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The County Managed Care Resource

BEHAVIORAL HEALTHCHOICES PROGRAM

Behavioral & Physical Health Integration Models

October 2023

Introduction

On behalf of Pennsylvania's 67 counties and our partner Behavioral Health Managed Care Organizations (BHMCOs), COMCARE is pleased to provide the following report highlighting more than two dozen Integrated Behavioral Health (BH) and Physical Health (PH) Care Models that are available to Pennsylvanians enrolled in Behavioral HealthChoices (BHC), the Commonwealth's BH managed care program for Medical Assistance consumers.

Today, approximately 3.7 million Pennsylvanians enrolled in the BHC program have access to BH and PH care upon enrollment. As demonstrated in these models, the counties and BHMCOs continue to successfully address Social Determinants of Health (SDoH), which are conditions and circumstances in which people live that affect a wide range of health risks and outcomes. Addressing social determinants of health through coordinated, whole-person care can greatly improve population outcomes.

In fact, Pennsylvania has consistently ranked in the top quartile of all states in positive care quality outcomes on national measures that rely on coordinating/integrating behavioral and physical health. The 28 Models of Care included in this report reflect just a sampling of the breadth of services available; the positive health outcomes our members are receiving; and the efficiencies and savings these models deliver. For instance, please consider the following snapshots:

Caring For Moms

Provides care management for mothers and mothers-to-be who are experiencing symptoms of depression with the goal of helping mothers remain healthy in their homes by helping them with follow-up appointments; and adhere to their antidepressant medications. The care team is also focused on the health, safety, and well-being of the infant in mom's care, and "… can provide support and referrals for assistance with any needs mom or family have in functioning as a family."

Integrated Care for Kids

Improves child health and reduces avoidable inpatient hospitalizations and out-of-home placements. The care team includes psychologists, therapists, social workers, community health workers, family peer specialists, and pharmacists. Services include screenings for BH conditions for children and their caregivers, identifying potential underlying social needs that affect health outcomes, and care coordination.

Mobile Psychiatric Nursing
Provides ongoing psychiatric and physical health assessment, medication management, physical health monitoring and clinical support by qualified nursing staff in home or community settings. Psychiatric assessments include a mental health status, personal safety review and physician-ordered nursing procedures such as injections in support of the member's psychiatric treatment.

Street Medicine
Brings integrated care teams into communities to support vulnerable populations and provides services in homeless encampments, community centers, churches, and more. The team comprises providers from a Health System, a Primary Care partner from the local FQHC, as well as social services, and Outpatient Behavioral Health and Drug and Alcohol (D&A) providers. These teams help resolve BH and PH needs in the community and help members avoid hospitalization.

In each of the models included in this report, we have provided a brief description of the services provided and how integration was achieved, the target population, outcomes, and considerations that must be considered before launching the program. Each model includes a contact person, as well, for further information.

We have divided the models we are sharing into two sections: those the Commonwealth requires, and those that originated from counties. It is important to note that all these models have been successful due to the innovative, hands-on approach taken at the county level and the partnerships with the BHMCOs. We have also provided a brief overview of the BHC program and a directory that includes a list of the BHMCOs participating in BHC.

BHC Background
The BHC program was created by the legislature in 1997 to replace a BH system that was failing vulnerable Pennsylvanians, and was prohibitively expensive for all taxpayers, as evidenced by annual double digit increases in the state Medicaid budget. The legislation also "carved-out" behavioral health capitated managed care contracts from physical health managed care contracts in the Medicaid program. Critically, the legislation gave the counties legislative authority for mental health and substance use delivery systems. (The County Commissioners Association of Pennsylvania created COMCARE to support the BHC program.)

As a result of this shift, BHC has become an integral component of the range of human services that counties provide. From the outset of the BHC program, counties, providers, advocates and BHMCOs recognized that individuals with serious mental illnesses, substance use disorders and children with serious emotional disturbance required more support. BH consumers are often affected by increased poverty rates, homelessness, unemployment, food insecurity and transportation limitations. They also experience a disproportionately high rate of incarceration. Because counties are responsible for all these associated services (child welfare, housing, courts, transportation, job training, food security, etc.), counties can screen for social determinants of health as part of the care management interventions for BHC members. Referrals are provided at the point of need for individuals participating in BHC.

Finally, a portion of the savings produced by the BHC program is invested back into the community to meet specialized needs at the county level. All funds that are not used for program management, services, or development of new services are returned to the state. In fact, state officials have estimated the BHC program has yielded statewide cost savings between $11 to $14 billion from the program's inception through 2016, in comparison to the pre-existing fee-for-service program.

The data is clear: under BHC, the counties have consistently met or exceeded national quality and access to care outcomes. Consumers continue to give the program high marks for quality of service and the counties have achieved significant cost savings for all taxpayers. Pennsylvania compares favorably to other states with respect to mental health care, with annual reports from Mental Health America ranking Pennsylvania in the top three states in the nation as measured by rates of access and prevalence of mental illness over each of the past three years.

An MCO Directory and Map of counties served by each BHMCO follows at the end of this document.

Section One:

State-Required Models

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Name of Program

Highmark Wholecare Carelon Case Management Provider Collaboration rounds

Model Description (Est. 2,000 character limit)

Highmark Wholecare rounds with Beaver County Behavioral Health, Heritage Valley and Carelon occur every other month.

Carelon and Highmark Wholecare reviewed potential collaboration efforts that could include providers in ICP collaboration. The MCOs first approached Beaver County Behavioral Health and presented the option of including blended case managers in a collaboration rounds discussing shared members. The MCOs, Beaver county and the provider had introductory meetings to discuss what the collaboration would look like and an agreed upon process was created. Members to be discussed during the collaboration are identified in advance so all entities can prepare and gather information, necessary consents and feedback from the member and their BCM. Members are identified by either MCO or the provider. Some shared members are reviewed only one time due to being stable and not having any care gaps, while others have been discussed over months to continue to problem solve, bring in other support/providers for a discussion, and/or provide updates.

The intervention was successful and the MCOs and Beaver County approached another provider, Heritage Valley Sewickley. After introductory meetings explaining MCO offerings and provider benefit, a similar process was established.

Target Population (Est. 300 character limit)

Shared membership; members who have an SPMI diagnosis who would benefit from PH BH collaboration

How is integration achieved? (Est. 300 character limit)

Collaboration between the BCM provider and physical and behavioral health MCOs; shared members are identified and discussed by each entity supporting the member; care gaps, SDOH needs, utilization, supports, successes and areas of support are reviewed and resources/skills are identified.

Outcomes (Est. 750 character limit)

Reduction in ER visits and Physical health hospitalizations, stable housing, ability to address SDOH needs, information sharing, ICP collaboration.

Start-up Considerations (Est. 750 character limit)

Starting up the project necessitated developing new coordination and collaboration processes with the physical health MCO. This included such points as understanding the scope of membership being part of the effort. The provider involvement introduced a second consideration as providers initially did not fully understand the initiative.

To learn more about this program, please contact:

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Name	Phone	Email

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Name of Program

Value Based Purchasing with Federally Qualified Health Centers

Model Description (Est. 2,000 character limit)

The Value Based Purchasing program serves Federally Qualified Health Centers and Rural Health Centers with a goal of improving Integrated Care Quality Metrics, representative of improved outcomes for members. The program tracks several Integrated Care Plan HEDIS metrics that indicate physical health outcomes that individuals with Serious Persistent Mental Illness are likely to struggle with. Tracking these metrics allows behavioral health providers within the FQHC/RHC to attend to individuals with SPMI. Data on specific members is provided to Providers so that interventions can be applied at the member level to improve the HEDIS metric rates. Additionally, emergency department utilization is tracked to support interventions that result in decreased ED utilization.

Target Population (Est. 300 character limit)

Adults living with severe and persistent mental illness and co-occurring medical diagnoses or physical health concerns.

How is integration achieved? (Est. 300 character limit)

Provider Quality Managers meet with FQHC/RHC providers monthly to share member level detailed data that helps providers meet BH and PH needs of members.

Outcomes (Est. 750 character limit)

In CY2022, FQHC providers saw an overall decrease in PH ED utilization, and an overall improvement in members receiving screening and treatment for common co-morbid conditions.

Start-up Considerations (Est. 750 character limit)

Access to BH and PH datasets; improved outcomes if able to coordinate with PH MCO

To learn more about this program, please contact:

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Name of Program

Community Health Choices Initiative at CBH

Model Description (Est. 2,000 character limit)

COMMUNITY HEALTHCHOICES (CHC) is Pennsylvania's mandatory managed care program for individuals who are eligible for both Medicaid and Medicare (dual eligibles), older adults, and individuals with physical disabilities. The goals of CHC are to serve more people in communities while giving them the opportunity to work, spend more time with their families, and experience an overall better quality of life. Three physical health managed care providers are managing all long-term services and supports for these members, the behavioral health managed care organization in each county will manage the behavioral health care, which includes CBH in Philadelphia.

CHC has impacted the CBH landscape through the following changes:
- The number of members enrolled in CBH increased;
- More specialized services have been applied (Mobile Mental Health Therapy, Supportive Peer Services, CRNP in Nursing facilities, Geriatric Inpatient Psychiatry Units, MPSR, CIRC);
- New providers have been added the CBH Network (OON and In-Network);
- Coordination with the three new CHC- MCO's and the PA Office of Long Term-Living has been established;
- Partnerships with the Aging Community, Advocacy, Nursing Facilities, and Home Health Care Agencies have been created and ongoing;
- New roles for CBH staff have been established; and
- Innovative programming has been developed.

Target Population (Est. 300 character limit)

The Dual Eligible (Medicare/Medicaid) residents of The City of Philadelphia, including Older Adults previously on the Aging Waiver, home-bound residents with physical disabiliities, and CBH members residing in Nursing Facilities (SNF/LTC).

How is integration achieved? (Est. 300 character limit)

Integration is achieved through outreach and coordination with the CBH provider network to deliver Mobile Mental Health, Supportive Peer Services, and other BH services. The continual coordination of care with the CHC stakeholders; including three CHC-MCOs, home health care agencies, nursing facilities, AAA, senior housing, and aging/physical disability advocacy agencies.

Outcomes (Est. 750 character limit)

From the 2022 year end behavioral health utilization data, 14,374 CBH members enrolled in Community HealthChoices have utilized CBH behavioral health services. Other outcomes are the increase in the number of CBH providers who have been able to add or utilize their Mobile Mental Health Therapy and Supportive Peer Services levels of care (15 providers in all). The CBH - CHC Operations team has collaborated with over 20 Home Health Care agencies, 12 Nursing Facilities, and 2 Senior Living agencies.

Start-up Considerations (Est. 750 character limit)

CBH has begun the development of a behavioral health care unit embedded in a long-term care facility. This is a pilot program designed to mange behavioral health challenges for individuals who are nursing home eligible and have had difficulties being admitted into nursing homes due to their mental health and substance use history. The program is partnering a behavioral health provider and a nursing home to deliver combined physical and behavioral health. Other start up considerations are the partnering of Mobile Mental Health and Supportive Peer Program providers with home health care agencies, senior living organizations, and nursing facilities. These partnerships will be able to support individuals in their care with behavioral health treatment to complete the continuity of care.

To learn more about this program, please contact:

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Name of Program

Integrated Care Plan (ICP)

Model Description (Est. 2,000 character limit)

Effective concurrent management of physical and behavioral health challenges is critical for individuals with co-morbid conditions. In 2016, the Pennsylvania Department of Human Services (PA DHS) launched an initiative designed to improve health care integration and address Social Determinants of Health (SDoH) for Medicaid recipients. This program requires Medicaid physical and behavioral health plans to work closely together and provides financial incentives to them for positive outcomes. The ICP program captures and monitors the case management activities of the BH/PH MCOs population of members diagnosed with serious mental illness (SMI) and remediates risk by coordinating BH/PH care.
Key elements of the ICP program are:
• Stratification of the member population into high and low need categories.
• Inpatient hospital notifications via daily Inpatient admission data sharing.
• Sharing of a target number of ICP plans between PH and BH MCO's.
• Meeting specific quality performance measures. Currently there are 10 measures.
In addition to the formal ICP performance measures, Community Care has established shared goals with each PH-MCO of increasing substance use disorder (SUD) consents to enhance the level of coordination that occurs for individuals with dual needs and increasing coordination for individuals who are pregnant.

Target Population (Est. 300 character limit)

Target population is adults aged 18-64 with SMI defined by Schizophrenia, Schizoaffective disorders, Manic Episode, Bipolar Disorder, Major Depressive Disorders, Unspecified Psychosis not due to a substance or known physiological condition and Borderline Personality Disorder.

How is integration achieved? (Est. 300 character limit)

Integration is achieved through strategic coordination among PH-MCOs, BH-MCOs, providers and members. Grand Rounds have been implemented as well as ongoing daily coordination activities such as daily admission file exchange, notification to treating providers, and care management case discussions.

Outcomes (Est. 750 character limit)

Outcomes are measured through successful completion of the required number of ICPs, positive performance on the 10 model indicators and sharing the ICP with the respective BH or PH MCO. Each year DHS produces an annual report with the earnings of each County which are calculated by the degree of improvement from the prior year.

Start-up Considerations (Est. 750 character limit)

DHS developed the ICP program in 2016 and the measures and expectations have grown over time. Initial start-up considerations would include:
• Standardizing procedures and formats for data sharing across all PH-MCO's and BH-MCO's.
• Create EMR templates to capture required data elements and care management coordination activities.
• Establish clinical round schedules and protocol with physical health plan.
• Train staff on required activities related to integrated care plan and coordination activities.

To learn more about this program, please contact:

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Name of Program

Tobacco Recovery

Model Description (Est. 2,000 character limit)

Tobacco use is the most preventable cause of death in the United States and results in over 480,000 deaths each year. According to a recent report by the American Lung Association, in Pennsylvania approximately 22,000 deaths annually are attributable to smoking. The Centers for Disease Control and Prevention (CDC) notes an estimated 34 million adults smoke cigarettes and tobacco use disproportionately impacts individuals with mental health conditions and substance use disorders. The rates of tobacco use in people with mental illness or SUD disorders are usually 2-3 times higher in the general population. Tobacco usage is a Health Equity concern as it disproportionately effects certain groups, for example, low-income individuals and individuals with Serious Mental Illness.
Community Care has implemented a comprehensive Tobacco Recovery plan addressing the following domains: Stakeholder Communication, Provider Outreach, Care Management, Physical Health and Behavioral Health MCO Care Coordination, Employee Staff Programs, Coordination with DOH Quitline, Community Partners and Consumer Outreach.
Key areas of intervention include:
1. Supporting Evidenced based Tobacco Recovery screening and treatment
2. Increasing behavioral health provider utilization of Tobacco Cessation Counseling
3. Increasing utilization of Nicotine Replacement Therapies (NRT's) and Oral Medications
4. Supporting providers to become Tobacco Free facilities and campuses

Target Population (Est. 300 character limit)

All individuals who use Tobacco products.

How is integration achieved? (Est. 300 character limit)

Routine tobacco screening and Tobacco Cessation Counseling is being prioritized across all BH and SUD providers. Education on the role NRT's and oral medication and coordinating with primary care and the PA Quitline.

Outcomes (Est. 750 character limit)

• A Value Based Payment (VBP) initiative to increase the utilization of Tobacco Cessation Counseling, and oral medication is currently underway and preliminary results indicate increases in both areas.
• Within the Behavioral Health Home plus (BHHP) program, there is near universal screening for tobacco using the Ask Advise, Refer protocol.
• The number of Tobacco Cessation Counseling providers has more than doubled.
• Starting in Q4 2021, there has been a quarter over quarter increase in usage of NRT’s and Tobacco cessation oral medications.

Start-up Considerations (Est. 750 character limit)

1. Educating behavioral health providers of their central role in addressing Tobacco Recovery.
2. Resistance and misinformation about Oral Medications and their safety and efficacy in supporting Tobacco Recovery.
3. Providers need support navigating the enrollment process to become a Tobacco Cessation Counseling Provider.
4. Provider concerns that becoming a Tobacco Free Facility may impact attendance at their programs.
5. Rates for Tobacco Cessation Counseling need to be high enough to support providers to do the work.
6. Consider using a VBP model to support Tobacco Recovery work.

To learn more about this program, please contact:

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Name of Program

Warm Hand-Off (WHO) Program

Model Description (Est. 2,000 character limit)

Individuals who present to the emergency department due to an overdose of opioids or other substances are at high risk of continued substance use and potentially overdosing again. Emergency departments provide an opportunity to engage members in specialty substance use disorder (SUD) treatment. Community Care has developed a Warm Hand Off (WHO) process to assist members move from the emergency room directly into SUD treatment. WHO creates a new front door to treatment that begins in the ED. The WHO process is the first step in improving the continuum of care for people with a SUD who are at high risk of experiencing a serious medical event or cycling through behavioral health services effective WHO models increase the likelihood that a person will both engage and be retained in treatment over time.

The WHO intervention uses existing case management and Certified Recovery Specialist to both intercept individuals in the ED as well as follow them to the community for several weeks. Members who are willing to receive ongoing support are eventually enrolled in services, including a range of behavioral services as well as case management or peer services. A specific set of billing codes have been made available to support payment for this work.

Target Population (Est. 300 character limit)

Members in crisis, with a focus on intercepting them in emergency departments due a substance related injury, though other members are also being intercepted, including those with suicidal behaviors or psychotic symptoms.

How is integration achieved? (Est. 300 character limit)

Single County Authorities (SCA's) and other behavioral health organizations work with local emergency departments to intercept individuals while they are in the ED. Case managers or peers are called to the ED (some work in the ED) to engage members and transfer them to behavioral health services. WHO staff can also work with members in the community over several weeks

Outcomes (Est. 750 character limit)

Community Care is implementing the WHO initiative across 29 counties. Between 1/1/22 and 6/30/23 968 unique members were engaged at the ED or in the community. 245 members had multiple WHO encounters, ranging from 2 to 20. On average, 44% of members intercepted in the ED receive behavioral health services within 7 days and other 14% receive services within 30 days. When pharmacy data is included the rates are even higher for those who received SUD or MH care in a PCP (e.g., buprenorphine from a PCP).

Start-up Considerations (Est. 750 character limit)

• Coaching SCAs and other behavioral health organizations on how to update service descriptions for billing the WHO codes
• Offering guidance on how to document crisis services and document specific WHO activities, such as engagement, assessment, and referral to behavioral health organizations.
• Training WHO staff on clinical pathways (e.g., offering MOUD services, instead of residential treatment, for individuals recovering from an opioid-related medical event)

To learn more about this program, please contact:

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Section Two:

County/Primary Contractor/BHMCO-Developed Models

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Name of Program

Mobile Psychiatric Nursing

Model Description (Est. 2,000 character limit)

Mobile Psychiatric Nursing Services (MPN) provides ongoing psychiatric and physical health assessment, medication management, physical health monitoring and clinical support by qualified nursing staff in home or community settings. Psychiatric assessments include a mental status, personal safety review and physician-ordered nursing procedures such as injections in support of the member's psychiatric treatment. Physical health monitoring includes vital sign monitoring, medication reconciliation, dietary orders, and general physical health well-being that has a direct impact on the person's psychiatric care. Additional clinical support may include consulting or facilitating contact with the member's physician; working with the Member to improve or maintain adherence to the physician-ordered medication and treatment; Member and family education regarding the member's psychiatric condition and treatment (including medication and side effects), preventative and wellness issues, and/or physical conditions which impact the Member's psychiatric symptoms and care. Services are delivered by Registered Nurses (RN) with psychiatric training and a minimum of 3 years relevant clinical experience or Licensed Practical Nurses (LPN) with psychiatric training and a minimum of 5 years relevant clinical experience. All initial Nursing assessments and initial treatment plans are completed by an RN. Assignment of the individuals care to a Nurse is based upon the complexity of identified problems and available Nursing expertise. All treatment plans are reviewed and co-signed by the nursing supervisor. At no time shall there be more than 2 FTE LPN's to one FTE RN. With each individual's care, it is expected that the use of mobile psychiatric nursing will offset the use of more restrictive and costly services such as emergency inpatient psychiatric or other crisis services. This is achieved by diverting persons who might otherwise have been admitted/readmitted, or by providing MPN support that permits earlier discharge from inpatient care. Whereas MPN frequently may attend physician appointments with the member, MPN does not provide transportation.

Target Population (Est. 300 character limit)

Services are provided for adult Members with Serious Mental Illness (SMI) and complex co-occurring medical conditions. This service is targeted to persons who are at risk of, or who have recently been discharged from inpatient psychiatric care and who are considered to be at high risk of readmission.

How is integration achieved? (Est. 300 character limit)

The psychiatric nurse approaches their engagement through looking at the whole person. This recognizes the importance of the attention to the person's mental, physical and social well-being. Direct medical observations are invaluable when working with the support team, including the PCP.

Outcomes (Est. 750 character limit)

Data shows material reduction in ED utilization as well as MH IP readmission rates. Member satisfaction is high. Co-Morbid conditions of members served over a 5 year period included: 40.0% had diabetes, 25.2% had heart disease, 55.1% had hyperlipidemia, 58.8% had hypertension, 32.1% had kidney disease, and 42.2% had respiratory disease. With advanced data, efficacy of supporting the PH conditions can be analyzed.

Start-up Considerations (Est. 750 character limit)

This is an OMHSAS approved in lieu of service, so start-up funding should be used to establish the program before switching it over to all HC BH Medicaid funding.

Nursing pools is a management model to consider if the agency runs other programs that use psychiatric nurses.

This is not a 24/7 on call service, which can be attractive when recruiting nurses. Member engagement is not long term, so there are ample opportunities for diversity and closure with cases.

To learn more about this program, please contact:

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Name of Program

Community Health Workers

Model Description (Est. 2,000 character limit)

The community health worker model is based on the IMPaCT™ model utilized by the Penn Center for Community Health Workers (CHW). The overall aim for the CHW is to assist identified persons “to achieve health goals they set with their primary care doctors." Once individuals have been enrolled into the program, CHWs will collect baseline data, including: age, race, ethnicity, employment, household income and size, and unmet or delayed need for medical care. The CHW will administer a 12-Item Short Form Health Survey, the Single Item Literacy Screener as well as PHQ-9 and GAD-7 scales and SBIRT screening. CHWs will assist patients in identifying health goals and create an individualized plan in order to help them meet their stated goals. These goals could be related to improved blood pressure or diabetes control, increased medication adherence, or ensuring regular follow up with their health care providers, as a few examples. Once a goal is identified by the person, the CHWs will work to identify an individual action plan, or steps needed in order to reach that goal. They will work to identify barriers that prevent persons from engaging in healthy behaviors and will assist them in engaging with community organizations in order to address those barriers. Finally, CHWs will encourage individuals to engage with their primary care providers and specialists, such as mental health providers, as indicated in their plan.

Target Population (Est. 300 character limit)

Individuals enrolled in the CHW program are targeted based on high ED and Inpatient utilization and BH conditions. The model focuses on adults 18 years and older, has an identified PCP within a hospital group, emergency department utilization of 6+ visits/12 month period and/or multiple PH IP admissions in a year, a mental health diagnosis, including severe mental illness.

How is integration achieved? (Est. 300 character limit)

CHWers function as the hands-on person who is actively engaged with a person, helping to coordinate care, work with the PCP and specialty care providers, overcome barriers to care and assist in the oversight of the whole person care.

Outcomes (Est. 750 character limit)

Research has been completed with UPenn Lancaster General Health that shows improved physical outcomes (CABHC’s full report is available). National research, including UPenn, of this integrated model is well documented. Expected outcomes would include improved detection of PH and BH needs, improved engagement with treatment for both PH and BH, improved member satisfaction with treatment and improved HEDIS measures, to include reduced readmission rates and total hospital days, as defined by the specific care being provided (see report).

Start-up Considerations (Est. 750 character limit)

a. Identification of a PH provider that operates PCP that would want to use the CHW model. Again, hospitals are best suited to do this. b. Determine which model would work best: Follow the CHW based on IMPaCT model or modify this based on resources and local needs. c. Work with BHMCO to set up credentialing process to streamline this for the PH provider. d. Ensure MA enrollment for this service and work with OMHSAS for billing codes or an APA. e. Assure Provider has complete service description that meets the model and a comprehensive training program is in place for the CHWers. f. Cost to fund the CHW will be primary cost of program with administrative, supervision, operating costs and training being the remaining costs. It is fully expected that the cost savings will offset these costs from both BH and PH claims.

To learn more about this program, please contact:

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Name of Program

Embedding MH Clinicians into Primary Care/Specialty PH Offices

Model Description (Est. 2,000 character limit)

This integrated model places MH Therapists into the office of PCPs and Specialty PH Clinics such an OBGYN, Cancer Centers, etc. Services provided in the office include assessment and brief treatment. The clinician is either employed by the physical health agency (works best with hospitals) or is under contract. The agency is then enrolled in MA to bill for the rendered MH services and the clinician is credentialed by the BHMCO. This would need to be psychologists, LCSWs, LFMTs or LPCs. Another option is to use a licensed MH OP Clinic and then identify the PCP or specialty offices as satellite locations that these services can be delivered.

The PCP can make warm hand offs to the therapist when they are seeing a patient, thus allowing for immediate access and coordinated care. If follow up appointments are needed with the therapist, this can be coordinated with the PCP (Provider) if they also need to be seen for PH treatment, or as a separate appointment. The Electronic Health Records capture all treatment for both the PH and BH services, and the therapist can meet with the PH team to discuss treatment interventions/approaches, including the person's SDOH needs.

Target Population (Est. 300 character limit)

All persons who are receiving their PCP or specialty PH care at the office that falls within the scope of practice that the clinician is able to support. Initial screening is done through the PCP or medical support staff to identify an internal referral to the clinician.

How is integration achieved? (Est. 300 character limit)

With this initial contact by a MH clinician occurring in the physical health office, the PCP or treating physician will have direct access to coordinate this care. If the assessment or ongoing treatment determines that the person is in need of more enhanced specialty BH services, this can be coordinated and the natural integration of care can continue with the specialty BH provider.

Outcomes (Est. 750 character limit)

Billing for the service is through the provider that is managing the clinicians. This allows for tracking of services rendered and to assess the efficacy of the program by integrating the PH data with the BH data. Referrals to other BH services can be monitored by looking at BH claims for concurrent services that are sequential services. Data shows improved engagement for both PH and BH services, coordinated whole person treatment and health indicators. Reduction in the use of ED is another outcome that is measured. Also, national research of this integrated model is well documented. Expected outcomes would include early detection of BH needs, improved engagement with treatment for both PH and BH, improved member satisfaction with treatment and improved HEDIS measures as defined by the specific care being provided.

Start-up Considerations (Est. 750 character limit)

a. Identification of a PH provider that operates PCP and Specialty Care offices that would want to offer this integrated model.
b. Determine which model would work best: credentialing of clinicians to do the service or use licensed MH OP Clinic satellites.
c. Work with BHMCO to set up credentialing process to streamline this for the PH provider.
d. Ensure MA enrollment for this service.
e. Assure Provider is fully trained not only in documentation and integrated health records, but also that they are fully trained on how to access specialty BH services.
f. Set rates (fee schedule of the BHMCO, but differential rates may be considered).

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Name of Program

MH IP Discharge Community Paramedicine

Model Description (Est. 2,000 character limit)

The community paramedicine program consist of a team of community paramedics and community paramedic technicians, with oversight from a medical director and executive director. Home visits by a community paramedicine provider will be offered for any referred PerformCare member being discharged from a MH IP hospital that could benefit from one or more of the services offered by these in-home visits. Members engaged in the community paramedicine program are typically seen within their home environment. Scope of services for the community paramedicine program are: • Environmental assessment • Conditioned focused patient assessment including weight, blood sugar, pulse ox, or ECG as needed • A review of discharge instructions or key knowledge points with the patient and teach-back • Medication reconciliation/patient list to physician list • Confirmation of provider follow-up appointments and transportation • Provide transportation to/from provider appointments • Lab draws/collection & lab drop off • Immunizations • Closure of open care gaps • Health screenings and wellness assessments • Disease management • Breathing treatments • Referrals to community resources • Infant safe sleep education • Wound care • Member navigation of the healthcare system. Once an eligible member is identified as a candidate for this service an outreach from the Community Paramedic Program will be completed to determine next steps. This identification process can take place through a number of different sources including but not limited to: • Post discharge referral • Plan level referral based on need.

Members are scheduled for four weekly in-home visits by the community paramedicine program. Additional visits will be scheduled at the discretion of the community paramedicine provider.

Target Population (Est. 300 character limit)

Adults enrolled with HC BH program that are being discharged from a MH IP facility. This should be an active part of the D/C plan with the member's agreement to participate in the program and prior authorized by the BHMCO to assure the person has no intensive services that should lead with post D/C.

How is integration achieved? (Est. 300 character limit)

Paramedicine staff are trained in MH and can fully integrate MH and PH supports.

Outcomes (Est. 750 character limit)

The goals of this program are to lower health care spending and to improve Quality of Life (QOL). Costs can be improved by reducing such things as preventable admissions, readmissions, unnecessary 911 ambulance requests, non-emergent visits to the ED with in-home visits, provide transportation to/from provider appointments and reduce potential barriers to care. QOL can be improved by increasing member knowledge about their disease and resources in the community, creating a better connection with their caregivers and fostering improved self-management and triage. This program just started in 2023 but there is growing research of the efficacy of paramedcine across the US.

Start-up Considerations (Est. 750 character limit)

1. Partner with local EMS agency who has experience in providing paramedicine services and have or are interested in developing expertise in supporting persons with a serious mental illness.
2. Establish referral/auth process so that persons who are already engaged in community supports such as ACT, PSS, TCM are not included.
3. Used CBCMP funding for program.

To learn more about this program, please contact:

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Name of Program

Caring for Moms

Model Description (Est. 2,000 character limit)

Overview: the Caring for Moms C3 program provides supportive care management for mothers and mothers-to-be who are experiencing symptoms of depression through warm outreach and connection with specialty programs in the community.

Individuals who may benefit from the program are identified through analysis of current diagnosis of a depressive disorder and perinatal status. C3 staff may outreach to qualifying individuals to engage in the program or individuals may contact the team and refer themselves. Engagement is expected to be less than 90 days but can vary based on need and members can unenroll at any time. Collaboration with the member's Physical Health Managed Care Organization is essential in ensuring the member and baby are wrapped in care and support.

Each MCO will review data to identify members who could benefit from outreach and collaboration, and work together to make sure each knows the shared population. Identified members are monitored following delivery and for up to a year afterward depending on member need.

Target Population (Est. 300 character limit)

Women who have recently delivered and identified as having a depressive disorder or assessment with a provider showing symptoms of depression.

How is integration achieved? (Est. 300 character limit)

Collaboration between care managers and other entities involved with the member. Care managers exchange essential information to contact the member successfully and update one another on progress, newly identified barriers and resolutions.

Outcomes (Est. 750 character limit)

We are looking to help mothers remain healthy in their homes and communities. Follow up on appointments, community tenure, and adherence to antidepressant medication when prescribed are some key goals of this program. We are also focused on the health, safety and wellbeing of the infant in mom's care and can provide support and referrals for assistance with any needs mom or family have in functioning as a family.

Start-up Considerations (Est. 750 character limit)

The MCOs had to work together to identify shared eligible population, data exchange processes and communication workflow.

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CCAP COMCARE
The County Managed Care Resource

Name of Program

Complete Care Coordination Program (C3)

Model Description (Est. 2,000 character limit)

The Complete Care Coordination Program (C3) is a telephonic outreach program for members who have accessed higher levels of care multiple times and may benefit from support and coordination from their health plan. The C3 program is designed to be a collaborative process that assesses, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost effective outcomes, and most importantly, their successful tenure in the community. The C3 care manager tracks utilization of identified members and is responsible to facilitate aftercare plans and linkages with community resources while maintaining regular contact with the member to encourage adherence with treatment recommendations and provide ongoing positive support. C3 care managers complete clinical assessments to determine clinical needs, care gaps, social determinants of health needs and potential referrals to other treatment or community resources.

To facilitate coordination of care and cohesive treatment planning, the care manager will involve the member's Physical Health MCO, and may include the county, providers, blended case managers, family, and other community supports as indicated. These interactions will occur as needed to assist the member in maintaining community tenure.

C3 care managers have contacts at all of the region's PH MCOs and have regular communication with them to provide updates on member status, barrier reduction and new presenting issues.

Target Population (Est. 300 character limit)

Adults living with severe and persistent mental illness and co-occurring medical diagnoses or physical health concerns.

How is integration achieved? (Est. 300 character limit)

The care managers at both MCOs develop a plan to ensure the member is wrapped in appropriate services and linked with beneficial programs. The MCOs work together to identify care gaps, barriers, solutions for SDOH and facilitate communication between all providers and programs working to support the member.

Outcomes (Est. 750 character limit)

The C3 Program continues to affect a positive change in mental health inpatient utilization for engaged members in 2022, demonstrating a decrease in overall inpatient admissions and inpatient admission days per 1000 members six months post C3 engagement. Members engaged in C3 showed increased utilization of lower levels of care, such as Assertive Community treatment, outpatient substance use disorder treatment, and outpatient psychiatric services.

Start-up Considerations (Est. 750 character limit)

-Communication and relationship building with partnering MCOs, counties, providers and community programs to establish warm hand off processes and pathways for information sharing
-Development of referral process
-Creation of data reporting elements and outcome tracking

To learn more about this program, please contact:

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CCAP COMCARE
The County Managed Care Resource

Name of Program

Recovery Support Program

Model Description (Est. 2,000 character limit)

The Recovery Support Program (formerly Complex Case Management) Protocol was developed in recognition of the changing and intensifying needs of members to access care during urgent and emergent mental health experiences. With resources constrained and fewer providers available particularly during the COVID 19 pandemic, we performed a 'reboot' of our active care management process resulting in a protocol to rapidly mobilize all stakeholders supporting a member in need to streamline access to necessary levels of care and coordinate treatment planning and identify responsible parties for follow up on actions to help the member achieve their recovery goals. Through analysis of utilization patterns for children, youth and adults with long lengths of stay in inpatient, residential, or other higher levels of care, we were able to isolate key factors that were linked with poorer outcomes to trigger referral and case escalation to this team. This in turn leads to mobilization of the clinical subject matter experts to pull together all stakeholders engaged in supporting the member and family in all areas of life to strategize on next steps and to link to next levels of care in addition to universalizing treatment goals across provider entities for consistency and continuity. Predominantly, the recovery support protocol serves members who have been admitted to an inpatient facility and awaiting discharge to another 24/7 level of care (LOC) or those in a 24/7 LOC awaiting discharge to a lower level of care (LLOC) but encountering barriers to access a discharge resource. Following engagement with the Recovery Support Program team, the member/family is monitored for ongoing need and intervention.

Target Population (Est. 300 character limit)

The target population for this intervention are individuals who have a series of complex needs including mental health, substance use, social determinants of health, and physical health conditions which are identified in a referral and triage form or through consultation with our Counties, Primary Contractors, or during a utilization review.

How is integration achieved? (Est. 300 character limit)

Recovery Support meetings are held to develop an action plan and can include the member, care managers, PH providers and/or PH-MCO's, Child and Family Services, Juvenile Probation, educational representatives, and county staff.

Outcomes (Est. 750 character limit)

Sample outcome is from Q3 2022 - Cost savings of close to $700,000 for members with Recovery Support involvement when comparing utilization 6 months pre and post involvement in the program. Follow-up after hospitalization 7 days was improved by 18% for members between the ages of 6-18 and by 10% for FUH 30 day.

Start-up Considerations (Est. 750 character limit)

Start-up considerations included staffing; the development of relationships with providers, PH-MCO's and medical providers as well as cross system collaboration with education, CYF, and Juvenile probation; the development of a referral process both internally and externally; development of data reporting and outcomes.

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CCAP COMCARE
The County Managed Care Resource

Name of Program

Integrated Care for Kids (InCK)

Model Description (Est. 2,000 character limit)

Integrated Care for Kids (InCK) is a Centers for Medicaid and Medicare (CMS) model to address whole person health. InCK is a child-centered local service delivery and state payment model created to improve child health and reduce avoidable inpatient hospitalizations and out-of-home placements. Through an interdisciplinary team of both CBH and St. Christopher's staff – which includes psychologists, therapists, social workers, community health workers, family peer specialists, and pharmacists – InCK enhances and expands services offered during and after a child's appointment with their pediatrician. These services include screenings for behavioral health conditions for children and their caregivers, identifying potential underlying social needs that affect health outcomes, and care coordination to help connect families to treatment services and community-based support.

Target Population (Est. 300 character limit)

Children ages birth to 20 and their care-givers

How is integration achieved? (Est. 300 character limit)

CBH Clinical Care Managers are co-located onsite at St. Christopher's to improve access to behavioral health services. Behavioral Health Care Navigators conduct comprehensive screenings to identify unmet needs in the area of social determinants of health (SDOH) and behavioral health. Child psychologists and a primarily adult behavioral provider are also a part of the team.

Outcomes (Est. 750 character limit)

HEDIS Metrics
- Follow-up care for children prescribed ADHD medication (initiation phase, continuation and maintenance phase)
- Follow-up after hospitalization for Mental Illness: Ages 6-17

Other Metrics
- Increase number of kids screened and connected to services for BH and SDOH
- Improve family experience in care coordination
- Decrease out of home placements and increase community-based treatment engagement

Start-up Considerations (Est. 750 character limit)

This project was approved by OMHSAS as a program that meets the Community Based Care Management requirement.

To learn more about this program, please contact:

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CCAP COMCARE
The County Managed Care Resource

Name of Program

Mommy's Helping Hands

Model Description (Est. 2,000 character limit)

Mommy's Helping Hands (MHH) is a voluntary program that utilizes an all-inclusive and person-centered approach to assist members who are pregnant or post-partum up to one year with history of substance use, misuse or substance use disorder access care needs. This may include, but not limited to, assisting with access to treatment, linking to community supports and services, coordinating care with treatment teams and supports, collaborating with physical health managed care organizations, providing education on behavioral health conditions, treatments and medications, and future planning. Mommy's Helping Hands supports the maximization of potential and well-being of members enrolled into the program. There are multiple points of referral for the program, these include a data report, external referral process and a member self-referral process. A brief chart review is completed to verify member meets criteria and contact information. Outreach is completed through up to 3 attempts (telephonic and mail). Once a member opts into the care management program, assessment scheduled and completed, individualized care management plan developed and follow up is made at least 2x a month to work on goals.

Target Population (Est. 300 character limit)

Adult members who are pregnant or post-partum up to one year with history of substance use, misuse or substance use disorder access care needs.

How is integration achieved? (Est. 300 character limit)

CBH utilizes multiple sources to develop an algorithm to identify the target population, including physical and behavioral health claims, as well as numerous other data and referral avenues. Enrolled members into MHH will receive longitudinal care coordination with a focus on whole person care under the umbrella of the complex care management of program.

Outcomes (Est. 750 character limit)

Measure 1: Facilitate linkages to an array of offered services for adults enrolled in the program. 100% of members received a referral resource within 90 days of enrollment; 59% followed up on a referral resource within 90 days of receiving the referral information
Measure 2: Increase overall member satisfaction with the program, 100% of members were outreached to participate in the survey. Of the members who agreed to participate in the survey, 86% of them reported to be satisfied or very satisfied with the program. Measure 3 : No members readmitted to a bed-based level of care 30 days post discharge from the program.

Start-up Considerations (Est. 750 character limit)

This is a small program with no more than 30 members at one time, it is NCQA accredited and developed according to their standards for complex care programs. Start up considerations are clearly identifying the cohort for this program and obtaining the correct data/referrals, as well as the necessity to set up excellent relationships with the PH-MCOs prior to the start of the program and on an ongoing basis. This program is managed by one full-time clinical care manger who has an approximately 30 maximum member cohort at any given time.

To learn more about this program, please contact:

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The County Managed Care Resource

Name of Program

Community Team

Model Description (Est. 2,000 character limit)

The Community Team care management program is a joint venture between UPMC For You and Community Care. The team provides comprehensive intensive care management and care coordination in the member's home and other community settings for UPMC Health Plan members. The program identifies members who have high levels of unplanned medical utilization and high costs that are typically related to behavioral health and Social Determinants of Health (SDoH).
Team members include nurses, social workers, and pharmacists that collaborate closely with the members PCP's, specialists, behavioral health providers, and other supportive services.
Goals of the Community Team are to decrease cost and utilization, enhance members' self-management of their chronic conditions, and address barriers in care. Medication education and medication reviews are important roles of the care manager and completed with members after unplanned care events. Addressing SDoH such as housing, food security, social supports, and transportation needs have been critical to engage members in optimal health and key components of the Community Team.

Target Population (Est. 300 character limit)

The Community Team identifies members based on high utilization, costs, chronic conditions, behavioral health co-morbidities, and social determinants of health concerns.

How is integration achieved? (Est. 300 character limit)

The Community Team is comprised of a multidisciplinary workforce able to address the needs of high risk, vulnerable population. Care coordination, collaboration, and interventions take place to address physical, behavioral, and SDoH needs.

Outcomes (Est. 750 character limit)

Over the past several years the Community Team reaches approximately 1,500 Medicaid members annually and engages approximately 480 members or 32% of those reached. Length of time enrolled on the team averages about 180 days. Comprehensive assessments and medication reviews are key interventions for this population.

Outcome goals include tracking cost and utilization, readmission rates, and follow-up rates. Medicaid members' 7 and 30 day readmission rates vs. population readmission rates have consistently been lower. Inpatient utilization and emergency room utilization per 1000 show a decreasing trend out to 18-24 months.

Start-up Considerations (Est. 750 character limit)

• Identify a physical or behavioral health plan to partner with.
• Develop protocols for identifying members with high levels of unplanned medical utilization and high costs associated with behavioral health and Social Determinants of Health needs.
• Create data sharing procedures and protocols that combine physical health, behavioral health, and SDOH data.
• Develop outreach procedures and interventions for shared members that are data driven.

To learn more about this program, please contact:

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CCAP COMCARE
The County Managed Care Resource

Name of Program

Behavioral Health Home Plus (BHHP)

Model Description (Est. 2,000 character limit)

Behavioral Health Home Plus is a comprehensive population health model created by Community Care, County partners, and providers. The BHHP program addresses physical health and wellness as part of recovery of individuals living with SMI, opioid use disorders, and children in residential treatment. BHHP enhances the capacity of behavioral health providers to assist individuals with identifying physical health and wellness challenges and activating people to become better informed and more effective managers of their overall health. Service delivery focuses on providing tools, education, and resources that activate individuals to be more informed and effective managers of their health and health care. Areas of focus include: Wellness Coaching, engagement with PCPs, hypertension, tobacco cessation, diabetes, and obesity.
The BHHP program has demonstrated a wide applicability and adaptability to many behavioral health settings. This includes being implemented in the following levels of care: Blended Case Management-Adult and Child, Psychiatric Residential Treatment Facilities, Opioid Treatment Providers, Outpatient (MH and SUD), Peer Support, Certified Recovery Specialist, and Psych-rehab.
Key features of the model include:
a. Training of Case managers and peer support staff, and other BH staff to serve as wellness coaches and care navigators.
b. Embedding nurses in agencies to support wellness coaches and link with primary care physicians.
c. Disease registries to identify members with high need and track interventions.
d. Self-management toolkits for weight loss, healthy diet, physical activity, tobacco cessation, and medication adherence.

Target Population (Est. 300 character limit)

Individuals with a Serious Mental Illness (SMI), opioid use disorders, and children in residential treatment. The BHHP program can be implemented in a wide variety of behavioral health clinical settings. The BHHP program focuses on individuals with high Physical Health and Behavioral Health needs.

How is integration achieved? (Est. 300 character limit)

Behavioral Health providers work with individuals to engage with primary care, coordinate care with physical health providers, close physical health gaps in care, and address modifiable health risks through wellness coaching.

Outcomes (Est. 750 character limit)

Research supported by a PCORI award has been completed. Key outcomes included: improved engagement in primary care (approximately 40% increase in number of visits) and improved patient activation in care; Advanced practice agencies participating in additional training achieved: at least 22% of smokers decreased use; and at least 17% of individuals with hypertension had improved blood pressure control. Financial results after the first year included: decreased PMPM total cost (15%); decreased behavioral and medical inpatient use (30-40%) and cost (20-25%); decreased PMPM case management cost (17%); and increased overall physical health service use (40-50%).

Start-up Considerations (Est. 750 character limit)

a. Identify behavioral health and SUD settings that would want to implement the model.
b. Assure Provider is fully trained in the model, this is typical achieved via a learning collaborative.
c. Ensure providers have access to ongoing technical assistance and tools that support the program e.g. population health registry, Wellness Coaching Train the Trainer trainings.
d. Costs would include cost of supplemental nursing program with other administrative, supervision, and training being the remaining.

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CCAP COMCARE
The County Managed Care Resource

Name of Program

Collaborative Care in Federally Qualified Health Centers (FQHC)

Model Description (Est. 2,000 character limit)

Collaborative Care is a team-based model that is delivered in primary care settings. Team members include a primary care physician, care manager, consulting psychiatrist and the patient. The primary care provider (PCP) oversees all aspects of a patient's care including mental health care. They make the initial diagnosis and complete a warm hand-off to the care manager (CM). The PCP also manages medication, seeks consultation from the consulting psychiatrist when necessary, and regularly meets with the patient. The CM, typically a master's level mental health clinician, is trained in evidence-based treatments that can be delivered in a primary care setting (e.g., behavioral activation, pleasant events scheduling, problem-solving treatment). The CM is responsible for facilitating patient engagement and education, working closely with the PCP, completing systematic initial and follow-up assessments, systematically tracking treatment responses, supporting medication management, reviewing progress with the consulting psychiatrist, and facilitating referrals to other services when needed. The Consulting Psychiatrist supports the PCP and CM regularly (weekly) by providing consultation on more complex patients as well as education and training as needed. Typically, all patients in a primary care practice complete a standardized measure; those scores are recorded in a database and monitored so that population outcomes are understood and treatment for individuals can be adjusted as needed to ensure improvements.

Target Population (Est. 300 character limit)

The Collaborative Care model has an extensive evidence base and has been shown to be effective for depressive disorders, anxiety disorders, PTSD, and behavioral health symptoms related to co-morbid medical conditions such as heart disease, diabetes, and cancer.

How is integration achieved? (Est. 300 character limit)

A care manager and consulting psychiatrist are integrated into primary care settings. Care is team-delivered, population-based, measurement-driven, and evidence-based.

Outcomes (Est. 750 character limit)

Community Care implemented a 12-month learning collaborative (2015-16) with 7 federally qualified health centers (FQHC's). A study of Collaborative Care implemented in FQHCs showed increased screening for depression. Many patients with depression were treated on-site, which led to improvements in depression and lower overall treatment costs compared to usual care. Additionally, 12% of monitored patients had at least a 50% improvement in their depression score as measured by the PHQ-9.

Start-up Considerations (Est. 750 character limit)

a. Identify Primary Care Settings that would want to implement the model.
c. Ensure MA enrollment for this service if paid separately rather than through a VBP model.
d. Assure Provider is fully trained in Collaborative Care model and has access to ongoing technical assistance.
f. Costs would include cost of program with administrative, supervision, operating costs and training being the remaining costs. Per published studies, cost savings likely would be seen in years 3 and 4 of implementation.
g. Education on the usage of Collaborative Care codes and billing.
h. Support the PCP providers with the effort to engage a consulting psychiatrist.

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CCAP
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The County Managed Care Resource

Name of Program

Community Care and Highmark Wholecare Medication Adherence

Model Description (Est. 2,000 character limit)

Optimizing adherence to medication is a national quality indicator. e.g.,NCQA and HEDIS, and leads to enhanced recovery via decreased hospitalization, better physical health outcomes and improved quality of life. Community Care and Highmark Wholecare are collaborating on an initiative that focuses on increasing medication adherence among our shared members. The target population is individuals with a diagnosis of schizophrenia, depression or bipolar disorder, who are prescribed an antipsychotic, an antidepressant, or a medication that could be prescribed as a mood stabilizer.
Claims data is then used to identify members and to determine the percentage of members adherent to their medication for at least 80% of the analysis period.

Interventions:
• Educational letters are mailed quarterly from Highmark Wholecare and Community Care to prescribers that identify members with less than 80% adherence and offer strategies to improve adherence and to address possible barriers.
• Educational letters are sent by Community Care to methadone providers and prescribers of buprenorphine and naltrexone identifying their members who are not meeting the 80% adherence threshold for their behavioral health medication as they may be more at risk of experiencing psychiatric symptoms and possible overdose.
• Members filling 6 or more prescriptions concurrently are identified and sent to Highmark Wholecare for referral to a medication packaging service.
• Members with a depression diagnosis and newly prescribed an antidepressant receive an educational booklet from Community Care offering information on depression and its treatment options.

Target Population (Est. 300 character limit)

Shared members with a diagnosis of schizophrenia, depression or bipolar disorder who are filling an antipsychotic, antidepressant or a mood stabilizer medication.

How is integration achieved? (Est. 300 character limit)

Shared members, with one of the three BH diagnoses, are identified via claims. This information is used by Community Care and Highmark Wholecare to intervene with prescribers and directly with members.

Outcomes (Est. 750 character limit)

On a quarterly average Community Care sent:
• 295 letters to BH prescribers.
• 11 letters to Methadone Providers.
• 168 letters to buprenorphine or naltrexone prescribers.
On a monthly average
• 355 shared members are identified for referral to a pill packaging service.
• 175 shared members are identified to receive the educational depression booklet.

Start-up Considerations (Est. 750 character limit)

• Identify a physical health plan partner with a shared interest in increasing medication adherence.
• Develop protocols for identifying members.
• Create data sharing procedures and protocols.
• Develop outreach procedures and interventions for prescribers and shared members.

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CCAP COMCARE
The County Managed Care Resource

Name of Program

SNP SMI (Special Needs Plan-Serious Mental Illness)

Model Description (Est. 2,000 character limit)

Starting in 2017, UPMC Health Plan partnered with Community Care Behavioral Health to provide enhanced population health care management to UPMC Health Plan Special Needs Plan (SNP), (UPMC for Life Complete Care) members with Serious Mental Illness (SMI).

The care management team offers member-centric, enhanced community-based care management specifically tailored for SNP SMI beneficiaries. The team serves a vulnerable population with complex needs who have high rates of healthcare utilization. Members who are recipients of the care management interventions are identified via a risk stratification process.
Goals of SNP SMI program include enhanced health outcomes through care integration for members' physical health and behavioral health conditions, promote effective self-management skills, and address barriers in care. Staffing consists of licensed professionals including nurse care managers, LSW/LCSWs, pharmacists, and licensed professional counselors (LPCs).

Wellness plans are completed with members to assist members in managing their physical and behavioral health. The plan serves as a comprehensive guide to help members manage their health by identifying warning signs, developing coping strategies, and establishing a support system and care providers.

Target Population (Est. 300 character limit)

Population is stratified into two acuity tier levels based on physical health (PH) and behavioral health (BH) indicators from physical, behavioral and pharmacy claims utilization data and risk indicators in a rolling 12-month period.

How is integration achieved? (Est. 300 character limit)

Specialized care managers focus on whole health and wellness and address the unique challenges often experienced by this most vulnerable SNP SMI population.

Outcomes (Est. 750 character limit)

A summary of some of the first year results of the program include:
• Significant reduction in BH IP of 7.9% was seen between intervention and comparison members with BH component.
• Significant reduction in ED cost and reduction of ED utilization was observed for Tier 2 (High physical health needs) members.
• Increase in antipsychotic and antidepressant medications were filled among intervention group along with decreases in benzodiazepines and opiate antagonists.

Start-up Considerations (Est. 750 character limit)

• Identify a physical or behavioral health plan to partner with.
• Develop a stratification process and data sharing protocols that uses physical, behavioral and SDoH data to identifying members.
• Develop outreach procedures and interventions for shared members that are data driven.

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CCAP COMCARE
The County Managed Care Resource

Name of Program

Enhanced Community Based Intensive Treatment (ECBIT)

Model Description (Est. 2,000 character limit)

Enhanced Community Based Intensive Treatment (ECBIT) is a team delivered integrated care model. This program delivers services to high acuity individuals who are recently discharged from an inpatient stay. Team staffing includes a nurse, a case manager, and a peer.

ECBIT was implemented in Cambria County in 2019 because an ACT-like model of service was needed to enhance whole health supports for those considered to have higher needs. However, the demand for ACT was not as high as in other counties so an alternative model was developed. ECBIT is currently offered through Nulton Diagnostic & Treatment Center.

Target Population (Est. 300 character limit)

Members 18 years of age and older who have had two or more acute inpatient hospitalizations in the past six months and display severe functional impairments resulting from symptoms of mental illness.

How is integration achieved? (Est. 300 character limit)

ECBIT teams collaborate on assessments/treatment planning and follow evidence-based practices/approaches. A variety of standardized tools are utilized to direct care planning and assess progress, including the Adult Needs and Strengths Assessment (ANSA), Patient Health Questionnaire 9, SDOH screening, Quality of Life Scale, and Assessment for Transition Readiness.

Outcomes (Est. 750 character limit)

An analysis of utilization showed that current ECBIT members, on average, stay engaged with the service for 115 days, with a median length of stay of 92 days. Utilization outcomes showed a decrease in PMPM acute inpatient admissions once members engaged in the program. Members experienced a decrease in admissions of 46% during ECBIT and 72% decrease post ECBIT. Members that did admit during ECBIT, usually did within 50 days of starting the service. Financial outcomes also showed positive results. Members experienced a decrease in medical costs of 56% in the post period.

Start-up Considerations (Est. 750 character limit)

Approval as an in lieu of service is required

To learn more about this program, please contact:

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CCAP
COMCARE
The County Managed Care Resource

Name of Program

Wellness Recovery Team & Nurse Navigators

Model Description (Est. 2,000 character limit)

Magellan supports two models promoting integrated care within behavioral health provider locations.

Wellness Recovery Teams: This integrated, team-based approach consists of a Registered Nurse Navigator, Behavioral Health Navigator, and Administrative Navigator who work jointly to support a member's physical and behavioral health needs.

Nurse Navigators: The Nurse Navigator model consists of a RN or LPN who is embedded within a behavioral health clinic. The Nurse Navigator works collabortively with the behavioral health services within their agency to promote a whole health approach to care.

While slight differences exist in the delivery of these programs, the overall intent and philosophy align. Both models are designed to support those with co-occuring behavioral and physical health needs and promote efforts that strengthen whole health. There is a focus on enhancing collaboration with behavioral health MCOs, physical health MCOs, physical and behavioral health treatment providers, and other resources to enhance member support and align goal discussions. Member profiles, which highlight a member's past years worth of behavioral and physical health utilization, are generated through a Magellan provider portal and help inform and guide health discussions. Screening tools are used to assess health needs and monitor progress over time. Both models focus on coordinating care, minimizing fragmentation of services, and supporting members and caregivers with self-care.

Target Population (Est. 300 character limit)

Adults age 18 and older who have a diagnosis which qualifies as a severe and peristsent mental illness and who have a co-occuring physical health diagnosis.

How is integration achieved? (Est. 300 character limit)

Both approaches include behavioral health and physical health staff within an organization that coordinate care. Additionally, both models utilize member consents allowing for coordination with a member's behavioral and physical health supports outside of their agency.

Outcomes (Est. 750 character limit)

When looking at enrollment combined, members enrolled with a Wellness Recovery Team or a Nurse Navigator saw a 67.26% decrease in per member per month mental health inpatient admissions and a decrease of 32.03% per member per month spending from a pre to post period comparison. Smart Screener results, which include the PHQ9, GAD7, ISI, and PEG, all showed improved scores from initial screening to rescreening.

Start-up Considerations (Est. 750 character limit)

Both programs are approved in-lieu of services

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CCAP COMCARE
The County Managed Care Resource

Name of Program

Integrated Health: Emergency Department Navigation

Model Description (Est. 2,000 character limit)

The Emergency Department Navigator role was created in partnership with Pottstown Hospital. This role's main objective is to meet patients that frequent the Emergency Department for non-emergency needs, but also have a behavioral health component impacting their access to care and navigation of the health system. The role is employed by Access Services, but is contracted to work inside the Emergency Department. The role has direct access to refer internally back to Access Services programs, but can also refer out to other providers. While this role is based inside the Emergency Department, it also has a community based component for follow up purposes to ensure gaps in service are closed. The role was created with the understanding that many individuals that struggle significantly to manage their physical health, specifically chronic illness, also have some behavioral health component that makes overall wellness challenging.

Target Population (Est. 300 character limit)

Frequent utilizers of the Hospital Emergency Department (Generally Adults 18 and over)

How is integration achieved? (Est. 300 character limit)

The ED Health Navigator is a Behavioral Health/Social Services based role that collaborates directly with physical health providers in the Emergency Department setting. This role also collaborates with the Street Medicine Program, Medication Assisted Treatment program, and other outpatient and community based support to refer patients out.

Outcomes (Est. 750 character limit)

Outcomes include increasing connection to care post hospitalization, decreasing hospital admissions, and increasing communication and support during and post hospitalization. Recently, 60 patients were engaged with, 21 of those individuals were successfully connected to resources, 32 of them are still in progress and actively being reached out to, and out of the 21 patients successfully connected to resources, 0 returned to the ED thus far. Out of the 60 patients, only 7 were closed from services due to disengagement and lack of interest in support.

Start-up Considerations (Est. 750 character limit)

Considerations should include establishing a formal partnership between social services and the local emergency department in need of this service. Establishing a clear description of the role and patient population to share with ED provider. Ensuring that the individual who takes on the role is well trained in patient engagement, motivational interviewing, and has good problem solving and critical thinking skills. Safety training around community-based engagement is also necessary.

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CCAP COMCARE
The County Managed Care Resource

Name of Program

Community Based Care Management - Food as Medicine

Model Description (Est. 2,000 character limit)

The concept of Food as Medicine is that healthy food and good nutrition play a substantial role in supporting a person's physical and mental health and wellness. This concept is implemented across the country in a variety of ways. In Montgomery County, we have developed a Food As Medicine pilot program under our Community Based Care Management initiative (CBCM), which aims to partner providers and Community Based Organizations (CBOs) in order to address health disparities and social determinants of health. Our provider is Creative Health Services (CHS), a Community Behavioral Health Center (CBHC) and our CBO is the Pennsylvania Horticultural Society (PHS). Additionally, Magellan Behavioral Health, our County's Behavioral Health MCO, is involved to help coordinate care for participants (described below). CHS team members include a Registered Dietitian, Registered Nurses, the Director of Intensive Outpatient (IOP) and Integrative Health Initiatives and the IOP Administrative Navigator. Team Members from PHS include the Farm Educator and Farm Manager as well as the Community Garden Manager. Montgomery County Health and Human Services Office of Managed Care Solutions provides oversight and technical assistance.

2022 had 17-20 consistent participants and 2023 has 38-40 consistent participants, who engage in workshops that consist of nutrition education, develop culinary skills and knowledge using healthy, seasonal foods. A portion of the workshop is dedicated to gardening in garden beds built at CHS for this program. The groups then take part in a cooking demonstration and share a healthy meal together. The workshop experience was developed by CHS' Registered Dietitian and PHS' Farm Educator. Each participant takes home a VeggieRx box, which includes seasonal foods grown at PHS' Norristown Farm Park location, along with recipe cards that align with the skills and knowledge taught in the corresponding workshop.

Target Population (Est. 300 character limit)

Individuals with Serious Mental Illness receiving services from CHS' IOP or outpatient programs that are also enrolled in CHS' Integrated Health Initiative/Wellness Recovery Team (IHI).

How is integration achieved? (Est. 300 character limit)

Individuals are enrolled in CHS' IHI programs and IOP or outpatient treatment. This means they are receiving services from Registered Nurses to optimize their access to and participation with their physical health care while engaged with clinical services such as therapy and medication management. Magellan IH Care Managers can also coordinate care with physical health MCOs.

Outcomes (Est. 750 character limit)

In 2022, despite a small sample size of 17 of participants who completed every pre/mid/post nutritional assessment and provided vitals throughout the program, outcomes are promising. 22% of participants lost at least 5lbs, and 39% maintained their weight. This is substantial given the medications some are prescribed. Blood pressure improved for 41% and stayed the same for another 41%. 40% saw improved pulse ox readings and 17% stayed the same. Total cholesterol improved for 67%, triglycerides improved for 53%, HDL and LDL saw improvements of 13% and 54%, respectively. Participants completed the SF-12 which is a self-reported mental and physical health measurement tool. 54% had an improvement in their mental health score and 15% had an increased in their physical health. 2217.95lbs of healthy foods were distributed via VeggieRx boxes.

Start-up Considerations (Est. 750 character limit)

Careful consideration to partnerships is important. CHS' leadership has been a strong advocate for integrated health projects over the years. PHS has demonstrated strong partnership and project implementation skills. Creative funding strategies are necessary to support this type of an integrative structure.

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CCAP COMCARE
The County Managed Care Resource

Name of Program

Montgomery County Overdose Response Team

Model Description (Est. 2,000 character limit)

Montgomery County Overdose Response Team is a partnership between Mobile Crisis and Montgomery County Department of Public Safety. Mobile Crisis provides CRS/Crisis Workers who partner with paramedics to respond to live overdose scenarios and to follow up on recent overdose scenarios. This effort blends the physical emergency response of paramedics with the recovery focus of the CRS and the systemic connections of Mobile Crisis to engage rapid treatment options.

This project has enhanced the rapid delivery of treatment engagement to individuals in Montgomery County who have overdosed. It has strengthened the working partnership between Mobile Crisis and Montgomery County Public Safety, and it has enhanced the capacity of the Mobile Crisis team to be more effective in substance-use disorder crises. Because each Crisis Worker/CRS is fully trained as a crisis worker and a certified recovery specialist, the MCORT team brings the full strength of the crisis team and it's resources to each engagement.

Target Population (Est. 300 character limit)

Individuals in Montgomery County with live or recent drug overdose experiences.

How is integration achieved? (Est. 300 character limit)

The Mobile Crisis Worker/CRS rides in the vehicles with the paramedic to respond to live overdose scenarios and to follow up on recent overdoses. The paramedic meets immediate health needs and the Crisis Worker/CRS engages the individual to consider treatment. For those who agree to treatment, the MCORT team presents immediate options.

Outcomes (Est. 750 character limit)

So far in calendar year 2023,
- MCORT has served 182 individuals
- 11 individuals have entered and completed rehab and inpatient treatment
- engaged the use of Narcan 7 times
- 58% of individuals engaged were Magellan members
- supported 5 hospital placements for medical reasons

Start-up Considerations (Est. 750 character limit)

The partnership with Montgomery County Office of Public Safety has been critical. Their place in the emergency response system paved forward the connections to local EMS and police. Dr. Wang's leadership and experience made implementation clear. The use of the relationships and skill set of Mobile Crisis supports engagement and makes follow-up efficient and accessible for the community on the crisis hot line. MCORT is a marriage of existing resource that creates great outcomes and minimizes duplication.

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CCAP COMCARE
The County Managed Care Resource

Name of Program

SLPF MHOP CCBHC Integrated Team

Model Description (Est. 2,000 character limit)

The goal of the MHOP Integrated Team is to implement team-based care in the MHOP clinic setting. This team works to improve and address whole health needs, increase system access and navigation to community-based services, support clinic providers and therapists, and improve patient and provider satisfaction. The team includes an RN, Navigators, a Community Health Worker (CHW) and crisis. Navigators do population health management, link clients to services, liaise with primary care providers and community stakeholders, and support the MHOP clinic staff. The office nurse acts as point person for medical issues, triage, and connection to physical health providers. The RN supports monitoring of labs, addresses metabolic education needs, and facilitates group and individual education. The CHW works as an extender into the community, addressing needs such as physical health connections to care and social determinants of health. They work with guidance from the office nurse to relay information and needs back to nurse and providers, link clients to physical health care and to SDOH support. The CHW receives referrals from navigators, nurse, or other programs. They also provide support to individuals with co-occurring behavioral and physical health needs who are not eligible for the Wellness Recovery Team (WRT or Nurse Navigation) due to payor or diagnosis. They can also serve as a step-down after graduation from the WRT/NN programs. The nurse and navigator lead regularly scheduled rounds with the MHOP providers to triage client needs and build communication across the care team. The crisis supervisor also attends team meetings, supports staff training on triage of cases, links to mobile crisis partners.

Target Population (Est. 300 character limit)

Individuals served in the MHOP Clinic

How is integration achieved? (Est. 300 character limit)

Communication with primary and secondary care related to referrals and physical health needs, communication regarding meds and labs, addressing social determinants of health and linkage to programs/services that support root causes of SDOH challenges. The team also rounds with the clinic psychiatric providers to review cases/needs, identify complex/high acuity clients.

Outcomes (Est. 750 character limit)

Provider and client satisfaction measured by brief surveys. Closing care gaps for labs and physical health measures, including labs (A1C, metabolic panel, etc.) Ensure linkage to PCP. Education around metabolic health for individuals on atypical anti-psychotics, measured by group and individual visit engagement and weight/BMI/vitals. Population level care management to assess for triage and movement through the system. Navigators track referral volumes, stratify by complexity category, track LOS in navigation care by complexity category, and track barriers to care linkage. Rounding outcomes are measured by no-shows, call volumes between visits, crisis encounters, and level of care transitions. Crisis follow-up calls for clients discharged to outpatient care are tracked, as well collaborations with mobile crisis partners (ROIs, collaboration cases/WHOs, referrals, and diversions).

Start-up Considerations (Est. 750 character limit)

Activities currently provided through SAMHSA CCBHC expansion grant funding. Consideration for billing differences between physical and behavioral health.

To learn more about this program, please contact:

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CCAP COMCARE
The County Managed Care Resource

Name of Program

Street Medicine: Integrated Approach

Model Description (Est. 2,000 character limit)

The foundation of Street Medicine (SM) is bringing community and providers together to support the most vulnerable populations, taking healthcare out into the community- providing services in homeless encampments, community centers, churches, and more. Integrated into the SM team is a Health System partner from Tower Health, a Primary Care partner from the local FQHC, Access Services, which serves as the social services and Street Outreach partner, and an Outpatient (OP) Behavioral Health and Drug and Alcohol (D&A) partner. This allows a team of professionals to meet the unhoused in their environment and connect them to care and resources. Each formal partnership brings its own network of resources. The Health System Partner gives access to ED physicians, psychiatrists, wound care specialists, and phlebotomists. These members play an essential role in resolving acute physical and behavioral health needs in the community avoiding hospitalization. The local FQHC sends Community Health Workers to meet patients, coordinate appointments, and connect to primary care. They also provide a Primary Care Physician who can examine patients and make referrals from the field. The FQHC is crucial, allowing access to primary care, but also dental, optometry, physical therapy, podiatry, behavioral health services, medication-assisted treatment, and transportation. The OP Behavioral Health and D&A partner provides access to psychiatry, therapy, case management, peer support, and inpatient treatment. Certified Recovery Specialists join the team in the community to engage individuals in considering D&A treatment. As the social services entity, Access Services is the voice of the individuals we serve, and guide through our SM Navigator role to the Street medicine team. We provide education on where to locate the target population, how to engage, as well as, the connection to Mobile Crisis, Street Outreach, Housing Support, Justice Related Services, IBHS, and Psych Rehab.

Target Population (Est. 300 character limit)

Unhoused and housing insecure individuals in Montgomery County

How is integration achieved? (Est. 300 character limit)

Integration is acheived through the partnership of 3 main providers that span all services an individual could need to gain fulfillment and overall wellness. The team is made up of Acute Physical Health providers, Primary Care Providers, Behavioral Health, and Social Services. This team has the internal and external network to solve SDOH issues with this population.

Outcomes (Est. 750 character limit)

The desired outcomes of this model include increasing access to care, decreasing hospitalization, increasing connection to resources, improving rapport, helping individuals develop the skills to manage their own wellness and decreasing the effects of SDOH. This Street Medicine program has seen 296 unique homeless patients since start-up in January 2021. Just this year in 2023 there have been 300 patient encounters, 34 psychiatrist visits, and 16 new patients have established Primary Care. In 2022, 172 patients were referred to Primary Care, 143 of those patients scheduled an appointment, and 128 of those individuals showed up to the FQHC for their appointment. In 2022 the total number of Street Medicine Patients who were connected to more than one service was 48; that number is projected to grow significantly with the new services the team has begun to offer in 2023.

Start-up Considerations (Est. 750 character limit)

Considerations should include development of formal partnerships that span a variety of services.This includes discussing and establishing HIPAA compliant protocols, documentation process and shared data management. Determination of a shared vision and outcomes measures. Considering what roles from each partnership make sense to join the team regularly. Creating safety protcol and guidelines to protect the team and the community we serve. Developing a budget to support staff, medical supplies, outdoor supplies, and medication.

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CCAP COMCARE
The County Managed Care Resource

Name of Program

Partnership with Central Behavioral Health and VNA

Model Description (Est. 2,000 character limit)

The Visiting Nurse Association Community Services (VNA) operates a clinic in which is currently being renovated. This clinic offers the most vulnerable residents in Montgomery and Bucks counties medical care. During the renovation period, together, Central Behavioral Health and the VNA work to identify individuals and families that are in need of behavioral health treatment as well as case management services to connect them to other referrals and resources in our community. The VNA will identify children, adolescents and adults who may be experiencing behavioral health symptoms during their medical appointment. At that time, the medical professional will share information about Central Behavioral Health and educate the person/family re: benefits of gaining support from a mental health professional. Central's Intake Coordinator will complete a pre-screening intake immediately with the identified client and coordinate an appointment for an intake to begin outpatient services at Central. After the intake, the assessor makes recommendations for programs and services at Central and in the community to help with identified treatment goals and objectives. Our ACM will also work with the client to help the individual and/or family improve their quality of life. This is a process which can have a turnaround time of the same day or within 24hrs M-F. Once the VNA facility is renovated, our partnership mission is planning to include a behavioral health therapist and ACM from Central Behavioral Health on site at the VNA clinic. We have a vision that once the client is in the clinic and working with his/her medical professional and identified as someone who could benefit from behavioral health services or case management services, then the provider will walk them over to the behavioral health clinicians or ACM office and immediately begin the pre-screening intake process. Collecting demographics during the pre-screen will serve as the beginning of their intake and referral process.

Target Population (Est. 300 character limit)

Children age 2-18; Adults ages 18 and older; vulnerable, low income population, insured and uninsured with mental health symptoms and disorders.

How is integration achieved? (Est. 300 character limit)

Central Behavioral Health and the VNA have developed a system to connect the identified client to the intake coordinator to get the process started and to get the identified client connected to Central to begin mental health services.

Outcomes (Est. 750 character limit)

The Columbia Suicide Severity Rating Scale (C-SSRS) is completed with each client age 14 and older at each therapy session and PHQ-9 completed with each client age 18 and older at designated treatment sessions.
This is also a young/newer program and outcome data not available at this time.

Start-up Considerations (Est. 750 character limit)

Once the VNA facility is renovated, we are planning to include a behavioral health therapist and ACM at their physical location. This will allow a clinician and ACM to meet with the client immediately following the identified individual's medical appointment.

To learn more about this program, please contact:

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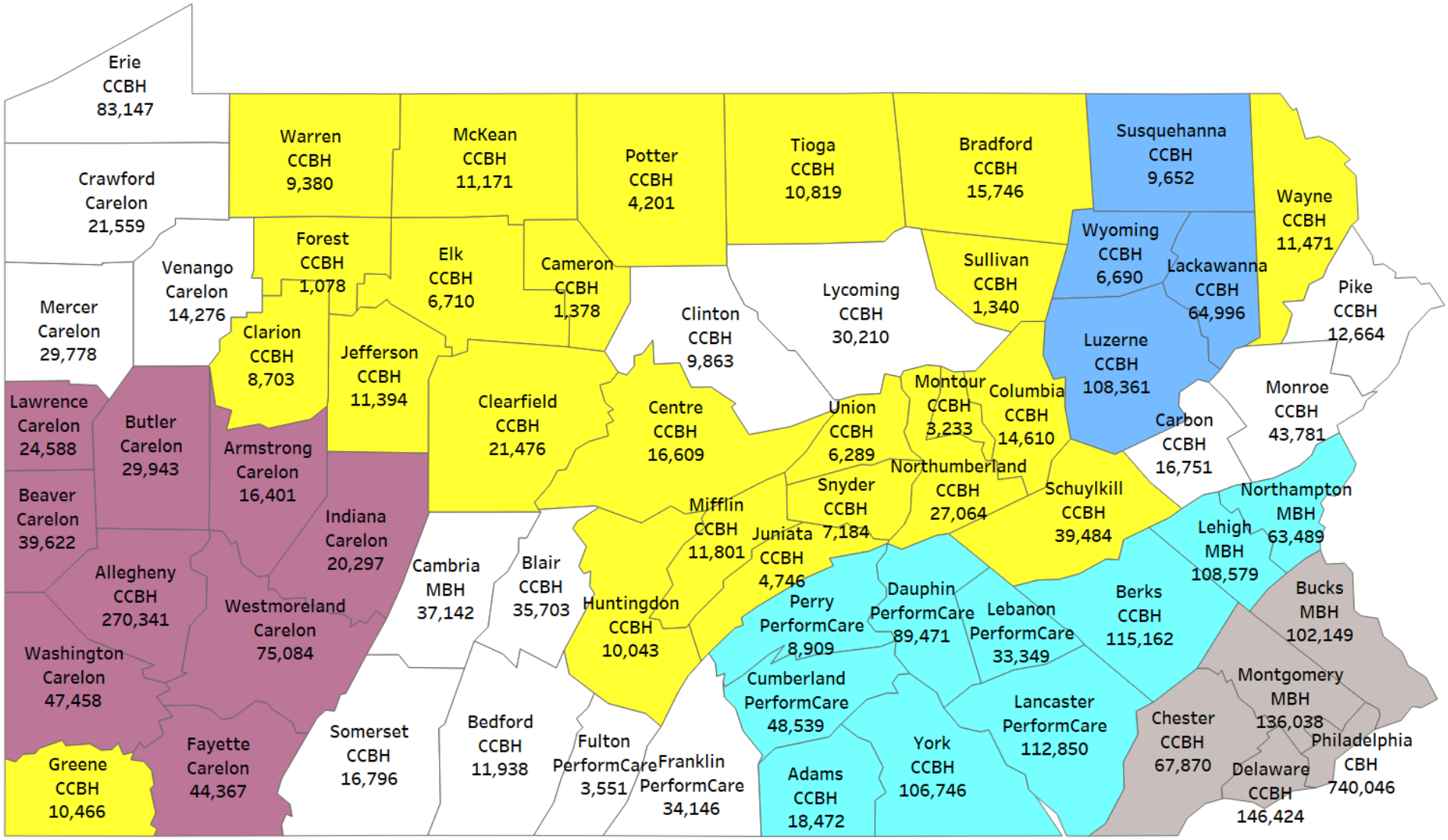
Department of Human Services
Office of Mental Health and Substance Abuse Services

June 2023 statewide total 3,323,594 covered lives
(i.e., HealthChoices Behavioral Health members)
Data source: ARM587 Report created 07/01/2023

HealthChoices Behavioral Health Eligibles: By Zone, County, and Behavioral Health Managed Care Organization



PENNSYLVANIA MEDICAID MANAGED CARE ORGANIZATION (MCO) DIRECTORY

September 2023

HealthChoices Physical Health
Southeast Zone: Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties
Southwest Zone: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland Counties
Lehigh/Capital Zone: Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York Counties
Northwest Zone: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, and Warren Counties
Northeast Zone: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming Counties

Health Partners Plans

Zones: Southeast, Southwest, Lehigh/Capital, Northwest, & Northeast
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Dental Benefit Manager: Avesis
Vision Benefit Manager: Davis/Versant Vision

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Keystone First – Southeast Zone

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Highmark Wholecare

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UPMC for You, Inc.

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HealthChoices Behavioral Health Southeast Zone

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HealthChoices Behavioral Health North/Central County Option

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HealthChoices Behavioral Health North/Central County Option

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Updated: September 2023

Community HealthChoices

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Keystone First CHC

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UPMC Community HealthChoices

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