Persons with Serious Mental Illness and Medical Co-Morbidities

GUIDELINE HIERARCHY

CPGs are updated every two years or as necessary due to updates made to guidelines or recommendations by the American Psychiatric Association (APA). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to the topic of Persons with Serious Mental Illness and Medical Co-Morbidities, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with the APA on the topic of Persons with Serious Mental Illness and Medical Co-Morbidities. The following are highlights from their guidelines.

AMERICAN PSYCHIATRIC ASSOCIATION (APA)

WellCare adheres to the American Psychiatric Association (2002) *Practice Guideline for the Treatment of Patients with Bipolar Disorder, Second Edition.* WellCare adheres to the 2005 *Guideline Watch* – the document contains an update of the 2002 guideline. The text of both can be found at http://psychiatryonline.org/guidelines

BACKGROUND

Persons with serious mental illness (SMI) are now dying 25 years earlier than the general population. Their increased morbidity and mortality are largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care.[1] We know that the numbers of members with high complexity may be small when compared with the total member population; however the overall system cost (both financial and time resources) present significant opportunities. One such opportunity has demonstrated results by delivering comprehensive, integrated case management. As an integrated health plan, WellCare is well positioned to coordinate the overarching needs for this vulnerable member population.

In 2013, WellCare conducted a pilot study of integrated case management (CM) inventions for the SMI+ 5 or more chronic physical health conditions in Kentucky. A total of 43 SMI members with 5 or more chronic medical conditions were enrolled and participated in the program. The intervention involved having a face-to-face meeting with the member and a WellCare clinical dyad consisting of a Care Management Nurse and a Care Management Social Worker. Meeting with the member, the WellCare CM dyad assessed the member's behavioral and physical health needs, identified care gaps, and assisted in connecting the member to a behavioral health (BH) and primary health provider (and any other specialists needed by the member). A single care plan was created and shared with the member's treating providers, thereby facilitating a coordinated care plan. Members who participated in the SMI+ program experienced a 42% reduction in medical expense compared to the prior year when they were not in a coordinated program. As a result of this pilot success, WellCare plans to expand the program to other markets where

high SMI+ members are served.

Relationship to WellCare's Standard Care Model

WellCare has developed a clinical model for care management based on the Four Quadrant Model. Care Model 2.0 encompasses services that will meet the broad Care Management needs of our member population. Included in Care Model 2.0 are integrated care teams that include behavioral health staff. The SMI+ program is NOT intended to duplicate services provided to the general population. Differences are shown in the table below.

Factor	Care Model 2.0	SMI+ Program
Staff	8 FTEs include BH and administrative support	Dyad of 1 BH and 1 PH staff
SMI Population	SMI+ 2 or less	SMI+ 3 or more
Staffing Ratio	1:60,000 members	1:125 SMI+
Program	Core	Bolt-On

DATA ANALYSIS

WellCare provides a monthly report in each of its markets of by line of business that computes the number of SMI members. The following BH diagnoses, when associated with severe functional impairments (Global Assessment of Functioning [GAF] score <50) qualify as SMI.

- Substance Abuse
- Depression
- Other Mental Health

This report is further divided into unique SMI members with 1 chronic medical condition, 2 chronic medical conditions, 3 chronic medical conditions, and so on up to a maximum of 7 chronic medical conditions. The chronic medical conditions are those that have been identified as having the most impact are:

- AIDS
- Asthma
- Coronary Arterial Disease (CAD)
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes Mellitus (DM, both Type 1 and Type 2)
- Hypertension (HTN)

Using the market SMI+, one can determine the number of SMI members with multiple chronic medical conditions and which chronic conditions combinations are found. The percentage of membership that qualifies for SMI will vary with the market's products. States with a high SSI membership or specific SMI carve-in populations will have high percentages of SMI members. States with child programs and TANF populations will have a lower percentage of SMI members. Using the SMI+ report, markets can determine the number of SMI+ members and set a threshold number of chronic conditions for enrolling in the SMI+ program. In addition to the number that meets the definition of SMI+X, there should be consideration given to the ability to impact the member's conditions, overall member utilization and service gaps. WellCare's Care Model design also has a focus on members with chronic medical conditions, it is recommended that the SMI+ program have a minimum of 3 chronic conditions for enrollment. SMI+ fewer than three chronic conditions should be addressed through the standard Care Model. In addition to knowing the potential number of SMI+ members in the program, one should consider the geographic distribution of those members. Ideally a concentrated membership rather than a widely dispersed population will lend toward an efficient deployment of staff.

STAFFING AND TRAINING

The SMI+ team is comprised of a dyad that includes a nurse Care Manager and a social worker Care Manager, representing the Physical Health and Behavioral Health (PH/BH) aspects of the member's needs. Industry staffing metrics do not currently exist, however we have empirically estimated that 1 full-time dyad can handle a case load of 125 SMI+ members. Based on this ratio, the following staff levels are recommended:

Number of SMI+	Dyads (2 FTEs)	FTEs
125	1	2
250	2	4
375	3	6
500	4	8

Staff on the SMI+ dyad should ideally have prior experience in managing the PH/BH population. In addition, to core case management training that includes motivational interviewing, case management safety and documentation, the SMI teams should have additional training in condition specific areas (schizophrenia, bipolar disorder, anxiety, depression, suicide assessment/intervention, substance use disorders, asthma, COPD, diabetes, hypertension/heart disease and obesity). In addition to this comprehensive training, ongoing supervision should address the interaction of the multiple co-morbidities and intervention plans. Another key component of staff development is clinical feedback provided during weekly team meetings (appendix E provides a description of the team/POD meeting).

KEY ACTIVITIES OF THE SMI+ MEMBER ENGAGEMENT

The Case Management Program in collaboration with the member and his/her family and health care team, identifies immediate, short-term, and continuous needs as well as develops appropriate and necessary case management strategies. The approach to offering case management services utilized motivational enhancement techniques that progressively engage the member.

Goals and Anticipated Outcomes	
Reduce Emergency Department Visits	**5%**
Reduce Hospitalizations	**25%**
Reduce Hospital Inpatient Readmissions	**10%**
Increase Frequency of PCP/Psychiatrist Visits	**10%**
Increase Pharmacy Utilization	**5%**
Reduce active symptoms and acute illnesses in members	**0%**
Improve the health and lifestyle of the member	**0%**

Upon identification of the member, a full assessment will be completed by the SMI dyad. The assessment will include:

- Comprehensive assessment of both behavioral health and physical health conditions (present and past).
- Substance abuse use/abuse
- Review of current treatment providers (potential duplication or care gaps)
- Medication profile (with goal of reconciliation)

In each instance, the CM team will work to engage the community providers (PCP and mental health providers) across systems to coordinate care. These interventions and activities are documented in the integrated care plan. Each step of the process is coordinated in an integrated fashion with the goal of moving the provider community toward a more comprehensive integration of care for all members. As the system progresses, WellCare will profile providers while looking for best practices. It is important to ensure that providers are equipped to deal with the member's complex needs and be willing to coordinate care.

HEDIS AND STAR MEASURES

CMS has not published any measures for this topic. NCQA has published the following measures for this topic:

Follow-Up After Hospitalization for Mental Illness. Members who are hospitalized due to a mental health diagnosis should follow up with a mental health practitioner:

- 7-Day Follow-Up should include an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge.
- 30 Day Follow-Up should include an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge.

RELATED CLINICAL PRACTICE GUIDELINES

In addition to the information contained in this document, please reference the following CPGs:

Behavioral Health Related

- Bipolar Disorder : HS 1017
- Depressive Disorders (Children & Adolescents) : HS 1022
- Major Depressive Disorders in Adults : HS 1008
- Schizophrenia : HS 1026
- Substance Use Disorders : HS 1031
- Suicidal Behaviors : HS 1027

Chronic Conditions

- Asthma : HS 1001
- Coronary Artery Disease : HS 1002
- Congestive Heart Failure : HS 1003
- Chronic Obstructive Pulmonary Disease (COPD) : HS 1007
- Diabetes Mellitus : HS 1009
- Hypertension : HS 1010
- HIV Antiretroviral Treatment in Adults : HS 1023

REFERENCES

1. National Association of Medical Directors Council published the "Morbidity and Mortality in People with Serious Mental Illness" October, 2006.
2. Collins, Hewson, Munger & Wade, 2010 and Mauer, 2006 in National Council for Community Behavioral Healthcare, 2006
3. Collins, C., Hewson, D.K., Munger, R., & Wade, T. (2010). Evolving models of behavioral health integration in primary care. Retrieved from http://www.milbank.org/uploads/documents/10430EvolvingCare/10430EvolvingCare.html
4. Mauer, B. (2006). Behavioral health/primary care integration: the four quadrant model and evidence-based practices. Rockville, MD: National Council for Community Behavioral Healthcare. Retrieved from http://www.thenationalcouncil.org/galleries/business-practice%20files/4%20Quadrant.pdf
5. Miller, Scott D, PhD. Outcomes Rating Scale (ORS). Retrieved from: http://scottdmiller.com/performance-metrics.
6. Substance Abuse and Mental Health Services Administration: Integrated Care Models. Retrieved from: http://www.integration.samhsa.gov/integrated-care-models.
7. Ward, John C., PhD, Dow, Michael G. PhD (1998). The Functional Assessment Rating Scale. Retrieved from: http://outcomes.fmhi.usf.edu/fars.cfm.
8. Practice guideline for the treatment of patients with bipolar disorder (2nd ed.). American Psychiatric Association Web site. http://psychiatryonline.org/guidelines. Published 2002. Accessed March 1, 2016.

LEGAL DISCLAIMER

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	History and Revisions by the Medical Policy Committee
3/3/2016	• Approved by MPC. Inclusion of APA reference and CPG Hierarchy.
2/5/2015	• Approved by MPC. New.