



**COMMUNITY HEALTH PLAN**  
of Washington

*Committed to your health.*

# **GA-U Mental Health Pilot Interim Evaluation**

Prepared: June 30, 2008

## GA-U Mental Health Pilot Interim Evaluation

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## I EXECUTIVE SUMMARY

At the direction of the Washington State Legislature, Community Health Plan was contracted in 2004 by DSHS to manage the General Assistance – Unemployable (GA-U) medical pilot program in King and Pierce Counties. In 2007, the Legislature allocated \$3.4 million to fund a companion pilot program integrating new mental health services with existing primary care services for GA-U clients.

The GA-U Mental Health Pilot aims to:

- Improve health and behavioral health care and outcomes for GA-U clients in King and Pierce Counties; and
- Reduce utilization of emergency rooms and other acute care resources, as well as overall medical costs.

The GA-U Mental Health Pilot has enrolled and provided services to over 1,000 clients in the first 6 months.

Community interest in, and support of, this project is unprecedented. This has been demonstrated in numerous ways, including: the leadership provided by the Advisory Steering Committee, comprised of representatives from an array of interested agencies and organizations; the partnerships with Community Health Centers, Community Mental Health Agencies, King County Regional Support Network and the University of Washington; the receipt of matching funds (both direct and in-kind); and general interest in expanding the pilot to additional counties.

This report will review the background, funding and structure of the GA-U Mental Health Pilot and examine Phases I and II of the implementation and launch of the pilot. In addition, it will analyze data collected on the first 1,000 enrollees and discuss challenges and direction for moving forward.

This report serves as a companion piece to the accompanying *GA-U Mental Health Pilot Implementation Monthly Report* prepared by the Center for Healthcare Improvement for Addictions, Mental Illness, and Medically Vulnerable Populations (CHAMMP), which provides an in-depth review of enrollment, use of screening tools, referrals and follow-up contacts.

In summary, Community Health Plan is pleased to submit this report to HRSA. We are proud of the work that our partnering organizations have accomplished in a short period of time to bring mental health services to over 1,000 GA-U clients who otherwise would have gone without. This report and the companion CHAMMP report highlight areas of potential improvement, including protocol refinements, ongoing training/communication, increased use of screening tools and improved follow-up contact rates. We will continue to strive to perfect the pilot to achieve the pilot aims of improving physical and behavioral health while reducing overall medical costs.

### II BACKGROUND – THE GA-U MEDICAL PILOT

In December 2005, Community Health Plan launched a pilot program in King and Pierce Counties to provide Medicaid medical benefits under a managed care framework to the General Assistance – Unemployable (GA-U) population. The goal of the “GA-U Medical Pilot” is to maintain clinical quality while saving money relative to the non-managed care fee-for-service (FFS) system, and thereby preserve the state funded entitlement of medical benefits to this vulnerable population.

The GA-U Medical Pilot has proven successful in a relatively short time frame. Initial discontent expressed by long-standing GA-U FFS clients who were forced to follow managed care protocol (eg, choose a primary care provider, obtain a referral for specialty care) was followed by significant medical savings with no reported or demonstrated degradation in clinical quality. As a testament to the success of the pilot, DSHS/HRSA and Community Health Plan are exploring the idea of expanding the GA-U Medical Pilot to other counties.

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### III BACKGROUND – THE GA-U MENTAL HEALTH PILOT

One challenge encountered early in the GA-U Medical Pilot was that primary care clinics were generally under-equipped to adequately deal with the significant mental health issues prevalent in the GA-U population, for two reasons: 1) care for complex mental illness is generally beyond the scope of a primary care provider (PCP), and 2) Medicaid benefits afforded the GA-U population do not include care for mental health issues. That is, neither Community Health Plan nor its providers are paid to treat mental health conditions under the GA-U Medical Pilot.

In an attempt to raise awareness of and address the unmet mental health needs of the GA-U population, Community Health Plan convened a “Mental Health Summit” in November 2006. Over 100 experts and leaders participated from a broad range of organizations representing state agencies, the Washington State Legislature, Community Health Centers, Community Mental Health Agencies and other community stakeholders.

At the Summit, Community Health Plan distributed a “Pilot Project Proposal” outlining a two-tier model as a recommended approach to addressing the mental health needs of the GA-U population.

- The first tier, referred to as “Level 1,” involves primary care clinic-based Care Coordinators (CCs) who screen GA-U enrollees for the presence of mental health conditions, provide counseling services, coordinate care with medical providers, and make referrals to “Level 2” (see below) as well as to ancillary service providers (e.g., chemical dependency counseling, vocational rehabilitation)
- The second tier, referred to as “Level 2,” involves Case Management staff at mental health specialty clinics that provide high-intensity mental health treatment to the most complex enrollees.

The proposal included two cost options: Option A – a higher level of service estimated to cost \$2.5 million per year; and Option B – a scaled back program estimated to cost \$1.9 million per year.

The overwhelming level of community and state agency support played a significant, if not definitive, role in the 2007 legislative session wherein the Legislature drafted and approved a budget proviso allocating \$3.8 million over two fiscal years to fund the development and implementation of a mental health add-on to the existing GA-U Medical Pilot, consistent with Option B from the Pilot Project Proposal.

On September 10, 2007 Washington’s Department of Social and Health Services (DSHS), Health and Recovery Services Administration (HRSA) and Community Health Plan executed DSHS Contract Number 0712-25787 marking the start of the “GA-U Mental Health Pilot.”

### IV FUNDING

The Legislative budget proviso allocated \$3,377,000 of state money, with a required match (direct and/or in-kind) equal to 1/9<sup>th</sup> of the state allocation (i.e., \$375,222), for a grand total funding level of \$3,752,222 over FY 2008 and FY 2009.

Total funding available from HRSA for FY 2008 equals \$1,688,000. Total funding available from HRSA for FY 2009 equals \$1,689,000.

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## V CONTRACTING STRUCTURE

Community Health Plan holds the contract with HRSA to be the administrator of the GA-U Mental Health Pilot.

However, in keeping with the spirit and community-level engagement under which the pilot came to fruition, Community Health Plan subcontracts with and relies upon key partner organizations:

1. The University of Washington, Department of Psychiatry (UW) played an instrumental role in designing the tiered delivery model, and developing and maintaining the Mental Health Integration Tracking System (MHITS) which is being used by all Level 1 and Level 2 providers to track services and outcomes.<sup>1</sup> In addition, the UW provides ongoing psychiatric consultation to the Level 1 providers, pilot training, and program oversight.
2. Community Health Centers (CHCs) of King and Pierce counties (HealthPoint – formerly CHCs of King County, Sea Mar, Puget Sound Neighborhood Health Centers, International Community Health Services, Country Doctor, and Community Health Care) and the primary care clinics of Harborview Medical Center are the entry points to the pilot for GA-U enrollees. It is within these sites that the Level 1 Care Coordinators provide risk screening and care coordination services.
3. The King County Regional Support Network (RSN) maintains a contracted network of Community Mental Health Agencies (CMHAs) who provide the Level 2 specialty mental health services to pilot participants in King County. In Pierce County, staff at Greater Lakes Mental Healthcare provides the Level 2 services.

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<sup>1</sup> MHITS was adapted from the tracking system used by the “IMPACT” model. The IMPACT model is an evidence- and outcomes-based stepped-care model designed to support the integration of mental health services in the primary care setting. This model has previously been tested primarily with depressed patients. The MHITS adaptation included expanding the model to serve clients with a wider range and complexity of mental health conditions.

### VI ADVISORY STEERING COMMITTEE

The collaborative process that engendered the GA-U Mental Health Pilot persists today in the form of a 30-person Advisory Steering Committee, convened by Community Health Plan, with representation from CHCs, CMHAs, DSHS, DVR, DASA, CSOs and other community stakeholders. The Advisory Steering Committee helped shape the implementation and continues to meet regularly to provide invaluable guidance. The committee identifies and addresses barriers, questions needing resolution, opportunities for collaboration and efficiency improvement. In addition, the Advisory Steering Committee has started to review initial data collected through MHITS and make recommendations on how to improve GA-U client care. The committee has also been involved in the development of the pilot evaluation being completed by the Research and Data Analysis (RDA) Division of DSHS and the UW Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations (CHAMMP).

We anticipate that, under the guidance of the Advisory Steering Committee, the pilot will create much more effective connections between different service providers, resulting in improved care and outcomes for clients and improved efficiency across the system.

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## VII IMPLEMENTATION AND LAUNCH

The implementation timeline was aggressive. The budget proviso was approved in April 2007. By mid-July 2007 HRSA and Community Health Plan came to the understanding that Community Health Plan would administer the pilot as a direct extension of the GA-U Medical Pilot.

The contract between DSHS/HRSA and Community Health Plan (CHP) was finalized November 10, 2007. Prior to enrollment of the first GA-U client, contracts between CHP and the majority of Level 1 and Level 2 partner organizations were finalized, and staff were hired and trained.

The first GA-U clients were screened by Level 1 providers the last week of December 2007. The MHITS system was adapted and officially launched with Level 1 functionality on January 4, 2008.<sup>2</sup>

At the end of January 2008, Level 2 functionality launched in MHITS and the first referrals of GA-U clients to Level 2 were made.

Community Health Plan completed all activities described in the DSHS contract as "Systems Development (Phase I)," including the following:

1. Convened an Advisory Steering Committee of community stakeholders, including Community Health Center staff, Community Mental Health Agency providers, chemical dependency providers and others who provide services to the GA-U population. The Advisory Steering Committee reviewed and approved plans for project implementation and continues to advise Community Health Plan on coordinating GA-U client care, including an outline of working relationships among community service providers.
2. Assigned a GA-U behavioral health primary point of contact for the department.
3. Developed protocols for screening, referrals, and coordination among CHCs and CMHAs. These protocols have also been published in a Care Coordinator Handbook.
4. Developed and executed grants and/or contracts to fund the hiring of the CHC-based Level 1 Care Coordinators.
5. Developed and executed grants and/or contracts with the King County RSN and Greater Lakes Mental Healthcare to fund Level 2 services.
6. Developed and implemented policies and procedures, along with Level 2 agencies, regarding the maximum amount of monthly Level 2 services. A modified 3A benefit (based on the King County RSN benefit structure) was agreed upon and has been outlined in the Care Coordinator Handbook and in a Level 2 Frequently Asked Questions document.

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<sup>2</sup> The implementation of Level 2 services in King and Pierce Counties are slightly different due to the diverse mental health infrastructure and relationships. In King County Community Health Plan holds a contract with the RSN and in Pierce County with Greater Lakes Mental Healthcare.

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7. Developed a system that shall optimize but not exceed, available contractual and matching funding for the behavioral health component. This included working with the RSN and Greater Lakes Mental Healthcare to allocate the appropriate amount of Level 2 slots to each Community Mental Health Agency. The ability to track the number of available slots and maintain a waitlist of referrals using MHITS was also developed.
8. Provided training to Care Coordinators prior to service provision and on an ongoing basis, as needed, throughout the pilot. Initial trainings were conducted in October and November of 2007 (10/19/07 and 11/29/07), with additional MHITS trainings in January and February of 2008 and on an ongoing basis, as systems modifications are made. In addition, Care Coordinator and Level 2 Case Manager roundtable trainings were held in April and June 2008, to share ideas, challenges and best practices, and to discuss potential MHITS enhancements. Care Coordinators have expressed that they find these trainings highly valuable and as one of the highlights of the pilot. In addition, they have requested that Level 1 and Level 2 continue to meet for trainings on a quarterly basis.
9. Developed methods to collect project data in a standard format by generating monthly reports out of MHITS.
10. Developed methods to assure quality of service provision, including ongoing monitoring by Community Health Plan's core monitoring team, the Advisory Steering Committee and through the evaluation conducted by RDA and CHAMMP.

Between launch and the present Community Health Plan has completed all activities described in the DSHS contract as "Service Provision (Phase II)," including the following:

1. Risk Screening – Prior to the provision of services, GA-U clients are screened and assessed in order to determine eligibility for, and the appropriate level of, behavioral health services (i.e. Level 1, Level 2 or referrals to Chemical Dependency or Vocational Rehabilitation).
2. Provision of Care – After the risk screening is completed the GA-U enrollee receives services either at Level 1 or Level 2, if appropriate. At Level 1, administered in the primary care setting, the Care Coordinator provides brief evidence-based behavioral health services and care coordination as appropriate to facilitate receipt of other needed services (i.e. GA-X, Chemical Dependency, Vocational Rehab and recertification of the GA-U benefit). Level 2 provides more intensive behavioral health services.
3. Psychiatric Consultation – The University of Washington consulting psychiatrists are available to both Care Coordinators and PCPs on a regular basis, either by telephone or in person. The psychiatric consultant can provide assistance with patient assessment, medication management and treatment planning.
4. Provider Training and Support—In addition to the Care Coordinator (CC) and MHITS trainings, the University of Washington and other experts in the field have offered trainings to both CCs and PCPs on the following:
  - Co-occurring Disorders

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- Problem-Solving Treatment
  - SOAR training, focused on transitioning GA-U clients to GA-X and SSI
  - Motivational Interviewing
  - Dealing with Psychiatric Emergencies
  - Personality Disorders and Difficult Patients
  - Supporting Medication Therapy
5. Project Oversight – Community Health Plan reports on the items under Phase I and Phase II on a monthly basis in the progress report to DSHS/HRSA.

July 1, 2008 will mark the beginning of Phase III, "Ongoing Service Provision."

Community Health Plan has fulfilled Section 5 of the DSHS contract, including:

1. Monthly reports containing:
  - Names of enrollees who have been screened for behavioral and chemical dependency issues.
  - Names of enrollees receiving case management and other behavioral health services from the CMHA, and types of services provided. (Please note: these data are reported on a lagged basis.)
  - Names of enrollees who received care coordination services through the primary care sites.
  - An update on matching fund contributions.
2. A Project Oversight Plan.
3. A Project Update.
4. An Interim Evaluation.

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## VIII STATUS

Level 1 Care Coordinators and Level 2 Case Managers have been trained to track client progress and outcomes in the Mental Health Integrated Tracking System (MHITS).

### Enrollment Statistics - Disclaimer

Enrollment reporting is highly sensitive to the date on which enrollment statistics are pulled from MHITS.

The analyses reported on in this document were performed on different days throughout the month of June by different parties involved in this pilot. While it would be ideal for all of the analyses to have been based on a single analytic dataset, that was not feasible given the number of parties involved and the short time frame.

The table below lays a framework for the enrollment statistics referenced at various points in this report.

Date Data Pulled from MHITS	Total Enrollees	Use/Analysis Discussed Below
June 2, 2008	915	Community Health Plan Monthly Progress Report to HRSA for May 2008
June 12, 2008	1,005	UW/MHITS analysis for June 17, 2008 Care Coordinator and Case Manager Training Session
June 30, 2008	1,086	MHITS Snapshot pulled strictly for this report

### Enrollment Statistics

As of June 2, 2008, Level 1 Care Coordinators had enrolled 915 GA-U clients in MHITS in King and Pierce counties. Looking at the current status of those 915 GA-U clients: 348 were enrolled in Level 1; 211 were referred to Level 2; 145 were discharged (i.e. treatment completed, non-compliant with treatment, lost eligibility or transitioned to GA-X / SSI); 116 were ineligible for Level 1 (i.e., had low scores when screened and did not qualify); and 95 were not yet assigned to either level (ie, members whose clinical assessments have not been completed).

The number of enrolled GA-U clients varies across Level 1 sites due to the number of allocated Care Coordinator units (allocations are based on the total number of GA-U clients assigned at each site). HealthPoint (formerly CHCKC) has three allocated units, the highest of all sites. Community Health Care, Harborview Medical Center and Puget Sound Neighborhood Health Centers all have two allocated units. Country Doctor and Sea Mar have one allocated unit, while ICHS has one-half of an allocated unit.

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Please see the accompanying *GA-U Mental Health Pilot Implementation Monthly Report* prepared by the Center for Healthcare Improvement for Addictions, Mental Illness, and Medically Vulnerable Populations (CHAMMP), for an in-depth review of enrollment statistics, as well as use of screening tools, referrals and follow-up contacts.

### Matching Funds

As previously mentioned above \$375,222 in matching funds (including both direct and in-kind contributions) are required. Matching funds received to date total \$564,261 and include: \$20,790 in direct funds from United Way of Pierce County's Healthcare Access Team; \$65,000 in direct funds from the Mental Health Transformation Grant; \$75,000 in direct funds from United Way of King County; and \$188,913 (November 2007- June 2008) and \$214, 558 (July 2008- June 2009) in in-kind contribution from the University of Washington.

In addition, an application by a consortium led by Community Health Plan, and comprised of King County Community Health Centers, Harborview Medical Center and Public Health Seattle-King County to King County's Veterans and Human Services Levy has been approved. Funding is expected to be approximately \$500,000 per year over four years, the majority of which will go toward expanding services for GA-U clients (the balance will be dedicated to uninsured adults).

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### IX INTERIM EVALUATION - CHAMMP

Under Section 5 of the DSHS contract, an interim evaluation is to be developed and conducted jointly by CHP and DSHS or a mutually agreed third party based on measures calculated from data sources readily available to both parties.

The matching funds provided by The Mental Health Transformation Grant have been allocated to the Research and Data Analysis (RDA) Division of DSHS to perform an evaluation of the GA-U Mental Health Pilot.

RDA devoted a portion of the funds for a subcontract with the University of Washington's Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations (CHAMMP) for the interim evaluation required by the DSHS contract.

The CHAMMP report tracks the progress of program implementation, based on the data readily available in MHITS. Please see the accompanying *GA-U Mental Health Pilot Implementation Monthly Report*.

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### X INTERIM EVALUATION – UW/MHITS

Additional data less readily available in MHITS, prepared and analyzed by the University of Washington, provide interesting insight into the types of GA-U clients being served.

The analysis below was presented at the June 17, 2008 Care Coordinator and Case Manager Training using the data recorded in MHITS.

As of June 12, 2008, 1,005 patients have been enrolled in the GA-U Mental Health Pilot.<sup>3</sup> The three tables below contain a preliminary demographic snapshot of the first 1,000 enrollees and a summary of their diagnoses.

<b>Demographics</b>	<b>Number/Percentage</b>
Mean Age	42 (range across sites 19-65)
% male	55% (range across sites 48-67%)
Problems with housing	22% (range across sites 6-52%)

<b>Diagnoses in Level 1</b>	<b>Number/Percentage</b>
Depression	635
Anxiety	309
Substance Abuse/ Chemical Dependency	143
Bipolar Disorder	104
PTSD	100
Psychotic disorder	22
Cognitive disorder	7
Chronic pain	67
Rule out axis II	37
Other	30

<b>Top Three Level 2 Diagnoses</b>
Depression
Bipolar Disorder
PTSD

#### Initial data from MHITS show the following challenges:

- There are very few referrals to GA-X, DVR and chemical dependency treatment that are being captured in the MHITS system, but this is improving. 30% of clients are currently being screened for chemical dependency using the GAIN-SS (a chemical dependency screening tool).

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<sup>3</sup> This number differs from the June 2, 2008 figure of 915, reflecting an additional week's worth of enrollment activity.

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- The data indicate high baseline depression and anxiety scores, demonstrating that the symptoms of the population enrolled are quite severe, telling us that this is a challenging population to engage in treatment.
- The number of follow-up appointments is relatively low, indicating a need to focus in the second fiscal year on improving the number of follow-up appointments, either in clinic or by phone.
- The number of medications being documented and tracked is low, indicating a need to streamline the protocol to improve tracking of medications in MHITS and a need to make tracking and effective communication about psychotropic medications used a major quality improvement focus for the project.
- The UW consulting psychiatrists are being utilized about 25% of the time. This is less than the available capacity indicating that a focus for the second fiscal year should be on better advertising the availability of the psychiatrists in order to increase utilization of their services for clients who are not improving as expected.
- Thus far, about 25% of clients are substantially improved after 10 weeks or more. This is a measure that will be watched closely in the second fiscal year as sites move from the ramp-up phase to steady state. Increasing the follow-up rate, the quality of medication tracking and adjustment (if needed) and use of consulting psychiatrists should all play a role in facilitating treatment changes for clients who are not improving over time.
- MHITS connection and response speed has been slow for staff at some sites.

### Future Direction

- Several “best practices” are emerging at various sites. These successes should continue to be shared through roundtable discussions and additional staff trainings (for Care Coordinators, Case Managers, PCPs and other staff).
- New updates to MHITS will prompt referrals to chemical dependency treatment, DVR and GA-X, to ensure that all referrals are being captured. In addition, trainings with DASA, DVR and the CSO are taking place to educate Care Coordinators about the referral process.
- New updates to MHITS will prompt care coordinators to enter medication information.
- Workflows will be evaluated. For example, in clinic versus by telephone sessions and the differential use of staff roles to improve the number of follow-up contacts will be explored.
- A goal has been set to increase psychiatric consultation usage from 20% of the total care coordinator caseload and to roughly 50%. To help facilitate this, the UW psychiatric consultants will increase their capacity to provide such consultations by 0.2 FTE in the coming year.
- Improvements will also be pursued in the interface between Levels 1 and 2, to better understand the types of services provided at each level in order to optimize use of services and coordination of care between the two levels.

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### XI INTERIM EVALUATION – COMMUNITY HEALTH PLAN

While the aforementioned CHAMMP report satisfies the contractual requirement for an interim evaluation, Community Health Plan felt it important to document additional issues in this GA-U Mental Health Pilot Interim Evaluation.

Community Health Plan's core monitoring team meets on a weekly basis to track progress and address issues as they arise. Monitoring reports were sent out to each Level 1 site in March and May 2008 to provide updates on enrollment and caseload statistics. Follow-up meetings with each site were held in April and June 2008 to discuss feedback on any problems/barriers that the sites are facing in implementing protocol and/or in ramping up to mature capacity levels. In addition, weekly meetings with the University of Washington, monthly meetings with the RSN and monthly Advisory Steering Committee meetings contribute to the monitoring process and the results are reported to HRSA in a monthly progress report.

Original caseload projections were set at 150 GA-U clients per unit, where a unit represents \$50,000 in annual funding provided to a Level 1 site. Based on the activities described immediately above, it is clear that that projection was too high for several reasons:

- While monthly caseload increases have been steep, many Level 1 sites are experiencing high no-show rates and difficulties recruiting GA-U clients.
- Some sites have had difficulty hiring and/or allocating caseloads to the appropriate staff.
- Across the primary care sites, five different electronic medical record (EMR) systems are in place. Care Coordinators are required to enter data for an encounter into both their respective EMRs as well as MHITS, causing a necessary but burdensome administrative workload.
- As mentioned above, the population has exhibited a higher intensity case mix than expected. Care Coordinators are spending much of their time with more severe cases, leaving little time for outreach.

While the caseload is expected to continue to increase, Community Health Plan believes caseloads may need to be adjusted downward to more closely reflect actual utilization of budgeted resources. Expectations in caseload increases will also be balanced against a focus, in the second year of the pilot, on increasing follow-up contact rates for those already enrolled, as pointed out in the CHAMMP report.

#### Notes from the Field

Despite those challenges, positive feedback has been received from Care Coordinators, Case Managers and clinical supervisors on the benefits of the pilot. Below are a few examples:

- A behavioral health specialist at a Level 1 site was excited to see that a client she had evaluated was referred to Level 2. The client had already been seen by a Level 2 psychiatrist and has had several housing and other referrals. The client was recently approved for GA-X

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and the Level 2 Case Manager is working on getting an outpatient mental health benefit (through the RSN).

- After looking at the Level 2 contact notes in MHITS, one Care Coordinator was happy to learn that her client (who has been diagnosed with schizoid personality) had completed several sessions with the Level 2 Case Manager. The client, who is homeless and has been visiting the clinic for 12 years, is now enjoying staying at a shelter despite being previously opposed to the idea. The Case Manager is continuing to put him on the shelter list each morning.

- A Level 2 Case Manager wrote:

*"I just wanted to share with you a recent success with our client. With his permission, I have been in contact with his older sister in eastern Washington, keeping her updated on his current situation and his safety. The client finally gave me permission to invite her to a session.... The 3 adult children (also estranged) will be next, but that will probably happen after we conclude our work together (which is what we want for our clients, the opportunity to practice skills on their own!)..."*

*I have also shared his progress/success with his Adult, Elder and Residential Services Case Manager and his HUD Case Manager at the...apartment that we were able to get for him. He has really bonded with his HUD CM and she was delighted to hear of his progress. His apartment will be ready in a couple of days; he is definitely ready for this new, independent chapter in his life.*

*I have hooked him up with an employment specialist at Goodwill, who places individuals 55 and older in the community for job training/work. This is a government supported program, so he can earn money on top of his GA-U benefit. He is really looking forward to having his life back, earning some money, having his own place, and having some honor and dignity in independent living."*

- When asked "What do you like best about the GA-U Mental Health Pilot?" one Care Coordinator replied, "Training opportunities have been excellent...Outcome based treatment and psychiatric consult has been excellent! The opportunity to serve the clients who have desperate need." Another Care Coordinator commented that, "[The GA-U Mental Health Pilot] is reaching a community that needs this support and the MHITS tracking system allows us to see clear progress and areas that need attention." One Level 2 Case Manager responded, "Collaboration with mental health care providers and medical staff etc (DSHS/DVR housing etc). Great population to serve! Challenging but gritty and appreciative. Useful trainings."

In summary, Community Health Plan is pleased to submit this report to HRSA. We are proud of the work that our partnering organizations have accomplished in a short period of time to bring mental health services to over 1,000 GA-U clients who otherwise would have gone without. This report and the companion CHAMMP report highlight areas of potential improvement, including protocol refinements, ongoing training/communication, increased use of screening tools and improved follow-up contact rates. We will continue to strive to perfect the pilot to achieve the pilot aims of improving physical and behavioral health while reducing overall medical costs.