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Delivery System Reform Incentive Payments (DSRIP) Stony Brook Medicine

Domain 3: Primary Care-Behavioral Health Integration
AND Domain 4 Project Choice

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DSRIP PURPOSE

- The waiver amendment dollars will address critical issues throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program.

- The DSRIP program will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years.

- Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement.

- Single providers will be ineligible to apply. Stony Brook is lead for Suffolk County and a minimum of one Behavioral Health project is mandatory.

- All DSRIP funds will be based on performance linked to achievement of project milestones.

Source: NYS DOH DSRIP website

SINCE THE LAST MEETING

- xG conducting sampling of key informant interviews and wrapping that up shortly.
- Needs data tabulation nearly complete and will be presented at the PAC meeting on 9/15.
- Significant needs in the area of behavioral health clearly rising to the surface.
- Champions continue to be identified across projects by providers and small work groups being formulated – people expressing interest and noted same in survey.
- Meetings and outreach to safety net PCPs being conducted.
- Individual discussions with many providers/organizations about DSRIP direction, opportunities and goals.

Dialogues held with individual providers pertaining to broad DSRIP concepts:

- Care Coordination capabilities/Capacity for expansion
- Health Home providers' direct connection to every hospital.
- OMH System Transformation (RCE) reinvestment $$ flowing through County for related projects will potentially work in tandem with DSRIP projects.
- Potential Psychiatry Residency Program expansion to increase County's capacity. Rotations in various locations.
- School district involvement.
- Data analysis of hospital patients with co-morbid mental illness and/or substance use disorders and roll out of SBIRT
- Need for Community Health Workers conducting home visits.
- Potential expansion of Mobile Crisis Team resources and observation initiatives
- Direct collaboration across all projects with HRH and their PCMH/FQHC locations
- Developmental Disabilities Agencies for Primary Care integration in Article 28 locations (7 D & T Centers)
- Nurse Practitioner practices across Suffolk expressing interest in collaboration

- **Domain 3: Primary Care-BH Integration - Ambulatory Focus**

  - ***Primary Care*** use of screenings for early identification BH concerns
    - roll out in stages, by location, for Years 1-3.
    - For inclusion - FQHCs, D & T Centers, Private PCP Offices (MD's and NP's)
  - ***Collaboration/co-location*** of BH providers with all Primary Care locations.
    - warm hand-offs, brief interventions, consultation, telepsychiatry, health home referrals, support/peer connections, housing, food, etc.
  - ***Fast track*** referrals from Primary Care to geographically close BH partners when co-located services are not feasible.
  - ***Proactive*** connection to Care Coordination Providers and Case Management.
  - ***Reverse*** integration relationships between primary care and BH providers particularly for medically high-risk population.
  - ***Expanded collaboration and use*** of available services such as Respite, Care Management, Mobile Crisis Team and pilot licensed crisis beds as well as respite beds.
  - ***Data Collection*** matrix across all DSRIP projects to monitor metrics through IT.

4.a.ii Prevent Substance Abuse and other Mental Emotional Behavioral Disorders

Healthcare Delivery System Sector Projects: PPS must show implementation of two of the three sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population. For each sector project, there is a list of potential interventions that the PPS can use to develop its project. These interventions are found on the Prevention Agenda website under "Interventions to Promote Mental Health and Prevent Substance Abuse" (http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/interventions.htm).

1. Identify and implement evidence-based practices and environmental strategies to prevent underage drinking, substance abuse and other MEB disorders.
2. Consider evidence based strategies to reduce underage drinking such as those promulgated by the U.S. Surgeon General and the Centers for Disease Control and Prevention.
3. Increase understanding of evidence-based practices for smoking cessation among individuals with mental illness and/or substance abuse disorder.

HOW WILL WE ADDRESS DOMAIN 4?

1. **Implementation of SBIRT Protocol across settings.**

2. **Reduce tobacco use among adults who report poor mental health.**

- Adopt tobacco-free regulations in all mental health facilities, as substance-abuse facilities have done.
- Assess the feasibility of expanding the Medicaid benefit for smoking cessation services such as medication for four 90-day courses of treatment a year for individuals with MEB disorders. Individuals with MEB disorders likely benefit from a longer duration of treatment.
- Identify and support interventions to address disparities in smoking rates for those with poor mental health.
- Support and strengthen licensing requirement to include improved screening and treatment of tobacco dependence by mental health providers as is already implemented by substance abuse providers.
- Expand efforts with DOH Tobacco Control Program and OMH Personalized Recovery Oriented Services Program (PROS) throughout New York State

Domain 4: Hospital-Based Focus Areas

- ***SBIRT*** in Emergency Departments and for all admitted patients in every Suffolk hospital connecting patients to community-based substance use disorder and mental health resources. Clear documentation of concerns in EMR so PCPs are aware through EMR IT connection.

- ***Psychiatry Consult-Liaison services*** strengthened in Hospitals for medical patients, as well as those identified through SBIRT, and "beefing up" discharge plans to ensure both medical and BH needs are met. – Collaboration with Health Homes.

- ***Telepsychiatry*** available in the EDs to more efficiently identify level of care needs and connect patients to resources appropriately when screening through SBIRT or otherwise.

- ***Collaboration/Co-location*** of BH providers in EDs through geographic partnerships to capture those in need at the point of care.

- ***Partnerships with Health Home/Care Management*** agencies for warm hand-offs at the hospital point of care.

- ***Expand*** observational capacity across hospitals for patients who may not need a longer-term admission.

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SBIRT IMPLICATIONS GOING FORWARD

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. **A big part of SBIRT is about education at the point of care. Only a percentage of individuals will need a formal intervention or referral to treatment.**

- Screening quickly assesses the severity of substance use and identifies the appropriate level of education, intervention and treatment. Can include at least 2 depression screening questions.
- Specific screening questions will be used across sites as part of the evidence-based model.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.
- Reduces ED visits, hospitalizations and long-term complications from use.
- Achieves DSRIP goals.

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SAMPLE OF DRG IMPLICATIONS FOR PATIENTS WITH SUBSTANCE DEPENDENCE

For hospitals, in the present fee-for-service reimbursement environment, alcohol and drug dependence have implications with respect to DRG payments. Identifying patients so that immediate interventions can be made is step 1, documenting the disorders properly is step 2. Getting people the ongoing services they need, the most important component, is step 3.

Examples of codes and the documentation needed:**

291.0 alcohol withdrawal with delirium tremens) CC
291.2 alcohol dementia CC
291.3 alcohol induced psychotic disorders with hallucinations CC
291.81 alcohol withdrawal CC
291.89 alcohol induced anxiety, mood disorder or sexual dysfunction CC
291.9 alcohol induced mental disorder (mania or psychosis) CC
292.0 drug withdrawal CC
292.11 drug induced psychotic disorder with delusions CC
292.12 drug induced psychotic disorder with hallucinations CC
292.81 drug induced delirium CC
292.82 drug induced dementia CC
304.01 opioid dependence, continuous CC
304.11 sedative, hypnotic dependence, continuous CC
304.21 cocaine dependence, continuous CC
304.41 amphetamine dependence, continuous CC
304.51 hallucinogen dependence, continuous CC
304.61 other specified drug dependence, continuous CC
304.71 combination of opioid drug with other drug dependence, continuous CC
304.81 combinations of drug dependence excluding opioid, continuous CC
304.91 unspecified drug (drug addiction) dependence, continuous CC

** This is simply a sample of how important it is to identify and document what is going on with patients and how to get them the help they need.

Something that impacts everything:

Care Coordination

Who is doing this?

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WHO IS AVAILABLE FOR CARE COORDINATION?

HEALTH HOME CARE COORDINATION AGENCIES IN SUFFOLK COUNTY

AGENCY	PROGRAM DIRECTOR	PHONE
Clubhouse	Andrea Hopkins	369-4418 X 1107
Family Service League	Kate Bishop	647-3117 X 26101
Federation	Veronica Harkins Tracy Faulkner Dina Vagelatos (SWP HH) Oneka Graham (NS/LIJ HH)	669-5355 X 1203 447-6460 X 2124 447-6460 X 5800 447-6460 X 4111
FEGS	Melissa Firmes Kerri Tamer	691-7080 X 332238 691-7080 X 332246
Pederson-Krag	Rosemary Sanchez-Moralez Jennifer Marino	920-8303
Sayville	Bridget Baio Charlene Tyson	563-2290
SC ICM	Galal Alzokm	761-4154
EOC of Suffolk	Nicole Mills Jennifer Jusu	968-8000 X 610 968-8000 X 603
LIAAC/Tri-Care	Andrea Smith	656-7219
Options for Community Living	Allison Covino Nicole Benjamin	361-9020 X 206 361-9020 X 190
The Outreach Program (MATS)	Mary Brite	286-0700

Source: Suffolk County Division of Mental Hygiene

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What does Care Coordination and Case Management need to look like going forward?

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BH DSRIP METRICS

Domain 3. Clinical Improvement Metrics

All Domain 3 metrics are pay-for-reporting in DY 1. As described below, some metrics continue as pay-for-reporting in DY 2-3 but become pay-for-performance in DY 4-5. In general, provider systems will include all metrics associated with the project selected, unless otherwise specified below.

Domain 3 – Clinical Improvement Metrics								
						DSRIP Years 2 – 3		DSRIP Years 4 - 5
	Measure Name	**Measure Steward**	**NQF#**	**Source**	**Measure Type**	**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
A. Behavioral Health (Required) – All behavioral health projects will use the same metrics except for SNF programs implementing the BIPNH project. These providers will include the additional behavioral health measures below in A-2.								
	PPV (for persons with BH diagnosis)	3M		Claims	Outcome	Performance		Performance
	Antidepressant Medication Management	NCQA	0105	Claims	Process	Performance		Performance
	Diabetes Monitoring for People with Diabetes and Schizophrenia	NCQA	1934	Claims	Process	Performance		Performance
	Diabetes Screening for People with Schizo./BPD Using Antipsychotic Med.	NCQA	1932	Claims	Process	Performance		Performance
	Cardiovascular Monitoring for People with CVD and Schizo.	NCQA	1933	Claims	Process	Performance		Performance
	Follow-up care for Children Prescribed ADHD Medications	NCQA	0103	Claims	Process	Reporting		Performance
	Follow-up after hospitalization for Mental Illness	NCQA	0576	Claims	Process	Performance		Performance
	Screening for Clinical Depression and follow-up	CMA	0418	Medical Record	Process	Reporting		Performance
	Adherence to Antipsychotic Medications for People with Schizophrenia	NCQA	1879	Claims	Process	Performance		Performance
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA	0004	Claims	Process	Performance		Performance
A – 2. Additional behavioral health measures for provider systems implementing the Behavioral Interventions Paradigm in Nursing Homes (BIPNH) project								
	PPR for SNF patients	3M		Claims	Outcome	Performance		Performance
	Percent of Long Stay Residents who have Depressive Symptoms	CMS		MDS 3.0	Process	Performance		Performance
B. Cardiovascular Disease								
	PQI # 7 (HTN)	AHRQ		Claims	Outcome	Performance		Performance

Partnership Plan - Approval Period: August 1, 2011 – December 31, 2014; as Amended April 14, 2014

Source: NYS DOH DSRIP website

Based on NYS DOH Prevention agenda

Promote Mental Health & Prevent Substance Abuse

- Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month BRFSS Statewide NYC/ROS County
- Age-adjusted percentage of adult binge drinking during the past month BRFSS Statewide NYC/ROS County
- Age-adjusted suicide death rate per 100,000 NYS NYSDOH Vital Statistics State, county.

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WHAT IS NEEDED FROM YOU?

August:

- Continue face-to-face meeting participation on **8/28.**
- Indication that your organization is on-board by **8/28**.
- Geographic locations and delineation of services by **8/28**.
- Champion(s) of project and contact info in each location by **8/28**.

September:

- Needs assessment data supporting need for integration by **9/15**.
- IT capabilities and anticipated IT needs/interests/concerns by **9/15**.
- Capital budget needs and staffing/other budget needs by **9/30**.

October-November:

- Narrative components assigned to you.
- Participation in a minimum of 2 meetings per month from now until **11/26** with conference calls as needed.
- Assistance with drafting the application from now until **11/26**.

Ongoing:

- Complete commitment to regional roll-out upon award **for next 5 years**.
- Ongoing dedication of administrative and “boots on the ground” resources to move project forward **for next 5 years**.

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MEETING DATES

Face-to-Face meeting dates, including IHI webinar series:

- August 28, 2014 — 1:30pm-5:00pm OVP Conference Room – HSC Level 4
  Meeting & IHI Webinar
- September 11, 2014 — 1:30pm-5:00pm Lobby Conference Room
  Meeting & IHI Webinar
- September 25, 2014 — 1:30pm-4:30pm Lobby Conference Room
  Meeting & IHI Webinar
- October 9, 2014 — 1:30-5:00pm OVP Conference Room – HSC Level 4
  Meeting & IHI Webinar
- October 30, 2014 — 2:30pm-4:30pm Lobby Conference Room
  Meeting Only
- November 20, 2014 — 3:00pm-5:00pm Lobby Conference Room
  Meeting Only

Conference Call dates: To be determined as necessary

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