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):

1. 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.

ECMC and BryLin Hospital are currently used for our mental/behavioral health (M/BH) inpatient admissions. Also, our ambulatory network includes 152 psychiatrists. The Community Partners of WNY has five NYS-licensed comprehensive community-based Behavioral Health Providers. Our primary care practice sites who have agreed to participate in this project have either achieved or begun the process to become a NCQA level 3 PCMH or Advance Primary Care Model by Year (DY) 3. Sisters of Charity Hospital Project Management Team has risk-based Medicaid managed care contracts; their actuarial data for 2013 shows a Mental Health admission rate of 6.74 and a Substance Abuse rate of admission of 8.42 per 1000. These are dramatically higher than the commercially-insured population that show a MH admission rate of 2.27 per 1000 and a SA rate of 1.0 per 1000. For the first six months of 2014, the MH rate for our Medicaid population increased to 7.16 per 1000 and the substance abuse rate to 10.12. Outpatient visits for the same period are also increasing. The CNA demonstrates major MH conditions driving utilization are depressive disorders and the major clinical conditions driving SA are alcohol and mixed drug abuse. The most recent HEDIS data show 51% of patients remained on anti-depressants for the acute phase of treatment. After six months this dropped to 34%. Follow-up 7 days after

hospitalization showed 28% of patients not meeting this HEDIS standard, and at 30 days 17% had not had a follow-up visit. Data on diabetes and cardiac care for the target population show additional disparities in management of these two conditions. This data shows serious gaps in care and opportunities to make improvements. The PPS will address the 4 key disparities listed above including:1. High rates of BH admissions 2. Patient compliance with medication recommendations 3. Continuity of care issues following discharge 4. Early identification and management of chronic behavioral and physical health conditions. Utilizing the Four Quadrant population-based planning framework for the clinical integration of health and behavioral health services our strategies include:1.Building SBIRT for both MH and CD into patient's annual PCP visit and having referral agreements between PCP and BH providers with rapid access and collaborative care plans. In some practices with higher Medicaid populations we will co-locate a BH provider in the clinical office with psychiatric backup support. 2.Improving patient education, engagement and medication compliance with embedded nurse care managers in PCPs. 3.Proactive Community Health Worker follow-up to all patients discharged from a BH inpatient facility who do not follow up within 7 days, and active follow-up of 2 days for patients with multiple BH admission history. Implementing the Collaborative Care Model with integrated nurse care managers in BH settings linked to a PCP in a team approach to monitor patient outcomes and make interventions to improve medication compliance, cardiac care, HTN management and DM care. The PPS will use registries and EMR reporting to stratify patients and engage the practice in overall population improvement.

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.

The target population for this intervention are all Medicaid patients seen in the PCP setting for an annual visit, patients who are prescribed anti-depressants, and patients transitioning from inpatient BH settings to home or a community setting. Additionally, Community Partners of WNY will identify/target patients in our BH settings with gaps in best practice standards for health care in the areas of DM, BP control and cardiac 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.

Community Partners of WNY will utilize our current network to develop PCP screening tools for early identification and formal/written referral agreements between PCP and BH providers to improve early intervention. Team-based BH interventions with be emphasized, using qualified MH and SA counselors with reliable back-up from pharmacists, psychiatric NPs and psychiatrists for medication management, referral accountability following hospitalization, and to improve access. We will use EMR-secure messaging to improve communications and reduce information exchange gaps that diminish continuity of care. Sisters of Charity Hospital/CMP Project Management Team will establish BH education to expand patient education regarding BH signs and symptoms and reinforce the importance of adherence to medication protocols. Patients who miss their

appointment will have active follow-up via geographically-based CHW teams. Secondly, we will place nurse care managers in the BH setting who are trained in providing proactive case and care management to patients. Community Partners of WNY has an active embedded care management program in PCP clinical settings and this PPS will expand this to the BH setting in five of our community-based comprehensive BH partners: Horizon Health Services, Spectrum Human Services, Catholic Charities-Monsignor Carr, Child and Adolescent Treatment Services, and BryLin Behavioral Health. The care managers will be trained in best practice care and case management and will use registries to close gaps in medical care for our target conditions.

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.

The CNA noted that only 13% of the PCPs in our region are safety net providers and that, of the PCP practices, only 21% are PCMH. The Community Partners WNY network has over 300 PCPs and in addition 450 midlevel practitioners. We have been attributed 58,000 patients. Our network is geographically distributed, our practices serve the Medicaid population based on our health plan contracts, and over 65% are PCMH-certified. PCP clinical offices will be challenged to develop BH protocols and integrate them into their workflow. There will also be challenges in staff training and determining what level of BH can be managed in the PCP office. The Community Partners WNY strategy will be to design PCP specific interventions that either utilize embedded staff or are virtual – namely, based on referral, access and information exchange agreements backed up by a team of pharmacists and psychiatrists. The PPS population health business model and our success will enable us to implement BH integration effectively. The PPS has conducted pilot BH/PCP integration with success, and has presented PCPs with specific training in effective Pain Management with an emphasis on addiction prevention.

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.

Community Partners of WNY and Millennium have worked together on the integration of BH and PCP and plan to collaborate throughout implementation.

2. <u>Scale of Implementation</u> (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
☒	☐

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

Renovations to primary care and behavioral health offices to enable co-location of services. IT infrastructure to support patient registries; stratification of patients; reporting; protocol development.

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
☒	☐

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
Lakeshore Behavioral Health	Health Home	7/1/2014		Provide care management to high risk individuals with chronic conditions

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.

Health Home: The health home provides care management services to qualified Medicaid recipients. The DSRIP project "Integration of Primary Care and Behavioral Health Services" builds upon a foundation of care management offered by the Health Home. The DSRIP goes further in ensuring that all Medicaid recipients with mental illness have access to high quality primary care.

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.