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Promoting “Perfect Depression Care” in New York State Using the Collaborative Care Model

September 19, 2017

The Relationship Between Depression & Suicide

Behavioral Health Treatment in the US

- Depression is the leading cause of disability worldwide
- ~7% of US adults had a least one episode of major depression;18% Anxiety
- **BUT, Only 40%** of adults with mental illness received treatment
- 90% of those that die by suicide have underlying mental illness
    - Clinical Depression present in 50% of cases
    - Those with Depression are at 25 times greater risk of suicide death

Traditionally, Suicide Prevention efforts have been focused on specialty BH and inpatient settings, targeting only a small percent of the population.

Current State

Diagnose, refer out and then…???

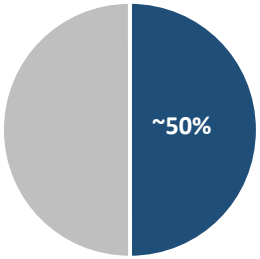
- ~50% of those referred out never follow up
    - *As low as 10% for BH*
- 40% patients receive treatment in primary care
- ~30 Million given antidepressant Rx
    - but only 20% improve w Rx alone
- 2/3 PCPs report poor access to mental health for their patients
- Go to the Emergency Room
    - Mood disorders are the third most common cause of hospitalization in the U.S. for both youth and adults aged 18–44

Barriers in Current System

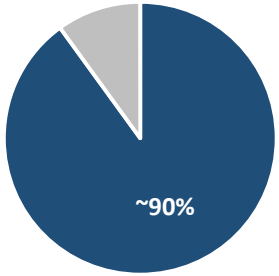
- Initiative Fatigue
- Providers already busy; hard to follow up
- Shortage of BH Specialists
  - None in area; Long wait times; Insurance coverage; Culturally competent
- Lack of reimbursement for BH in primary care or regulatory restrictions
- More than half of patients do not go when referred out to specialty

Contact with Healthcare Providers Before Suicide Death

Saw PCP in Month Prior

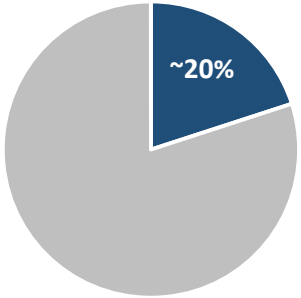


Saw PCP in Year Prior

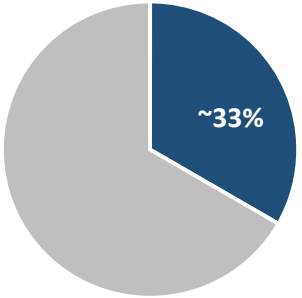


Average of 6-7 visits

Saw Mental Health in Month Prior



Saw Mental Health in Year Prior



= Visited Provider

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Depression Screening

- Many delivery system reform initiatives focus on universal Depression Screening
  - 2016 United States Preventive Services Task Force recommendation
- **Nationally, only 4.2% of adults are screened for Depression**
- Only 22% of those that complete suicide verbally reported suicide ideation or intent to any physician during the 28 days before suicide completion (2011)
- Those who answered “nearly every day” or “more than half the days” 53% and 54% of suicides in the following year

Suicide Prevention in Primary Care is Possible!

- 2001, Henry Ford Health System set out to radically transform its mental health care delivery system by participating in the Robert Wood Johnson Foundation's "Pursuing Perfection National Collaborative."
- Called their initiative "Perfect Depression Care"
- If BH care was "perfect," how many suicides would you expect?
  - "Zero Suicide" was born

Henry Ford Health System Strategies

- Commit to “perfection” (zero care processes defects, or zero suicides) as a goal
- Improve Access to BH Care
- Planned Clinical Care Model
- Patient-Centered
- Collaboration and Communication
  - Use of technology, EMR

Saw an 75% reduction in suicide death & sustained that success!

Recommendations of the Clinical Care and Intervention Task Force to the National Action Alliance for Suicide Prevention

Core Values – the belief and commitment that suicide can be eliminated in a population under care (for a given population), by improving service access and quality and through continuous improvement (rendering suicide a "never event" for these populations); **Systems Management** – taking systematic steps across systems of care to create a culture that no longer finds suicide acceptable, set aggressive but achievable goals to eliminate suicide attempts and deaths among members, and organize service delivery and support accordingly; and

Evidence-Based Clinical Care Practice – delivered through the system of care with a focus on productive patient/staff interactions. These methods (e.g., standardized risk stratification, targeted evidence-based clinical interventions, accessibility, follow-up and engagement and education of patients, families and healthcare professionals) achieve results.

Best Practices in Primary Care as Identified by the Task Force

1. Follow national recommendations to screen for depression by implementing a simple screening tool, such as the
2. Every patient is screened for suicide risk, using a screening instrument that asks at least one question about suicide risk.
3. The screen should be completed at the initial visit
4. Each practice and/or provider would consider the most practical approach to administration, scoring, and interpretation of results, based on their resources. Policies and Procedures should be developed to operationalize the process.
5. A positive screen, indicating potential risk for suicide, would lead medical staff to consider a variety of potential action steps and interventions that have clear pathways for accessing them.
6. A positive screen should additionally result in a more comprehensive assessment, completed by a trained behavioral health professional. Factors of desire, intent, capability, and buffers should be included in this assessment. The behavioral health professional should be able to determine level of risk based on the outcome of this assessment.
7. The behavioral health professional should collaborate with the medical provider to determine the most appropriate level of interventional,
8. PCP's should be provided with a Toolkit to assist the practice of suicide risk screening and to identify follow-up steps.
9. National Policies and Procedures should be developed to promote use of best practices and consistency among providers in this setting
10. Trainings identified as best practices for PCP personnel should occur regularly

Addressing Behavioral Health in Primary Care using the Collaborative Care Model

What is Collaborative Care?

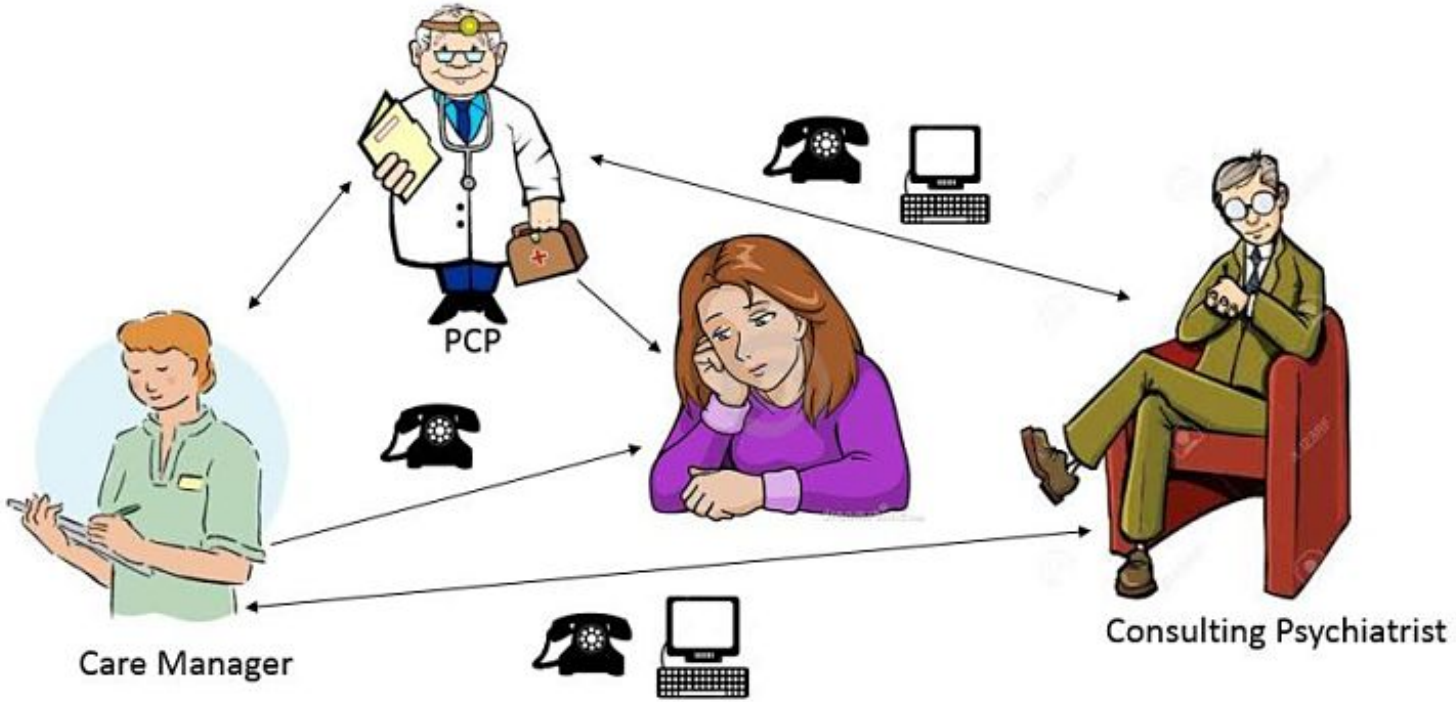
Collaborative Care (sometimes called IMPACT) is the most empirically supported model of behavioral health integration that seeks to treat commonly occurring mental health conditions such as depression and anxiety in the primary care setting.

- Over 80 randomized controlled studies have shown Collaborative Care to be more effective than “usual” care
- Improves not only mental health, but has shown improvements in chronic disease

Collaborative Care Team

- Primary Care Provider (PCP)
  - The PCP engages the patient and manages clinical aspects of care, including prescribing and managing medications
- Behavioral Health Care Manager (CM)
  - The CM is the liaison between all members of the team; Works directly with the patient, including Psychotherapy; Manages a registry to track patient progress; Meets with Psych Consultant weekly
- Psychiatric Consultant (MD Psychiatrist or Psych NP)
  - Provides consultative support on patients not improving or complex cases; Provides medication management support to PCPs to build their capacity

The Collaborative Care Team



5 Pillars of the Collaborative Care Model

Patient Centered Team Care / Collaborative Care

- **Collaboration is not co-location**
- **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

Accountable Care

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

Evidenced-Based Care

Collaborative Care - Enrollment

1. Screening – **Consistently screening all patients** with standardized tool (at least annually)
2. Capturing that screening in your EMR
3. Patient screens positive, communication to PCP; PCP makes diagnosis and treatment recommendations; **Warm Connection to BHCM*** if Collaborative Care is the appropriate treatment
4. BHCM evaluates patient and creates treatment plan

Collaborative Care - Treatment

5. BHCM manages treatment ongoing (avg. **3-6 months duration**)

-Maintain regular clinical contact, in-person, group, or phone, at least monthly; **PHQ-9 at least monthly for monitoring;** Delivers Psychotherapy when needed; Enters progress in to registry; communicates with PCP; **Meets weekly w/ Psych Consultant to review cases where patient is not improving**; Relapse prevention planning

Benefits of the Collaborative Care Model

- Allows for regular contacts, telephonic and otherwise
- Treatment to target – Patients do not remain in ineffective treatment
- Patients treated where they are comfortable, and can get access right away
    - Minimizes loss to follow up
- Improved efficiency and provider satisfaction
    - In house capacity to treat BH, Patients improving on chronic physical health conditions, Someone on team that keeps track
- No issues with licensing, thresholds, billing restrictions

How Collaborative Care Supports Suicide Prevention

- Providers are reluctant to screen without being prepared to handle to answers
- CC creates capacity to handle BH conditions in-house
    - Support for the PCP
- Primary Care is ‘prevention’ setting - Regular screening and access to treatment can improve depression earlier
- Culture change – BH becomes part of the language (staff & patients)
- Access to a Psychiatrist

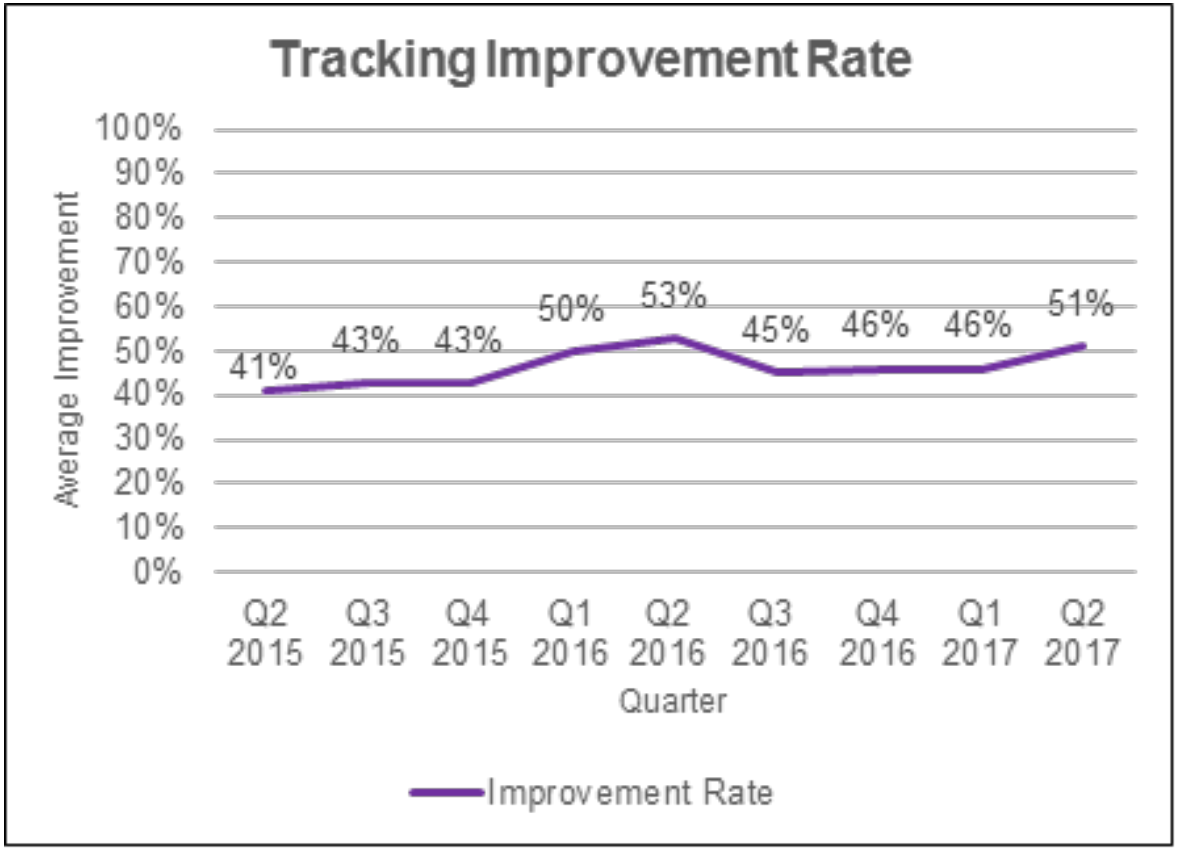
What is NYS doing to support and incentivize behavioral health integration in primary care?

NYS Collaborative Care Medicaid Program

- 2013-2014, NYS DOH Medical Home Grant Program established CC programs in academic medical centers

- To sustain the progress, OMH launched the Medicaid program in 2015
  - More than **80** sites currently participating
  - Over 2,000 patients enrolled each quarter
  - Pay for performance accountability

NYS Collaborative Care Medicaid Program



Average Depression Screening Rate in Quarter 2 2017

82%

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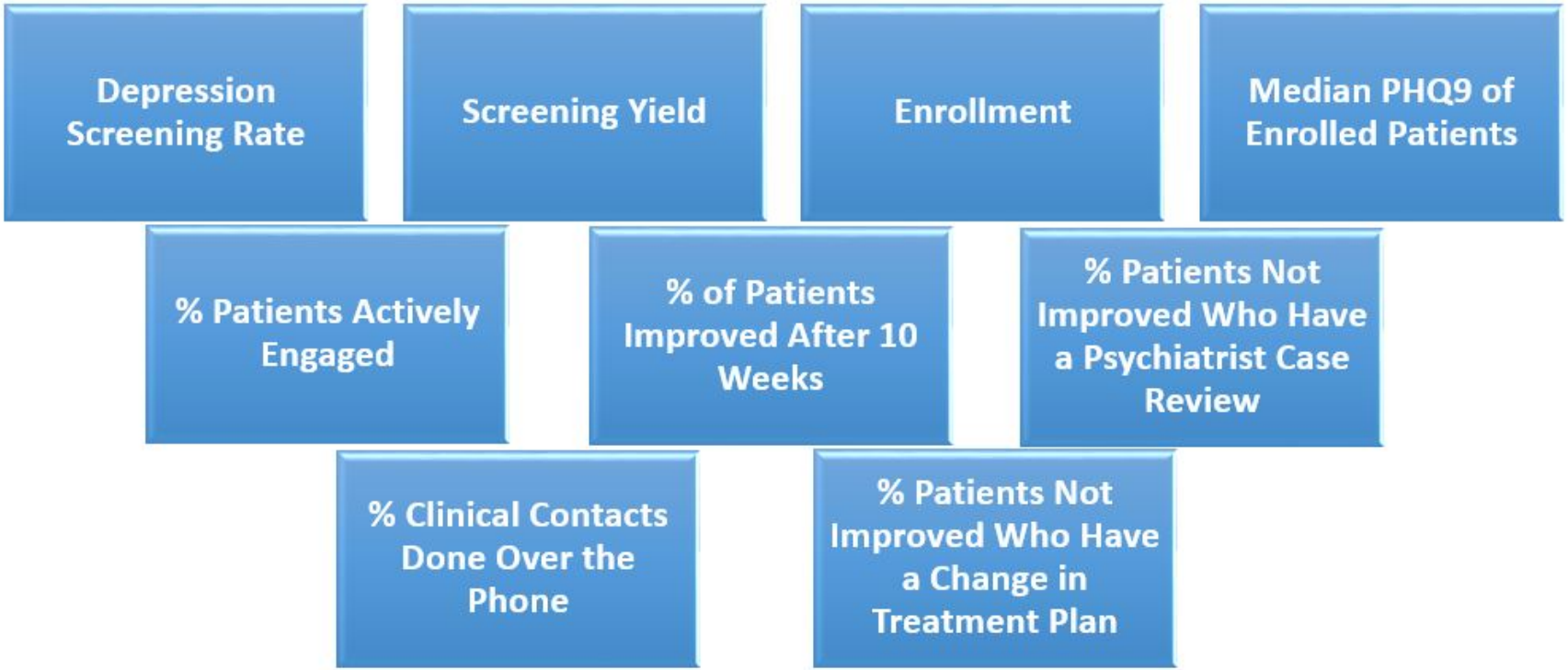
Monthly Case Rate Reimbursement Methodology

- *Collaborative Care services are not reimbursable under most current financing mechanisms*
- Designed a Medicaid Monthly Case Rate
  - Carve out, not Managed Care
  - Value Based
  - Bundled services
- $150 per patient per month
  - 75% up front, 25% quality retainage

Process & Outcome Measures - Reported Quarterly



Next Steps

- Provide training to CCMP practices on how to address suicidal ideation within CC framework
    - Training for providers and care managers
    - Create a defined process, like the CC model, to clarify roles
- Promote the optimization of EMRs to assist in screening and tracking of patients at high risk

Questions?

Amy Jones-Renaud, MPH
Director, Primary Care Behavioral Health Integration
NY Center for the Advancement of Behavioral Health Integration
NYS Office of Mental Health
amy.jones@omh.ny.gov

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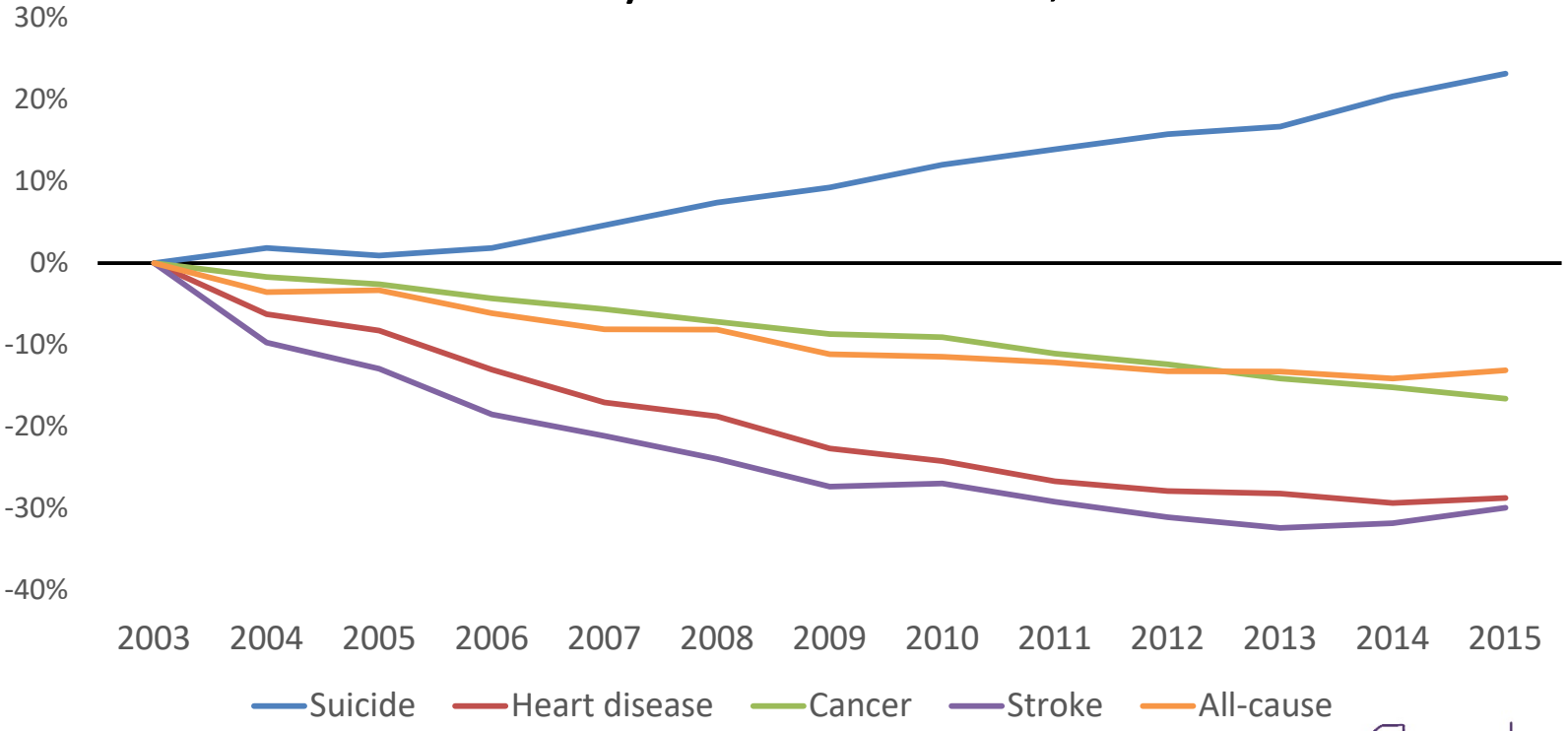
Addressing the Intersection of Substance Use and Suicide

Screening, Brief Intervention, and Referral to Treatment

Brett Harris, DrPH

September 19, 2017

Percent Change in Age-Adjusted Death Rates since 2003 by Cause of Death, 2003-2015



Source: CDC Vital Statistics Reports, 2003-2015

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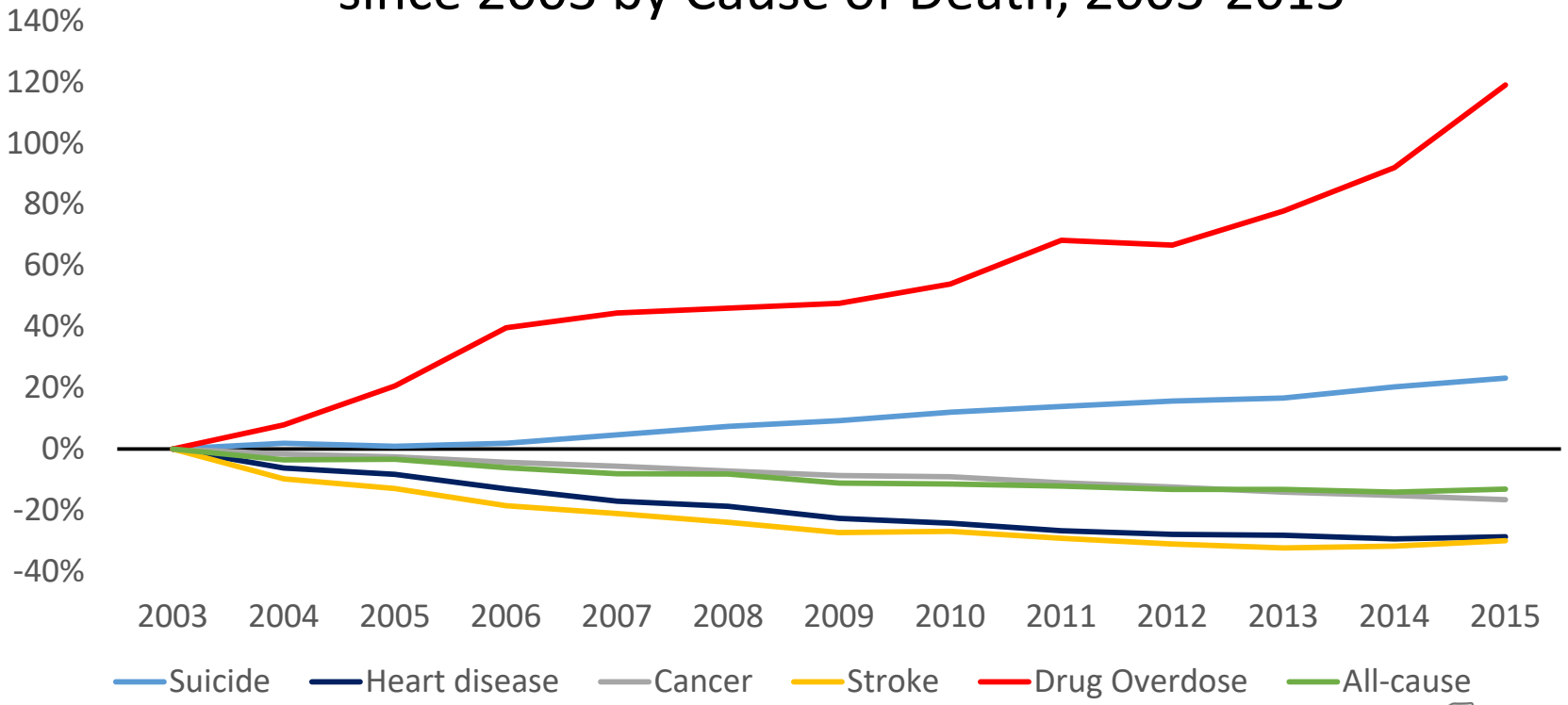
Percent Change in Age-Adjusted Death Rates since 2003 by Cause of Death, 2003-2015



Source: CDC Vital Statistics Reports, 2003-2015

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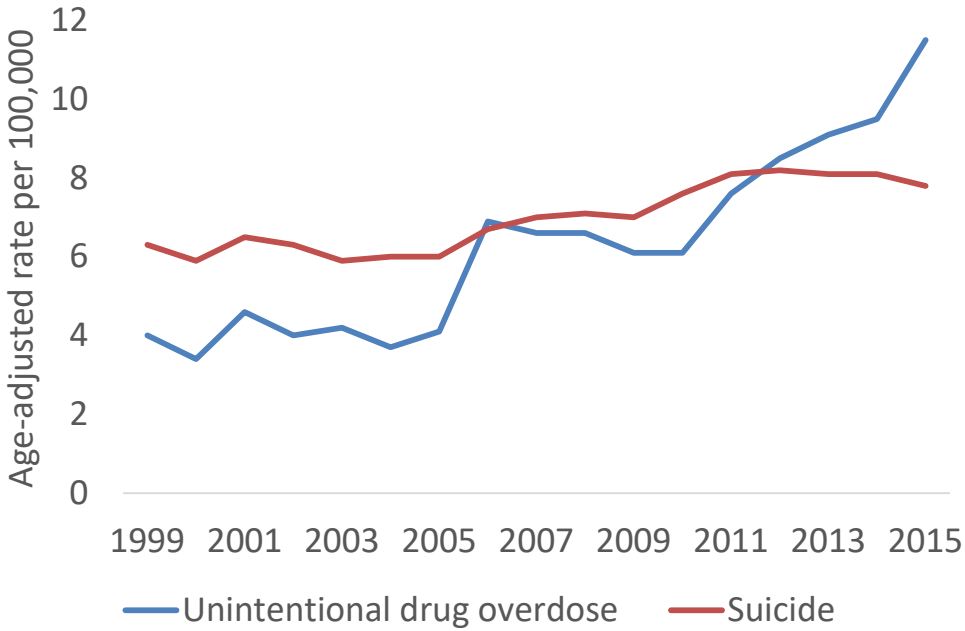
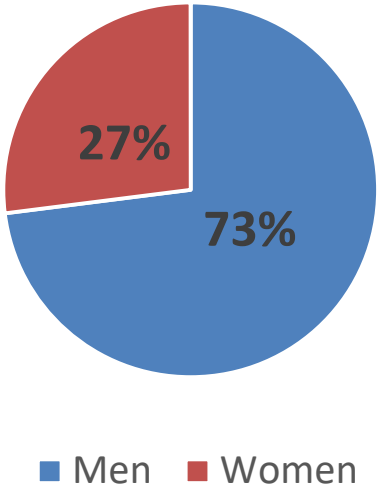
Age-adjusted Drug Overdose and Suicide Rates, NYS, 1999-2015



Drug overdose and suicide break down the same by gender in NYS in 2015



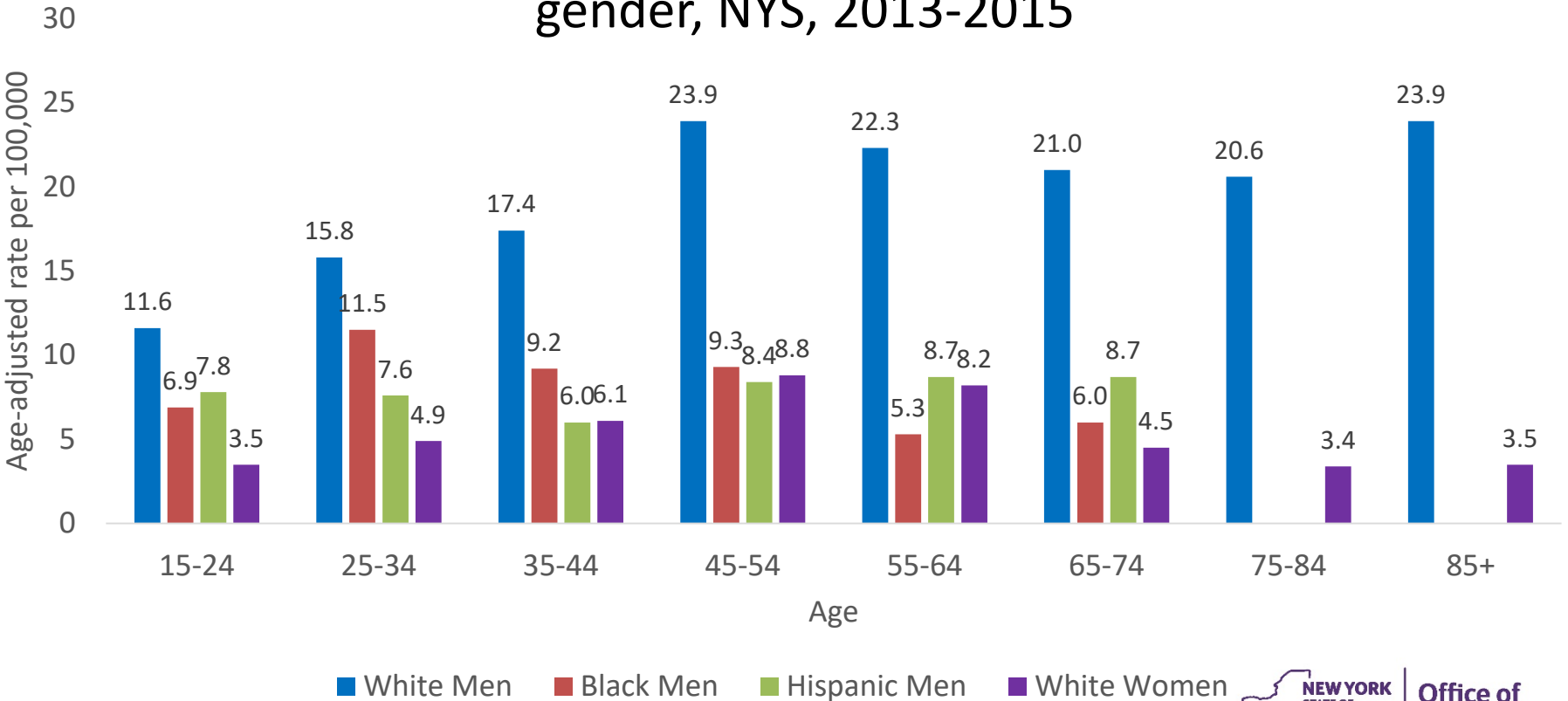
2,326 unintentional drug overdose deaths and 1,652 suicides in 2015
Age-adjusted death rate per 100,000: Drug overdose 11.8; Suicide 7.8

Age-Adjusted Death Rate per 100,000
Drug overdose: Men 17.3; Women 5.9
Suicide: Men 12.6; Women 4.3

Source: CDC WISQARS
http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html

NEW YORK STATE OF OPPORTUNITY. Agency Name

Suicide rate per 100,000 by age, race and gender, NYS, 2013-2015



Source: CDC WISQARS
https://webappa.cdc.gov/cgi-bin/broker.exe

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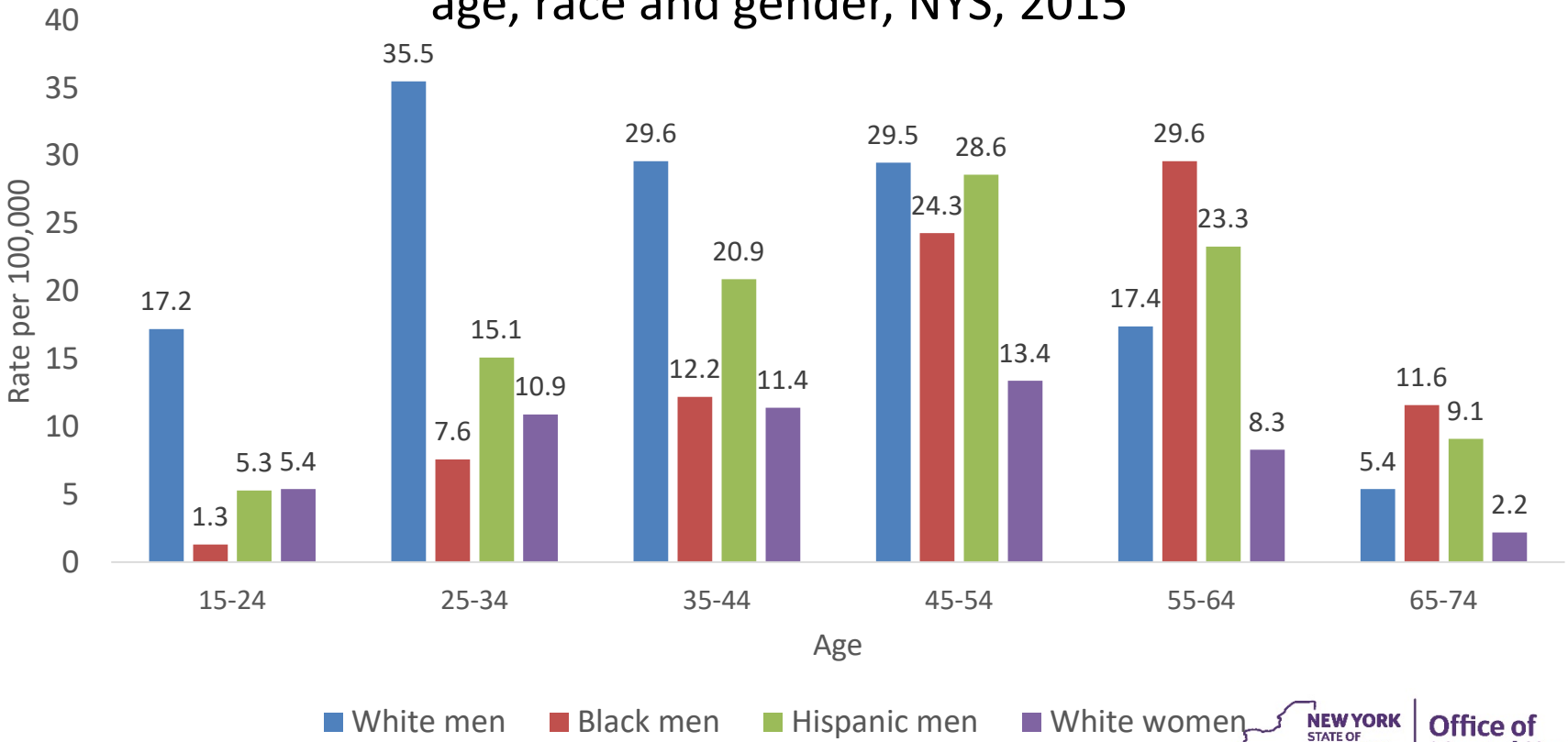
Unintentional drug overdose death rate per 100,000 by age, race and gender, NYS, 2015



Source: CDC WISQARS
http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html

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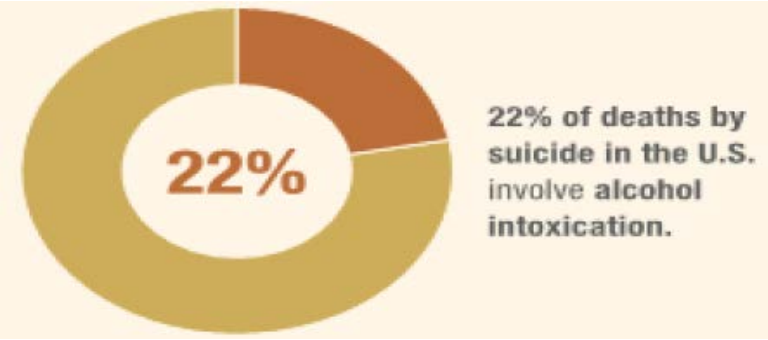
Substance Misuse and Suicide

- Substance use is the 2nd most frequent risk factor for suicide
  - Alcohol misuse or dependence increases risk tenfold



  - Alcohol intoxication in 30-40% of attempts

Substance Abuse and Mental Health Services Administration. Substance use and Suicide: A nexus requiring a public health approach. 2016. Available at: http://store.samhsa.gov/shin/content//SMA16-4935/SMA16-4935.pdf. Accessed April 21, 2017.

Substance Misuse and Suicide

- Also present at time of death
  - Marijuana – 10.2%
  - Cocaine – 4.6%
  - Amphetamines – 3.4%
- Number of substances used more predictive than types used
- 230,000 ED visits from drug-related attempts in 2011 (almost all involving prescription drugs or OTC medications)
- ED visits for drug-related suicide attempts increased 51% between 2005 and 2011

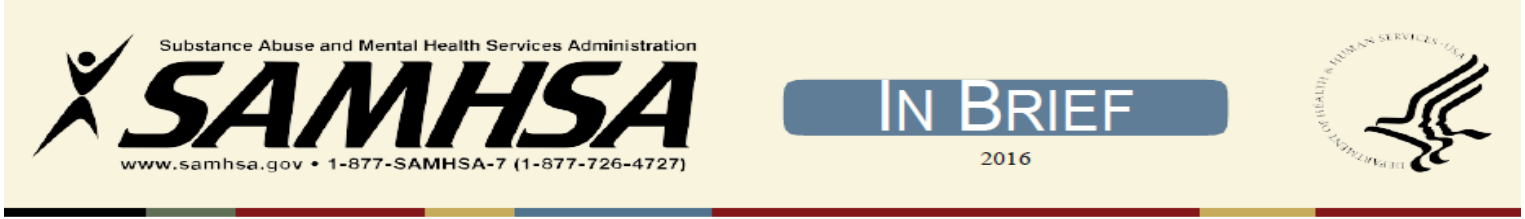
Substance Abuse and Mental Health Services Administration. Substance use and Suicide: A nexus requiring a public health approach. 2016. Available at: http://store.samhsa.gov/shin/content//SMA16-4935/SMA16-4935.pdf. Accessed April 21, 2017.

Connection between Substance Use and Suicide

- Disinhibition during intoxication
- Increasing depressed mood
- Alcohol increases proximal risk
  - Increases psychological distress
  - Increases aggressiveness
  - Propels ideation into action through suicide-specific alcohol expectancies
  - Constricts cognition, impairing the generation and implementation of alternative coping strategies

Substance Abuse and Mental Health Services Administration. Substance use and Suicide: A nexus requiring a public health approach. 2016. Available at: http://store.samhsa.gov/shin/content//SMA16-4935/SMA16-4935.pdf. Accessed April 21, 2017.

Call to Action



SUBSTANCE USE AND SUICIDE: A NEXUS REQUIRING A PUBLIC HEALTH APPROACH

Suicide is a serious and preventable public health problem in the United States. Collaboration among prevention professionals across behavioral health fields has the potential to reduce suicide rates. While multiple factors influence suicidal behaviors, substance use—especially alcohol use—is a significant factor that is linked to a substantial number of suicides and suicide attempts. This "nexus" between substance use and suicide provides an opportunity for behavioral health leaders to develop a cohesive strategy within a public health framework to reduce suicidal behaviors and suicide rates.

This *In Brief* summarizes the relationship between substance use and suicide and provides state and tribal prevention professionals with information on the scope of the problem, an understanding of traditional barriers to collaboration and current programming, and ways to work together on substance misuse and suicide prevention strategies.

http://store.samhsa.gov/shin/content//SMA16-4935/SMA16-4935.pdf

Substance Use Early Intervention

Current Alcohol and Drug Use among New Yorkers

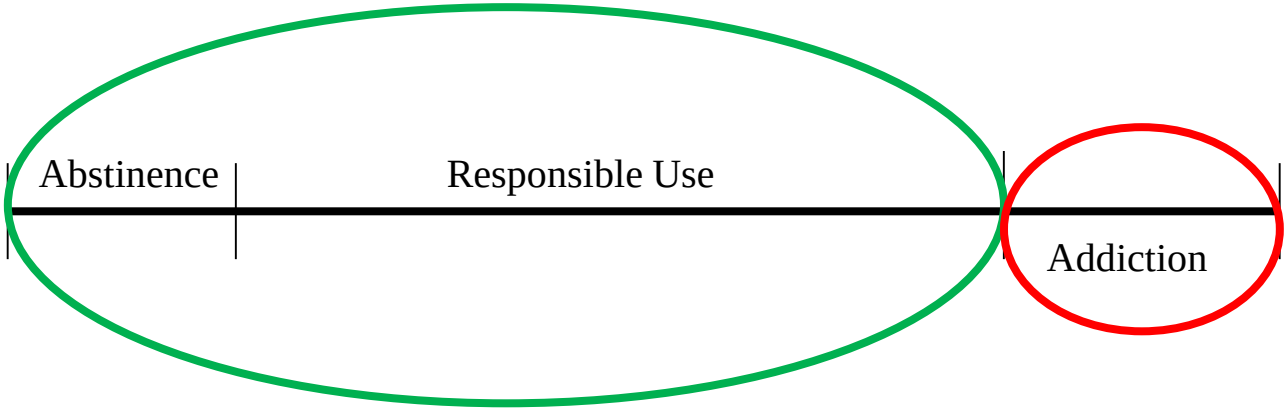
- 55.5% are current drinkers
- 6.6% are current heavy drinkers
- Among adolescents:
  - 33% are current drinkers and 8% binge drinkers
  - 22% are current marijuana users
  - 17% ever took prescription drugs without a prescription; 4% reported past year nonmedical use of pain relievers

Sources: CDC Behavioral Risk Factor Surveillance System, 2015
SAMHSA National Survey on Drug Use and Health, Behavioral Health Barometer, NY, 2015
CDC Youth Risk Behavior Survey, 2015

Addressing Problem Substance Use

- Historically, the focus has been on
  - Prevention: prevent abstainers from initiating use
  - Treatment: provide substance abuse treatment for those with substance use disorders (SUDs) with the goal of abstinence
- What about for everyone else?
  - Most who drink or use drugs do not have an SUD and do not seek treatment
  - Can benefit from early intervention outside of substance use treatment settings to reduce risky use before more severe problems occur

The Current Model
A Continuum of Substance Use

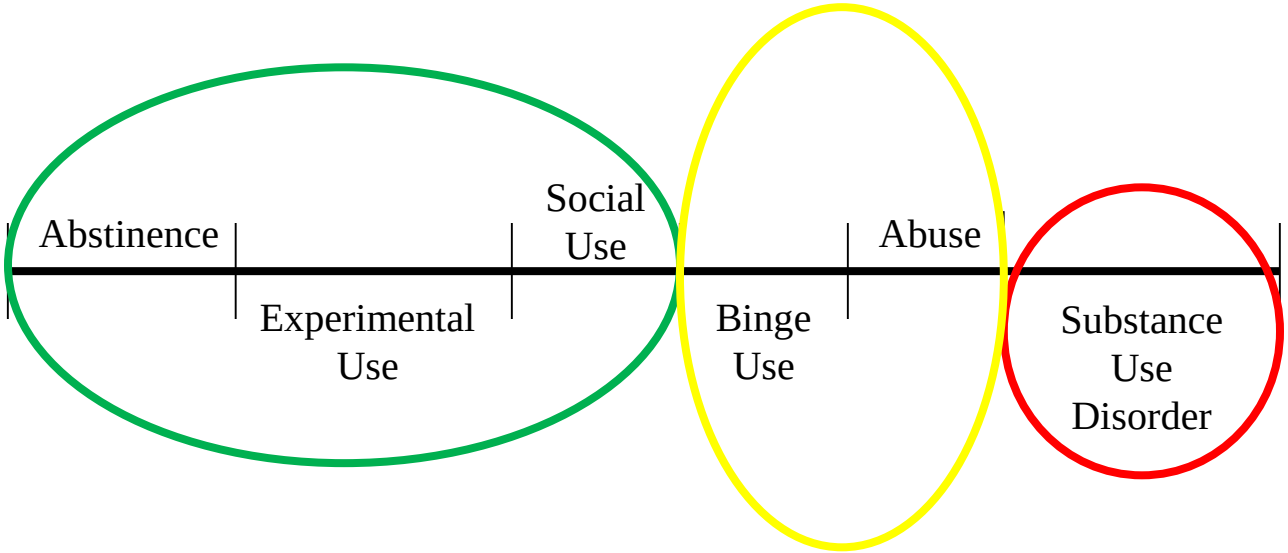


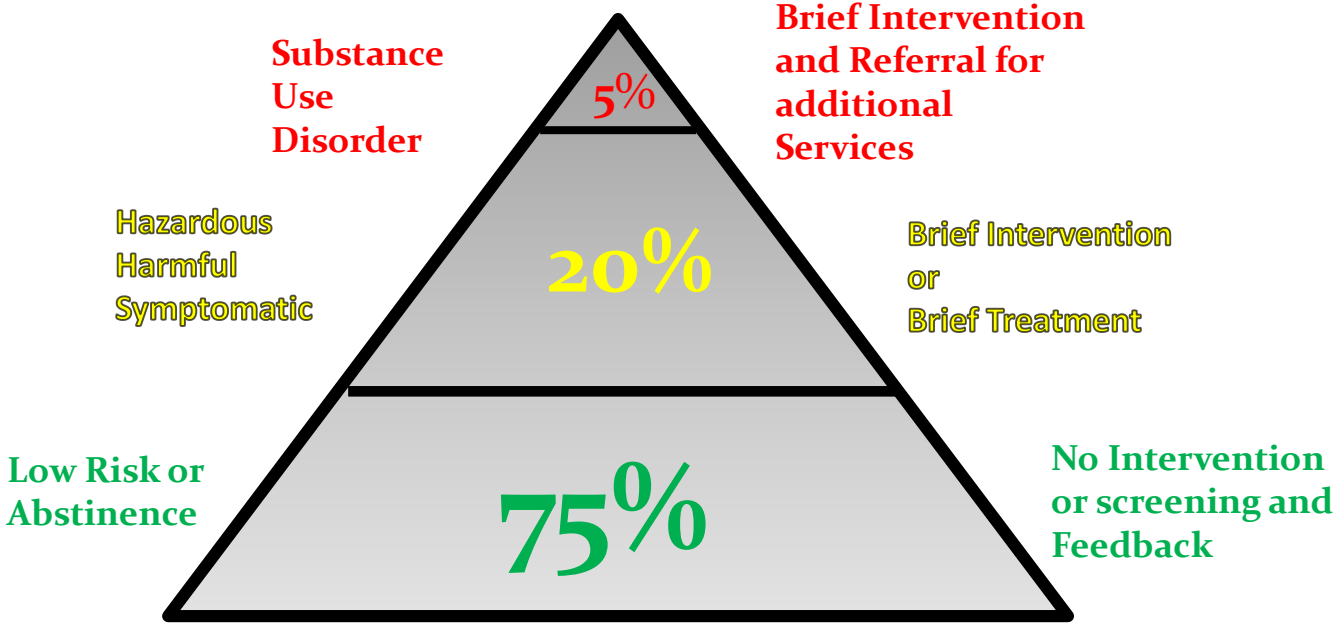
What is SBIRT?

An evidence-based prevention and early intervention model to address the full spectrum of substance use

- **Screening**
- **Brief Intervention**
- **Referral to Treatment**
- **Goal:** Identification of *at-risk substance users* in non-substance abuse treatment settings and provision of appropriate services

The SBIRT Model – A Continuum of Substance Use





Source: Babor, T.F. & Higgins-Biddle, J.C. (2001). Brief intervention for hazardous and harmful drinking: a manual for use in primary care. *World Health Organization.* Retrieved from http://apps.who.int/iris/bitstream/10665/67210/1/WHO_MSD_MSB_01.6b.pdf.

SBIRT is implemented in…

- Primary care
- Federally-qualified health centers
- Emergency departments
- Mental health settings
- OB/GYN
- Pediatric practices
- Schools and school-based health centers
- Colleges and Universities
- Workplaces
- Dental clinics

United States Preventive Services Taskforce Recommendation

Population	Recommendation	Score (out of 10)
Adults aged 18 and older	The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse	8

Ranked in top 5 most cost-effective preventive services. Only 3 are ranked higher (child immunization, counseling to discourage tobacco initiation among youth, and counseling to discourage tobacco cessation among adults).

SBIRT for alcohol results in decreases in drinking, binge drinking, ED visits, hospitalizations, non-fatal injuries, arrests, motor vehicle accidents, STD acquisition, 4:1 cost savings.

Maciosek et al., 2017; Fleming et al., 2002; Kaner et al., 2009; Brown et al., 2009; Gentillelo et al., 2005; Solberg et al., 2008; Rogers et al., 2015; Yu et al., 2015

Still Insufficient Evidence For…

SBIRT for drug use among adults and alcohol and drugs among adolescents: "I" rating meaning the **evidence is insufficient to assess the balance of benefits and harms.**

Emerging research with adolescents found:

- Decreases in alcohol and drug use and intentions to use
- Prevention of initiation
- Decreased drinking and driving
- Satisfaction with services and intentions to follow through on advice

*****Recommended by the American Academy of Pediatrics for primary care**

Harris et al., 2012; D'Amico et al., 2008; Knight et al., 2005; American Academy of Pediatrics, 2016

Integrating suicide prevention into the SBIRT model

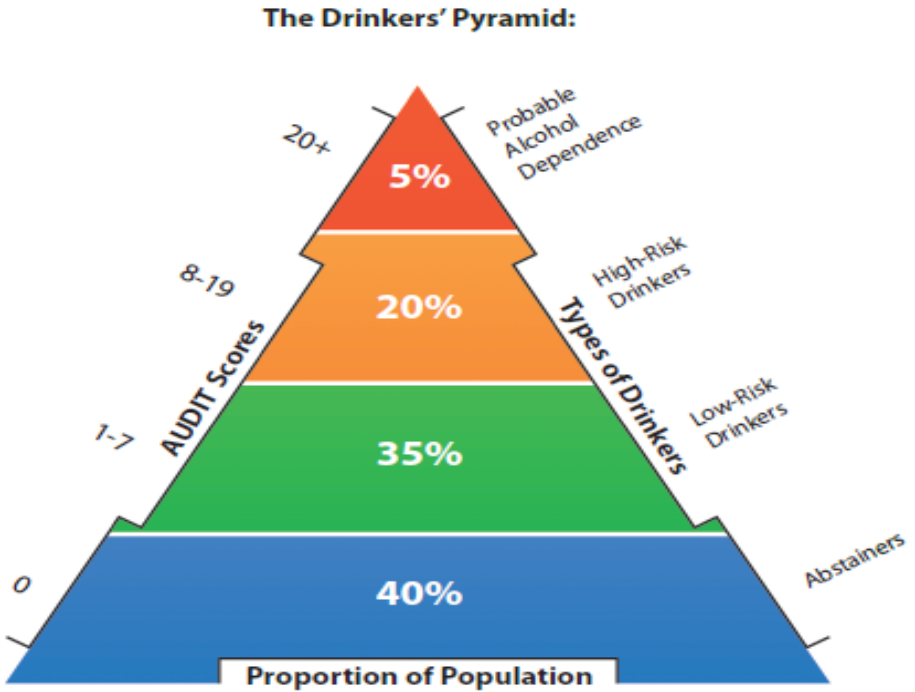
Screening

- Pre-screening
  - AUDIT-C (alcohol)
  - DAST-1 (drugs)
  - ***Add PHQ-3 (depression and suicide)***
- Screening using standardized tools
  - AUDIT
  - DAST-10
  - CRAFFT 2.0 for adolescents (alcohol and drugs)
  - PHQ-9
  - ***Add C-SSRS for a yes response to the last question of the PHQ-3/PHQ-9***
    - Screen followed by C-SSRS assessment version if necessary

Using and Interpreting the C-SSRS

Question Intent: Thoughts and Behaviors	Response
Q1. Wish to be dead	Behavioral Health Referral
Q2. Suicidal thoughts	Behavioral Health Referral
Q3. Suicidal thoughts with method (w/o specific plan or intent)	Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Q4. Suicidal intent (without specific plan)	Behavioral Health Consultation and Patient Safety Precautions
Q5. Suicidal intent with specific plan	Behavioral Health Consultation and Patient Safety Precautions
Q6. Suicidal behavior not within the past 3 months	Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Q6. Suicidal behavior within the past 3 months	Behavioral Health Consultation and Patient Safety Precautions

Interpreting the AUDIT Score



http://sbirtinaction.org/docs/SBIRT_Drinkers_Pyramid.pdf

Interpreting the AUDIT and/or DAST-10 Score

Score	Assessment	Service
Pre-screen: **AUDIT-C: Men ≥ 4; Women ≥ 3** **DAST-1 = yes**	Positive pre-screen	Administer full screen
AUDIT = 0-7 **DAST = 0**	Not indicative of risky or excessive substance use	Informational literature
AUDIT = 8-15 **DAST = 1-2**	Possible hazardous and harmful substance use	Brief Intervention (BI)
AUDIT = 16-19 **DAST = 3-5**	Moderate to high level misuse and possible DSM IV abuse	Up to 12 Extended Brief Intervention sessions (EBI)
AUDIT ≥ 20 **DAST ≥ 6**	Probable substance dependence	Referral for specialized substance abuse treatment (RT) or EBI if not ready for RT

Brief Intervention and Referral

- Brief intervention using the Brief Negotiated Interview
  - Build rapport
  - Pros and cons
  - Information and feedback (elicit-provide-elicit)
  - Readiness ruler
  - Action plan
- Safety Planning Intervention for patient at-risk for suicide
  - Warning signs
  - Internal coping strategies
  - Social situations and people as distractions
  - People to ask for help
  - Professionals or agencies to contact during a crisis
  - Making the environment safe
- Have referral agreements in place and make warm handoffs

NYS Medicaid Reimbursement Codes for SBIRT

- SBIRT may be billed to NYS Medicaid using the following Healthcare Common Procedure Code System (HCPCS) procedure and diagnosis codes:

Procedure Code	Diagnosis Code	Service
H0049	Z13.9	Encounter for screening, unspecified
H0050	Z71.41 Z71.51	Alcohol abuse counseling and surveillance of alcoholic Drug abuse counseling and surveillance of drug abuser

To be eligible for reimbursement, licensed providers must complete a 4-hour training by an OASAS-certified trainer. Non-licensed providers must complete a 12-hour training

Questions?

Brett Harris, DrPH
Suicide Prevention Project Manager
NYS Office of Mental Health
brett.harris@omh.ny.gov

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