Integrating General Medical and Behavioral Health Care: The New York State Perspective

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This column describes recent policy and program initiatives implemented by the New York State Office of Mental Health to enhance integration of general medical and behavioral health services throughout the state public mental health system. Recent initiatives were implemented to improve access to health and wellness-oriented services, redesign managed care programs to improve engagement and retention of high-need individuals, and raise the bar on quality while lowering costs. Taken as a whole, these initiatives represent a 21st-century transformation of a state mental health authority into an accountable and more fully integrated public health delivery system. (*Psychiatric Services* 64: 828–831, 2013; doi: 10.1176/appi.ps.201300197)

Integrated health care is the new gold standard for individuals with general medical and mental disorders, whether their "medical home" is a primary care clinic or a community mental health center. When a "no wrong door" policy is in place, individuals need not (and will not) seek different settings for detection and routine treatment of highly prevalent general medical and mental disorders. Integration, therefore, opens the door to collaboration, timely care, improved quality, and parity for general medical and behavioral illnesses—and closes the door on disconnected treatment that is divisive, ineffective, and inaccessible.

Chronic illnesses now dominate both general medical and psychiatric practices and represent the major source of worldwide disease burden and mortality (1,2). The effective management of heart and lung diseases, diabetes, hypertension, cancers, Parkinson's and other neurological conditions, mood and anxiety disorders, and more serious and persistent illnesses—as well as serious behavioral risk factors such as obesity, smoking, sedentary life style, and overuse of alcohol and drugs—requires leaving old ways of siloed practices behind and implementing transformative changes in medical practices. This column describes how New York State (NYS) is working to put individuals first to improve overall quality of health care and reduce unnecessary and wasteful spending.

NYS has over 19 million citizens, including five million who are Medicaid beneficiaries. Approximately 250,000 of these Medicaid beneficiaries receive Social Security disability benefits because of serious mental illness. The NYS Office of Mental Health (OMH) licenses and oversees mental health services (excluding those provided by solo practitioners) provided to more than 700,000 individuals each year by more than 100 not-for-profit hospitals, 80 assertive community treatment teams, and 250 agencies offering clinic and other ambulatory programs. The NYS OMH also operates 24 state psychiatric hospitals (4,000 adult, forensic, and child beds) and more than 90 outpatient clinics. These state-operated programs serve over 30,000 individuals per year.

In 2009 total Medicaid expenditures in NYS exceeded $54 billion, including $7 billion spent on individuals with behavioral health conditions. As in other states, Medicaid is a "budget buster," and in 2011 NYS Governor Andrew Cuomo convened a Medicaid Redesign Team to provide recommendations for restructuring the state's Medicaid program. More than 800,000 individuals were identified as the most costly, indicating both that expenditures were not under effective control and that the health of these individuals was poorly managed (3,4). Over 50% of these individuals had a primary or secondary behavioral health diagnosis. These findings supported the ensuing Medicaid reform initiatives and emphasized the urgency of integrating general medical and behavioral health (mental and addiction) services into a comprehensive service delivery system.

NYS has faced other public health concerns that underscore the need for greater integration of general medical and behavioral health services. Clusters of violent episodes involving individuals with mental illness in New York City (NYC) suggested that high-need individuals were often inadequately engaged or retained in services that could reduce their risk of injury to self and others (5). The NYC Mental Health Care Monitoring Initiative, a collaboration of NYS and

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NYC, began in 2009 and used Medicaid data to identify high-need populations with serious mental illness who appeared to be disengaged from services. This initiative prompted providers to increase outreach, engagement, and retention efforts for these individuals (6,7) and was met with individual and family approval in part because the "surveillance" was of the performance of the care system and not of the individuals per se. The initiative demonstrated that data collected from general medical, behavioral health, and forensic sources can identify individuals who need outreach; however, for many of these individuals, a majority of service contacts were with general medical, emergency department, or substance use treatment providers (8). Successful engagement and retention in care for these highly vulnerable individuals clearly require integrated efforts between general medical and behavioral health providers.

NYS has subsequently implemented clinical quality improvement efforts that emphasize integrated approaches, including improved standards for screening and monitoring general medical conditions among individuals with serious mental illness; incentives for integration between behavioral and general medical providers; and redesign of state financing, licensing, and regulatory policies. A description of these initiatives and their impact follows.

Monitoring medical conditions in behavioral health settings

The NYS OMH perspective is "what gets measured gets managed." This is evidenced by the NYS OMH PSYCKES (Psychiatric Services Clinical Knowledge Enhancement System) program, a Web-based clinical decision support tool that provides general medical and behavioral health data from Medicaid claims (for example, cardiometabolic monitoring and psychotropic prescription data) to support clinical quality improvement activities (9). Beginning in 2009, the NYS OMH required monitoring of cardiometabolic status and antipsychotic prescribing in all state-operated behavioral health facilities for adults, youths, and forensic populations. Subsequently, NYS OMH established standards for quarterly electronic reporting of monitoring for blood pressure, body mass index, and smoking status for all adults in state-operated outpatient settings. For youths (age 13–18), indicators include monitoring of physical activity levels; body mass index; and tobacco, alcohol, and drug use. Quarterly learning collaboratives were implemented for individual facility leaders and clinical staff to enhance buy-in, examine performance, and develop strategies for improvement—both in collection rates and in clinical interventions that improve individuals' health and wellness.

Uptake of this initiative took time, from the mechanics of ordering scales to weigh individuals to addressing clinical practices and culture ("We are a mental health clinic; we don't put blood pressure cuffs on people"). Clinical leadership was held accountable, however, and adherence to monitoring protocols improved significantly over two years. Monitoring for cardiometabolic risk factors is now a routine part of the shared decision-making process between the clinician and individual in these programs (10,11). A recent review of approximately 4,000 NYS OMH adult inpatients showed that cholesterol levels dropped over time and that levels were significantly lower than the national norm for this population, even when adjusted for age (12).

In parallel with the cardiometabolic monitoring project, NYS OMH implemented a requirement for systematic assessment of antipsychotic polypharmacy in state-operated facilities. A checklist was created to promote evidence-based antipsychotic medication prescribing and to foster individual (and family) attention to health, wellness, and recovery needs (13). The SHAPEMEDs checklist addresses Side effects of the medication, physical Health issues of the individual, Adherence, individual Preference, Expense (to the individual and for the system as a whole), and MEDication monitoring. SHAPEMEDs was implemented in all state-operated facilities in 2009, and its uptake exceeded 80% statewide in 2012, involving more than 15,000 individuals who were being prescribed antipsychotic medications. As with the cardiometabolic indicators project, NYS OMH used learning collaboratives, frequent engagement of local champions at state-operated facilities, and data-driven accountability as strategies to ensure success of this initiative.

Building on the foundation of SHAPEMEDs, NYS OMH launched "The Clozapine Campaign" in 2012, a best-practices initiative to increase the appropriate utilization of clozapine among individuals with persistent disability and impaired quality of life. This campaign also monitors facility and practitioner performance, openly shares data among clinical leaders, includes an online clinical resources tool kit, and provides an on-call expert clozapine consultation service to assist prescribers with questions regarding specific cases. The online resource center includes a handbook with up-to-date clinical and academic information regarding clozapine, as well as training modules and videos for prescribers and individuals with serious mental illness. For example, one video guides prescribers in how to best approach speaking about clozapine with an individual, and another video is patient focused and empowers individuals to ask their doctor pertinent questions regarding clozapine. As with its other initiatives, NYS OMH utilized its learning collaborative, local champion, and data-accountability implementation strategy, with the expressed purpose of teaming facilities with high performance to those with low performance and sharing expert resources across the system.

Incentives for general medical and behavioral health collaboration

Hypertension, hyperlipidemia, and HbA1c (for diabetes) are now routinely monitored in primary care settings. Individuals with common behavioral health disorders, such as depression, anxiety, and substance use disorders, are predominantly seen in primary care settings, but too often these disorders are not effectively detected, diagnosed, or treated. National studies have shown that only one in five persons receives minimally adequate mental health care—and, lamentably, one in ten receives adequate monitoring for substance use disorders (14,15). Too often, a "don't ask, don't tell" culture dominates primary care practice

when it comes to the treatment of behavioral health disorders. Sadly, the results are poor health, impaired quality of life, and increased health care costs—three strikes, not the "triple aim" (16).

Proven and feasible approaches to integrating mental health care into primary care exist. The collaborative care model developed by Unutzer and colleagues (17–21) has been validated for integrating depression screening and treatment into primary care. Collaborative care involves routine screening for depression with subsequent follow-up when indicated, monitoring with a depression registry (not unlike a diabetes registry), patient education with care managers, and specialty behavioral consultation with collaborating psychiatrists when there is a lack of therapeutic improvement. Moreover, 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 had a true impact: summaries of more than 80 replication studies, as well as return-on-investment data, are available through the University of Washington's Advancing Integrated Mental Health Solutions Center (uwaims.org).

In October 2012, through a partnership between the NYS OMH and the NYS Department of Health, NYS implemented its own collaborative care project at 22 primary care training clinics at academic medical centers statewide. The initiative will train primary care providers to screen for and treat depression, use care managers to engage and educate individuals, and have psychiatrists available to consult regarding individuals whose depression scores show little evidence of improvement. The NYS Collaborative Care Initiative is using quality improvement techniques to raise the bar of clinical practice, promote cost containment, and, most important, improve clinical outcomes.

NYS Medicaid reform

Integration of general medical and behavioral health services is also a guiding principle and a keystone to NYS Medicaid redesign. This commitment is evident in two major redesign initiatives: health homes and behavioral health managed care. In 2012, NYS opted to implement the Medicaid health home option outlined in the Affordable Care Act. In NYS, more than 800,000 individuals met the federal health home eligibility criteria: the presence of two or more chronic illnesses (diabetes, asthma, heart disease, and obesity) or one serious and persistent mental illness (4). As outlined by the Centers for Medicare and Medicaid Services, health homes provide a person-centered system of care that includes coordination of general medical, behavioral, and community-based health services and supports in an effort to improve the quality of care and contain costs (22,23). NYS has approved some health homes that have behavioral health providers as the lead agency in order to take advantage of these providers' expertise in engaging high-need individuals with serious mental illness. Accordingly, NYS will give enrollment priority for these individuals to providers whose specialty is integrated care.

A total of 37 health homes are now operating in NYS, several of which have behavioral providers as lead agencies. Each assigned recipient has an identified health-home care coordinator who is responsible for establishing a comprehensive care plan. All providers serving an individual will have access to this plan. When fully operational, health homes are expected to enable collaboration and coordination of services heretofore not available. Health home performance measures will include both behavioral indices (for example, follow-up after hospitalization and antidepressant and antipsychotic management) and general medical indices (for example, appropriate care for asthma and cardiometabolic conditions).

Cost containment is essential too. Although NYS has contracted for more than 15 years with managed health care organizations to oversee general medical services, individuals with serious mental illness and substance use disorders have been excluded from managed health care enrollment. NYS Medicaid redesign will require that all Medicaid recipients be enrolled in capitated managed health care plans beginning in 2014. This means an end to fee-for-service payments by Medicaid for behavioral health services, which had persisted in NYS (unlike most states) for about 50% of the state's Medicaid recipients.

An important design feature of NYS managed care involves the distribution of funds to manage behavioral health services via plans that are already contracted to manage general medical services for NYS Medicaid recipients. This will diminish fragmentation that can be seen with carved-out plans and encourages integration of benefits and care coordination. Moreover, NYS mental health and substance use regulatory authorities will establish clinical standards for integrated health care plans to address behavioral health network adequacy, adherence to practice guidelines, and outreach and engagement protocols for individuals with high service needs. Meeting these standards will require effective partnerships among behavioral health providers, managed care plans, and public authorities. NYS Medicaid design envisions managed care plans that are responsible for both general medical and behavioral health services at all times.

The NYS mental health and substance abuse treatment agencies will also participate in oversight of plan performance to ensure that quality of integrated health care improves amid fiscal consolidation. Clinical performance will be tracked with measures of continuity of care (for example, time to initial appointment after referral), engagement and retention in care (for example, rates of sustained attendance in community-based programs), medication choice with patterns of prescribing and adherence, and access to specialty behavioral health services. Current NYS OMH quality-monitoring initiatives and performance objectives will extend, through Medicaid managed care plans, to the behavioral health providers who will serve individuals in state-operated programs. Goals include greater access to preventive care, primary care, and health and wellness programs, as well as better access to mental health and substance abuse treatment services when needed.

Conclusions

If crisis offers opportunities, then this is surely an opportune time in behavioral health care. All states, including NYS, face crushing financial and public health challenges. There is, however, an emerging body of services research that not only highlights the need for greater integration of general medical and behavioral health care but also provides evidence for its clinical and cost-effectiveness. Adoption of quality improvement initiatives and evidence-based practices that promote integration can initially increase provider burden, and culture change is a slow process. But with health and mental health transformation under way and a "triple aim" mandate that cannot be avoided, the future of public behavioral health services is simple: Lead or be left behind. The implications are huge for the health and well-being of individuals served by the public health system.

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References

1. Druss BG, Walker ER: Mental Disorders and Medical Comorbidity. Research Synthesis Report 21. Princeton, NJ, Robert Wood Johnson Foundation, Synthesis Project, 2011. Available at www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438/subassets/rwjf69438_1
2. Alwan A (ed): Global Status Report on Noncommunicable Diseases 2010. Geneva, World Health Organization, 2011
3. Redesigning the Medicaid Program: Medicaid Redesign Team (MRT), Behavioral Health Reform Work Group, Final Recommendations. Albany, New York State Department of Health, 2011. Available at www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf
4. A Plan to Transform the Empire State's Medicaid Program: Better Care, Better Health, Lower Costs—Multi-Year Action Plan. Albany, New York State Department of Health, 2012. Available at www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf
5. Smith TE, Sederer LI: Changing the landscape of an urban public mental health system: the 2008 New York State/New York City Mental Health–Criminal Justice Review Panel. Journal of Urban Health 87:129–135, 2010
6. Smith TE, Appel A, Donahue SA, et al: Use of administrative data to identify potential service gaps for individuals with serious mental illness. Psychiatric Services 62:1094–1097, 2011
7. Smith TE, Appel A, Donahue SA, et al: Using Medicaid claims data to identify service gaps for high-need clients: the NYC Mental Health Care Monitoring Initiative. Psychiatric Services 62:9–11, 2011
8. Smith TE, Appel A, Donahue SA, et al: Determining engagement in services for high-need individuals with serious mental illness. Administration and Policy in Mental Health and Mental Health Services Research (Epub ahead of print, May 1, 2013)
9. Finnerty MT, Kealey E, Leckman-Westin E, et al: Long-term impact of Web-based tools, leadership feedback, and policies on inpatient antipsychotic polypharmacy. Psychiatric Services 62:1124–1126, 2011
10. Mangurian C, Essock SM, Sederer LI: Incentives to reduce metabolic side effects of antipsychotics (letter reply). Psychiatric Services 62:1235–1236, 2011
11. Mangurian C, Miller GA, Jackson CT, et al: Physical health screening in state mental health clinics: the New York health indicators initiative. Psychiatric Services 61:346–348, 2010
12. Essock SM, Jackson CT, Kent L: Unexpectedly low cholesterol levels among New York State inpatients. Psychiatric Services 63:294–295, 2012
13. Sederer LI, Lieberman JA: Is Your Doctor Using a Checklist? Huffington Post, Feb 23, 2010. Available at www.huffingtonpost.com/lloyd-i-sederer-md/is-your-doctor-using-a-ch_b_473068.html
14. Wang PS, Demler O, Kessler RC: Adequacy of treatment for serious mental illness in the United States. American Journal of Public Health 92:92–98, 2002
15. Wang PS, Lane M, Olfson M, et al: Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. Archives of General Psychiatry 62:629–640, 2005
16. Berwick DM, Nolan TW, Whittington J: The triple aim: care, health, and cost. Health Affairs 27:759–769, 2008
17. Unützer J, Katon W, Callahan CM, et al: Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA 288:2836–2845, 2002
18. Katon W, Russo J, Lin EH, et al: Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. Archives of General Psychiatry 69:506–514, 2012
19. Unützer J, Katon WJ, Fan MY, et al: Long-term cost effects of collaborative care for late-life depression. American Journal of Managed Care 14:95–100, 2008
20. Unützer J, Schoenbaum M, Druss BG, et al: Transforming mental health care at the interface with general medicine: report for the President's Commission. Psychiatric Services 57:37–47, 2006
21. Miller BF, Druss B: The role of family physicians in mental health care delivery in the United States: implications for health reform. Journal of the American Board of Family Medicine 26:111–113, 2013
22. Mechanic D: Seizing opportunities under the Affordable Care Act for transforming the mental and behavioral health system. Health Affairs 31:376–382, 2012
23. Bao Y, Casalino LP, Pincus HA: Behavioral health and health care reform models: patient-centered medical home, health home, and accountable care organization. Journal of Behavioral Health Services and Research 40:121–132, 2013