

Best Practices for Mental Health and Substance Abuse Issues

as noted by Family Care MCOs

In 2010 the Office of Family Care Expansion (OFCE) held site visits with each of the Managed Care Organizations (MCOs) to discuss mental health and substance abuse care options available to their members. One outcome of the site visits was identification of best practices MCOs have used to address mental health and substance issues. All MCOs agreed there are both internal and external gaps in services for members with mental health or substance abuse issues. OFCE will work with each MCO to construct a work plan to better serve their members with these issues. Below is a list of some of the practices that various MCOs have used, or are planning to use, to accomplish this task. OFCE is sharing this document as a tool for exchange of knowledge and ideas, which MCOs can use in development of their work plans.

1.) For Crisis

- **Crisis Plans:** MCO interdisciplinary teams (IDTs) create crisis plans and give copies to appropriate supports to aid in member stabilization. Examples of appropriate supports could be a member's family, friends and/or coworkers. It could be therapists, residential providers, county systems and/or police. Any person or place listed to aid in (or stay out of) a crisis situation, should have a copy of the plan. IDTs should present the plan to those listed and discuss their role in the plan, how to carry out their role, and determine if they are willing to accept that role. This assures consistent follow through.
- **Call Centers:** MCOs have contracted with, or created their own, crisis call centers that are available 24/7. The people who handle the phone calls know crisis diversion techniques and have access to members' crisis plans.
- **Effective Relationships with Community Resources:** MCOs work to improve relationships with the crisis teams in the community. MCOs have memoranda of understanding (MOUs) with counties or other community providers. MOUs are very specific and the MCO and county have regular meetings to discuss issues.
- **Data Collection:** Use data to determine the outcome of crisis interventions and to make adjustments to interventions as needed. For example data can be collected and analyzed to determine:
 - Whether crisis calls, and/or having access to the crisis plans, deescalated the situation and diverted inpatient admission.
 - The number of member admissions by MCO and/or by county.
 - The number of days of inpatient services for those admitted.
 - The length of time between admissions, if a member was admitted more than once.

- **Collateral Sources:** MCOs receive information from collateral sources to better understand members, especially when risk is identified. MCOs use this information in crisis planning.
- **Effective tools for use in crisis:**
 - Safe houses set up, especially for people with developmental disabilities, to avoid admissions. Also the use of CBRFs for the same purpose.
 - Mobile crisis units are helpful because they can go to a member's home.
 - Local police with critical incident training have made interactions with members more positive and have been successful in deescalating situations.

2.) For Outpatient Services

- **Request Plans:** If a member has mental health/substance abuse issues listed on their member-centered plan (MCP) and are seeing a provider in the community, request the assessment, treatment plan and all reviews (usually quarterly) from the provider. The MCO is the payer and has the right to this information. Care Managers need this information to verify the member's continuity of care and to ensure that the provider's plan is consistent with the member's MCP.
- **List Expectations:** MCOs could make the request for the member's plan and other information part of their contract agreement with providers. The request could include assessments, treatment plans and reviews.
- **Educate:** May need to educate providers related to:
 - The Family Care benefit package;
 - Need for collateral sources;
 - Harm reduction;
 - Trauma informed care; and
 - The difference in planning care between a person who has mental health and/or substance abuse issues and those that, in addition, have some of the comorbidities of Family Care target groups.
- **Peer Specialists:** Learn more about peer specialists, understand this treatment resource, determine how to contract for these services and how to use this as an effective/cost-effective alternative.
- **Support Groups:** Some MCOs offer support groups to members, such as geriatric Alcoholics Anonymous. Others are collaborating with community supports to best meet the needs of the different Family Care target groups.

3.) **For Community Support Programs**

- **Relationship/Communication:** Effective communication with area Community Support Programs (CSPs) results in a better working relationship between the MCO and CSPs. Clearly define contracts and very specific MOUs tend to aid in addressing issues such as coordination of care, roles and responsibilities, overlap in services, bundling vs. unbundling of services, and psychiatric access.

4.) **For Behavioral Health Team Options**

- **Dedicated Behavioral Health Teams.** All members with behavioral health (BH) issues are on a dedicated BH Team. These specialty teams have smaller caseloads (30-35 members per team). There are specific enrollment and transfer guidelines to place a member on a BH Team. The member is transferred to a non-behavioral health team when risk decreases. BH Teams offer consultation and education within the guidelines. These teams need a great deal of internal and external support including education. Due to staff turnover, MCOs conduct annual reviews of staff and their knowledge of behavioral health issues.
- **Behavioral Health Teams** (carry a small caseload and co-care manage). These teams may have a caseload of 10-11 members who co-care manages for members on other IDTs. This increases the regular team's expertise for all members and avoids burnout.
- **Behavioral Health Coordinators** (do not carry caseloads). BH coordinators consult with all teams that have members with behavioral health issues. The BH coordinators do not carry a caseload; instead they visit members, write behavioral support plans, write restrictive measures plans, monitor plans and provide quality assurance.
- **Teams with Knowledge:** Each MCO has IDT staff members with some mental health and substance abuse knowledge. If any one team has a large number of members with mental health/substance abuse issues, then their caseloads are smaller. IDTs communicate with ADRCs to plan ahead for team placement of a member. Some IDTs are specialized by target group and those teams with members with high risk for behavioral health issues have smaller caseloads, see members more often and consult with all teams.

5.) **For Assisting Teams** (current strategies MCOs are using)

- Behavioral Health Best Practices workgroup explores mental health and stages of recovery, along with core competencies.
- Biographies on all employees' expertise/skills and interests; all staff have this information and can consult appropriately.
- Specialized committees to help with challenging cases.
- Workbooks including examples of plans and checklists, and protocols for writing, reviewing and updating plans.

- PACE/Partnership programs have Behavioral Health Specialists that are MSWs and LCSWs, who have caseloads, conduct some of the therapy for members, develop behavioral support plans and consult with other teams.
- Members with mental health or substance abuse issues that do not wish to work on the MH/SA issues will have the issues noted on their plan to explore further in the future and/or monitor.
- Team members complete the assessment tools together with the member.
- Hire a person dedicated to training internal MCO staff, as well as providers. Contract with consultants who have appropriate specialty expertise.
- Boot Camp training and mentor relationships to orient new care management staff.
- Continued education on a variety of topics and annual education on the most important topics related to member care.

6.) For Working with Providers

- Education for providers about behavioral support plans and the importance of consistency and follow through to support member outcomes.
- Pay attention to cultural and ethnic compositions of MCO members and make sure that culturally competent resources are available.
- Training for residential staff on the vision and mission of FC. Have the member's provider staff involved to identify outcomes for the member and the cost-effectiveness of their plan.
- Assess all needs before medications are used or increased.
- Formalized referral forms for day treatment; assure that CSP and MH/SA specialists report back to the MCO about member plans and outcomes.

7.) For Shortage of Psychiatry

These are brainstorming ideas presented by MCOs. Brainstorming is putting all the ideas out there even if they may not be feasible so we don't miss any possible solutions.

- Contract with traveling psychiatrists. These are psychiatrists that work for one institution at different sites or those that contract with many different agencies so to be available at many different sites; should increase accessibility. MCOs could contract for consultation.
- The use of video psychiatry. Psychiatrists that conduct video sessions can be located on line via "telehealth" or "psychiatric video conferencing." Also when MCOs contract with agencies they can inquire about this service. As of last summer 23 counties in Wisconsin had this option available.
- Physician Assistants and Nurse Practitioners having the ability to write prescriptions for medications.
- Providers having clinical teams that MCOs could contract with for services. The "clinical teams" could include psychiatry and other specialists; MH/SA, RN (multidisciplinary) that could be billed as consultation.
- Co-op of psychiatrists that offer medication management for their patients and others psychiatrist's patients as needed within the co-op. Increases availability, like a

practice that has more than one psychiatrist so they can cover for each other. This would offer even more coverage because it would cover a larger area of services and include more doctors because psychiatrists would co-op regionally.

- Collaborate better with counties and coordinate the use of their psychiatrists.
- Direct hire for psychiatry. Again this is brainstorming because in reality Family Care MCOs do not provide psychiatry. The idea here was there could be such big savings to have greater access to psychiatry for medication, admissions, discharges, and referrals for treatment that it may cost less in the long run because members may need less care if they didn't have to wait on their psychiatry needs to be met.
- Look into grant opportunities for psychiatry. This has not been done yet but some MCOs have talked about looking into this possibility.

8.) For Data Collection

Explore options available and look at the next steps to access data that address:

- Effectiveness/cost effectiveness of treatment modalities;
- Collection of behavioral health data before transition of a member;
- Access to data collection and analysis to demonstrate effectiveness, or lack of, for new ideas MCOs implement to better serve their members.