Behavioral Health Integration and Health Reform: Are We at the Tipping Point?

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Montefiore Care Management Company
And
Associate Professor of Clinical Psychiatry
Albert Einstein College of Medicine
Agenda

• Why does Integration Matter?
• What does the evidence base tell us about the effectiveness of Collaborative Care Models?
• How is the Montefiore ACO trying to implement integration?
Rationale for Integration

- Global disability
- Worse morbidity and mortality
- $293 Billion additional costs due to MH and SUD co-morbidity to medical disorders (Milliman report, 2014)
- Mental Health Parity
- ACA and focus on increasing value (improve quality and lower costs)
Case Example: Higher Risks for People with Depression

• Medical illnesses and depression are strongly linked, esp. chronic illnesses:
  – Diabetes
  – Heart disease
  – Asthma
  – Cancer

• Individuals with depression have 2X the risk of developing CAD and to have a stroke; they are 4X more likely to die within 6 months from a myocardial infarction
The Need for Care Coordination: Potentially Preventable Readmissions (PPR’s)

- Patients without MH/SA diagnosis, medical readmission $149M
- Patients with MH/SA diagnosis, medical readmission $395M
- Patients with MH/SA diagnosis, MH/SA readmission $270M

NYS Medicaid 2007
Depression: Employer and Societal Costs

- People who are depressed but not receiving care use 2-4x healthcare resources of other enrollees
- Depression annually costs employers in indirect costs (absenteeism, lost productivity, disability, etc.) $44 billion
- An employee suffering from depression loses 2.2 hours of productivity/day
- The odds of missed work due to health problems were 2x greater for employees with depressive symptoms than for those w/o depressive symptoms
# Accountable Care Organization (ACO) Preventive Care Measures

<table>
<thead>
<tr>
<th>Preventive Measures</th>
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<tbody>
<tr>
<td>Influenza Immunization</td>
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<tr>
<td>Pneumococcal Vaccination</td>
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<tr>
<td>Adult Weight Screening and Follow-up</td>
</tr>
<tr>
<td>Tobacco Use Assessment and Cessation Intervention</td>
</tr>
<tr>
<td><strong>Depression Screening and Follow-up</strong></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
</tr>
<tr>
<td>Mammography Screening</td>
</tr>
<tr>
<td>Adults 18+ who had BP Measured in previous 2 years</td>
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“Trying harder will not work. Changing systems of care will.”

Don Berwick
Institute for Healthcare Improvement
Primary Care and Behavioral Health Integration Models (Mechanic D)

- Enhanced screening, treatment and referral
- Co-location of services
- Systematic integration with shared protocols, shared health information, and shared quality metrics and outcomes
Key Randomized Collaborative Care Controlled Trials in Depression

• IMPACT – Older Adults and Depression
• RESPECT-D – Primary Care Patients and Depression
• TEAMcare – Depression with CAD/Diabetes
• PRISMe – Older adults with depression in primary care or at-risk drinking randomized to collaborative care vs enhanced specialty care
Engagement and treatment of depression in PRISM-E

N=599

Integrated Care
Engaged: 71%
Response: 29%

Specialty
Engaged: 49%
Response: 37%

N=621
What is Collaborative Care?
Modified from Katon, JAMA 2014
Cost Savings of Collaborative Care

• IMPACT Study

Cost Savings: Over 4 years, intervention patients had an average cost savings of $3363 per patient compared with usual care. Mostly driven by reduction in medical hospital admissions


Return on Investment: $6.50 per dollar spent

Behavioral Health and Measurement: A Quality Imperative

• Why Measurement?
  – Improve individual outcomes by assisting in treatment planning
  – Group level outcomes serve as benchmarks and goals used as critical information to address effectiveness of service model changes
  – Creates a common language across disciplines to promote effective collaboration
# PHQ-9 Symptom Checklist

1. Over the **last 2 weeks**, how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th></th>
<th><strong>Not at all</strong></th>
<th><strong>Several days</strong></th>
<th><strong>More than half the days</strong></th>
<th><strong>Nearly every day</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Little interest or pleasure in doing things</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>b. Feeling down, depressed, or hopeless</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Trouble falling or staying asleep, or sleeping too much</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. Feeling tired or having little energy</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e. Poor appetite or overeating</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>f. Feeling bad about yourself, or that you are a failure . . .</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>g. Trouble concentrating on things, such as reading . . .</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>h. Moving or speaking so slowly . . .</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>i. Thoughts that you would be better off dead . . .</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Subtotals:</th>
<th>Total:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>
## Translating PHQ-9 Depression Scores into Initial Planning

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Community Norms</td>
<td>No further action</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild Symptoms</td>
<td>Watchful waiting, periodic re-screening, education, patient activation and evaluation</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Moderate Symptoms</td>
<td>Develop treatment plan, consider counseling, education, assertive follow-up and evaluation, pharmacotherapy</td>
</tr>
<tr>
<td>15 – 19</td>
<td>Moderate -Severe</td>
<td>Immediate institution of treatment including medication and/or counseling</td>
</tr>
<tr>
<td>≥ 20</td>
<td>Severe</td>
<td>Pharmacotherapy, counseling &amp; referral to mental health specialist</td>
</tr>
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Using the PHQ-9 to Monitor & Adjust Treatment at 4-6 Weeks

<table>
<thead>
<tr>
<th>PHQ-9</th>
<th>Treatment Response</th>
<th>Treatment Plan</th>
</tr>
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<tbody>
<tr>
<td>Drop of 5 points from baseline</td>
<td>Adequate</td>
<td>No treatment change needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Follow-up in four weeks</td>
</tr>
<tr>
<td>Drop of 2-4 points from baseline</td>
<td>Possibly Inadequate</td>
<td>May warrant an increase in antidepressant dose</td>
</tr>
<tr>
<td>Drop of 1 point, no change or increase</td>
<td>Inadequate</td>
<td>Increase dose; Augmentation; Informal or formal psychiatric consultation; Add psychotherapy</td>
</tr>
</tbody>
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STAR-D: Similar Outcomes in Primary and Psychiatric Care Settings

N = 2,876

Trivedi M,
# Integration Priority: SBIRT for Alcohol in Primary Care

<table>
<thead>
<tr>
<th>SBIRT</th>
<th>Components</th>
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<tr>
<td>Screening</td>
<td>Brief strategy to identify at-risk population</td>
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</table>
| Brief Intervention           | One or more discussions with clinician (10-15 min each):  
1. Assessment & feedback on drinking  
2. Advice, goal setting, agree on plan  
3. Follow-up contact            |
| Referral to Specialty Treatment | Patients with more severe problems require more than a brief intervention                                                                 |

*SBIRT: Screening Brief Intervention Referral to Specialty Treatment*
SBI for Alcohol in Primary Care

Effectiveness and Cost-Effectiveness

- Most effective intervention for alcohol problems based on clinical trials research

- Solberg et al. (2008):
  - SBI for alcohol ranked among top 5 of 25 USPSTF-recommended screening practices based on effectiveness and cost-effectiveness
  - Similar in ranking to screening for hypertension or colorectal cancer
Outcomes of Integrated Care for Patients with SUD and Chronic Illness

(Weisner et al, JAMA 2001)

Effectiveness and Cost-Effectiveness

- SUD and Chronic Illness Patients with integrated care patients had significantly higher abstinence rates than usual care patients (Kaiser Permanente Northern California study).
- Integrated care patients demonstrated a significant decrease in inpatient admissions while average medical costs (excluding addiction treatment) decreased from $470.39 to $226.86 PMPM.
MONTEFIORE and BH INTEGRATION:
A WORK IN PROGRESS
Montefiore ACO Interventions

• ED Case Management
• Post-discharge calls
• Expand PCMH
• SNF initiative (readmissions)
• Care Guidance (care management)
• House Calls (medical home visit program)
• Integrated medical and behavioral care management
• Clinical pathways
Collaborative Care Initiative

- Under the HMH (Hospital Medical Home) Grant from the NYS DOH and OMH
- Started in July of 2013 at CHCC and Grand Concourse
- Transformed traditional model of behavioral health care delivery:
  - SW’s implementing PST
  - PHQ9 administered at every counter to measure symptoms
  - Case Management
  - Psychiatrist as a Consultant
  - Patient Registry to track outcomes
Preliminary CCI Results: Behavioral Health Outcomes

- Enrollment Numbers: 218 total patients
- % of Pts with +5 Improvement PHQ9: 46%
- % of Pts with +5 Improvement GAD7: 34%
- Pts enrolled for >10 weeks, % with 50% improvement or clinical score of <10 in PHQ9: 51%
- Pts enrolled for >10 weeks, % with 50% improvement or clinical score of <10 in GAD7: 41%
Preliminary CCI Results: Medical Outcomes

- **Wait Times**: % of time PCPs have been satisfied with time for pt to see Behavioral Health Provider for evaluation: **90%**

- **PCP Utilization**: Once enrolled and engaged in care visits to PCP decreased by **22%**

- **Systolic BP**: \(\downarrow 15\%\)

- **Diastolic BP**: \(\downarrow 12\%\)

- **LDL**: \(\downarrow 5.8\%\)

- **HGA1C**: 10.1 to 9.3
MMG CFCC: OUTCOMES OF DIABETIC PATIENTS WITH DEPRESSION

Total DM Patients: 2171
Enrolled: 111
Enrolled, Completed, Kept appt and PHQ9 improved: 53
Not Enrolled: 2061
Montefiore Synergy Team: Care Management Model

**PCMH Primary Care Team**
12 PCP, Nursing Staff
- Educate about benefits of treatment
- Initiate appropriate medication treatment based on depression severity (PHQ-9 score) and patient choice
- Screen for depression, confirm clinical diagnosis
- Receive active feedback from Synergy Team via EMR and/or telephone

**Behavioral Health Manager (LCSW)**
1 FTE
- Initiates screening, eligibility, assessment
- Conducts face-to-face behavioral health treatment assessment and reviews treatment plan with consulting psychiatrist
- Provides onsite and telephonic brief psychotherapy tailored to patient’s needs
- Collaborates with nurse care manager, Monitors PHQ-9, and medication effects, including side effects

**Nurse Care Managers**
3 experienced RNs, totaling 1 FTE effort
- Conducts comprehensive biopsychosocial assessment
- Monitors PHQ-9 and medical indicators
- Chronic disease education
- Assists with appointments and concrete services
- Uses patient-centered motivational strategies to promote self management and wellness

**Consulting Psychiatrist**
0.4 FTE
- Reviews cases with Synergy Team with focus on patients not at target goals
- Reviews EMR and confirms/recommends psychotropic medication adjustments or additional workup to PCP
- Limited face-to-face treatment for complex patients
- Available for telephone or email collaboration

Chung H et al, Gen Hosp Psych 2013, supported by NYCT and UHF
Synergy Program Outcomes

- Overall intent to treat (12 weeks and greater), n = 134
- Insurance: 34% Commercial, 32% Medicaid, 34% Medicare
- Gender: Female 75% Male 25%
  - Mean PHQ9 reduced from 15.3 to 10.4 (32% reduction)
  - 30% in partial remission (PHQ<10)
  - 13% in full remission (PHQ <5)
  - Framingham Score (Mean CV Risk) (n=61) reduced from 16.4 to 12.3 (25% reduction)
SBIRT Pilot at CHCC: Patient EMR Data

14,066 unique patients with \( \geq 1 \) visit

6,023 (42.8%) screened with AUDIT-C

386 (6.4%) with positive screener*

5637 (93.6%) with negative screener

15 (3.9%) referred to SW

8043 (57.2%) not screened

*Note: Of those with a positive score, 14.0% have DM, 31.9% have HTN
AUDIT-C

1. How often did you have a drink containing alcohol in the past year?
   Never = 0       Monthly or less = 1  2 - 4 times/month = 2
   2 - 3 times/wk = 3       4 or more times/wk = 4

2. How many drinks containing alcohol did you have on a typical day when you were drinking in the last year?
   1 or 2 = 0  3 or 4=1  5 or 6 = 2  7-9 = 3  10 or more = 4

3. How often did you have 5 or more drinks on one occasion in the last year?
   Never = 0           Less than monthly = 1       Monthly = 2
   Weekly = 3       Daily or almost daily =4

Cutoff score ≥ 3 identifies at-risk alcohol use for women and ≥4 for men
Is there support for SBIRT at CHCC?

Most staff...

Agree SBIRT is supported by medical directors: 70%

Are favorable toward SBIRT in PCP Setting: 82%

Are favorable toward SBIRT at CHCC as is: 67%

Believe it is improving patient care: 53%

Feel the AUDIT-C is more useful than the CAGE: 73%
Integrated Care Pyramid

1. **Intensive Case Management for High Cost and Complex Patients**
2. **Enhanced Referral and Engagement in Specialty Care**
3. **Collaborative Care**
4. **Screening, Diagnosis, Education and Initial Treatment**
Tipping Point? (Gladwell)

• Point at which a movement/event/intention becomes inevitable, inescapable, when everything changes all at once

• Transformation occurs through initial infection (idea) then contagiousness (others latch on, tell others), little actions having big effects (multiple pilot testing, things begin to work, new application seems to work), change is often sudden (then everybody gets it)

• Examples – flu epidemic, internet usage, Google.
So Are We at a Tipping Point for BH Integration?