

Integrating Mental Health Services into Primary Care: A Roundtable
June 25, 2012
Executive Summary

Background

On June 25, 2012, the United Hospital Fund (UHF) and the Primary Care Development Corporation (PCDC) invited over 40 content and policy experts to a Roundtable discussion of the issues central to the integration of mental health services for adults with depression in primary care practices in New York State Article 28- licensed facilities. The purpose of the session was to identify issues and develop recommendations to facilitate the integration of mental health services into primary care, a summary of which would be circulated to the participants, and transmitted to the Commissioners of Health and Mental Health for their consideration. The following is a summary of the discussion and recommendations.

The Challenge

Depression, anxiety, and substance use disorders are common in primary care settings, occurring in roughly 20 to 25 percent of patients seen in a primary care practice, with patients with chronic diseases and pregnancy exhibiting even higher rates. However, these disorders go unrecognized as much as 50% of the time, and when identified are typically ineffectively treated. The consequences include poor control of chronic physical health conditions, impaired parenting, avoidable healthcare utilization, and increased costs – especially for those with serious chronic disorders. The consequences of untreated depression itself include serious functional impairments in work, school, and home and risk of suicide. Standardizing the use of screening and evidence-based treatments, monitoring and quality improvement approaches to improving care in primary care settings is a clinical and economic imperative.

The Collaborative Care Model

The Collaborative Care model is a well-studied and replicated, evidence-based approach to depression care which has been shown to improve patient outcomes in diverse primary care settings. The Collaborative Care model is not the only model for integrating mental health services into primary care, but it is a proven, well-defined, effective approach that has been implemented in a number of other counties and states, including urban and rural areas and with people of diverse socio-economic, ethnic and racial groups. It has specific and auditable measures of program fidelity, patient care processes and outcomes.

The State DOH and OMH support the adoption of this standardized model of care throughout NYS as a service that can be offered by primary care providers licensed under Article 28. In order to achieve that end, the State agencies, providers and payers need to clearly define the key elements, process and outcome measures, fiscal mechanisms, and reporting requirements for providers offering Collaborative Care in Article 28-licensed primary care settings, under Article 28, which would facilitate its adoption.

The Roundtable identified a number of critical areas to be addressed in order to advance this model of care and to better integrate health and mental health in Article 28 primary care practices:

Licensure and Regulatory Issues

First, current OMH guidance specifies that an Article 28 provider must obtain Article 31 licensure if its volume of mental health visits exceeds certain thresholds: more than 10,000 mental health visits annually, or 30% of total visits. This threshold can and should be reconsidered, *at least* for providers who are providing services in keeping with state definitions (to be established) of Collaborative Care, and who can provide data to document program compliance.

Second, concerns about sharing of patient information among providers of health and mental health services was identified as an area in which “official” clarity (i.e. clarification of existing or the development of revised guidance) regarding privacy requirements would be highly useful.

Billing and Payment Issues

Developing a payment policy for Collaborative Care that works for the diverse provider systems, and that can be implemented across different payers (including the Behavioral Health “carve-out” plans) is an essential goal. The State should provide leadership and policy guidance in working with the plans and payers to formulate a coherent payment system for Collaborative Care, including (1) defining the “product” and covered services (e.g., which patients and which providers are covered); (2) clarifying network and credentialing issues, mechanisms of payment (FFS procedure based or “bundled” rates), and who should pay; and (3) establishing standards for measurement, reporting and auditing of Collaborative Care programs, services and payments.

Start-up

Provision of technical assistance and support for practice redesign (over several years) will likely be necessary to enable primary care providers to implement Collaborative Care programs. Workforce retraining will be essential, as will supports for culture change to enable primary care providers and clinic staff to incorporate integrated care into their clinical thinking and patient centered care.

Next Steps

If New York State DOH and OMH expect to expand Collaborative Care across a diverse set of Article 28 primary care providers and payers, there will need to be more specifically defined and established programmatic, licensing, billing and performance measures and standards; feasible administrative measures that will allow for practice audits that verify and track their fidelity to the program model; and measures that can document the program’s clinical effectiveness and costs.

Two “natural experiments” are currently under way in New York State (one involving health centers/clinics and another focused on hospital teaching clinics) in which providers have already implemented or are in the process of implementing the Collaborative Care Model.

It was recommended that the State DOH and OMH select from within these two groups a defined cohort of “early adopters” and work with those providers and the payers with whom they interact (i.e., Medicaid managed care plans and behavioral health “carve-out” plans):

- To establish and define the program model, its core elements, and elements can be amenable to local “tailoring” (e.g., based on location, available resources, cultural and linguistic needs, the unique requirements for residency training programs);
- To define a process for recognizing or “certifying” programs adhering to the elements of Collaborative Care;
- To define what measures need be collected and reported by providers to document program fidelity and to report on program operations and effectiveness (including both process measures and population-based measures of impact on mental health, chronic disease management, functional improvements, service utilization and costs), and consumer satisfaction;
- To define, craft and then pilot changes in licensure and regulations as well as billing and payment methods that respond to recognized barriers to effective and efficient program operations and sustainability posed by current state policies and presumptive processes, and to modify those methods over time based on emerging knowledge and evidence .

Doing so will create a framework for broad, rapid adoption of the Collaborative Care model in New York State.

Integrating Mental Health Services into Primary Care: A Roundtable
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Meeting Summary

Background

On June 25, 2012, the United Hospital Fund (UHF) and the Primary Care Development Corporation (PCDC) invited over 40 content and policy experts to participate in a Roundtable discussion of the issues central to the integration of mental health services into primary care, in NYS. This session focused on identifying ways to facilitate the integration of health and mental health services for adults with depression who are served in the state's Article 28-licensed primary care settings.

The understanding was that a summary of the discussions would be developed, circulated to the participants and transmitted to the Commissioners of Health and Mental Health for their consideration.

The discussion at this session was organized around three topics:

- I. The Need: Background and Goals for Integration
- II. The Collaborative Care Model, an evidence-based model responding to that need, and
- III. Some of issues and impediments facing providers in implementing this model of care, including
 - Legal/regulatory,
 - Billing/payment, and
 - Start-up

I. The Need

Depression, anxiety and substance use disorders are highly common in primary care settings, occurring in approximately 20 to 25% of patients seen in a primary care practice, and in patients with chronic diseases and pregnancy at even higher rates. However, these disorders go unrecognized as much as 50% of the time, and when identified are typically ineffectively treated.

The consequences of ineffective treatment include poor control of chronic physical health conditions, impaired parenting, avoidable healthcare utilization, and increased costs – especially for those with serious chronic disorders. The consequences of untreated depression itself include serious functional impairments in work, school and home and risk of suicide. Standardizing the use of screening and evidence-based treatments, as well as monitoring and quality improvement approaches to improving the care of these patients, in primary care settings is a clinical and economic imperative.

Untreated depression affects patients' quality of life and their ability to function, and when it co-occurs in patients with chronic physical illnesses (a population at significantly higher risk for depression) it also compromises their ability to participate effectively in the management of their physical illnesses. Such patients have significantly worse indicators of physical health status and higher rates of emergency department and hospital inpatient utilization than patients with only chronic physical diseases.

Of all patients with mental health problems, 60% receive no clinical treatment; of the 40% who receive some treatment, roughly half (including those with severe mental health illness) are cared for in specialty mental health settings and half receive their mental health care in primary care settings.

There is evidence that good care, well delivered, will result in outcomes significantly better than exist today, in “usual care” settings. Between 75-80% of patients who receive appropriate mental health treatment in controlled studies of depression care show improvements.

Unfortunately patients receiving care for depression in most “real-world” primary care settings do not receive care that is concordant with evidence-based guidelines. Such services are characterized by lack of detection of the disorder, inadequate engagement in effective treatments, and insufficient follow-up and monitoring of patients and their response to therapy. Access to care managers and staff trained in managing patients with mental health problems is often challenging.

Take-away

Increasing the use of screening and evidence-based treatments to improve the care of patients with depression (at this initial step in development) in primary care settings is a clinical and economic imperative. Its utility is especially evident for people with co-occurring chronic physical illnesses and depression.

II. The Collaborative Care Model

Overview of Collaborative Care: The clinical model presented for consideration at the Roundtable was the Collaborative Care model, an evidence-based approach to depression care based on the work of clinicians at the University of Washington (and others), which has been shown to improve patient depression and chronic physical disease outcomes in primary care settings. The Collaborative Care model employs on-site care managers and mental health consultants who function as members of the primary care team. This enables those providers to provide more effective patient engagement, more frequent patient follow-up, better tracking and monitoring of outcomes, and more timely referrals to mental health specialists, when necessary. This model has a number of core elements:

1. Consistent *use of a validated depression screening tool* – the Patient Health Questionnaire, PHQ-9 – for assessment and ongoing management of depression (improvement in depression results in reliable reductions in the scores on the instrument, much like blood pressure scores are reduced with effective anti-hypertensive treatment)
2. *Systematic patient follow-up*, tracking and monitoring based on repeat PHQ-9 measurements and use of a patient registry
3. Use of *evidence-based guidelines and a stepped-care treatment approach* (i.e., consultation and changes in treatment or referral for patients who do not show improvement in specified periods of time)
4. *Patient self-management and relapse prevention* where patients learn how to manage their illness (as they would with any chronic disease)
5. An on-site *care manager* to educate, coordinate, and troubleshoot services for patients with depression
6. *Psychiatric consultation* and caseload review, actively delivered on a weekly basis to the primary care physician and team when depression scores are not improved

This model was discussed at some length at the Roundtable, with the following observations:

Article 31 Clinics: The use of the Collaborative Care model by primary care providers differs from the role of Article 31 mental health clinics. Article 31 providers have traditionally (and appropriately) focused mainly on the care of the seriously mentally ill (SMI) population, which is not a population appropriately treated in the primary care setting. This, coupled with an overall shortage of mental health providers, has resulted in access problems in those sites, particularly for patients with “mild to moderate” mental disorders.

The populations appropriate for Collaborative Care are quite different from those served by (or likely to be referred to) Article 31 providers. The Collaborative Care Model is “primary mental health care”, focusing on mild to moderate depression and improving patients’ access to mental health services in the primary care setting.

This "one-stop" shopping can reduce patient resistance, perceived stigma, and reduce the high levels of non-adherence seen when patients are referred to mental health services (which may have waiting lists for services)

Impact on Chronic Care Management: Effective management of mental health issues like depression is critical to the provision of effective primary care, particularly in managing patients with chronic physical health problems and is consistent with the principles of the Primary Care Medical Home. Depression and other common mental health problems greatly complicate the care of such individuals, reducing patients' adherence to therapy, and their participation in managing their own physical health problems.

Integration vs. Co-location: There are substantial differences between an "integrated" approach - in which the mental health care manager is part of the primary care team - and "co-located services". In the latter, mental health services are provided by clinicians who are co-located with the primary care service but may not work together in an effective and integrated fashion with other health care providers. They may be employed by a partner mental health agency; the provider organizations are generally separately licensed, use separate and different medical records, and bill for care independently. Co-location may be insufficient on its own, to promote collaborate and integrated care; the integrated model is a more effective way of organizing and providing mental health services in primary care, whenever possible.

Article 28 Differences: Successful implementation of Collaborative Care may differ among Article 28 primary care sites. FQHCs and primary care practices that have adopted the Patient-Centered Medical Home model will have already progressed toward integrated care for chronic diseases. Those practices new to the PCMH will likely have greater start up challenges.

Take-Aways

The Collaborative Care Model is not the only model for integrating mental health services into primary care, but it is a proven, well-defined, effective, and evidence-based approach, with specific and auditable measures of program fidelity, patient care processes and outcomes.

Moreover, it has been implemented in diverse and multiple states and settings, with diverse patients, and within Medicaid paid service systems. The Collaborative Care model has demonstrated its effectiveness in over 40 replication studies.

The State DOH and OMH should promote adoption of that model of care as a service that should be offered by primary care providers licensed under Article 28 throughout NYS.

In order to do that, the State agencies, providers and payers will need to clearly define the key elements, measures, fiscal mechanisms, and reporting requirements for Collaborative Care in primary care settings, under Article 28.

III. Issues and Impediments in Implementing the Collaborative Care Model

A. Legal and Regulatory Concerns

The Roundtable considered a variety of licensure/regulatory issues (including privacy/confidentiality concerns) cited by providers as impediments to the initiation and ongoing operation of Collaborative Care programs in Article 28 clinics, with the following observations:

Licensure Concerns: Article 28 providers are clearly authorized to provide mental health services, including the Collaborative Care Model. However, the volume of mental health services (measured by visits) that an Article 28 can provide *within its license* is currently limited by OMH. Under current OMH guidance, if an Article 28-licensed primary care site provides a volume of mental health visits above a certain threshold, it must apply for and gain licensure under Article 31.

Under current OMH guidance, an Article 28 primary care provider must obtain Article 31 licensure if it provides more than 10,000 mental health visits annually, or its mental health visits comprise over 30% of its total annual visits. This guidance, which does not apply to sites licensed under both Article 28 and Article 31, is not based in

law or regulation; it is included in an OMH guidance document (14 NYCRR Part 599, “Clinic Treatment Programs”, Interpretive / Implementation Guidance, 01-04-2012; page 6) that is within OMH control to change.

DOH and OMH staff are currently working on a range of initiatives to better integrate licensure under Article 28 and Article 31 for licensed providers of both physical and mental health services. The visit threshold issue has not been a specific focus, to date.

Take-Away

The visit threshold issue should be reconsidered, *at least* for providers who are providing services in keeping with state definitions (to be resolved) of Collaborative Care, and who can provide data to document program compliance.

Confidentiality and Privacy Concerns: The Collaborative Care Model depends on the ability of clinicians providing care in an integrated primary care program (often with a unified EMR) to share information about patients’ mental health problems and treatment plans, including prescription drugs. In the context of a single provider setting, this is not a problem. Nonetheless, providers continue to be concerned about sharing sensitive information that is otherwise protected (particularly a therapist’s clinical notes) among providers of physical and mental health care within the same program. However, there are indeed important confidentiality issues between an Article 28-based provider and separately licensed Article 31 (OMH) or 32 (OASAS) clinicians and programs, including those who are co-located or separately located.

Take-Away

State agency guidance would be helpful to providers in understanding what exchange of information is legally permissible and what requires specific permission to satisfy Privacy and Confidentiality requirements.

B. Billing and Payment Issues and Concerns

The Roundtable considered a variety of billing and payment issues cited by providers as impediments to the implementation and scaling up of Collaborative Care programs in Article 28 clinics, including:

Basic Issues for Billing and Payment: Developing payment systems to support Collaborative Care requires clarification of some basic issues:

- What is the “covered service(s)”?
- Who can and should be credentialed and able to bill and be paid for providing those service(s)?
- For which patients should those payments be made?
- To which providers should payment be made?
- How much does the service it cost, and how much should be paid?
- How should the payments be designed - FFS, bundled payments, or a mix?
- How best to audit performance and payments?

Diversity of Providers and Payers: Changing payment for Collaborative Care is further complicated by the diversity of both providers and payers.

Providers: Clinics and FQHCs are paid differently for their basic primary care services. Article 28 clinics are paid by health plans using variations on the APG system and/or primary care capitation; FQHC’s are paid by health plans in various ways and receive a payment directly from Medicaid of a “wrap-around” payment, up to their approved comprehensive visit rate.

Payers: Medicaid payment for programs like Collaborative Care is modulated by the policies and procedures of a diverse group of Medicaid health plans and behavioral health “carve-out” plans, each of which determines what they cover and how they pay for services. Medicaid managed care plans have differing ways of managing mental health services. Many plans use Behavioral Health “carve-out” providers, to whom they delegate responsibility for managing their mental health provider network and credentialing, billing and payment; others retain those responsibilities in house.

It would also be helpful for the State to engage the plans in an effort to craft solutions that align provider payments and incentives across payers so that the plans define, pay for and track services provided in a similar manner.

Billing and Payment Logistics: Billing and payment for Collaborative Care services in NYS is currently quite complex. Under the existing systems, the providers offering mental health services within Article 28 sites must:

- 1) Be included in the Medicaid managed care plan's / Behavioral Health "carve-out" plan's provider panel/network;
- 2) Be appropriately licensed and credentialed by the plan to provide the "covered service";
- 3) Provide documentation to the plan justifying the necessity and appropriateness of the visit/service, for the plan's approval;
- 4) Bill and be paid for that "covered service"- payments which may not include or reflect the full costs of the program (i.e., would not reflect costs of care management, non-face-to-face patient contact, team meetings, and phone consultations with the psychiatrist); and
- 5) Be prepared to have the appropriateness of their services and billing subjected to retrospective audits.

Fee for Service (FFS) vs. "Bundled Payments": Like the Patient-Centered Medical Home, Collaborative Care is in many ways a "new" form of clinical care, which adds new functions not traditionally delivered as part of primary care: it involves new staff (mental health-trained care managers), new definitions of teams and forms of teamwork, new relationships with "outside" psychiatrists, and changing the practice's operations, clinical care processes and patient flow, all of which represent significant investments.

Some of the elements of the Collaborative Care model are captured and paid for using existing fee-for-service(FFS) billing mechanisms; but other elements (e.g. care management, non-face-to-face patient contact and consultations with the psychiatrist) are not built into, or reflected in current payment methods (APGs in clinics, visit payment rates in FQHCs). Costs in the latter category may be better handled by bundled payments, blended FFS and PMPM payments, which would require Medicaid approvals.

While the group noted that FFS and "bundled" payment systems for services (like Collaborative Care) each has advantages and disadvantages, in light of the difficulty involved in billing and paying for "non-visit" services there was support for moving away from a pure FFS payment approach and towards a payment system that "bundles" or consolidates payments for Collaborative Care as a program, using a "mental health care management" payment.

Bundled payment approaches have been used in other states (e.g., Washington and Minnesota) with broad, statewide efforts to initiate and support the implementation of the Collaborative Care Model in primary care settings. In New York State, one plan (Independent Health) is paying differently for Collaborative Care services uncovered by the traditional FFS payment system, paying a monthly fee for care coordination/tracking/follow-up and using a non-claims-based reimbursement for the consulting psychiatrist.

Take-aways

Developing a consistent payment policy for Collaborative Care services, one that works for the diverse provider systems and that can be implemented across different payers (including the Medicaid managed care plans and Behavioral Health "carve-out" plans) is critical, but it will be a challenge.

State leadership and involvement in that process will be essential to achieving a coherent payment (and thereby effective clinical) system: defining the "product", providing policy guidance for how those services should be paid for, establishing standards for measurement, reporting, and audit of services and payments. State agencies should engage payers and providers to develop payment method(s) for Collaborative Care that can work in both clinic and FQHC settings/systems.

Program Start-up Concerns

During the Roundtable, a number of providers described the effort and expense required to put into place Collaborative Care programs. Their experience provides insights into the implementation challenges ahead.

Investing in Change: Investments involved in establishing a Collaborative Care program include:

- 1) identifying, hiring and training mental health professionals to work in a new role, as mental health care managers, within the primary care setting;
- 2) Training staff (including primary care clinicians) to work in re-defined patient care teams, with new relationships among its members;
- 3) Re-designing care processes and patient flow within the practice;
- 4) Acquiring and/or redesigning IT systems to include and support the program;
- 5) Developing new relationships with “outside” psychiatrists and other mental health professionals, to provide consultations, as needed;
- 6) Acquiring technical assistance from content experts to facilitate program design and implementation; and
- 7) Promoting culture change within an organization.

Start-up Funding: Based on program experience, the availability of technical assistance from content experts and start up funding or other support has proven essential, helping to bridge the operation to the time when enhanced rates lead to program break-even. Many of the current providers received grant funding to assist with program start-up; such support is likely to be critical to providers in implementing Collaborative Care into their practices.

Take-Away

Provision of technical assistance, practice redesign support and initial funding may be necessary and appropriate to enable primary care providers to implement Collaborative Care programs.

C. Other Issues and Concerns

A number of other issues were raised relative to the implementation and future expansion of the Collaborative Care Model in New York State:

Workforce: To implement the Collaborative Care model, primary care practices will require mental health staff functioning in new and non-traditional roles:

- (1) a licensed mental health professional (e.g., LCSW, psychiatric nurse, or clinical psychologist) to serve as a care manager and member of the primary care team and a
- (2) a psychiatrist who reviews the registry of patients and reports and consults weekly to the primary care physician and team on cases not improving and assists in making referrals as required.

There is a shortage of mental health personnel with those skills and training and who are interested and able to work effectively within Collaborative Care programs; this may represent an important limiting step in the expansion of this model and require retraining of existing staff and repurposing of existing positions.

Expanding the Focus: While it makes sense to begin, as the Roundtable did, with a sharply-focused effort (on improving the care of adults with depression in Article 28-licensed primary care settings), there is a need to expand that focus over time, to include:

- 1) Additional populations, notably adolescents and young adults, aged 16-24, and children, as well as other mental health disorders – especially anxiety disorders including PTSD and generalized anxiety disorder;
- 2) Attention to substance use disorders, building on the evidence (and payment) for SBIRT (Screening, Brief Intervention and Referral for Treatment);
- 3) Additional service sites and settings, notably private practice offices and groups; and
- 4) Additional payers, including Medicare and commercial insurance.

IV. Next Steps

Throughout the day's Roundtable discussions, there was a broad consensus that the Collaborative Care model is an important and needed innovation, worthy of further testing, and – if supported by evidence of its effectiveness – further expansion in New York State.

To expand implementation of Collaborative Care in Article 28 clinics, New York State DOH and OMH will need:

- to fully and clearly define the essential and auditable elements of Collaborative Care, and to establish standards regarding key program components and processes of care;
- to establish measures to be collected and reported by providers that enable state agencies, payers, plans and emerging ACOs to track performance and verify providers' fidelity to the program model and document the program's impact and effectiveness;
- to undertake needed changes in agency policies, licensure and regulation to allow and support the operation of thus-defined Collaborative Care programs in Article 28 primary care facilities;
- to work with providers, plans and Behavioral Health "carve-out" plans to develop appropriate approaches to billing and payment for Collaborative Care in Article 28 primary care facilities; and
- to help support the startup of new programs.

There are two natural experiments currently under way in New York State:

Roughly 25 clinics and FQHCs across the state have *already* implemented versions of Collaborative Care. In addition, there are two grant-funded initiatives currently under way (a learning collaborative led by the Community Health Center Association of New York State, CHCANYS, and by the Mental Health Association of New York City, MHANYC) through which an additional 10 FQHCs are receiving consultation, technical assistance and support, helping them to design, develop and implement Collaborative Care programs in their facilities.

As part of a new State DOH and OMH initiative, technical assistance and support will be made available to hospital teaching clinics to assist them in achieving NCQA recognition as PCMHs. Within that initiative, there is an option for hospitals to include the implementation of the Collaborative Care model in an effort to support integration of behavioral and physical health care. A number of hospitals plan to pursue that option. As part of that initiative, the OMH plans to make available to those hospitals willing to implement the Collaborative Care model with fidelity, technical assistance and support provided by experts from the University of Washington's AIMS Center.

It was noted that these two efforts provide an opportunity for the state, the payers and the involved practices implementing the Collaborative Care model to advance the implementation of Collaborative Care in New York State and to learn what Article 28 providers offering that model of care can do within primary care, as well as what their clinical limits are that require specialty referral.

It was recommended that the State DOH and OMH select from within these two groups a defined cohort of "early adopters" and work with those providers and the payers with whom they interact (Medicaid managed care plans and behavioral health "carve-out" plans):

- To establish and define the program model, its core elements, and features that can be amenable to local "tailoring" (e.g., based on location, available resources, cultural and linguistic needs);
- To define a process for recognizing/"certifying" programs adhering to the elements of Collaborative Care;
- To define what measures need be collected and reported by providers to document program fidelity and to report on program operations and effectiveness (including both process measures and population-based measures of impact on mental health, chronic disease management, functional improvements, service utilization and costs), and consumer satisfaction;

- To define, craft and then pilot changes in licensure and regulations as well as billing and payment methods that respond to recognized barriers to effective and efficient program operations and sustainability posed by current policies and processes.

In closing, it was recommended that the State DOH and OMH:

- Commence this effort *not* as a demonstration, but as “Phase I” of a process focused on a broad state-wide implementation of Collaborative Care;
- Conduct a “rapid-cycle program evaluation and quality improvement” of the efforts of these early adopter practices, focused on assessing and improving feasible, meaningful and actionable outcomes; and
- Use that experience - and insights gained from other states’ efforts to advance the use of Collaborative Care in their settings - to inform further changes in state policy, moving the implementation of the Collaborative Care model in Article 28-licensed primary care settings as rapidly as is indicated by the evidence from pilot programs to statewide scale.