THE NYS COLLABORATIVE CARE INITIATIVE:
RAISING THE STANDARDS FOR DEPRESSION CARE

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NYS CCI: OVERVIEW

- How far have we come in advancing implementation of Collaborative Care for Depression?
- Summary Data from April-June 2014 (Portal & MPR)
- Evaluation Criteria
- Sustainability: What does the future hold for Collaborative Care in New York?
  - HMH Demonstration Project Funds
  - 2014 NYS Legislative Item Support
  - DSRIP
  - Integrated Licensing Regulations
- Discussion: progress and barriers
## NYS CCI: HOW FAR HAVE WE COME?

<table>
<thead>
<tr>
<th>Principles of Care</th>
<th>We apply this principle in the care of our patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Patient-Centered Care</strong></td>
<td>None        Some    Most/All</td>
</tr>
<tr>
<td>Primary care and behavioral health providers collaborate effectively using shared care plans.</td>
<td>□           □          □</td>
</tr>
<tr>
<td><strong>2. Population-Based Care</strong></td>
<td>None        Some    Most/All</td>
</tr>
<tr>
<td>Care team shares a defined group of patients tracked in a registry. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.</td>
<td>□           □          □</td>
</tr>
<tr>
<td><strong>3. Measurement-Based Treatment to Target</strong></td>
<td>None        Some    Most/All</td>
</tr>
<tr>
<td>Each patient’s treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are adjusted if patients are not improving as expected.</td>
<td>□           □          □</td>
</tr>
<tr>
<td><strong>4. Evidence-Based Care</strong></td>
<td>None        Some    Most/All</td>
</tr>
<tr>
<td>Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.</td>
<td>□           □          □</td>
</tr>
<tr>
<td><strong>5. Accountable Care</strong></td>
<td>None        Some    Most/All</td>
</tr>
<tr>
<td>Providers are accountable and reimbursed for quality care and outcomes.</td>
<td>□           □          □</td>
</tr>
</tbody>
</table>
Early emphasis on process measure as markers for implementation:

- Screening, Screening Yield
- Enrollment
- Depression Care Manager FTE
NYS CCI: SCREENING RATE – Q2 ‘14

- CCI Goal: 85%
- Range: 44%-99%
- Mean: 85%
- Median: 95%
HOW PREVALENT IS DEPRESSION IN PRIMARY CARE?

- Olfson et al Arch Fam Med 2000;9876-883
  - N = 1007 @ NYC general medicine practice
  - Depression (18.9%) PHQ-9*
  - GAD (14.8%)
  - Panic (8.3%)
  - Substance use disorders (7.9%)
  - Suicidal ideation (7.1%)
  - Minority reported receiving mental health treatment
CCI goal: 13%; (~5%-30% in the literature)

Range: 0.3%-55.4%

Mean: 9%

Median: 4%
those enrolled/those screened positive

CCI Algorithm goal: 13% x 75% x 50%

Range: 21-520

Mean: 104

Median: 79
Minimum Standard: scored “acceptable for 2 of 3 process measures using MPRs:
- Screening: $\geq 85\%^*$
- Enrollment: CCI algorithm but with 5% screening yield
- DCM FTE = 0.5 or more

Final Review by OMH/DOH
- Progress across MPRs counts
NYS CCI: RETENTION

- Nation: Only 50% of patients who receive a referral for specialty mental health care ever follow through
- NYS: Among adults who went to an Article 31 clinic: modal visit rate was ONE; next most frequent 2-4 (OMH 2011 data)
- More patient-centered to provide access in primary care setting
MONTHLY PROGRESS REPORTS: APRIL RETENTION

- Retention Definition: AFTER time of enrollment, 3 clinical contacts where care was delivered within 3 months; at least one of which is in-person.
- CCI goal: ?
- Range: 0%-100% (0-75 numerator)
- Mean: 49% (14 pts)
- Median: 51%
NYS CCI: Q2 OUTCOMES

- # of those whose phq-9 dropped to < 10/ among those enrolled for at least 16 weeks
- CCI goal: ?
- Range: 0%-100% (0-58)
- Mean: 43%
- Median: 41%
FUTURE OF COLLABORATIVE CARE IN NY? Forces Behind Integration:

- 4 Months Left – NOW’S NOT THE TIME TO LET UP!
- NYS Fee-for-service Medicaid for certified providers
- Move away from volume to value purchasing in health care
- DSRIP: Infrastructure development to curtain preventable hospitalization and ER visits
- Integrated Licensing: Article 28, 31, 32?
POTENTIAL FUNDING SOURCES:

- **HMH Demonstration Project:**
  - $ ear-marked for your project — it’s your money!
  - Unspent $ can be used after grant ends
  - Preaching to the choir: how can we help you capture any unspent monies?
    - [Jay.Carruthers@omh.ny.gov](mailto:Jay.Carruthers@omh.ny.gov)
    - [Lloyd.Sederer@omh.ny.gov](mailto:Lloyd.Sederer@omh.ny.gov)
FUNDING SOURCES: NYS MEDICAID

- Must become certified “Collaborative Care for Depression” provider by OMH

- Medicaid “Fee-for-service” Reimbursable – not part of managed care – from recurring $10 M legislative support

- Upon certification:
  - Case rate: e.g. $150 per enrollee per month; no acuity adjustments
  - 25% “at risk” for quality:
    - Must show 50% reduction in phq-9 or < 10
    - Or change in treatment
MEDICAID PROVIDER CERTIFICATION

- Must have core components of Collaborative Care in place:
  - Trained Depression Care Managers
  - Off-site Psychiatrist to provide weekly caseload supervision with focus on those not getting better
  - State-approved registry
  - Primary care physicians trained in screening and providing evidence-based stepped care for depression
STATE APPROVED REGISTRY:

- Ability to track and manage caseloads toward evidence-based care delivery
- Clinical decision support and report writing - standard
- Supports treatment to target (PHQ-9) and caseload review for depression care manager
- Psychiatrist consultation for those not improving
Supplies reports to monitor progress toward goals, including processes of care, quality of care and patient outcomes metrics

Able to supply de-identified reports to outside auditors to demonstrate regulatory compliance, intensity of clinical contacts, staffing ratios, and outcomes
STATE-APPROVED REGISTRY (Cont)

- CMTS is the standard
- Several sites are using it
- Window for free access closing?
- Q: Is hospital IT leadership threatened by this acquisition?
  - How can we help you get IT and Counsel’s buy-in?
- EPIC user group – Depression and suicide care registries
NYS MEDICAID COLLABORATIVE CARE PROVIDER CERTIFICATION

- Other factors:
  - Track Record in Providing Collaborative Care
  - Ability to scale model

- Certified Provider Subject to Audit

- Financial Penalties for violations

- Timeline:
  - Goal accept applications by October
  - goal to be able to bill by November
DSRIP: IS INTEGRATION OF BH & PH

- Reinvesting $8 billion MRT savings
- Ambitious goal: 25 percent reduction in avoidable hospital use over five years
- Promote system reform through community collaborations – “Performing Providers Systems”
- Infrastructure seed $ year 1
- $ disbursements linked to performance metrics in out years
DSRIP (Continued)

- Project Plan Applications due in December
- 90% of PPS’ chose integration of behavioral and physical health
- P4P era
- CCI Sites well positioned
- PPS’ that show fidelity to IMPACT model in process measures should receive higher scores – we hope
DSRIP (Continued)

DSRIP germane evidence for IMPACT Savings:

- Data not disaggregated to isolate “ED Visits or Hospitalizations”
- 60+ and +/- diabetes cohorts studied
  - Net savings (inpt and outpt) of $896/pt over 2 years (Katon Diabetes Care 2007)
  - Average 4 year Savings: (Unutzer Am J Managed Care 2008)
    - ‘Other Outpt Costs’ which includes ED Visits -- $296/pt
    - ‘Other Inpt Costs’ which includes medical hospitalizations -- $2578/pt
INTEGRATED LICENSING

- Collaboration between OMH, OASAS and DOH
- Goals: to reduce regulatory burden and facilitate integrated services
- Pilot underway after much work
- Integrated Licensing Regulations – coming Jan 2015
INTEGRATED LICENSING (Continued)

- Eligibility: Providers that have Article 28, 31, 32 in their system
- Host regulatory agency does certification visits with guidance from other agencies
- E.G. – Art. 28 clinic with an Art. 31 licensed clinic elsewhere in the same health system can apply to add IL status to their operating certificate
From example above, DOH would be lead agency

- Allows one medical record
- Efforts to provide flexibility around physical plant standards
- Utilize IL billing codes to cover mental health
- Art. 28 site would not need to acquire Art. 31 license to be eligible for IL status
- Details are being worked out now
DISCUSSION:

- Biggest challenges to date in implementing collaborative care at your sites?
  - Meeting Demand – DCM Staffing?
  - Sustainability?
  - Referrals?
  - Engaging challenging population?
  - Other?
NYS CCI: Making a Difference in the lives of New Yorkers

- Thank you for your time and hard work!
MORE INFORMATION:

- **DSRIP:**
  [http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_design_grant_appl.htm](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_design_grant_appl.htm)

- **NYS Collaborative Care Provider Certification:**
  - [jay.carruthers@omh.ny.gov](mailto:jay.carruthers@omh.ny.gov)

- **Integrated Licensing:**
  - At NYS DOH: TBA