Integrated Care Resource Center

Exploring Medicaid Health Homes: Collaborative Care: An Evidence-Based Approach to Integrating Physical and Mental Health In Medicaid Health Homes

January 10, 2013; 2:00 – 3:30PM (ET)

- For audio, dial: 888-791-4316; Passcode: 707373
- A video archive will be available shortly following the event.

The Integrated Care Resource Center, a joint initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office and the Center for Medicaid and CHIP Services, provides technical assistance for states coordinated by Mathematica Policy Research and the Center for Health Care Strategies.

Technical Assistance for State Health Home Development

- Established by CMS to help states develop health home models for beneficiaries with complex needs
- Technical assistance led by Mathematica Policy Research and the Center for Health Care Strategies includes:
  - One-on-one technical support
  - Peer-learning collaboratives
  - Webinars open to all states
  - Online library of hands-on tools and resources, recent updates include:
    - Matrix of Approved Health Home SPAs
    - Map of State Health Home Activity
    - *NEW* Draft Health Homes SPA Template

New in 2013: CMS Health Home Information Resource Center

- State technical assistance (TA) resources for health homes will transition out of ICRC* and to a new home on *Medicaid.gov* in early 2013
- Same TA team and resources – including webinar series – will be available to states
- Stay tuned for more information on where to find and access TA resources

* *NOTE: ICRC will continue to provide state technical assistance for Medicare-Medicaid integration*

New in 2013: New Online System for SPA Submission

- New web-based system for SPA submission launching in January
- Enhancements include:
  - Accommodates multiple SPA submissions at same time
  - More structured data inputs (e.g. drop-down lists)
- Training webinars will be held for states the week of January 15th

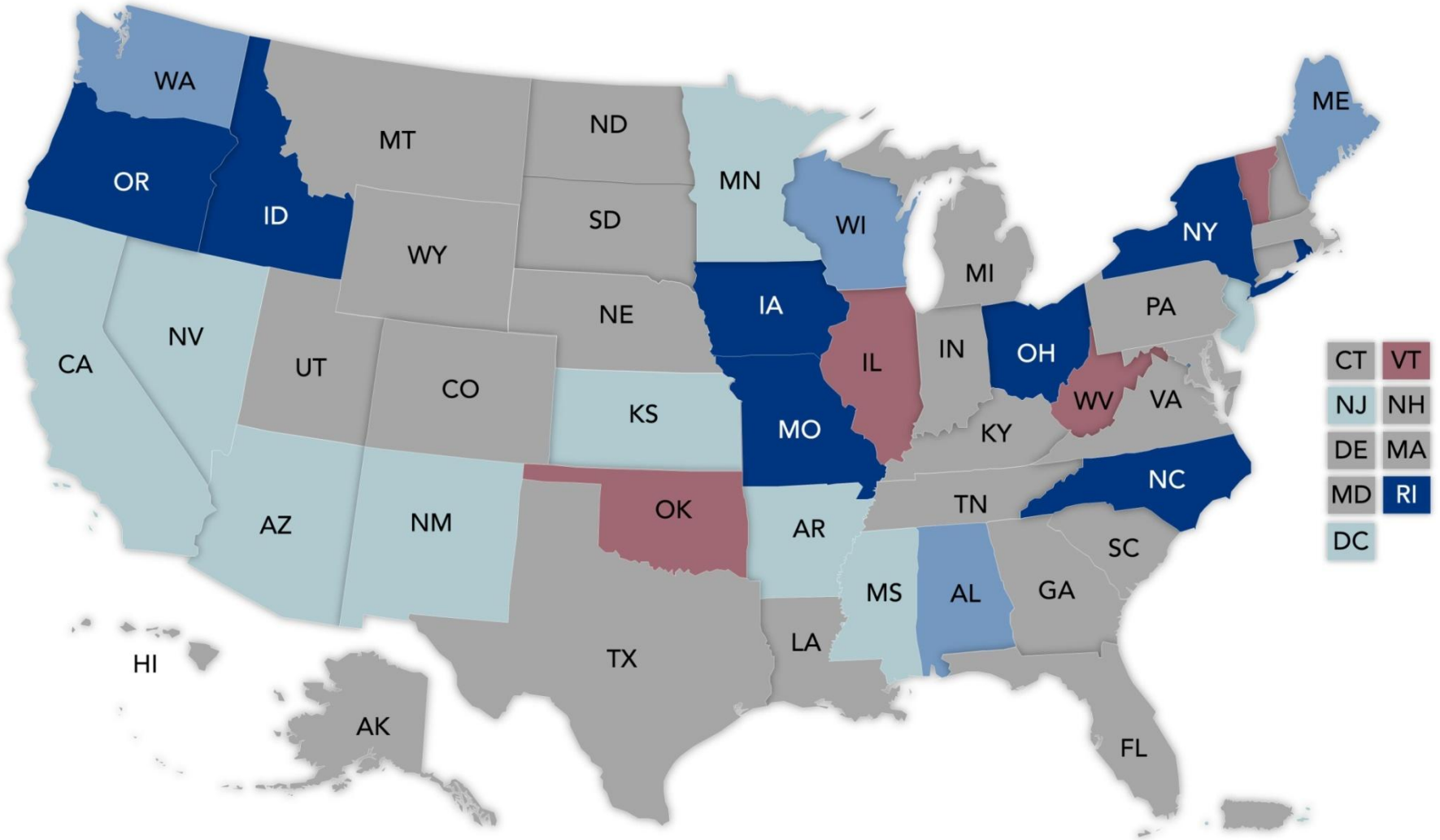
Exploring Medicaid Health Homes Webinar Series

- Provides forum for states to share models, and successes or challenges in their development process
- Creates opportunity for CMS to engage in conversation with states considering and/or designing health home programs
- Disseminates existing knowledge useful to health home planning
- Open to any state considering or pursuing health homes; broader audiences where relevant, as with today's event

National Landscape to Date

- 12 approved State Plan Amendments in eight states: IA, ID, MO, NC, NY, OH, OR, and RI
- Growing number of states in active discussions with CMS
- Many other states exploring the opportunity to develop health homes

State Health Home Activity



	Approved Health Home State Plan Amendment (SPA)
	Health Home SPA "On the Clock" (officially submitted to CMS)
	Draft Health Home SPA Under CMS Review
	Approved Health Home Planning Request
	No Activity

Physical-Behavioral Health Integration and Health Homes

- One of the core goals of the health homes model is to improve PH/BH integration
- Opportunity to pay for services previously difficult to reimburse (care management, care coordination, telephonic contacts, etc)
- Significant interest across the states in implementing models with demonstrated ability to improve outcomes and reduce costs

Goal of Today's Discussion

- Present one evidence-based approach to integrating physical and mental health care: the Collaborative Care Model
- Future webinars may highlight other models
- See CHCS' online toolkit for more information on various models and resources to support PH/BH integration

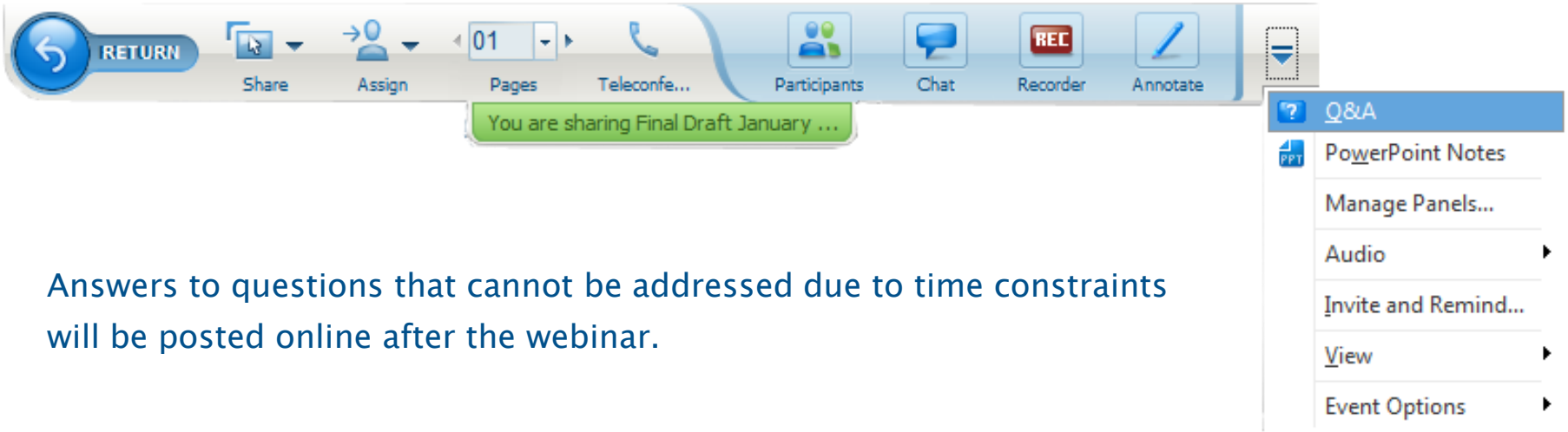
Today's Presenters

- **Jürgen Unützer**, MD, MPH
  Professor and Vice Chair, Psychiatry and Behavioral Sciences;
  Director, AIMS Center, University of Washington
- Panel:
  - **Benjamin Druss**, MD, MPH
    Professor, Rollins School of Public Health, Emory University
  - **Henry Harbin**, MD
    Independent Consultant, former CEO of Magellan Health Services
  - **John S. Kern**, MD
    Chief Medical Officer, Regional Mental Health Center, Indiana
  - **Virna Little**, PsyD, LCSW-r
    Senior Vice President, The Institute for Family Health, New York

Questions?

To submit a question please click the question mark icon located in the toolbar at the top of your screen.

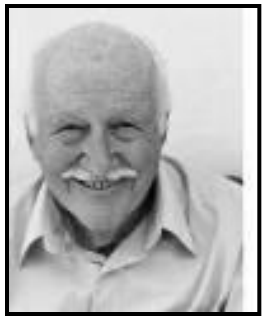
Your questions will be viewable only to CHCS staff and the panelists.



Answers to questions that cannot be addressed due to time constraints will be posted online after the webinar.

Jürgen Unützer, MD, MPH, MA
University of Washington

- Professor & Vice Chair, Dept. of Psychiatry
  - Director, Division of Integrated Care and Public Health
  - Director, AIMS Center: Advancing Integrated Mental Health Solutions
- Adjunct Professor, Health Services; Global Health



Collaborative Care

Integrating Physical and Mental Health Care in Medicaid Health Homes

Jürgen Unützer, MD, MPH, MA

AIMS CENTER
Advancing Integrated Mental Health Solutions

University of Washington

AIMS CENTER

Advancing Integrated Mental Health Solutions

20 years of Research and Practice in Integrated Mental Health Care

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Overview

- **The case for collaborative care**
- **Core elements of collaborative care**
- **Evidence for collaborative care:**
  - **satisfaction, clinical outcomes, cost-effectiveness**
- **Implementing collaborative care for safety-net populations**

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Medicaid and Behavioral Health

Medicaid Claims for Behavioral Health Care in Washington State Dually Eligibles

	Aged		Working-Age Disabled	
	TOTAL	PERCENT	TOTAL	PERCENT
Alcohol/Drug Treatment Need (SFY 2008-2009)	1,464	**2.2%**	9,212	**15.9%**
Mental illness Diagnosis (SFY 2008-2009)	29,335	**44.0%**	38,379	**66.0%**
Psychotic	3,928	5.9%	10,090	17.4%
Depression	16,617	24.9%	19,779	34.0%
Delirium and Dementia	13,207	19.8%	2,271	3.9%
Mental Health Medication (SFY 2008-2009)	31,498	47.3%	39,028	67.1%
Antipsychotic	5,815	8.7%	15,094	26.0%
Antidepressant	18,169	27.3%	25,626	44.1%
Meets CCM medical risk threshold (SFY 2009)	13,900	20.9%	12,519	21.5%

David Mancuso, PhD
Senior Research Supervisor
WA DSHS Research and Data Analysis Division
February 17, 2011
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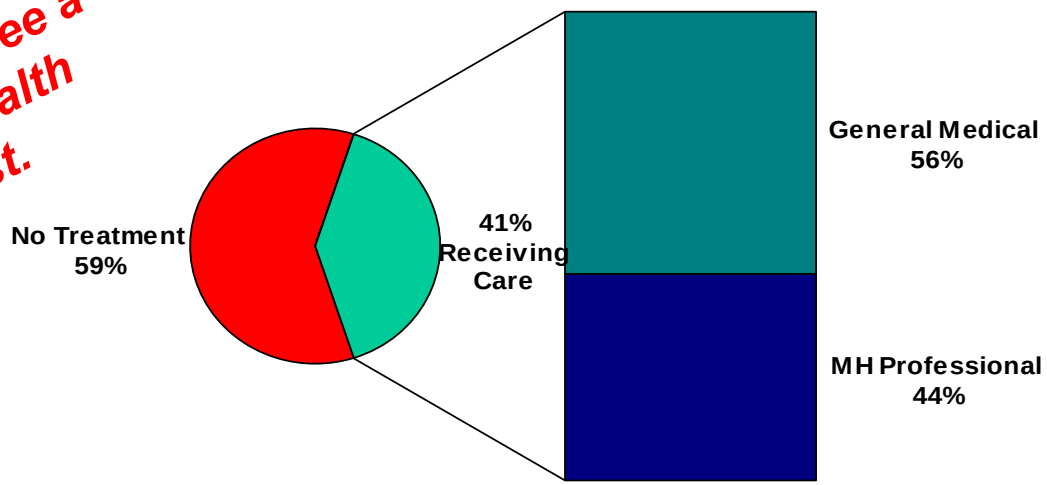
Primary Care is De Facto Mental Health System

National Comorbidity Survey Replication

Provision of Behavioral Health Care: Setting of Service

Only 2/10 of patients with diagnosable mental health problems see a mental health specialist.



Wang P et al., Twelve-Month Use of Mental Health Services in the United States, *Arch Gen Psychiatry*, 62, June 2005

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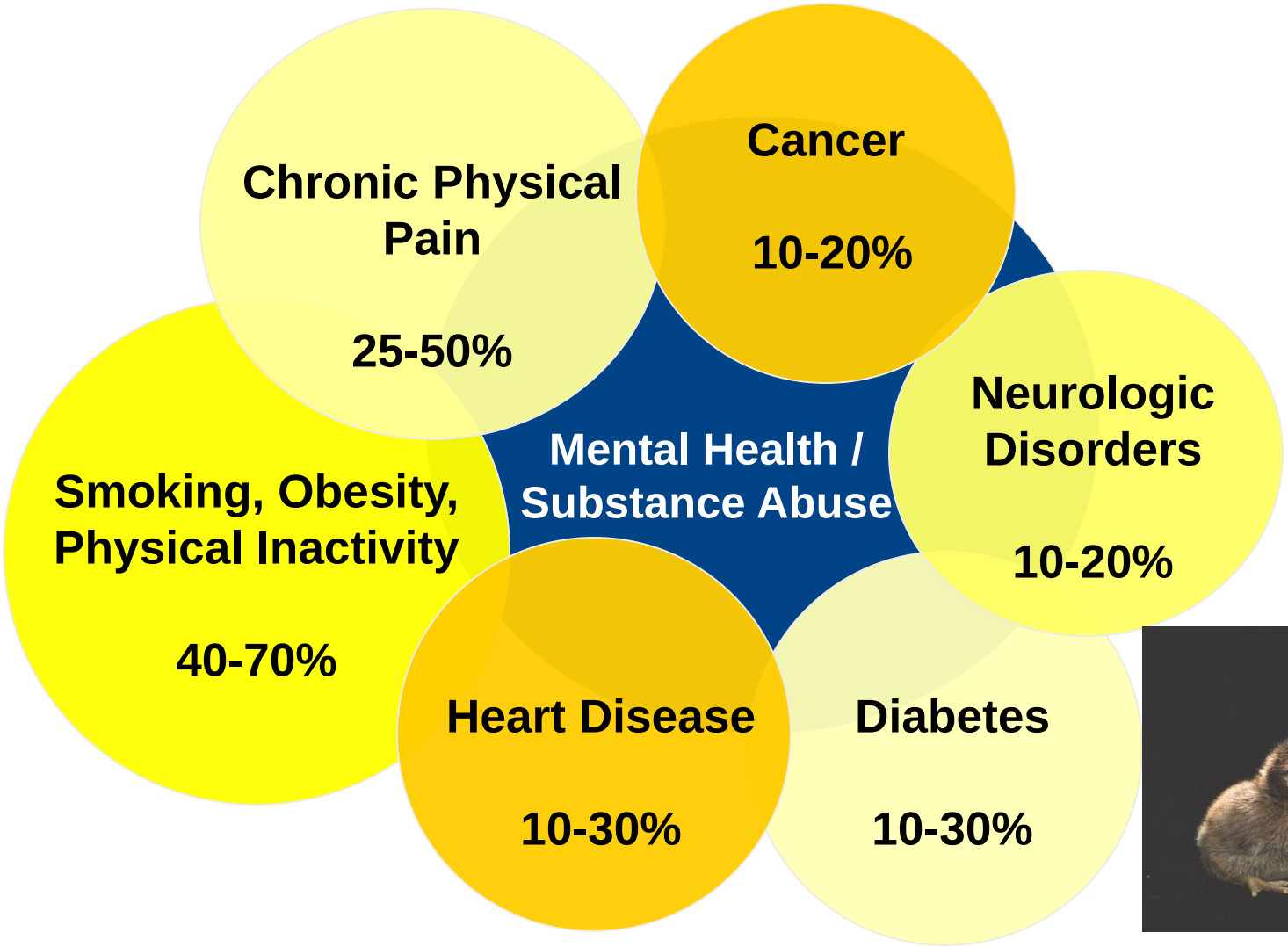
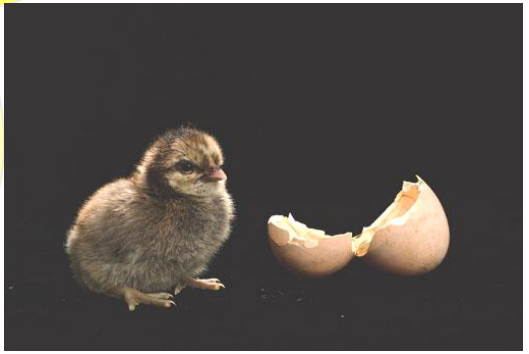
Mental Disorders are Rarely the Only Health Problem





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Services Poorly Coordinated, not Patient-Centered

Example: Depression Care

1/10 see psychiatrist

4/10 receive treatment in primary care

~ 30 Million with an antidepressant Rx but only 20 % improve

"Of course you feel great. These things are loaded with antidepressants."

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"We couldn't get a psychiatrist, but perhaps you'd like to talk about your skin. Dr. Perry here is a dermatologist."

Cunningham PJ, *Health Affairs*, 2009;28(3)490-501

2/3 of PCPs report poor access to mental health services for their patients

We need more effective care models

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Good ideas that DON'T WORK

Screening in primary care without adequate treatment / follow-up

- 20 years of negative studies
- "You can't fatten a cow by weighing it."

Provider education

- Knowledge is not enough
- Providers need systems and help to do the right thing

Telephone-based disease management

16 negative studies with ~ 300,000 Medicare recipients

- McCall N, Cromwell J: N Engl J Med 2011;365:1704-12.
- Peikes D et al: *JAMA. 2009;301(6):603-618*

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What DOES work?

Over 80 randomized controlled trials (RCTs) show that **Collaborative Care** is more effective for common mental disorders such as depression and anxiety than care as usual

- Gilbody S. et al. *Archives of Internal Medicine*; Dec 2006
- Thota AB, et al. Community Preventive Services Task Force. *Am J Prev Med.* May 2012;42(5):521-524.
- Archer J, et al. Cochrane Collaborative. Oct 17, 2012.: 79 RCTs with a total of 24,308 patients

Collaborative Care is more cost effective than care as usual

- Gilbody et al. BJ Psychiatry 2006; 189:297-308.
- Unutzer et al. Am J Managed Care 2008; 14:95-100.
- Glied S et al. MCRR 2010; 67:251-274.

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Collaborative Care Model

Primary Care Practice with Mental Health Care Manager

Outcome Measures

Treatment Protocols

Population Registry

Psychiatric Consultation

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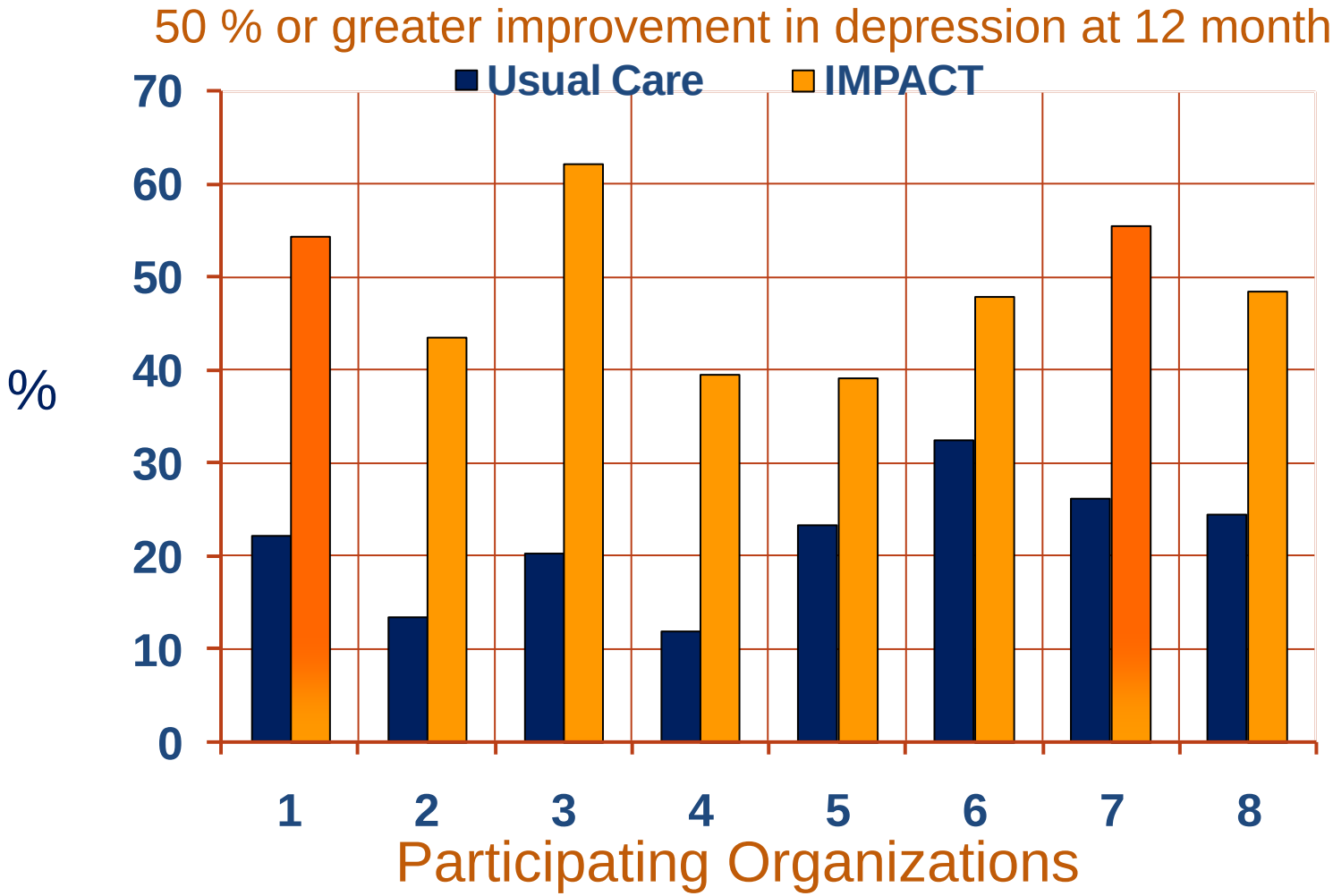
Collaborative Care doubles effectiveness of depression care



Unützer et al., *JAMA 2002*; *Psych Clin NA* 2004.

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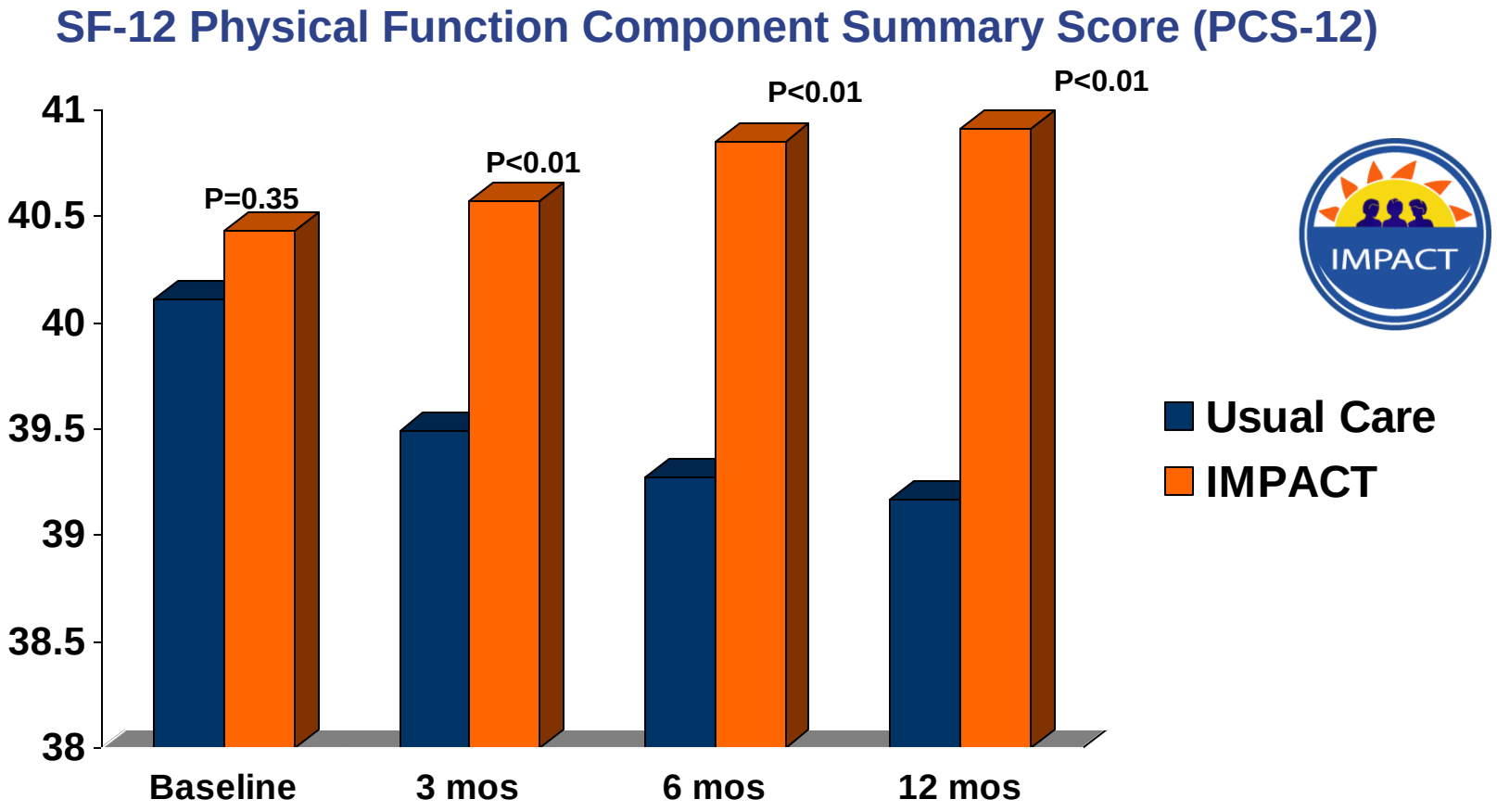
…improves physical function



Callahan et al., *JAGS* 2005.

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… and reduces health care costs

ROI: $6.5 saved / $1 invested

Cost Category	4-year costs in $	Intervention group cost in $	Usual care group cost in $	Difference in $
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7,284	6,942	7,636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8,452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
Total health care cost	**31,082**	29,422	32,785	**-$3363**

Savings

Unützer et al., *Am J Managed Care 2008.*

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IMPACT: Summary

- **Less depression**
  - **IMPACT more than doubles effectiveness of usual care**
- **Less physical pain**
- **Better functioning**
- **Higher quality of life**
- **Greater patient and provider satisfaction**
- **More cost-effective**

"I got my life back"

THE TRIPLE AIM

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Replication studies show the model is robust

Patient Population (Study Name)	Target Clinical Conditions	Reference
Adult primary care patients (Pathways)	Diabetes and depression	Katon et al., 2004
Adult patients in safety net clinics (Project Dulce; Latinos)	Diabetes and depression	Gilmer et al., 2008
Adult patients in safety net clinics (Latino patients)	Diabetes and depression	Ell et al., 2010
Public sector oncology clinic (Latino patients)	Cancer and depression	Dwight-Johnson et al., 2005 Ell et al., 2008
Health Maintenance Organization	Depression in primary care	Grypma et al., 2006
Adolescents in primary care	Adolescent depression	Richardson et al., 2009
Older adults	Arthritis and depression	Unützer et al., 2008
Acute coronary syndrome patients (COPES)	Coronary events and depression	Davidson et al., 2010

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Principles of Effective Patient- Centered Integrated Behavioral Health Care

Patient Centered Team Care / Collaborative Care

- Colocation is not Collaboration. 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.

Evidence-Based Care

- Treatments used are evidence-based.

Accountable Care

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

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Translating Research into Practice

"It is one thing to say with the prophet Amos, 'Let justice roll down like mighty waters,' and quite another to work out the irrigation system."

William Sloane Coffin, social activist and clergyman

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Translating Research into Practice

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Large Scale Implementations

Washington: Mental Health Integration Program

- Managed Medicaid Population
- 130 clinics; >25,000 patients

Minnesota: DIAMOND Program

- 6 Commercial health insurance plans
- 86 clinics; 400 PCPs; >10,000 patients

California

- Kaiser Permanente Southern California
- Los Angeles, Santa Clara, Ventura, Alameda County

New York, Texas, Alaska

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Washington State MHIP Program

- **Funded by State of Washington as a managed Medicaid program and Public Health Seattle & King County (PHSKC; through a Tax Levy)**
- **Administered by Community Health Plan of Washington and PHSKC in partnership with the UW AIMS Center**
- **Initiated in 2008 in King & Pierce Counties & expanded to over 100 CHCs and 30 CMHCs state-wide in 2009**
- **Over 25,000 clients served**
- **http://integratedcare-nw.org**

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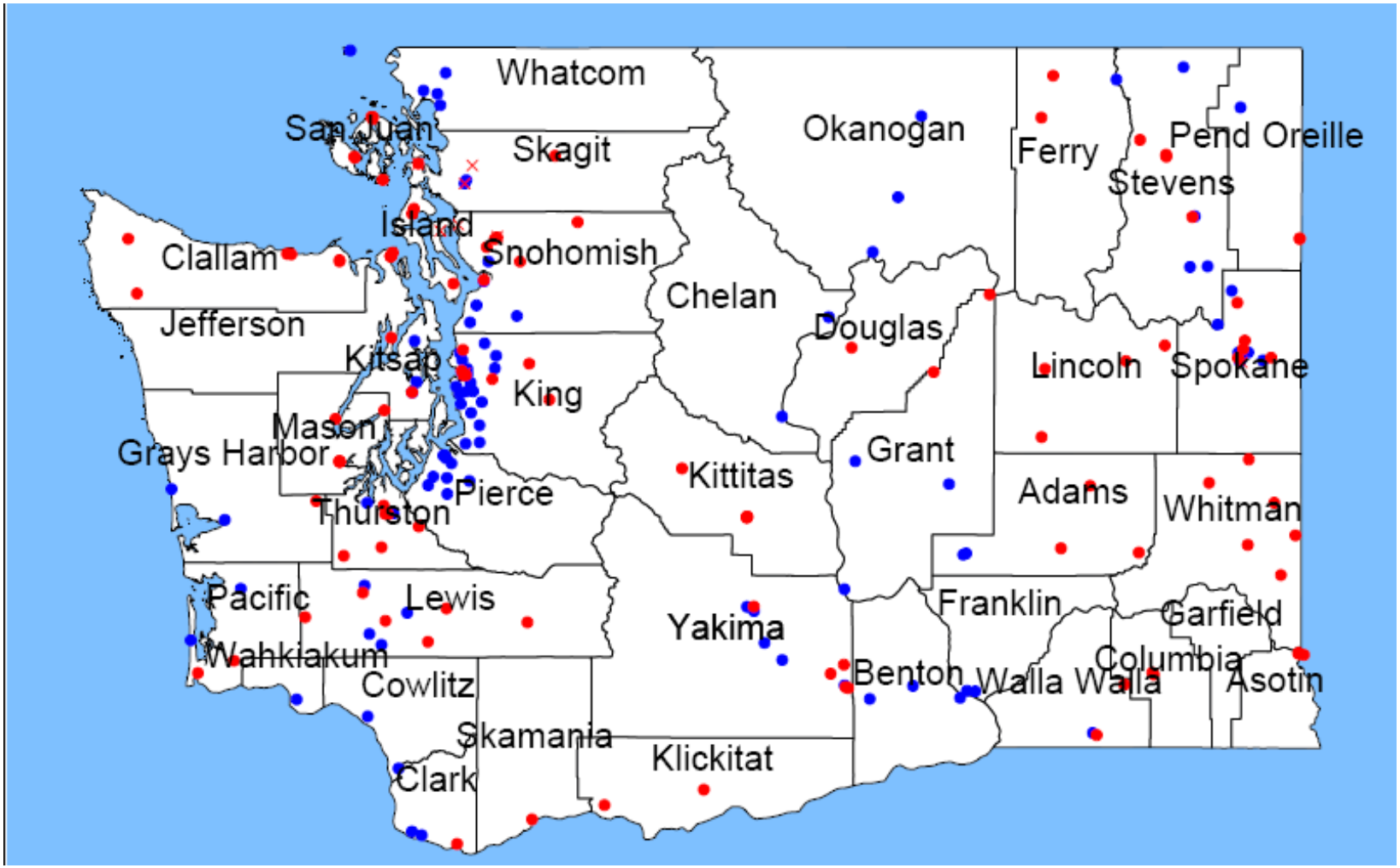
Mental Health Integration Program

> 25,000 clients served … 5 FTE psychiatrists



Community Health Plan of Washington

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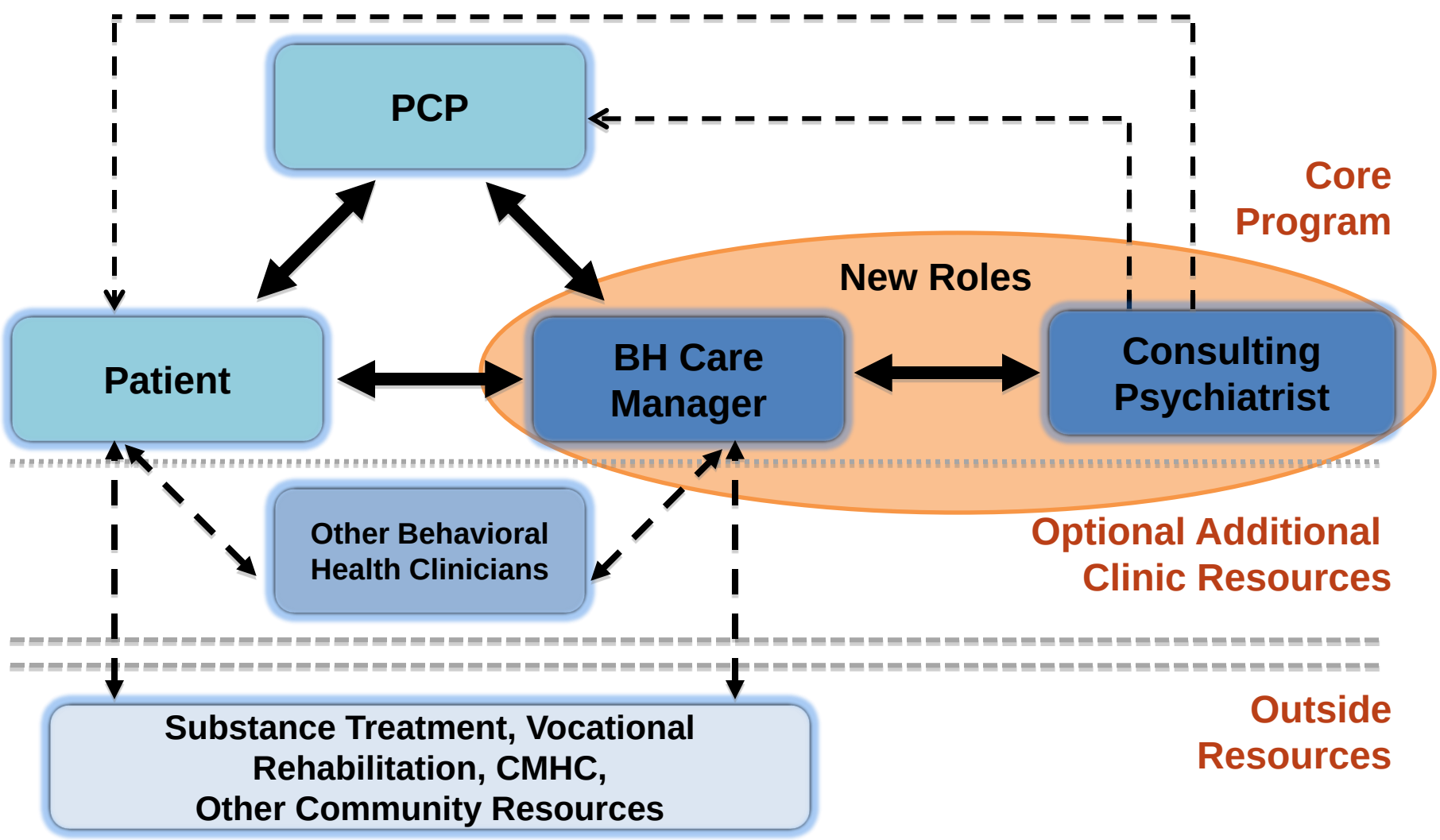
Collaborative Team Approach



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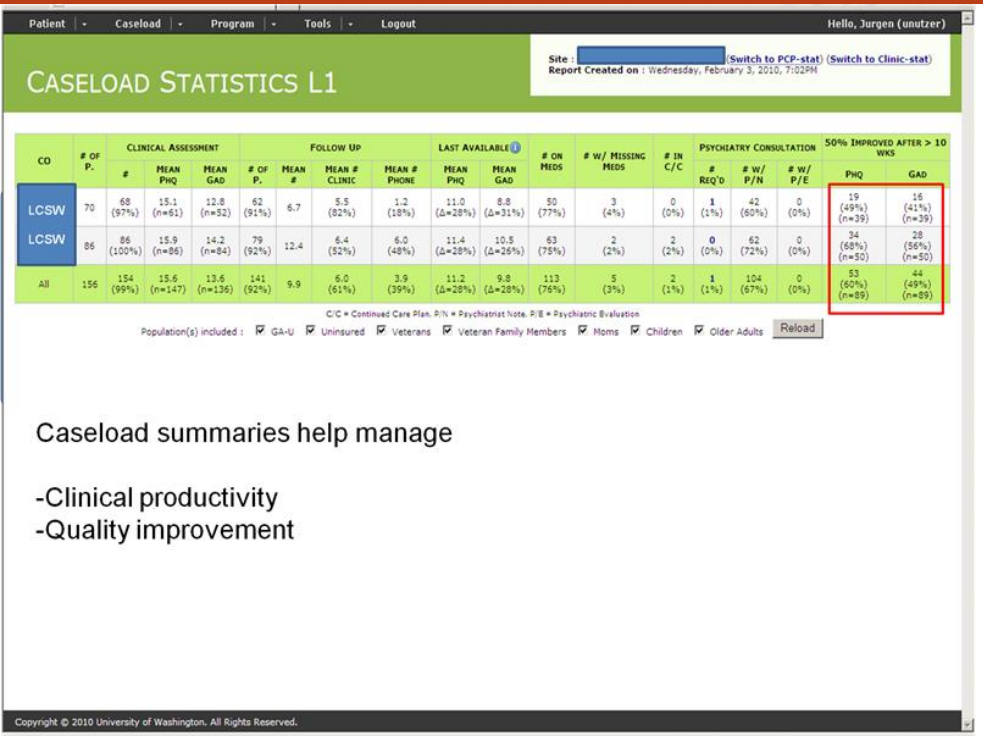
Web-based Registry (CMTS©)

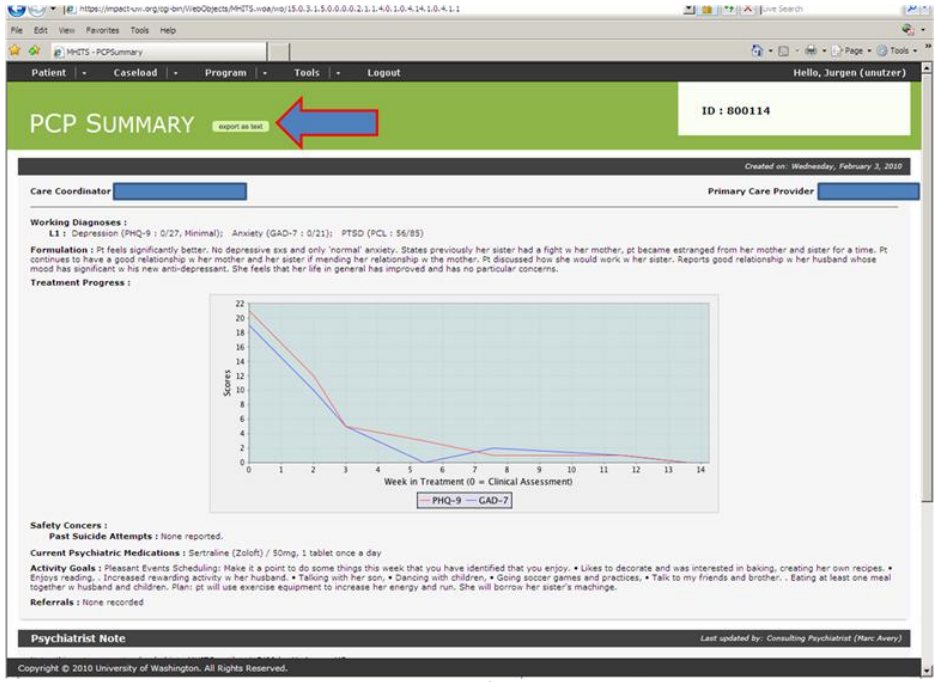


Caseload summaries help manage

-Clinical productivity
-Quality improvement

- Structures clinical encounters.
- Prompts follow-up and outcomes tracking.
- Facilitates consultation.

- Access from anywhere.
- Population-based.
- Keeps track of ‘caseloads’.
- Allows research on highly representative populations



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MHIP for Behavioral Health

Mental Health Integration Program

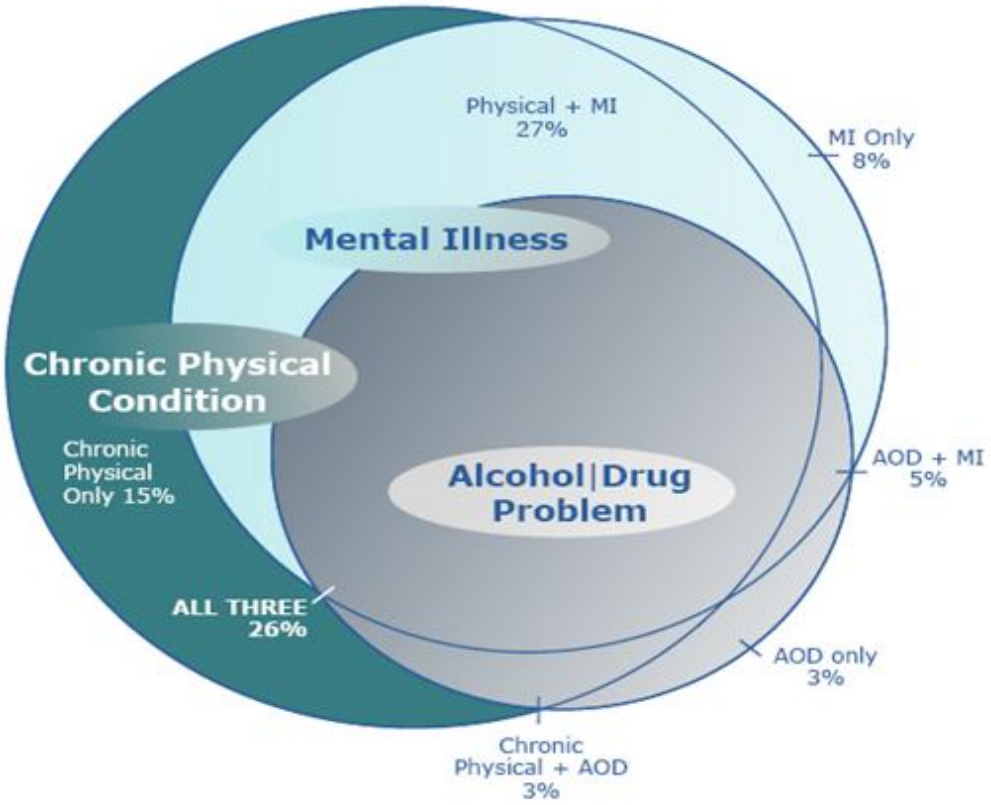
Co-occurring diagnosis among DL-U clients

DISEASE CONDITIONS

Chronic Physical	**71%**
Mental Illness	**66%**
Substance Abuse	**38%**

***72 percent** had **substance abuse** or **mental illness** identified*

***15 percent** had a **chronic physical condition** only*



SOURCES: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2006-07. Chronic physical and mental illness diagnosis groups derived from CDPS grouper. Mental illness also indicated by receipt of mental health medications.

Washington State Senate Ways and Means, January 31, 2011

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MHIP Common Client Diagnoses

Diagnoses	%
Depression	71%
Anxiety (GAD, Panic)	48%
Posttraumatic Stress Disorder (PTSD)	17%
Alcohol / Substance Abuse	17%*
Bipolar Disorder	15%
Thoughts of Suicide	45%

… plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty, ….

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Accountable Care

Quality Improvement:

Pay-for-performance initiative

- **Introduced in 2009**
- **25% of clinic payments for collaborative care services are contingent on meeting quality indicators**
  - **2 contacts / month**
  - **Clinical improvement or psychiatric case review / consultation**
  - **Medication reconciliation**

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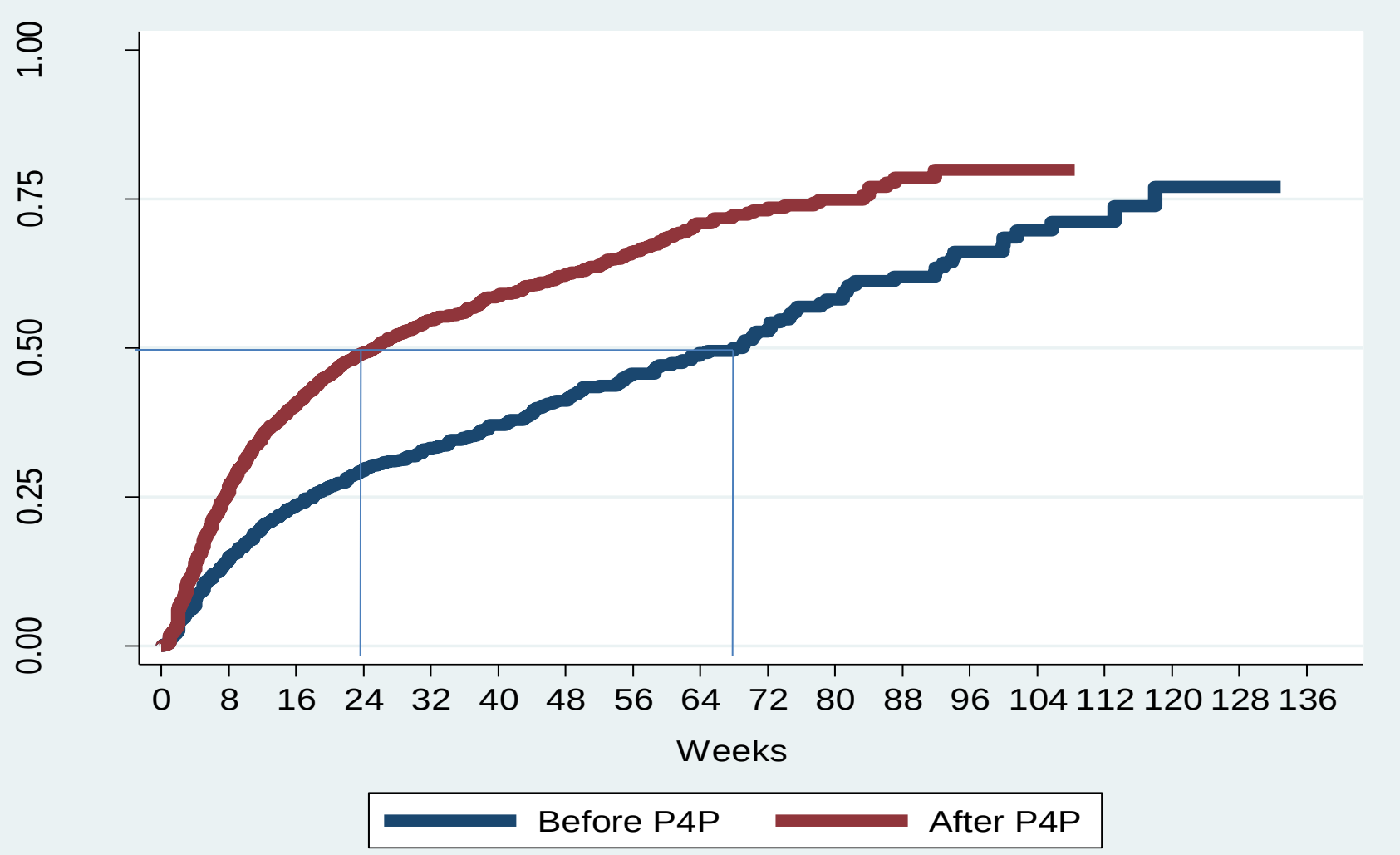
P4P-based quality improvement cuts median time to depression treatment response in half



Unutzer et al, *AJPH*, 2012.

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Bottom Line

- **Collaborative care is a cost-effective approach to address the substantial behavioral health (mental health and substance use) needs in Medicaid and other high risk populations**
- **State Medicaid programs can leverage Health Homes as a new opportunity to support implementation of evidence based collaborative care**

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Thank you

Jurgen Unutzer, MD, MPH, MA
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Discussion Panel

- **Benjamin Druss**, MD, MPH
  Professor, Rollins School of Public Health, Emory University
- **Henry Harbin**, MD
  Independent Consultant, former CEO of Magellan Health Services
- **John S. Kern**, MD
  Chief Medical Officer, Regional Mental Health Center, Indiana
- **Virna Little**, PsyD, LCSW-r
  Senior Vice President, The Institute for Family Health, New York

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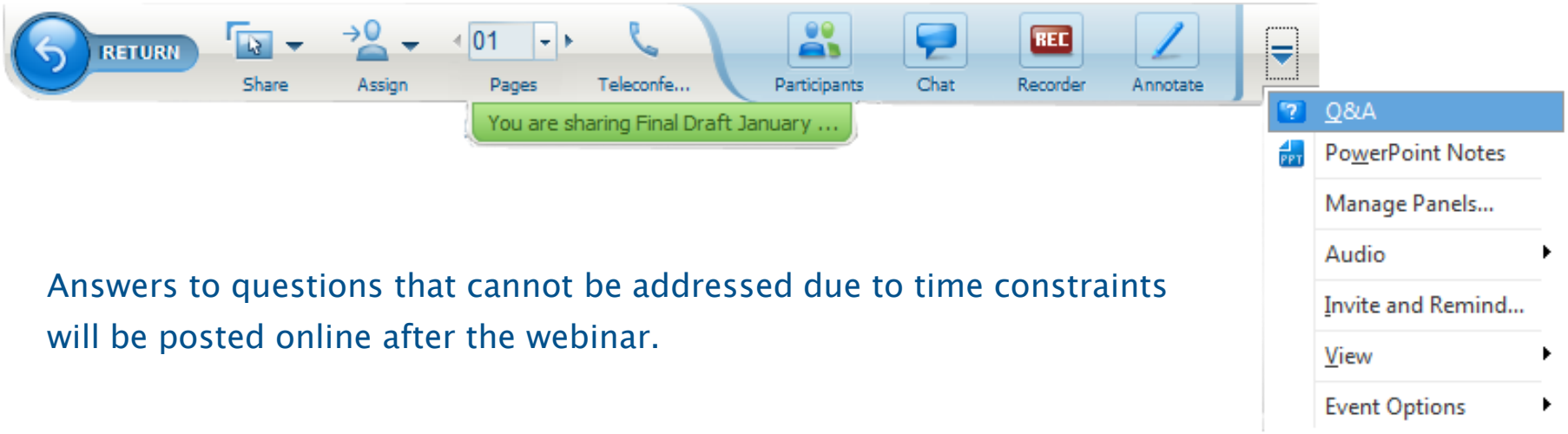

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For More Information

- **Stay tuned** for updates on the new *Health Home Information Resource Center* at Medicaid.gov.
- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services.
- **Subscribe** to e-mail Updates to learn about new programs and resources.
- **Learn** about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries.

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