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.
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
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
University of Washington

AIMS CENTER
Advancing Integrated Mental Health Solutions

20 years of Research and Practice in Integrated Mental Health Care
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
### Medicaid Claims for Behavioral Health Care in Washington State

#### Dually Eligibles

<table>
<thead>
<tr>
<th></th>
<th>Aged</th>
<th>Working-Age Disabled</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TOTAL</td>
<td>PERCENT</td>
<td>TOTAL</td>
</tr>
<tr>
<td><strong>Alcohol/Drug Treatment Need</strong> (SFY 2008-2009)</td>
<td>1,464</td>
<td>2.2%</td>
<td>9,212</td>
</tr>
<tr>
<td>Mental illness Diagnosis</td>
<td>29,335</td>
<td>44.0%</td>
<td>38,379</td>
</tr>
<tr>
<td>Psychotic</td>
<td>3,928</td>
<td>5.9%</td>
<td>10,090</td>
</tr>
<tr>
<td>Depression</td>
<td>16,617</td>
<td>24.9%</td>
<td>19,779</td>
</tr>
<tr>
<td>Delirium and Dementia</td>
<td>13,207</td>
<td>19.8%</td>
<td>2,271</td>
</tr>
<tr>
<td>Mental Health Medication</td>
<td>31,498</td>
<td>47.3%</td>
<td>39,028</td>
</tr>
<tr>
<td>Antipsychotic</td>
<td>5,815</td>
<td>8.7%</td>
<td>15,094</td>
</tr>
<tr>
<td>Antidepressant</td>
<td>18,169</td>
<td>27.3%</td>
<td>25,626</td>
</tr>
<tr>
<td>Meets CCM medical risk threshold (SFY 2009)</td>
<td>13,900</td>
<td>20.9%</td>
<td>12,519</td>
</tr>
</tbody>
</table>
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
Mental Disorders are Rarely the Only Health Problem

- Chronic Physical Pain: 25-50%
- Cancer: 10-20%
- Mental Health/Substance Abuse: 40-70%
- Smoking, Obesity, Physical Inactivity: 40-70%
- Heart Disease: 10-30%
- Diabetes: 10-30%
- Neurologic Disorders: 10-20%
Services Poorly Coordinated, not Patient-Centered

“Don’t you guys talk to each other?”

- Primary Care
- Community Mental Health Centers
- Alcohol & Substance Abuse Treatment
- Social Services
- Vocational Rehab
- Other Community Based Social Services
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.”
We need more effective care models
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

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

**Collaborative Care** is more cost effective than care as usual

- Gilbody et al. BJ Psychiatry 2006; 189:297-308.
- Glied S et al. MCRR 2010; 67:251-274.
Collaborative Care Model

Primary Care Practice with Mental Health Care Manager

- Outcome Measures
- Treatment Protocols
- Population Registry
- Psychiatric Consultation
Collaborative Care doubles effectiveness of depression care

50% or greater improvement in depression at 12 months

...improves physical function

Callahan et al., JAGS 2005.
... and reduces health care costs
ROI: $6.5 saved / $1 invested

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

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
Replication studies show the model is robust.

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

In-person training:

Upcoming Presentations and Training Events:

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Organization/Type of Training</th>
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<tbody>
<tr>
<td>October 2-3, 2006</td>
<td>Skagit, WA</td>
<td>University of Washington / IMPACT Training conference</td>
</tr>
</tbody>
</table>

Past Presentations and Training Events:

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Organization/Type of Training</th>
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<tbody>
<tr>
<td>February 20-21, 2008</td>
<td>Anchorage, AK</td>
<td>Alaska Mental Health Trust</td>
</tr>
<tr>
<td>February 12-13, 2008</td>
<td>Minneapolis, MN</td>
<td>ICBC/OMH/DSM/CR ACT Training conference</td>
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Clinicians Trained:

- 5,000 clinicians in over 600 clinics

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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
• 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](http://integratedcare-nw.org)
Mental Health Integration Program
> 25,000 clients served … 5 FTE psychiatrists
Collaborative Team Approach

- PCP
- Patient
- BH Care Manager
- Consulting Psychiatrist
- Other Behavioral Health Clinicians
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

Core Program
New Roles
Optional Additional Clinic Resources
Outside Resources

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AIMS CENTER | Advancing Integrated Mental Health Solutions
Web-based Registry (CMTS©)

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

Caseload summaries help manage
- Clinical productivity
- Quality improvement

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

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

Co-occurring diagnosis among DL-U clients

- 72 percent had substance abuse or mental illness identified

- 15 percent had a chronic physical condition only

Mental Illness

Chronic Physical Condition

Alcohol/Drug Problem

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
# MHIP Common Client Diagnoses

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>71%</td>
</tr>
<tr>
<td>Anxiety (GAD, Panic)</td>
<td>48%</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder (PTSD)</td>
<td>17%</td>
</tr>
<tr>
<td>Alcohol / Substance Abuse</td>
<td>17%*</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Thoughts of Suicide</strong></td>
<td>45%</td>
</tr>
</tbody>
</table>

... plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty, ...
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
P4P-based quality improvement cuts median time to depression treatment response in half

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
Thank you

Jurgen Unutzer, MD, MPH, MA
unutzer@uw.edu
http://uwaims.org
Discussion Panel

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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.

[http://www.chcs.org](http://www.chcs.org)