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

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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

Health System

- Home Care
  - Home Health Agency
  - House Call Program

- Clinics
  - Satellite
  - Mobile
  - School

- Primary & Specialty Care
  - Medical Group
  - Outpatient

- Hospitals
  - 3 Campuses
  - 4 Hospitals
  - 1,491 Beds

Noteable Centers of Excellence

- Cancer Care
- Cardiac Care
- CHAM
- Transplant
- Neuroscience

Academic

- Basic
- Clinical
- Translational
- Health Services

Research

- 1,200 Residents and Fellows
- 750 Medical Students
- 500 Multidisciplinary
- 1,200 Nursing Students
- Health Professional Ed.
- CME

Teaching

Community

- Obesity prevention
- Lead poisoning prevention
- Teen pregnancy
- Nutrition
- Disease management
- Wellness

Population Health

Emerging Health

- Information Technology

CMO

- Care Management

Montefiore

17,500 Employees
2,562 Medical Staff
1,644 F/T Faculty
3,163 RN/LPN (F/T, P/T, PD)
The Bronx:
Poor, Minority, Young, Heavy Disease Burden

Population < Poverty
Bronx vs NYC and NYS

Race / Ethnicity
Asian Other

Hisp. 48%

Black 31%

White 15%

Other 3%

White 15%

Black 31%

Hisp. 48%

Ambulatory Care Sensitive Hospital Admits

<table>
<thead>
<tr>
<th>ACS Admits/K</th>
<th>New York City</th>
<th>Bronx</th>
<th>Brooklyn</th>
<th>Manhattan</th>
<th>Queens</th>
<th>Staten Island</th>
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<tr>
<td></td>
<td>9.95</td>
<td>13.08</td>
<td>10.38</td>
<td>8.26</td>
<td>7.85</td>
<td>8.60</td>
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Bronx Population Overview

Bronx Total Health Care Spend = $13.4B
Bronx Duals Spend = $1.5 B
Experience with Managing Populations
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

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<tbody>
<tr>
<td>Risk Contracts</td>
<td>140,000</td>
<td>$850 m</td>
<td>185,000</td>
<td>$1,085 m</td>
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<tr>
<td>Shared Risk</td>
<td>78,000</td>
<td>$490 m</td>
<td>80,000</td>
<td>$685 m</td>
</tr>
<tr>
<td>Medicaid health Home (Care Coordination)</td>
<td>5000</td>
<td>$5 m</td>
<td>5000</td>
<td>$5 m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>223,000</strong></td>
<td><strong>$1,345 m</strong></td>
<td><strong>270,000</strong></td>
<td><strong>$1,775 m</strong></td>
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</table>

The organization is moving from a transaction-oriented business to a value-based source of revenue.
Care Guidance: Population Health Management Strategy

**APPLICATION OF SCREENING LOGIC**

- **SELF-ID**
- **Data Mining**
- **Sentinel Events, e.g. Post Discharge**
- **MD Referrals**

**STRATIFICATION**

- **WELL & WORRIED WELL**
- **FUNCTIONAL CHRONICALLY ILL**
- **FRAIL ILL/ HIGH UTILIZERS**

**POPULATION**

**WELL & WORRIED WELL**

- Members access information, as needed
  - My Montefiore
  - General Health Information
  - PHR

**FUNCTIONAL CHRONICALLY ILL**

- Members access information, as needed
  - Health education & interventions are targeted to members
  - Self-management/empowerment tools
  - Customized assessments

**FRAIL ILL/HIGH UTILIZERS**

- Interventions are targeted to members
  - Health information accessed by caregivers, as needed
  - Intensive/complex case management
  - Palliative care
  - Transitional care management
University Behavioral Associates

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
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
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
THE MONTEFIORE ACO
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
Pioneer ACO Model Reimbursement

• 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
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
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
Quality Evaluation

• 33 quality metrics in 4 domains:
  – Patient/Caregiver Experience
  – Care Coordination and Patient Safety
  – Preventive Health
  – At-Risk Populations
<table>
<thead>
<tr>
<th>Preventive Measures</th>
<th>Method of Data Submission</th>
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<tbody>
<tr>
<td>Influenza Immunization – MU Menu CQM and 2012 EHR-based PQRS</td>
<td>GPRO Web-Interface</td>
</tr>
<tr>
<td>Pneumococcal Vaccination – MU Menu CQM</td>
<td>GPRO Web-Interface</td>
</tr>
<tr>
<td>Adult Weight Screening and Follow-up – MU Core CQM</td>
<td>GPRO Web-Interface</td>
</tr>
<tr>
<td>Tobacco Use Assessment and Cessation Intervention - MU Core CQM and 2012 EHR based PQRS</td>
<td>GPRO Web-Interface</td>
</tr>
<tr>
<td>Depression Screening and Followup</td>
<td>GPRO Web-Interface</td>
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<tr>
<td>Colorectal Cancer Screening – MU Menu CQM</td>
<td>GPRO Web-Interface</td>
</tr>
<tr>
<td>Mammography Screening – MU Menu CQM</td>
<td>GPRO Web-Interface</td>
</tr>
<tr>
<td>Adults 18+ who had BP Measured in previous 2 years</td>
<td>GPRO Web-Interface</td>
</tr>
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</table>
RATIONALE FOR BEHAVIORAL HEALTH INTEGRATION
The Need for Care Coordination: Potentially Preventable Readmissions (PPR’s)

- Patients without MH/SA diagnosis, medical readmission $149M
- Patients with MH/SA diagnosis, medical readmission $395M
- Patients with MH/SA diagnosis, MH/SA readmission $270M

NYS Medicaid 2007
Figure 1

Interaction between length of stay and postdischarge mental health care for patients with moderate health care costs

Benzer et al; Psychiatric Services 2012
### Montefiore ACO Population:
Medical and Behavioral Patient Expenses

<table>
<thead>
<tr>
<th>Values</th>
<th>Non-Mental Health</th>
<th>Mental Health</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td># Beneficiaries</td>
<td>14,972</td>
<td>6,921</td>
<td>21,893</td>
</tr>
<tr>
<td>Average HCC (Calculated)</td>
<td>1.2248</td>
<td>1.9950</td>
<td>1.4757</td>
</tr>
<tr>
<td>$ Claims Paid</td>
<td>$153,044,474</td>
<td>$202,915,796</td>
<td>$355,960,270</td>
</tr>
<tr>
<td># Inpatient Admissions/1000</td>
<td>245</td>
<td>906</td>
<td>454</td>
</tr>
<tr>
<td>% MMC Inpatient Admissions</td>
<td>53%</td>
<td>42%</td>
<td>46%</td>
</tr>
<tr>
<td>$ Claims PMPY</td>
<td>$10,222</td>
<td>$29,319</td>
<td>$16,259</td>
</tr>
<tr>
<td>% Total Beneficiaries</td>
<td>68%</td>
<td>32%</td>
<td>100%</td>
</tr>
<tr>
<td>% Total Paid</td>
<td>43%</td>
<td>57%</td>
<td>100%</td>
</tr>
<tr>
<td>% Inpatient Paid</td>
<td>36%</td>
<td>48%</td>
<td>43%</td>
</tr>
<tr>
<td>% Outpatient Paid</td>
<td>17%</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td>% Physician Paid</td>
<td>24%</td>
<td>16%</td>
<td>19%</td>
</tr>
<tr>
<td>% SNF Paid</td>
<td>6%</td>
<td>16%</td>
<td>12%</td>
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</table>
Readmission Predictive Model Pilot: Impact of Behavioral Health Comorbidity

Readmit Model Coefficients

- Depression
- Psychoses
- Drug Abuse
- Deficiency Anemia
- Blood Loss Anemia
- Fluid and Electrolyte Disorders
- Weight Loss
- Obesity
- Coagulopathy
- Metastatic Cancer
- Lymphoma
- AIDS/HIV
- Liver Disease
- Renal Failure
- Hypothyroidism
- Diabetes Complicated
- Chronic Pulmonary Disease
- Other Neurological Disorders
- Hypertension Uncomplicated
- Peripheral Vascular Disease
- Pulmonary Circulation Disorders
- Valvular Disease
- Congestive Heart Failure Values
- Charlson Est Pericardial Systolic
- Charlson Combined Score
- Charlson Score
- Prior DC30d Yes No
- ER 6m Count
- Inpatient Count
- MedNarc Analgesic Days
- MedNarc Rx Days
- Psych Med 30d
- Malignancy
- Lobmcr
- Lobmcd
- IPA
- LOS
- Adm From NH
- Age at Discharge
- Female
- (Intercept)
Evidence Based and Evolving Aspects of BH Integration for Populations
What types of BH integration Models DO NOT Work?

- 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)
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
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**

- **Enrolled** - 297
- **Completed** - 218
- **Ended** - 48
- **Active** - 31
- **Reduced PHQ9 by 50%+** - 221
OUTCOMES OF HYPERTENSIVE PATIENTS WITH DEPRESSION

• Total HTN Patients: 1651
• Enrolled: 165
• Enrolled, Completed, Kept appt and PHQ9 improved: 79
• Not Enrolled: 1486
OUTCOMES OF DIABETIC PATIENTS WITH DEPRESSION

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

<table>
<thead>
<tr>
<th></th>
<th>% Became controlled</th>
<th>% Became or Stayed controlled</th>
<th>With Two+ Reads</th>
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<tbody>
<tr>
<td>Successful PIC (53)</td>
<td>11%</td>
<td>66%</td>
<td>74%</td>
</tr>
<tr>
<td>Not enrolled (2061)</td>
<td>7%</td>
<td>44%</td>
<td>53%</td>
</tr>
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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 Comprehensive Baseline 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.
Psychiatrist

- 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
Baseline Clinical Characteristics of Pilot Sample (n = 55)

- 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
• 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
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)
Next Steps

• 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
Challenges

- 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?