OVERVIEW OF THE BEHAVIORAL HEALTH EXPERT PANEL PROCESS AND THE 4 QUADRANT MODEL

NM Behavioral Health Sub-Committee

September 7th, 2012

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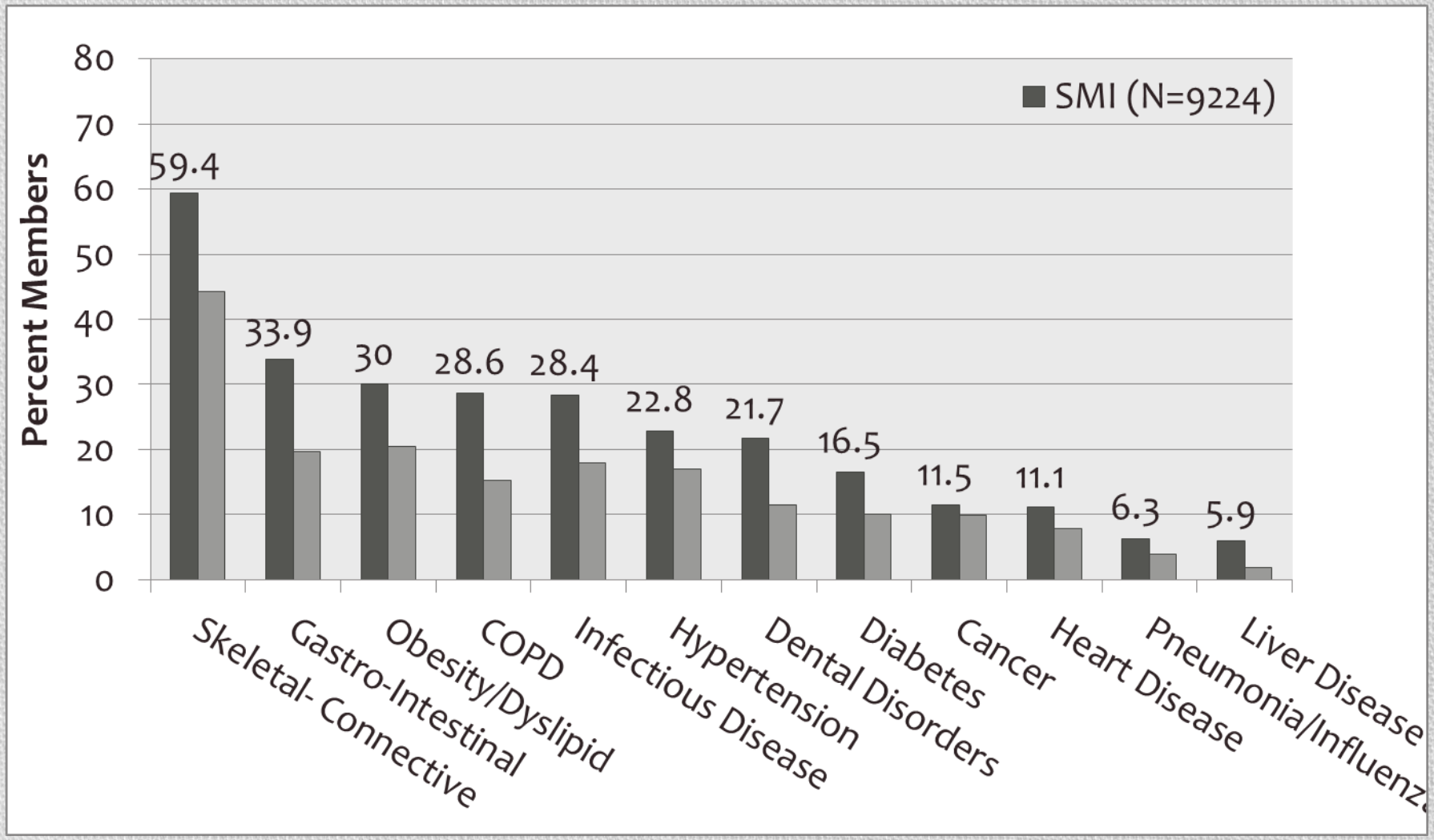
25 Years Disparity in Life Expectancy for People with Serious Mental Illness

Higher medical costs associated with untreated depression for people with chronic illnesses such as diabetes, chronic pain, etc.

Maine Study Results: Comparison of Health Disorders Between SMI & Non-SMI Groups



Total Years Potential Life Lost by Primary Cause among individuals in the public mental health system

Primary cause of death (MO, OK, RI, TX, and UT ,1997–2000)	Total YPLL (Person-years lost)	Deaths (n)
Heart disease	14,871.2	612
Cancer	5,389.9	241
Suicide	4,726.1	115
Accidents, including vehicles	3,467.0	98
Chronic respiratory	2,700.9	113
Diabetes	1,419.6	61
Pneumonia/influenza	1,254.2	67
Cerebrovascular disease	1,195.9	58
All causes of death*	47,812.2	1,829

*Includes deaths from causes not listed; YPLL = years of potential life lost.

Mental health conditions are a health risk factor because of:

- Individual factors, e.g.: amotivation, fearfulness, homelessness, victimization/trauma, resources, advocacy, unemployment, incarceration, social instability, IV drug use, diet, smoking, etc.
- Provider factors: Comfort level and attitude of healthcare providers, coordination between mental health and general health care, stigma,
- System factors: Funding, fragmentation

Psychiatric medications can exacerbate these risks

- Modifiable Risk Factors Affected by Psychotropics:

- Overweight / Obesity
- Insulin resistance
- Diabetes/hyperglycemia
- Dyslipidemia

Newcomer JW. *CNS Drugs* 2005;19(Supp 1):1.93.

Cardiovascular Disease (CVD) Risk Factors

Modifiable Risk Factors	Schizophrenia	Bipolar Disorder	Major Depression	U.S. Population NHANES 2005-6
Obesity	36% [1]	36% [1]	36% [1]	35.7%
Smoking	49% [1]	49% [1]	37% [1]	19.3%
Diabetes	15-21% [2,3]	8 - 19% [3, 4]	23% [3]	7.7%
↑ BP	46% [3]	48% [3]	55% [3]	29%
↑ Lipids	29 % [3]	32% [3]	38% [3]	16%

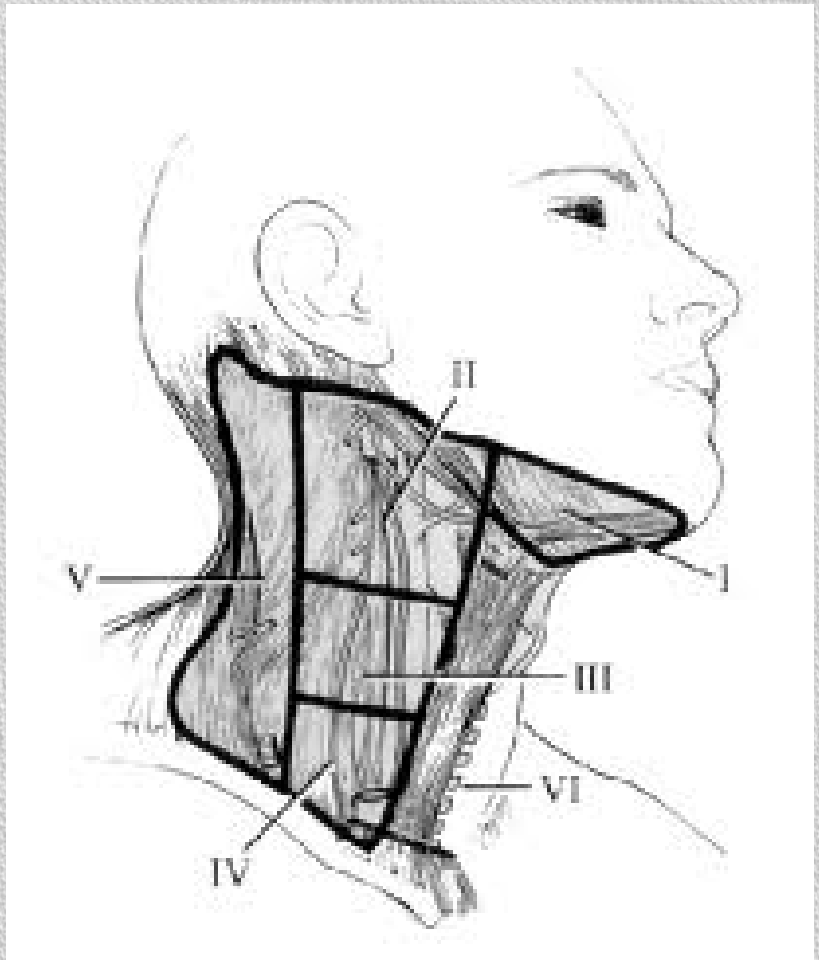
1. Chwastiak et al., Psychosomatics 2011
2. Dixon et al., J Nerv Ment Dis, 1999
3. Kilbourne et al., Gen Hospital Psychiatry, 2011
4. Fagiolini et al., Bipolar Disorders 2005

Integrated health homes can improve health care quality and prevention

- Individuals with SMI are less likely to be assessed for metabolic risk factors than those without SMI (Correll et al., 2010; Kilbourne et al., 2008).

- However, in large VA study, individuals with SMI who received their primary care in an integrated setting were more likely to be monitored for lipids, hypertension, diabetes, and obesity than those who received their primary care through general medical services. (Kilbourne et al., 2011)

The Body Has A Neck!!



Many States are Moving to Integrated Models at Clinical, Financial, and Structural Levels

- New York
- Missouri
- Vermont
- Massachusetts
- Oregon
- Colorado
- Washington

New Mexico's Behavioral Health Restructuring Process
http://www.cbhtr.org/bhept

- **A Behavioral Health Steering Team** formed to develop a process to gather input
- **A Behavioral Health Expert Panel** (BHEP) of 50 behavioral health state experts representing:
  - Consumers and family members
  - Advocates
  - Providers (youth and adult)
  - With support from state agency personnel and national experts

The BHEP Meetings

The First Meeting (July 7, 2011)

- Introductions, education, and overview of the process

The Second Meeting (July 29, 2011)

- Addressed questions of carve in/out
- Models for tracking funding
- Governance structure

The Third Meeting (August 18, 2011)

- Review white paper initial draft
- Review state history with different BH models
- Discuss integrative care practice models

The Fourth Meeting (December 9, 2011)

- Medicaid BH change suggestions
- Protecting BH funds in Integrated care world
- Managing Non-Medicaid funds

The Fifth Meeting (May 21, 2012)

- Updates

Guiding Principles for Behavioral Health System Restructuring

- Protecting and strengthening behavioral health
- Integrating behavioral health and physical health for the whole person
- Shaping our future using what we have learned from the past and our vision for the future
- Maintaining focus on recovery and resilience
- Focusing on individual outcomes and wellness

The Questions

1. How do we build a statewide model of integrated care that supports a strong behavioral health system?
2. Should behavioral health be carved out, carved in, or should a hybrid model be developed?
3. What is unique to New Mexico that must be addressed in the development of any structure, contract or RFP?

Question 1

How do we build a statewide model of integrated care that supports a strong behavioral health system?

Given the Consideration of BH-PC Integration, How Do We:

- Develop and ensure a continuum of care for behavioral health, including prevention, early recognition and early intervention?
- Link behavioral health services to medical homes, be they in primary care or behavioral health settings?
- Ensure effective medical care for people with behavioral health conditions?
- Ensure effective behavioral health care for people with medical conditions?
- How do we identify and re-invest any cost savings back into the appropriate health system?

TABLE 1: FOUR QUADRANTS OF CLINICAL INTEGRATION BASED ON PATIENT NEEDS

LOW ← BEHAVIORAL HEALTH RISK/COMPLEXITY → HIGH	**QUADRANT II** Patients with high behavioral health and low physical health needs Served in primary care and specialty mental health settings (Example: patients with bipolar disorder and chronic pain) Note: when mental health needs are stable, often mental health care can be transitioned back to primary care.	**QUADRANT IV** Patients with high behavioral health and high physical health needs Served in primary care and specialty mental health settings (Example: patients with schizophrenia and metabolic syndrome or hepatitis C)
	QUADRANT I Patients with low behavioral health and low physical health needs Served in primary care setting (Example: patients with moderate alcohol abuse and fibromyalgia)	**QUADRANT III** Patients with low behavioral health and high physical health needs Served in primary care setting (Example: patients with moderate depression and uncontrolled diabetes)

LOW ← PHYSICAL HEALTH RISK/COMPLEXITY → HIGH

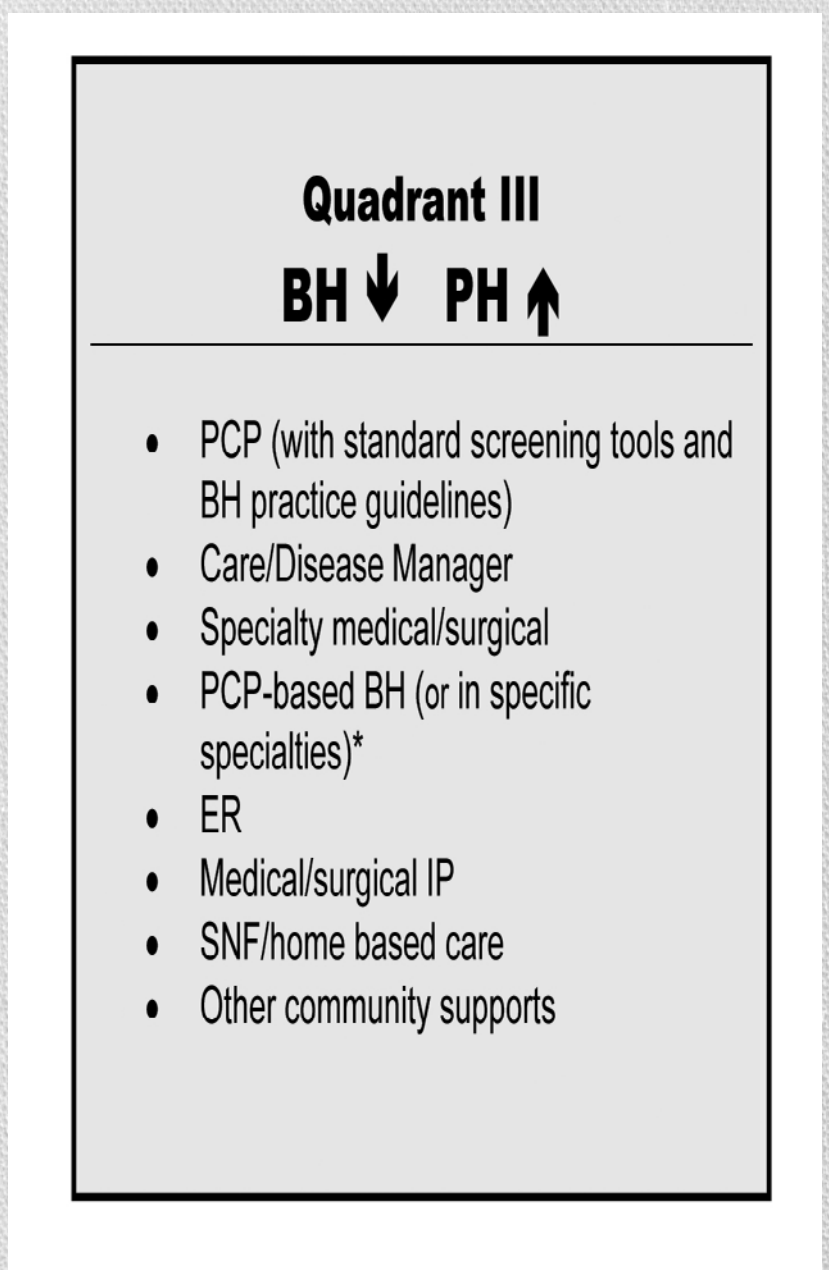
Source: Adapted from Mauer 2006.

Quadrant I

BH ↓ PH ↓

- PCP (with standard screening tools and BH practice guidelines)
- PCP-based BH*

- Screening and early detection, early intervention as priority
- Potential SBIRT site
- Wellness and education support
- Cost-Savings from early detection, early treatment, prevention of movement to high end behavioral health/ medical conditions



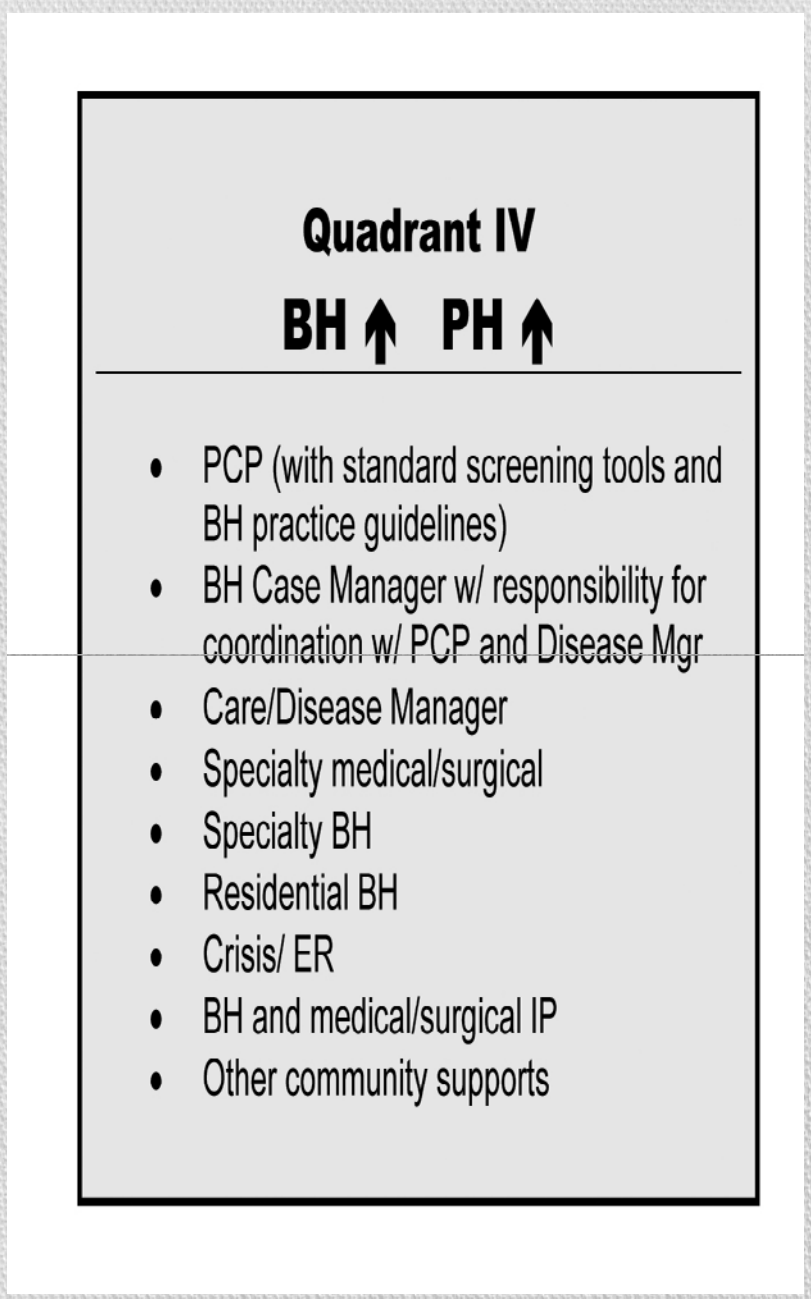
- Primary health site with strong behavioral health consultation
- Early screening of people with medical conditions for behavioral health problems
- Savings come when people with chronic illness get depression treatment, leading to better self-care, less time in ER, hospital, and with less BH treatment needs.
- Cost savings mostly seen on medical side

Quadrant II

BH ↑ PH ↓

- BH Case Manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

- BH side of system, with community based & Core Service Agency (CSA) services for people with SED and SMI
- Physical health is done as a potential consult or with warm handoff to primary care
- Cost-savings come from effective early intervention and treatment for BH, leading to decreased inpatient and RTC services
- Later cost savings after several years with successful community care



- Strongest Integration quadrant for people with chronic or severe behavioral health and medical conditions
- BH medical home in CSAs
- Easy access to both BH and PC services, working side-by-side to ensure quality care
- Cost savings come from both effective community-based BH care, minimizing IP and RTC, and effective medical care, minimizing ER and medical IP visits.

Question 2

Carve In, Carve Out, or Hybrid of Carve In with Protections of Behavioral Health Funds?

Carve In-Minimal BHEP Support

- Physical health and behavioral health funds and services are managed together
- Historically in New Mexico, Managed Care Organizations (MCOs) have subcontracted for management of the behavioral health benefit with a behavioral health Managed Care Organization, which then pays providers
- Sometimes done with a regional component
- No clear way to track and manage the specific behavioral health dollars

Carve Out-Our Current Model in New Mexico-**Some BHEP Support**

- BH funds and services are managed by a behavioral health managed care organization(s), "carved out" from the physical health managed care organization(s)
- A rigid separation exists between behavioral and physical health dollars, so funds cannot easily cross from one side to the other
- Makes integrated BH and PC more difficult to implement or manage
- Provides the strongest protection for BH funds

Hybrid-Carve In with Protection of Behavioral Health Funds-**Strong BHEP Support**

- MCO(s) manage both behavioral health and physical health funds, with special condition in place to protect and promote the development of behavioral healthcare and the integration of behavioral healthcare and physical healthcare
- A more permeable line that allows tracked funds to flow between BH and PC to support health needs of people with mental illness and BH needs of people with medical conditions
- Funds for behavioral health services would be tracked and accounted for separately from funding for physical health
- Could have multiple MCOs, as well as regional components
- The Behavioral Health Collaborative would still sign the contract and have oversight of the implementation of the Behavioral Health components of the contract(s), as well as track outcomes, integration, efficiencies, etc.

Examples of Protections for Hybrid Model

- Separate per member per month rate for behavioral health
- Requirement that MCO(s) contract directly with New Mexico providers/provider networks
- Requirement that behavioral health savings be tracked and reinvested into BH system

Question 3

Overarching Conclusions and unique aspects of New Mexico that must be addressed in the development of any structure, contract, or RFP

Overarching Conclusions- Structure

- Improvement in specific behavioral health outcomes for consumers and families is more critical than the specific model selected (carve in, carve out, or a hybrid model)
- Critical need to increase integration of behavioral health with primary care
- Interest in local/regional governance and administrative structures within any new model
- Some strong voices that the next entity/entities that manage the behavioral health system should be a non-profit(s) and possibly a New Mexico agency(ies)

Overarching Conclusions-Funding

- The need to protect behavioral health funding
- Funding for behavioral health services should be tracked and administered separately
- A greater percent of behavioral health dollars should be spent on services and a smaller percent on administration

Overarching Conclusions-Governance

- Increased consumer, family, and provider involvement in policy development and decision making related to behavioral health care and services
- Greater transparency and accountability throughout the BH system to improve quality of care, with access to, and state ownership of, behavioral health data
- Continued active support for local and regional governance, involvement, and decision making
- Governance must be “transparent”, with the ability to make significant decisions and provide clearly understood rationales
- Mission, roles, expectations, and relationships for all components of the governance structure (Collaborative, local entities, Planning Council, etc.) must be clearly defined and delineated

Overarching Conclusions-Focus Areas

- Increased focus on children and youth, with better integration with all systems that serve them (the school, juvenile justice, tribal and foster care systems)
- Expanded focus on prevention, early detection and early intervention for the full range of behavioral health conditions
- Greater attention and flexibility to the diversity of the state in terms of geography, race/ethnicity
- There must be an increased focus on strengthening peer and family support services
- Ongoing focus on recovery and resiliency
- Focus on wellness, prevention, and stigma reduction

Overarching Conclusions- Other Components

- A thoughtful transition plan
- Dollars saved through efficiencies must go back into the behavioral health system
- Billing and paperwork must be simplified and reduced
- Integration between behavioral and physical health must also focus on the educational system and schools; the Tribes and Tribal systems; the criminal and juvenile justice systems and Jail Diversion
- An expanded focus on the state's behavioral health workforce must begin, especially in frontier and rural regions

For more information

- Please visit the Center for Behavioral Health Training and Research (CBHTR) website at: www.cbhtr.org\bhept

- At this site you will find meeting minutes, notes, BHEP presentations, relevant articles and a copy of the white paper