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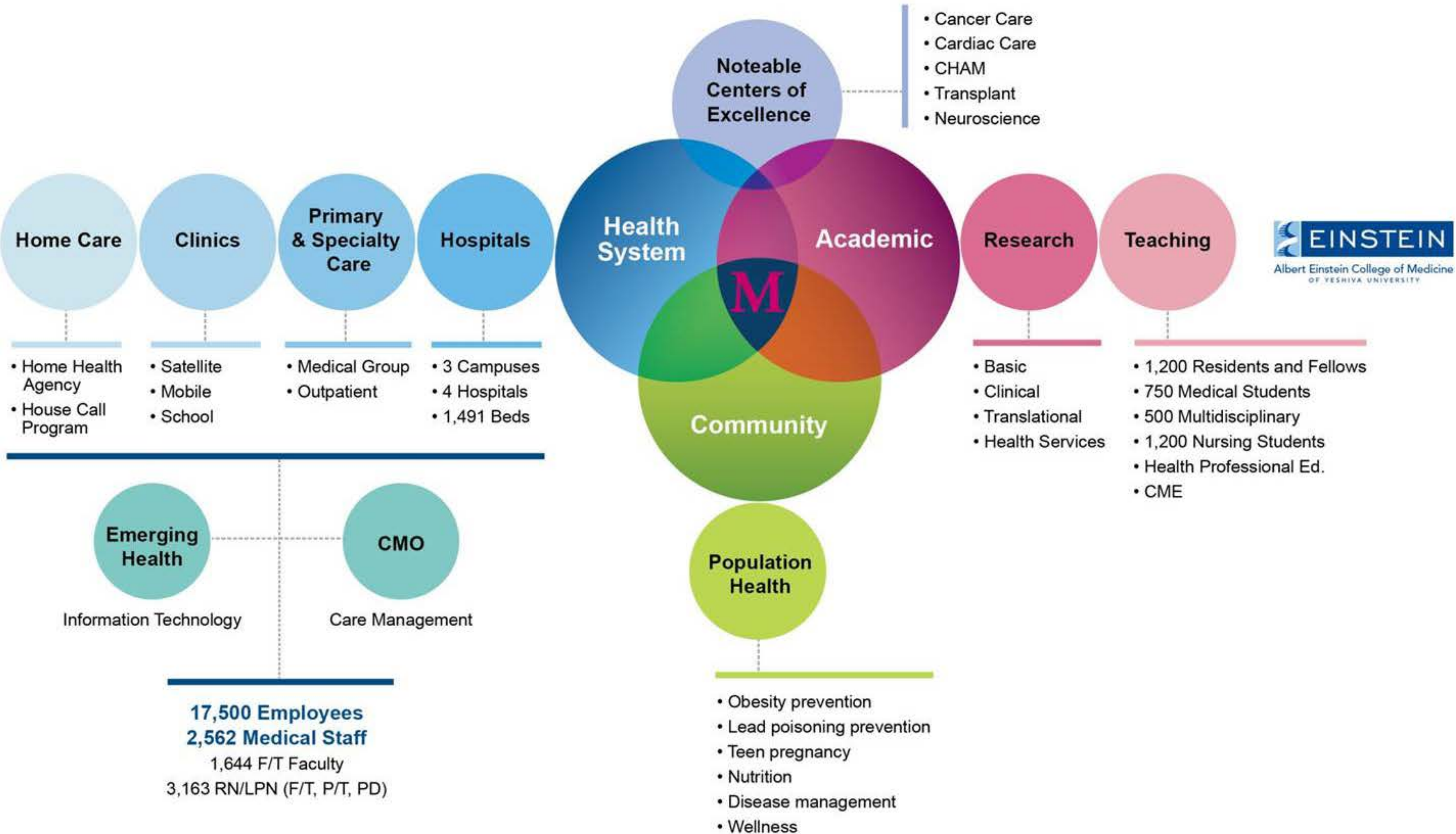
The Montefiore ACO and Behavioral Health Integration: A Work in Progress

Henry Chung, MD
Bruce Schwartz, MD

Agenda

- Describe the Montefiore Medical Center delivery system and experience in managing vulnerable populations
- Provide an overview of the Montefiore ACO and its focus on behavioral health integration
  - Rationale and approach
  - PCMH and collaborative care models
  - Challenges and Next Steps

Montefiore Medical Center – University Hospital of the Albert Einstein College of Medicine



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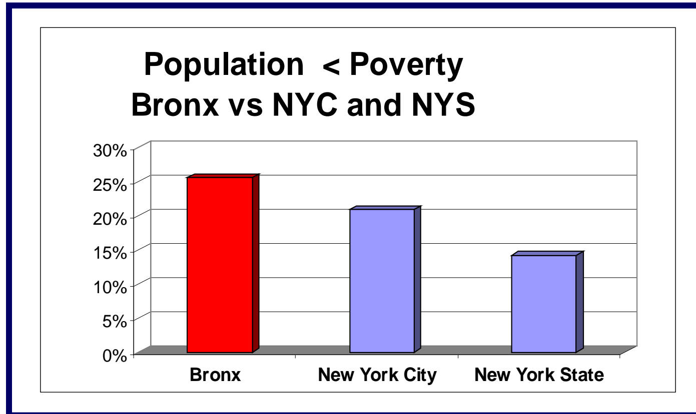
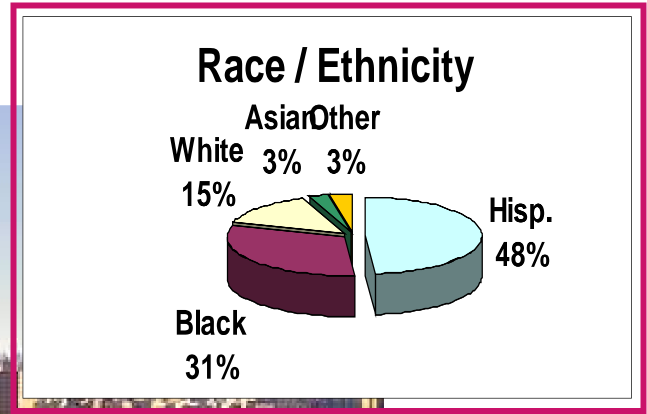
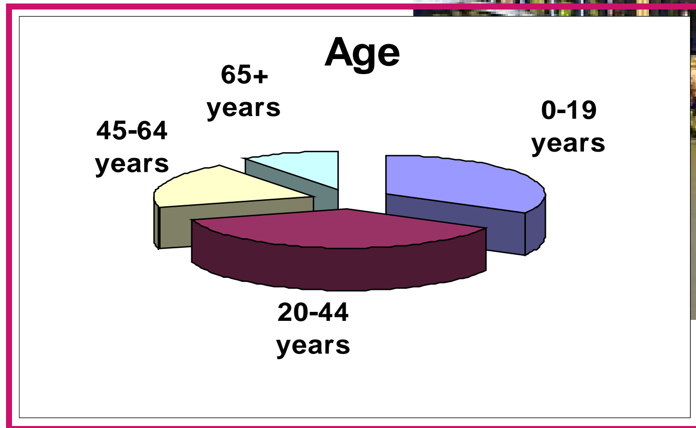
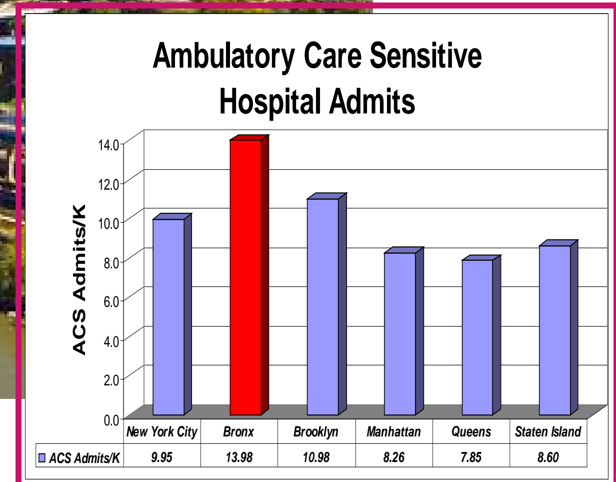
The Bronx:

Poor, Minority, Young, Heavy Disease Burden









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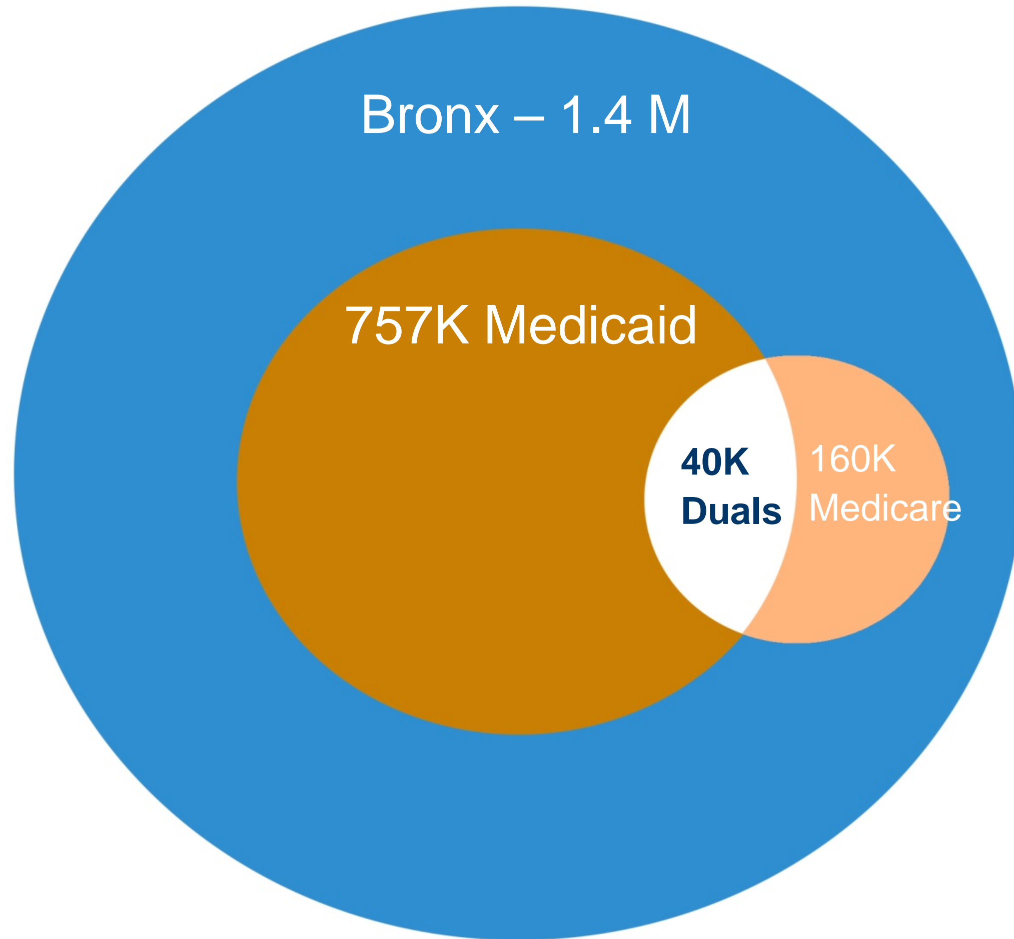
Bronx Population Overview



Bronx Total Health Care Spend = $13.4B
Bronx Duals Spend = $1.5 B

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Experience with Managing Populations

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IPA and Montefiore Care Management

Montefiore IPA/MBCIPA

- Formed in 1995
- MD/ Hospital Partnership
- Contracts with managed care organizations to accept risk
- Over 1,900 physician members
  - 400 PCPs
  - 1500 Specialists

CMO and UBA Montefiore Care Management

- Established in 1996
- Montefiore subsidiary
- Performs medical and behavioral care management delegated by health plans as well as other administrative functions, e.g. claims payment, credentialling

Montefiore's Risk and/or Value-Based Population and Revenue

Source	2012 Population	2012 Est. Revenue	2013 Population	2013 Est. Revenue
Risk Contracts	140,000	$850 m	185,000	$1,085 m
Shared Risk	78,000	$490 m	80,000	$685 m
Medicaid health Home (Care Coordination)	5000	$5 m	5000	$5 m
	223,000	$1,345 m	270,000	$1,775 m

The organization is moving from a transaction-oriented business to a value-based source of revenue.

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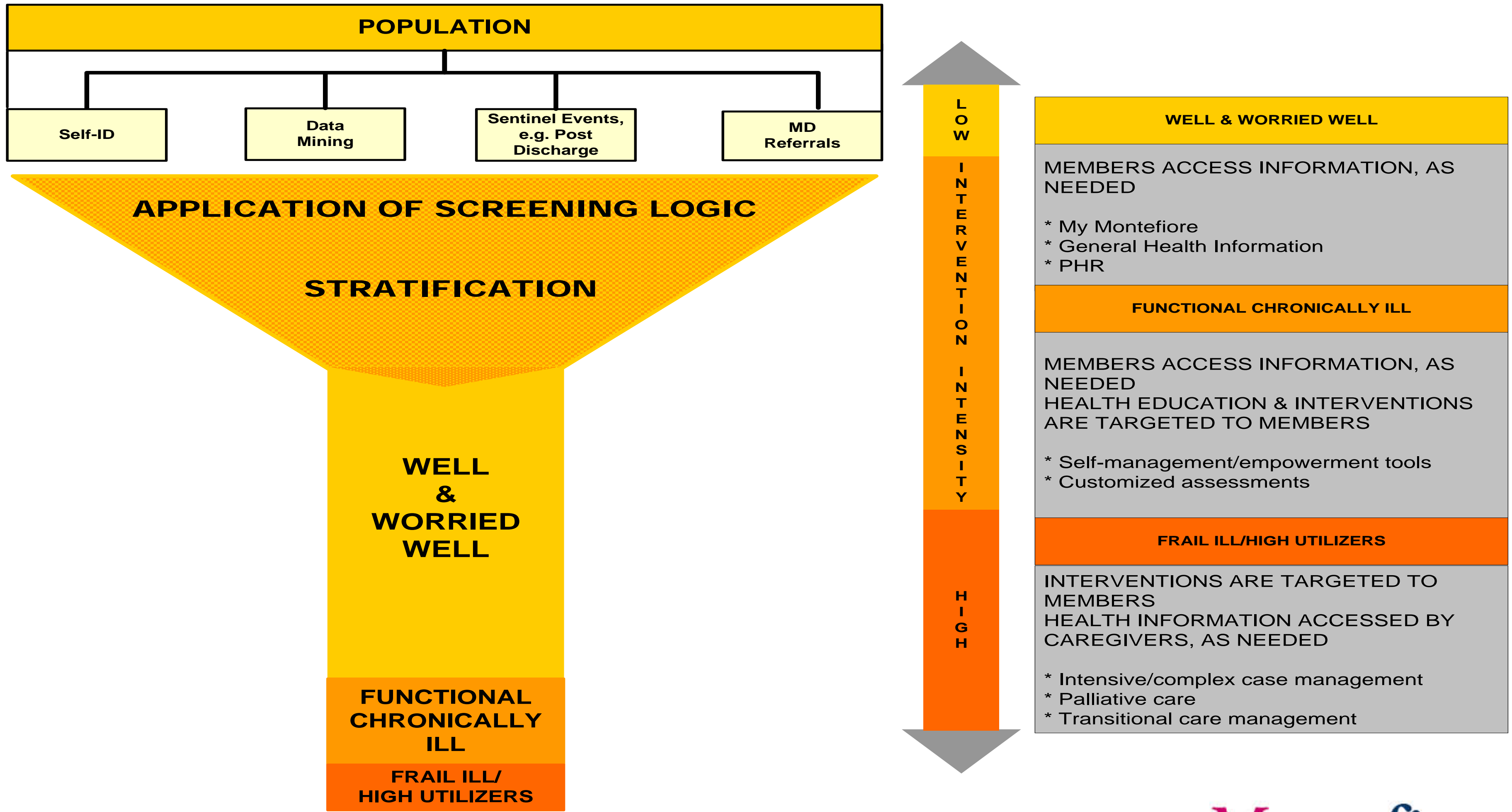
Care Guidance: Population Health Management Strategy



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Founded by the Department of Psychiatry and Behavioral Sciences

Goals were to:

1. Engage in risk contracting to restrict the intrusion of health plans and BHOs into clinical care
2. Establish a strong identity for behavioral health aligned with population health initiatives
3. Transform behavioral managed care into a quality-driven, provider friendly and patient-centered practice

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University Behavioral Associates

Initial focus on risk contracting with HMOs, PHSPs and Med-Surg IPAs

Provider network – Montefiore Behavioral Care IPA

- Bronx, lower Westchester and Manhattan
- Strong psychiatric network along with psychology/social work
- Incentivize faculty/MDs to participate via innovative payment methodologies (contact capitation)

Network Management and Development

- Maintain and re-route care in-network
- Flexible reimbursement strategies (salaried providers, fee-for-service, case rates, bonuses based on achieving quality measures or surpluses)
- **Behavioral services in primary care**

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Inclusion of Behavioral Care in the PCMH: Key Goals

- Model development for delivery of behavioral care in primary care settings (FQHCs, case rates, FFS, grants, telephonic consultation for depression management, etc)
- Goal: Extension of behavioral EMR (Mindlinc) and utilization/quality oversight of behavioral care provided by increasing activity by on-site social work and psychology staff
- Quality improvement of behavioral care
- Coordination of medical and behavioral care
- Case management services both telephonic and on-site
- Financial modeling and monitoring of behavioral care impact on medical costs

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CMS Pioneer ACO Program

- Serves Medicare fee-for-service beneficiaries
- Program started January 1, 2012
- Scheduled to last 3-5 years
- ACO must receive majority of revenue from outcomes-based health plan contracts by Dec. 2013
- Patient satisfaction and quality standards

Pioneer ACO Model (Cont'd)

- Designed for organizations with prior experience managing population-based, performance risk

- Applicants must have the provider infrastructure and technology already in place

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- No up-front payments
- Does not alter current FFS billing practices
- Cost benchmark established each year based on historical expenditures/patient characteristics

Key to Success: Care Manage High-risk Patients

- Analysis of patient-level clinical and billing data
  - Use of predictive modeling tools
- Sentinel events
  - Post-discharge calls
  - Emergency department and inpatient case managers
- Physician referrals
- Patient self-referrals

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Montefiore ACO Interventions

- ED Case Management
- Post-discharge calls
- Expand PCMH
- SNF initiative (readmissions)
- Care Guidance (care management)
- House Calls (medical home visit program)
- Integrated medical and behavioral care management
- Clinical pathways

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Quality is Essential

- No shared savings payments will be received if quality thresholds are not met
  - Year 1: based only on reporting
  - Years 2 and 3: mix of performance and reporting
  - Results will be compared to national benchmarks
- Measures emphasize the ambulatory setting
- Data will be derived from
  - Patient satisfaction surveys
  - Claims and administrative data
  - Medical record and EMR reviews

- 33 quality metrics in 4 domains:
  - Patient/Caregiver Experience
  - Care Coordination and Patient Safety
  - Preventive Health
  - At-Risk Populations

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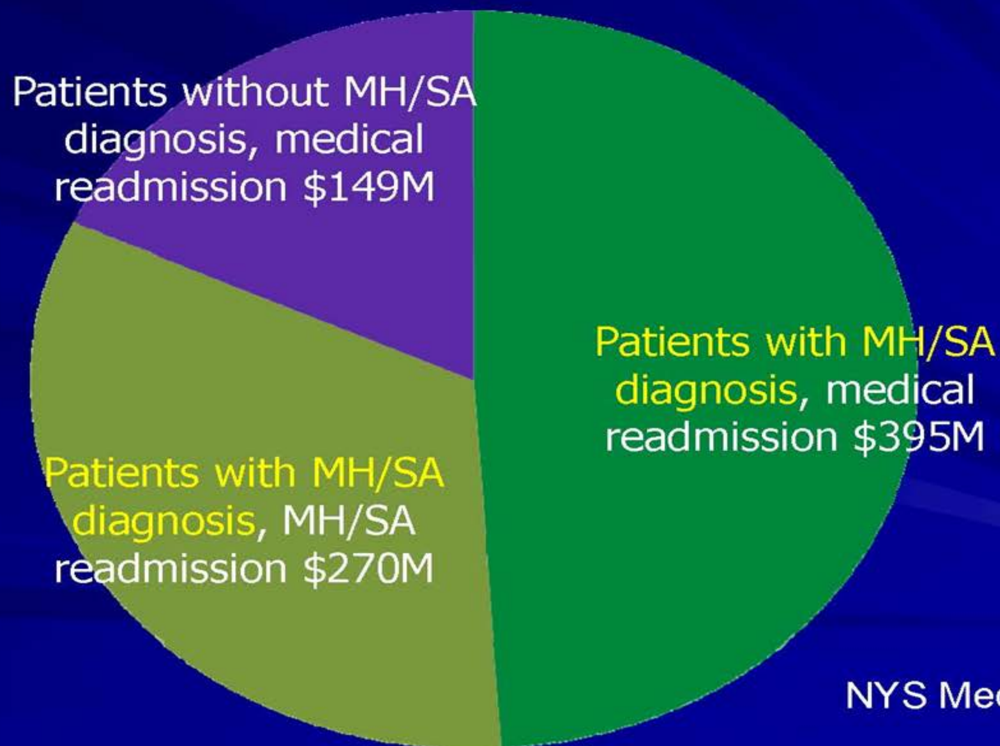
Quality Metrics – Preventive Care

Preventive Measures	Method of Data Submission
Influenza Immunization – MU Menu CQM and 2012 EHR-based PQRS	GPRO Web-Interface
Pneumococcal Vaccination – MU Menu CQM	GPRO Web-Interface
Adult Weight Screening and Follow-up – MU Core CQM	GPRO Web-Interface
Tobacco Use Assessment and Cessation Intervention - MU Core CQM and 2012 EHR based PQRS	GPRO Web-Interface
Depression Screening and Followup	GPRO Web-Interface
Colorectal Cancer Screening – MU Menu CQM	GPRO Web-Interface
Mammography Screening – MU Menu CQM	GPRO Web-Interface
Adults 18+ who had BP Measured in previous 2 years	GPRO Web-Interface

RATIONALE FOR BEHAVIORAL
HEALTH INTEGRATION

The Need for Care Coordination:
Potentially Preventable Readmissions (PPR's)



NYS Medicaid 2007

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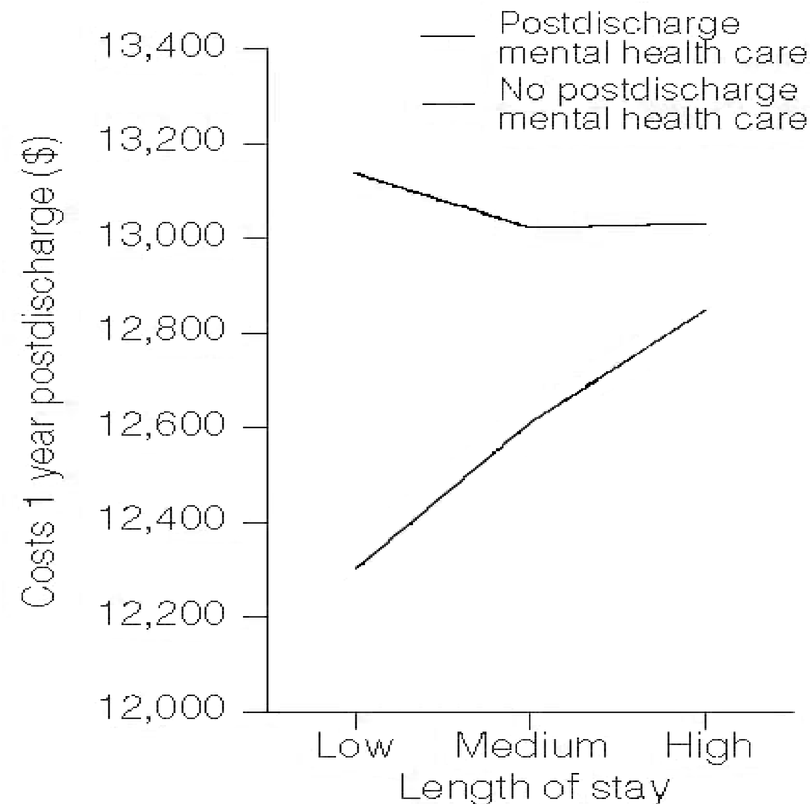
Post Discharge Behavioral Healthcare Associated with Decreased Costs



Benzer et al; Psychiatric Services 2012

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Montefiore ACO Population: Medical and Behavioral Patient Expenses

Values	Non-Mental Health	Mental Health	Total
# Beneficiaries	14,972	**6,921**	21,893
Average HCC (Calculated)	1.2248	**1.9950**	1.4757
$ Claims Paid	$153,044,474	$202,915,796	$355,960,270
# Inpatient Admissions/1000	245	**906**	454
% MMC Inpatient Admissions	53%	42%	46%
$ Claims PMPY	$10,222	**$29,319**	$16,259
% Total Beneficiaries	68%	32%	100%
% Total Paid	43%	57%	100%
% Inpatient Paid	36%	**48%**	43%
% Outpatient Paid	17%	**8%**	12%
% Physician Paid	24%	16%	19%
% SNF Paid	6%	**16%**	12%

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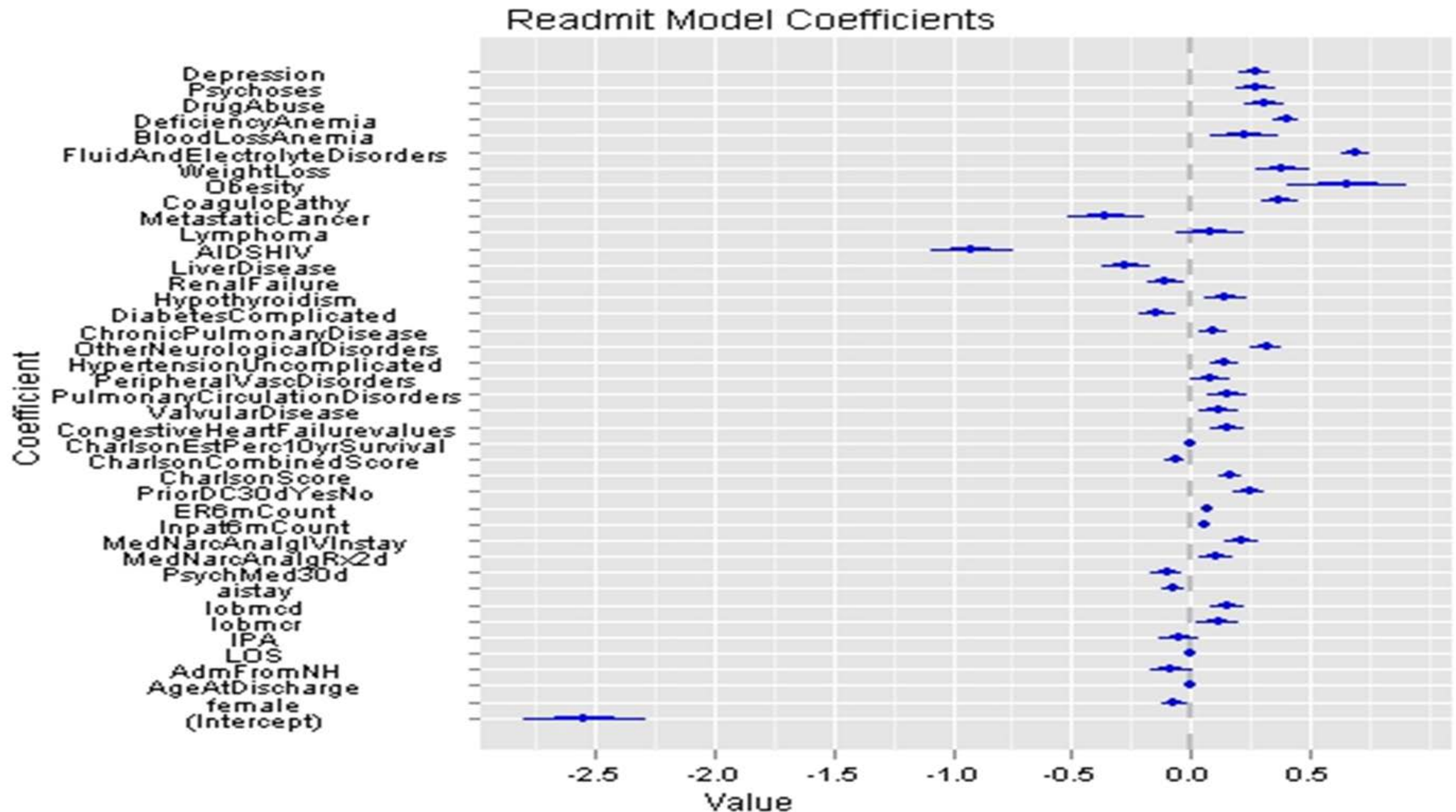
Readmission Predictive Model Pilot: Impact of Behavioral Health Comorbidity



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Evidence Based and Evolving
Aspects of BH Integration for
Populations

- Primary Care management alone
- Screening in Primary Care and then External BH Referral
- Simple Co-Location (Placing BH Staff in Primary Care or Located Nearby)

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Patient Centered Health Homes

- Team based care using the Collaborative Care Model
  - Screening and Assertive Followup
  - Partnership with PCP and staff using measurement based approaches and stepped care
  - Care management to provide safety net and behavioral activation

- Supported by IMPACT, RESPECT-D, TEAMcare, SBIRT, and many real world implementations
- Appears cost effective; possibly cost saving in patients with chronic medical illness and BH disorders
- Not sustainable based on FFS payments alone

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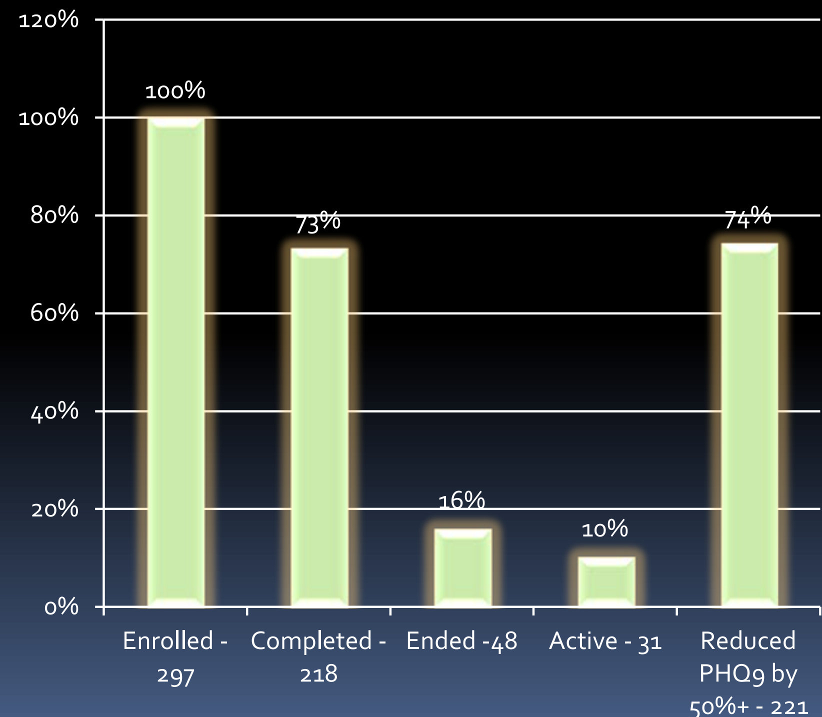
MMG CFCC Summary of Project Impact

Measures

- Enrolled 297 total patients into Project Impact
- 218 (73.4%) of those enrolled have completed program, kept all appointments
- 48 (16%) ended program by choice. Did not keep appointments
- 31 (10.4%) are still actively working on reducing their PHQ9 scores
- 221 patients reduced their PHQ 9 scores by 50%

Graph of Measures



OUTCOMES OF HYPERTENSIVE PATIENTS WITH DEPRESSION

- Total HTN Patients: 1651
- Enrolled: 165
- Enrolled, Completed, Kept appt and PHQ9 improved: 79
- Not Enrolled: 1486

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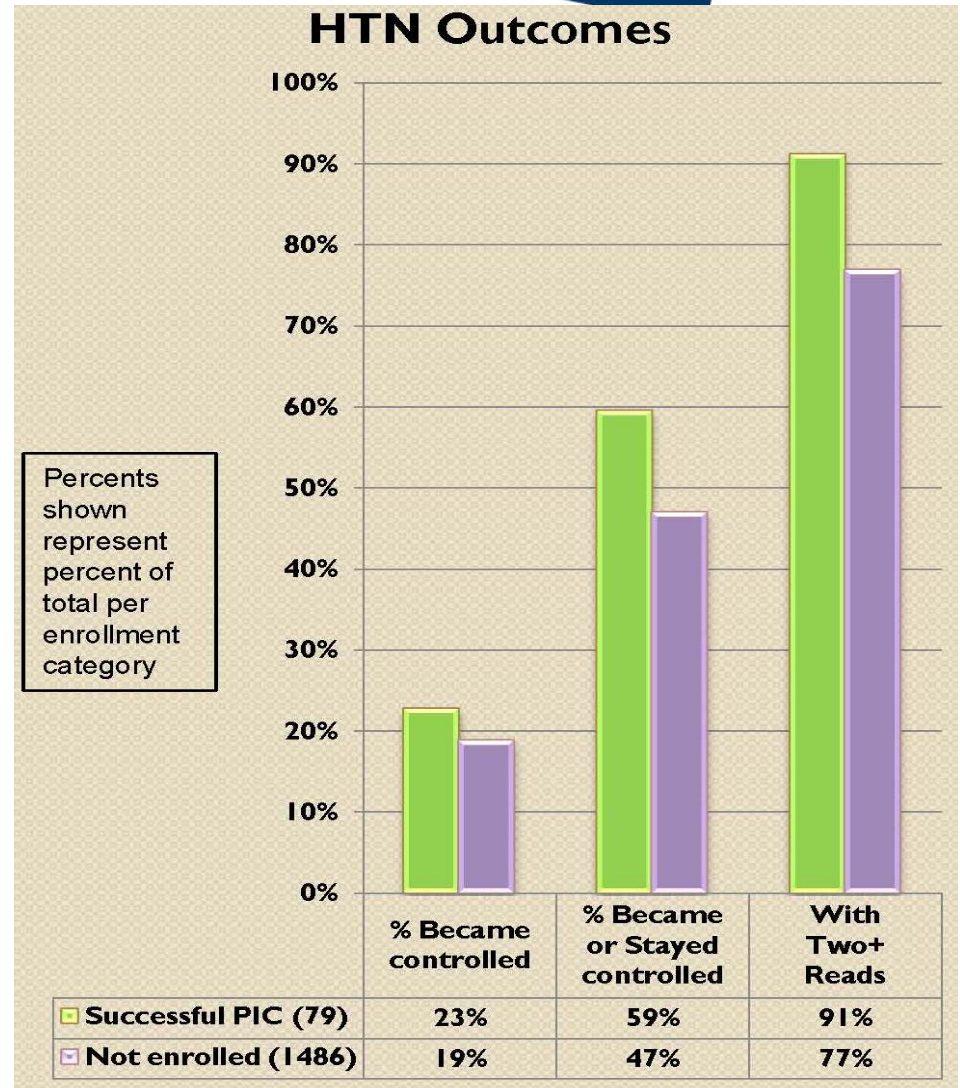

	% Became controlled	% Became or Stayed controlled	With Two+ Reads
Successful PIC (79)	23%	59%	91%
Not enrolled (1486)	19%	47%	77%

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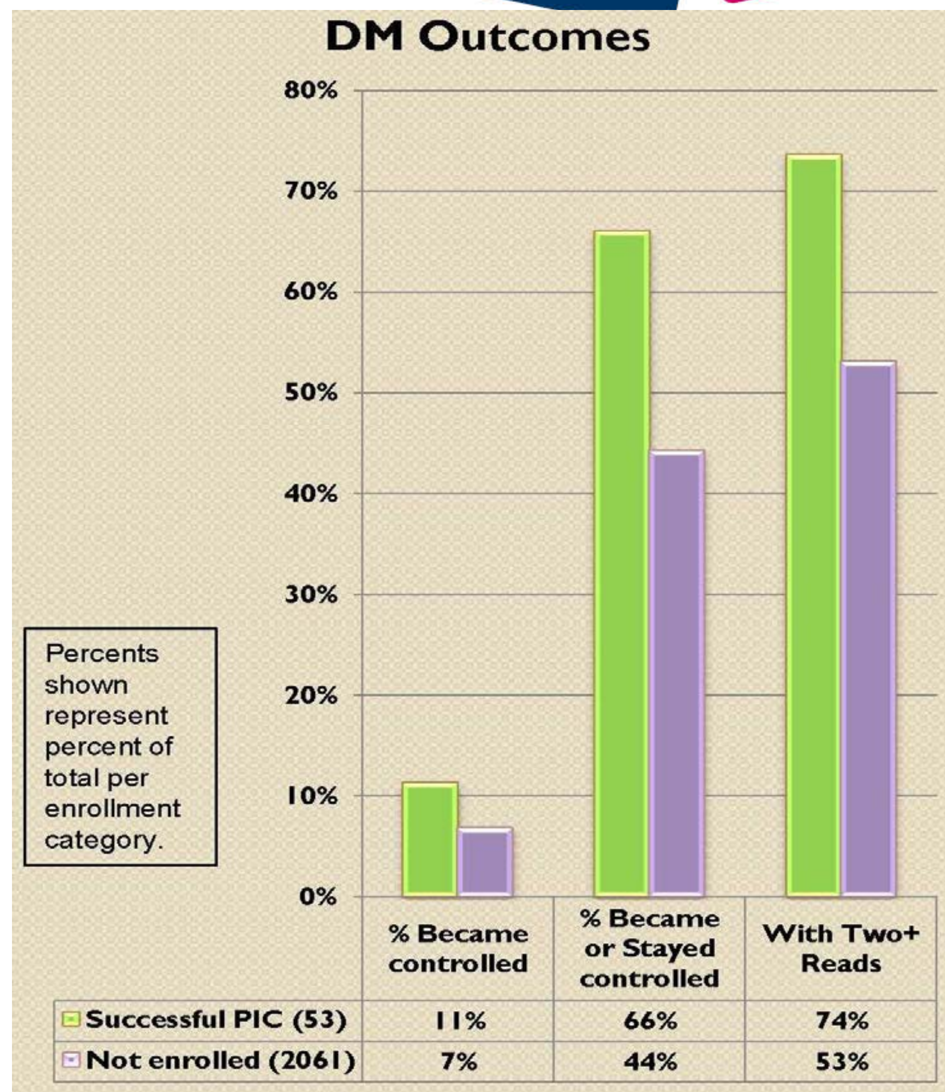
OUTCOMES OF DIABETIC PATIENTS WITH DEPRESSION

- Total DM Patients: 2171
- Enrolled: 111
- Enrolled, Completed, Kept appt and PHQ9 improved: 53
- Not Enrolled: 2061



	% Became controlled	% Became or Stayed controlled	With Two+ Reads
Successful PIC (53)	11%	66%	74%
Not enrolled (2061)	7%	44%	53%

PCMH and Integrated Care Management: Synergy Team Program Goals

- Augment behavioral health services in a patient centered medical home (PCMH) that does not have strong co-location resources
- Implement evidence-based models for treatment of patients with poorly controlled depression and at-risk drinking with chronic medical conditions (diabetes, CAD, CHF)
- Develop a joint care management “synergy” team approach to support and manage these complex patients
- Uses RN care manager, LCSW, psychiatrist in a “virtual” mode as standard approach
- Evaluate clinical outcomes, patient and provider satisfaction and cost

RN Accountable Care Managers

- **Complete ComprehensiveBaseline Assessment**
- **Monitor** PHQ-9 and AUDIT-C.
- **Chronic Disease Education**: treatment and targets reviewed until pt can verbalize.
- **Assist** appointments, home care, community referrals, Access-a-ride.
- **Define member goals** and assess progress toward them.
- Use **client-centered** motivational strategies to promote wellness.

- Case reviews with Synergy team and regular meetings with BHM for patients not at target goals
- EMR review and PCP “coaching” of psychotropic medication treatment through the EMR
- Provide onsite face to face treatment for complex patients and for those not responding in a reasonable time frame
- Available for telephone or email advice and collaboration

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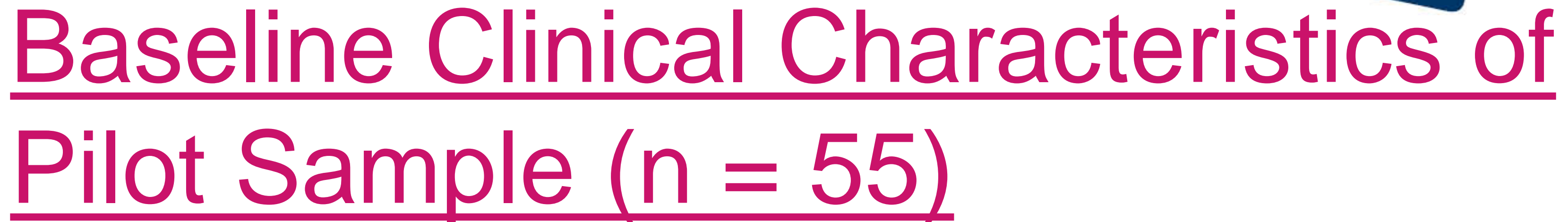

- Mean HgBA1c =7.9 (n=36)
- Mean PHQ9 Depression Score = 14.5
- Mean AUDIT-C score = 3.7 (n= 11)
- Mean Framingham Risk Score = 20% (n=43); 49% with Risk Score of 15% or greater

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ITT Preliminary Outcomes (minimum of 8 weeks of enrollment)

- 46% of patients with threshold depression (n=50) had a clinically significant 5 point reduction in PHQ9; Of these patients, the mean scores decreased from 15.0 to 7.9

- 44% of patients had a reduction in score to <10, indicating a return to subclinical depressive symptoms; of these patients, the mean scores decreased from 12.9 to 6.5

Diabetes and Depression Data

At Baseline : 34% (n=17) had HbA1c >8 and PHQ9>10.

After Synergy participation for at least 8 weeks:

- Mean HBA1c reduced from 9.56 to 8.40 (12% reduction)
- Mean PHQ9 reduced from 15.2 to 10.8 (29% reduction)
- Mean LDL was reduced from 130.2 to 125.0 (3% reduction)
- 59% of this subgroup had a HgBA1c reduction of 0.5 or greater

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Moderate CV Risk Subgroup Analysis

At baseline: 48% had Framingham risk scores >15

After Synergy participation for a minimum of 8 weeks:

- Mean HBA1c reduced from 8.2 to 7.2 (13% reduction)
- Mean PHQ9 reduced from 13 to 10.3 (20% reduction)
- Mean LDL reduced from 115.8 to 106.4 (8% reduction)

- Scale PCMH and collaborative care models for BH integration across the Montefiore outpatient network
- Pilot improved primary care access in a CMHC operated by Einstein-Montefiore through NYSOMH grant
- Started integrated care management assessments in NYS Health Homes Program as part of the Bronx Accountable Healthcare Network

- What is the role of C-L Psychiatry in inpatient and outpatient sectors?
- How do we strengthen HIT processes and content to support BH integration at all levels?
- Are Psychiatry and Behavioral Health Networks Ready to support Measurement Based Outcomes as proposed by the new MU Stage 2 measures?

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