

Behavioral Health and Delivery System Reform:

Drowning in the Mainstream or Left on the Banks

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BH/GMC Clinical Examples

- 35 year old male with schizophrenia, diabetes, and tobacco dependence
 - Can expect up to 25 year shortened life span, increased medical costs
- 25 year old HIV+ female IV drug user with PTSD
 - Frequent ED visits, non adherence to meds, increased medical costs
- 60 year old female with diabetes, CHF and depression
 - Frequent (re-) hospitalizations, poor self management and adherence, early candidate for LTC

Currently, Poor Quality and Care Coordination for All Populations

- Patients primarily in contact with the general medical sector with co-morbid BH conditions (e.g., depression, substance abuse)
 - Not treated or treated as acute problems with little follow-up
- Patients with severe and persistent BH conditions (e.g., schizophrenia, bipolar disorder) and treated in BH specialty settings
 - Poor self-care, medications worsen general medical conditions
 - Limited provider capacity and incentives for
 - Accessing treatment of co-morbid medical conditions
 - Preventive and wellness care
- Medical and BH providers operate in silos







New York State Health Foundation Conversation
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Behavioral and General Health Integration and Healthcare Reform

- Why?
- Why Not?
- What is “it”?
- Who?
- Does What?
- For Whom?
- When?
- Where?
- How?
 - Clinical, Organizational and Policy Strategies

2020 World Health Organization Burden of Disease (DALYs)

1. Ischaemic heart disease
2. Unipolar major depression
3. Road traffic injuries
4. Cerebrovascular disease
5. Chronic obstructive pulmonary disease
6. Lower respiratory infections
7. Tuberculosis
8. War
9. Diarrhoeal diseases
10. HIV

DALY = Disability-adjusted life year

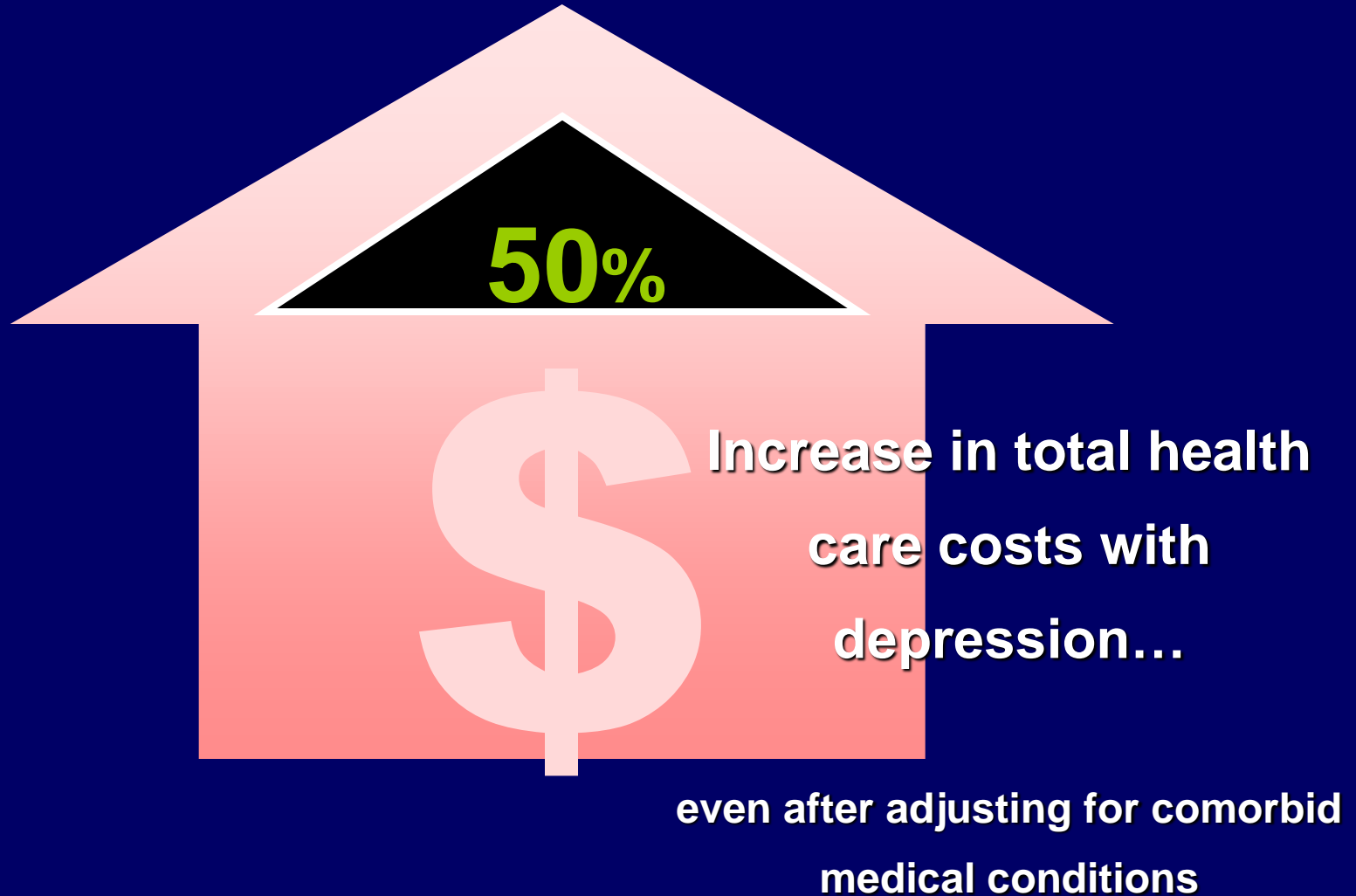
Source: WHO, Evidence, Information and Policy, 2000

Leading Causes of Years of Life Lived with Disability (YLD) in 15- to 44-Year-Olds

(WHO, Mental Health: New Understanding, New Hope, 2001)

		% total
1	Unipolar depressive disorders	16.4
2	Alcohol use disorders	5.5
3	Schizophrenia	4.9
4	Iron-deficiency anemia	4.9
5	Bipolar affective disorder	4.7

High Health Care Costs



“Faces of Medicaid” White Paper

- “Mental illness is nearly universal among the highest cost, most frequently hospitalized Medicaid beneficiaries”

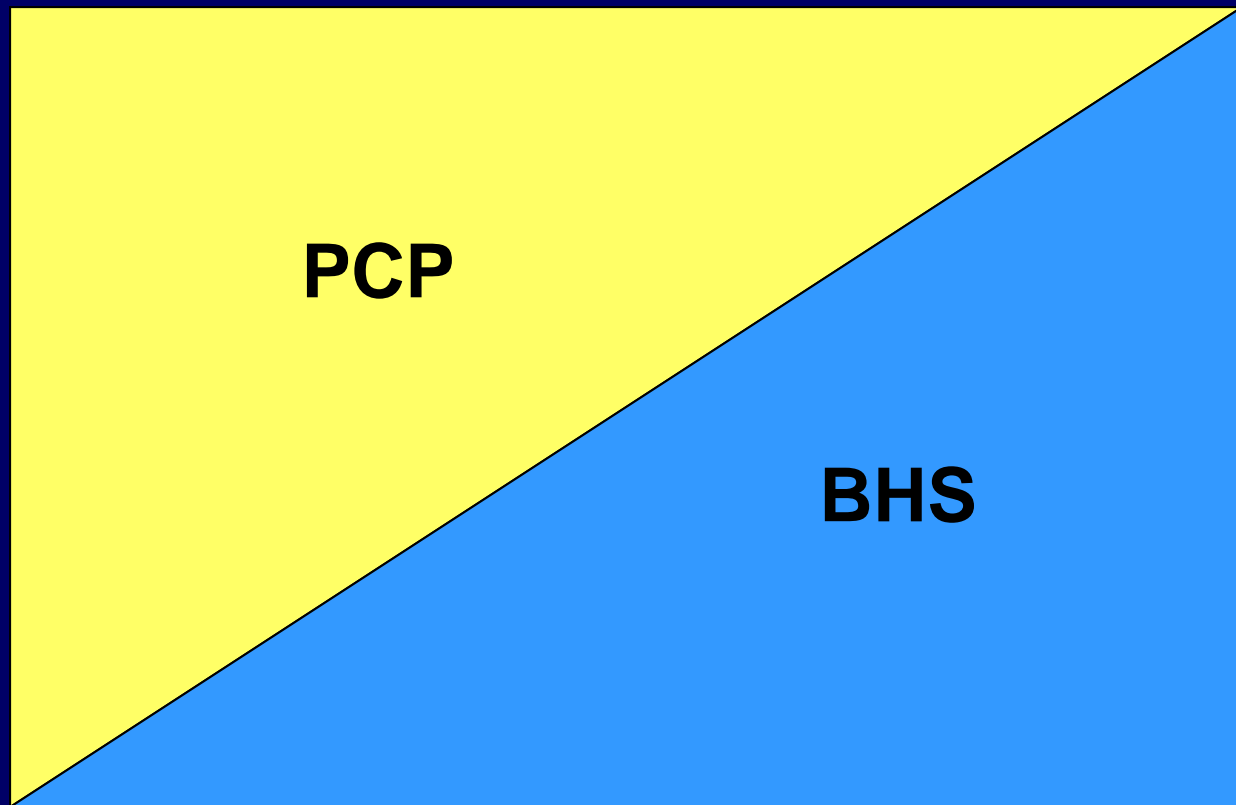
Center for Healthcare Strategies (2010)

Why Not?

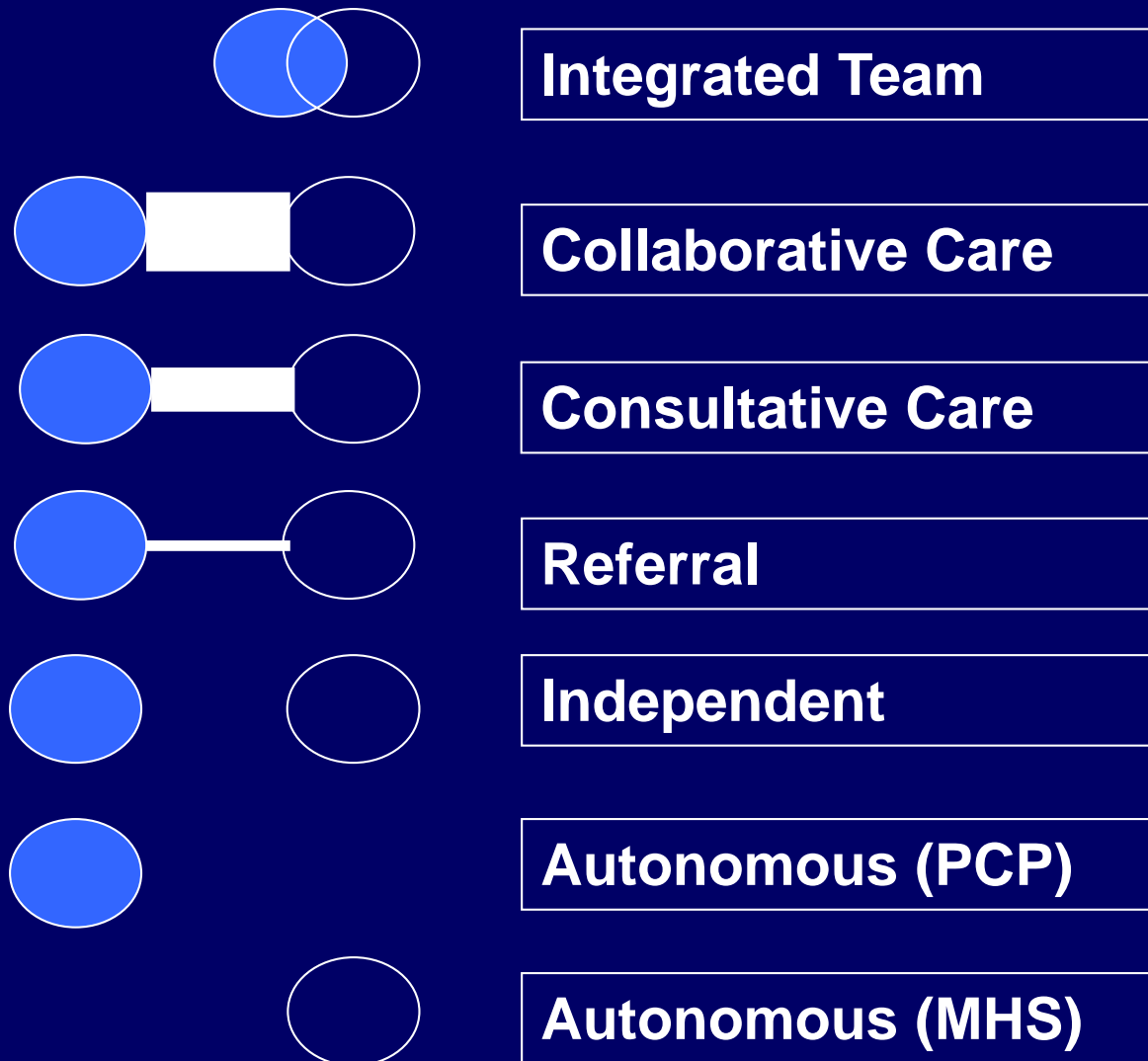
Barriers and Differences

- Mind-body dualism
- Stigma
- Historical role of the state
- Separate delivery systems (FQHC v. CMHC)
- Different diagnostic systems (ICD v. DSM)
- No lab tests/Few procedures
- Different financing systems (MCO v. MBHO)
- Legal/regulatory distinctions (e.g., privacy/coercion)
- Costs are hidden (Direct BH costs 5-7%)
- Effective organizational and policy solutions exist

Who Is responsible for care?



How are providers connected?



When is care provided?

Risk Factor Identification/ Prevention	Diagnosis/ Assessment	Short-term Management	Continuing Care
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"The picture's pretty bleak, gentlemen. ... The world's climates are changing, the mammals are taking over, and we all have a brain about the size of a walnut."

How do we evolve into mammals?

Or

Can we implement effective “integrated care”?

What is “Integrated Care”?

- What Part of the Elephant?
 - Integrated care looks different from different perspectives, to different stakeholders
 - MH providers, PC providers, consumers, policy makers
 - Directionality of integration
 - PC into MH vs. MH into PC
 - Range of “name brand” models
- What Part of the Jungle?
 - How is it implemented clinically/organizationally?
 - How does it relate to reform initiatives?
- Challenges, mechanisms, solutions are different at
 - Clinical level
 - Organizational level
 - Policy level



An Integration Lexicon

Models	Programs	Mechanisms	System Reform Opportunities
Chronic/ Collaborative Care	PCMH	Recognition/ Enhanced Payment	ACA
IMPACT	Health Home	Care Management	CMMI
RESPECT	PBHCI	Grant	Duals Demonstrations
Partners in Care	MHIP Washington State	Shared savings	ACO
GLAD-PC	NYS Medicaid Incentives	Licensing/Services Augmentation	State Health Innovation Program
PCARE	DIAMOND	Co-Location	DSRIP
HOME/HARP	Community Care of North Carolina	Quality Measurement	Behavioral Health Transition to Managed Care

Evidence-Based Chronic (Planned) Care Approaches for Treating Depression Are Effective



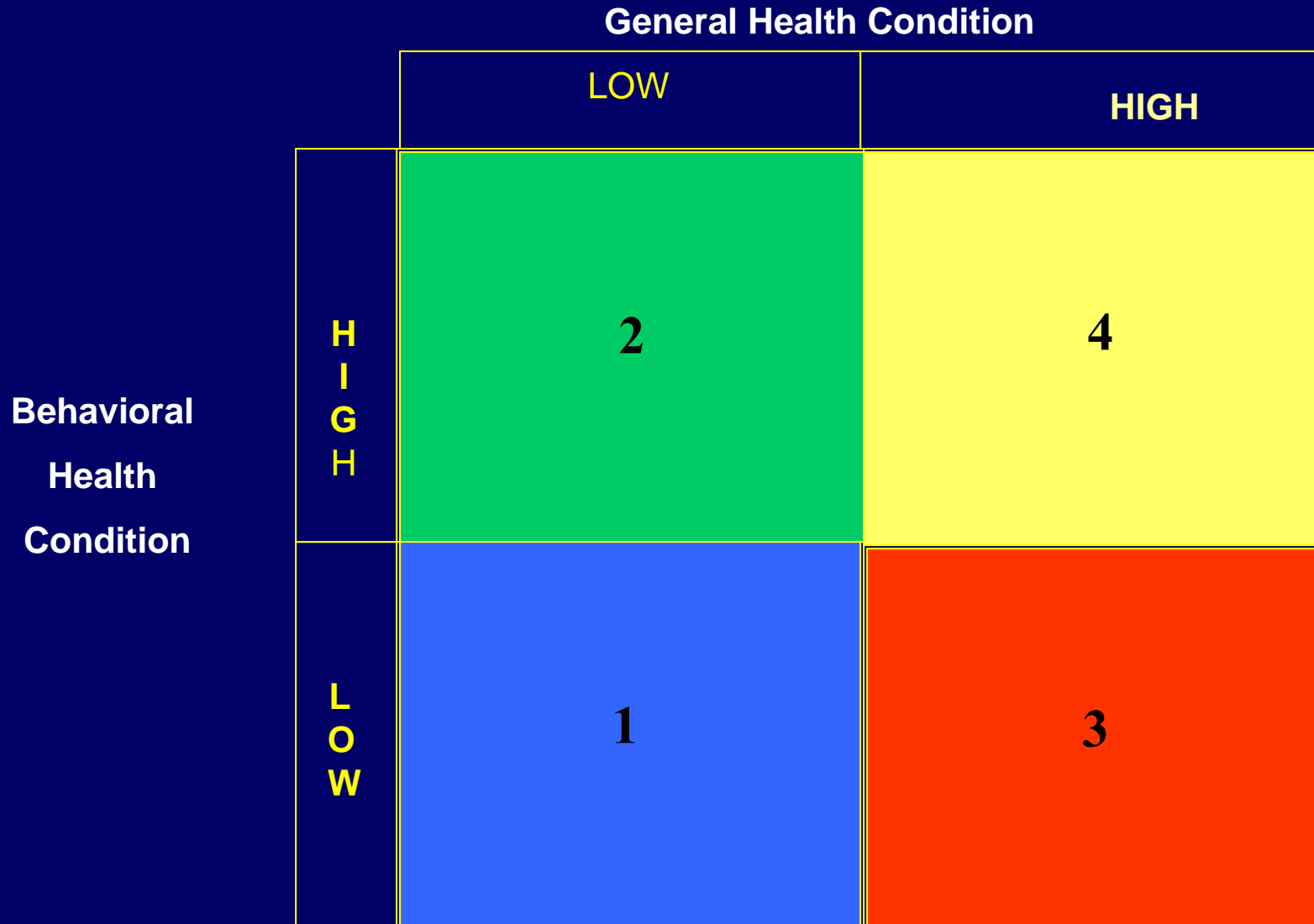
Key Questions

- **For Whom?**
- **Do What?**
- **Where?**
- **How?**

Key Question 1: For Whom

- Specific GH conditions
 - e.g., diabetes, post myocardial infarction
- Mild-moderate behavioral conditions
 - e.g., depression, anxiety disorders
- Specific combinations of GH and BH conditions
 - e.g., diabetes and depression
- Severe/Persistent BH conditions
 - e.g., schizophrenia, drug dependence
- Combinations of broader levels
 - e.g., the “four quadrant” framework
- An entire population
 - e.g., geographic/enrolled
 - Population segments identified via predictive modeling

Four Quadrant Model

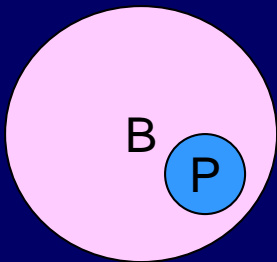


Key Question 2: DO WHAT?

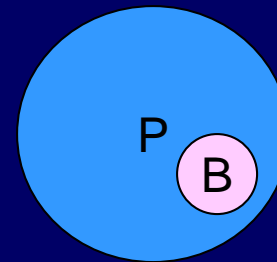
- Mental health services
 - Pharmacotherapy
 - Psychosocial interventions
 - Inpatient/Partial care
- Substance abuse services
- Crisis management
- General medical
 - Preventive care/Screening
 - Primary care for acute and chronic conditions
 - Specialty care for complex conditions
 - Acute medical/surgical
- Dental
- Laboratory
- Pharmacy benefits
- Wellness services
- Case management
- Social services
 - Housing
 - Transportation
- Economic support
- Peer support
- Rehabilitation/Vocational services

Key Question 3: WHERE?

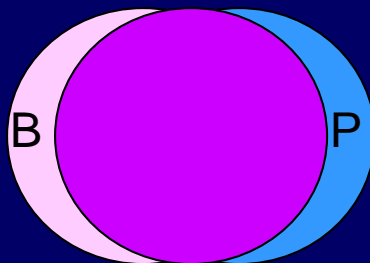
Embedded PCP in BHS



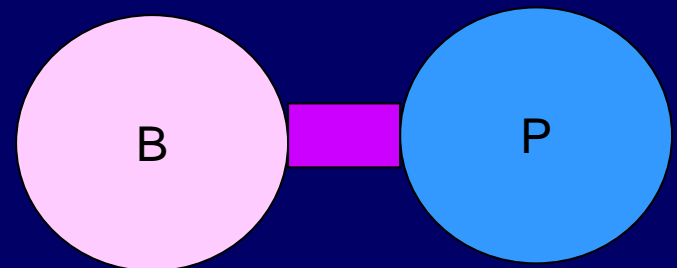
Co-location of BHS in PC



Unified



Coordination / Collaboration



Key Question 4: HOW?

- RAND Projects
 - SAMHSA PBHCI
 - NYSHHealth Project
- Clinical Strategies
- Organizational Strategies
- Policy/Economic Strategies

PBHCI Evaluation

- **Objective:** Independent evaluation of PBHCI grants program
- **Purpose:** Demonstrate value of integrating PC/BH for SMI adults; Create a roadmap for replication of program successes
- **Evaluation Approach:**
 - **Process:** How do grantees integrate care?
 - Site visits, implementation reports, service use data
 - **Outcomes:** Does consumers' PH improve?
 - Quasi-experiment
 - **Model features:** What are “active ingredients”?
 - Mixed methods

PBHCI Grants

100+ grantees nationwide. First n=56 included in evaluation

Required

- Screening and referral
 - PC prevention and treatment
- Registry/tracking system
 - Needs and outcomes
- Care management
 - Promote participation, follow-up
- Prevention and wellness

Optional

- Coordinate PC-BH visits
- Co-locate PCP in BH facility
- Supervising PC physician
- Embedded nurse care mgr
- Preventive service EBPs
- Wellness engagement EBPs

Plus: infrastructure development, data and monitoring

PBHCI Results

- **Grantee characteristics:**
 - Diverse clinics, all serving diverse, high-need clientele
- **Program successes:**
 - Grantees offer array of services via multidisciplinary teams
 - Implement co-location, CM, some integrated practices
 - Modest improvement in some clinical measures
- **Program challenges:**
 - Consumer enrollment/engagement; sustainability; communication/integrated clinic culture; wellness programs; smoking and weight; EBP implementation

NYSHealth Overview

- Objective: Examine NYS' ongoing integrated PC-MH initiatives for adults with SMI
- Purpose: Help state policymakers streamline the adoption of promising approaches
- Approach: Characterize, compare, contrast three NYS integrated care initiatives from the perspective of MH clinics
 - Site visits to 9 leader clinics
 - Web surveys to random sample of clinics across initiatives

New York State Initiatives

- **Medicaid Incentives:** Limited PC services on-site, reimbursed through Medicaid, referrals for specialty care.
- **PBHCI:** Extensive PC services available on-site or via partner agency, funded by grant, referrals to specialty care.
- **HH:** Care coordination among diverse network of community providers operating under existing scope of services. All care within network.

NYS Results

- **MI**
 - Smaller, free-standing clinics; low PC as per license
 - PC provided by MH staff, low culture change
- **PBHCI**
 - Larger, hospital-affiliated clinics w/ PC on-site
 - Program supports infrastructure development, staff training, evidence of culture change
- **HH**
 - Different approach to integration
 - No change to MH clinics' scope of practice
 - Potential complement to PBHCI and MI if additional services are available in the community

Key Question 4: HOW?

- RAND Projects
 - SAMHSA PBHCI
 - NYSHHealth Project
- Clinical Strategies
- Organizational Strategies
- Policy/Economic Strategies

Clinical Strategies

- Evidence-Based Practices
 - Specific interventions
 - Medications, psychotherapies, team-based, etc.
 - Appropriateness/fidelity measurement
 - Inter-professional training, supervision
- Measurement-Based Care (MBC)
 - Clinical measures (e.g. HA1c, PHQ-9)
 - Systematic, consistent, longitudinal (“Ruthless Follow-Up”)
 - Action-oriented/menus of reasonable options
- Person-Centeredness
 - Accessibility
 - Therapeutic alliance
 - Recovery orientation
 - Cultural competence

“Superuser” Summit

- “Determining the right dose of the right intervention with the right individual at the right time in the right location is at the heart of successful super-utilizer programs”.
- http://www.chcs.org/usr_doc/FINAL_Super-Utilizer_Report_-_for_release_on_10_10.pdf

10 Key Organizational Practices

1. Formalized Partnerships (Co-location?)*
2. Population Management /Predictive Modeling*
3. Effective Communication*
4. Care Management with Relentless Follow-Up*
5. Clinical Registries for Tracking and Coordination*
6. Decision Support for Measurement-Based/Stepped Care*
7. Access to Evidence-Based Psychosocial Services
8. Self-Management as Part of a Recovery Framework*
9. Link with Community Services/Resources*
10. Data-Driven Quality Measurement and Improvement*

* = Health Information Technology-sensitive practice

Recommendations to Programs

Design

- Conduct a systematic needs assessment
 - Assess local resources, anticipate barriers and identify viable solutions ahead of time
- Invest early in strategies that directly facilitate consumer access to care
 - Transportation, longer hours, more days
- Build partnerships with community partners
 - Hospitals, FQHCs, housing, social services
- Use EBPs and assess fidelity to EBPs
- Implement a sophisticated integrated care orientation/training program for staff early
 - Hire staff that are well prepared for integrated care
 - Regular interprofessional team meetings/trainings

How: Policy/Economic Strategies 1

- Reinforce evidence-based clinical models
- Provide flexibility to sustainably pay for/incentivize:
 - PCP BH assessment/care
 - MHS consultation to PCP
 - Primary care for SMI
 - Care Management
 - Measurement-Based Care
 - Start-up/Implementation costs
- Provide effective implementation strategies
 - Technical assistance focused on key practices
- Build on new policy/organizational options (PBHCI, PCMH, Health Home, ACO, State adaptations)

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How: Policy/Economic Strategies 2

- Realign financial and non-financial incentives
- Establish “Shared Accountability”
- Establish national quality measures for integrated care
- Alter contractual/organizational arrangements between/among Providers and Payers
- Develop HIT infrastructure/policies supporting effective communication and measurement
- Build bridges to “non-health” services
 - Transportation, Housing, SUD, Dental, CJ, SS
- PCEBBHH?

Person-Centered, Evidence-Based Behavioral Health Home

- Patient-Centered Medical Home Standards as Base
- Formal Linkage to or Provision of Primary Care and Preventive/Wellness Services
- Information Systems with Registry Functionality for Measurement-Based Care
- Structures to Support Specific Evidence-Based Practices (training, supervision, fidelity/outcomes measurement)
 - E.G., Medication Management, CBT, IPT, Exposure-Based, ACT, Supported Employment
- Recovery-Oriented, Shared Decision-making Tools and Services

Recommendations to Policymakers

- Measurement and Reporting and Evaluation
 - For individual initiatives:
 - Establish core performance monitoring requirements
 - Articulate performance expectations
 - Apply phase in strategies/Avoid hypercomplexity
 - Implement program evaluation from the outset
 - Include/expand utilization, economic, network analysis
- Licensing and Regulations
 - Flexibly adapt facility and privacy regulations to simplify and expedite integration
 - Clarify/operationalize and support roles for peer specialists and care managers
- Create, enhance and enforce core HIT functionality
 - Access to state registries/databases for coordination
- Recognize unique issues in local context

Shared Accountability

- Relatively simple concept
- Difficult to implement
- PCP is jointly responsible for assuring quality for both GH **and** BH care
- BHS is jointly responsible for assuring quality for both BH **and** GH care
- The same applies to Med/Surg Health Plan and BH Carveout Health Plan
- Instantiated in contracts and performance measurement and incentives

“6 P” Conceptual Framework



Key Challenges

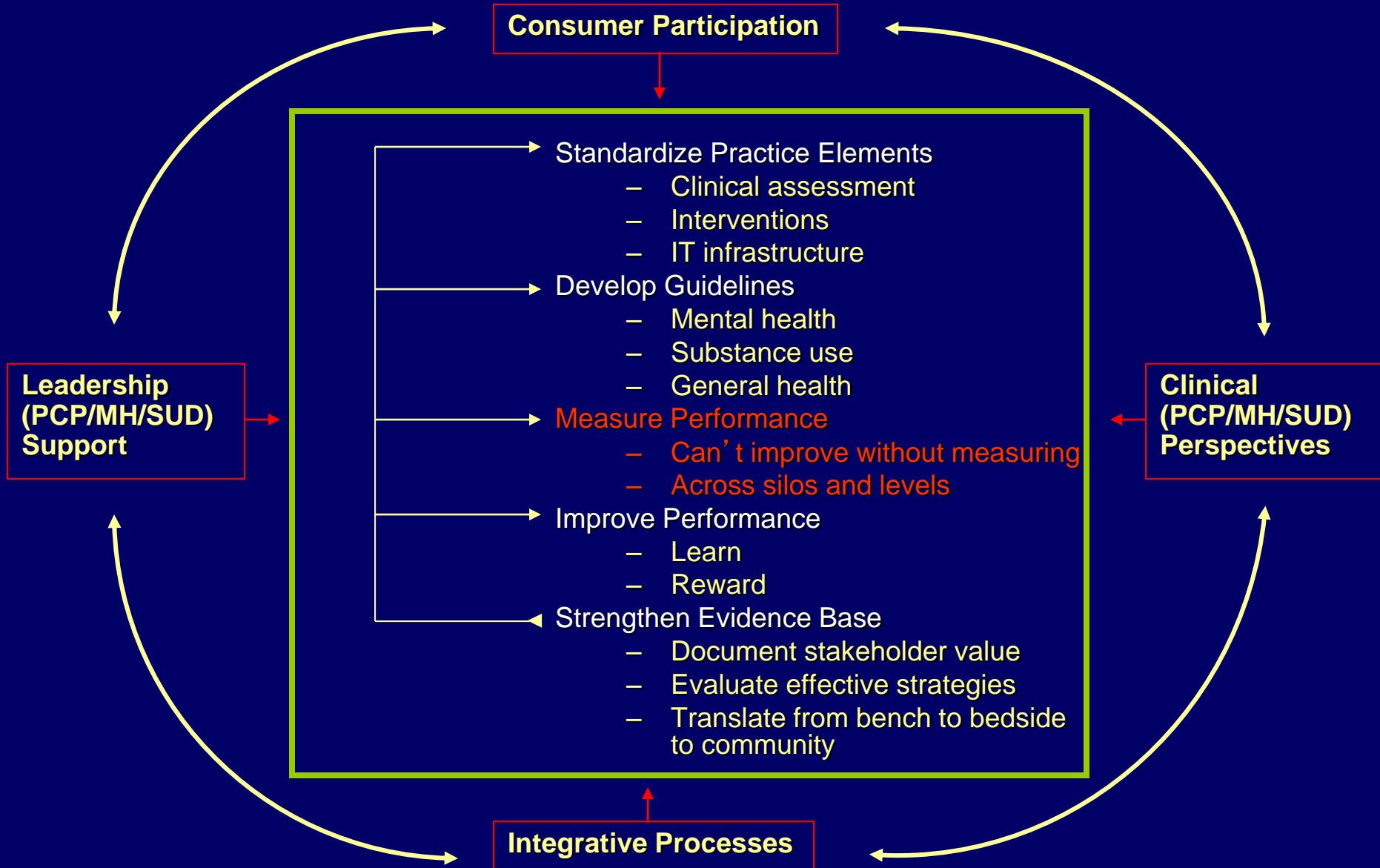
- Changing Cultures
 - GH/BH (including Substance Abuse)
 - Recovery
- Establishing Shared Accountability
- Building a Quality Measurement Infrastructure
 - Stewardship and Resources
- Changing Incentives and Developing Sustainable Payment Models
- Bridging Technology Gaps/Registries (HITECH Exclusion)
- Work Force Needs
 - Access to Psychiatry and Primary/Specialty Care
 - Developing New Models for Training and Education
- Linking with Social Services/Criminal Justice/etc.
- Dealing with "Cost Effectiveness Conundrums"

Fewer Psychiatrists Seen Taking Health Insurance

WASHINGTON — Psychiatrists are significantly less likely than doctors in other specialties to accept insurance, researchers say in a new study, complicating the push to increase access to mental health care.

http://www.nytimes.com/2013/12/12/us/politics/psychiatrists-less-likely-to-accept-insurance-study-finds.html?_r=0

Preparing for the Future

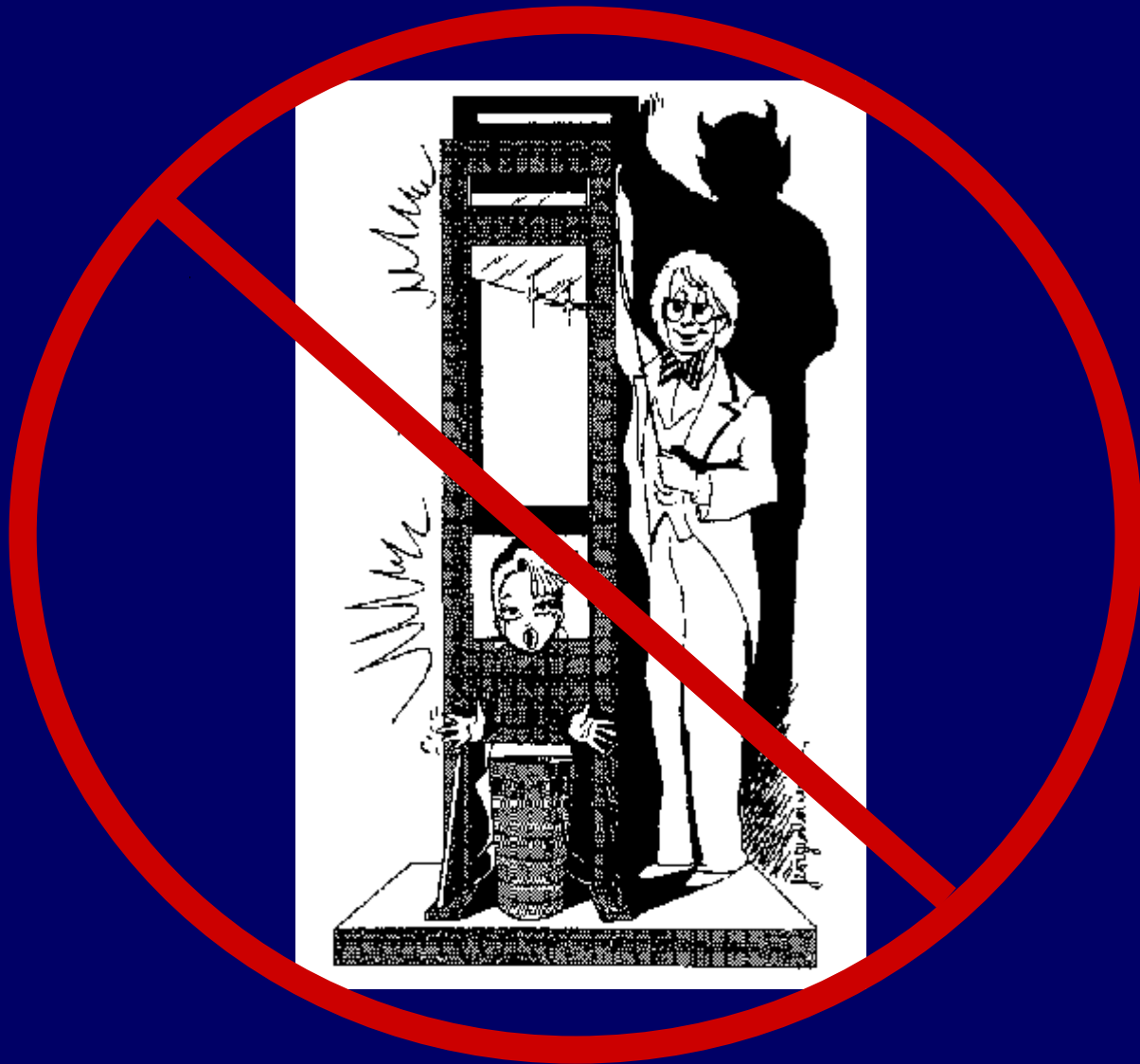


The Bottom Line

- Behavioral/General medical co-morbidity is highly prevalent
- Especially concentrated among high cost patients
- These individuals die at younger ages
- Impacts and solutions go both ways across the GM/BH divide
 - Primary Care patients needing Mental Health Care
- and
- Behavioral Health patients needing Primary /Specialty Medical Care
- Evidence-based integrated care models are well documented
- Structural/Financial barriers/disincentives limit implementation
- ACA/NYS Reforms provide flexibility, incentives and opportunity
- Must bridge measurement, technology, culture gaps and regulatory barriers/complexity

Questions

- Which populations should be targeted?
 - Which are left out?
- Who should do what?
 - What are PCP expectations for MH/SUD screening/identification? Follow-Up? Evidence-based treatments?
 - What are BHS expectations for Preventive/Primary/Chronic Disease Care for General Medical/”Physical” Conditions?
- How can we measure whether expectations are being met?
- What are the optimal organizational arrangements for meeting these expectations? (is there a “secret sauce”?)
 - Person-Centered Evidence-Based Behavioral Health Home”?
- What policy instruments work best for assuring accountability on all sides?
- What sustainable financing mechanisms work best to incentivize accountability, efficiency and collaboration?
- What are the regulatory barriers and how to balance accountability, complexity and flexibility?
- How do we develop a work force that can adapt to these challenges?
- What are the knowledge gaps and how do we fill them?



Don't Split Mind and Body

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