ACHP
Innovation Profile

Community Health Plan Strategies for Improving Mental Health

Case Studies in Improving Care, Reducing Mental Illness Stigma

November 2014

Some 60 million Americans — one in four adults — are affected by mental health problems each year. Every day, millions with mental illness struggle in silence, either because they cannot get the right care or are too ashamed to speak up. Approximately 60 percent of adults and almost one-half of children ages 8 to 15 with a mental illness received no mental health services in the previous year.[1] Finding and treating those in need is of paramount importance to their health, safety and ability to function in day-to-day life.

When we talk about mental illness, we often think of serious mental illness (SMI), which includes schizophrenia, bipolar, severe depression and conditions that involve psychosis. However, fewer than one quarter of people who are diagnosed with mental illness are considered to have SMI. Mental illness refers to a wide range of mental health conditions — disorders that affect mood, thinking and behavior. Examples include mood disorders, such as mild or moderate depression; anxiety disorders, such as obsessive-compulsive disorder; and post-traumatic stress disorder. Additionally, many who struggle with their mental health face socioeconomic challenges like hostile living situations and behavioral concerns such as drug or alcohol abuse. Treating a person with the aim of achieving total health requires simultaneously addressing the full spectrum of mental, physical, social and behavioral issues they may face. Improving care for those with mental illness requires answering three key questions:

1. **How can we change the culture of stigma surrounding mental illness?**
2. **How can we identify and reach those who need care?**
3. **How can we approach treatment so that it focuses on long-term mental and physical health and functioning?**

Consistently rated as the best health plans in the country, members of the Alliance of Community Health Plans (ACHP) are committed to continually developing systems that are better at identifying and treating mental health issues. Outlined here are examples of how five ACHP health plans are using their deep local knowledge to answer these key questions for their communities, and how they are developing innovative programs that lead the way in mental health care.

The Facts on Mental Illness

- Affects 60 million American adults each year.*
- Serious mental illness (SMI) costs the U.S. $193.2 billion in lost earnings each year.*
- Mood disorders such as depression are the third most common cause of hospitalization in the U.S for both youth and adults ages 18 to 44.*
- Adults living with SMI die an average of 25 years earlier than other Americans, largely due to treatable medical conditions.*
- SMI most often includes schizophrenia, bipolar disorder and severe depression. In the U.S., about 2.4 million people live with schizophrenia, 6.1 million people with bipolar disorder and 14.8 million people with major depression. An estimated 26 percent of homeless adults staying in shelters live with SMI.*
- 46 percent of Medicare beneficiaries with an SMI diagnosis and older than 65 were hospitalized in 2010, compared to 17 percent of Medicare beneficiaries without SMI.+

* National Alliance on Mental Illness, Mental Illness Facts and Numbers. Accessed October 2014.

+ The SCAN Foundation, Data Brief: Medicare Beneficiaries With Severe Mental Illness and Hospitalization Rates, February 2014.

[1] National Alliance on Mental Illness, Mental Illness Facts and Numbers. Accessed October 2014.

Changing the Culture of Stigma Surrounding Mental Illness

A cultural shift away from regarding mental illness as shameful and a sign of weakness is critical to improving mental health care across the country.

HealthPartners—Minneapolis, Minnesota

For many people, mental illnesses are shrouded in shame, confusion and fear. Fewer than one-quarter of those with mental health conditions believe that people are caring and sympathetic toward those with mental illness. Embarrassment associated with accessing mental health services is one of the barriers to receiving care, as those affected tend to hide their symptoms.[2]

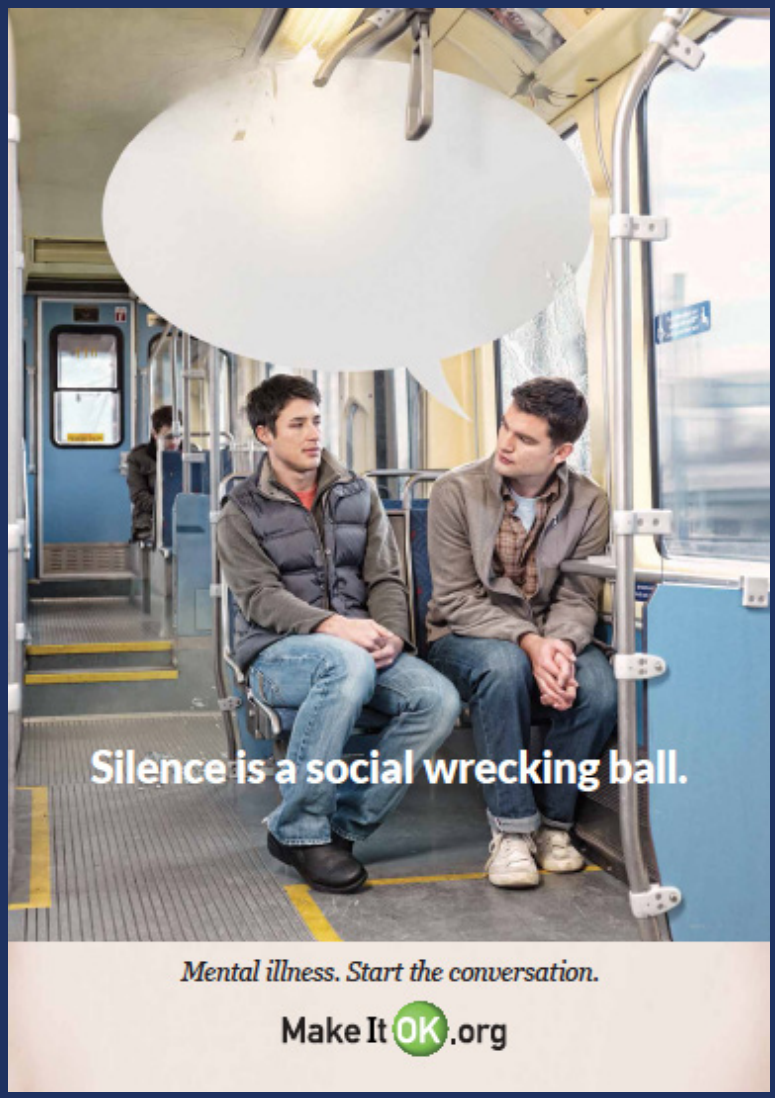
To fight stigma, HealthPartners is collaborating with national and local partners, including the Minnesota chapter of the National Alliance on Mental Illness (NAMI) and Twin Cities Public Television, on the *Make It OK* campaign to encourage people to talk more openly about mental illnesses, ask for help when they need it and understand that their illness is not shameful. The campaign includes print ads and radio and television commercials, all emphasizing that mental illnesses are not character flaws or something to "get over."

An ongoing *Make It OK* ad campaign says that silence "makes the mental illness stigma even worse." This specific campaign is not directly targeted at those with mental illness, but rather the friends and family in whom they confide. *Make It OK* asks society to more readily talk about how mental illnesses are affecting loved ones, and offers tips and strategies for having difficult conversations about the challenges of mental illnesses. These ads typically run during Mental Health Awareness Month in May and Mental Health Awareness Week in October, and the campaign has also collaborated with Twin Cities Public Television to produce a documentary series on mental illness, which recently received a regional Emmy.

To connect directly with the community, representatives from the campaign lead education and coaching sessions for business and community groups. The advisory committee that sets the campaign's agenda includes community members, the local police and government and hospital groups that aim to fine tune the campaign to the tenor and specific needs of Twin Cities communities. A local organization can request trained speakers from the campaign to lead an educational session on mental illnesses. Groups requesting sessions have included local businesses, churches, community groups and the city of Red Wing, Minn., which reached out to the campaign after its leadership recognized the city's cultural approach to mental health was problematic. Through its national name recognition, NAMI has also directed a number of people and organizations to the learning opportunities the campaign offers.

An advertisement from the Make It OK campaign.

[2] Centers for Disease Control and Prevention, Attitudes Toward Mental Illness, May 28, 2010.



An advertisement from the Make It OK campaign.

Sharing Mental Illness Stories to "Make It OK"

Make It OK shares the story of Jim, who in his youth almost died as a result of his illness. In his twenties, Jim started to experience symptoms of a severe mental illness, and eventually had a mental breakdown that led to jail time. "My mind became very confused and mixed up and I thought God wanted me to hurt myself," he said. Although his father bailed him out of jail, Jim's symptoms worsened to the point that he dove headfirst off a high bridge in Minneapolis, hitting the water so hard that he was temporarily paralyzed. He survived, but spent the next 84 days in an inpatient mental health facility.

"If we can only stop treating it as a character flaw and treat it like any physical illness, it would sure be great. After all, we certainly don't make someone feel ashamed for breaking an arm or getting cancer."

While Jim has since found respite from his illness and started a family, he is still reluctant to speak openly about his struggles. "I am extremely guarded and afraid to tell my story for fear of ridicule, shame, loss of respect," Jim says. "If we can only stop treating it as a character flaw and treat it like any physical illness, it would sure be great. After all, we certainly don't make someone feel ashamed for breaking an arm or getting cancer."

When local members of the community become *Make It OK* ambassadors, they receive a toolkit with a presentation to give to neighbors and their community, a video on the stigma of mental illnesses, stories of people who have experienced a mental illness, flyers to pass out and talking points to help focus their message.

Results: The campaign began in May 2013 and ***connected with more than 100,000 people*** during its first year. This includes those who have visited the website, taken the campaign's pledge to erase the stigma surrounding mental illness, watched the documentaries, received the toolkit and participated in a *Make It OK* learning session.

Identifying and Reaching People in Need of Care

Screening for signs of mental illness and establishing personalized interventions that respond to individual needs help identify and treat people who might otherwise go untreated.

CareOregon—Portland, Oregon

Identifying those who are struggling is the first step in getting people the treatment they need. CareOregon created the *Health Resilience Program* to connect with individuals who often do not receive care because they do not fit the definition of SMI.

The *Health Resilience Program* is designed for medically complex individuals with multiple chronic conditions and various mental and social challenges, not just those with SMI. While 15-20 percent of people in the program have an SMI diagnosis, most struggle with different behavioral health challenges, including mild or moderate depression, anxiety, post-traumatic stress disorder and, most frequently, substance addiction. A full 62 percent of those in the program have a substance use disorder, which, in many cases, began when individuals self-medicated other mental health conditions. Members also typically face difficult social situations such as unstable housing, food insecurity and social isolation.

CareOregon uses claims data to identify members who are receiving an unusually high volume of care, and the plan's providers meet with those members to decide whether they would benefit from the program. Once enrolled, CareOregon dispatches a Health Resilience Specialist, a health care worker with a behavioral health background, who is tasked with developing close, meaningful partnerships with program participants. Specialists are masters-level social workers — often with experience working in the Portland community with the Medicaid population — who have worked with individuals who are resistant to treatment. CareOregon's program is founded on the concept of taking care to the patient, recognizing the value of non-traditional care and building a relationship that weaves mental health treatment into day-to-day life. Specialists guide patients through a web of clinical treatments and lifestyle changes, and ensure that individuals receive the medical attention and emotional support they need.

Health Resilience Specialists visit participants in their homes and communities to help them work toward wellness and stability in their lives, and play an important role in developing a highly-individualized approach to address each person's unique set of challenges. These range from traditional medical assistance — such as accompanying individuals to their appointment with a mental health practitioner — to non-traditional meetings and interactions, such as helping them move out of a destructive home environment, or meeting in a park, restaurant or other place the person is particularly comfortable. Other interventions include motivational interviewing that supports health-related behavior change in a manner compatible with participants' values, assistance in adhering to a care plan, health education and building confidence and the feeling of success.

Results: After one year of work with a Health Resilience Specialist, participants had ***reduced inpatient admissions of more than 30 percent and half the number of emergency department (ED) visits.*** Prior to being identified as candidates for the program, they averaged 3.1 hospital inpatient admissions and 13.1 ED visits each year. One year after the initial intervention, enrollees averaged one hospital inpatient admission and 5.8 ED visits per year.

A Health Resilience Specialist works with a program member.

Group Health Cooperative—Seattle, Washington

Up to 20 percent of U.S. teenagers experience an episode of major depression by the time they turn 18. Depression can lead to serious impairment in daily functioning, physical health problems such as obesity, high-risk behaviors such as drug and alcohol abuse, and suicide. Recent data indicate that approximately 40 percent of adolescent mood disorders go untreated. [3]

Currently, all Group Health teen members are screened for depression at their annual physical with a quick-and-easy diagnostic tool called the PHQ-2. To better treat teens diagnosed with depression, Group Health partnered with Seattle Children's Hospital and the University of Washington to create *Reach Out 4 Teens*, a pilot program that offers a personalized approach to treatment. The program uses a collaborative care model to offer teens specialized treatment in the primary care setting by embedding a depression care manager in primary care practices.

Each step of the treatment process is customized to the teen's needs. At the beginning of each intervention, the depression care manager creates a safety document for the teen, regardless of suicide risk. Formed with the teen's input, it includes personal warning signs for worsening of depression, teen-identified strategies to alleviate stress, a list of trusted adults the teen can call for support and emergency phone numbers. The care manager also educates the teen and his or her parents about depression, and through collaboration with the primary care physician, the teen has the option to receive psychotherapy, medication or a combination of the two.
Ongoing care is provided by a team that includes the depression care manager, primary care provider, the teen and parents and a mental health supervisory team comprising psychiatrists, psychologists or adolescent medicine specialists with expertise in adolescent mental health. The team meets with the depression care manager for one hour each week to discuss individual strategies for new cases and review progress for the full caseload. Throughout the program, primary care providers continue to have regular appointments with teens, and the depression care manager monitors symptoms, medication side effects and the teen's engagement with treatment. The care manager is also available to update parents on the treatment plan and address their concerns. At the end of the intervention, the teen and his or her depression care manager work together to create a relapse prevention plan that is shared with parents and the primary care provider. It includes a description of ongoing treatment, personalized relapse warning signs, information regarding what has helped the teen with depression in the past and strategies for finding help and re-engaging in care if symptoms reappear.

Results: Of those who took part in the *Reach Out 4 Teens* program, ***67 percent showed a positive response to treatment and 50 percent had a remission of their depression***. By comparison, 38 percent of teens in traditional care responded to treatment and 20 percent experienced remission.

The Patient Health Questionnaire-2 (PHQ-2)

Over the past 2 weeks, how often been you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PHQ -2 Assessment

[3] The Journal of the American Medical Association: Collaborative Care for Adolescents With Depression in Primary Care, August 27, 2014.

Treatment That Focuses on Long-Term Mental and Physical Health

Integrating care for physical and mental health conditions ensures patients receive consistent, coordinated care from everyone involved in their treatment. Partnering with local organizations and family members extends the reach of care beyond the doctor's office.

Capital District Physicians' Health Plan (CDPHP)—Albany, New York

More than 68 percent of adults with a mental health disorder also have at least one physical condition. Individuals living with SMI have a significantly higher prevalence of major medical conditions that are potentially preventable, most notably diabetes, hypertension and lung, liver and cardiovascular disease. CDPHP created a program to improve care coordination between mental and physical health providers for individuals with SMI and substance use disorders.

To help manage the treatment and health status of those with SMI, CDPHP embeds a behavioral health case manager into primary care offices. The case manager has two core responsibilities: working with physicians to help coordinate care, and working with patients to engage them in their care. Once a CDPHP provider identifies a person as a potential beneficiary of the program, he or she is referred to in-office case management. The case manager spends two days per week working directly in a primary care office, and assists in treatment and care coordination among primary care physicians (PCP), mental health providers and the patient and his or her family.

Through their collaboration with the PCP, the care manager monitors medication compliance and effectiveness, and assists primary care physicians with the referral process to outpatient behavioral health providers, including facilitating communication and ensuring there is a consistent care plan among all providers.

The case manager partners with patients to develop care plans and self-management goals; ensures the patient receives daily care and support by creating a collaborative link with social service agencies, housing agencies and mental health intensive case management programs; and works with family members and loved ones involved in the person's care on a daily basis.

Results: Following intervention, ***83 percent of individuals seen by a case manager did not have another hospital admission in the next year, and 76 percent had a reduction in ED visits***; almost half of participants had no ED visits in the following year. These reductions led to an ***average cost savings of $1,154 per person*** in the program. Out of 180 program referrals in 2012, 101 individuals engaged in treatment with a behavioral health provider. Of those 101, 65 remained committed to and engaged in their treatment more than a year later.

UPMC Health Plan—Pittsburgh, Pennsylvania

Medicaid is the single largest payer for mental health services in the United States.[4] In 2009, UPMC Health Plan, along with its partner Community Care Behavioral Health Organization (CCBH), teamed with the Pennsylvania Department of Public Welfare and Allegheny County (Pittsburgh, Pa.) to form *Connected Care,* a program that integrates behavioral and physical health care for Medicaid enrollees with SMI. CCBH is dedicated to managing behavioral health services for individuals with Medicaid and treating people with behavioral health needs. The largest not-for-profit behavioral health managed care organization in the country, it has a core focus on recovery and works on peer and family involvement, physical and behavioral health integration and community-based care management.

To identify Medicaid patients who would benefit from the intensive care the program offers, CCBH and UPMC

[4] The Center for Medicaid and CHIP Services, Behavioral Health Services. Accessed September 2014.

use claims data to identify individuals with significant physical and behavioral health needs. Eligibility for *Connected Care* is contingent upon an SMI diagnosis from a physician.

Initiating contact and building patient acceptance for the treatment process are challenges. The first step in the *Connected Care* program involves sending letters and making phone calls to eligible members that describe the program and its potential benefits. Members are encouraged to have close contact with their primary care physician. These appointments allow the doctor to screen for substance abuse and mental illness, discuss the possibility of mental health treatment and refer to specific services.

Once the Medicaid member enrolls, a CCBH care manager assesses his or her needs and custom tailors an intervention to fit the individual's circumstances. CCBH and UPMC work together to support multidisciplinary case review meetings in which they discuss and coordinate care plans and review hospitalizations, ED visits, potential gaps in care and the patient's medication regimen. These efforts are supported by a robust data infrastructure that maintains care coordination by ensuring that all providers have the most up-to-date and complete information available on a patient.

Throughout the program, patients are linked to a medical home, through which they receive continuing education for self-management and detailed discharge instructions when they leave the hospital or a medical appointment. All of this information is coordinated and agreed upon by the integrated care team.

Results: An evaluation by an external assessment agency showed ***statistically significant reductions in ED use and 30-day readmission rates*** compared to participants in a comparison study group.

An Ongoing Challenge

There is no perfect solution to treating mental illness. Patients are often difficult to diagnose and engage, and numerous medical and social challenges can complicate the treatment process. Despite these obstacles, because of their focus on innovation and patient-centered care, ACHP plans are proving that significant improvements in mental health care are achievable.

Through their deep community ties, ACHP plans are positioned to be a trusted resource for information and education about mental illness. Our member plans help de-stigmatize mental illness through partnerships with local and national organizations; identify people in need of care and engage them "where they are"; and coordinate physical and mental health care for effective long-term treatment. Finally, ACHP plans bring mental and physical health care together by embedding behavioral health specialists in primary care practices and creating medical homes that include behavioral health.

ACHP plans remain committed to providing the best mental health care for their members as they develop innovative programs that will lead their communities and the country toward new and better ways to treat mental illness.

For more information on these plans and the Alliance of Community Health Plans, contact Rachel Schwartz at rschwartz@achp.org or (202) 785-2247.

About ACHP

The Alliance of Community Health Plans (ACHP) is a national leadership organization bringing together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care.

Our Innovation Profiles series describes how ACHP plans are working with communities, provider groups, patients and other stakeholders to improve the quality and affordability of care and the overall health of their communities.

About the Plans in This Brief

Serving 160,000 Oregonians, primarily in the Medicaid population and in the Portland area, CareOregon is a managed care company with a goal of making high-quality care available to all Oregon residents, regardless of income. CareOregon participates in five of the state's new Coordinated Care Organizations that provide integrated and total care for Medicaid enrollees.

Founded by physicians, CDPHP provides care for more than 440,000 residents of upstate New York. The plan's Medicaid and Medicare plans rate among the top 15 in the country and three commercial plans are ranked in the top 40.

Group Health provides coverage and care to more than 600,000 people, nearly two-thirds of whom receive care at Group Health medical centers. All of Group Health's 25 clinics are recognized by NCQA as meeting the highest level of quality for a patient-centered medical home. The plan's commercial product ranks in the top 30 nationally, and its Medicare Advantage plan received a five-star rating for the fourth year in a row.

A non-profit, consumer-governed health plan, HealthPartners has been named one of the nation's five top-performing health plans by the National Business Coalition on Health and a J.D. Power "Customer Champion," one of only five health plans in the country to receive the honor.

UPMC Health Plan

UPMC Health Plan insures more than 830,000 people in the Pittsburgh area, including 279,000 Medicaid enrollees. Its Medicaid plan ranks in the top 25 nationwide, and two of its commercial offerings are in the top 25 plans in the country.