



Domain 3 Projects

3.a.i Integration of Primary Care and Behavioral Health Services

Project Objective: Integration of mental health and substance abuse with primary care services to ensure coordination of care for both services.

Project Description: Integration of behavioral health and primary care services can serve 1) to identify behavioral health diagnoses early, allowing rapid treatment, 2) to ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects, and 3) to de-stigmatize treatment for behavioral health diagnoses. Care for all conditions delivered under one roof by known healthcare providers is the goal of this project.

The project goal can be achieved by 1) integration of behavioral health specialists into primary care clinics using the collaborative care model and supporting the PCMH model, or 2) integration of primary care services into established behavioral health sites such as clinics and Crisis Centers. When onsite coordination is not possible, then in model 3) behavioral health specialists can be incorporated into primary care coordination teams (see project IMPACT described below).

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones & Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

There are three project areas outlined in the list below. Performing Provider Systems (PPSs) may implement one, two, or all three of the initiatives if they are supported by the Community Needs Assessment.

Any PPS undertaking one of these projects is recommended to review the resources available at <http://www.integration.samhsa.gov/integrated-care-models>.

A. *PCMH Service Site:*

1. Co-locate behavioral health services at primary care practice sites. All participating primary care providers must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by Demonstration Year (DY) 3.
2. Develop collaborative evidence-based standards of care including medication management and care engagement process.
3. Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
4. Use EHRs or other technical platforms to track all patients engaged in this project.



- B. *Behavioral Health Service Site:*
1. Co-locate primary care services at behavioral health sites.
 2. Develop collaborative evidence-based standards of care including medication management and care engagement process.
 3. Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
 4. Use EHRs or other technical platforms to track all patients engaged in this project.
- C. *IMPACT:* This is an integration project based on the Improving Mood - Providing Access to Collaborative Treatment (IMPACT) model. IMPACT Model requirements include:
1. Implement IMPACT Model at Primary Care Sites.
 2. Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.
 3. Employ a trained Depression Care Manager meeting requirements of the IMPACT model.
 4. Designate a Psychiatrist meeting requirements of the IMPACT Model.
 5. Measure outcomes as required in the IMPACT Model.
 6. Provide "stepped care" as required by the IMPACT Model.
 7. Use EHRs or other technical platforms to track all patients engaged in this project.

Project Response & Evaluation (Total Possible Points – 100):

2. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

- a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

PCMH SITES: CNA survey reports 54.7% of the target Suffolk County Medicaid population reported chronic symptoms of depression (total population 27.3%). In a survey of providers, 72% reported mental health (MH) issues and 60% reported substance use disorders (SUD) as major clinical gaps in the County. Medicaid claims indicate that significant MH issues are the most prevalent condition in Suffolk. SPARCS data indicate the primary driver of hospital admissions is all behavioral health (BH) conditions combined, while MH issues are the number one driver of emergency department (ED) visits, with SUDs second. In 2012 Stony Brook's Omnibus Survey indicated only 35%-45% of survey respondents were asked by their primary care provider (PCP) about emotional health and/or alcohol use, with lower percentages for Blacks and Latinos. BH resources across disciplines are fewer per 100,000 than other areas of NY. We will expand BH resources and co-locate BH providers in 40 PCP sites meeting NCQA PCMH standards by DY3. Standards of care will be applied and collaboration fostered through communication and EHR protocols, including dedicated coordination with existing Health Home resources. Through the use of evidence-based screening (PHQ/SBIRT), individuals will be identified, educated, tracked through EHR and connected to services. Training, like that offered



by The Reach Institute, will be leveraged to educate PCPs about prescribing for BH conditions. BH SITES: Key informant interviews and Office of Mental Health (OMH) Patient Characteristic Survey data indicate that individuals with serious mental illness are not routinely engaged in primary care. Approximately 50% of those attending OMH programs have a chronic medical condition. OMH Behavioral Health Organization (BHO) data notes only 50-60% of those with medical needs at discharge have a medical appointment within 45 days. We will co-locate primary care at 8 BH sites to improve access and outcomes and ensure integration. The same standardization of care and use of IT platform/EHR protocols noted above will be applied in these settings.

IMPACT SITES: Because not all sites will be able to accommodate co-location, a collaborative care model will be used to foster coordination based on geography and practice needs. The roll-out will be established with fidelity to the model, including screenings, designated case manager (CM), dedicated psychiatrist time based on practice needs, treatment options, and appointments available with BH specialists within 4 weeks. Standardization of care and use of IT platform/EHR protocols noted above will also be applied in these settings.

- b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

PCMH/IMPACT SITES: The target population includes all Medicaid patients in the participating safety net primary care and Federally Qualified Health Center (FQHC) practices. The project will be rolled-out first to primary care sites with high Medicaid population volumes and geographies that have been identified from CNA data as hotspots for disparities (Wyandanch, Brentwood, Patchogue and Southampton), where significantly higher percentages of residents are Black and Latino. This project will then expand to include patients in lower volume and non-safety net PCP sites as the project progresses.

BH SITES: Targeted population will be Medicaid patients who are cared for at 8 participating OMH/Office of Alcoholism and Substance Abuse Services (OASAS) licensed programs; including patients being discharged from hospitals to OMH/OASAS licensed programs who are not currently receiving primary care. These care sites provide care and resources for a high volume of Medicaid patients, particularly in the geographies as noted above where high disparities in care exist. The target population will increase over time as a result of the efforts to engage the uninsured population. We will work collaboratively to ensure those who have recently become eligible for Medicaid, i.e. those released from jail, to ensure they have proper follow-up care.

- c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

County resources include: 4 Article 31 and 11 Article 28 hospitals, 7 Assertive Community



Treatment teams and mobile crisis, 1 Comprehensive Psychiatric Emergency Program, 27 OMH clinics, 15 Personalized Recovery Oriented Services, 1 children's MH day program, 2 psychiatric partial hospitals, 2000+ Residential congregate, apartment and supported housing sites, 42 OASAS clinics/satellites, 5 hospitals providing detox and rehab, 4 Methadone Maintenance clinics, 74 voluntary Office for People With Developmental Disabilities (OPWDD) agencies, 385 psychiatrists, 872 psychologists, 2,349 social workers, 353 licensed mental health counselors, 22 licensed behavior analysts, 3 Health Homes with legacy CM providers.

ASSETS/RESOURCES PCMH/IMPACT SITES: 1) Hampton Community Health Care, East End Pediatrics, South Oaks, Family Service League and Association for Mental Health and Wellness (MHAW) have all piloted integration models. We will leverage/mobilize their expertise for training/mentoring and will be among the first sites implemented within the program. 2) Brookhaven has conducted collaborative care for 5 years in a PCMH level 2 and is rolling out the model in other PCP practice and will implement a PCMH at their recently-opened Bellport Primary Care Center. Brookhaven's Mental Health/Chemical Dependency clinics in Shirley and Patchogue are already referring patients needing a PCP. 3) HRH Care, an FQHC network with PCMH level 3 standing in sites outside Suffolk, is operating or taking over 11 primary care clinics in Suffolk to be transformed into PCMH/FQHCs leveraging HRH's experience. 4) 6 OPWDD licensed Article 28 diagnostic and treatment centers have some co-located BH services and will become PCMHs/FQHCs with expanded capacity.

ASSETS/RESOURCES BH SITES: 1) MHAW has peer staff and one supervisor practicing as Peer Health coaches using SAMHSA's Wellness Health Action Management. This training/expertise will be leveraged/mobilized to expand this resource. 2) OMH licensed programs with current integration models will expand this capability to other sites and provide technical assistance to others developing this "reverse" integration model. 3) The Quality Consortium, a coalition of OASAS providers including many PPS members, will be leveraged to continue campaigns with hospitals/PCPs to promote screening and heighten awareness of resources. 4) Local BH experts have presented on integration locally/nationally and will be mobilized to deliver training/mentoring. Three Health Homes in Suffolk County are enrolling patients who are receiving treatment in these same care settings. The Health Home CMs will be leveraged to continue their foundational support for this highest risk population as well as to learn from their knowledge of the community and community based resources.

- d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.



INFRASTRUCTURE CHALLENGES: 1) Hire more BH staff, existing staff must adjust to new model. 2) Agencies may not be able to meet the demand as additional people in need are identified. 3) Demand for CM outstrips supply. REMEDIES: 1) Experienced staff will train providers and develop curricula for future workforce. Stony Brook's Psychiatry Residency is developing a community-based Residency to expand the number of psychiatrists. 2) Address through workforce training and a web-based platform for disease self-management and telepsychiatry. 3) CM structure and workforce strategy is planned under project 2.a.i.

PROVIDER CHALLENGES: 1) PCPs/FQHCs may struggle with PCMH standards. 2) PCPs lack understanding of antidepressant medication management (AMM), documentation and treatment of BH conditions. 3) Overall provider participation. REMEDIES: 1) Leverage Current PCMH providers to provide technical assistance. 2) Engage prescribing experts to provide education and work with payers to improve AMM HEDIS measures. 3) Align providers through pay for performance incentive.

PATIENT CHALLENGES: 1) Language, health literacy, cultural competency barriers 2) Food/housing issues for target population 3) Transportation and health care access challenges. REMEDIES: 1) Provide access to Spanish speaking providers, patient materials translated, and at 5th grade reading level. Staff training on cultural competency 2) Address through geographic collaboratives linking sites with CM, housing providers, food pantries. 3) CM Service Dollars for legacy providers available for medical/non-medical transportation, but will build additional resources.

- e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

3. Scale of Implementation (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress



towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? *(Please mark the appropriate box below)*

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>

If yes: Please describe why capital funding is necessary for the Project to be successful.

Facility Costs - The project will require renovations/reconfiguration of space in several of the sites. An additional capital expense is anticipated for an expansion of a specific behavioral health site to increase its capacity to deliver on-site primary care/wellness services to the target population in a high volume region of Suffolk.

Equipment - Furthermore, it is anticipated that office furniture, computer stations and/or tablets will be needed in a number of sites for the co-located staff.

Care Management – The major capital resources for care management (tele-health, space, technology, equipment etc.) are included in the IDS project but will be allocated to this project on a proportional basis.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project’s objective?

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.

Name of Entity	Medicaid/ Other Initiative	Project Start Date	Project End Date	Description of Initiatives
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New York Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Project Plan Application

Name of Entity	Medicaid/ Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Town of Smithtown Horizons Counseling and Education Center	Federal BLOCK grant preceded Medicaid redesign; also participating in "Reconnecting Youth" Program			Reduce smoking among patients with MEB disorders



New York Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Project Plan Application

Name of Entity	Medicaid/ Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Town of Babylon Division of Drug and Alcohol Services: Beacon Family Wellness Center				Prevent SA in town of Babylon residents through education and treatment services and partnership in community coalitions. Reduce/prevent mental illness symptoms in patients in SA programs. Provide smoking cessation education/resources to town of Babylon residents and patients in SA program



New York Department of Health
 Delivery System Reform Incentive Payment (DSRIP) Program
 Project Plan Application

Name of Entity	Medicaid/ Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Central Nassau Guidance & Counseling Service				3-year grant for on-site primary care; also received OMH funding for short-term crisis respite - hospital division - 2 years
Long Island Association for AIDS Care	Health Homes			Case management / care coordination
Gurwin Jewish Nursing & Rehabilitation Center	GNYHA NY-RAH	9/23/ 2012	9/22/ 2012	To increase tool usage, Stop & Watch SBAR to recognize ACOC to reduce avoidable hospitalizations in the LT population
St. Christophers Inn				Bx LEB PPS



Name of Entity	Medicaid/ Other Initiative	Project Start Date	Project End Date	Description of Initiatives

- c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

5. **Domain 1 DSRIP Project Requirements Milestones & Metrics:**

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March



1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

- c. Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.
- d. Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.