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Health Insurance for New Yorkers

Spectrum of Health

June 2016

Integrated Care

Highlights:

- Current standards for mood and substance use screening and assessment
- Effective alternatives for integrating healthcare for your patients
- HEDIS requirements measuring behavioral health and substance use disorders
- Best practices and tools for the integrated approach to patient health

Dear Colleagues:

Management of mental health conditions and substance use disorders involves both prevention and chronic care management. Our members set personal health goals that are focused on practical health outcomes: to be healthy, to feel well, and to avoid premature death. Achieving optimal physical health cannot be disconnected from optimal mental health.

Using New York State Department of Health (NYS DOH) Statewide Planning and Research Cooperative System (SPARCS) 2014 data, an assessment of chronic condition categories (AHRQ CCS) and codes demonstrates that approximately 26.8% of all adult hospital inpatient discharges involved patients with major mental behavioral health conditions: mental illness, alcohol abuse, and/or other substance abuse conditions. Of these, two-thirds had at least two other forms of physical health chronic disease. More than half of these patients were estimated to be living with a significant social functional impairment, including, but not limited to, managing violent behavior, maintaining relationships, holding a job, and/or retaining a place to live in the community.[1]

For patients, physical, mental, and emotional health needs are intertwined. The solution lies in integrating care; that is, in coordinating mental health and substance use disorders with primary care. Integrated care has proven to be the most effective approach to care and service for people with complex healthcare needs.[2]

This Spectrum of Health bulletin highlights:

- current standards for mood and substance use screening and assessment
- effective alternatives for integrating healthcare for your patients
- HEDIS requirements measuring behavioral health and substance use disorders
- best practices and tools for the integrated approach to patient health

Ultimately, our shared aspiration is early identification and management to goal for your patients who are at risk for future or actual chronic physical, behavioral, and/or substance use disorders. Thank you for all that you do to achieve the best health outcomes for our members.

Sincerely,

Susan J. Beane, M.D.
VP, Medical Director
Clinical Partnerships
Healthfirst

Psychological distress is directly linked to poor outcomes for physical health.

THE PROBLEM

People with mental illness die earlier than the general population and have more co-occurring health conditions

68%
of adults with a mental illness have one or more chronic physical conditions

MORE THAN 1 in 5
adults with mental illness have a co-occurring substance use disorder

Source: www.integration.samhsa.gov

Case Studies: Do you recognize these patients?

Your reliable patient denies stress at home or work but begins to "forget" medical appointments or to pick up medications.

A teen parent is living with multiple stresses such as inadequate preparation for parenting, housing insecurity, and/or education instability. You are concerned that s(he) is at risk for poor medical outcomes and depression postpartum.

A senior adult with mild dementia develops poor dietary control, incontinence, inconsistent medication schedules, and episodes of lashing out. Is this a signal that there is an underlying mood disorder or increased alcohol intake?

A family in your practice may state that nothing is wrong, yet you suspect that there is post-traumatic stress disorder connected to their recent immigration to the United States.

What is Integrated Care and how does it improve outcomes?

Integrated Care is the meshing of behavioral health and substance use disorder screening, treatment, and monitoring concomitantly with all physical health needs.[3] This strategic approach to caring for patients addresses the whole person. The evidence indicates that use of Integrated Care to improve outcomes results in a reduced burden of disease and decreases the rates of emergency room visits and subsequent hospitalizations.[4]

Behavioral health and substance use disorders affect a significant proportion of the U.S. population. In fact, nearly half of all Americans develop a mental illness during their lifetime.[5] According to the National Institute of Mental Health, in 2014 there were an estimated 43.6 million adults aged 18 or older in the United States with some form of mental illness. This number represented 18.1% of all U.S. adults.

New York State, like other states over the past decade, has been prompting primary care practice transformation with patient-centered medical homes for Medicaid patients who are seriously ill. For behavioral health, the NYS Office of Mental Health has developed a partnership with the Department of Health to collaborate with health plans and providers statewide to improve outcomes for those who have serious mental illness.[6]

Managing Adult Depression in Primary Care

The Healthfirst Quality Improvement Committee has approved a standard approach to the screening, assessment, and management of adult depression based on the Institute for Clinical Systems Improvement (ICSI) Health Care Guideline for managing "Depression in Primary Care" ("Guideline").[7] A full copy of the ICSI Guideline can be accessed here:

www.icsi.org/_asset/fnhdm3/Depr-Interactive0512b.pdf.

The first recommendation is to routinely screen all adults for depression using validated and reliable instruments, such as screening and tracking tools, to enhance the clinical interview of patients. The Guideline highlights the PHQ-2, and the strong evidence for use of the PHQ-9 in patients with chronic disease.

What is Integrated Care and how does it improve outcomes? *(continued)*

According to the Guideline, "Risk factors for major depression include:

- Family or personal history of major depression and/or substance abuse
- Recent loss
- Chronic medical illness
- Stressful life events that include loss (death of a loved one, divorce)
- Traumatic events (e.g., car accident)
- Major life changes (e.g., job change, financial difficulties)
- Domestic abuse or violence"

According to the Guideline, key steps following a potential diagnosis of depression are to:

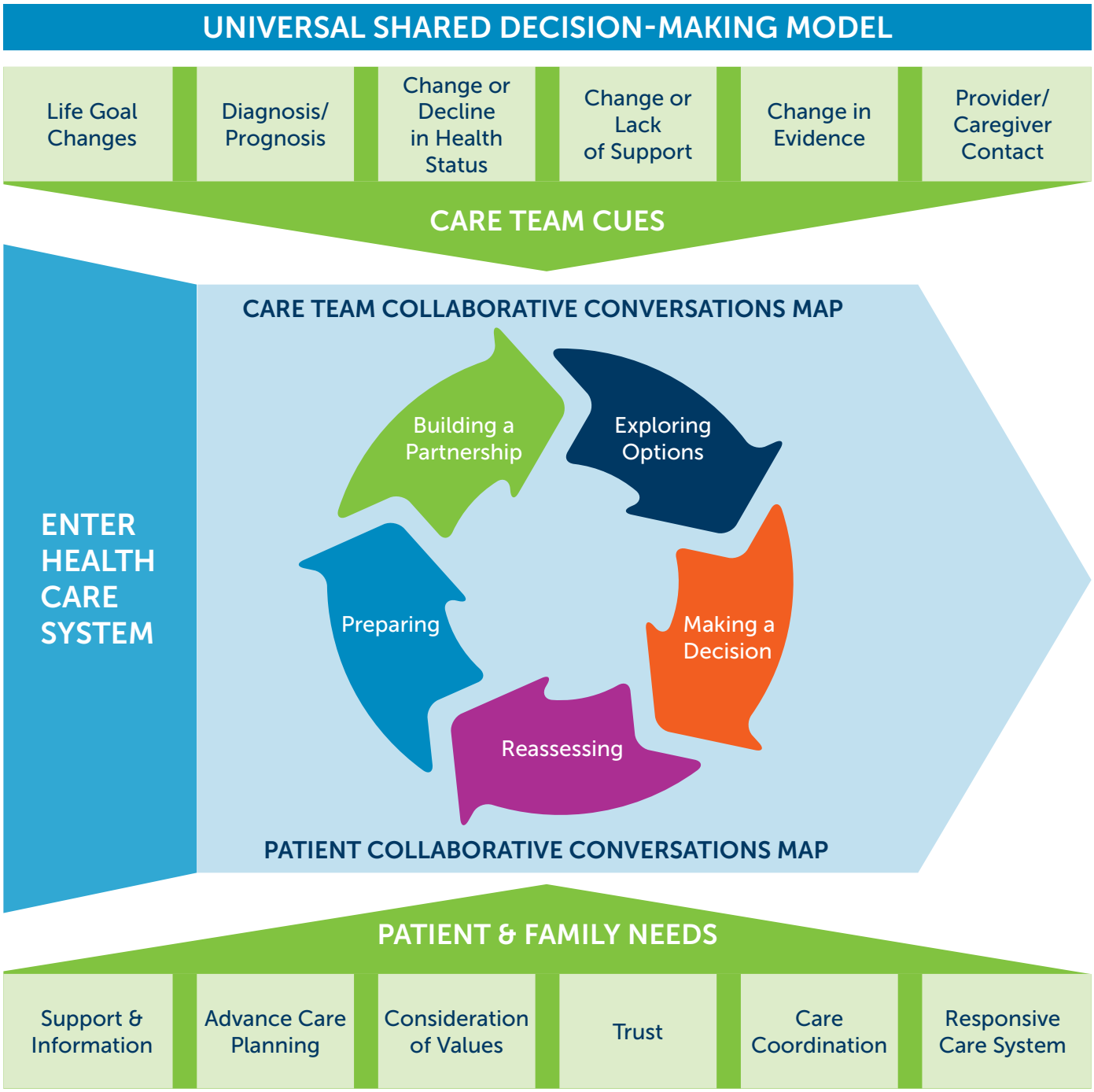
- Characterize the major depression/persistent depressive disorder with clinical interview
- Determine if the patient is safe to self and/or others
- Implement protocol to assess and minimize suicide risk, which may involve mental health specialists
- Assess for the presence of substance use disorder or psychiatric comorbidity if suspected

Once depression is diagnosed and characterized, the Guideline outlines milestones in creating a comprehensive treatment plan. These include:

- Discussing treatment recommendations to achieve remission and/or a patient that is predominantly symptom-free (i.e., a PHQ-9 score of less than five), with recommended use of shared decision-making as the process to do so
- Behavioral activation as an evidence-based intervention, including appropriate physical activity
- Implementation of appropriate psychotherapies and pharmacotherapy

A follow-up plan should be established which includes an assessment of:

- Whether the patient reached remission
- Continuation and maintenance treatment duration based on episode
- Use of a stepped-care approach to achieve improvement if patient shows no improvement on initial treatment



ICSI Institute for Clinical Systems Improvement

Source: www.icsi.org/_asset/fnhdm3/Depr-Interactive0512b.pdf

The Guideline also stresses that "A collaborative care approach is recommended for patients with depression in primary care." Because the quality of the evidence is high, such an approach is strongly recommended.[8]

What is Integrated Care and how does it improve outcomes? *(continued)*

Finally, the Guideline recommends four key components in the design of a team-based collaborative care approach based on *Unützer, 2002*:

- Primary care clinicians using evidence-based approaches to depression care, and a standard tool for measuring severity, response to treatment plan, and remission
- A systematic way of tracking and reminding patients at appropriate intervals of visits with their primary care physician and monitoring of treatment adherence and effectiveness
- A team member (care manager role) to utilize the tracking system, to make frequent contact with the patients to provide further education and self-management support, and to monitor for response in order to aid in facilitating treatment changes and in relapse prevention
- Communication between primary care team and psychiatry to consult frequently and regularly regarding patient under clinical supervision, as well as direct patient visits as needed[9]

IMPACT is a Collaborative Care model focused on Depression

Recommended as a "best practice" by the Surgeon General's Report on Mental Health, the President's New Freedom Commission on Mental Health, and the National Business Group on Health

What is the Collaborative Care Model?

The collaborative care model developed by Unützer and colleagues has been validated for integrating depression screening and treatment into primary care. Collaborative care involves routine screening for depression with monitoring for outcomes using a depression registry, patient engagement, and education with practice-based care managers, and collaboration with psychiatrists when necessary.[10]

The collaborative care model establishes performance improvement methods that continuously assess for opportunities to enhance clinical outcomes. The IMPACT study (Improving Mood-Promoting Access to Collaborative Treatment) and similar evidence-based projects have demonstrated true impact.

IMPACT is the most widely tested form of collaboration between primary care and behavioral health. Patients enrolled in the IMPACT Collaborative Care model for up to eight years were significantly less likely to experience a serious or fatal cardiovascular event than patients who received usual depression treatment.[11]

Summaries of more than 80 replication studies and 24,308 patients worldwide,[12] as well as return-on-investment data, are available through the University of Washington's Advancing Integrated Mental Health Solutions Center (**uwaims.org**).

- Improved satisfaction with depression care
- Doubles the effectiveness of usual care for depression
- 50% or greater improvement in depression at 12 months
- Additional 116 depression-free days over two years

There are five core IMPACT elements for the classic collaborative care model:

1) The patient's primary care physician: develops a treatment plan and implements it through a practice care manager with consultation with a psychiatrist to modify treatment plans for patients who do not improve
2) Depression care manager: may be a nurse, a social worker, or a psychologist to educate patients, support psychotropic therapy, coaching, offer problem solving, monitor depression symptoms, and complete a relapse prevention plan with each patient
3) Designated psychiatrist: consults and implements specialized treatment protocols and plans for patients who do not respond to treatment as expected
4) Outcome measurement: monitoring of the course of evidence-based care using, at a minimum, the PHQ-9 to determine if the patient will achieve optimum outcomes—a 50% reduction in symptoms within 10–12 weeks
5) Stepped care: if the patient does not improve within 10–12 weeks, treatment plans are adjusted accordingly, based on the psychiatrist's recommendations

Clinical and administrative staff training on collaborative care; practice commitment to patient- and family-centered shared decision-making, education, and activation; and a continuous performance improvement approach by the practice are also essential elements of the IMPACT model.

The "Recovery Process" and Primary Care

The principle of recovery from mental illness and substance use disorders is a key concept that has been widely accepted and adopted by government agencies, communities, healthcare providers, peers, families, researchers, and advocates. SAMHSA has established a working definition of recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.[13] Four major dimensions that support a life in recovery have been delineated:

- **HEALTH**—overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being
- **HOME**—having a stable and safe place to live
- **PURPOSE**—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- **COMMUNITY**—having relationships and social networks that provide support, friendship, love, and hope

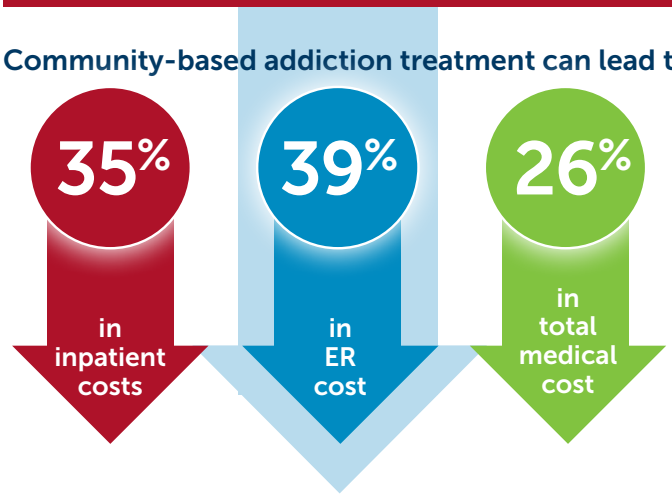
"Recovery" is a highly personal and individual phenomenon, and occurs in diverse ways. Thus, resources and support for a person's recovery journey should be individualized, collaborative, and tailored to the priorities of the client. Recovery support is provided through clinical treatment, community services, peer providers, family members, friends and social networks, the faith community, and people with experience in recovery. Recovery support services help people enter into and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and live full lives in communities of their choice. These support services can be provided before, during, or after clinical treatment and also to those who are not in treatment but who seek such services.

Roadmap to Integrated Care

Primary care settings deliver over 80 percent of mental health treatment for depressed older adults.[14]

INTEGRATION WORKS

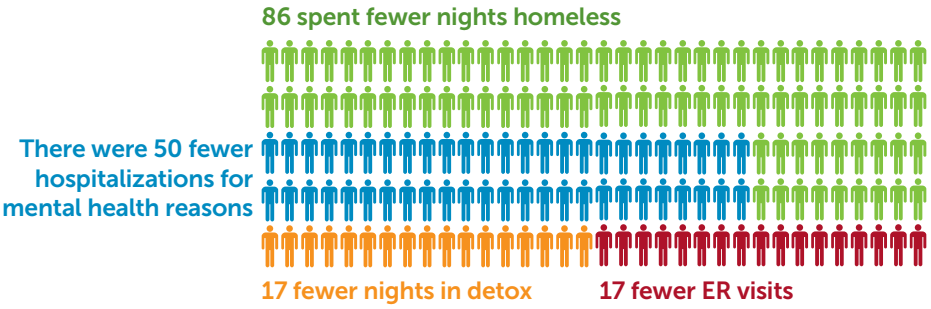
Community-based addiction treatment can lead to...



Reduce Risk → Reduce Heart Disease
(for people with mental illnesses)

Maintenance of ideal body weight (BMI = 18.5–25)	=	**35%–55%** decrease in risk of cardiovascular disease
Maintenance of active lifestyle (30 min walk daily)	=	**35%–55%** decrease in risk of cardiovascular disease
Quit Smoking	=	**50%** decrease in risk of cardiovascular disease

One integration program enrolled 170 people with mental illness. After one year in the program, in one month:



This is
$213,000
of savings per month.

That's
$2,500,000
in savings over the year.

Integration works.
It improves lives.
It saves lives.
And it reduces healthcare costs.

Source: www.integration.samhsa.gov

The Integrated Care Model can facilitate not only timely, effective management of this common disorder, but also the identification of other common conditions like anxiety, and complex psychiatric disorders requiring referral to specialty psychiatric care, such as schizophrenia, post-traumatic stress disorder, personality disorders, and bipolar disorder.

We believe that the Integrated Model is well suited for primary care practices.

Readiness for advanced collaboration, including the IMPACT model, requires processes to support the following milestones:

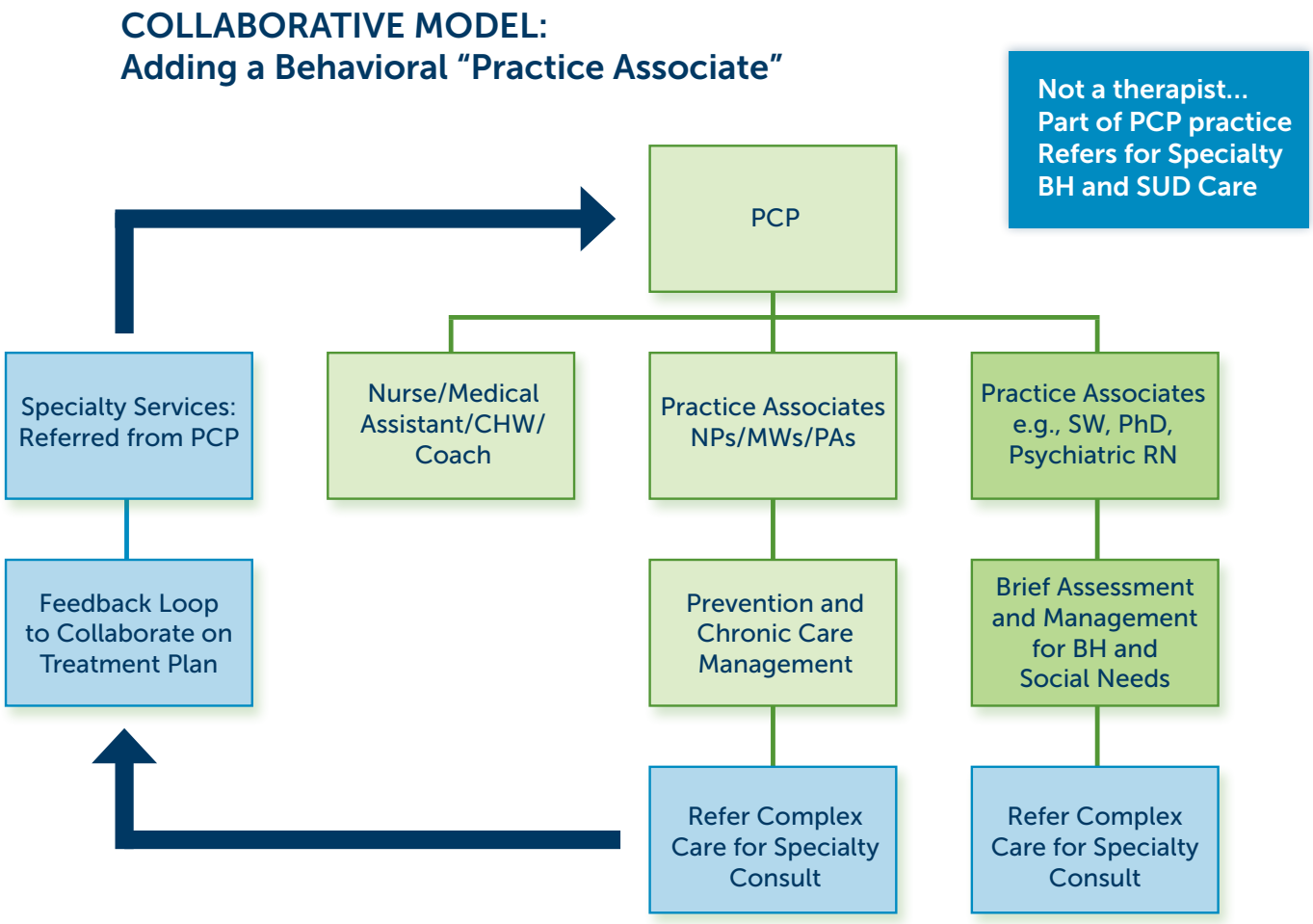
1) RESPONSIVE NETWORK OF COLLEAGUES AND LINKAGES

Primary care practices will need confidence that patients screened and assessed as complex can receive specialized diagnosis and treatment as needed. This means surrounding a primary care practice with a cadre of capable, willing, accessible, and available behavioralists and social service practitioners.

This means mental health and substance use disorder colleagues that communicate in a timely fashion with primary care. If a referral is made by a PCP, the referral is not complete until there is a report back about the patient's status, needs, and/or next steps.

PROPOSED PRACTICE ROADMAP	
☐	DECISION: what is the most appropriate model for our practice to implement collaboration with behavioral health
☐	Creation of linkages to enhanced ability of our practice to make meaningful and timely behavioral health referrals
☐	Optimize use of our practice screening, assessment, managing, and monitoring tools to result in treatment to targets and improved outcomes for our patients
☐	DECISION: how can we implement practice coaching/chw/sw services
☐	DECISION: what training/workshops can we access to enhance practice-based skills
☐	DECISION: what training/workshops can we access to implement an integrated care model
☐	Implement optimized practice tools for collaborative and integrated approach to improving BH outcomes for our patients
☐	Implement co-management/collaborative care infrastructure
☐	Discover and close contracting "gaps," if any, to finalize integrated, co-management/collaborative care

2) AN ACTIVATED STAFF AND REFERRAL PROCESSES THAT "WORK"



Source: Healthfirst

A culture of shared decision-making and recovery-focused treatment planning is key to successfully meeting the needs of patients with complex physical health and mental health needs.

Process redesign will not be "one size fits all" but can be tailored to the health goals and health needs of a practice's patients, families, and communities. Thus, for one practice, a social worker as a practice associate may be critical. For another, a health worker or a nurse may serve as care coordinator or care manager.

Each practice is unique, and these referrals should work as well as, or better than, other primacy care practice referral processes.

3) PRACTICE SCREENING, ASSESSMENT, AND MANAGEMENT: IMPLEMENTED!

Effective co-management of patients requires a primary care practice to implement screening tools and evidence-based protocols for coordinating care, planning to address service needs and treating patients with straightforward needs, and those who respond to treatment.

a. Universal screening

Universal screening is the best way to ensure that patients' needs are holistically addressed. Screening implemented with brief tools (see list below) will support ongoing identification of patients who will benefit from assessment and management for behavioral health and substance use disorders.

b. Assessments that determine specific pathways for patients

Once screening indicates that a patient may require integrated care planning, assessments determine specific needs and govern patient and provider choices regarding next steps. Assessments include understanding how people perceive their condition, whether medication or therapy should be used, and an individual's readiness to address the health needs that are discovered.

Assessment tools will generate information needed to stratify severity and intensity of a person's need for intervention. For example, evidence of suicidal ideation or active substance use can be successfully managed in primary care practices with defined clinical pathways. A useful approach is to embed tools, alerts, and referral pathways in the practice electronic health record. But paper-based tools work as well if used consistently and tracked rigorously, and they result in timely interventions. The following is a list of helpful tools:

SCREENING TOOLS:
Behavioral health and substance use tools for use by primary care practices for screening and monitoring.

Depression PHQ-2 and PHQ-9 are multipurpose instruments for screening, diagnosing, monitoring, and measuring the severity of depression. They incorporate the DSM-IV diagnostic criteria in a brief self-report tool.
www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf

Anxiety Generalized Anxiety Disorder is a seven-question screening tool that identifies whether a complete assessment for anxiety is indicated.
www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf

Perceived Stress Scale a snapshot of a patient's overall reaction to everyday stressors and can indicate a change in the level of stressors and the potential impact on physical or behavioral health needs or outcomes.
www.psy.cmu.edu/~scohen/Cohen%2C%20S.%20%26%20Williamson%2C%20G.%20(1988).pdf

Brief Screening Instrument for Adolescent Tobacco, Alcohol, and Drug Use
BSTAD is a screening tool for use in pediatric settings, identifying adolescents with substance use.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4006430/

Tobacco Use Agency for Healthcare Research and Quality recommends a simple tool such as the following to make tobacco use a "vital sign" for all practices in both paper and electronic charts:

Vital Signs

Blood Pressure: _____

Pulse: _____ Weight: _____

Temperature: _____

Respiratory Rate: _____

Tobacco Use: Current Former Never (circle one)

Alternatives to expanding the vital signs are to place tobacco-use status stickers on all patient charts or to indicate tobacco use status using electronic medical records or computer reminder systems.

Five Major Steps to Intervention (the "5 As"). December 2012. Agency for Healthcare Research and Quality, Rockville, MD.
www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.html

SCREENING TOOLS:

Behavioral health and substance use tools for use by primary care practices for screening and monitoring.

Alcohol Use The AUDIT-C is a three-item alcohol screening to assist in identification of patients who have alcohol use disorders or who are drinking hazardously. Scored on a scale of 0–12, each question has five answer choices. In men, a score of four or more is considered positive; in women, that score is 3 or more. The screening instrument and scoring chart can be found here: www.integration.samhsa.gov/images/res/tool_auditc.pdf

Substance Use Disorders The DAST-10 (Drug Abuse Screen Test) is a 10-item, yes/no self-report instrument that has been condensed from the 28-item DAST and should take less than eight minutes to complete. The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth. The tool and more information about it can be found here: www.emcdda.europa.eu/attachements.cfm/att_61480_EN_DAST%202008.pdf

Postpartum Depression Postnatal depression encompasses a wide range of mood disorders that can impact women during or after their pregnancy. A fact sheet for providers about this potentially devastating illness can be found here: www.health.ny.gov/community/pregnancy/health_care/perinatal/maternal_factsheet.htm

The Edinburgh Postnatal Depression Scale (EPDS) was developed for screening postpartum women in outpatient, home visiting settings, or at the 6–8-week postpartum examination. It has been utilized among numerous populations, including U.S. women and Spanish-speaking women in other countries. The EPDS consists of 10 questions. The test can usually be completed in less than five minutes. Responses are scored 0, 1, 2, or 3, according to increased severity of the symptom. The EPDS is only a screening tool. It does not diagnose depression—that is done by appropriately licensed healthcare personnel. Users may reproduce the scale without permission, providing the copyright is respected by quoting the names of the authors, its title, and the source of the paper in all reproduced copies. The screening tool and more information about it can be located here: www.state.nj.us/health/fhs/postpartumdepression/pdf/PPD-Edinburgh-Scale.pdf

Post-Traumatic Stress Disorder The Abbreviated PCL-C is a shortened version of the PTSD Checklist – Civilian version (PCL-C). It was developed for use within primary care or other similar general medical settings. The instrument and a detailed description of it can be found here: www.integration.samhsa.gov/clinical-practice/Abbreviated_PCL.pdf

Measuring Recovery Toolkit listing multiple instruments that will help practices assess their readiness to support their consumers, patients, families, and clients in recovering, as well as tools for consumers to self-assess where they are in the recovery process. www.nyc.gov/html/doh/downloads/pdf/mh/measuring-recovery-toolkit.pdf

Shared Decision-Making In addition to the ICIS Shared Decision-Making Model which is a section of the ICIS Depression Guideline (www.icsi.org/_asset/w48v61/Depr-SDM.pdf) – AHRQ's SHARE Approach is a five-step process for shared decision-making that includes exploring and comparing the benefits, harms, and risks of each option through meaningful dialogue about what matters most to the patient. www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

STEP 1: Seek your patient's participation.

STEP 2: Help your patient explore and compare treatment options.

STEP 3: Assess your patient's values and preferences.

STEP 4: Reach a decision with your patient.

STEP 5: Evaluate your patient's decision.

c. Treating to target

Follow-up is critical, so the practice must have a pathway to assure close follow-up in early stages of treatment or management, and timely, periodic reassessments for progress and improvement.

4) MONITORING AND QUALITY IMPROVEMENT

Once the practice has implemented milestones 1–3, monitoring the outcomes for these patients becomes critical. There are quality measures that are monitored by Managed Care Organizations like Healthfirst. These are listed below. There is a focus on care transitions, medication management for children, and co-management of physical and behavioral health conditions:

INTEGRATING CARE TO OPTIMIZE QUALITY: HEDIS MEASURES

CODE	MEASURE NAME	AGE BAND	DENOMINATOR EVENT	NUMERATOR REQUIREMENT	LOB
ADD	Follow-Up Care for Children Prescribed ADHD Medication	6–12	Children with newly prescribed medication for attention-deficit/ hyperactivity disorder (ADHD)	Need at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: **1.** Initiation Phase: The percentage of members with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. **2.** Continuation and Maintenance Phase: The percentage of members with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	Medicaid QHP
AMM	Antidepressant Medication Management	18+	Members who: ▪ were treated with antidepressant medication, and ▪ had a diagnosis of major depression, and ▪ remained on an antidepressant medication treatment	Two rates are reported: **1.** Effective Acute Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). **2.** Effective Continuation Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	Medicaid QHP Medicare
APC	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	1–17	Entire eligible population	Members on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year. *LOWER RATE IS BETTER	Medicaid QHP

CODE	MEASURE NAME	AGE BAND	DENOMINATOR EVENT	NUMERATOR REQUIREMENT	LOB
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	1–17	Members who were on two or more antipsychotic prescriptions	Had both of the following during the measurement year: ▪ At least one test for blood glucose or HbA1c ▪ At least one test for LDL-C or cholesterol	Medicaid QHP
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	1–17	Members who had a new prescription for an antipsychotic medication during the measurement year	Documentation of psychosocial care in the 121-day period from 90 days prior to the diagnosis date through 30 days after the diagnosis date.	Medicaid QHP
FUH	Follow-Up After Hospitalization for Mental Illness	6+	Members who were hospitalized for treatment of selected mental illness diagnoses	Had a follow-up outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner after discharge. Two rates are reported: **1.** The percentage of members who received follow-up within 30 days of discharge. **2.** The percentage of members who received follow-up within 7 days of discharge.	Medicaid Medicare QHP
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	13+	Adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence	Two rates are reported: **1.** Initiation of AOD Treatment: The percentage of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis. **2.** Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Medicaid Medicare QHP
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	19–64	Members with schizophrenia	Dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Medicaid
SMC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	18–64	Members with schizophrenia and cardiovascular disease	Had an LDL-C test during the measurement year.	Medicaid
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	18–64	Members with schizophrenia and diabetes	Need both: ▪ an LDL-C test and ▪ an HbA1c test during the measurement year	Medicaid
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	18–64	Members with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication	Had a glucose screening test or an HbA1c screening test during the measurement year.	Medicaid

5) PATIENT ENGAGEMENT

Coaching your patients to meet their health goals of quality of life and longevity is a critical component of integrated care. Once he or she is on the road to recovery, your patient will benefit from advice and support to promote opportunities for maintaining recovery and optimal health. This may include opportunities to reduce stress and to add physical activity and other healthy habits to daily life.

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The New York State Office of Mental Health Behavioral Health Managed Care site provides an overview of the state's activity in this domain: www.omh.ny.gov/omhweb/bho/

Online video overviews of integration in a practice setting and training opportunities are available through the University of Massachusetts Medical School: http://umassmed.edu/cipc/

Additional screening tools for adolescent and pediatric patients can be found at the New York State of Mental Health–funded CAP PC site: www.cappcny.org/home/index.php/clinical-resources

FREQUENTLY ASKED QUESTIONS

1. I am very concerned that my patients with behavioral health needs are not receiving all of the care and services that they need. But how do I start?

Our first recommendation is to locate mental health and substance use physicians, practitioners, clinics, and agencies that your patients feel comfortable seeing for their complex needs. The Healthfirst Network, Care Management, and Clinical Partnerships teams are glad to assist you for Healthfirst members.

2. I think that my practice is ready to go. What's a next step to take?

The journey to implementing tools, referral networks, and, ultimately, co-management of patients usually begins with a "readiness assessment." Healthfirst provides this service free of charge to our primary care practices, with a practice-specific report generated to help you and your team focus on your needs. Use this link to complete the assessment—it takes 5–8 minutes: **www.surveymonkey.com/r/SpectrumofHealth**

3. I work closely with a substance use disorder clinic and a psychiatrist. Is this an opportunity for integrated care?

Absolutely! The recommendation would be to create a practice procedure that includes screening every patient for depression, anxiety, and stress, for example. All patients that score in a positive manner could start treatment and management in your office and/or receive a referral to your colleague organization. The consultation note back would complete the workflow and make your patients and families feel as if they are not "lost in the system."

4. What help can I receive from Healthfirst Behavioral Health Case Management?

Healthfirst Behavioral Health Case Managers are available to receive referrals and do outreach to patients if requested by providers, or to receive direct requests from patients for services. The Case Manager will do triage and referral based on a psychosocial assessment of patient need and will use a patient-centered approach to engage the patient and align with their goals for treatment. The Case Manager will remain involved with the patient through the referral process until they are well-connected with the appropriate provider or program.

Here are direct contacts providers can use to contact the Behavioral Health Case Management department at Healthfirst: Heather Stein, Manager, Case Management: **1-646-313-4607** or Audra Vance, Supervisor, Case Management: **1-212-519-1743**. Patients calling directly should call the Member Services number on the back of their card and ask to speak to Behavioral Health Case Management; they will be connected directly.

5. Can Healthfirst Case Managers help my members with access to recovery services?

Yes. Healthfirst Case Managers have knowledge of many Healthfirst network community and treatment resources, including settings that offer recovery services such as substance use disorder rehabilitation, intensive outpatient substance use disorder programs, medication-assisted treatment, and self-help options that provide services to the patient as well as family members who want to be able to support members' recovery.

Additionally, Healthfirst Case Managers also are knowledgeable about many resources to help members achieve and maintain mental health recovery from psychotherapy, medication management, psycho-education programs for members and families, and support programs.