Suffolk Care Collaborative
Primary & Behavioral Health Integrated Care Program

3ai: Integration of Primary Care and Behavioral Health Services

Project Charter

Through the Delivery System reform Incentive Payment Program (DSRIP), a grant waiver administered by the NYS DOH, $6.42 Billion Medicaid dollars were allocated to fundamentally restructure the health care delivery system to transition care delivery from a largely inpatient-focused system to a community-facing system that addresses both medical needs and social determinants of health. DSRIP is a 5-year, performance payment-based program with primary goal of reducing avoidable hospital use by 25% over 5 years. At the end of program life, the aim is for the newly-transformed system to be sustainable. Program efforts are focused on achieving improved overall health through integration of behavioral health and primary care, provision of appropriate levels of care management, and care delivery models designed to improve chronic disease prevention and outcomes.

Objective Statement:

The purpose of this project improve identification and access to Behavioral Health Services in Suffolk County while ensuring those residents who are enrolled in a behavioral health treatment program are receiving primary care services. Over the five-year DSRIP program, the project seeks to implement one of two models at primary care sites across Suffolk County. In addition, the project seeks to implement primary care services at participating Behavioral Health sites including mental health and substance abuse sites.

High Level Deliverables:

Model 1) Implement Integrated care by embedding behavioral health specialists into primary care settings and supporting the PCMH model

Model 2) Implement Integrated care by embedding primary care services into established behavioral health sites

Model 3) Integrate primary care and behavioral health using the IMPACT model, as described below

In all three models above, care should be as integrated as possible, offering warm handoffs when providers are embedded and coordinated care performed by all members of care team.

Target Population:

For implementation at primary care 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.

For implementation at behavioral health sites, the targeted population will be Medicaid patients who are cared for at 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. The target population will increase over time as a result of the efforts to engage the uninsured population.

Benefits:

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.

Assumptions:

- Evidence based Integrate care standards will be used to develop model
- Project has buy in and adequate participation from partners
- Workforce supports are available to support needs
- IT systems are set up to track patient care

Constraints:

- BH workforce is limited in Suffolk County
- Amount of time/technical assistance required to roll out integration
- Restrictions in current OMH/DOH Policies and licensures
    - Stark Laws, Tele-psychiatry, Satellite application requirement

Success Criteria:

- Public, community and key project stakeholders were engaged to approve project design and framework
- Project objectives are achieved
- Providers in PPS report their patients' behavioral health needs are being met
- Speed and scale is achieved for both patient and project engagement – see 3ai Speed and Scale document
- Successful completion of all Domain 1 requirements, including meeting patient engagement and project engagement commitments
- Improvement throughout DSRIP Measurement Years across all Domain 2-3 outcome measurers (achievement of 10-20% gap to goal)

Stakeholder Analysis:

- Primary Care Practices in Suffolk County including physicians, practice champions who are engaged in project

- PCMH providers who can embed primary care services at identified BH sites
- Primary Care practices who are currently implementing some level of integration will be engaged
- Behavioral Health Providers and clinics in Suffolk County
- Behavioral Health providers who are currently implementing some level of integration will be engaged

Closeout Criteria:

- Close out will be managed during the monitoring phase of the project lifecycle and is tentatively scheduled for period ending March of 2020
- Evaluate and ensure all Archive Data and final project records/documents are filed in a secure location and appropriate to demonstrate achievement of DSRIP metric/project commitments within Domain 1 - 4
- Archive all project data in a central repository. Include best practices, lessons learned, and any other relevant project documentation.
- Verifying acceptance of final project deliverables/ data sources by the NYS DOH
- Completion of the post-project assessment and lessons learned
- Completion of post-project review and evaluation

Project Strategy:

- The PPS will engage in a contract with a group of experts from the Center of Excellence for Integrated Care to perform a detailed assessment current state of integration among partners
- Consultant group will develop cohorts and facilitate a learning collaborative for each cohort
- With input from the 3ai workgroup and the Center of Excellence, the SCC Integrated Care Program will be developed with supporting documentation and toolkits
- Assist sites with implementation and technical assistance
- Align PCPs through pay for performance incentives.