BHI COLLABORATIVE PRESENTS

November 12, 2020

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Overcoming Obstacles Webinar Series

This series is focused on enabling physicians to sustain a collaborative, integrated, whole-person, and equitable approach to physical and behavioral health care in their practices during the COVID-19 pandemic and beyond.

About the BHI Collaborative

*The BHI Collaborative was established by several of the nation's leading physician organizations** to catalyze effective and sustainable integration of behavioral and mental health care into physician practices.*

With an initial focus on primary care, the Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patients' mental and behavioral health needs.

***American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Osteopathic Association, and the American Psychiatric Association.*

TODAY'S TOPIC:

Financial Planning: Quantifying the Impact of Behavioral Health Integration

TODAY'S SPEAKERS

Henry Chung, MD

Senior Medical Director of BHI Strategy at Montefiore Care Management Organization; Prof. of Psychiatry at Albert Einstein College of Medicine

Paul Saladino, MD

Founding member, Cross Valley Health & Medicine, P.C.; Medical Director, MAT Program at Montefiore St. Luke's Cornwall Hospital

Christian Plaza MBA, MSN, FNP-C

Co-founder and Clinical & Business Director of Cross Valley Health & Medicine, P.C.; Allied Health Professional at Montefiore's Saint Cornwall Hospital

Katherine Suberlak

Vice President of Clinical Programs at Oak Street Health

Roadmap to Financial Sustainability for Behavioral Health Integration in Primary Care

Henry Chung, MD
Senior Medical Director
Montefiore Care Management Organization
and
Professor of Psychiatry
Albert Einstein College of Medicine

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Framework 2.0: Revised and Expanded Guide to Implementing Behavioral Health Integration

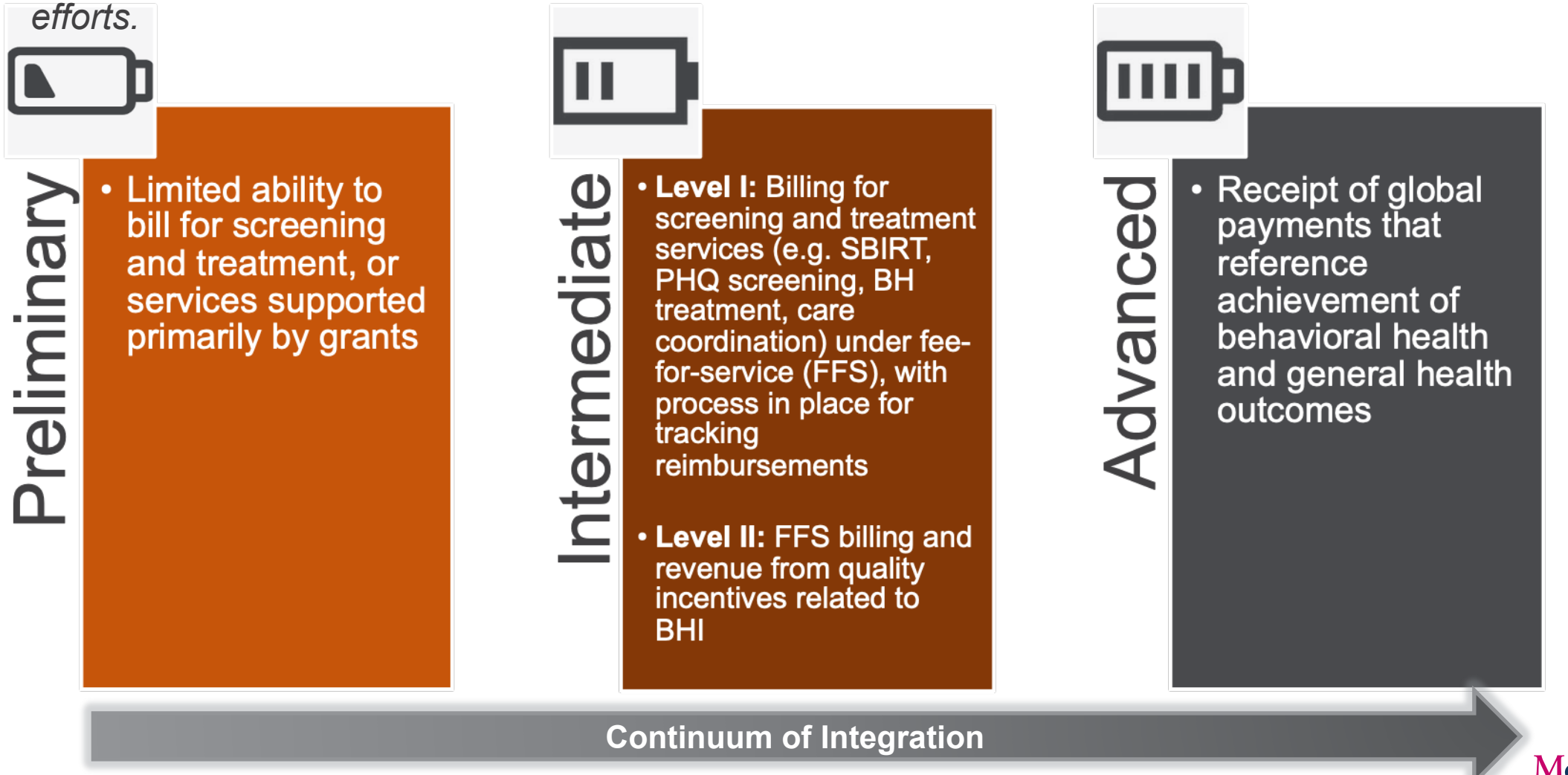
Role	Key elements of integrated care		Integration continuum			
	Domains	Components	Preliminary	Intermediate		Advanced
Clinical Workflow	1. Case finding, screening, referral to care	Screening, initial assessment, follow-up for BH conditions	Patient/clinician identification of those with BH symptoms—not systematic	Systematic BH screening of targeted patient groups (e.g., those with diabetes, CAD), with follow-up for assessment	Systematic BH screening of all patients, with follow-up for assessment and engagement	Analysis of patient population to stratify patients with high-risk BH conditions for proactive assessment and engagement
		Facilitation of referrals, feedback	Referral only, to external BH provider(s)/ psychiatrist	Referral to external BH provider(s)/psychiatrist through a formal agreement detailing engagement, with feedback strategies	Enhanced referral to internal/ co-located BH provider(s)/ psychiatrist, with assurance of "warm handoffs" when needed	Enhanced referral facilitation with feedback via EHR or alternate data-sharing mechanism, and accountability for engagement
	2. Decision support for measurement-based stepped care	Evidence-based guidelines/ treatment protocols	None, with limited training on BH disorders and treatment	PCP training on evidence-based guidelines for common behavioral health diagnoses and treatment	Standardized use of evidence-based guidelines for all patients; tools for regular monitoring of symptoms	Systematic tracking of symptom severity; protocols for intensification of treatment when appropriate
		Use of psychiatric medications	PCP-initiated, limited ability to refer or receive guidance	PCP-initiated, with referral when necessary to prescribing BH provider(s)/psychiatrist for medication follow-up	PCP-managed, with support of prescribing BH provider(s)/ psychiatrist as necessary	PCP-managed, with care management (CM) supporting adherence between visits and BH prescriber(s)/ psychiatrist support
		Access to evidence-based psychotherapy with BH provider(s)	Supportive guidance provided by PCP, with limited ability to refer	Referral to external resources for counseling interventions	Brief psychotherapy interventions provided by co-located BH provider(s)	Range of evidence-based psychotherapy provided by co-located BH provider(s) as part of overall care team, with exchange of information
	3. Information exchange among providers	Sharing of treatment information	Minimal sharing of treatment information within care team	Informal phone or hallway exchange of treatment information, without regular chart documentation	Exchange of treatment information through in-person or telephonic contact, with chart documentation	Routine sharing of information through electronic means (registry, shared EHR, shared care plans)
	4. Ongoing care management	Longitudinal clinical monitoring and engagement	Limited follow-up of patients by office staff	Proactive follow-up (no less than monthly) to ensure engagement or early response to care	Use of tracking tool to monitor symptoms over time and proactive follow-up with reminders for outreach	Tracking integrated into EHR, including severity measurement, visits, CM interventions (e.g., relapse prevention techniques, behavioral activation), proactive follow-up; selected medical measures (e.g., blood pressure, A1C) tracked when appropriate

Framework 2.0: Revised and Expanded Guide to Implementing Behavioral Health Integration

Role	Key elements of integrated care		Integration continuum			
	Domains	Components	Preliminary	Intermediate		Advanced
Clinical Workflow (continued)	**5. Self-management support that is culturally adapted**	Use of tools to promote patient activation and recovery with adaptations for literacy, language, local community norms	Brief patient education on BH condition by PCP	Brief patient education on BH condition, including materials/handouts and symptom score reviews, but limited focus on self-management goal-setting	Patient education and participation in self-management goal-setting (e.g., sleep hygiene, medication adherence, exercise)	Systematic education and self-management goal-setting, with relapse prevention and CM support between visits
Workforce	**6. Multi-disciplinary team (including patients) used to provide care**	Care team	PCP, patient	PCP, patient, ancillary staff member	PCP, patient, ancillary staff member, CM, BH provider(s)	PCP, patient, ancillary staff member, CM, BH provider(s), psychiatrist (contributing to shared care plans)
		Systematic multidisciplinary team-based patient care review processes	Limited written communication and interpersonal interaction between PC-BH provider(s), driven by necessity or urgency, or patient as conduit	Regular written communication (notes/consult reports) between PCP and BH provider(s), occasional information exchange via ancillary staff or labs, on complex patients	Regular in-person, phone, or e-mail meetings between PCP and BH provider(s) to discuss complex cases	Weekly team-based case reviews to inform care planning and focus on patients not improving behaviorally or medically, with capability of informal interaction between PCP and BH provider(s)
Management Support	**7. Systematic quality improvement**	Use of quality metrics for program improvement	Informal or limited use of BH quality metrics (limited use of data, anecdotes, case series)	Use of identified metrics (e.g., depression screening rates, depression response rates) and some ability to regularly review performance	Use of identified metrics, some ability to respond to findings using formal improvement strategies	Ongoing systematic quality improvement (QI) with monitoring of population-level performance metrics, and implementation of improvement projects by QI team/champion
	8. Linkages with community/ social services	Linkages to housing, entitlement, other social support services	Few linkages to social services, no formal arrangements	Referrals made to agencies, some formal arrangements, but little capacity for follow-up	Screening for social determinants of health (SDOH), patients linked to community organizations/ resources, with follow-up	Developing, sharing, implementing unified care plan between agencies, with SDOH referrals tracked
	9. Sustainability	Build process for billing and outcome reporting to support sustainability of integration efforts	Limited ability to bill for screening and treatment, or services supported primarily by grants	Billing for screening and treatment services (e.g., SBIRT, PHQ screening, BH treatment, care coordination) under FFS, with process in place for tracking reimbursements	FFS billing, and revenue from quality incentives related to BHI	Receipt of global payments that reference achievement of behavioral health and general health outcomes

Framework Levels of Integration

- **Domain 9: Sustainability.**
- **Component 1:** *build process for billing and outcome reporting to support sustainability of integration efforts.*



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Practices' Self-Reported Quality Metrics (n=8 responses to survey, of 11 practices)

Depression Monitoring Metric	Prompt Follow-Up for Patients Diagnosed with Depression
NUMERATOR: Patients with documented results of at least two PHQ9 or PHQA scores (including the initial PHQ9 or PHQA), within 4-8 weeks after initial assessment	**NUMERATOR:** Patients with two documented contacts (e.g., visits, successful phone calls) within 4-8 weeks after initial assessment of depression
DENOMINATOR: Patients age ≥12 seen for any reason, with a new or existing diagnosis of Major Depressive Disorder or Dysthymic Disorder, or with clinically significant symptoms on a standardized tool (e.g., PHQ-9 score ≥10)	**DENOMINATOR:** Patients age ≥12 seen for any reason with a new diagnosis of Major Depressive Disorder or Dysthymic Disorder, or with clinically significant symptoms on a standardized tool (e.g., PHQ-9 or PHQA score ≥10)

Depression Monitoring	Site 3		Site 5		Site 10	
	2017	2018	2017	2018	2017	2018
Total %	42%	62%	41%	71%	31%	51%

Prompt Follow-up for Patients with Depression	Site 3		Site 5		Site 10	
	2017	2018	2017	2018	2017	2018
Total %	42%	62%	20%	36%	31%	51%

Revenue Metrics	Site 2		Site 3*		Site 4		Site 5	Site 6
	2017	2018	2017	2018	2017	2018		
Monthly revenue for depression screening	$20.92	$2,139.94	$1,090.40	$955.63	$382.20	$2,357.44	No ability to report on relationship between depression screening and revenue	No billing in 2018, only DSRIP reimbursement
Number of patients billed for depression screening	1	573	135	201	55	249		

* Site 3 noted that despite performing more screens in 2018 revenue was comparatively less—possibly due to delays in the billing system capturing the most recent payments. There might also be a difference in reimbursements based on the payer mix for each year, they noted, with some insurance covering depression screening on a fee-for-service basis and others as part of a capitation agreement.

Goldman ML, Smali E, Richkin T, Pincus HA, Chung H.Transl Behav Med. 2020 Aug 7;10(3):580-589. doi: 10.1093/tbm/ibz142.

Evaluation of Novel Continuum Based Framework of Integration in Primary Care. https://uhfnyc.org/media/filer_public/61/87/618747cf-9f4b-438d-aaf7-6feff91df145/bhi_finalreport.pdf

The Impact of Behavioral Health Integration in a Primary Care Practice

Paul I. Saladino, MD,
Christian J. Plaza, MBA, MSN, FNP-C

Cross Valley Health & Medicine, P.C. (CVHMPC) Profile

- CVHMPC is a Primary Care and Addiction Medicine practice located in Newburgh, NY
- CVHMPC founded in 2007 and currently provides outpatient care for over 8500 patients in the Hudson Valley
  - Patient demographics
- Since 2007, CVHMPC has differentiated itself by providing diverse medical services for the diverse communities in an urban setting
  - Outpatient Services: Behavioral Health, OUD MAT Program
  - Inpatient Services: OUD MAT Treatment
- CVHMPC currently consist of 2 providers: Physician and Family Nurse Practitioner
  - Collaborative Approach / Strengths of MD/NP Team

CVHMPC Mission & Highlights Supporting Its Vision

- In 2019, Mission and Vision Statement Updated:
  - *To transform into a medical practice that provides patients specialized high quality primary care services through an innovative and modern model*
- In 2019, Opportunity to Collaborate with Montefiore Behavioral Health Integration Program and Participate in the Medicaid's Collaborative Care Program
  - Enhanced our current services increasing access to care for patients who otherwise normally experiences barriers
  - Improved communication with specialists and expanded medical management within primary care
- Collaboration provided CVHMPC to innovate, lead, and expand its Behavioral Health and Addiction Medicine services in the community further improving patient retention and patient outcomes
- In 2020, the Impact of COVID19 & Opportunity to implement Telemedicine in Primary Care
  - Expanded Behavioral Health Treatment via telemedicine
  - Expanded ability to continue providing MAT treatment within primary care

Reasons for Integrating Behavioral Health in CVHMPC

- Differentiation of services typically not offered in a standard primary care practice
  - Implementation of Level I Outpatient OUD MAT Treatment
  - Standardization of screenings - Opportunity
  - Practice retention while overcoming patient barriers

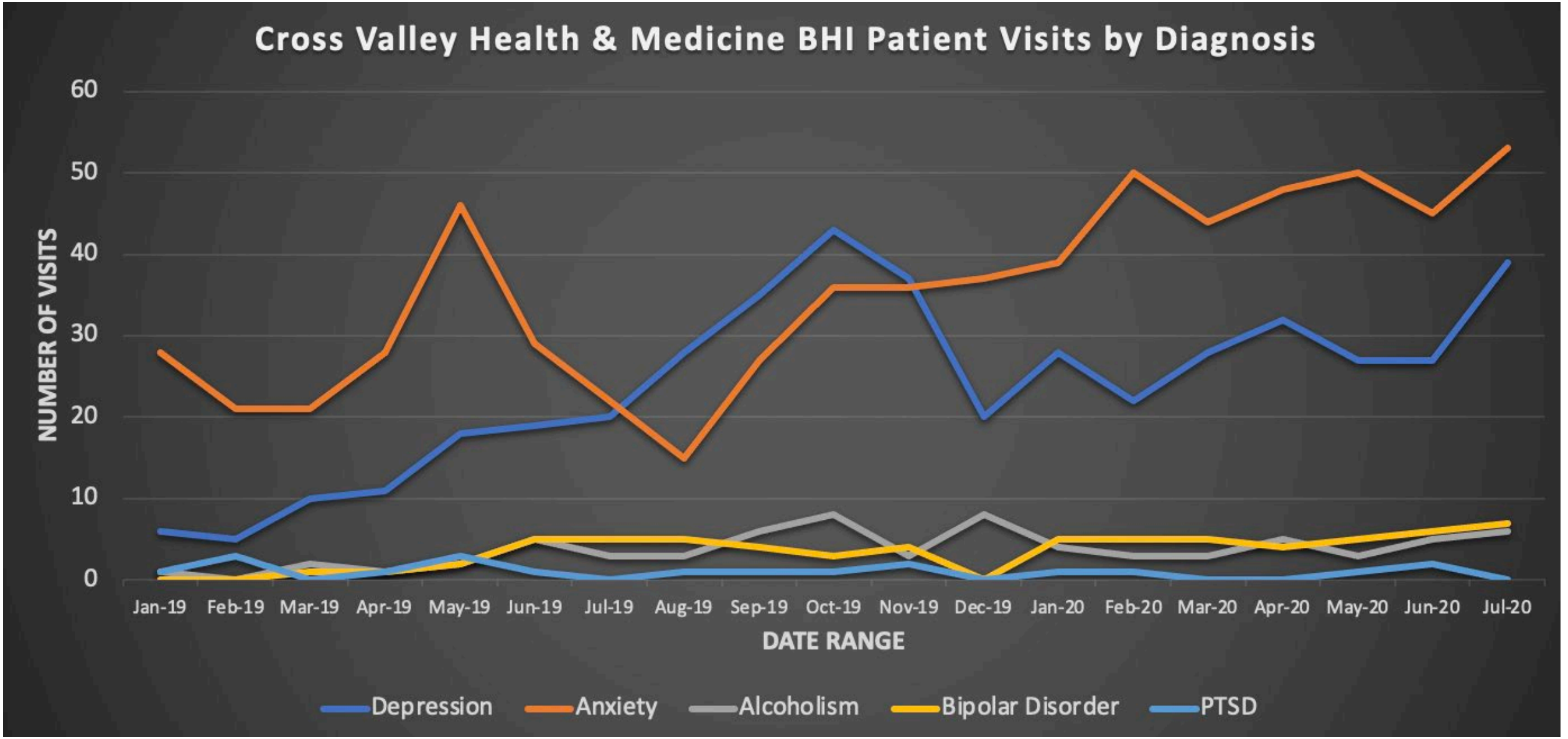
- Availability of Resources
  - Electronic Health Record System
  - Current Collaborative Partnerships
    - Behavioral Health Services of the Hudson Valley
    - Montefiore Behavioral Health Integration Program
  - Leadership

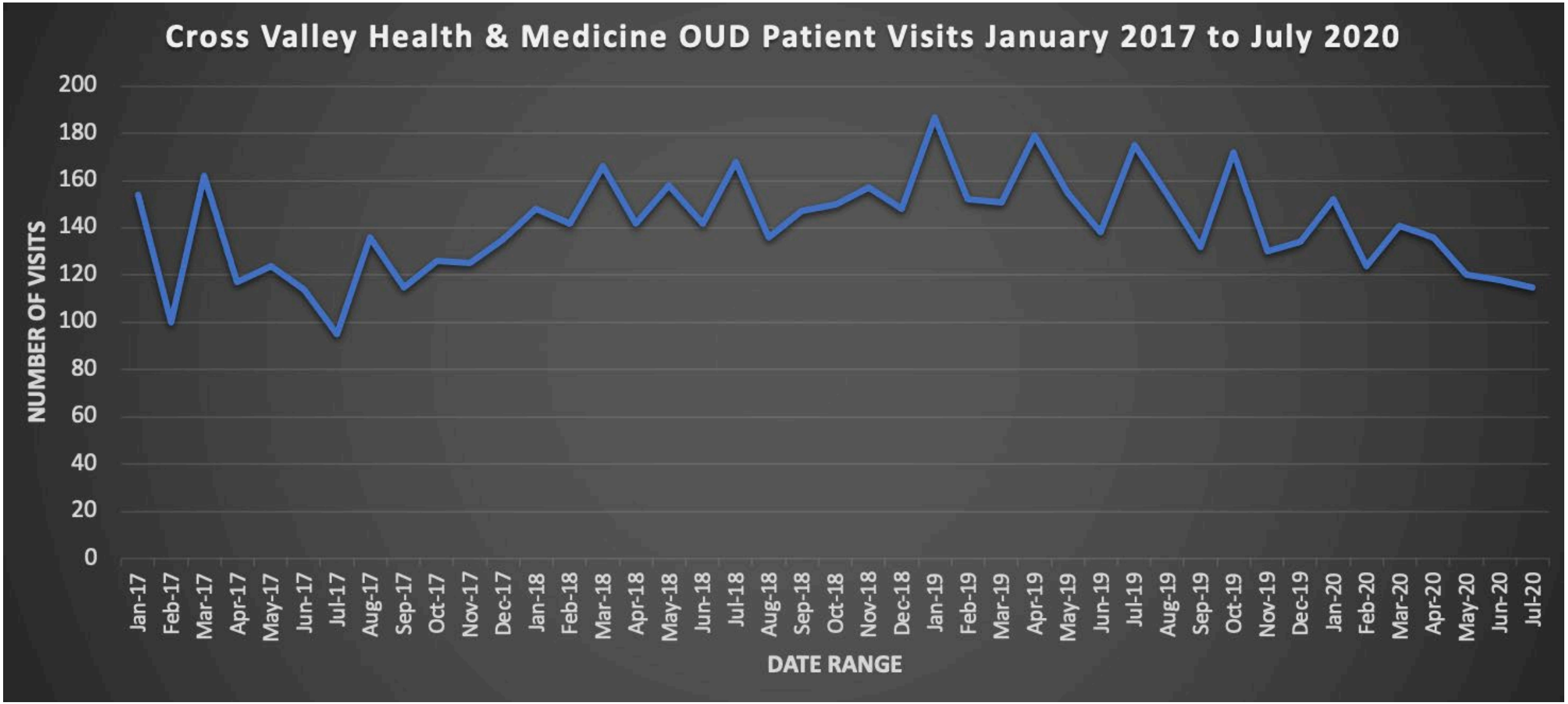
- Within the Framework Levels of Integration
  - Transition from Level II to an Advanced Integration

Reasons for Integrating Behavioral Health in CVHMPC

- Financial Incentive
  - In NYS, by participating in a Collaborative Care Model, there is an additional payment on top of a fee-for-Service encounter
  - Increasing frequency of encounters produce revenue increase
  - Achieve certain quality-based incentives in primary care
    - PHQ9/GAD7/AUDIT Screenings
  - Complex plan of care justifies higher level coding

- Improved Patient Outcomes
  - Achieve certain quality-based incentives in primary care
    - PHQ9/GAD7/AUDIT Screenings
  - Patient more likely to adhere to recommendations, treatment and follow up


Cross Valley Health & Medicine BHI Patient Visits by Diagnosis
NUMBER OF VISITS
60
50
40
30
20
10
0
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
DATE RANGE
Depression
Anxiety
Alcoholism
Bipolar Disorder
PTSD


Cross Valley Health & Medicine OUD Patient Visits January 2017 to July 2020
NUMBER OF VISITS
200
180
160
140
120
100
80
60
40
20
0
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
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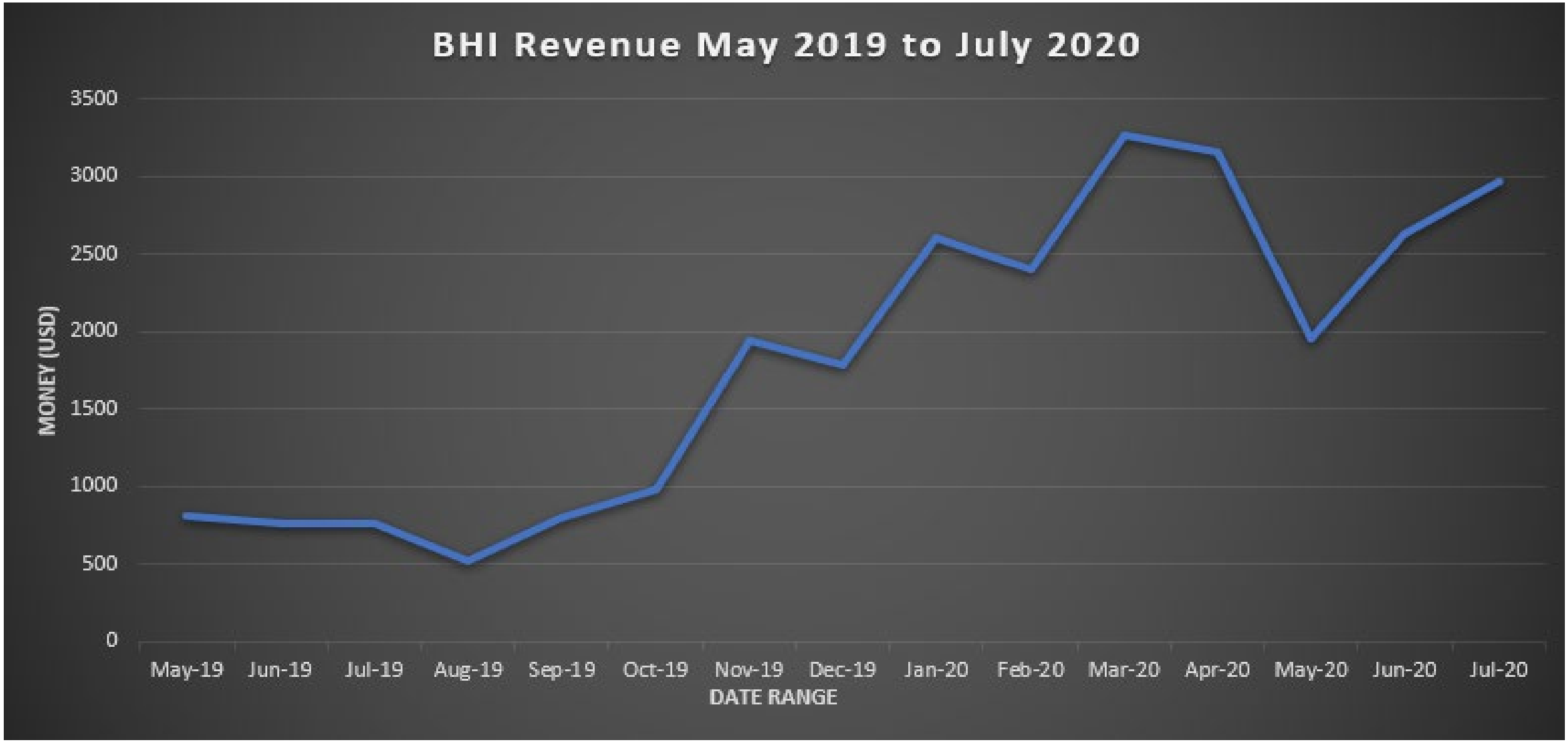
DATE RANGE


BHI Revenue May 2019 to July 2020
3500
3000
2500
2000
1500
1000
500
0
MONEY (USD)
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
DATE RANGE

Practical Billing Guide for Behavioral Health

CMS.gov Physician Fee Schedule Search Locality #1320203 (Poughkeepsie/NYC Suburbs) Non-Facility

Code	Description	Medicare Reimbursement Rate	Real World NYS Medicaid Managed Care Plan (MVP Medicaid)
99213	E&M Level 3 Primary Care Visit	$81.63	$56.75
99214	E&M Level 4 Primary Care Visit	$118.08	$84.69
99215	E&M Level 5 Primary Care Visit	$158.41	$111.74
99492	Initial Case Management Visit - Behavioral Health Care Management	$168.22	$165.06
99493	Subsequent Case Management Visit - Behavioral Health Care Management	$134.99	$89.54
99494	Additional Case Management Visit - Behavioral Health Care Management	$68.22	$47.99
99484 T2022	Generic Case Management Visit - Behavioral Health Care Management	$51.45	$35.08
96127	Behavioral Health Assessment - Monthly/Annual (Medicare)	$5.63	$3.82
G0442	Alcohol Screening - Annual	$19.73	-
G0444	Depression Screening - Annual	$19.73	$12.35
99406	Smoking Cessation Screening - Annual	$16.59	$11.51
99407	Smoking Cessation Screening - Annual	$31.70	$26.13
H0049	Alcohol Drug Screening - Annual	-	$8.83

https://www.cms.gov/apps/physician-fee-schedule/

Consideration of Financial Sustainability of Behavioral Health in CVHMPC

- Expand treatment and management of Behavioral Health
  - Include Bipolar Disorder, Binge Eating Disorder
- Partner with other virtual collaborative partners supporting the Collaborative Care Model
- Continue performing routine behavioral health screenings
- Embrace additional Behavioral Health Care training
- Compromise in pursuit of financial models/incentives available
- Balance Behavior Health alongside Chronic Disease Conditions

Oak Street Health Collaborative Care Approach: Integration of Behavioral Health into Primary Care Practice

Katherine Suberlak, VP Clinical Program

November 12, 2020

Objectives for today's webinar

Share Oak Street Health's experience on how we have implemented behavioral health through:

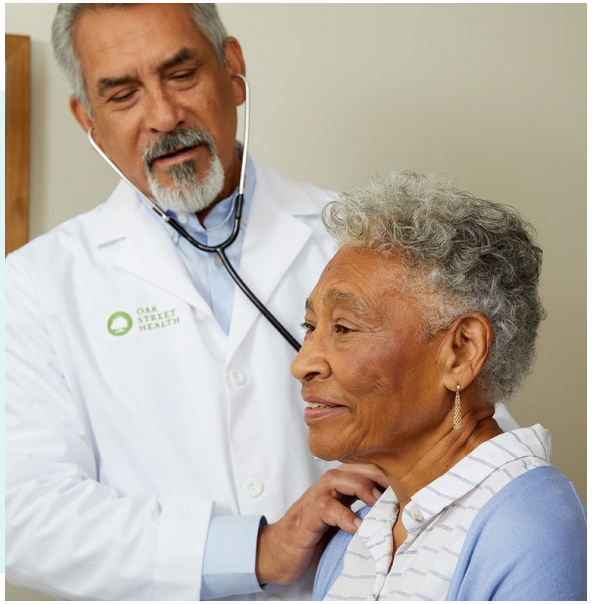
- **Increased access** to qualified mental health professionals in primary care
- Care design that is both **sustainable and fiscally responsible** - we will share how we complete results review
- Adherence to our organizational mission: *Rebuilding healthcare as it should be*

Introduction to Oak Street Health

- Founded in 2012
- Network of primary care centers for adults on Medicare, including dual eligibles, with a focus on driving value, not volume
- Treat patients at more than 70 locations across 10 states (Illinois, Indiana, Michigan, Pennsylvania, Ohio, Rhode Island, North Carolina, New York, Texas and Tennessee)
- Innovative care model integrating team-based care with population health analytics and proprietary suite of workflow applications
- Fully capitated "risk-based" contracts with Medicare Advantage insurance plans to capture the savings earned by keeping our patients healthy, subject to limited exceptions

Our Mission…
Rebuilding Healthcare As It Should Be

Our Vision…
To Provide Measurably Better Health In All Communities



70+ Oak Street Health centers with an average capacity for ~3,500 patients

~200 Primary Care Providers delivering care in a value-focused model

80,000+ Patients have been served by Oak Street Health

A Patient's Journey

Intake & Assessment

Face-to-Face Intake
- Multiple visits
- Health Risk Survey

Evidence-Based Assessments
- Screenings[1]
- Diagnostics[2]

Historical Health Synthesis
- Blue Button
- EMR / HIE access
- Payer claims

Risk Stratification

Data Science
- Proprietary Algorithms
- Predictive Analytics
- Machine Learning

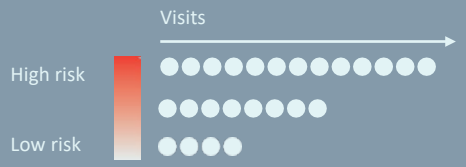
+

Clinician Expertise

1 Longitudinal Primary Care

Preventive care addressing the whole person – medical, social, behavioral – in a welcoming community setting

"Dosage" of Primary Care Visits Driven by Patient Risk Factors



- Interdisciplinary Care Team
- Evidence- Based Clinical Protocols
- Targeted Patient Education
- Same-Day Visits, Weekend Visits
- 80% Smaller Panels
- Primary Care Enhancers:
  Podiatry Group Education Transportation

2 Population Management

Connecting our patients to the right programs, resources, and care to ensure no one falls through the cracks

Daily Huddling | Weekly Planning | Monthly Reviews

3 Population Health Interventions

Delivering multi-disciplinary interventions on high-risk patients to improve outcomes and cost

Integrated Behavioral Health
- IMPACT model

Home Care Delivery by PCPs
- Led by specialized Nurse Practitioners

Medication Management
- Focus on adherence and reconciliation

Social Determinant Support
- Assistance with community resources

24/7 Clinical Call Center
- Live agents, nurse triage, on-call providers
- Real-time response to patient needs

Hard to Reach
- Local targeted outreach to engage patients

4 Care Navigation

Navigating the patient journey outside-the-center

Utilization Management

Transitions-in-Care Program
- Transitions Nurses involved in hospital and SNF discharge planning

High-Value Network
- ED / Hospital Relationships
- Post-Acute Partnerships Preferred Specialty Network
- Virtual Consultations (e-consults)

1: Screenings used are validated geriatric assessments; examples include Fall Risk Screening, Activities of Daily Living, VES-13, PHQ, AUDIT-C, DAST-10
2: Diagnostics used are Lab Panels, EKGs, Ultrasounds (Vascular and Cardiac), Pulmonary Function Tests

Use of data to FOCUS behavioral health intervention

- We have established an integrative BH model with an impressive ROI opportunity. In a full risk model who cares for patients longitudinally we are well positioned to replicate the studies.

To achieve this we focus on two areas:

1) Operations: Enroll optimal number of eligible patients
    a) Leverage and enhance data infrastructure to support point of care interventions and prompt proactive follow up
2) Clinically: Teach teams to use the model effectively
    a) Address provider culture via clinical guidelines
    b) Ongoing training

The purposeful planful model has additional layers since we intend to care for all patients. It is in both the patients interest and our financial model for OSH to be the outpatient provider for behavioral health needs.

Collaborative Care (IMPACT) model & Long term Cost Effects

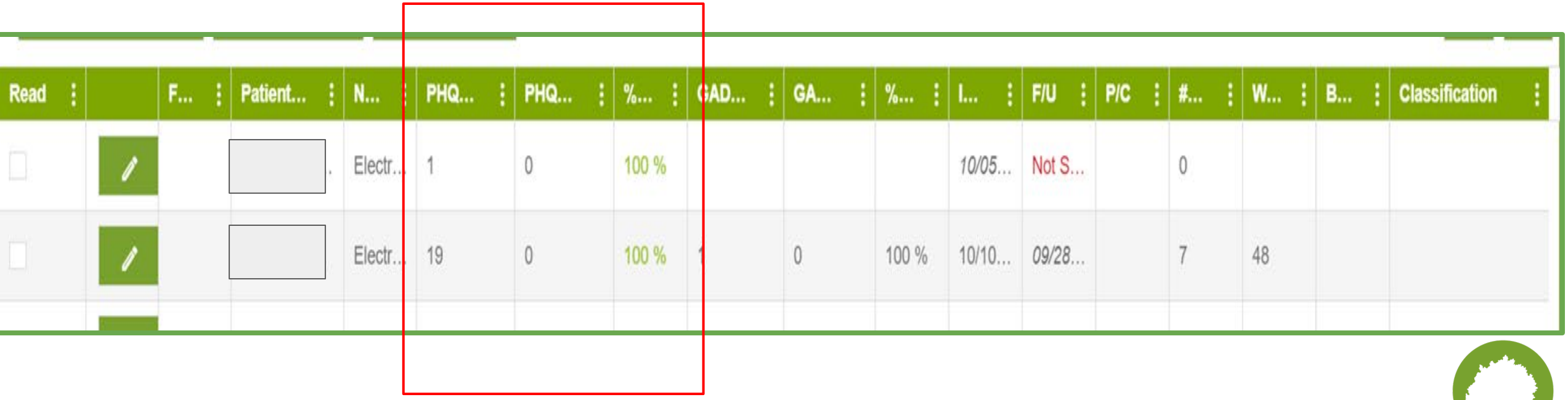
Distinction between IMPACT model and OSH Integrated BH

- The IMPACT model references intervention for older adults who experience unipolar depression.
- We have a responsibility to implement this model with fidelity. This implementation has been the primary focus on 2020. We know that not all OSH patients meet this criteria.
- We also have a responsibility to provide behavioral health care interventions for patients who will not be part of our collaborative care approach.

Both statements are true that we provide integrated behavioral health for all patients and operate IMPACT model of care for patients that meet criteria.

IMPACT Model - Shared Registry - Addressing Population Health

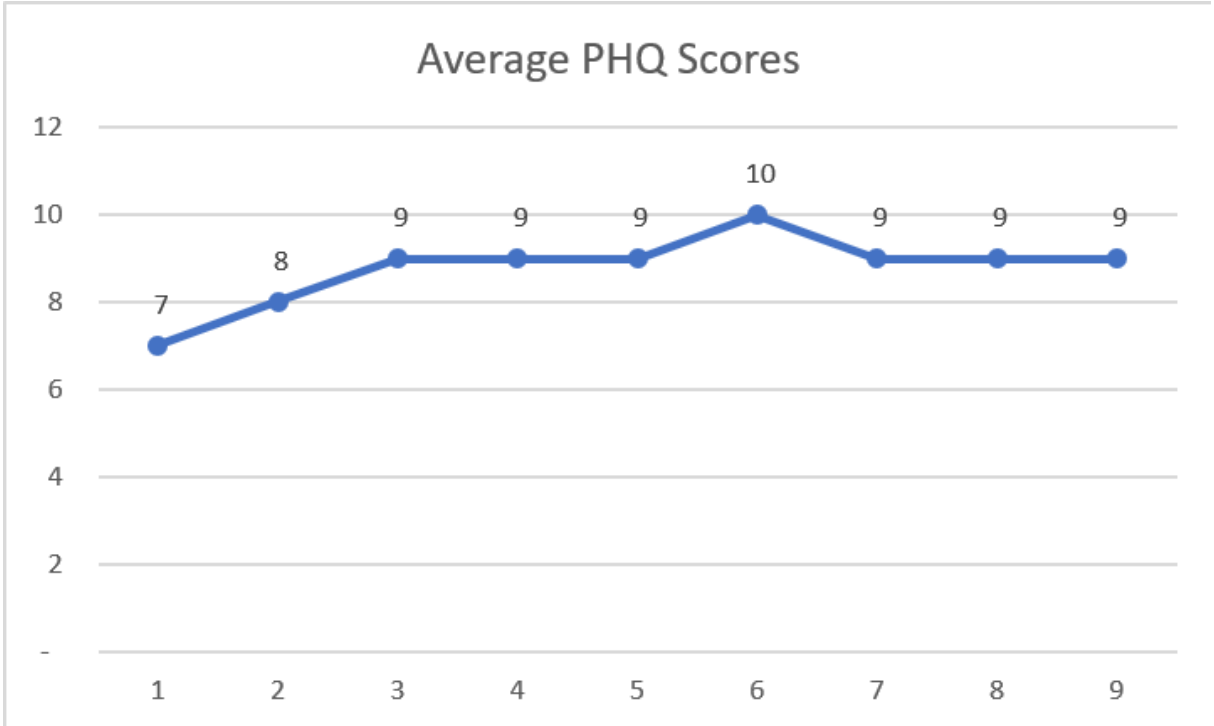
- The BH Team shares a defined group of patients tracked in this Shared Registry to ensure no one falls through the cracks. The BH Team can track and reach out to patients who are not improving and the BH Team provide caseload-focused consultation, not just ad-hoc advice.
- Of utmost importance are the 3 columns that contain the PHQ-9 information--The PHQ-9 First, The PHQ-9 Last, and the % Change
- The PHQ-9 columns will show the progress of the patient through “treatment toward target” and direct the treatment interventions effectively and efficiently



Read		F...	Patient...	N...	PHQ...	PHQ...	%...	GAD...	GA...	%...	I...	F/U	P/C	#...	W...	B...	Classification
				Electr...	1	0	100 %				10/05...	Not S...		0			
				Electr...	19	0	100 %	1	0	100 %	10/10...	09/28...		7	48		

PHQ 9 Analysis

Count of PHQ-9 Results
13,507
PHQ-9 Value >10
5,894
Count of enrolled Patients with PHQ-9 >10 in BH
2,728
PHQ-9 Count of patients who took a second test
2,612
Difference of 5+ on PHQ-9 Count
892
Average Score Difference
9



Timeline: Jan-Sept 2020

Items to Note:

- 44% of patients scored a 10 or greater on their PHQ9, 46% of these patients are enrolled in the BH program
- Of those patients who scored a 10 or greater, **44% repeated PHQ9, ~15% increase from last month**
- Of those patients who took a second PHQ9, 889 of them had a reduction of 5pts or more

How we calculate a reliable Return on Investment

1

Expected Post-Treatment Contribution Margin for Enrolled Patients

We calculate an expected post-treatment contribution margin based on the experience of the comparison group. We use the % change in the comparison group's pre and post treatment contribution margin for this equation, to account for any baseline differences between treatment and comparison group.

The accuracy of the ROI depends on an accurate comparison group

2

Change in Enrolled Patients Contribution Margins

We compare the observed post-treatment contribution margin for the enrolled group to the expected contribution margin. The difference between observed and expected is the value added by the intervention.

3

Program ROI

We multiply the per member per month added value by the enrolled MM to calculate the total program value and divided by 2019 costs to result in the estimated ROI.

Care Model Results

Enrolled Outcomes

	Pre-treatment								Post-treatment					
Program	*ADK*	*EDK*	*PMPM**	*Revenue*	*Cont. Margin*	*MM*	*% PPO*	*% Low CM Region*	*ADK*	*EDK*	*PMPM*	*Revenue*	*Contr. Margin*	*MM*
Behavioral Health Specialists	414	1425	$872	$1,066	$194	47,377			380	1184	$844	$1,052	$209	36,640
									-8%	-17%	-3%	-1%	7%	-23%

Comparison Outcomes

	Pre-Treatment Outcomes								Post-Treatment Outcomes					
Program	*ADK*	*EDK*	*PMPM*	*Revenue*	*Cont. Margin*	*MM*	*% PPO*	*% Low CM Region*	*ADK*	*EDK*	*PMPM*	*Revenue*	*Cont. Margin*	*MM*
Behavioral Health Specialists	284	909	$731	$997	$265	104,989			272	839	$710	$1,029	$319	52,947
									-4%	-8%	-3%	3%	20%	-50%

The expected contribution margin was $234 for this result review, the results show -$25. Based on this approach what might be our challenges as we continue to evaluate?

Our Opportunities going forward

- We can demonstrate care excellence when we implement with operational excellence
  - There remain unengaged patients who have screened positive on PHQ9
- Program evaluation continues to face challenges with identifying the right comparison group
  - Future iterations plan to look at intention to treat rather than current definition
- Our future success depends on our ability to have a purposeful integrate program that builds on the components of the collaborative care.
  - OSH Behavioral Health team cares for patients with serious mental illness (SMI: Bipolar disorder, psychotic disorders, schizophrenia, substance use disorders, PTSD)
    - Outcomes measures are in development
    - Patients in this designation are not included in the program evaluation of collaborative care

Appendix

Overview of use of Collaborative Care

- Leverage the IMPACT model and telepsychiatry to maximize limited psychiatric resources
- Emphasize training and rapport building between site staff and remote providers
- Where possible, schedule BH appointments in accordance with PCP appointments
- Build a consistent care team

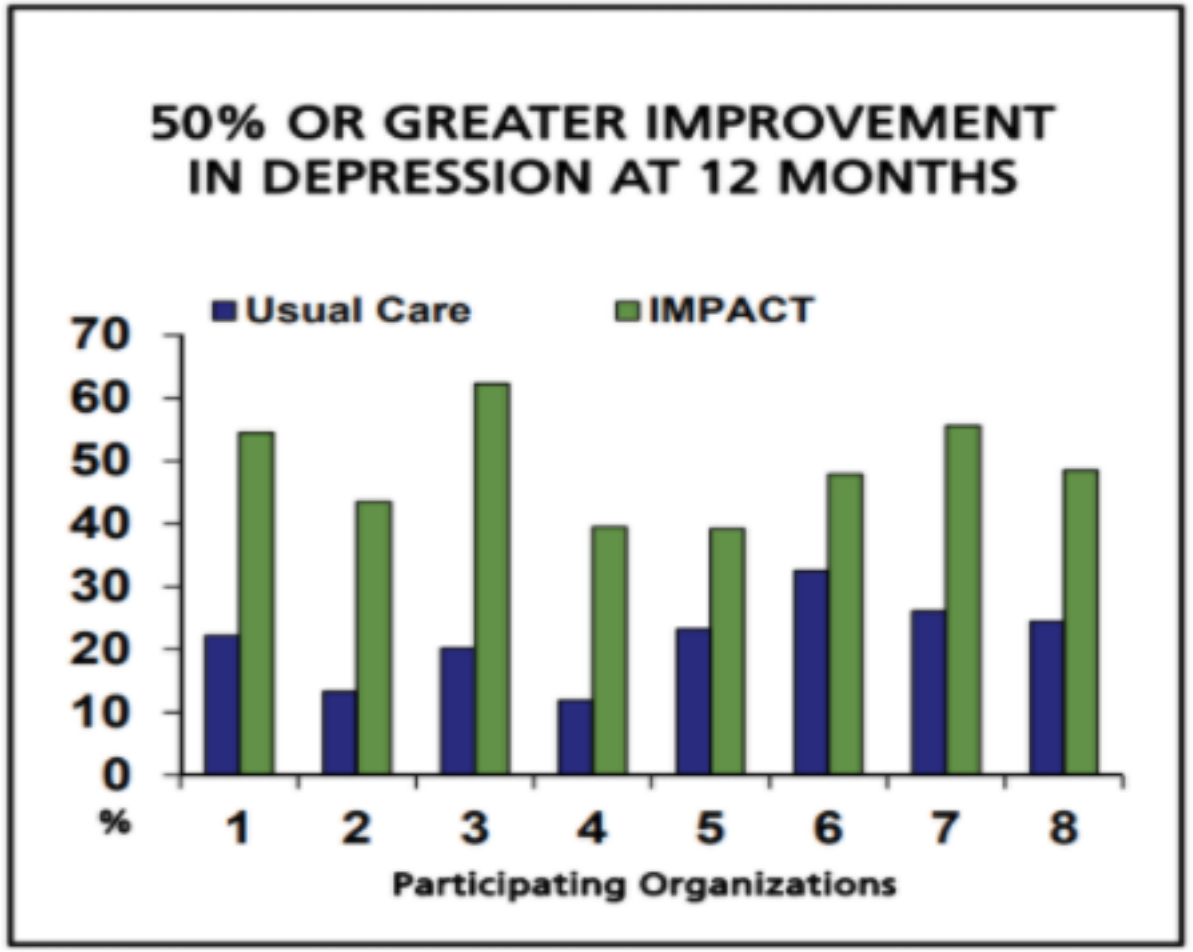
Shift towards Integrative BH

Traditional Approach
• Maximum # of visits for $ • Individual provider • Lack of cohesive communication across providers

Collaborative Care

OSH Approach
• Provide quick access to a BH Team • Tracking care with population health registry • Cost Control

IMPACT model: How well does it work?



N=1600

Twice as many patients responded to treatment for depression as in usual care, using team based model in a primary care setting.

IMPACT model: Why Does it Work?

5 Principles of Collaborative Care

Population-Based Care

Measurement-Based Treatment to Target

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care

What is Treatment To Target?

Continuing to address treatment of patients not responding, using measurement tools.

Adjusting the **treatment plan based on symptom measures** is one of the most important components of collaborative care. Clinicians **change the treatment until the patient has at least a 50% reduction** in measured symptoms.

Collaborative care **requires a change in the treatment plan every 4 - 6 weeks** if the patient has not had at least a 50% improvement in symptoms using a validated measure (PHQ9).

In order to make clinical decisions team members need to complete **repeat PHQ9s**.

PHQ 9: Directing Treatment to Target

Medication

Counseling

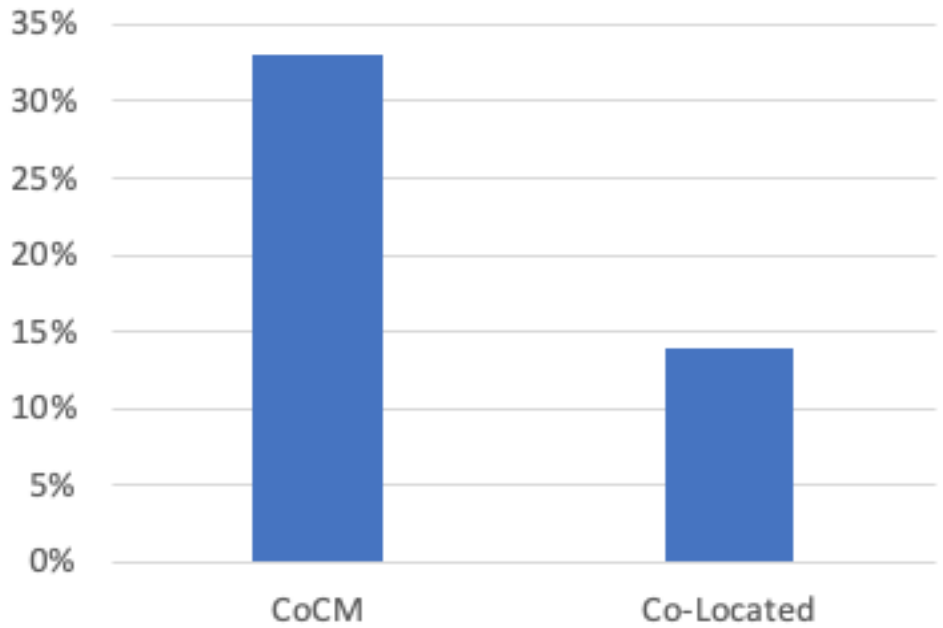
USING THE PHQ-9 TO ASSESS PATIENT RESPONSE TO TREATMENT

Initial response after Four weeks of an Adequate Dose of an Antidepressant		
PHQ-9	***Treatment Response***	***Treatment Plan***
Drop of 5 points from baseline	Adequate	No treatment change needed. Follow-up in four weeks.
Drop of 2-4 points from baseline.	Possibly Inadequate	May warrant an increase in antidepressant dose
Drop of 1-point or no change or increase.	Inadequate	Increase dose; Augmentation; Switch; Informal or formal psychiatric consultation; Add psychological counseling
Initial response after Six weeks of Psychological Counseling		
PHQ-9	***Treatment Response***	***Treatment Plan***
Drop of 5 points from baseline	Adequate	No treatment change needed. Follow-up in four weeks.
Drop of 2-4 points from baseline.	Possibly Inadequate	Probably no treatment change needed. Share PHQ-9 with psychotherapist.
Drop of 1-point or no change or increase.	Inadequate	If depression-specific psychological counseling (CBT, PST, IPT*) discuss with therapist, consider adding antidepressant. For patients satisfied in other type of psychological counseling, consider starting antidepressant For patients dissatisfied in other psychological counseling, review treatment options and preferences

** CBT-Cognitive-Behavioral Therapy; PST-Problem Solving Treatment; IPT-Interpersonal Therapy*

CRUCIAL ROLE OF CASELOAD REVIEW FOR EFFECTIVENESS OF COLLABORATIVE CARE

Reduction in PHQ-9 scores with and without Caseload review :

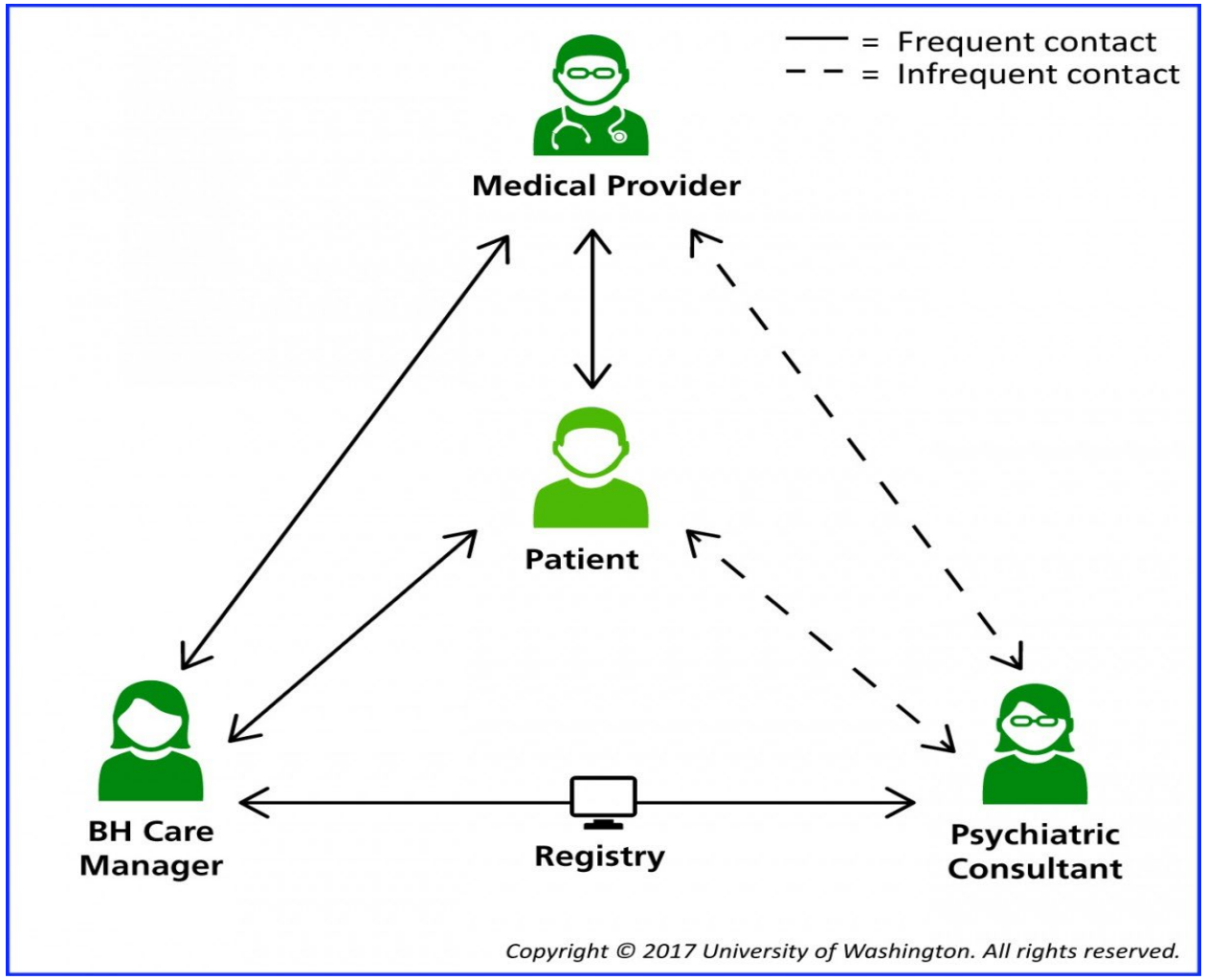


Functional differences:

- More frequent care manager contact
- Caseload Review

Blackmore M et al,, Psychiatric Services in Advance (doi: 10.1176/appi.ps.201700569)

Collaborative Care Model - Basic Team outline

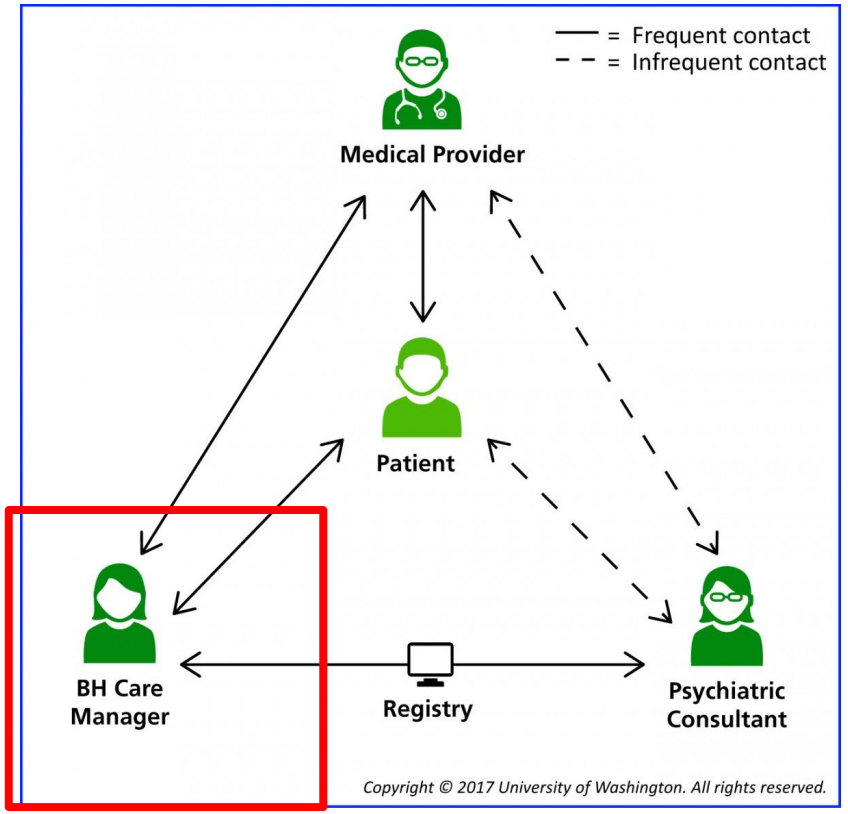


Role of the Behavioral Health Specialist

Behavioral Health Specialist (BHS)

- Assess the mental/behavioral needs of patients, support with **case management**, make **referrals** to appropriate behavioral health resources and specialists, and provides **counseling** and evidence-based treatments as indicated
- Screening for common **mental health** and/or **substance use** disorders
- Work with team to provide treatment for mental health and/or **substance use** disorders
- Collaborate with care team around patients with complex **medical** care needs

BHS Role in Collaborative Care



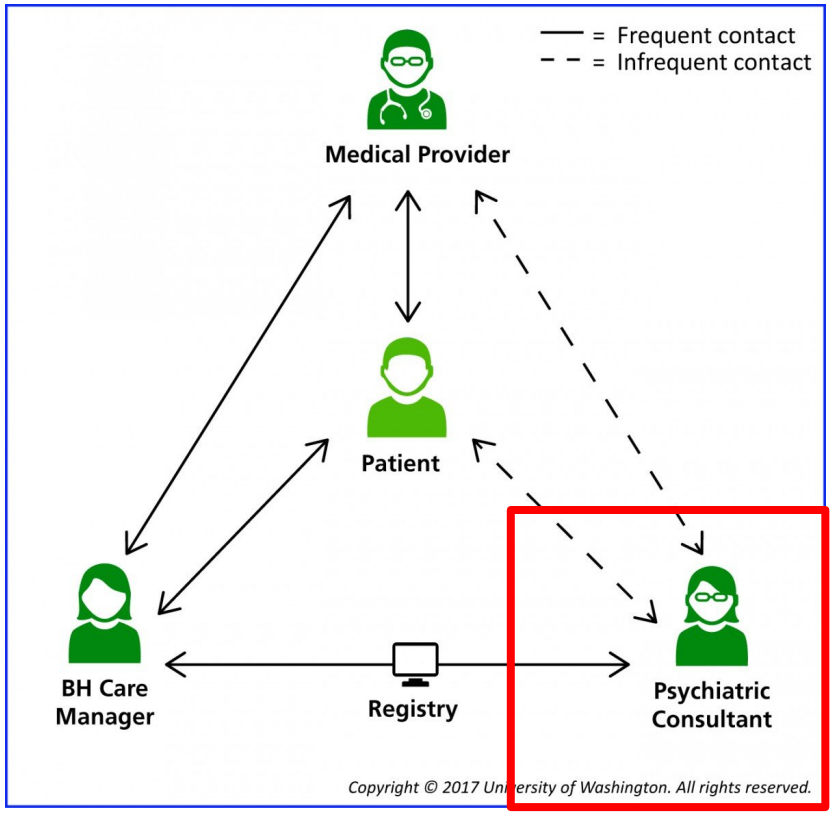
Role of the Telepsych Consultant

Telepsych Consultant

Provides care in more than one way:

- Acts as a **consultant** to the BHS & PCP, for patients cared for by them.
- May provide direct care.
- Collaborate with care team around patients with **complex medical care needs**

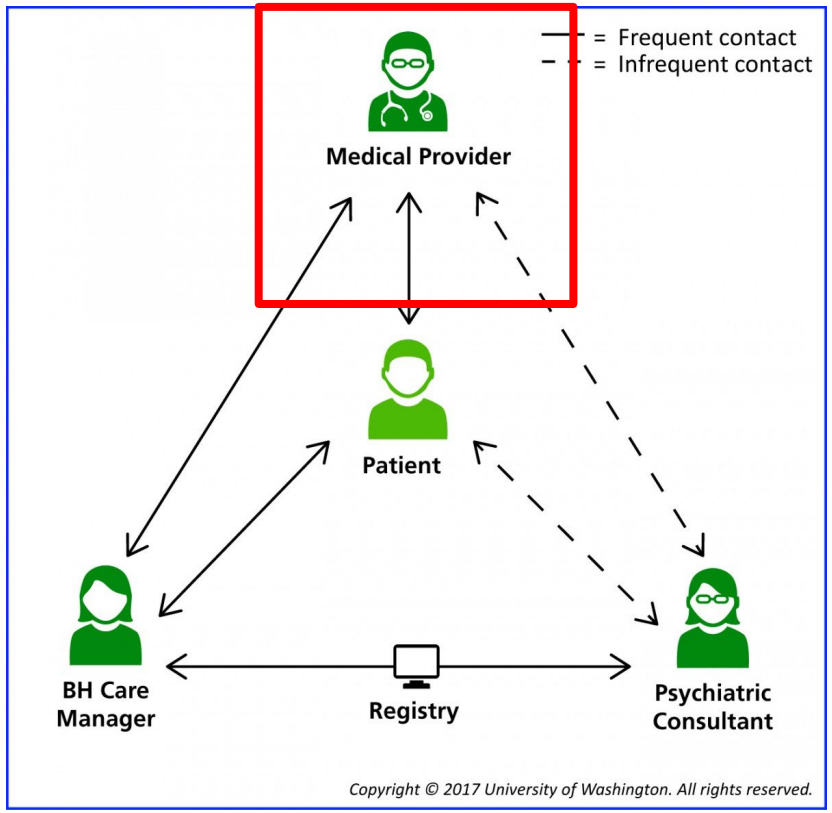
Psych Consultant in Collaborative Care



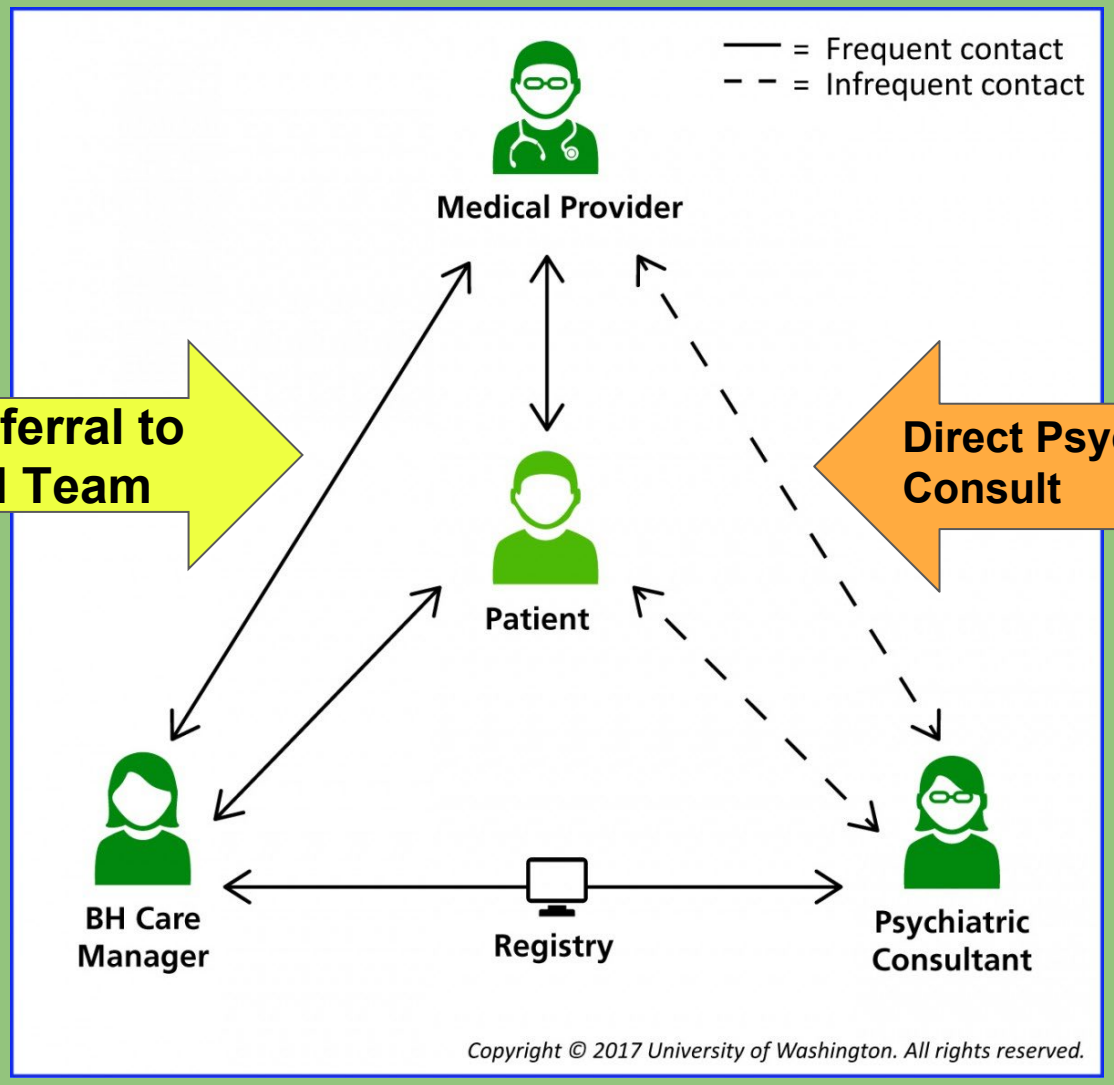
PCP role within Collaborative Care

PCP

- **Identifies and Engages**
  - Discusses Collaborative Care to the patient
  - Develops treatment alliance with the patient--***crucial***
  - Obtains patient's consent
  - Initiates a Warm Hand-off
- **Makes a diagnosis in some cases**
  - Uses the PHQ 9, gathers history
  - Works with the BH Team for complex conditions
  - Observes over time
- **Treats in most cases**
  - Works with BH Team to develop treatment plan
  - Prescribes medications as needed
  - Addresses safety concerns
  - Monitors physical health and any potential interactions
  - **With support from BH team**



The 2 Arms of Securing a Psychiatric Consultation



Deeper: How to obtain a Psych Consult

The 2 Arms of Securing a Psychiatric Consultation

Referral to Behavioral Health Team

- This arm is used when there is a BHS in the clinic.
- A referral is generated in Canopy and an assessment is obtained by the BHS. The BHS and the Psych Provider will plan the management of the case via ***the shared BH Registry***
- If the Psych Provider determines a consultation is appropriate *which includes medication PCP is responsible for prescribing the medication(s)*
- **OR** the patient may need to be scheduled to see the Psych Provider, the *BHS will arrange for this*. Once seen by the Psych Provider, the *Psych Provider is responsible for prescribing medication(s)* ***** *Consultation could include a medicine be started by the PCP prior to the visit with the Psych Provider*

Direct Psych Consult (PCP to Psych Provider)

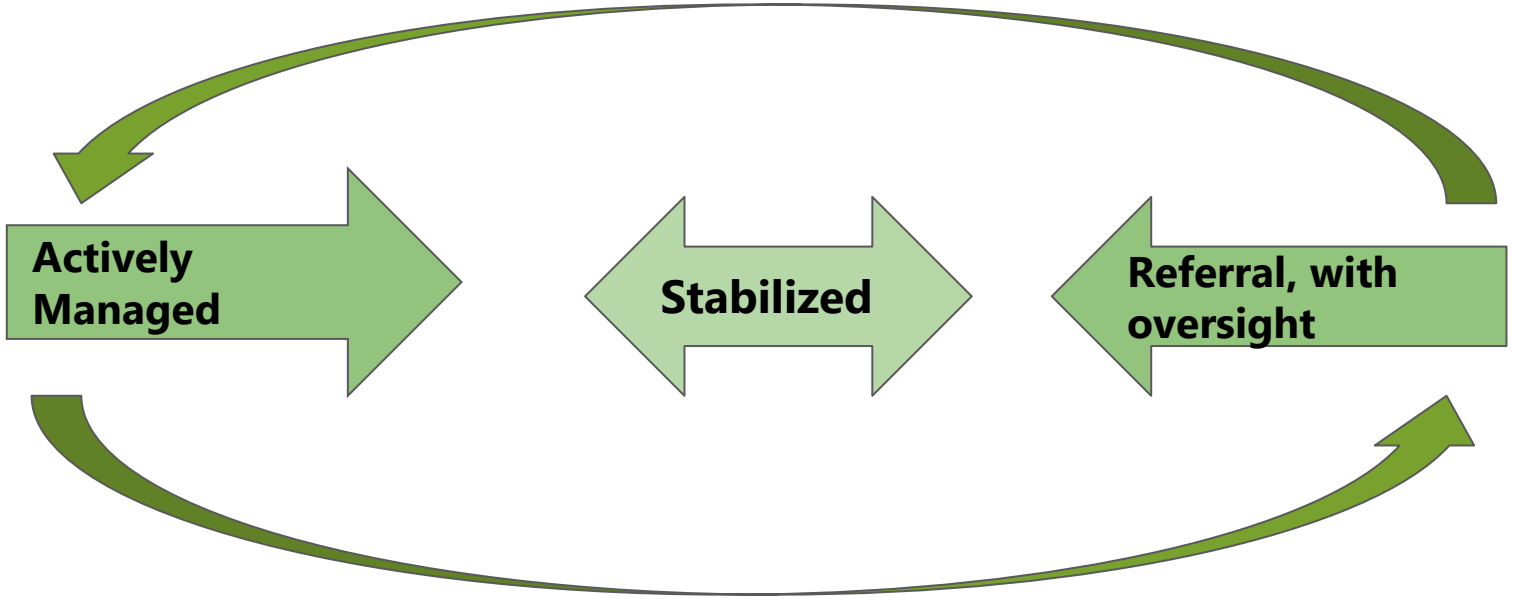
- This arm is used when there is no BHS in the clinic. *Exceptions would be in an emergency or if the BHS is not available
- This is accomplished by completing a quick note **Direct Psych Consult in Greenway**
- This process is very similar to using Rubicon
- The Psych Provider will then complete a consultation which may include medications or scheduling the patient to be seen by the psych provider
- If medication is included in the consult, the *PCP is responsible for prescribing the medication(s)*
- If the Psych Provider consult includes to be seen for a psychiatric evaluation, the *PCP will arrange this*. The consult may include medication until the patient can be seen by the Psych Provider, *PCP is responsible for prescribing the medication(s)*

“Curbsides”

Informal consultations called “Curbside Consults” can be done if patient data or specific patient information is not shared

- **Example**: “If a patient is on the max dose of an xxx medication and still symptomatic is it OK to just add xxx medication?” or “Is there any medication for xxx symptom?”
- Curbside consults do not need to be formally documented in the patient’s record
- Most patients in need of a consult are complex and a thorough review of the record is needed

Internal BH Patient Classification Overview



Actively Managed

Followed by the BH team
For some: telepsych provider doing the ongoing prescribing
Being followed in registry until stable.

Stabilized

Followed by the BH team
For some: telepsych provider doing the ongoing prescribing
Being followed in registry until graduated (if applicable)

Referral, with oversight

BHS to monitor progress of outside psychiatric care
Complex enough to require external care [if available]

Some patients may ***move*** between the three classifications over time.

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QUESTIONS?

UPCOMING WEBINARS

Physicians Leading the Charge: Dismantling Stigma around Behavioral Health Conditions & Treatment
November 19, 2020, 6PM - 7PM CT

In this webinar, speakers will share examples of how physicians, and other non-physician clinicians of the care-team, can be leaders in breaking the stigma barrier and normalizing treatment for people with mental health conditions. They will describe key action steps to implement stigma reduction strategies for all patients with an emphasis on those who are underserved or are of special populations in which stigma is magnified. Attendees will also learn how they can integrate an interdisciplinary approach to reduce stigma in their practice settings and support patients in reporting symptoms and seeking care.

Thank you for joining!