group diagnosed with SMI. The table below demonstrates these increases.



“Thank God for *HealthChoices HealthConnections* … the last two years have been good for me. I’m going back to school in two weeks and I have my finances together. I have no major depression and I haven’t been hospitalized in about 14 months. I’ve managed to do all this through the support of this program and the NHS team.”

– Joseph M. who receives HCHC services at Northwestern Human Services

In 2010, 50 percent of individuals in Montgomery County with a serious mental illness were aged 40 to 63. A greater number are females (59 percent). The most common diagnostic group represented mood disorders inclusive of the different types of bipolar and major depressive disorders.

Age Group	
18 to 21	9%
22 to 29	18%
30 to 39	19%
40 to 49	25%
50 to 63	25%
64+	4%

Gender	
Female	59%
Male	41%

Diagnostic Group	
Schizophrenia and Other Psychotic Disorders	28%
Mood Disorders including Bipolar and Major Depressive Disorders	70%
Borderline Personality Disorders	2%

The HCHC program approach was embraced with a purpose to better assist and coordinate physical and behavioral health supports for men and women of all ages with many different challenges.

HCHC in Montgomery County

Participating Providers

Six of Montgomery County's behavioral health provider agencies became designated sites for implementation of *HealthChoices HealthConnections* to improve health care for persons with serious mental illness, substance use disorders and co-morbid physical health conditions. This includes two Assertive Community Treatment (ACT) programs.

Provider HCHC Sites

- Abington Memorial Hospital (Abington)
- Central Montgomery MH/MR Center (Norristown)
- Creative Health Services (Pottstown)
- Northwestern Human Services (Lansdale)
- Penn Foundation (Sellersville)
- Horizon House (ACT—Norristown)
- Penn Foundation (ACT—Pottstown and Sellersville)

These core providers were involved in the planning and decision making for this project from its early stages to ensure their partnership. Each agency serves a different geographic region or service area of Montgomery County.

Identification and Engagement of Individuals

Individuals with serious mental illness served in Montgomery County were identified for engagement based on many behavioral health and physical health care needs, as well as through provider recommendations. Mailings were sent by Magellan, followed by personalized outreach by regional Navigators.

A total of 2,135 Montgomery County HealthChoices members were identified as qualifying for participation in the *HealthChoices HealthConnections* program. The Navigators reached out to engage individuals in order to introduce the HCHC program and to encourage their participation. As of November 2011, 396 individuals have consented to sharing and coordination of their health and treatment information among their listed treatment providers (including their behavioral health plan, physical health plan, primary care practitioners, substance abuse providers and specialty providers), and to begin participation in the HCHC program.

Formation of Teams

Using best practices and innovative ideas to transform care delivery, an integrated approach was developed in partnership with the Montgomery County Department of Behavioral Health and Developmental Disabilities and Magellan Behavioral Health of Pennsylvania. To "navigate" the health care system, clinical teams of health advocates/Navigators referred to as Wellness Recovery Teams (WRT) were developed within each participating agency. Navigators work together to develop engagement strategies, stages of interventions and several other promising practices.

This model is based on the "person-centered health care home," which is summarized by the National Council for Community Behavioral Healthcare as follows: "The core of the clinical approach of the patient-centered medical home is **team-based care** that provides care management and supports individuals in their self-management goals." By providing coordinated and integrated care within a team-driven model and whole-person orientation, individuals will feel that their treatment is less fragmented and their quality of care is improved.

"Team-based care is a way to close care gaps and holistically address health care by utilizing interventions from many health care systems. The members of team-based care drastically benefit from having coordination on all levels," said Penn Foundation ACT director Julie Williams.

WRT is Montgomery County's unique program model of the *HealthChoices HealthConnections* initiative. Each team is comprised of a registered nurse (RN) and a behavioral health (BH) professional with, at minimum, a master's degree. Each Navigator assumes discipline-specific clinical responsibilities with an emphasis on team service delivery to ensure that a person's health care needs are optimally met. The team model also includes an Administrative Navigator who is the point person to ensure that clinical and operational standards are upheld with the utmost integrity and commitment to the program's mission—*improving the health care status of all members served while supporting their ability to make decisions that positively affect their health.*

Every RN and BH Navigator has participated in a six-month certification training offered by the University of Massachusetts, Department of Family Medicine and Community Health to enhance their professional skills, as integrating behavioral health into primary care is a relatively new concept within the United States over the last few years. In addition to this intensive integrative training, the Navigator teams are competent to address any co-occurring substance-related issues.

Marco Magdamo, director of service integration for Central Montgomery MH/MR Services, shared that Central's mission is to be a community dedicated to helping people of all ages improve their emotional and behavioral health, develop resiliency and achieve personal fulfillment. "I see the HCHC program as the next step in the evolution of that community in which the importance of overall health (physical as well as emotional) is addressed, recovery is enhanced and full integrated health care is achieved."

Collaborative Focus

An essential component of the HCHC program is its collaborative focus. Examples of partnerships include initial trainings for all Navigator teams completed by Keystone Mercy Health Plan and Magellan staff, Magellan Care Management staff co-located in Montgomery County, onsite monthly meetings co-led by County and Magellan staff, a monthly learning collaborative with all Navigators, joint case rounds, storytelling training led by Montgomery County consultant Joan King, and a Consumer and Family Advisory Board.

The mobility of the Navigators has many advantages and enables them to meet those they serve within the community and other non-traditional settings. Navigators accompany members to doctor's appointments to discuss complex medical issues. They meet with family members, therapists, recovery coaches, peer specialists and other member-identified supports, all referred to as "virtual team" participants. Navigators are focused on continually building strong partnerships with members (and their virtual team), particularly with primary care physicians, pharmacy, specialty health care services and community resource specialists.

One contributing factor to the success of the virtual team's ability to infuse recovery principles is the strong foundation of recovery-oriented services in Montgomery County. The County is rich in peer specialist and evidence-based practices.

Other Navigator connections include maintaining close contact with the Montgomery County Department of Behavioral Health and Developmental Disabilities, and Magellan and Keystone Mercy Health Plan staff to ensure that health care is carefully coordinated.

HCHC participant Lisa G. with Nurse Navigator Joan Kovar at Northwestern Human Services

Lisa G., an HCHC individual at Northwestern Human Services, shared how the collaboration between her Behavioral Health Navigator Dr. Sonja Kenney and the nursing home where she was receiving rehabilitative services following surgery resulted in an effective care plan. "Sonja worked with the nursing home social worker to gather and share information, which helped my transition back to the community. I'm so grateful for the program," stated Lisa. Dr. Kenny commented, "Lisa has confronted multiple physical health challenges along her recovery journey. I continue to be amazed at the tremendous strength, spirit and humor that she bravely demonstrates while maneuvering through a turbulent sea of adversity and uncertainty." Nurse Navigator partner Joan Kovar added, "Lisa is an incredible optimist who has such survival skills! My response to her—You go, girl!"

Montgomery County and Magellan's commitment to strong relationship building—a key aspect to a recovery oriented practice—whas led to the assignment of a *HealthChoices HealthConnections* Community Support Care Manager, Deborah Bukovec, who along with County Behavioral Health Adult Clinical Program Manager, Marylynn Windish, is partnered with all the Navigator agencies to support the program's mission and provide direction as the program expands. Monthly meetings are held at each Navigator agency to provide team support and resources from both Montgomery County and Magellan. Each month all the Navigators within Montgomery County come together for a Learning Collaborative. This meeting is a forum where ideas and experiences are shared with the goal to advance integrative health care so that it becomes more widely recognized as a best practice.

Montgomery County Learning Collaborative

Montgomery County Adult Clinical Program Manager Marylynn Windish highlighted at a recent Learning Collaborative how Navigator interventions are centered upon the goals and invested interests of the individual. She emphasized, "Because of the Navigator's expertise in motivational interventions and commitment to recovery-oriented care, this has contributed to members taking steps toward self-advocacy and self-management of their health care."

Many members participating in *HealthChoices HealthConnections* have found a forum of their own by sharing their stories of success in partnership with their Navigator. These stories have been a testimonial to how the program has made a difference in their lives.

Stephanie M. shared with the clinical staff at Magellan her personal challenges of what life was like prior to becoming involved with the HCHC Navigator team at Penn Foundation. "Before *HealthChoices HealthConnections* came into my life, arranging doctor appointments and convincing one doctor to communicate with another for my care was impossible. It was extremely stressful and frustrating, which only added to the pain and exacerbation of my disease. I felt as if I was in a tunnel with no sign of light at either end.

"I would sit at night in the dark crying and screaming into a pillow from the pain, so my children would never know exactly how much pain I was in. While I already suffered from depression, being diagnosed with a chronic life-altering incurable disease would make anyone depressed.

HCHC participant Stephanie M. (center) with Nurse Navigator Lori Marshall (seated on left) and therapist Charlotte Leedom (standing) at Penn Foundation

"Many things have changed since coming in to the HCHC program. One of the biggest changes is the compassion and the caring that Lori Marshall, my Nurse Navigator, has always shown me from day one. Her determination for verifying that the correct doctors, the correct medications and the correct testing are in my best interest has always put my mind at ease and relieved my stress and frustration. *HealthConnections* has made it easier to locate doctors and specialists, schedule blood work and diagnostic testing, allow my doctors to request copies of the blood work and tests from each other and refer me to specialists with the help of my Nurse Navigator.

"With the help of my Behavioral Health Navigator Angela Hackman, mobile therapy was arranged due to the deterioration of my health and inability to keep my weekly therapy sessions at Penn Foundation. Without Angela's visits, there are some weeks I don't know how I would make it through the next week with my full plate of stress and frustration.

"Lori and Angela's determination to help me both medically and mentally over the past year has helped to coordinate my health needs, my mental health needs and complex special health care needs. Without the two of them, the stress, depression and frustration would've caused my disease to spiral even further out of control."

The Wellness Recovery Team at Creative Health Services met with Michael when he was hospitalized to discuss how involvement in *HealthChoices HealthConnections* would be an option available to him upon discharge. He agreed to give it a try as his history with the agency was extensive, and he was open to trying something new.

Over the years, Michael has struggled with a heart condition, chronic joint pain and substance abuse. He also lives with bipolar depression and post-traumatic stress disorder. The first step toward Michael's recovery involved a comprehensive review of his health record, symptoms and treatments. Following consultation with staff psychiatrist Dr. Vigar, several "tweaks" were made to Michael's medication profile, which produced some promising results. Michael now sleeps better, eats healthily and functions on a much higher overall level. He attends individual outpatient therapy sessions within Creative Health and AA and NA meetings (almost daily) within the community.

Dr. Vigar with Wellness Recovery Team

His Wellness Recovery Team commented that, "Michael has secured a more stable living situation, budgets his money more pragmatically and has taken ownership of both his physical and mental health care. His ability to make good choices regarding his activities and housing and the fact that he feels better overall are a big improvement in Michael's life. Since enrolling in the HCHC program, Michael has not returned to the hospital and continues to make steady progress toward his recovery."

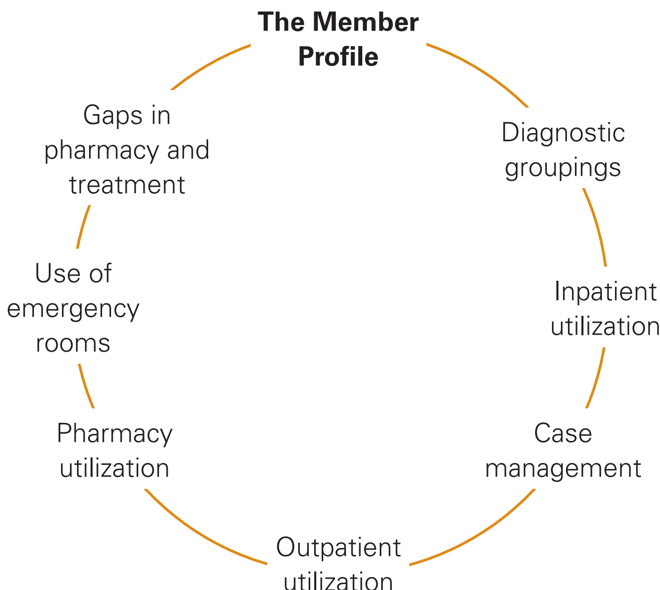
Michael reported, "I used to live day to day—sometimes moment to moment. Now I think about the future and the things I will do. It makes me hopeful."

Left to right, Consumer Satisfaction Team member Michelle Gough, Magellan Certified Peer Specialist Carla Neely, and Quality Management Coordinator at Montgomery County Behavioral Health Andrea Galambos

To provide members and families with a forum to offer their feedback to the HCHC program, the Consumer and Family Advisory Board was formed. The board, which meets monthly at the Human Services Center in Norristown, has been a voice to oversee the program and ensure that recovery principles are fully incorporated.

Integrated Member Profile

The Member Profile is a tool developed to combine an individual's behavioral health and physical health information into a comprehensive report. This profile includes:



The Member Profile is a useful tool for integrating health care needs, which Navigators can access once an individual has consented to participate in the program. Navigators review the physical health and behavioral health aspects of the Member Profile and, if needed, consult with medical staff and/or psychiatrists. Information from the record is shared with every individual in HCHC. As a way to address any concerns, referrals can be made to medical specialists, self-help support groups, educational information, wellness activities, drug and alcohol interventions, peer supports, community resources, rehab services and natural/family supports. Any referrals accepted by a member become part of that individual's action steps on his or her wellness/recovery plan.

Review of an HCHC participant's health record by Nurse Navigators Donna Wisely and Deb Reber and Behavioral Health Navigator Lizanne Welding-Mills at Creative Health Services

"I really feel like I have more control over my life now. I also feel like I have someone who I can always trust and talk to. I think the program has really been a gift … clients come first. And they (the Navigators) don't do things for you. They help you learn to do things for yourself. I can now make appointments for myself. I was too nervous to do that before. I've learned how to take care of myself better. I've learned that I can really feel better mentally when I feel better physically."

– Pat H. who receives HCHC services at Central

Integrated Wellness Plan

The HCHC program recognizes "that people recover and lead healthy lives within the context of communities, and so will work with people to identify natural supports in the community that can contribute to their overall wellness, as well as ways they can contribute to their communities," said Montgomery County Deputy Administrator LeeAnn Moyer. She outlined the key benefits of HCHC:

- Improved understanding of medications.
- Improved self-management and wellness strategies, including (but not limited to) stress management, diet and nutrition, exercise and the use of preventive care.
- Development of improved relationship skills.
- Increased confidence at relating to physicians of all types, and an understanding of how to negotiate and communicate with health care providers.
- Increased coordination of care.
- Increased self-advocacy.

HCHC participant Angela F. working on a wellness goal with support from Penn Foundation ACT Team Leader Deborah Strouse and ACT Nurse Elizabeth Frederick

To help individuals reach their goals, an integrated wellness/recovery plan becomes the blueprint for helping guide each person in recovery on a path toward empowerment and hope. Every individualized plan is done by the participant in collaboration with the Navigator team and other designated persons.

Integrating Medical and Behavioral Health Care—A Success Story

Ann consented to participate in *HealthChoices HealthConnections* after she cancelled multiple appointments for a Navigator to come to her home. Nurse Navigator Madelyn Pontari at Central Montgomery MH/MR Center focused on building a relationship with Ann after Ann's husband encouraged her to keep trying and not give up. "Developing a relationship is so important in my role, and I was persistent because Ann was engaged with me over the phone and admitted to many health needs. I knew I could help her. Over time, I connected with Ann to establish a meaningful relationship.

"Along with a mental health diagnosis, Ann has faced mutliple medical problems. She has been in recovery from a long history of alcohol and drug abuse. Once signed on to the HCHC program, I was able to obtain medical records from her primary care physician and specialists. Our initial contact was sporadic, primarily by phone, because Ann shared that she was doing well. However, the frequency of our contact changed once Ann's health care needs began to require more attention from her Wellness Recovery Team.

"Then Ann experienced severe foot pain and went to the emergency room at a community hospital, where she was admitted for the treatment of blood clots in two toes. She was discharged back to home and treated with local wound care. She returned to see her surgeon because her toes were not healing properly and gangrene set in.

"Further medical workup showed poor circulation and clots in the arteries of her leg. Despite receiving treatment to remove the clots, more inpatient medical stays were required because of continued poor healing and infection. After several months, Ann received the devastating news from her surgeon that she would require an above-the-knee amputation due to non-healing.

"As her Navigator and advocate, I encouraged Ann to get a second opinion at another hospital. Intially, she was hesitant because she didn't want to hurt the surgeon's feelings. But after she and her husband consulted with the Wellness Recovery Team, they agreed to get another medical opinion. Diagnostic studies assessed her as a candidate for revascularization surgery to salvage the remainder of her foot. Following the surgery, her specialist is optimistic that her foot will heal. As her Navigator, I feel that I had a positive impact on the care she received and that I could make a difference," concluded Nurse Navigator Madelyn Pontari.

Ann sums up what HCHC has meant for her: "The program has helped me so much. The Wellness Recovery Team made sure that I received safe, good care. My Nurse Navigator Madelyn made sure that my psychiatrist knew about the many times I was hospitalized and couldn't see him, and she made sure that I had my psych meds. The team even made home and hospital visits, which shocked me! They have really been there for me."

Recognition to Executive Directors

Executive directors of the agencies involved in this initiative worked with LeeAnn Moyer and Magellan's Scott Donald to identify how to best implement this pilot. It was neither a quick nor easy task to identify a way to do this well while adding substantial value for the individuals served and getting costs covered to sustain agency budgets, which included additional positions for Wellness Recovery Teams. Each of the executive directors and/or program directors is to be congratulated on his or her commitment to this valuable project: Clark E. Bromberg, Ph.D., Central MHMR; Andrew Tretacoste, Psy.D., MBA, Creative Health Services; Sharon Testa, Psy.D., Northwestern Human Services; Rick Fullan, MSW, Abington Memorial Hospital; and Donna Duffy-Bell, MA, Penn Foundation; as well as the ACT Directors Marie Kearns, Ph.D., Horizon House; and Julie Williams, MA, Penn Foundation.

"It's a support system for me. They [the Navigator team] come to the doctor with me … they'll visit me at home to make sure I'm taking my meds. It was 110 degrees in my house and when they came, my blood pressure was way up. I was really in danger. If it wasn't for them, I might not be here."

– Karen H. who receives HCHC services at Creative Health Services

Outcomes

Early Findings
Since the onset of *HealthChoices HealthConnections,* there are expected outcomes in both the physical health and behavioral health aspects of the individual's life. Some of the anticipated primary outcomes are focused around the following objectives:

- Decrease in inpatient utilization for medical and mental health conditions.
- Decrease in utilization of crisis services.
- Decrease in use of emergency rooms for primary and/or behavioral health care.
- Improved communication with primary care physicians.
- Increased connection with the community and treatment resources.

During the program's first year, the Navigators conducted an outcomes review of 68 members. The findings from this preliminary survey in April 2010 showed that as a result of HCHC interventions, 100 percent of members were connected to a primary care physician; 92 percent were connected to a medical specialist; 100 percent were connected to a behavioral health resource; and 89 percent had maintained recovery/begun treatment/made improvement related to substance use. Upon review of subsequent data for Montgomery, Bucks and Delaware Counties, there are early findings by Mathematica Policy Research (an external quality review organization assigned to evaluate the pilot project) that show decreased emergency room visits and hospitalizations/readmissions for physical health and mental health issues, and increased outpatient visits.

Longer-term outcomes are expected to show lasting benefits for members enrolled in HCHC. Improved health and quality of life resulting from a better integrated health care system will further transform the recovery oriented approach to services begun in Montgomery County. Such effects can be fully realized when those systems of care impacting a person's life are further engaged in a collaborative effort to better understand the unique needs and supports of those with a serious mental illness.

Consumer Health Inventory (CHI)

One tool used to identify each individual's own perspective on his or her areas of strength and needs is the Consumer Health Inventory (CHI). Magellan staff trained individuals on the CHI as well as on its valuable outcome reporting capacity. HCHC Navigators have appreciated its clinical applications as they work with their clients to complete this valuable screening tool. Information from the CHI has served as a springboard for identifying areas of focus on the member's individualized wellness recovery plan.

Behavioral Health Navigator Dr. Sonja Kenney of Northwestern Human Services, sharing her knowledge with colleagues about the benefits of using the CHI

According to NHS Navigator Dr. Sonja Kenney, "The CHI screens, monitors and assesses the progression of health problems and concerns that we may or may not know about, and follow-up administrations can inform us about subtle and not so subtle changes in a person's health and well-being. It's a tool of communication between the Navigator and the member. And it can help to expand shared, collaborative and informed decision-making with our members."

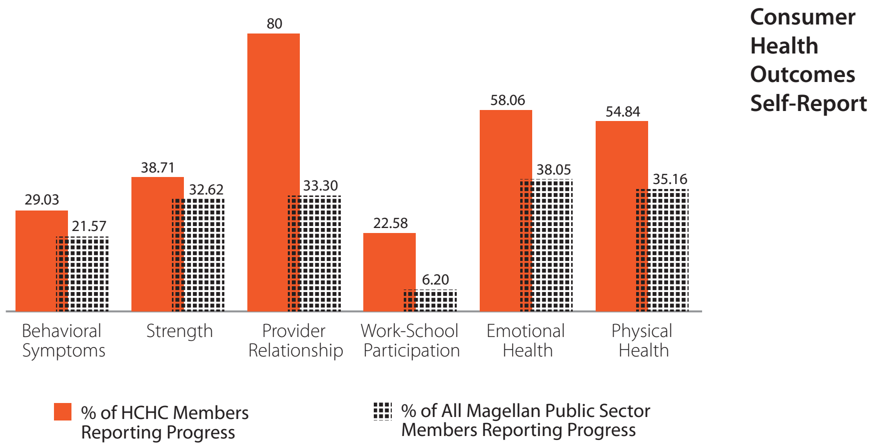
An individualized wellness plan includes the individual's goal(s), steps to take to achieve those goals, individuals who will help, what else might be needed and a timeframe to achieve the goals. Key elements of an individualized wellness plan include:

- Person-directed planning
- Holistic assessment across many life domains
- Strength-based approach

"We are a partner and we bring our best ideas and experience as Navigators, but it is the individual's plan. We want to start with what is important to the person with a focus on wellness. As the relationship expands, the plan expands," as summarized by Montgomery County Navigators at a learning collaborative.

CHI Results

The purpose for the CHI assessment is to evaluate individuals' progress in key domains over time. This section summarizes key findings in member reports of the following domains on the CHI assessment: behavioral symptoms, strength, provider relationship, work-school participation, emotional health and physical health. Results for the Montgomery County HCHC CHI group are compared with results for all Magellan Public Sector respondents.



Consumer Health Outcomes Self-Report

As demonstrated in the table above, outcomes for the HCHC group were consistently better than outcomes for the larger Magellan Public Sector group in each of the domains. The CHI assessment measures progress over time. It is expected that gains will continue to be shown with subsequent CHI assessments.

In comparison to the prior CHI assessment, aggregated results for HCHC participants show:

- Progress in behavioral symptoms for about 29 percent of those completing the assessment;
- Nearly 39 percent report improvement in identified strengths;
- 80 percent report improvement in the relationship with their provider;
- Almost 23 percent report progress in their work or school participation;

- In relation to emotional health, 58 percent of the HCHC group reported improvement;
- 55 percent reported improvement in their physical health.

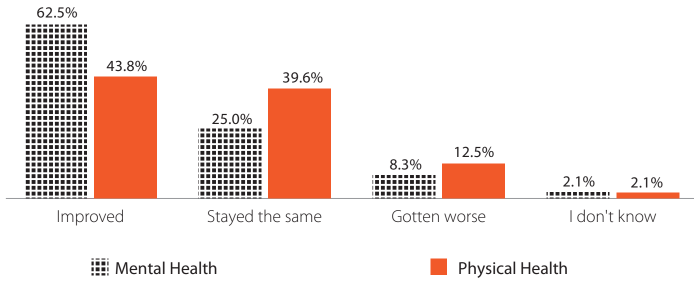
Individuals in the Montgomery County HCHC group also reported on their perception of the relationship with their provider. Those reporting a strong relationship increased from 70 percent to 87 percent at the second administration of the CHI assessment. Similarly, respondents answered with their degree of agreement with the statement, "I am confident that treatment/therapy can help me." The responses "Agreed" and "Strongly Agreed" with the statement remained the most common, together indicating that 80 percent of respondents expect the interventions provided will help, compared with 69 percent of the larger Magellan Public Sector group. Overall, participants in the Montgomery County HCHC appear to be making gains in several key areas and express that the interventions and support are beneficial.

HCHC participant Toni S. with Behavioral Health Navigator Pat McCaffrey at Central discussing her satisfaction with HCHC.

Consumer Satisfaction Team Survey

In another method to gain a perspective on how individuals view this program, the Consumer Satisfaction Team (CST) of Montgomery County conducted surveys for the *HealthChoices HealthConnections* pilot program. A Consumer Satisfaction Team is a team of people and family members who have used services, and who then interview individuals and families about their services. Through interviews, focus groups and/or surveys about resiliency, recovery, satisfaction and quality of life, people's opinions and suggestions about services are gathered. This information is used by Magellan, the County and providers to develop and implement recommendations for change.

The 48 participants in the survey were adults who used the HCHC Navigator services; 75 percent of respondents are female, and most were age 41 or older.

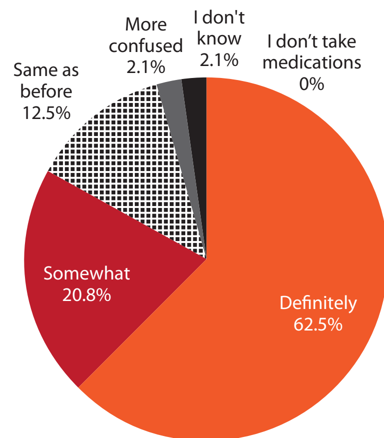


How has your physical and mental health changed since starting this program?

CST reported there was a high satisfaction with the HCHC program. Participants in the survey said they became more aware of their mental and physical health needs and that being in the program helped them become more active in getting those needs met. CST survey results showed that 62.5 percent felt their mental health was improved, and 43.8 percent felt their physical health had improved.

Survey results showed 83 percent felt they had a better understanding of their medications; more than half felt their medications had a positive impact on their life.

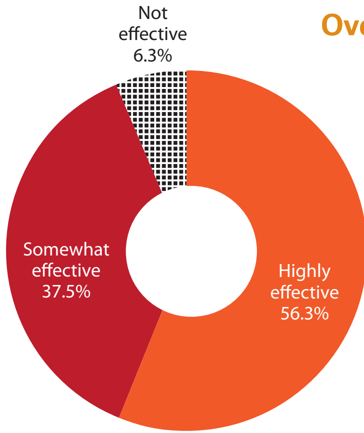
- CST reports that most of those surveyed felt their relationships with family and friends had improved.
- More than half of the people surveyed said that their relationship with their primary doctor "definitely" improved as a result of having Navigator service.



Do you have a better understanding of the medications you take as a result of using this service?

Respondents relate feeling that both their Behavioral Health Navigator and their Nurse Navigator treat them with dignity and respect, are kind and encouraging, understand both their behavioral and physical difficulties, are enthusiastic, knowledgeable, and really listen to them.

A common theme was that participants said they are less afraid to go out into the community as a result of how the Navigator service is impacting their lives.



Please rate the effectiveness of this service on your quality of life

Overall, nearly 94 percent felt this service was effective.

CST team members meet with the Navigator staff to discuss the results after the survey reports are sent out. Navigators then make a plan of action, which will include at least one strength identified to celebrate/explore/learn, and two to three opportunities to change/grow/discover. The purpose of this process is to establish a communication and action process that ensures that the individual's *voice is heard and acted upon.*

Service Utilization

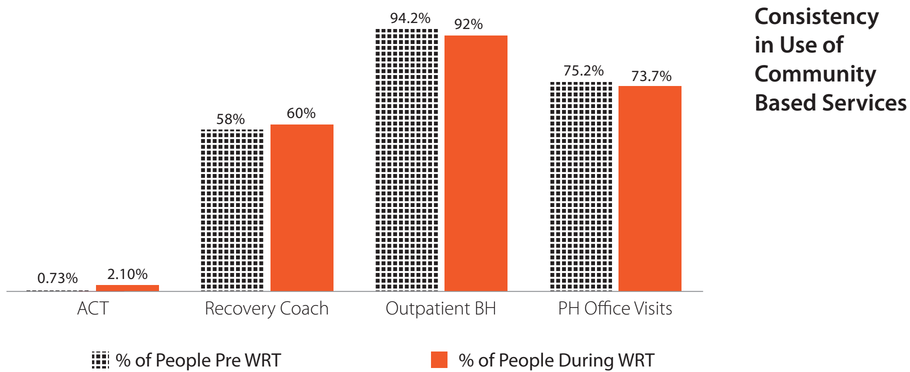
Service utilization was measured for individuals identified as having active participation in Montgomery County's HCHC Wellness Recovery Team (WRT) service model as of Nov. 30, 2010. For the 137 people who qualified based on this criteria, service utilization for two periods of time was measured. For each person in the study, the *pre-measurement period* considers the six months prior to the member's participation in the WRT service and the *during-measurement period* considers a six-month period during participation in the WRT service.

For the 137 individuals included, their use of the following levels of care/services was measured: Assertive Community Treatment (ACT) units and sessions; Recovery Coaching (RC) units and sessions; behavioral health and physical health hospitalizations (Hospital Admits and Days); Outpatient (OP) units and sessions; Residential (such as crisis or substance abuse related) units and sessions; Emergency Room (ER) visits; Pharmacy use (Claim Count); and "Other" combined services units and sessions.

The following charts show the change in service utilization for the 137 individuals from their *pre* to their *during* measurement periods.

The percent of the 137 active participants in the pilot who utilized community based services prior to and during their involvement with WRT remained very similar, as shown below.

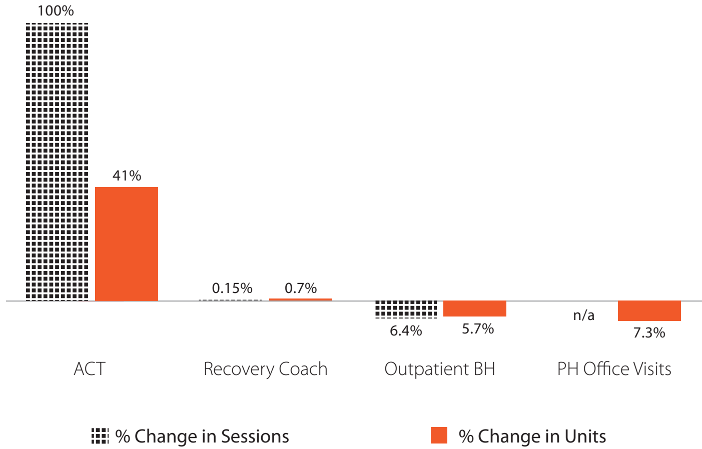
Consistency in Use of Community Based Services



Individuals' engagement with their ACT team, Recovery Coach, Outpatient behavioral health provider or physical health outpatient (Office Visit) provider does not need to end when they engage with the WRT team. The WRT team complements, but is not intended to replace, the other services an individual receives and works to bring everyone together for what is in the best interest of the individual's physical and behavioral health needs. It is understandable, then, that the number of participants using community based services other than WRT did not diminish once they began participation in the program.

Looking in more detail at the amount of services individuals used, we examine the change in number of sessions of service and the change in the number of service units utilized for each treatment type. Note that sessions and units may not be the same and that one session can be made up of more than one unit of service. For example, a one hour *session* could be made up of four 15-minute *units.*

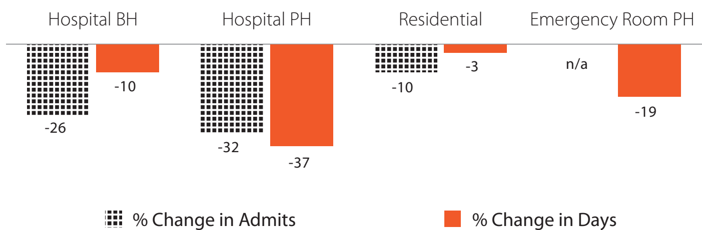
Change in Use of Behavioral Health Sessions and Units During WRT Participation



The chart above shows that for individuals using the service during participation in WRT, the use of ACT sessions and units increased. The use of Recovery Coaching (sessions and units) remained about the same. A slight decrease was found in the use of Outpatient behavioral health units and sessions, as well as physical health outpatient (Office Visit) services. Along with the use of treatment services, the number of claims for Pharmacy use also was explored; this increased by a total of 150 units during the six months during WRT participation. Such an increase in the number of Pharmacy claims shows more medication prescriptions were getting filled for individuals for whom medications can help on the road to recovery.

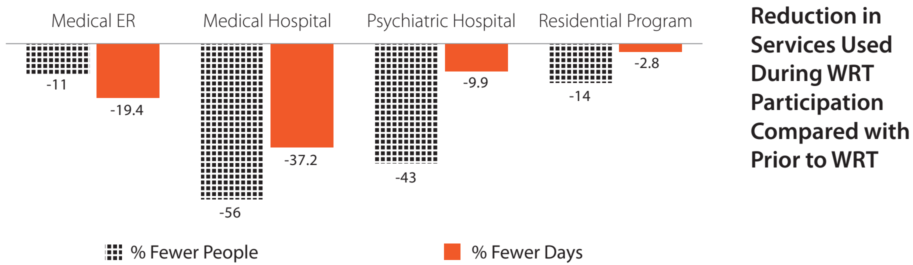
In addition to the use of community based services prior to and during involvement with WRT, the need for more intensive types of treatment was also examined.

Change in # of Admits and # of Days During WRT Participation



During participation in WRT, there were fewer admissions to behavioral health and physical health care hospitals, and residential programs. Those people who were admitted to these services remained there for fewer days. Likewise, there was less need for physical health emergency room visits.

A more specific look at the need for seeking treatment in a hospital or residential setting is shown in the chart below, which indicates a reduction in the number of individuals using these intensive services during participation in WRT services compared with before engagement. What these two charts show is that fewer admissions involved a smaller number of individuals, and they spent less time in the hospital.



Reduction in Services Used During WRT Participation Compared with Prior to WRT

- The number of people needing emergency care in a medical facility emergency room decreased by 11 percent; those needing an ER spent 19 percent less time there.
- The number of people with an admission to medical facilities reduced by 56 percent; those needing such care spent 37 percent less time there.
- The number of people with an admission to psychiatric hospitals reduced by 43 percent; those needing such care spent nearly 10 percent less time there.
- The number of people with the need for an assisted residential environment declined by 14 percent; those needing such care spent nearly three percent less time there.

The change found in individuals' use of treatment in 24-hour settings while participating in WRT is substantially lower compared with such need prior to WRT involvement.

The support and proactive coordination of services and wellness activities found with the WRT approach has resulted in a reduced need for these high-level and often invasive interventions. This suggests that individuals engaged with WRT were able to utilize community supports and treatment and diminish their need for hospital and residential care.

Montgomery County Navigator Focus Groups
A focus group was held by Mathematica with Navigators who work with Montgomery County HCHC participants. Many key areas of how the program works were discussed. The Navigator role is to help build relationships, advocate and provide education for participants and other health care providers, particularly related to integrating physical and behavioral health care. Navigators receive training and resources to better help participants. Navigators said they most like that the program is flexible and that physical and behavioral health care providers are able to share their knowledge to help participants with their individual needs. The flexibility to implement the program within the framework of their own agencies, that is, not requiring a 'one-size-fits-all' approach, was agreed upon as an integral aspect of the program.

Lessons Learned
Although *HealthChoices HealthConnections* is a young program, there are many lessons learned so far, as evidenced by the success stories shared by members, feedback from our Navigator teams, and the early studies from data collected. The following is a highlight of some key lessons that have been recognized as contributing to the program's success:

- Mobile capacity of Navigators has many advantages.
- Registered nurses provide an integral complement to a team approach by providing medical expertise in terms of assessments and education.
- Primary care physician (PCP) connection with Navigator teams is a priority focus.
- County-based structure provides resources and supports with other County systems to improve coordination of care.

- Integrated Member Profiles provide valuable physical health and behavioral health information to best serve each member's needs.
- Collaboration with staff involved in a person's recovery within agencies and across systems assures that everyone is "on the same page" in the integrated delivery of services.
- Resource sharing for members, supports and providers enhances knowledge and provides empowerment.
- Connections to community supports/resources have been further developed.
- Identification and treatment of co-occurring disorders has taken place.
- Continual building of relationships (with the individual, primary care physician and other medical staff, managed care companies, treatment staff and other systems involved, community resources and natural supports) is paramount to each individual's success.

Navigator Lori Marshall shared from a nursing perspective how her interventions were useful during active involvement with a HCHC member. She had performed a lung assessment on a member with a history of pneumonia and asthma. Lori noticed some wheezing in one of the right lobes of the lung. She asked the member to use her inhaler and observed an incorrect administration of the medication. Lori then demonstrated proper inhaler technique by utilizing a straw, and had the member demonstrate back with the cap on her inhaler. When Lori was certain that the correct technique was used, she had the member administer a puff of medication with her inhaler. The member shared with Lori that no one had ever showed her the proper way to use the inhaler. "This is just one of many teaching/wellness education opportunities a Nurse Navigator is able to provide to someone who otherwise would not have had access to this important level of care," stated Lori.

Moving Forward

Capacity for HCHC to reach more individuals is our goal. This may be achieved by program expansion in combination with integration of the HCHC approach in routine service delivery.

The enhancement of HCHC will continue to be a partnership effort with the Counties, behavioral health provider agencies, physical health plans and local health care community as key lessons learned are further incorporated into day-to-day practice. “Magellan believes that the best outcomes to system transformation can only be fully realized through a thorough, team-driven approach,” stated Magellan Health Services General Manager Evon Bergey.

Processes are being developed in cooperation with the Department of Public Welfare to share health care data between physical health plans and behavioral health plans. The sharing of data will enhance our ability to expand our partnership with the remaining physical health plans serving Montgomery County residents. In addition, we are seeking ways and means to obtain Medicare data for a more successful approach in coordinating care for individuals with both Magellan and Medicare insurance coverage.

Some of the proposed activities include extending HCHC to the children’s program in the future. An electronic medical record (EMR) will be designed for those individuals enrolled in the program to include such key components as: diagnostic groupings, inpatient utilization, case management, outpatient utilization, pharmacy utilization, use of emergency rooms, gaps in pharmacy and treatment. A customized “whole health” treatment plan will focus on prevention, early intervention, and wellness and coordination of physical and behavioral health case management. In addition, a health risk assessment will routinely be done as a “best practice” to provide integrative care to every participant.

Peer support will continue to be valued as a service commitment to an individual's recovery and wellness. Ongoing training and educational opportunities will be available for all who touch a person's life on a journey toward wholeness.

By moving forward to enhance HCHC, Montgomery County and Magellan are committed to *improving the health care status of all members served, while supporting their ability to make decisions that positively affect their health.*

"I was on a downward spiral. The Abington Hospital Navigators helped me move from an area where I felt so unsafe I couldn't leave my apartment. They helped me get a new apartment and contingency funding. Without HCHC support, I couldn't have done it… they helped me get back on track."

– Karen K. who receives HCHC services at Abington Memorial Hospital

"My Navigator team has helped me to stay out of the hospital and deal with my [medical condition]. They have taken me to different doctors and I now have a dentist. I used to have a lot of what ifs in my life. Now I believe that with every problem there is a solution. They have helped me to increase my self-esteem."

– Toni S. who receives HCHC services at Central

Magellan Behavioral Health
of Pennsylvania

www.MagellanofPA.com

©2011 Magellan Health Services, Inc.

P-B106 (11/11)