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Reflections on Primary Care and Behavioral Health Integration at the Front Lines: from FQHCs to ACOs

Henry Chung, M.D.
Vice President and Chief Medical Officer
Care Management Company of Montefiore Medical Center
And
Associate Professor of Clinical Psychiatry
Albert Einstein School of Medicine

Agenda

- The Imperative for Disseminating Integration
- Real World Translations: Personal and Professional Journey
- Addressing Disparities with Collaborative Care Models in Behavioral Health
- Potential of Health Reform and BH Integration

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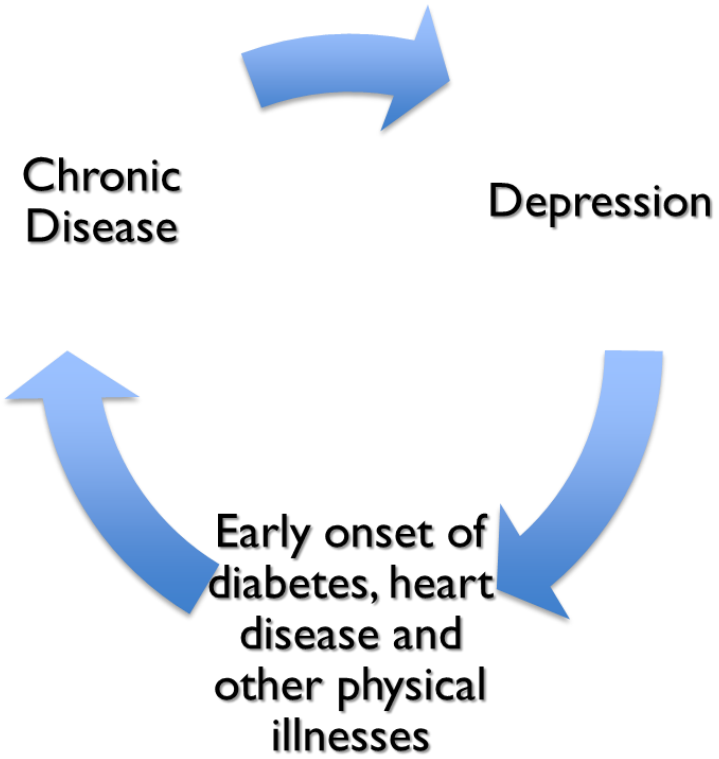
Depression and MH/SUD Increases Risk for Chronic Disease



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Primary Care and Behavioral Health Integration Models (Mechanic D)

- Enhanced screening, treatment and referral - Trained primary care providers screen, identify, treat and /or refer to mental health specialists (usually off site) for treatment
- Co-location of services –behavioral health clinicians provide consultation and/or short term treatment
- Systematic integration with shared protocols, health information, and quality metrics and outcomes

NEW: These models can also be implemented in traditional BH settings as well

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Key Randomized Controlled Trials for Depression in Primary Care

- **IMPACT (Unutzer)**– Older Adults and Depression
- **RESPECT-D (Dietrich)**– Primary Care Patients and Depression
- **PRISMe (Bartels)**– Older adults with depression in primary care or at-risk drinking randomized to primary collaborative treatment or enhanced specialty care
- **TEAMcare (Katon)**– patients with diabetes/CAD and depression

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The U.S. Preventive Services Task Force Recommendation (2002): for Depression Screening

- Screening improves patient identification (Level B)
  - 2 question screen
  - Prepared practice
- Treatment decreases morbidity
  - Benefit of feedback to patient or clinician regarding diagnosis is small
  - Dx that results in **coordinated care** shows largest benefit

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Don Berwick

Institute for Healthcare Improvement

"Trying harder will not work.
Changing systems
of care will."

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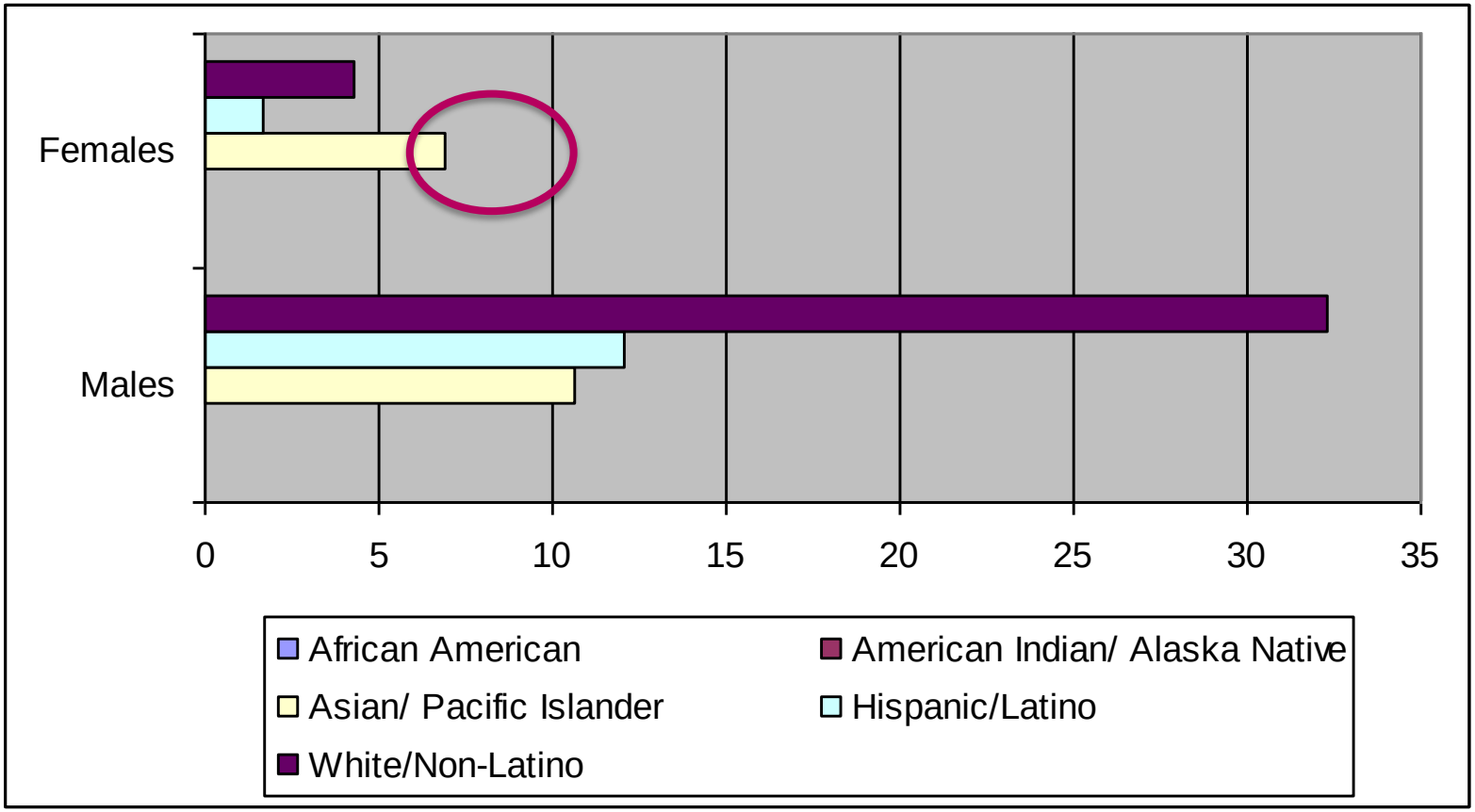
2006 Death Rates For Suicide by Ethnicity: 65+years



***Note: For AA and AI/AN Based on fewer than 20 deaths are considered unreliable and are not shown**

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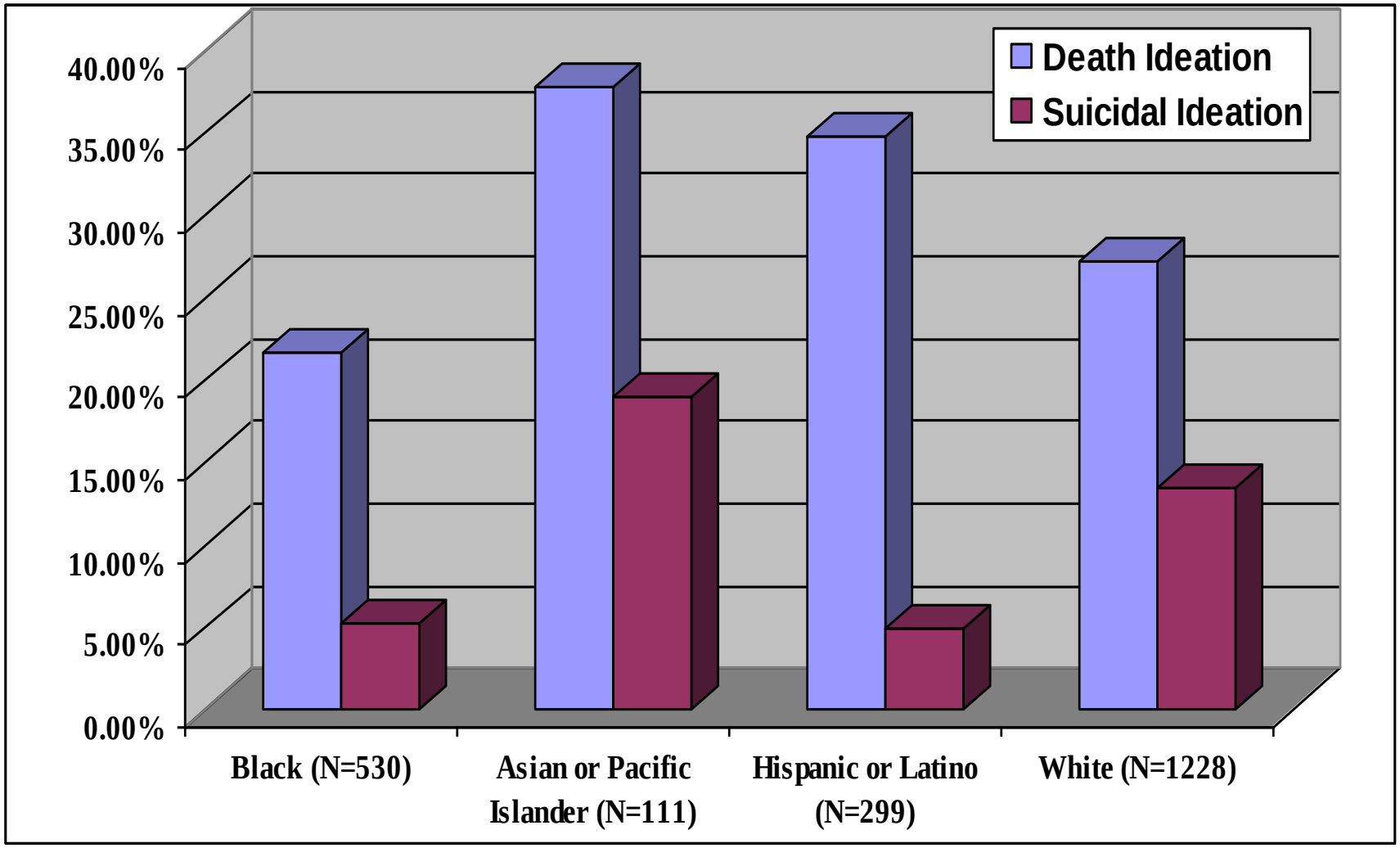
Suicide and Death Ideation in Depressed Primary Care Elderly (PRISM-E Study)



Bartels, SJ et al, Am J Geri Psych 2002

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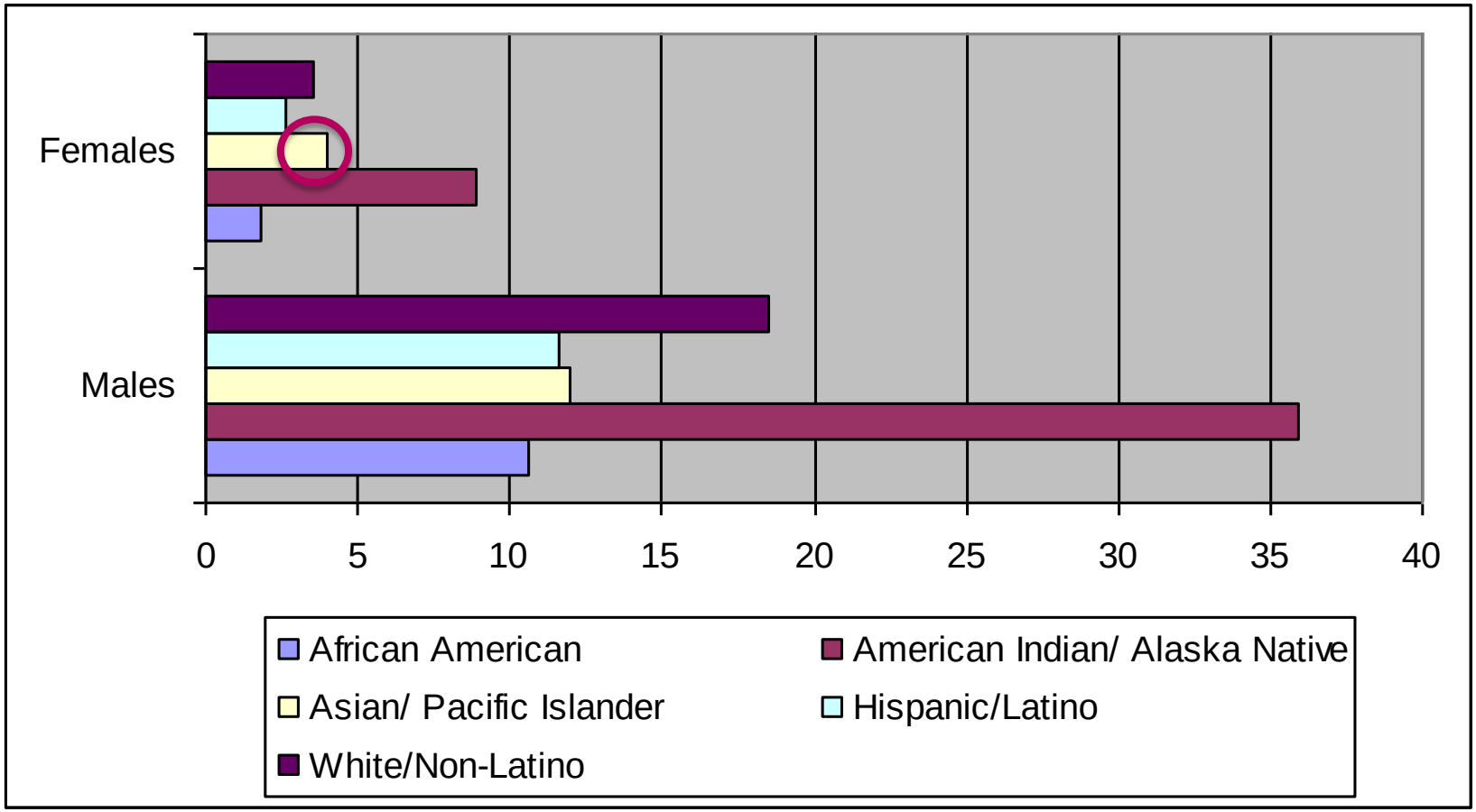
2006 Death Rates For Suicide by Ethnicity Age: 15-24 years



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Risk Factors for Suicide in College Students (Kisch et al, 2005)

2000 NCHA analysis for those seriously considering suicide attempt

- 9.5% had seriously considered an attempt and 1.5% had attempted
- Over 90% had depressed mood several times in past year
- Issues of sexual identity, problematic relationships, being of Asian background, and obesity were predictors
- <20% were receiving any treatment

Kisch et al, Suicide and Life Threatening Behavior 2005

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Prevalence and Recognition of Depression in Low Income Asians & Latinos in Primary Care

	Asian (*n*=91)	Latino (*n*=133)
Sig Depressive Sx	41.6%	47.3%
Physician ID of a problem**	23.6%	43.8%

**p<.01. *Chung et al., Community Mental Health Journal , 2002*

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Rate of Mental Health Care Use in Medicare Managed Care

	White	African American	Asian	Hispanic	Overall
Denominator size	4,319,145	486,696	68,865	141,322	5,016,028
Any mental health care (rate per 1000 members*)	24.6	16.6+	11.7+	24.1	23.6

*** Rates are age and sex adjusted**
+ P<0.05 vs. white

Source: Virnig, B, et al. (2004). Does Medicare Managed Care Provide Equal Treatment for Mental Illness Across Races? *Archives of General Psychiatry,* 61, 201-205.

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Medicare Managed Care: Adherence to Guideline Based Treatment

Percentage of Patients Taking Antidepressants Receiving Care

Patients receiving care (%*)	White	African American	Asian	Hispanic	Overall
Optimal practitioner contacts	12.5	12.0	11.1	10.6	11.7
Effective acute-phase treatment	60.1	48.5+	40.7+	57.6	58.6
Effective continuation-phase treatment	46.7	32.7+	31.9+	39.6+	43.1

*** Rates are age and sex adjusted**
+ P<0.05 vs. white

Source: Virnig, B, et al. (2004). Does Medicare Managed Care Provide Equal Treatment for Mental Illness Across Races? *Archives of General Psychiatry,* 61, 201-205.

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The Asian American Bridge Program at CBWCHC (Phase 1, 1998)

- Co-location in primary care using partnering BH specialty agency (HHC) shared resource (LCSW) and psychiatrist.
- Training of PCPs and LCSW in the model.
- BH documentation in the Medical Record.
- Referral to BH specialty agency for most complex patients.
- Results: Improved access and engagement rates compared to baseline.
- Funded by UHF

Chen H et al, Psychiatric services, 2003

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IHI Depression "Breakthrough" Series in Primary Care

- Funded by Robert Wood Johnson Foundation (1999), HRSA, SAMHSA
- 23 racially and geographically diverse sites incl 15 FQHC sites
- 2000 patients initiated treatment with 58% of patients responding in 12 weeks, and high levels of patient self management
- 1st use of the PHQ9 for depression severity monitoring in a national quality improvement project

Katzelnick DJ, et al Jt Comm J Qual Patient Saf 2005

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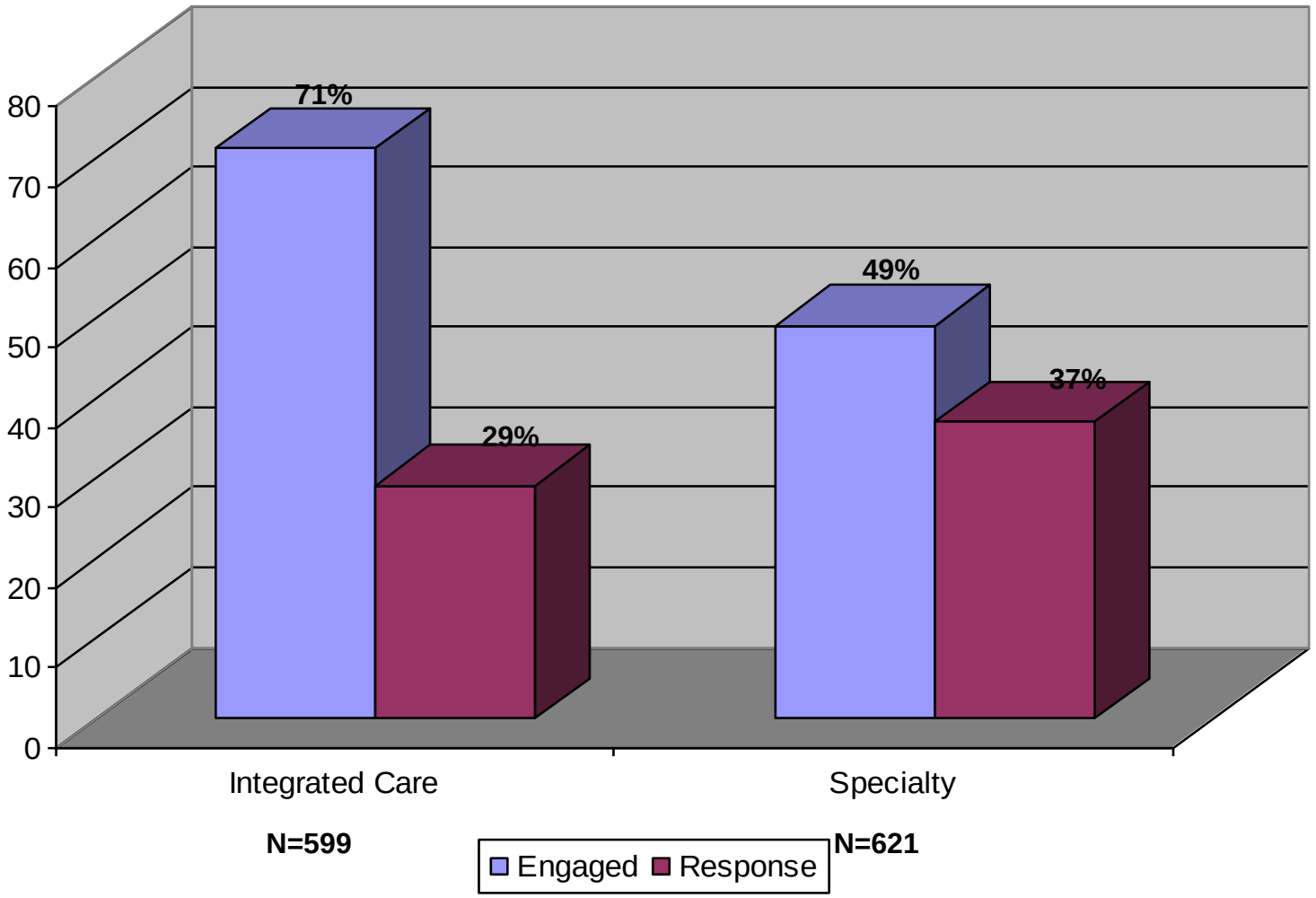
Engagement and depression treatment response in PRISM-E



Bartels S et al, Amer J Psych 2004; Krahn D et al, Psych Services 2006

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The Asian American Bridge Program at CBWCHC (Phase 2, 2001-2005)

- Co-location in primary care using internal resources (LCSW), psychiatrist, care manager in 2 separate sites.
- Care manager role in both face to face and telephonic follow-up.
- Increase responsibility of PCPs to screen, diagnose and treat using PHQ9 .
- Results: Improved access and engagement rates maintained with measurable positive outcomes.
- Replication at other API focused FQHC in the US
- Funded by RWJ, NYCT, Van Ameringen, Pfizer, HRSA

Chen T et al, 2006

Yeung A et al, 2004

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National College Depression Partnership (NCDP)

- **Maximizes existing health resources for quality care via:**
  1. **Effective collaboration between medical and counseling services using shared measures (PHQ9 for depression, AUDIT-C for alcohol)**
  2. **Depression screening in primary care to identify problems earlier or if not responding**
  3. **Provide treatment choices with proactive follow-up using a tracking registry to assure safety net**
  4. **Outcomes data to support resource allocation**
  5. **Community engagement and resources**

Chung et al, J Am College Health, 2011

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NCDP 42 Partnering Institutions Since 2006

- Baruch College
- **Boston University**
- Bowling Green State University
- Case Western Reserve University
- Colorado State University
- Columbia University
- Cornell University
- Evergreen State College
- Finger Lakes Community College
- Hunter College/CUNY
- **Lewis-Clark State College**
- Louisiana State University
- **McMaster University**
- Michigan State University
- **Montana State University**
- The New School
- Northeastern University
- New York University
- Penn State – Altoona
- Princeton University
- Rensselaer Polytechnic Institute
- Rio Hondo College
- **Rutgers University**
- Sarah Lawrence College
- School of the Art Institute of Chicago
- St. Lawrence University
- Skidmore College
- **Texas A&M University**
- Texas Christian University
- Tufts University
- University of Arizona
- University of California, Los Angeles
- **University of Central Florida**
- **University of Louisville**
- **University of Maryland**
- University of Missouri - Columbia
- University of Nevada, Las Vegas
- **University of Pennsylvania**
- **University of Vermont**
- **University of Wisconsin - Madison**
- Wagner College
- West Valley College

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APA National Depression Leadership Initiative to implement Measurement Informed Care

- PHQ9 was helpful in Tx decisions 93%

  (n=6,096 Patient Contacts)

- For contacts where PHQ9 was helpful, how did PHQ9 influence Tx? (n=5,578 Patient Contacts)
  - Change Tx 40%
  - Confirm Tx 60%

Duffy et al,Psych Services 2010

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Primary Care Access Referral and Eval (PCARE) Study - Relevance for SMI Health Home Patients

- Goal: Improve quality of medical care for SPMI patients at one CMHC
- Method: 12 month RCT of Patients in one CMHC randomized to nursing care management (MI, coaching, navigation, follow-up with appts.) versus encouragement and PCP list
- Demo: 85% of patients had schizophrenia, depression and bipolar. 25% had co-occurring SA disorders. Most common CMI were: HTN, arthritis, dental, diabetes.

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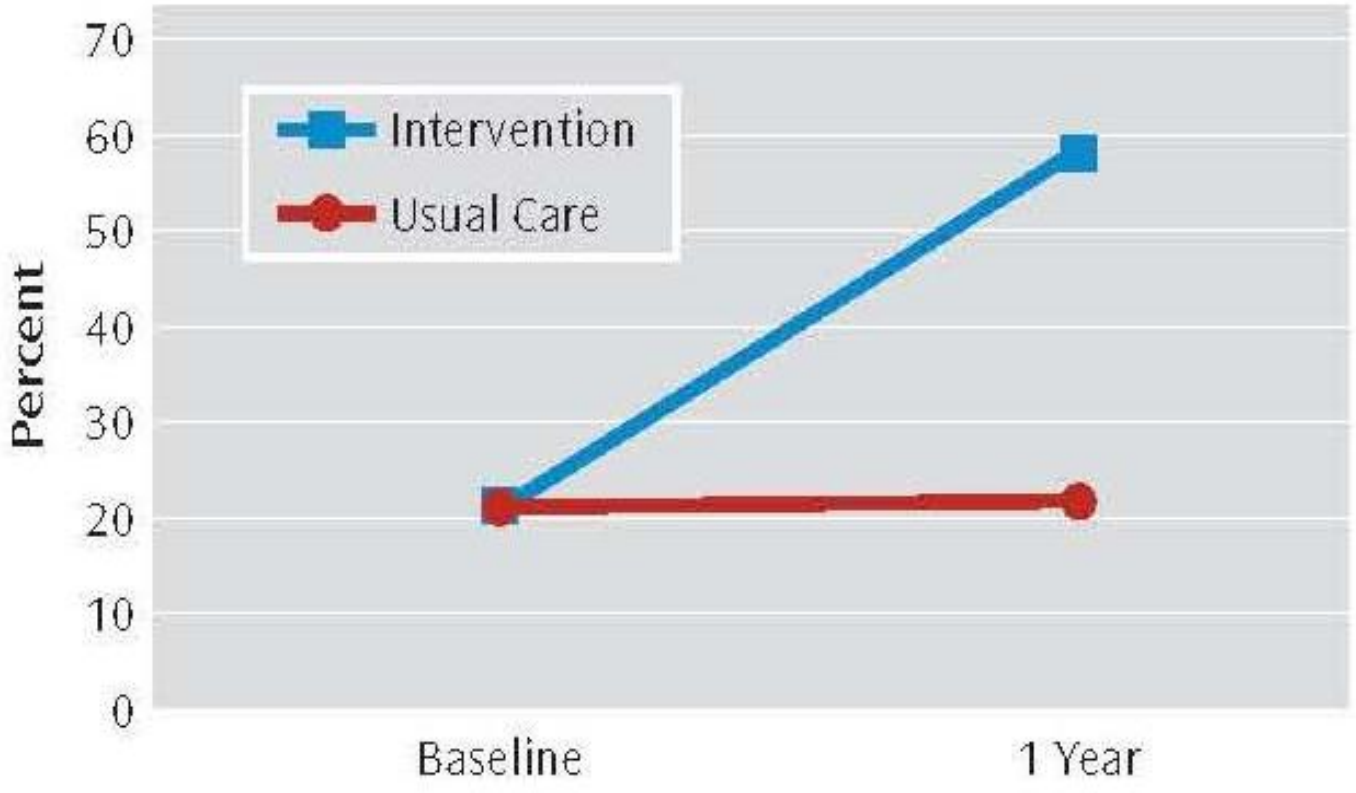
PCARE Improvement in Medical Care

FIGURE 2. Quality of Preventive Health Services in Mentally Ill Community Patients Randomly Assigned to Medical Care Management Intervention or Usual Care



Druss BG et al, Am J Psych 2010

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Health Care Reform: ACOs

- Medicare shared savings program:
  - promotes accountability for a patient population and encourages investment in infrastructure and redesigned care processes for high quality and lower cost. Under such program:
    - groups of providers meeting pre-determined criteria may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an ‘ACO’); and
    - ACOs that meet lower total cost and meet quality performance standards are eligible to shared savings

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Care Coordination Activities

- Determine and update care coordination needs
- Create and update a proactive plan of care
- Communicate: **PCMH**
  - Between health care professionals & patients/family
  - Within teams of health care professionals
  - Across health care teams or settings
- Facilitate transitions
- Connect with community resources
- Align resources with population needs **ACO**

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[24] Fisher, Elliott; Grumbach, Kevin; Meyers, David, et al. Unpublished, September 8, 2010 Consensus Meeting Briefing Materials on Care Coordination: Issues for PCMHs and ACOs.

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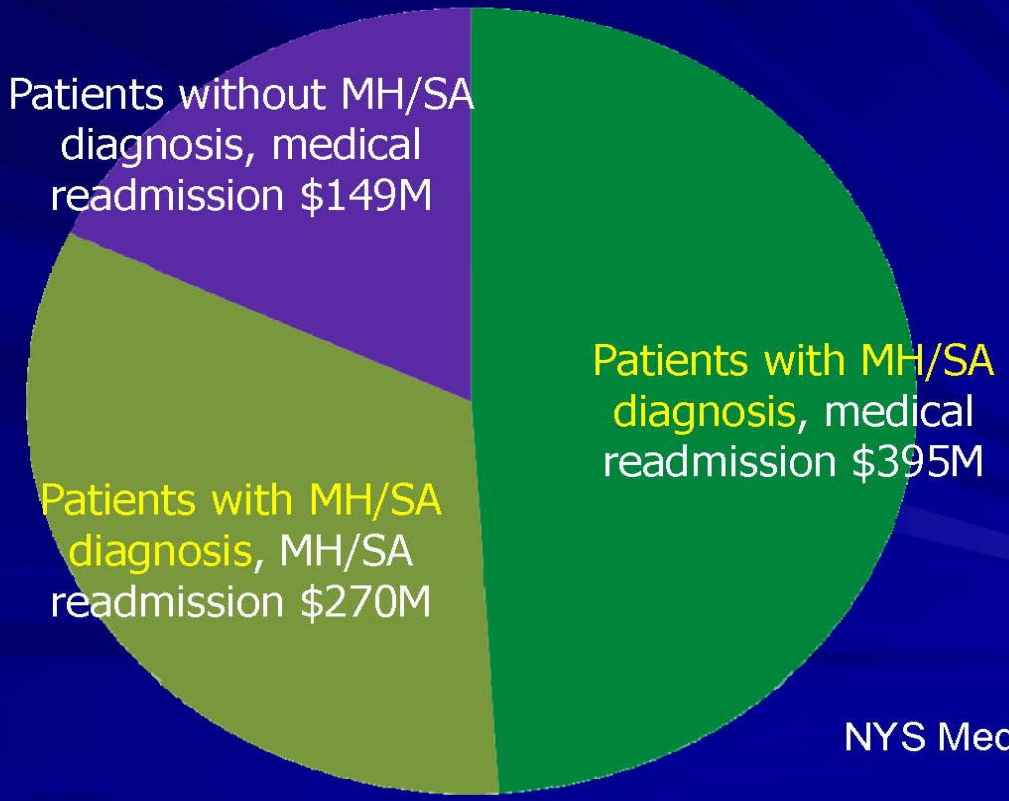
The Need for Care Coordination:
Potentially Preventable Readmissions (PPR's)



NYS Medicaid 2007

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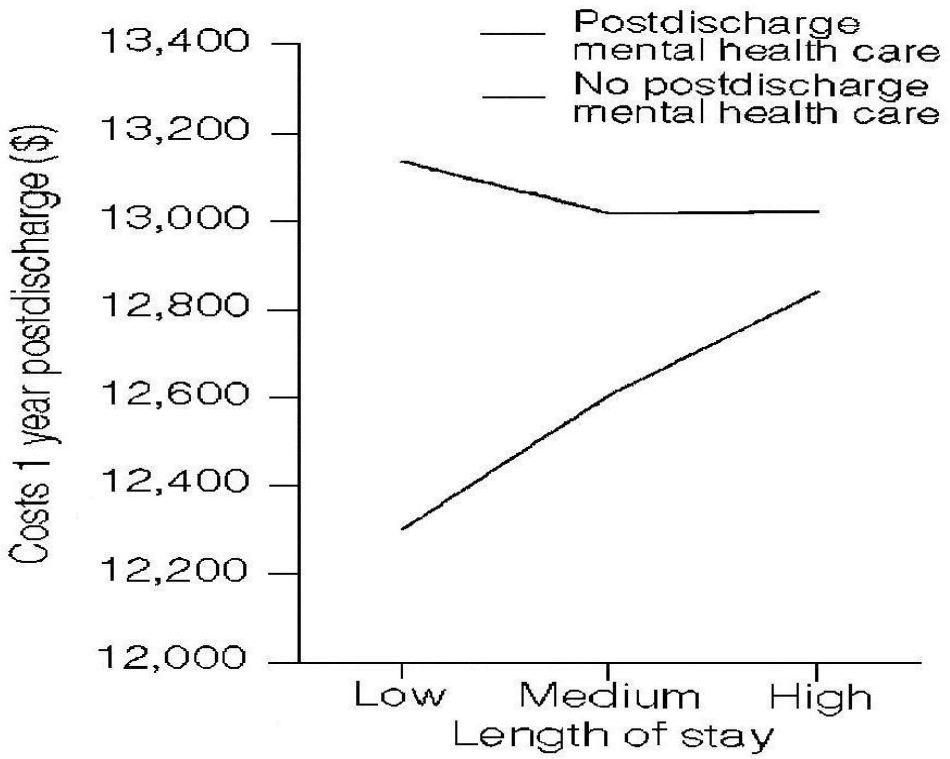
Post Discharge Behavioral Healthcare Associated with Decreased Costs

Figure 1

Interaction between length of stay and postdischarge mental health care for patients with moderate health care costs



Benzer et al; Psychiatric Services 2012

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Montefiore ACO BH Integration Activities

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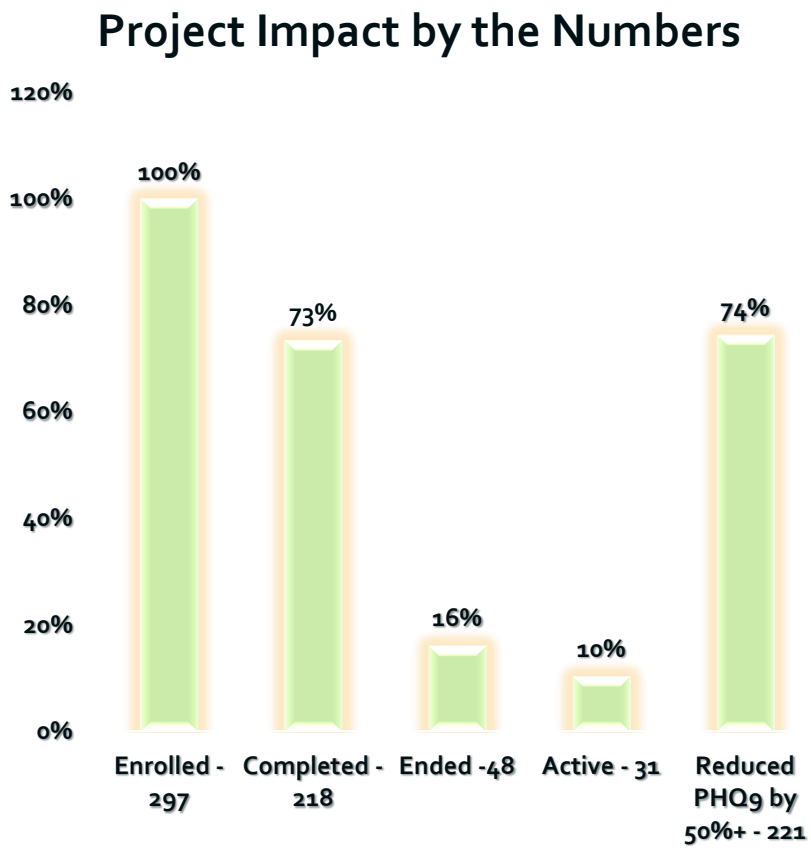
Summary of Project Impact at Montefiore FQHC

Measures

- Enrolled 297 total patients into Project Impact
- 218 (73.4%) of those enrolled have completed program, kept all appointments
- 48 (16%) ended program by choice. Did not keep appointments
- 221 (74%) patients reduced their PHQ 9 scores by 50%

Graph of Measures



Ward V et al, CHCANYS 2012, supported by Samuels Foundation and Institute for Urban and Family Health

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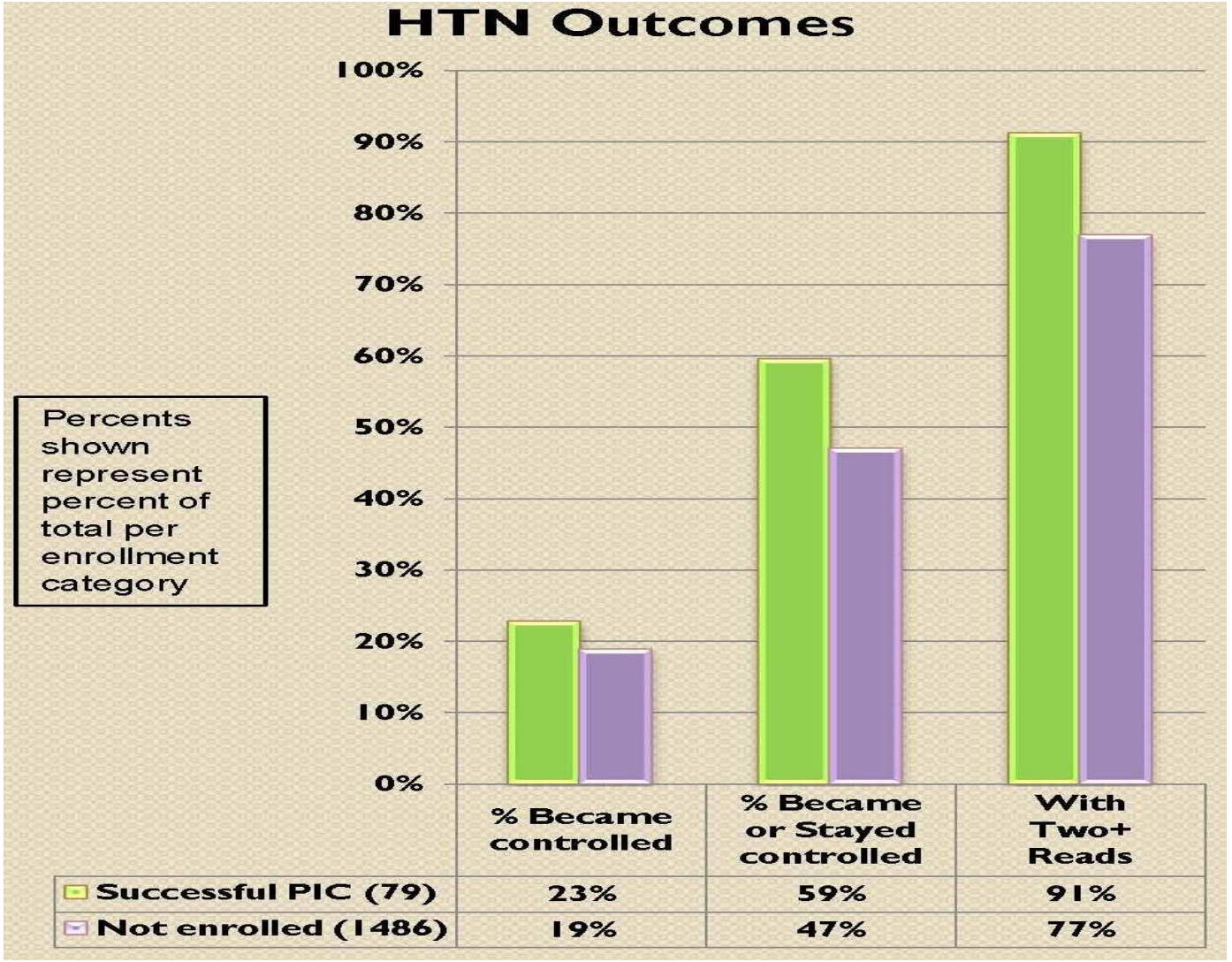
OUTCOMES OF HYPERTENSIVE PATIENTS WITH DEPRESSION



Ward V et al, CHCANYS 2012

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Improving Health and Mental Health in among SMI Patients at Montefiore CMHC

Clinical Indicator	At Risk Level	# of Patients (x/198)	Percentage (x/198)
Blood Pressure-Systolic	<121	122/198	61.6%
Blood Pressure-Diastolic	<81	80/198	40.4%
BMI	<25	144/198	72%
PHQ9	<10	58/198	29.3%
Tobacco- smoker, current status unknown	*	0	0
Tobacco- smoker, current some days	*	10/198	5.1%
Tobacco- smoker, current every day	*	57/198	28.8%

Betzler T et al, unpublished data , 2013, supported by NYSOMH

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Montefiore Synergy Team: Chronic Illness and Depression 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

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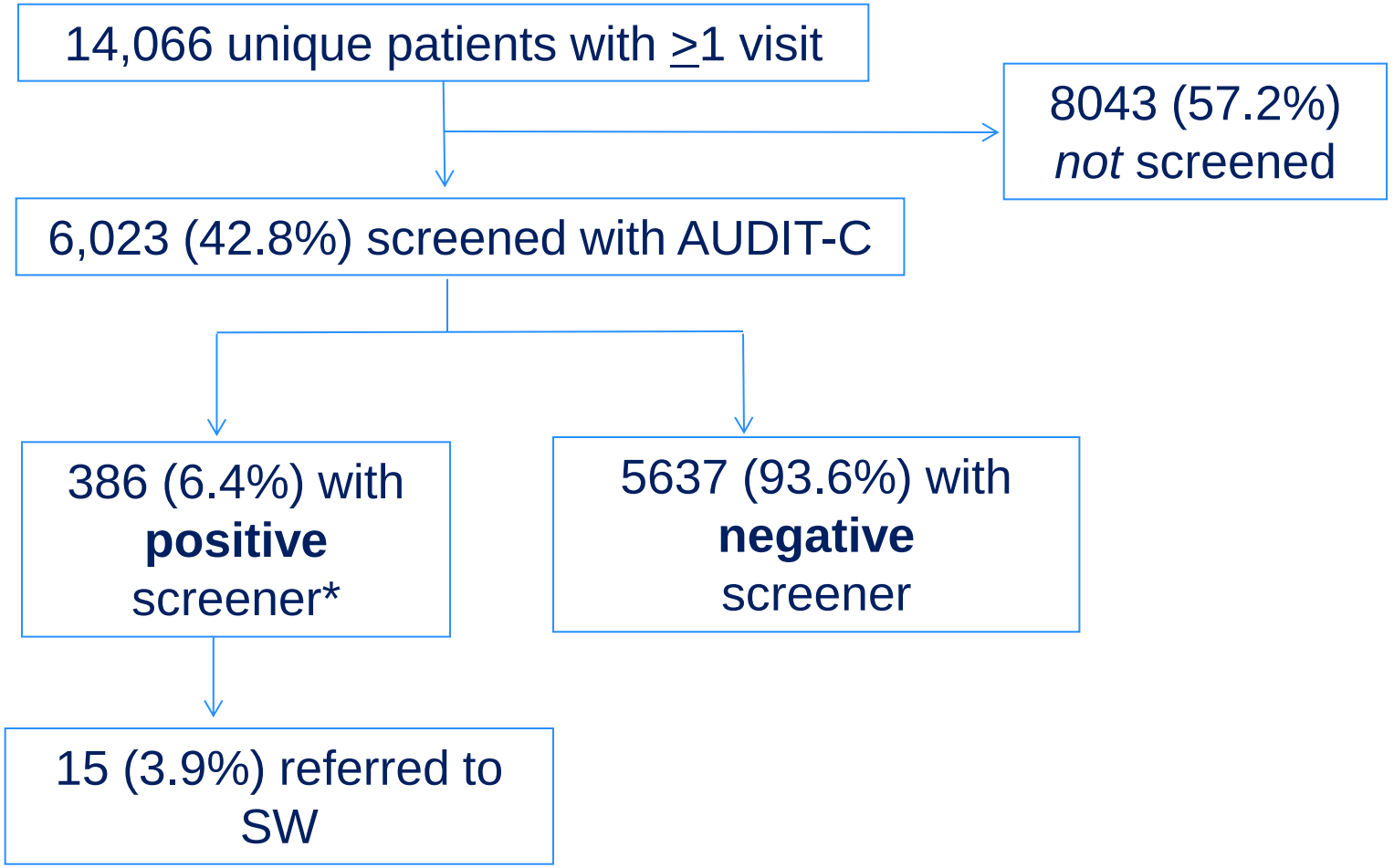
Alcohol Screening at Montefiore CHCC – The First 7 Months



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

Cunningham C et al, Unpublished data 2013, supported by UHF, NYSHF

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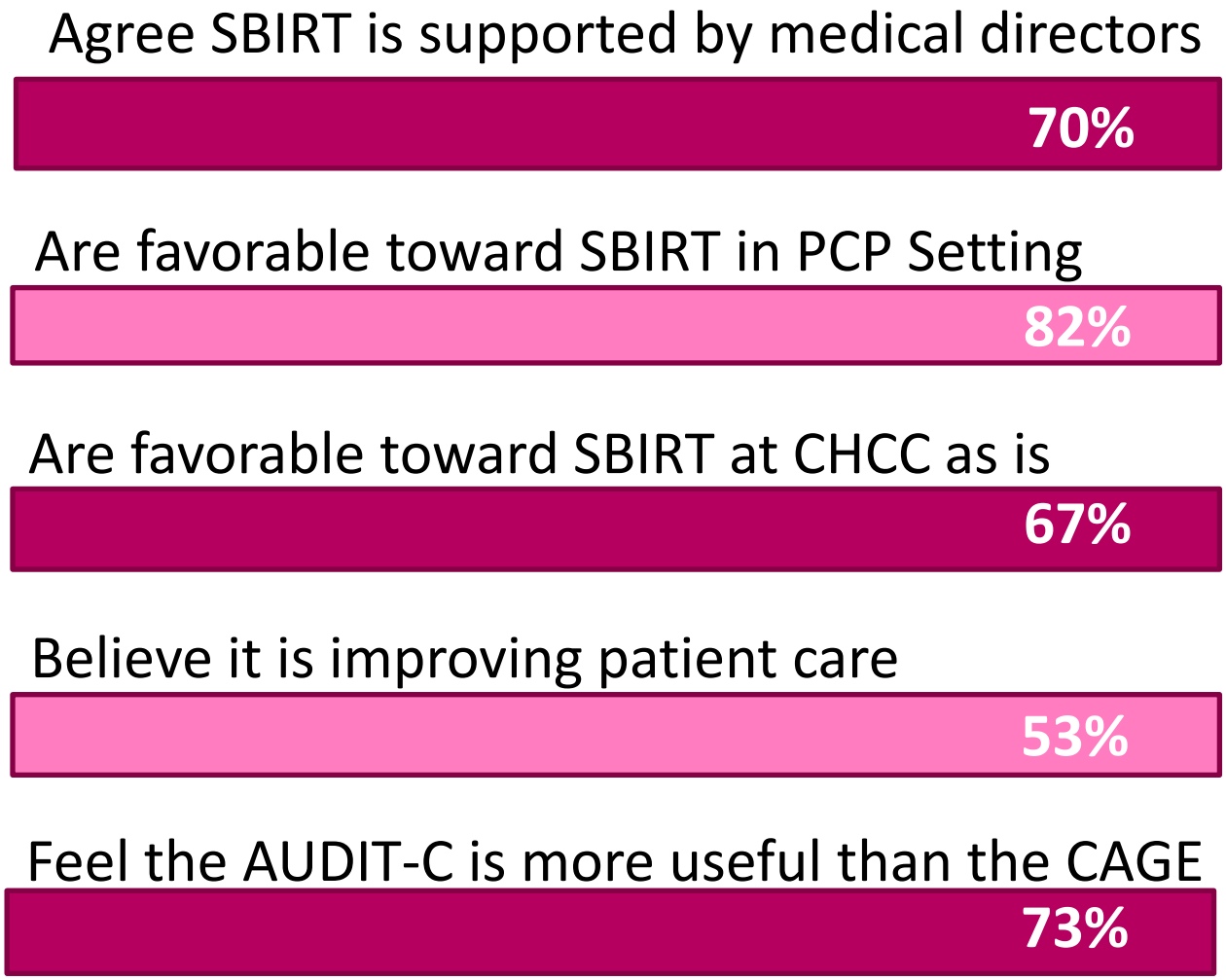
Is there support for SBIRT at CHCC?

Most staff…



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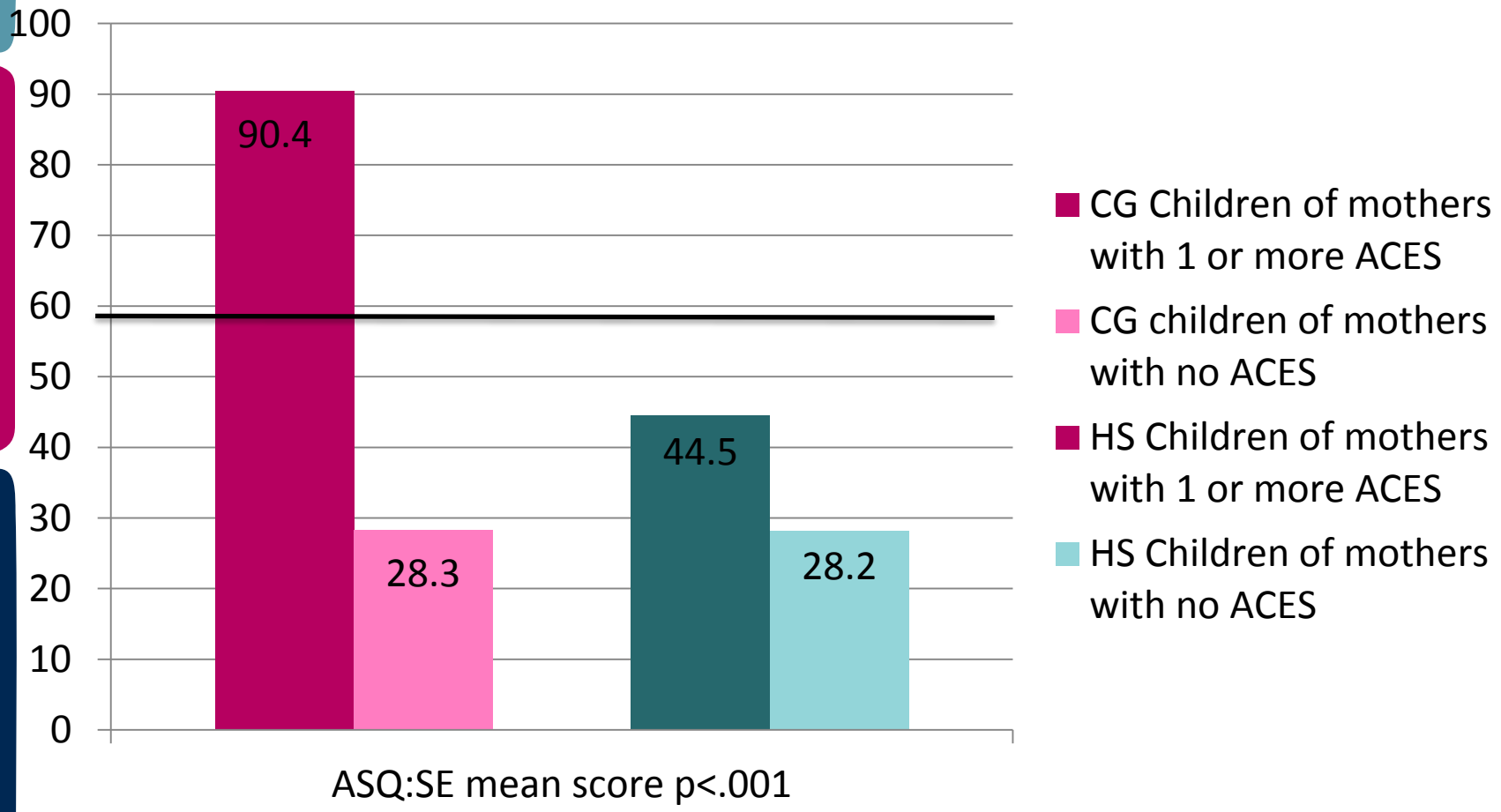
Impact of Healthy Steps on social emotional development of vulnerable children



Briggs et al., Pediatrics 2012, supported by Altman Foundation

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Looking Forward

- What is the role of C-L Psychiatry in inpatient and outpatient sectors?
- How do we scale Pediatric Integration?
- How do we strengthen HIT processes (incl tele-mental health technology) and content to support BH integration at all levels?
- How do we ensure access to State of the Art Treatments (Therapy and Medications)?
- Are We Ready to scale Measurement Based Outcomes for Behavioral Health?

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If we want person centered care, then primary and BH integration must be foundational!

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