CMO

MONTEFIORE CARE MANAGEMENT

Fulfilling the Promise of Behavioral Health Integration under NYS Health Reform

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Agenda

- Integration Models supported by NYS Health Reform
- Supporting the Journey to Effective Implementation
- Challenge for Sustainability: Potential Innovations

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Rationale for BH Integration

- Global disability
- Worse morbidity and mortality
- $293 Billion additional costs due to MH and SUD co-morbidity to medical disorders (APA/Milliman report, 2014)
- Mental Health Parity
- ACA and focus on increasing value (improve quality and lower costs)
- Medicaid Reform

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Initiative	Brief Description	Accountability metrics

Delivery System Reform Incentive Payment (DSRIP) Program	• Promotes community-level collaborations to reduce avoidable hospital use by 25% over 5 years
	• Project 3.a.i. (Integration of PC and BH services) selected by all PPS statewide
	  • Model 1: co-location
	  • Model 2: reverse integration
	  • Model 3: IMPACT
		• State identified process and performance metrics for the PPS – reward process for providers not well-specified
		• DSRIP Learning Network created to provide TA and training to sites implementing IMPACT – initial reporting of process measures, followed by outcome measures

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DSRIP Challenges for Integration Projects

- Broad variation in models permitted but may not be attainable for many (especially independent practices) because of resource limits
- NYS Quality Measures are NOT directly linked to integration process and outcome measures
- Workforce training and capacity
- Financial sustainability
- PPS leadership and advocacy is critical

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NY SHIP - Overarching Goals

- 80% of the state's population will receive primary care within an advanced primary care (APC) setting, with a systematic focus on population health and integrated behavioral healthcare
- 80% of primary care paid for under a value-based financial arrangement
- Emphasis on integration with possible early steps such as PHQ9 screening, enhanced referral arrangement, CME on integrated care

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SAMHSA-HRSA INTEGRATION FRAMEWORK

MINIMAL COLLABORATION	BASIC COLLABORATION FROM A DISTANCE	BASIC COLLABORATION ONSITE	CLOSE COLLABORATION/ PARTLY INTEGRATED	FULLY INTEGRATED
▸▸ Separate systems ▸▸ Separate facilities ▸▸ Communication is rare ▸▸ Little appreciation of each other's culture	▸▸ Separate systems ▸▸ Separate facilities ▸▸ Periodic focused communication; most written ▸▸ View each other as outside resources ▸▸ Little understanding of each other's culture or sharing of influence	▸▸ Separate systems ▸▸ Same facilities ▸▸ Regular communication, occasionally face-to-face ▸▸ Some appreciation of each other's role and general sense of large picture ▸▸ Mental health usually has more influence	▸▸ Some shared systems ▸▸ Same facilities ▸▸ Face-to-Face consultation; coordinated treatment plans ▸▸ Basic appreciation of each other's role and cultures ▸▸ Collaborative routines difficult; time and operation barriers ▸▸ Influence sharing	▸▸ Shared systems and facilities in seamless bio-psychosocial web ▸▸ Consumers and providers have same expectations of system(s) ▸▸ In-depth appreciation of roles and culture ▸▸ Collaborative routines are regular and smooth ▸▸ Conscious influence sharing based on situation and expertise
"Nobody knows my name. Who are you?"	*"I help your consumers."*	*"I am your consultant."*	*"We are a team in the care of consumers"*	*"Together, we teach others how to be a team in care of consumers and design a care system."*

Overview of Integration Models

- Multiple variations of integration models implemented in a wide variety of settings
  - Implementation approaches largely based on Wagner's Chronic Care Model
  - Apply "Measurement-Based Care" approaches
  - Mostly depression and anxiety disorders in adults
  - Multiple high quality clinical trials demonstrate their effectiveness
- IMPACT most studied Collaborative Care Model
- Ultimately, "integration" is on a continuum
  - Other integration models support alternative ways to implement and support key elements of integrated care

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Study/Model	Description	Key Outcomes
PRISM-E *(**P**rimary Care **R**esearch **I**n **S**ubstance Abuse and **M**ental Health for the **E**lderly)*	• RCT of **co-located model vs. enhanced referral model** • Adults age 65+ in **diverse primary care settings** • Enhanced referral model included **clear referral process** from PCP→BH specialist, with required notification from BH for missed appointments	• Greater treatment engagement among patients in co-located model • In major depression subgroup, better outcomes for enhanced referral despite lower engagement rate
RESPECT-D *(**R**e-**E**ngineering **S**ystems for **P**rimary **C**are **T**reatment of **D**epression)*	• RCT of **integrated model vs. usual care** in **small primary care settings** • Integrated model featured **shared centrally-based care managers**, supervised by shared psychiatrists via weekly telephone contact • 180 clinicians in 60 practices, majority suburban or rural	• Integrated model had significantly better clinical outcomes and more favorable patient responses on quality of care • Feasibility of using shared resources

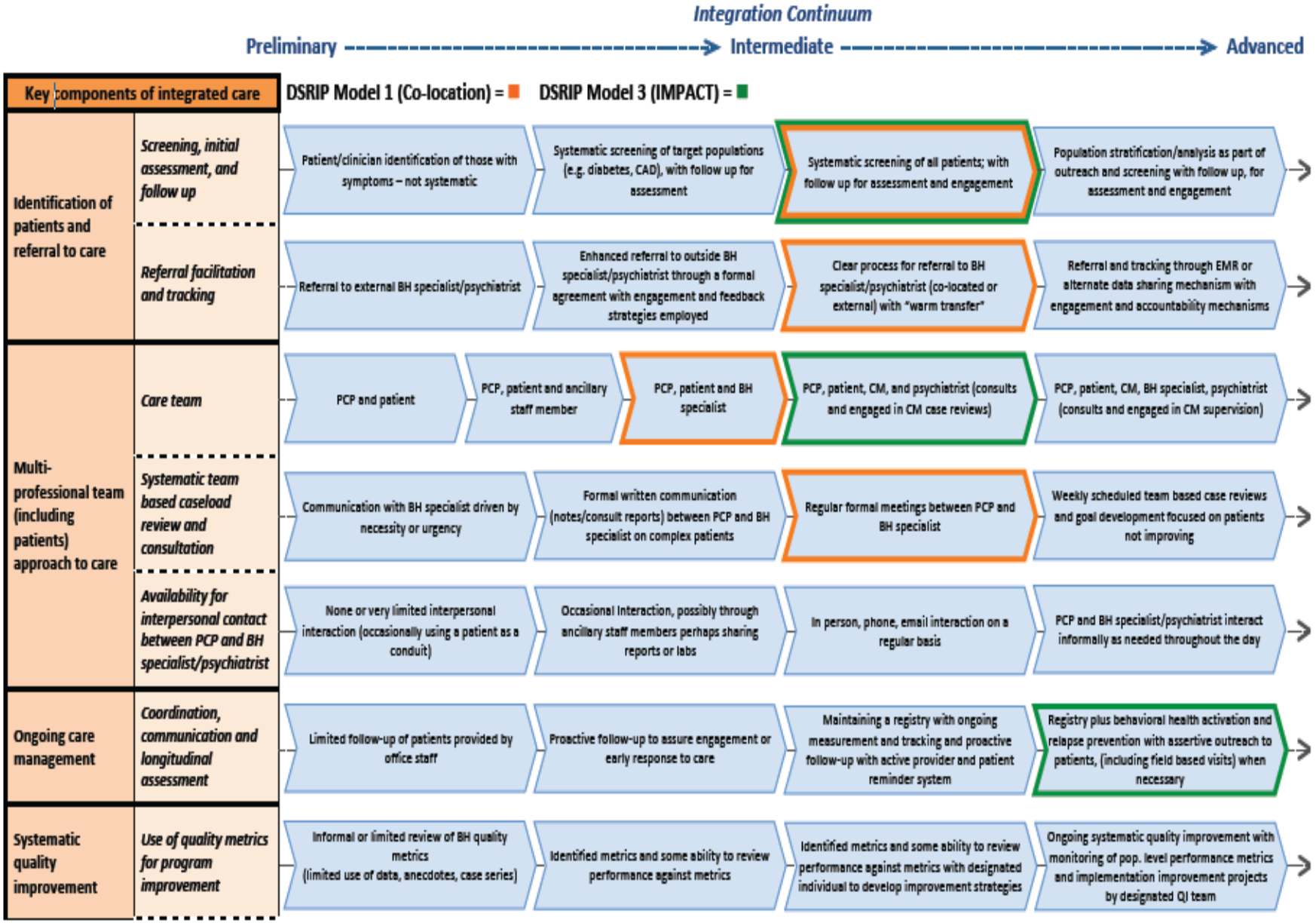
Study/Model	Description	Key Outcomes
Partners in Care	• RCT of **usual care vs. 2 separate QI programs**: QI-meds (enhanced medication management support) and QI-therapy (enhanced resources for psychotherapy) • Both QI programs followed a collaborative care model • PC clinics in 6 managed care organizations in geographically, socioeconomically, and ethnically diverse communities	• Quality of care, mental health outcomes, and employment retention all improved in QI model • Modest investment required for QI initiative implementation
IMPACT *(**I**mproving **M**ood-**P**romoting **A**ccess to **C**ollaborative **T**reatment)*	• RCT of **collaborative care vs. usual care** in **patients aged 60+ with depression** • CC model included: - Care manager and consulting psychiatrist added to care team - Systematic diagnosis and outcomes tracking; stepped care • Diverse health care systems in five states (urban and semi-rural)	• IMPACT doubled the effectiveness of usual care • Effects persisted after the program ended

Several **key components of integrated care** emerge across different models of primary care-behavioral health integration

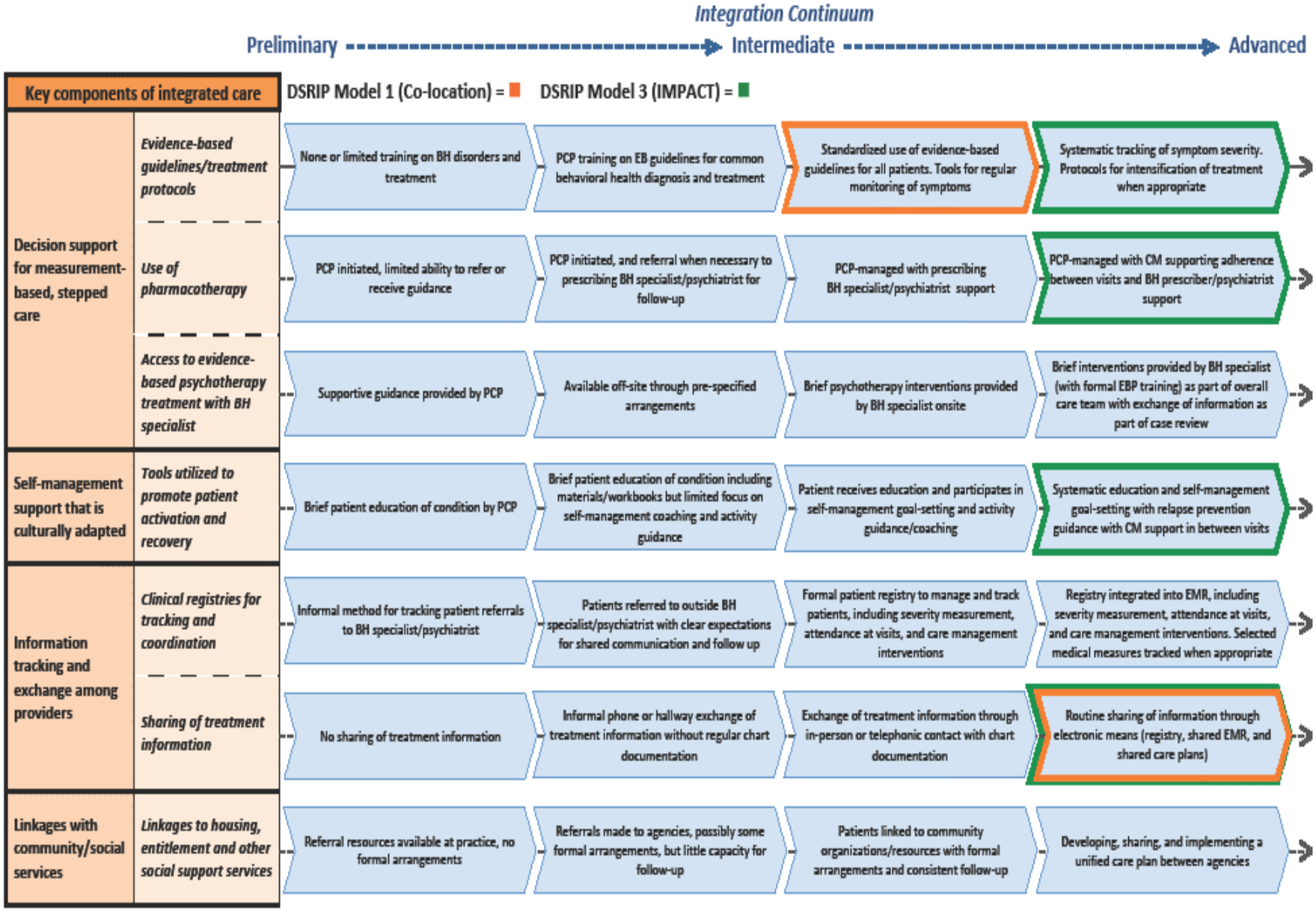
Identification of patients and referral to care	**Screening, initial assessment, and follow up**
	Referral facilitation and tracking
Multi-professional team (including patients) approach to care	**Care team**
	Systematic team based caseload review and consultation
	Availability for interpersonal contact between PCP and BH specialist/psychiatrist
Ongoing care management	**Coordination, communication, and longitudinal assessment**
Systematic quality improvement	**Use of quality metrics for program improvement**

Key components of integrated care - *continued*

Decision support for measurement-based, stepped care	Evidence-based guidelines/treatment protocols
	Use of pharmacotherapy
	Access to evidence-based treatment with BH specialist or PCP/med specialist
Self-management support that is culturally adapted	Tools utilized to promote patient activation and recovery
Information tracking and exchange among providers	Clinical registries for tracking and coordination
	Sharing of treatment information
Linkages with community/social services	Linkages to housing, entitlement and other social support services



Notes: ***BH Specialist*** refers to any provider with specialized behavioral health training
CM can refer to a single person, or multiple individuals who have training to provide coordinated care management functions in the PC practice
Ancillary staff member refers to non-clinical personnel, such as office staff, receptionist, and others



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Lessons Learned for BH integration in Primary care

- Screening: Patient self report is superior to interview administered = **technology** (patient portal, IVR, apps?)
- Treatment: Early followup after initial assessment, treatment changes when appropriate, and behavioral activation are priority factors = **technology** (tracking registry)
- Substance Use – needs further exploration and standardization, ie what are the key ingredients to SBIRT, for whom, and for what conditions?
- Support Patient choice in treatment
- Small and independent practices will need shared resources

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Lessons Learned for PC Integration into Behavioral Health

- Screening and severity monitoring using validated scales and measures – need strong leadership commitment and support
- Strong focus on information exchange and tracking – data exchange with PCMH = **Technology**
- Treatment model variation - preventive screening and education, tight navigation especially to medical specialists; continuity of care model vs episodic; targeting patient segments; allowing patient choice
- Patient Engagement – Improving BH Provider Training for whole person care; roles of peers/navigators and technology

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Payment Reform and sustainability

- Billable and nonbillable components need support during transition to value based payments
- Incremental Cost and longer term cost savings (whose cost and whose savings?) needs to be measured
- Consider building out regional shared resources “utility” that supports care management, referral engagement, and telebehavioral health

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Conclusions

- Watershed moment for BH and Primary Care Integration
- Tremendous passion and momentum are major positives
- Integration models must incorporate sustainability concepts from Day 1 BUT practices should not wait for solutions before initial implementation
- PC integration into Behavioral Health needs more systems based evidence
- BH integration into Primary Care needs to reliably improve substance use disorder care
- Policy makers need to simplify payment models while encouraging practices to achieve scale and assume financial risk
- Strong consideration for fostering shared resources and infrastructure to overcome small practice concerns

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