Fulfilling the Promise of Behavioral Health Integration under NYS Health Reform

Henry Chung, MD
Agenda

• Integration Models supported by NYS Health Reform
• Supporting the Journey to Effective Implementation
• Challenge for Sustainability: Potential Innovations
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
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Brief Description</th>
<th>Accountability metrics</th>
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</table>
| 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 |
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
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
# SAMHSA-HRSA Integration Framework

<table>
<thead>
<tr>
<th>Minimal Collaboration</th>
<th>Basic Collaboration From a Distance</th>
<th>Basic Collaboration Onsite</th>
<th>Close Collaboration/Partly Integrated</th>
<th>Fully Integrated</th>
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</thead>
<tbody>
<tr>
<td>Separate systems</td>
<td>Separate systems</td>
<td>Separate systems</td>
<td>Some shared systems</td>
<td>Shared systems and facilities in seamless bio-psychosocial web</td>
</tr>
<tr>
<td>Separate facilities</td>
<td>Separate facilities</td>
<td>Same facilities</td>
<td>Some shared systems</td>
<td>Consumers and providers have same expectations of system(s)</td>
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<tr>
<td>Communication is rare</td>
<td>Periodic focused communication; most written</td>
<td>Regular communication, occasionally face-to-face</td>
<td>Some shared systems</td>
<td>Shared systems and facilities in seamless bio-psychosocial web</td>
</tr>
<tr>
<td>Little appreciation of each other’s culture</td>
<td>View each other as outside resources</td>
<td>Face-to-Face consultation; coordinated treatment plans</td>
<td>Some shared systems</td>
<td>Consumers and providers have same expectations of system(s)</td>
</tr>
<tr>
<td></td>
<td>Little understanding of each other’s culture or sharing of influence</td>
<td>Basic appreciation of each other’s role and cultures</td>
<td>Some shared systems</td>
<td>Some shared systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Collaborative routines difficult; time and operation barriers</td>
<td>Some shared systems</td>
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<tr>
<td></td>
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<td>Influence sharing</td>
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"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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<th>Study/Model</th>
<th>Description</th>
<th>Key Outcomes</th>
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| **PRISM-E**               | • 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 |
| *(Primary Care Research In Substance Abuse and Mental Health for the Elderly)* |                                                                                                                                                                                                           |                                                                                                                                                                                                            |
| **RESPECT-D**             | • 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                                                                                                                                  |
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| 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                              | • 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

<table>
<thead>
<tr>
<th>Decision support for measurement-based, stepped care</th>
<th>Evidence-based guidelines/treatment protocols</th>
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<tbody>
<tr>
<td></td>
<td>Use of pharmacotherapy</td>
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<tr>
<td></td>
<td>Access to evidence-based treatment with BH specialist or PCP/med specialist</td>
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| Self-management support that is culturally adapted | Tools utilized to promote patient activation and recovery |

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<tr>
<th>Information tracking and exchange among providers</th>
<th>Clinical registries for tracking and coordination</th>
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<td>Sharing of treatment information</td>
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| Linkages with community/social services | Linkages to housing, entitlement and other social support services |
### Key components of integrated care

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<th>Multi-professional team (including patients) approach to care</th>
<th>Ongoing care management</th>
<th>Systematic quality improvement</th>
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<td>Screening, initial assessment, and follow up</td>
<td>Patient/clinician identification of those with symptoms – not systematic</td>
<td>Enhanced referral to outside BH specialist/psychiatrist through a formal agreement with engagement and feedback strategies employed</td>
<td>Limited follow-up of patients provided by office staff</td>
<td>Informal or limited review of BH quality metrics (limited use of data, anecdotes, case series)</td>
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<td>Referral facilitation and tracking</td>
<td>Systematic screening of target populations (e.g., diabetes, CAD), with follow up for assessment</td>
<td>Clear process for referral to BH specialist/psychiatrist (co-located or external) with “warm transfer”</td>
<td>Proactive follow-up to assure engagement or early response to care</td>
<td>Identified metrics and some ability to review performance against metrics</td>
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<td>Care team</td>
<td>Patient/clinician identification of those with symptoms – not systematic</td>
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<td>Systematic team based caseload review and consultation</td>
<td>Systematic screening of all patients; with follow up for assessment</td>
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<td>Availability for interpersonal contact between PCP and BH specialist/psychiatrist</td>
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<td>Ongoing care management</td>
<td>PCP and patient</td>
<td>PCP, patient and CM, and psychiatrist (consults and engaged in CM case reviews)</td>
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#### 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.
Integration Continuum

Preliminary ————————— Intermediate ————————— Advanced

Key components of integrated care

Decision support for measurement-based, stepped care

- Evidence-based guidelines/treatment protocols
- Use of pharmacotherapy
- Access to evidence-based psychotherapy treatment with BH specialist

DSRIP Model 1 (Co-location) =
- None or limited training on BH disorders and treatment
- PCP training on EB guidelines for common behavioral health diagnosis and treatment
- Standardized use of evidence-based guidelines for all patients. Tools for regular monitoring of symptoms
- Systematic tracking of symptom severity. Protocols for intensification of treatment when appropriate

DSRIP Model 3 (IMPACT) =
- PCP initiated, limited ability to refer or receive guidance
- PCP initiated, and referral when necessary to prescribing BH specialist/psychiatrist for follow-up
- PCP-managed with prescribing BH specialist/psychiatrist support
- PCP-managed with CM supporting adherence between visits and BH prescriber/psychiatrist support

Self-management support that is culturally adapted

Tools utilized to promote patient activation and recovery

- Supportive guidance provided by PCP
- Available off-site through pre-specified arrangements
- Brief psychotherapy interventions provided by BH specialist onsite
- Brief interventions provided by BH specialist (with formal EBP training) as part of overall care team with exchange of information as part of case review

- Brief patient education of condition by PCP
- Brief patient education of condition including materials/workbooks but limited focus on self-management coaching and activity guidance
- Patient receives education and participates in self-management goal-setting and activity guidance/coaching
- Systematic education and self-management goal-setting with relapse prevention guidance with CM support in between visits

Information tracking and exchange among providers

Clinical registries for tracking and coordination

- Informal method for tracking patient referrals to BH specialist/psychiatrist
- Patients referred to outside BH specialist/psychiatrist with clear expectations for shared communication and follow up
- Formal patient registry to manage and track patients, including severity measurement, attendance at visits, and care management interventions
- Registry integrated into EMR, including severity measurement, attendance at visits, and care management interventions. Selected medical measures tracked when appropriate

Sharing of treatment information

- No sharing of treatment information
- Informal phone or hallway exchange of treatment information without regular chart documentation
- Exchange of treatment information through in-person or telephonic contact with chart documentation
- Routine sharing of information through electronic means (registry, shared EMR, and shared care plans)

Linkages with community/social services

Linkages to housing, entitlement and other social support services

- Referral resources available at practice, no formal arrangements
- Referrals made to agencies, possibly some formal arrangements, but little capacity for follow-up
- Patients linked to community organizations/resources with formal arrangements and consistent follow-up
- Developing, sharing, and implementing a unified care plan between agencies

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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
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
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
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