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Mental Health

Collaborative Care in NYS

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What is Collaborative Care

Collaborative Care (sometimes called IMPACT) is the most empirically supported model of behavioral health integration that seeks to treat commonly occurring mental health conditions such as depression and anxiety in the primary care setting.

- Over 80 randomized controlled studies have shown Collaborative Care to be more effective than “usual” care
- Improves not only mental health, but has shown improvements in chronic disease

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5 Pillars of the Collaborative Care Model

1.**Patient-Centered Team Care:** Primary care & behavioral health providers collaborate effectively using shared care plans. More than simply co-location.

2. **Population-Based Care:** Care team shares a group of patients tracked in a **registry**. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation

5 Pillars of the Collaborative Care Model

3. **Measurement-Based Treatment to Target:** Treatment plan articulates personal goals and clinical outcomes are routinely measured. Treatments changed if patients are not improving as expected so patients don't remain in ineffective treatment too long

4. **Evidence-Based Care:** Treatments supported by credible research evidence

5. **Accountable Care**: Providers are accountable and reimbursed for quality of care and clinical outcomes, *not just the volume* of care provided.

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Collaborative Care Process

- Patient screened for Depression with standardized tool (PHQ-2 or 9)
- Screened positive, reviewed by PCP to verify diagnosis; PCP gets patients buy-in for collaborative care
- Hand off to DCM; DCM conducts assessment and establishes treatment plan
- Patient entered into registry and officially ‘enrolled’

Collaborative Care process cntd.

The DCM oversees the patient's progress, provides brief interventions, maintains an up to date record in the registry, and coordinates with the Psychiatrist for case review when necessary, and the PCP to manage medications when appropriate.

NYS Collaborative Care Medicaid Program

- 2013-2014, NYS DOH Medical Home Grant Program estd. CC programs in academic medical centers
- To sustain the progress, OMH launched the Medicaid program in 2015
  - 36 sites currently participating; DOH grant sites and FQHCs
  - Provides a monthly case rate per patient enrolled to participating sites

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DSRIP Learning Network

- DSRIP 3ai, Model 3 sites implementing Collaborative Care
- 18 sites in Learn Network
    - Receive technical assistance and training to learn & implement the CC model
    - Will be eligible for case rate if successful
- **Spread what they've learned to others in network**

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Pay for Performance

Accountability is key!

- Performance metrics data collected
- Payment based on meeting minimum program requirements and performance standards
  - Must have one contact with patient per month
  - One face to face everything 90 days
- 25% Retainage withheld for 6 months
  - Patient must show improvement or have a change in treatment/ review by a Psychiatrist

Data Collection

- Depression Screening Rate
- Positive Screening Yield
- Total program enrollment
- Median PHQ-9 Score
- Active Patients
- Improvement Rate
- Consultation (Case Review) Rate
- Change in Treatment Rate
- Contacts by Phone

Future Directions for Collaborative Care

- Expanding participation in the Medicaid Collaborative Care program
- CMS Proposed Rule to reimburse for Collaborative Care under Medicare in 2017
- Explore ways to adapt the model for small practices
- Focus on ways to increase capacity of behavioral health workforce

Questions?

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