Summary of 2010 Mental Health and Substance Abuse Site Visits to Managed Care Organizations

Introduction

As of November 2010, there were 35,593 people enrolled in the managed long-term care programs[1] in Wisconsin. Data from 2009 long term care functional screens indicated that 57% of enrollees in that year had a verified mental health diagnosis of some kind, while 25% had a diagnosed substance abuse issue. However, substance abuse may be under reported to primary care physicians and thus also under reported on the functional screen. Due to the high number of enrollees with mental health and/or substance abuse issues, staff from the Office of Family Care Expansion (OFCE) scheduled site visits in 2010 with each Managed Care Organization (MCO) to discuss the mental health/substance abuse care options available to their members.

The purpose of the sites visits was to assess the MCOs' provider networks and determine if there were provider availability or other challenges related to mental health and substance abuse services. Further, the intent was to identify best practices already being implemented by MCOs to address the mental health and substance abuse needs of members. Another goal was to identify areas where MCOs could potentially improve services to members through development of internal capacity or creative development of purchased services. These discussions highlighted the complexity of the Family Care members' issues and the need for improvement to ensure an adequate service infrastructure in comparison to the population needing services.

The outcome of these site visits resulted in the Department developing a plan to share best practices across the MCOs to address systems gaps identified across the state, to work collaboratively between the Department and the MCOs to identify technical assistance for improvement of services and supports to people with mental health and substance abuse issues.

OFCE will work with each MCO to develop a work plan to improve mental health/substance abuse services and assist with performance measures to assure the success of changes that are made. The overall goals are to work together with MCOs to improve mental health and substance abuse services to members, and to help interdisciplinary team staff identify and support individual member outcomes.

Current data show the rates of both severe mental illness and less severe mental illness to be much higher for PACE/Partnership members than Family Care members. However, the rates of all mental illness for both programs is very high; 53.6% for Family Care and 66.8% for PACE/Partnership.

It appears from the data that Family Care and PACE/Partnership members who are frail elders have the highest rates of mental illness and substance abuse; and it appears that PACE/Partnership members with physical disabilities have a high rate of substance abuse at 48.39%. This would suggest a significant need for mental health and substance abuse services and supports for these populations.

[1] Wisconsin's managed long-term care programs include Family Care, Family Care Partnership and PACE.

External Resources

Barriers to obtaining psychiatric care was the primary access issue identified by all the MCOs. Some psychiatrists are connected to service delivery systems and if members cease to be connected to that system, such as a county Community Support Programs (CSP), they lose their psychiatrist. In some rural areas there is no availability of psychiatry for Medicaid recipients. Most members who receive psychiatric care get brief medication checks. Members with developmental disabilities usually do not have access to a psychiatric provider with specific expertise with developmental disabilities. MCOs report the wait list for psychiatry is anywhere from three months to a year, with resultant delays in relocations from institutional settings, medication reassessments for best practice care and delay of treatment for mental health needs.

Access to inpatient mental health/substance abuse services did not appear to be a problem even in rural areas. The exception to this is inpatient treatment for elders with dementia and individuals with aggressive behaviors. This mirrors access issues for the general Medicaid population.

Access to residential services for the Family Care population with mental health/substance abuse issues is problematic. Lack of physical accessibility of some residential service providers is a barrier for Family Care members in the frail elder or physical disabilities target groups. Many residential programs for mental health/substance abuse are not suitable for people with cognitive impairments; for example, AODA treatment that includes total abstinence is not generally a good fit for a population that need ongoing medications and/or may need unique supports to develop the insight necessary for treatment. Three MCOs recognized a gap for AODA residential treatment for elders, and four MCOs identified a gap in specialized housing for people with serious mental illness and co-morbidities.

MCOs reported availability of outpatient services, although less so in the rural areas. However, the expertise of practitioners to deal with specialty populations was generally lacking. Access to evidence-based practices for certain conditions such as post traumatic stress disorder, cognitive impairment, personality disorders, and behavioral issues is limited. Half of the MCOs indicated a shortage of therapists for people with developmental disabilities and concurrent mental health and/or AODA issues.

Utilization of specialty services such as Community Support Programs (CSP) and Crisis Programs are varied. MCOs and counties continue to develop their working relationships and define respective roles and responsibilities for shared clients. A number of rural counties are not interested in hiring additional staff to serve the small number of people the MCO may refer for CSP, since this would not be cost effective for the county. Many MCO members with mental health/substance abuse needs do not qualify for CSP even though their mental health needs require intense case management beyond outpatient treatment.

MCO utilization of county crisis programs is also varied. Some MCOs purchase crisis beds when the county has that capacity. Four MCOs identified the lack of crisis beds for people with developmental disabilities as a gap they need to address. All of the MCOs identified a need for alternative crisis processes for people with dementia and/or people with aggressive behaviors that cannot use regular crisis beds in order to divert these members from inpatient hospital settings. Mobile Crisis was an identified need by some MCOs, particularly for people with

developmental disabilities where such a team could provide effective intervention and people could stay in their homes.

One of the major growth areas identified by eight of the MCOs for 2011 is the development of peer specialists. There is a great interest among MCOs in developing this resource for their members. MCOs will continue to work with key stakeholders such as independent living centers (ILCs) and training providers to increase the availability of peer specialists. Traditionally MCOs only provide in-house care management so the challenge is to create agencies (such as ILCs) that will employ peer specialists statewide that MCOs can contract with for their members. The MCOs have indicated that they would require peer specialists who have knowledge of people with other disabilities, and who also have knowledge of Wellness Recovery Action Planning (WRAP).

Internal Resources

Six of the ten MCOs have specialized mental health/substance abuse teams for their members with those needs. In addition, four of the MCOs contract with psychiatrists and/or gero-psychiatrists for consultation and nine of the MCOs have an in-house or contracted consultant in behavioral support planning for people with challenging behaviors.

Training at all of the MCOs has been extensive. Training has included sessions on personality disorders, dementia, crisis intervention with local police, motivational interviewing, and gerontology and mental illness.

MCOs intend to focus improvement efforts on some of the gaps identified, including:

- Creation of more specialty teams, or develop specialty teams in the MCOs that do not have this resource;
- Establish or expand external collaborative relationships with the existing mental health and substance abuse system;
- Develop peer support capacity;
- Integrate evidence-based practices in the Family Care benefit package;
- Establish workgroups on mental health/substance abuse;
- Train providers in mental health/substance abuse best practice treatment planning; and
- Improve quality management of mental health and substance abuse services including outcomes definition and outcome measurements.

The Future

The Department will follow up with each MCO to review the site visit assessment results and to establish a plan for improving overall mental health services and supports. The OFCE Mental Health and Substance Abuse Services Specialist will work with each MCO, and other resources, on system enhancement and improvement, and will continue to provide technical assistance and consultation to accomplish each MCO's goals.