RPC and OMH Collaborative Care Webinar

February 1, 2018

1-2pm

AGENDA

- Welcome & Introductions
- OMH Care Collaborative Overview
- Q&A

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INTRODUCTIONS

- **Amy Jones-Renaud, MPH**

Director, Primary Care Behavioral Health Integration

NYS Office of Mental Health

- In her current role at OMH, Ms. Jones-Renaud coordinates OMH's efforts to support the integration of BH into Primary Care, including managing the Collaborative Care Medicaid Program, and supporting the Integration components of Healthcare Delivery Reform efforts such as DSRIP and SIM/APC. She holds a Master's in Public Health from the University at Albany and a Bachelor's Degree in Psychology from Siena College. Previously, Amy worked at the Healthcare Association of New York State, working with primary care practices to support quality improvement activities, and in Chronic Disease Prevention at the NYS Department of Health.

NYS Collaborative Care Medicaid Program

Amy Jones-Renaud, MPH

Director, Primary Care Behavioral Health Integration

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The Impact of Mental Health on the Healthcare System

- In NYS, Medicaid members with a BH diagnosis account for
  - 30% of the population but 60% of Medicaid expenditures
  - 54% of hospital admissions
  - 45% of ED visits
  - 82% of all readmissions within 30 days of the original admission
- The average length of stay per admission for BH Medicaid users is 30% longer than for the overall Medicaid population
- 60% of adults with a Mental Illness in the US do not receive treatment

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Barriers in Current System

- Providers are busy, hard for them to follow up
- Lack of access to BH Specialists
- More than half of patients do not go when referred out to specialty
  - Those that do, average 1-2 visits
- Lack of reimbursement for BH in primary care and regulatory restrictions for co-location

Not *All* Integration Efforts Are Effective

Most models of integrated care are not evidence based

Some models of integrated care are known *NOT to work*:

- Screening alone without adequate systems in place to ensure accurate diagnosis and treatment
- Co-located behavioral health specialists without systematic tracking of outcomes or evidence-based treatments
- Disease management without direct collaboration with PCP

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Collaborative Care Model

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

Collaborative Care Team

- Primary Care Provider (PCP)
  - The PCP engages the patient and manages clinical aspects of care, including prescribing and managing medications
- Behavioral Health Care Manager (CM)
  - The CM is the liaison between all members of the team; Works directly with the patient, including Psychotherapy; Manages a registry to track patient progress; Meets with Psych Consultant weekly
- Psychiatric Consultant (MD Psychiatrist or Psych NP)
  - Provides consultative support on patients not improving or complex cases; Provides medication management support to PCPs to build their capacity

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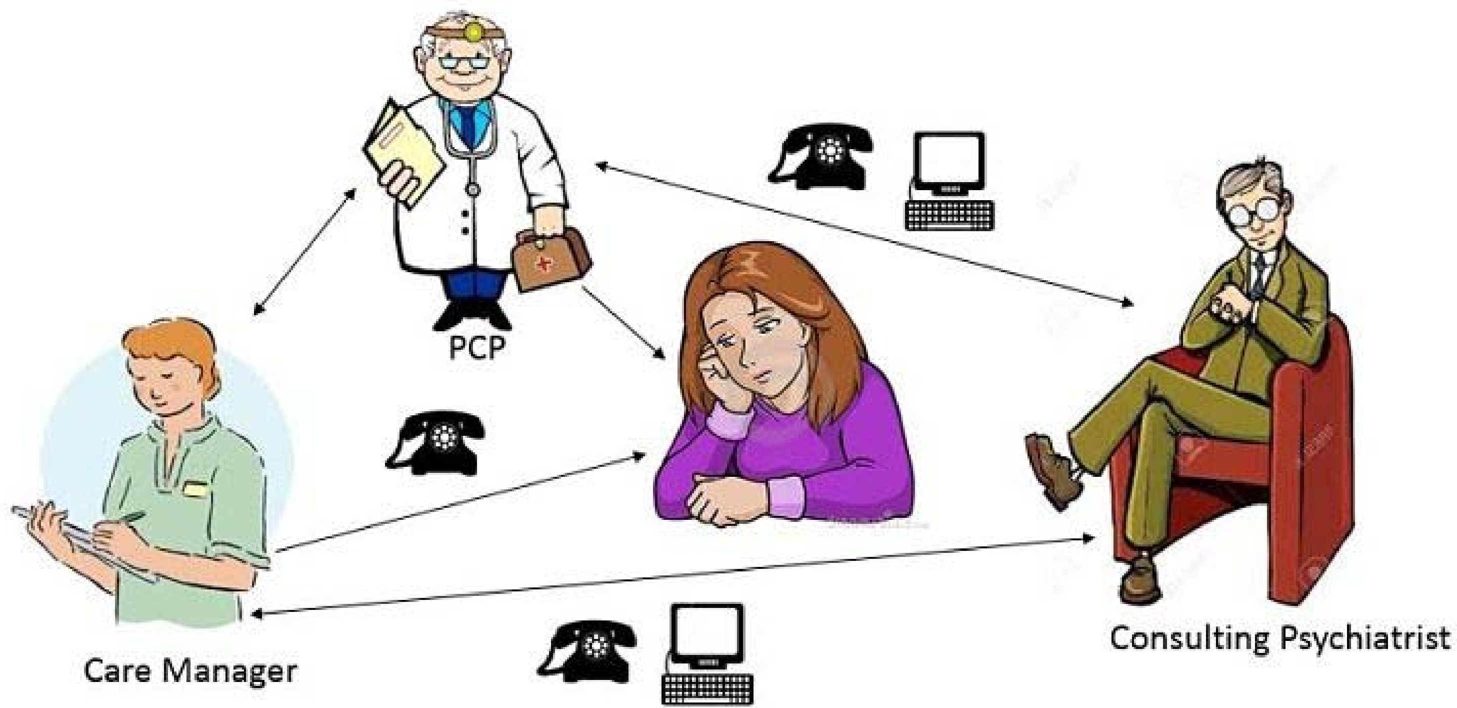
The Collaborative Care Team



5 Pillars of the Collaborative Care Model

Patient Centered Team Care / Collaborative Care

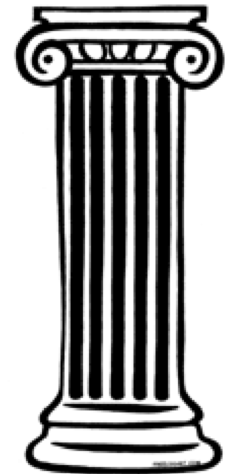
- **Collaboration is not co-location**
- **Team members have to learn new skills**

Population-Based Care

- Patients tracked in a registry; no one falls through the cracks

Measurement-Based Treatment to Target

- Treatments are actively changed until the clinical goals are achieved



Accountable Care

- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided

Evidenced-Based Care

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Collaborative Care - Enrollment

1. Screening – **Consistently screening all patients** with standardized tool (at least annually)
2. Capturing that screening in your EMR
3. Patient screens positive, communication to PCP; PCP makes diagnosis and treatment recommendations; **Warm Connection to BHCM*** if Collaborative Care is the appropriate treatment
4. BHCM evaluates patient and creates treatment plan

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Collaborative Care - Treatment

5. BHCM manages treatment ongoing (avg. **3-6 months duration**)

-Maintain regular clinical contact, in-person, group, or phone, at least monthly; **PHQ-9 at least monthly for monitoring;** Delivers Psychotherapy when needed; Enters progress in to registry; communicates with PCP; **Meets weekly w/ Psych Consultant to review cases where patient is not improving**; Relapse prevention planning

Benefits of the Collaborative Care Model

- Allows for regular contacts, telephonic and otherwise
- Treatment to target – Patients do not remain in ineffective treatment
- Patients treated where they are comfortable, and can get access right away
    - Minimizes loss to follow up
- Improved efficiency and provider satisfaction
    - In house capacity to treat BH, Patients improving on chronic physical health conditions, Someone on team that keeps track
- No issues with licensing, thresholds, billing restrictions
- Aligns with other initiatives and supports VBP

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NYS Collaborative Care Medicaid Program

- 2013-2014, NYS DOH Medical Home Grant Program established CC programs in academic medical centers

- To sustain the progress, OMH launched the Medicaid program in 2015
  - More than **100** sites currently participating
  - Over 2,000 patients enrolled each quarter
  - Value based reimbursement
  - Address regulatory and reimbursement barriers

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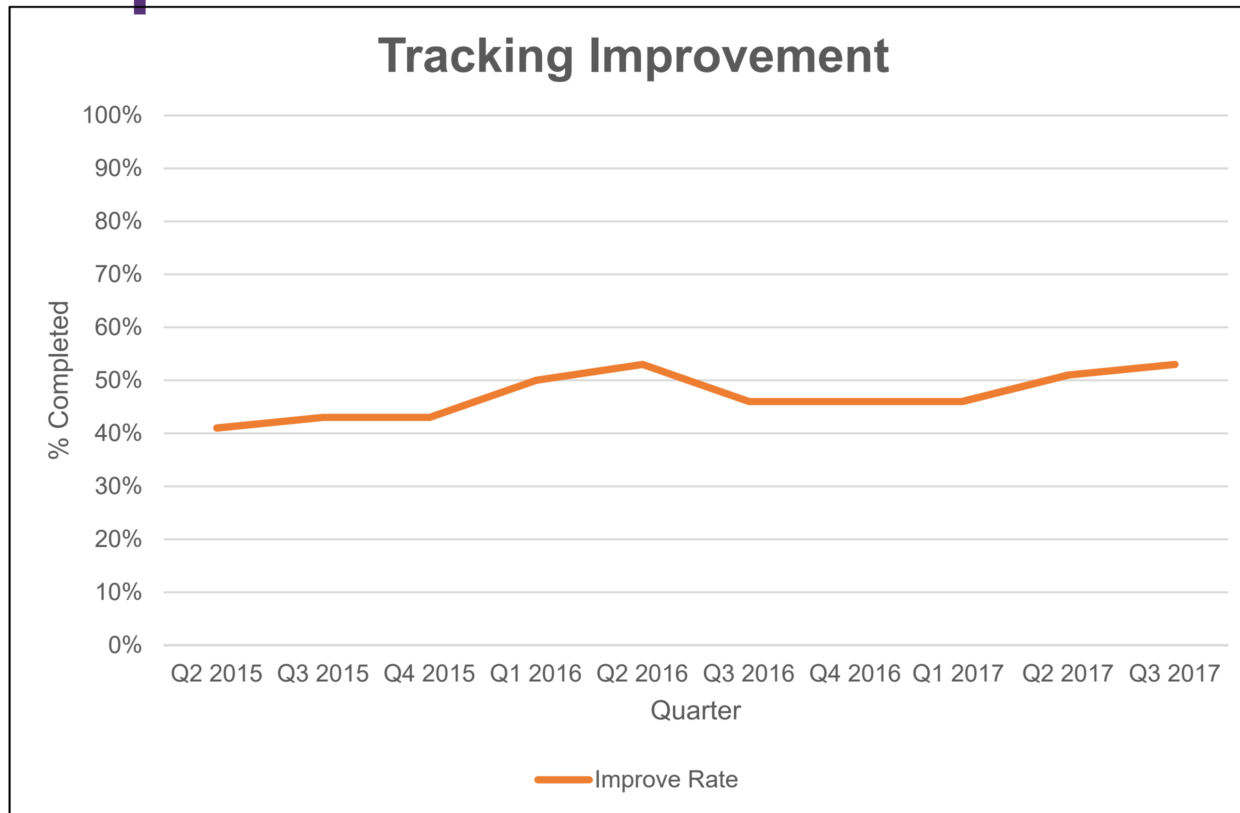
Improvement Rate



Almost all sites are continually meeting or exceeding the Improvement Rate goal of at least 50% of patients improving after 10 weeks of treatment. Sites continue to improve as they optimize their workflows.

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Monthly Case Rate Reimbursement Methodology

- *Collaborative Care services are not reimbursable under most current financing mechanisms*

- PCP coordination time
- BHCM (SW, LMHC, or other) care management and brief intervention, phone and group time
- Psychiatric Consultation, not face-to-face with patient
- Data entry and registry management

NYS CCMP Monthly Case Rate

- For meeting the monthly engagement requirements, providers get 75% of the payment, $112.50.
- After three months of enrollment, if the patient has received one of the following, the practice can receive the 25% Retainage withhold retroactively, and can receive the 25% for each additional month they continue to meet criteria. *

- ❑ Patient has met clinical improvement criteria (PHQ9 50% dec. or <10)
- ❑ Documented change to Treatment Plan
- ❑ Documented case review by Psychiatric Consultant

*Non- Article 28 clinics do not receive Retainage

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New for 2017 – Medicare G Codes

HCPCS Medicare Payment Summary

HCPCS	Description	Payment/Pt (Non-Fac) Primary Care Settings	Payment/Pt (Fac) Hospitals and Facilities
G0502	Initial psych care mgmt, 70 min - CoCM	$142.84	$90.08
G0503	Subsequent psych care mgmt, 60 min - CoCM	$126.33	$81.11
G0504	Initial/subsequent psych care mgmt, additional 30 min CoCM	$66.04	$43.43

http://aims.uw.edu/new-bhi-services-fact-sheet

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Process & Outcome Measures - Reported Quarterly

- Enrollment
- Newly Enrolled
- Average Duration of Treatment
- % Monthly Contacts
- % Clinical Contacts by Phone
- % Patients Improved after 10 weeks
- % Patients who have achieved Remission
- % Patients Not Improved who have received a Psych Consultation or Change in Treatment plan
- % Depression Screen Rate and Yield Rate
- % Generalized Anxiety Screen Rate and Yield Rate

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Requirement for CCMP Reimbursement

- ✓ **Adult Primary Care Practices:** Internal Medicine, Family Medicine, Women's Health; Art. 28, FQHC or Private Practitioner
- ✓ **Using the evidence based elements of the CC model:**
- Embedded BH Care Manager
- Process for screening and warm hand-off
- Consulting Psychiatrist
- Use a registry to track and treat to target

Where do I start?

NYS OMH has technical assistance and training resources to support workflow development, implementation, and staff training.

What do you need to do?

- Assemble your team
    - Job descriptions available: http://aims.uw.edu/collaborative-care/team-structure
- **Get buy-in, especially from leadership**

Addressing Barriers in Small Practices

Lack volume or capacity to hire BH professional

Could benefit the most due to lack of access for referrals

Exploring a shared services model to enable rural providers to access BH services virtually, as needed.

Questions?

Amy Jones-Renaud, MPH

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