NYS OMH
Collaborative Care Medicaid Program
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The 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 for Other Mental Health Conditions

<table>
<thead>
<tr>
<th>Evidence Base Established</th>
<th>Emerging Evidence</th>
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<tbody>
<tr>
<td>• Depression</td>
<td>• ADHD</td>
</tr>
<tr>
<td>- Adolescent Depression</td>
<td>• Bipolar Disorder</td>
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<tr>
<td>- Depression, Diabetes, and Heart Disease</td>
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<tr>
<td>- Depression and Cancer</td>
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<tr>
<td>- Depression in Women’s Health Care</td>
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<tr>
<td>• Anxiety</td>
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<tr>
<td>• Post Traumatic Stress Disorder</td>
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<td>• Chronic Pain</td>
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<td>• Dementia</td>
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<td>• Substance Use Disorders</td>
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Core Principles of Collaborative Care

**Patient-Centered Care.** Primary care and mental health providers collaborate effectively using shared care plans.

**Population-Based Care.** A defined group of patients is tracked in a registry so that no one falls through the cracks.

**Treatment to Target.** Progress is measured regularly and treatments are actively changed until clinical goals are achieved.

**Evidence-Based Care.** Providers use treatments that have research evidence for effectiveness.

**Accountable Care.** Providers are accountable and reimbursed for quality of care and clinical outcomes, not just volume of care.
## Collaborative Care Team Model

<table>
<thead>
<tr>
<th>TWO PROCESSES</th>
<th>TWO NEW ‘TEAM MEMBERS’</th>
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<tbody>
<tr>
<td><strong>1. Systematic diagnosis and outcomes tracking</strong></td>
<td><strong>BH Care Manager</strong></td>
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<tr>
<td>PHQ-2/9 &amp; GAD-2/7 to facilitate diagnosis and track outcomes</td>
<td>- Patient education / self management support</td>
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<td>- Close follow-up to make sure patients don’t ‘fall through the cracks’</td>
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<td><strong>2. Stepped Care</strong></td>
<td><strong>Consulting Psychiatrist</strong></td>
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<tr>
<td>a) Change treatment according to evidence-based algorithm if patient is not improving</td>
<td>- Weekly caseload consultation for care manager and PCP (population-based)</td>
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<tr>
<td>b) Relapse prevention once patient is improved</td>
<td>- Diagnostic consultation on difficult cases</td>
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<tr>
<td></td>
<td>- Support anti-depressant Rx by PCP</td>
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<tr>
<td></td>
<td>- Brief talk treatment (behavioral activation, PST-PC, CBT, IPT)</td>
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<tr>
<td></td>
<td>- Facilitate treatment change / referral to specialty behavioral health, as needed</td>
</tr>
<tr>
<td></td>
<td>- Relapse prevention</td>
</tr>
<tr>
<td></td>
<td>- Consultation focused on patients not improving as expected</td>
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<tr>
<td></td>
<td>- Recommendations for additional treatment / referral according to evidence-based guidelines</td>
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</tbody>
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Working as a Team

- **PCP:** Recognize the signs of possible diagnoses, perform/review screening of symptoms, gather additional history, consider potential medical causes, educate, coordinate with Care Manager

- **Care Manager:** Complete assessment of symptoms and functional impairment, safety plan (if indicated), provide psychoeducation, engage, discuss treatment options. *RN or BH provider from your community*

- **Psychiatric Consultant:** Clarify, determine, and/or refine diagnosis. Request further information. Assist in determining appropriate level of care.

- **Patient:** Responds to self-report questions, communicates symptoms and problems.
Collaborative Care - Enrollment

1. Screening – *Consistently screening all patients* with standardized tool (at least annually)
2. Capture 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
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 into 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
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
Financial Sustainability
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
  • Value based reimbursement
  • Address regulatory and reimbursement barriers
NYS CCMP

- More than 150 primary care practices currently participating
  - Article 28s, FQHCs, and Private Practitioners
  - 1,000+ Primary Care Providers
  - Over 2 Million covered lives
- Over 3,000 patients receiving CC treatment
NYS CCMP 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
NYS Collaborative Care Medicaid Program Metrics

- # Enrolled Patients
- % Patients engaged in care
- % Patients Improved
- % Patients Getting Interventions if not Improved
- % Patient in Remission
- Avg. Treatment Duration
- % Contacts by Phone
- Screening Rate and Yield
  - (PHQ and GAD)
Tracking Data Q4 2015 - Q4 2017

- Active Patient Rate
- Improvement Rate
- Psychiatrist Consultation Rate
- Change in Treatment Rate
Treatment to Target Drives Early Improvement

In a recent retrospective study (2008 – 2013) of over 7,000 patients:

• Time to depression remission was 86 days for patients in Mayo Clinic collaborative care program
• Time to remission was 614 days in usual care

New HEDIS Remission & Response Metric

Time to Remission for Depression with Collaborative Care Management in Primary Care:  http://www.ncbi.nlm.nih.gov/pubmed/26769872

JAM Board Fam Med, 2016 Jan-Feb
CC patients are less likely to have ED/IP visits with time in treatment
Questions?

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NYS Collaborative Care Info: https://aims.uw.edu/nyscc/