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MEETING PURPOSE

Delivery System Reform Incentive Payments (DSRIP) Stony Brook Medicine

Primary Care-Behavioral Health Integration

Set-up, Handoffs, and Communication between Diverse Disciplines in an Integrated Workforce

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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

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PROJECT CONCEPT

- Primary Care/Physical-Behavioral Health Integration
- Geographically Driven Collaborative Teams
  - Includes both primary care and behavioral health team members, as well as other key team members working together
  - Includes hospitals and behavioral health team members addressing ED visits and admitted patients
- Based on Specific Local Community Needs
  - Each community is different and may have different types of partnerships and different kinds of team members
- Routine Information Sharing & EMR Connections
  - What is needed to make communication easy?
- All Team Members Responsible to Move Metrics
  - Financial rewards are based on everyone's buy-in and success

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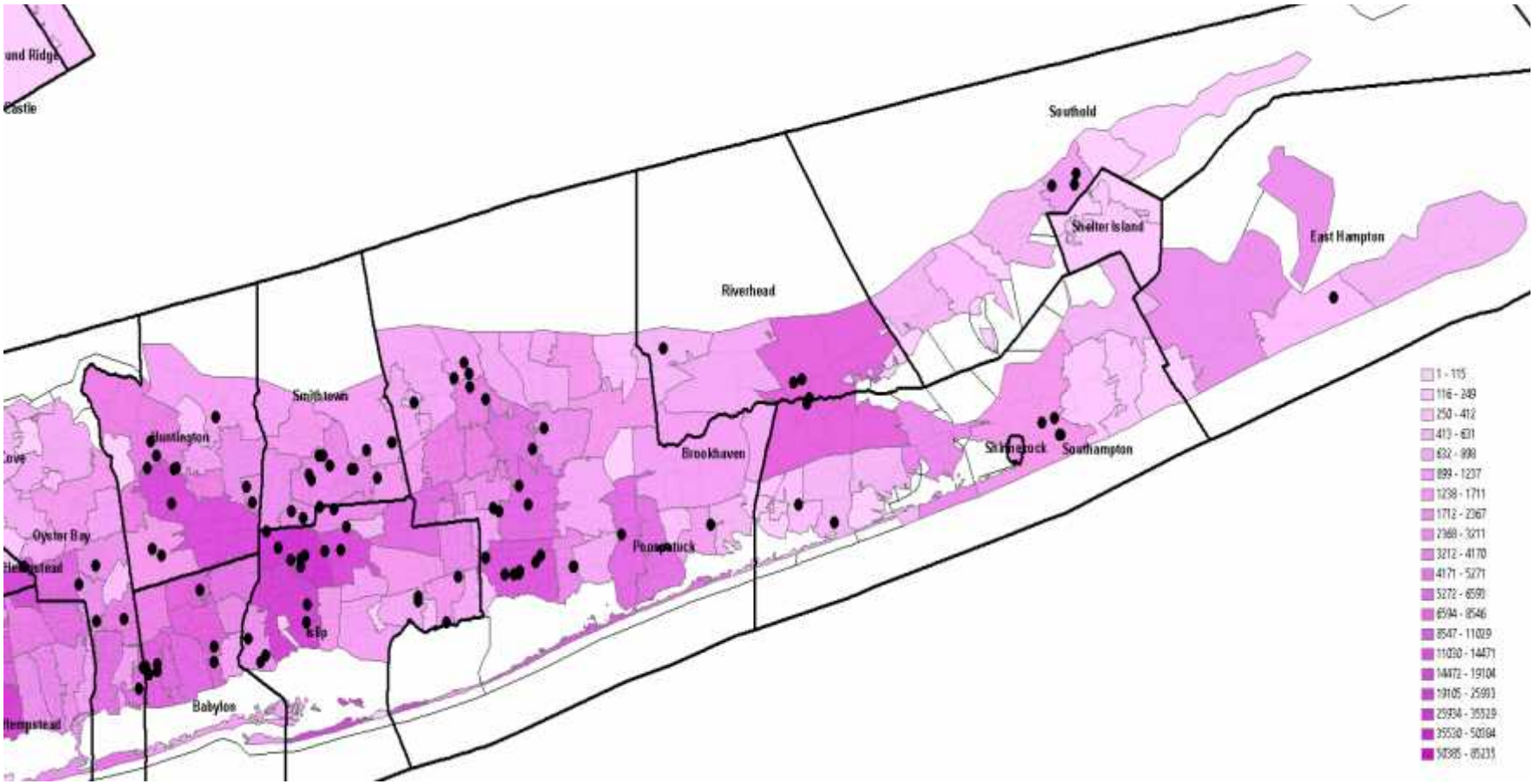
WHAT GEOGRAPHY IS INCLUDED?



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WHAT IS INTEGRATION?

- Physical-behavioral health integration is an evidence-based approach that supports collaboration between physical health and behavioral health providers to improve the identification and triage of those in need of interventions for mental health and/or substance use disorders.

- Promotes the collaboration between primary care providers, hospital medical providers, behavioral health specialists, care managers, peers and other professionals and lay persons.

- Various models of how to integrate services being implemented nationwide.

- Psychosomatic Medicine (C/L) expanding in hospitals.

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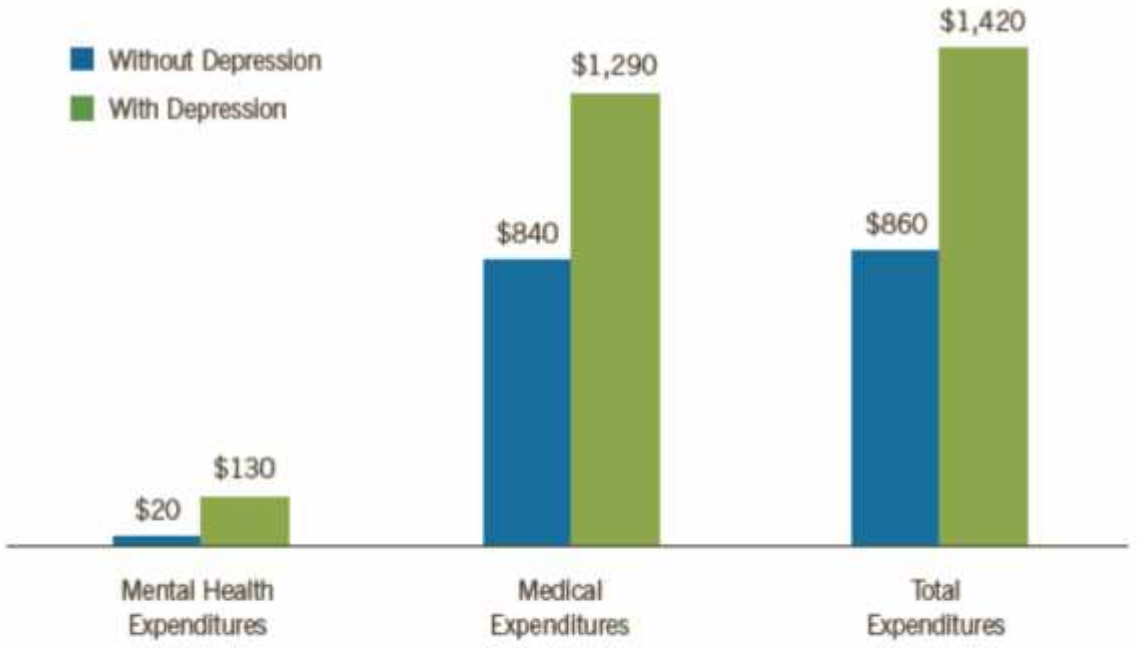
INTEGRATION BACKGROUND

- Poor outcomes and high costs for patients with medical + behavioral comorbidities.
- Getting to the Triple Aim will require addressing behavioral health.
- Changing incentives will facilitate this.*

The presence of a mental health disorder raises treatment costs for chronic medical conditions.

Chart 3: Monthly Health Care Expenditures for Chronic Conditions, with and without Comorbid Depression, 2005



Source: Melek, S., and Norris, D. (2008). *Chronic Conditions and Comorbid Psychological Disorders*. Cited in: Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

*Source: Behavioral Health Integration *Mara Laderman , MSPH and Kedar Mate, MD IHI Innovation Team Presentation 7/15/14*

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RESEARCH SNAPSHOT

DIABETES AND DEPRESSION

- Individuals with diabetes were twice as likely as a comparable sample from the general U.S. population to have diagnosed depression.
- Younger adults (<65 years), women, and unmarried individuals with diabetes were more likely to have depression.
- Patients with diabetes and depression had higher ambulatory care use and filled more prescriptions than their counterparts without depression.
- Among individuals with diabetes, total health care expenditures for individuals with depression was 4.5 times higher than that for individuals without depression ($247,000,000 vs. $55,000,000, $P < 0.0001$).

Source: Comorbid Depression is Associated With Increased Health Care Use and Expenditures in Individuals With Diabetes
Leonard E. Egede, MD, MS, Deyi Zheng, MB, PHD, Kit Simpson, DRPH (funded through a grant from AHRQ and published by the ADA in 2001)

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Non duals including children 199,389

Non dual minus children 114,607

SNAPSHOT OF SUFFOLK DATA

Chronic disease grouping	Members with condition	Members with condition who had an admission	Total inpatient admissins generated	Members with condition who had an ED visit	Number of ED Visits	% of population with an admission	Admissions per year per admitted member	% of population with ED visit	ED visits per year per visitor	% of non duals	% of non duals minus children
Mental Diseases And Disorders	72,137		14,029	34,273	22,099	72,337					
Attention Deficit / Hyperactivity Disorder	3,522	539	1,033	1,371	3,205	15.3%	1.9	38.9%	2.3	1.8%	3.1%
Bi-Polar Disorder	3,062	1,422	3,714	1,933	7,416	46.4%	2.6	63.1%	3.8	1.5%	2.7%
Bi-Polar Disorder - Severe	358	206	666	249	1,075	57.5%	3.2	69.6%	4.3	0.2%	0.3%
Chronic Mental Health Diagnoses - Minor	1,186	453	1,470	642	2,459	38.2%	3.2	54.1%	3.8	0.6%	1.0%
Chronic Mental Health Diagnoses - Moderate	668	309	909	400	1,617	46.3%	2.9	59.9%	4.0	0.3%	0.6%
Chronic Stress and Anxiety Diagnoses	7,445	1,975	4,647	3,875	12,795	26.5%	2.4	52.0%	3.3	3.7%	6.5%
Conduct, Impulse Control, and Other Disruptive Behavior Disorders	1,037	308	808	490	1,484	29.7%	2.6	47.3%	3.0	0.5%	0.9%
Depression	11,678	3,697	8,559	5,842	17,745	31.7%	2.3	50.0%	3.0	5.9%	10.2%
Depressive and Other Psychoses	4,936	2,155	5,328	2,831	9,654	43.7%	2.5	57.4%	3.4	2.5%	4.3%
Depressive Psychosis - Severe	913	554	1,610	608	2,435	60.7%	2.9	66.6%	4.0	0.5%	0.8%
Major Personality Disorders	61	49	159	49	244	80.3%	3.2	80.3%	5.0	0.0%	0.1%
Post Traumatic Stress Disorder	510	212	559	306	1,228	41.6%	2.6	60.0%	4.0	0.3%	0.4%
Schizophrenia	6,761	2,150	4,811	3,503	10,980	31.8%	2.2	51.8%	3.1	3.4%	5.9%
Substance Abuse	17,013	9,448	24,484	10,269	37,641						
Chronic Alcohol Abuse	4,369	2,298	5,733	2,521	8,885	52.6%	2.5	57.7%	3.5	2.2%	3.8%
Cocaine Abuse	1,707	1,019	2,632	1,101	3,870	59.7%	2.6	64.5%	3.5	0.9%	1.5%
Cocaine Abuse - Continuous	22	22	91	18	123	100.0%	4.1	81.8%	6.8	0.0%	0.0%
Delirium Tremens	325	314	1,007	244	1,221	96.6%	3.2	75.1%	5.0	0.2%	0.3%
Drug Abuse - Cannabis/NOS/NEC	2,891	1,484	4,148	1,782	7,156	51.3%	2.8	61.6%	4.0	1.4%	2.5%
Opioid Abuse	3,640	1,983	4,777	2,143	7,586	54.5%	2.4	58.9%	3.5	1.8%	3.2%
Opioid Abuse - Continuous	683	632	1,747	483	1,897	92.5%	2.8	70.7%	3.9	0.3%	0.6%
Other Significant Drug Abuse	3,206	1,541	3,878	1,857	6,387	48.1%	2.5	57.9%	3.4	1.6%	2.8%
Other Significant Drug Abuse - Continuous	170	155	471	120	516	91.2%	3.0	70.6%	4.3	0.1%	0.1%

Source: https://health.data.ny.gov/Health/Medicaid-Chronic-Conditions-Inpatient-Admissions-a/2yck-xisk

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SBUH SAMPLE: ADULT LONG STAY CASES SNAPSHOT

Insurance	%	Average Days
Managed Medicaid	27.66%	66
Medicaid	27.66%	70
Medicare/Medicaid	21.28%	61
Commercial	6.38%	78
Medicare	6.38%	72
Medicare/HMO	4.26%	40
Self-pay/Uninsured	4.26%	131
Managed Medicare/HMO	2.13%	31

76.6% Touch Medicaid in some way having an average of 62.44 days.

Source: Sample of 50 Long-stay cases on Stony Brook's Adult Psychiatry Unit

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LONG STAY CASES: STATISTICAL SIGNIFICANCE

When examining each variable in *isolation* with LOS the following variables were statistically significant ($p<0.05$):

- Housing Issues
- ★ Physical Health
- Awaiting Pilgrim Transfer
- 2+ Placement issues

When examining all variables *together* in multiple regression the following variables were statistically significant:

- ★ Physical Health Issues
- Medicine Non-Compliance
- ECT

Source: Sample of 50 Long-stay cases on Stony Brook's Adult Psychiatry Unit

Physical Health Issues Affecting *Placement*

- Diabetes
- Dementia
- Developmental Disabilities & Related Disorders
- Multiple Issues
- Substance Use Disorders

Other physical health issues noted

- 70% of all patients had some physical health issue(s) even if it did not affect discharge disposition

Source: Sample of 50 Long-stay cases on Stony Brook's Adult Psychiatry Unit

WHY INTEGRATE?

Primary Care

- Individuals/families that are closely connected with a PCP have a trusting relationship with that doctor
- Individuals/families are more likely to follow up with appointments either in their PCP's familiar location or coordinated by their PCP rather than traveling to a new doctor or initiating an appointment on their own
- Creates opportunity for "early" intervention
- Ensures coordinated care among specialties producing better health outcomes

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WHY INTEGRATE CONTINUED…

Hospital ED and Inpatient Units

- Attending MD is currently aware of patient symptoms and can ask for a consultation with a BH specialist
- Patient is in the hospital location where they are a "captive audience" for services to be initiated
- Creates opportunity for "earlier" intervention when on an inpatient medical unit or in an emergency department
- Better communication among all parties when rounding together

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BENEFITS OF INTEGRATION

- Better chronic disease management.
- Decreased severity of behavioral health symptoms.
- Improvements in overall health/functioning.
- Fewer ED visits and readmissions.
- Reduced primary care utilization.
- Lower mean total health care costs compared to usual care.

*Source: Behavioral Health Integration *Mara Laderman , MSPH and Kedar Mate, MDIHI Innovation Team Presentation 7/15/14*

Barriers to Integration

Barrier	Proposed Solution
FFS Environment	Creative workarounds necessary. Consider ACOs, integrated delivery systems, PCMHs.
Separate funding streams and non aligned incentives	Identify federal and state level incentives (i.e. ACA provisions, Medicaid waivers). Form "regional alliances" with like-minded organizations to increase bargaining power with payers to negotiate global payments and better rates for provision of integrated care.
Savings accrue to system, not organization that made initial investment	Create systems that understand where savings occur and 'share the savings' throughout the system if possible.
Communication between providers	Modify the electronic health record to accommodate behavioral health input.
Cultural clashes between behavioral health and primary care providers	Trainings for both types of staff to reinforce the benefits of integration for patient care. Let staff who want to leave go elsewhere and hire staff who are more open to operating in a new, integrated environment. Accept that high turnover will be an issue.
Divided leadership and low staff engagement	Leadership need to present a shared vision of integrated care to staff Redesign work so that integrated care is not added to usual work

*Source: Behavioral Health Integration *Mara Laderman , MSPH and Kedar Mate, MDIHI Innovation Team Presentation 7/15/14*

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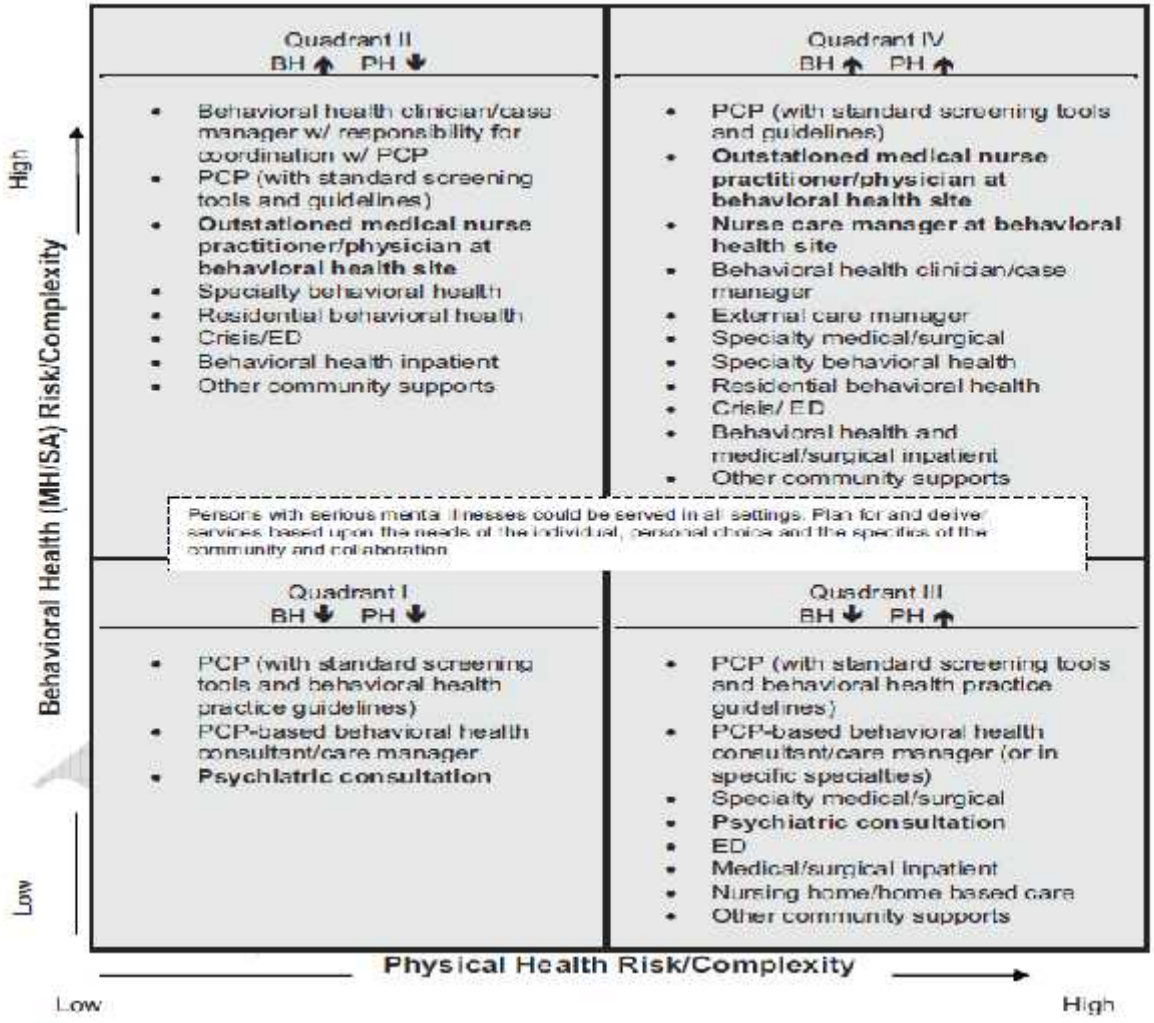
"Right Place-Right Time-Right Service"



Source: AHRQ Integration Academy

Integration May Include:

- Self-care support/peer support
- Care management and interdisciplinary care team responsible for care
- Stepped care – move patients through levels based on risk
- Routine caseload review by team, consultation, referral and FOLLOW-UP
- Integrated IT capability and shared EMR when possible
- Patient tracking and data elements collected as outcomes measures
- Adoption of evidence-based interventions/guidelines (screening/interventions)
- Engagement with social service agencies (housing, food pantry, employment, justice, etc.)

Who, What, Where, How is it set up?

- PCP Office/PCMH/FQHC
- Adults & Pediatrics
- “Reverse” Integration In Behavioral Health Settings
- Hospital Units/EDs/Ambulatory Clinics/Specialty Centers
- Health Home Initiative - Chronic Care/Care Management
- Transitional Care/Post Acute Services
- Housing Programs
- Health Education Programs
- Through Technology

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WHO WILL WORK TOGETHER?

What discipline(s) is needed?
Is more than one person necessary?

- Primary Care Physicians/Nurse Practitioners/Nurses
- Psychiatrists/Psychologists/Neuropsychologists
- Social Workers/Mental Health Counselors
- Health Coaches/Peer Specialists/Family Advocates
- Alcohol & Substance Abuse Counselors
- Care Managers/Case Managers
- Health Educators
- Residential Program Staff
- Volunteers

Who is affordable/sustainable?

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LEVELS OF INTEGRATION

Full Spectrum Integration

Layer of Service	Frequency of Interaction	Where service is provided	Who provides service	
1 – Acute Care	Continuous (during hospitalization)	Hospital	Physician	Cost ↓
2 –Clinic Care	Quarterly	Clinic	Physician; could include group visits	
3 – Community Care	Weekly; more than once a week initially	Home, workplace, community organization	Community health workers; mobile clinics. Could include group visits	
4 – Family Engagement in Care	Daily	Home	Family members	
5 – Self-care	Daily	Home	Patients	
6 - Policy and Financial Considerations				

Source: Behavioral Health Integration *Mara Laderman , MSPH and Kedar Mate, MD IHI Innovation Team Presentation 7/15/14*

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PROJECT SCOPE: WHERE TO START

TASK	TIMELINE FOR DSRIP APPLICATION	TIMELINE FOR PROJECT
Step 1: Assess readiness for integration in chosen setting a. Understand patient needs and demographics by location b. Understand PCP/clinic characteristics, culture and space needs by location. c. Understand local and state policy and regulations that need to be considered (i.e. satellite requirements, shared space issues) d. Understand financial environment and current billing mechanisms	a. August-Sept. – Prepare for Narrative b. August-Sept. – Prepare for Narrative	c. & d. Begin upon award
Step 2: Select collaborative care components and identify partnerships based on geography/regional	August-Sept. – Rough Plan for Narrative	Formalize Upon Award
Step 3: Identify and define roles of each partner.	Sept.-Oct. – Rough Plan for Narrative	Elaborate Upon Award
Step 4: Plan to operationalize components into clinical workflows. - Who, what, where, when how to be answered - Engage clinical staff in process of developing project narrative	Sept-Oct. – Rough Plan for Narrative	Solidify Plan Jan.-June 2015
Step 5: Set implementation dates and roll out Year 1 locations. - Years 2-5 to be continuously rolled out as defined by the group in the rough and finalized workplan.	October-November – Rough Workplan	Finalize Workplan Tasks Jan-June 2015 Begin Roll-Out Feb.-December
Step 6: Make Population Healthier and Receive Incentive Payments!		

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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								
	Measure Name	**Measure Steward**	**NQF#**	**Source**	**Measure Type**	**DSRIP Years 2 3 Pay for Reporting/Pay for Performance**		**DSRIP Years 4 5 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) Antidepressant Medication Management	3M NCQA	 0105	Claims Claims	Outcome Process	Performance Performance		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 Cardiovascular Monitoring for People with CVD and Schizo.	NCQA NCQA	1932 1933	Claims Claims	Process Process	Performance Performance		Performance Performance
	Follow up care for Children Prescribed ADHD Medications Follow-up after hospitalization for Mental Illness	NCQA NCQA	0108 0576	Claims Claims	Process Process	Reporting Performance		Performance Performance
	Screening for Clinical Depression and follow up	CMA	0418	Medical Record	Process	Reporting		Performance
	Adherence to Antipsychotic Medications for People with Schizophrenia Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA NCQA	1879 0004	Claims Claims	Process Process	Performance Performance		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 Percent of Long Stay Residents who have Depressive Symptoms	3M CMS		Claims MDS 3.0	Outcome Process	Performance Performance		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

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MONITORING DSRIP

- Design how, where and by whom data will be collected and analyzed in each location.

- Utilize EMR to communicate, track data and measure progress.

Additional Outcomes & Research Considerations

- Design how to measure/capture other health outcomes, i.e. reduced health/illness symptoms, better patient engagement.

- Design how to measure “life” outcomes, i.e. living independently, socializing, improved school outcomes, relationship development, improved job function/employment outcomes, etc.

- Utilize satisfaction surveys - staff, patient and referral source to assess system transformation outcomes.

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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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