



Persons with Serious Mental Illness and Medical Co-Morbidities

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for the treatment of Persons with Serious Mental Illness (SMI) and Medical Co-Morbidities. In addition, the CPG outlines the organizations that WellCare aligns with regarding this topic and relevant Measureable Health Outcomes.

OVERVIEW

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 shown 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

Hierarchy of Support

GUIDELINE HIERARCHY

CPGs are updated annually 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's *Practice Guideline for the Treatment of Patients with Bipolar Disorder, Second Edition* (2002). The guideline provides recommendations to help psychiatrists develop plans for the care of adult patients with bipolar disorder. Part A discusses the treatment recommendations for those with bipolar disorder. Sections focus on main treatment recommendations, a guide to the formulation and implementation of a treatment plan for the individual patient, and a range of clinical considerations that could alter the general recommendations discussed earlier in Part A. Part B provides background information and a review of available evidence; this details evidence underlying the treatment recommendations of Part A. Also included in Part A is an overview of DSM-IV bipolar disorder criteria, features of the disorder, and general information on its natural history, course, and epidemiology. Part B ends with a structured review and summary of published literature regarding available treatments. Future research needs conclude the *Practice Guideline* (Part C) with a summary of the previous sections with respect to helping providers improve clinical decisions.²

WellCare also adheres to the *Guideline Watch* (2005), an update of the 2002 guideline. The 2005 publication discusses controlled treatment studies of second-generation (atypical) antipsychotics as monotherapy and as adjunctive treatment (with more traditional mood stabilizers) for the acute treatment of mania, studies of antiepileptic agents for the acute treatment of mania, trials for three medications for the acute treatment of bipolar depression, four monotherapy and one combination therapy relapse prevention studies, and studies of psychosocial interventions for maintenance.³

Both the full *Practice Guideline* and the *Guideline Watch* can be accessed at <http://psychiatryonline.org/guidelines>.

Evidence Based Practice

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The Agency for Healthcare Research and Quality (AHRQ) has not published reports on this topic.

MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Quality Improvement*.

NOTE: To access Clinical Policy Guiding Documents visit www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

Care Management

Seventeen percent of the adult population in America has a comorbid mental and medical condition, with 68% of adults with a mental disorder having at least one medical disorder and 29% of those with a medical disorder having a comorbid mental health condition.⁴ People with serious mental illness have increased mortality rates than the general population with the leading cause of death of this population being cardiovascular disease which is often the result of obesity, metabolic syndrome and diabetes. Mortality from cardiovascular disease is 2-3 times as high among this population as the general population and people with SMI die as much as 15 – 25 years younger than the general population. Due to problems such as inadequate access to quality care, poor lifestyle choices and the association between antipsychotic medications and weight gain, this population have worse outcomes than the general population. Weight-neutral or weight-reducing medications, behavioral weight management programs and coordinated psychiatric and somatic treatment can reduce the effects of CVD in this population. Suicide and accidents are the second and third leading cause of death in this population, behind heart disease. Obesity, HTN, diabetes, and COPD are the most prevalent comorbidities, which are all risk factors for cardiovascular death. Some psychiatric disorders may also predispose individuals to glucose intolerance.⁵

MEASURABLE HEALTH OUTCOMES

Targeted Case Management outcomes (**Extended Program Goals**) result from successful self-management (see Case Management Objectives).

- **Symptoms:** (For prediabetic and Diabetic) Member will check and log blood glucose as prescribed by provider and share log with provider resulting in glucose levels 80-120 before meals >80% of the time as evidenced by provider or member/caregiver report
- **Symptoms:** Member will check and log BP daily and share with provider with BP results <140/90 >80% of the time as evidenced by member written report or provider report
- **Engagement:** Member will maintain a healthy diet and exercise regimen resulting in HbA1C less than 7% as evidenced by lab results or provider report
- **Engagement:** Member will engage in physical activity for at least 30 minutes a day >80% of the time as evidenced by member self-report or activity log
- **Engagement:** (For smokers) Member will reduce smoking by one cigarette a day resulting in smoking less than half a pack a day as evidenced by member or caregiver report
- **Adherence:** Member will adhere to a (low fat, low salt, low cholesterol, low carbohydrate) diet as recommended by physician resulting in LDL <70 as evidence by lab results or provider report
- **Adherence:** Member's prescription refills for (statins, ASA, beta-blockers, other) will demonstrate at least an 80% adherence rate as evidenced by pharmacy claims
- **Adherence:** Member will adhere to diet and exercise recommendations resulting in 5% weight loss as evidenced by weight log or provider report
- **Utilization:** Member will attend scheduled PCP appointments >80% of the time as evidenced by medical claims or provider report

CASE MANAGEMENT GOALS

Goals should target specific care gaps and/or adherence issues, and measure the member's progress towards self-management and adherence which lead to the targeted health outcomes above.

- **Symptoms:** Member will verbalize 3 adverse reactions and side effects of prescribed antipsychotic medications including cardio metabolic risks if indicated
- **Engagement:** Member will have a Safety/Crisis Plan in place for suicidal ideations
- **Engagement:** Member will verbalize at least 2 ways to increase physical activity by 10 minutes a week to at least 30 minutes a day
- **Engagement:** Member will be connected to smoking cessation programs and support groups if needed
- **Engagement:** Member will be referred to substance abuse programs and support/self-help groups if needed
- **Engagement:** Member will be connected to support or educational groups for medical condition through local medical center or online
- **Engagement:** Member will be connected to community resources such as stable or supportive housing or local mental health organizations such as NAMI

- **Engagement:** Member will verbalize at least 3 healthy foods to eat and at least 3 foods to avoid eating
- **Adherence:** Member will have a review of medications by PCP, psychiatrist and/or pharmacist to see if another antipsychotic should be prescribed to reduce the risk of metabolic syndrome
- **Adherence:** Member will receive annual flu vaccine and pneumonia vaccine at least every 5 years as recommended by physician
- **Utilization:** Member will be connected to Primary Care Home that has integrated Behavioral if possible, or communication between PCP and psychiatrist will be ensured

Specific for Members requiring hospitalization: The Member participates in provider follow-up visit within 7 days of hospital discharge.

CASE MANAGEMENT OBJECTIVES

- Assess for suicide risk including past attempts, plan, intent and access to means
- Educate on the importance of physical activity for mental and physical health and ways to increase physical activity and implement it into daily life
- Use Motivational Interviewing to promote behavioral change with regards to weight management, smoking cessation, self-care etc.
- Educate on the importance of quitting smoking and refer to smoking cessation programs and self-help/support groups
- Encourage social interaction and refer to support groups for medical and mental health conditions and encourage family and friend involvement
- Assess for substance abuse and refer to substance abuse treatment and self-help/support groups if needed
- Educate on heart disease including recommended diet and exercise regimens and recommended screenings
- Refer to resources on stable or supportive housing if needed
- Educate on self-care related to medical condition such as checking BS or BP, diet and exercise, proper hygiene, regular PCP appointments etc.
- Educate on the importance of baseline and continual monitoring of cardio metabolic risks when on antipsychotic medications and educate on adverse reactions to medications including metabolic syndrome
- Encourage HIV screening if indicated
- Ensure member has access to quality healthcare for management of medical condition and is attending appointments and following through with treatment
- Educate on recommended diet for medical condition including how to choose healthy options and incorporate them into lifestyle

MEMBER EDUCATIONAL RESOURCES

WellCare contracts with Krames/StayWell for Member educational materials utilized by Case Managers. Items are available to review with Members to address knowledge gaps. Case Managers verbally educate Members on the topics below related to behavioral health conditions and substance use disorder.

Providers may wish to research the titles above related to pneumonia that Case Managers utilize with Members.

Behavioral Health Conditions and Substance Use in High Risk Pregnancy

- | | |
|---|---|
| • Recognizing the Signs of Substance Abuse in Teens | • Cocaine: Getting Help |
| • When you Suspect Your Child is Using Alcohol or Drugs | • Alcoholism: Getting Help |
| • For Teens: Understand the Cycle of Addiction | • Alcoholism: Resources for Family and Friends |
| • Signs of Addiction: Social Use | • Treating Heroin Addiction |
| • Understanding the Disease of Addiction | • Treating Drug Abuse and Addiction |
| • Understanding Inhalant Abuse | • Treating Inhalant Abuse |
| • Understanding Methamphetamine Abuse and Addiction | • Life After Combat: Coping with Alcohol Abuse |
| • Understanding Marijuana Abuse | • Recovering from Addiction: Continuing with Counseling |
| • Understanding Heroin Abuse and Addiction | • Recovering from Addiction: Coping with Relapse |
| • Addiction: Ask Yourself These Questions | • Recovering from Addiction |
| • Addiction: Getting Help | |

Bipolar Disorder

- Treating Affective (Mood) Disorders
- Treating Bipolar Disorder
- Understanding Affective (Mood) Disorders
- Understanding Bipolar Disorder
- Understanding Schizoaffective Disorder

Schizophrenia

- Treating Schizophrenia
- Understanding Schizoaffective Disorder
- Understanding Schizophrenia
- Understanding Selective Mutism

Substance Use Disorders

- Recognizing the Signs of Substance Abuse in Teens
- When you Suspect Your Child is Using Alcohol or Drugs
- For Teens: Understand the Cycle of Addiction
- Signs of Addiction: Social Use
- Understanding the Disease of Addiction
- Understanding Inhalant Abuse
- Understanding Methamphetamine Abuse and Addiction
- Understanding Marijuana Abuse
- Understanding Heroin Abuse and Addiction
- Addiction: Ask Yourself These Questions
- Addiction: Getting Help
- Cocaine: Getting Help
- Alcoholism: Getting Help
- Alcoholism: Resources for Family and Friends
- Treating Heroin Addiction
- Treating Drug Abuse and Addiction
- Treating Inhalant Abuse
- Life After Combat: Coping with Alcohol Abuse
- Recovering from Addiction: Continuing with Counseling
- Recovering from Addiction: Coping with Relapse
- Recovering from Addiction

PHARMACOLOGY

Atypical antipsychotics can cause metabolic syndrome including obesity, hyperlipidemia and diabetes. Weight gain due to increased appetite and decreased metabolism seems to be the main cause in this, although some studies suggest that the medications can change the tolerance to glucose. In just 10 weeks of treatment, people taking clozapine and olanzapine gained on average 4 kg (8.8 lbs) and those taking risperidone gained 2 kg (4.4 lbs). Atypical antipsychotics also increase the risk of impaired glucose metabolism and diabetes by 1.2 – 5 times. Clozapine and olanzapine also increase serum triglycerides by 30 – 40%. Patients prescribed these medications should be screened for cardio metabolic risks before starting the medications and continually thereafter including HbA1C testing and LDL testing annually. A medication review to see if an alternate antipsychotic can be prescribed should also be completed.⁵

A database of medication guidelines has been developed by the University of South Florida (USF) and is available [here](#). Medications are searchable by childhood or adult disorders.⁷

Related WellCare 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

NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

References

1. National Association of Medical Directors Council published the “Morbidity and Mortality in People with Serious Mental Illness” October, 2006.
2. Practice guideline for the treatment of patients with bipolar disorder (2nd ed.). American Psychiatric Association Web site. <http://psychiatryonline.org/guidelines>. Published April 2002. Accessed June 27, 2018.
3. Guideline watch: bipolar disorder. American Psychiatric Association Web site. <http://psychiatryonline.org/guidelines>. Published November 2005. Accessed June 27, 2018.
4. Druss, Benjamin & Reisinger Walker, Elizabeth. “Mental disorders and medical comorbidity.” The Synthesis Project, Research Synthesis Report No. 21, February 2011. https://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf. Accessed June 27, 2018.
5. Morden NE, Mistler LA, Weeks WB, Bartels SJ. Health Care for Patients with Serious Mental Illness: Family Medicine’s Role. J Am Board Fam Med. 2009; 22(2):187-195. 10.3122/jabfm.2009.02.080059.
6. WellCare Internal Case Management Training. 2015.
7. Florida Medicaid Drug Therapy Management Program for Behavioral Health. University of South Florida Web site. <http://www.medicaidmentalhealth.org/searchGuidelines.cfm>. Accessed June 27, 2018.

Disclaimer

Clinical Practice Guidelines (CPGs) made available by WellCare are informational in nature and are not a substitute for the professional medical judgment of treating physicians or other health care practitioners. CPGs are based on information available at the time and may not be updated with the most current information available at subsequent times. Individuals should consult with their physician(s) regarding the appropriateness of care or treatment options to meet their specific needs or medical condition. Disclosure of a CPG is not a guarantee of coverage and is not intended to be used for Utilization Management Decisions or for claims. Members of WellCare Health Plans should consult their individual coverage documents for information regarding covered benefits. WellCare does not offer medical advice or provide medical care, and therefore cannot guarantee any results or outcomes. WellCare does not warrant or guarantee, and shall not be liable for any deficiencies in the information contained herein or for any inaccuracies or recommendations made by independent third parties from whom any of the information contained herein was obtained. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

*Easy Choice Health Plan – Harmony Health Plan of Illinois – Missouri Care – Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care1st Health Plan Arizona, Inc.) – Staywell of Florida – WellCare Prescription Insurance – WellCare Texan Plus (Medicare – Dallas and Houston markets)
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)*

Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
7/12/2018	<ul style="list-style-type: none"> • Approved by MPC. Inclusion of Pharmacology section with reference to database. Inclusion of member education topics.
8/18/2017	<ul style="list-style-type: none"> • Approved by MPC. Included Care Management section.
3/3/2016	<ul style="list-style-type: none"> • Approved by MPC. Inclusion of APA reference and CPG Hierarchy.
2/5/2015	<ul style="list-style-type: none"> • Approved by MPC. New.

Addendum

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; and Other Mental Health Issue. 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.

<i>Goals and Anticipated Outcomes</i>	
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.