Consolidated Project Information

Project 3.a.i Primary & Behavioral Health Integrated Care Program

For more information please contact Laura Siddons, Project Manager Laura.Siddons@stonybrookmedicine.edu 631-638-1349
Version 5 – 10.25.15

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

3.a.i Project Objective & Requirements

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).

The project must clearly demonstrate the following project requirements:

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.

Model 1: *Embedding a Behavioral Health Specialist in Primary Care*

Actively Engaged Definition: The total number of patients receiving appropriate preventive care screenings that include mental health/substance abuse.

Clarifying Information:

- The PPS is expected to utilize the preventive care screening based on nationally-accepted best practices determined to be age-appropriate.
- Any staffer working at a PCMH/APCM Service Site who is qualified to perform a preventive care screening can do so. However, preventive care screenings conducted with a patient via telepsychiatry alone will not count within this active engagement definition.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.
- The expectation of a co-located primary care-behavioral health site is that there is a licensed behavioral health provider on site engaged in the practice.

Model 2:

Actively Engaged Definition: The total number of patients receiving primary care services at a participating mental health or substance abuse site.

Clarifying Information:

- Primary Care Services are defined as preventive care screenings billed through Current Procedural Terminology (CPT) codes.
- The mental health and substance abuse sites have to be partners in the Network Tool in order to count
- Any staffer working at a Behavioral Health Site who is qualified to perform a preventive care screening as required within the project can do so.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.
- The only types of "primary care providers" that may be utilized to provide primary care services within the BH site are participating PCPs, NPs, and physician assistants working closely with a PCP.

Model 3: IMPACT model

Actively Engaged Definition: The total number of patients screened using the PHQ-2 or 9/SBIRT.

Clarifying Information:

- Patients for this project will only count as actively engaged if they receive either the PHQ-2 or 9 or SBIRT screenings.

- All five principles of the IMPACT model must be in place for a site to count.
- Any staffer working within the IMPACT model who is qualified to perform a preventive care screening as required within the project can do so.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.

DOMAIN 1 Project Requirements

Project System Changes (Green): Based upon the work plan section in Attachment I, NY DSRIP Program Funding and Mechanics Protocol, no more than the first two years will be utilized to implement major system changes related to the project. Example project requirements that fall into this time period cohort include: training for care coordinators, developing systematic approaches like clinical protocols, the identification of key project personnel, performing population health management activities, or using EHRs or other technical platforms to track patients engaged in the project.

Project Requirements with Specific Time Periods (Pink): A number of project requirements include prescribed end dates for achievement. Example project requirements include: safety net providers actively sharing medical records with RHIO/SHIN-NY by the end of DY 3 or PCPs achieving Level 3 PCMH certification by the end of DY 3.

Project Requirements Tied to PPS Speed and Scale Commitments (Yellow): The due dates for these project requirements are at the discretion of the PPS and should be consistent with commitments each PPS made in the speed and scale sections of the submitted project application. Project requirements within this time period include components like implementing open access scheduling in all PCP practices, deploying a provider notification/secure messaging system, or converting outdated or unneeded hospital capacity into needed community-based services.

Project-Unit Level Reporting - These are Domain 1 requirement metrics/deliverables which will be reported by the PPS lead at the project-wide level demonstrating the PPS' overall project performance and success. These are requirements not specific to individual provider but rather are requirements that must be organized and administered by the PPS lead through the PPS' participating providers and partners. Some of these requirements include performing population health management activities, monthly meetings with MCOs, establishing partnerships between primary care providers and participating Health Homes, and developing materials meeting the cultural and linguistic needs of the population.

Provider-Unit Level Reporting - These are Domain 1 requirement metrics/deliverables for which performance and success must be demonstrated at the provider level. Some of these requirements include PCPs meeting 2014 NCQA Level 3 PCMH standards, EHR meeting RHIO HIE and SHIN-NY requirements or implementing open access scheduling in PCP practices.

Domain 1 Requirements

Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.a.i (Model 1)
Project Title	Integration of primary care and behavioral health services

Index Score = 39

Definition of Actively Engaged	The total number of patients engaged in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level
1	Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP); Certification documentation	Provider (PCP)
		Behavioral health services are co-located within PCMH/APC practices and are available.	List of practitioners and licensure performing services at PCMH and/or APCM sites; Behavioral health practice schedules	Provider (BH)
2	Develop collaborative evidence-based standards of care including medication management and care engagement process.	Regularly scheduled formal meetings are held to develop collaborative care practices.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Project
		Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.	Evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to guidelines and protocols	Project

Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.a.i (Model 1)
Project Title	Integration of primary care and behavioral health services

Index Score = 39

Definition of Actively Engaged	The total number of patients engaged in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level
3	Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Policies and procedures are in place to facilitate and document completion of screenings.	Screening policies and procedures	Project
		Screenings are documented in Electronic Health Record.	Screenshots or other evidence of notifications of patient identification and screening alerts; EHR Vendor documentation	Project
		At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).	Roster of identified patients; Number of screenings completed	Project
		Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	Sample EHR demonstrating that warm transfers have occurred	Provider (PCP)

Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.a.i (Model 1)
Project Title	Integration of primary care and behavioral health services

Index Score = 39

Definition of Actively Engaged	The total number of patients engaged in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level
4	Use EHRs or other technical platforms to track all patients engaged in this project.	EHR demonstrates integration of medical and behavioral health record within individual patient records.	Sample EHR demonstrating both medical and behavioral health Project Requirements	Project
		PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.a.i (Model 2)
Project Title	Integration of primary care and behavioral

Index Score = 39

Definition of Actively Engaged	The total number of patients engaged in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level
1	Co-locate primary care services at behavioral health sites.	PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP); Certification documentation	Provider (PCP)
		Primary care services are co-located within behavioral Health practices and are available.	List of practitioners and licensure performing services at behavioral health site; behavioral health practice schedules.	Provider (PCP, BH)
2	Develop collaborative evidence-based standards of care including medication management and care engagement process.	Regularly scheduled formal meetings are held to develop collaborative care practices.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Project
		Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation	Project

For more information please contact Laura Siddons, Project Manager Laura.Siddons@stonybrookmedicine.edu 631-638-1349

Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.a.i (Model 2)
Project Title	Integration of primary care and behavioral

Index Score = 39

Definition of Actively Engaged	The total number of patients engaged in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level
3	Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.	Screening protocols included in policies and procedures; Log demonstrating the number of screenings completed	Project
		Screenings are documented in Electronic Health Record.	Screenshots or other evidence of notifications of patient identification and screening alerts; EHR Vendor documentation	Project
		At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).	Screenings documented in EHR	Project
		Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	Sample EHR demonstrating that warm transfers have occurred	Provider (PCP)

For more information please contact Laura Siddons, Project Manager Laura.Siddons@stonybrookmedicine.edu 631-638-1349

Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.a.i (Model 2)
Project Title	Integration of primary care and behavioral

Index Score = 39

Definition of Actively Engaged	The total number of patients engaged in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level
4	Use EHRs or other technical platforms to track all patients engaged in this project.	EHR demonstrates integration of medical and behavioral health record within individual patient records.	Sample EHR demonstrating both medical and behavioral health Project Requirements	Project
		PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	

For more information please contact Laura Siddons, Project Manager Laura.Siddons@stonybrookmedicine.edu 631-638-1349

Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.a.i (Model 3)
Project Title	Integration of primary care and behavioral health services

Index Score = 39

Definition of Actively Engaged	The total number of patients engaged in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level
1	Implement IMPACT Model at Primary Care Sites.	PPS has implemented IMPACT Model at Primary Care Sites.	Quarterly report narrative demonstrating successful implementation of project requirements	Provider (PCP Practices)
2	Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation	Project
		Policies and procedures include process for consulting with Psychiatrist.	Documentation of evidence-based practice guidelines	Project

For more information please contact Laura Siddons, Project Manager Laura.Siddons@stonybrookmedicine.edu 631-638-1349

Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.a.i (Model 3)
Project Title	Integration of primary care and behavioral health services

Index Score = 39

Definition of Actively Engaged	The total number of patients engaged in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level
3	Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.	Identification of Depression Care Manager via Electronic Health Records	Project
		Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.	Evidence of IMPACT model training and implementation; Sample EHR demonstrating relapse prevention plans, patient coaching, and other IMPACT interventions	Project
4	Designate a Psychiatrist meeting requirements of the IMPACT Model.	All IMPACT participants in PPS have a designated Psychiatrist.	Register of IMPACT participants and designated psychiatrist; Policies and procedures in place to follow up with care of patients; Electronic Health Record identifying Psychiatrist for eligible patients	Project

For more information please contact Laura Siddons, Project Manager Laura.Siddons@stonybrookmedicine.edu 631-638-1349

Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.a.i (Model 3)
Project Title	Integration of primary care and behavioral health services

Index Score = 39

Definition of Actively Engaged	The total number of patients engaged in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level
5	Measure outcomes as required in the IMPACT Model.	At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).	Roster of screened patients	Project
6	Provide "stepped care" as required by the IMPACT Model.	In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.	Documentation of evidence-based practice guidelines for stepped care; Implementation plan	Project
7	Use EHRs or other technical platforms to track all patients engaged in this project.	EHR demonstrates integration of medical and behavioral health record within individual patient records.	Sample EHR demonstrating both medical and behavioral health Project Requirements	Project
		PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

For more information please contact Laura Siddons, Project Manager Laura.Siddons@stonybrookmedicine.edu 631-638-1349

3.a.i Domain 3 Clinical Improvement Metrics

Domain 3 - Clinical Improvement Projects										
Potentially Preventable Emergency Department Visits (for persons with BH diagnosis) ±	3M	NA	3.a.i – 3.a.iv	Number of preventable emergency visits as defined by revenue and CPT codes	Number of people with a BH diagnosis (excludes those born during the measurement year) as of June 30 of measurement year	0.0^ per 100 Medicaid enrollees with Behavioral Health Qualifying Service *High Perf Elig	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Antidepressant Medication Management – Effective Acute Phase Treatment	HEDIS 2015	0105	3.a.i – 3.a.iv	Number of people who remained on antidepressant medication during the	Number of people 18 and older who were diagnosed with depression and treated with an	60.0% *High Perf Elig	0.5 if annual improvement target or performance	NYS DOH	P4P	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and may be changed following Measurement Year 1 results.

Measure Name	Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
				entire 12-week acute treatment phase	antidepressant medication		goal met or exceeded			
Antidepressant Medication Management – Effective Continuation Phase Treatment	HEDIS 2015	0105	3.a.i – 3.a.iv	Number of people who remained on antidepressant medication for at least six months	Number of people 18 and older who were diagnosed with depression and treated with an antidepressant medication	43.5% *High Perf Elig	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Diabetes Monitoring for People with Diabetes and Schizophrenia	HEDIS 2015	1934	3.a.i – 3.a.iv	Number of people who had both an LDL-C test and an HbA1c test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia and diabetes	89.8% *High Perf Elig	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	HEDIS 2015	1932	3.a.i – 3.a.iv	Number of people who had a diabetes screening test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication	89.0%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS 2015	1933	3.a.i – 3.a.iv	Number of people who had an LDL-C test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia and cardiovascular disease	92.2% (health plan data) *High Perf Elig	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and may be changed following Measurement Year 1 results.

Measure Name	Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
Follow-up care for Children Prescribed ADHD Medications – Initiation Phase	HEDIS 2015	0108	3.a.i – 3.a.iv	Number of children who had one follow-up visit with a practitioner within the 30 days after starting the medication	Number of children, ages 6 to 12 years, who were newly prescribed ADHD medication	72.3%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Follow-up care for Children Prescribed ADHD Medications – Continuation Phase	HEDIS 2015	0108	3.a.i – 3.a.iv	Number of children who, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits in the 9-month period after the initiation phase ended	ages 6 to 12 years, who were newly prescribed ADHD medication and remained on the medication for 7 months	78.7% (health plan data)	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Follow-up after hospitalization for Mental Illness – within 7 days	HEDIS 2015	0576	3.a.i – 3.a.iv	Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 7 days of discharge	Number of discharges between the start of the measurement period to 30 days before the end of the measurement period for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders	74.2% *High Perf Elig	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Follow-up after hospitalization for Mental Illness – within 30 days	HEDIS 2015	0576	3.a.i – 3.a.iv	Number of discharges where the patient was seen on an ambulatory	Number of discharges between the start of the measurement	88.2% *High Perf Elig	0.5 if annual improvement target or	NYS DOH	P4P	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and may be changed following Measurement Year 1 results.

Measure Name	Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
				basis or who was in intermediate treatment with a mental health provider within 30 days of discharge	period to 30 days before the end of the measurement period for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders		performance goal met or exceeded			
Screening for Clinical Depression and follow-up		0418	3.a.i – 3.a.iv	Number of people screened for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen	Number of people with a qualifying outpatient visit who are age 18 and older	100%^	1 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Adherence to Antipsychotic Medications for People with Schizophrenia	HEDIS 2015	1879	3.a.i – 3.a.iv	Number of people who remained on an antipsychotic medication for at least 80% of their treatment period	Number of people, ages 19 to 64 years, with schizophrenia who were dispensed at least 2 antipsychotic medications during the measurement year	76.5%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and may be changed following Measurement Year 1 results.

Measure Name	Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	HEDIS 2015	0004	3.a.i – 3.a.iv	Number of people who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode	Number of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence	86.0%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)	HEDIS 2015	0004	3.a.i – 3.a.iv	Number of people who initiated treatment AND who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Number of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence	31.4%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

For more information please contact Laura Siddons, Project Manager Laura.Siddons@stonybrookmedicine.edu 631-638-1349

3.a.i Active Engagement Definition

The active engagement definition for project 3.a.i is the total of number of patients engaged per each of the three models in this project, including:

A. PCMH Service Site: Number of patients screened (PHQ-2 / PHQ-9 / SBIRT)

B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site.

C. IMPACT: Number of patients screened (PHQ-2 / PHQ-9 / SBIRT)

Project	# of Actively Engaged	Attributed Population	% of Attributed	Definition of Actively Engaged	Counting Method
3.a.i	45,059	148,118	30%	1) PHQ/SBIRT screening at PCMH site 2) Primary care services at BH site 3) PHQ/SBIRT screening at IMPACT site	3

The purpose of counting methods is to estimate the number of patients that will be impacted by a particular project. This feeds the patient scale portion of the application.

Each counting method should be used in conjunction with the definition of "actively engaged" patients for that project.

Summary of counting method 3:

- Counted within a DSRIP year; resets each year

For more information please contact Laura Siddons, Project Manager Laura.Siddons@stonybrookmedicine.edu 631-638-1349

- Patients are to be counted only once
- So long as “at least” one encounter with the patient resulted in A.E. definition being met, it counts towards total

e.g., if a patient visits the PCP 5 times a year but get a1C tested just one of those 5 times, she is actively engaged

3.a.i Speed and Scale Submission

Scale is a measure of the magnitude of providers in the project and the volume of patients affected. Speed is a measure of how quickly project requirements are executed and how quickly patient impact occur. Speed and Scale represent 80% of the points for each project application – and therefore, most significantly impact initial valuation.

Project Implementation Speed for Project 3.a.i

Project	DY 0 (2014)		DY 1 (2015)		DY 2 (2016)		DY 3 (2017)		DY 4 (2018)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
3.a.i								X		

Patient Engagement Speed for Project 3.a.i

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of *Actively Engaged* Patients	0	0	2245	6785	8995	22489	17991	33734	22489	45059
Expected # of Actively Engaged Patients	45059	45059	45059	45059	45059	45059	45059	45059	45059	45059

Rationale for Project 3.a.i

The rationale related to project 3.a.i implementation speed is as follows:

- PCMH Level 3 certification by DY3 is a project requirement so 100% is achieved at end of DY3 to give practices maximum amount of time to achieve

The rationale related to project 3.a.i patient engagement speed is as follows:

- The total of number of patients engaged per each of the three models in this project, including:
    A. PCMH Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SU.
    B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site.
    C. IMPACT: Number of patients screened (PHQ-2 / PHQ-9 / SBIRT)
- Patients are counted as those who meet the criteria over a 1-year period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years**.**

For more information please contact Laura Siddons, Project Manager Laura.Siddons@stonybrookmedicine.edu 631-638-1349

The patient scale rationale is calculated as detailed below.

Patient Scale Rationale					
	Adult Population		Child Population		BH – PC sites
Baseline # of Patients	100,988 Patients	Baseline # of Patients	47,130 Patients.	Estimated Patients receiving PC at participating Mental Health or Substance Abuse Sites	5,000 Patients
35% Engagement Factor	35,346 Patients	10% Engagement Factor	4,713 Patients		
Total	35,346 Patients	Total	4,713 Patients	Total	5,000 Patients
Expected # of Actively Engaged Patients =		45,059 Patients			

References

Please see pages 47-54 in the Suffolk Care Collaborative DOH Application for additional project related information.

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/stony_brook_university_hospital/stony_brook_project_plan.pdf