

**WMC DSRIP PPS Project Plans**

**Application Section 4**

*Submitted December 22 2014*

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

**Project Response & Evaluation:**

**1. Project Description and Justification**

**1a. 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.**

Ambulatory behavioral health (BH) treatment (e.g. mental health, substance use and alcohol abuse services) may not be reaching the right people at the right time in our region. An analysis of data from the NY Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) for our CNA found, for example, nearly 350,000 Westchester County residents had a history of a BH disorder, yet only 27% had a BH-related ambulatory visit last year. The age adjusted suicide rate in the County is 7 per 100,000 and, 18% of adults engaged in binge drinking in the past month; both of these numbers could decline with timely care.

Our region-wide resident survey indicates that 22%-30% of respondents do not know where to go for BH services, though close to 80%-90% of respondents reported having a healthcare provider and seeing a doctor for a check-up in the last year. This suggests that BH services co-located with primary care could improve access to those who need BH services.

In addition, many Medicaid beneficiaries may not be diagnosed with or receiving treatment for the most common BH disorders, including depression which produces a greater decline in health than angina, arthritis, asthma or diabetes. In our region, over 30% of those with depression had one or more medical or BH inpatient admissions, and 45% had one or more emergency department (ED) visits.

Medicaid beneficiaries with serious BH disorders may not be receiving adequate primary care. In our region, 23% of adults with BH disorders discharged from community hospitals had one or more chronic medical conditions. Our CNA focus group participants said integrated care with a single, integrated treatment plan would help facilitate better coordination of care and reduce patient barriers to accessing BH services.

This project is designed to reach a broad population of Medicaid beneficiaries with a wide range of unmet BH and primary care needs. Eight PPS Participants across 22 sites will implement the PCMH-integrated model to provide on-site BH screening, assessment and integrated services, including medication management and other evidence-based care coordination services. Integrated care sites will be aligned with our PPS' BH providers, BH Crisis Systems as defined in Project 3.a.ii, and hospitals to provide the right care at the right time.

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**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.**

This project will target all attributed Medicaid beneficiaries ages 12 and older who receive primary care services and have a visit during the year at one of the 22 project sites. The primary care provider (PCP) will ask target patients to complete both the PHQ 9 (screen for depression) and SBIRT (screen for alcohol and/or drug use). One participating FQHC that has implemented routine depression screening with the PHQ-9 reports a screening rate of 50%. Using this as a benchmark, it is reasonable to expect that completion rates will be lower when both PHQ-9 and SBIRT are required instruments.

Our PPS will seek to engage the highest need populations in integrated care as identified within certain high need areas of our regions and by our BH Crisis Stabilization project. This project will work in tandem with Projects 2.a.iii, "Health Home At-Risk Intervention Program" and 2.b.iv, "Create a Medical Village Using Existing Hospital Infrastructure" to target outreach to beneficiaries with serious BH conditions (e.g., bipolar disorder, depression, schizophrenia, other psychoses, chronic alcohol abuse, opioid abuse, heroin and/or cocaine abuse), HIV, developmental disabilities (DD) and/or those who are homeless and living in high need areas with significant African American and Hispanic populations. These areas include Mount Vernon, Yonkers, New Rochelle, Poughkeepsie, Newburgh, Middletown, Port Jervis and Kingston, many of which are also medically underserved areas.

**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.**

Our PPS will implement the PCMH Service Site model and will provide planning, workforce training, capacity building and implementation support to project Participants.

Eight Participants in our PPS, representing over 22 project sites will participate in this project. This includes three hospitals (Bon Secours, Phelps Memorial, WMC), four FQHCs (Greater Hudson Valley Family Health Center, The Institute for Family Health, Open Door Medical Center, Mount Vernon Neighborhood Medical Center), and one Diagnostic and Treatment Center (DTC) (United Cerebral Palsy Association of Putnam and Southern Dutchess Counties). Most sites are in high need counties with cultural competencies for diverse populations. One site primarily serves people with DD, and another site serves people with HIV. A number of the Participants' sites will offer urgent care.

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The participating FQHCs currently offer some on-site BH screening and services and will develop/expand BH screening and/or on-site service capacity to meet the project requirements. Depending on regulatory flexibility and funding availability, BH clinics can affiliate with PCMH integrated care sites to (1) provide BH clinicians for on-site services; (2) participate in the delivery of team-based care when specialty care is needed and in alignment with protocols set by our PPS; and/or (3) connect BH clients with primary care at integrated care sites. To ensure that patients receive appropriate services, our PPS will identify Medicaid beneficiaries engaged in BH care who have not received primary care and will work with BH providers to assess these patients using the 13-question Patient Activation Measure, offer subsequent coaching when indicated and address common service gaps (e.g. flu shots, immunizations, basic medical assessments, smoking status) to improve overall health status.

About half of the 22 project sites have achieved 2011 NCQA PCMH accreditation. Our PPS will provide all sites with assistance to achieve 2014 Level 3 PCMH recognition by the end of DY 3, including adoption of electronic health records (EHRs) or other systems to enable the PPS to effectively track patients and project outcomes. WMC is currently developing telepsychiatry capabilities that may be used to provide psychiatric consultations to integrated care sites which will significantly enhance their capability to diagnose and treat more complex BH disorders.

Care coordination and social service programs are also critical to improving outcomes for Medicaid beneficiaries with social and economic challenges that can trigger or worsen depression, anxiety and substance abuse. Our region's three Health Homes collectively serve 7,446 unique Medicaid members with BH and/or other conditions. The integrated care sites will help facilitate enrollment of additional eligible beneficiaries. Our PPS can offer concrete, essential help with social services: shelters, food pantries, supportive housing, entitlement assistance, and the soon-to-be available the HARP 1915i benefit services such as employment and peer support. These services will target beneficiaries in neighborhoods with high measures of socioeconomic disadvantage.

**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 barrier to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.**

Our PPS anticipates several challenges in implementing this project. Currently, there are limitations on providing BH services in Article-28 licensed sites, which could pose a challenge to co-locating services. If regulatory waivers are not granted, Participants may pursue licensure from the Office of Mental Health (OMH) and/or Office of Alcoholism and Substance Abuse Services (OASAS) at primary care sites serving sizable BH populations. Our PPS will request waivers for these barriers as needed.

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We also anticipate financial challenges. Today, FQHCs can only bill for one daily service, which will impede the financial sustainability of this project; as such, our PPS has requested that the NYS DOH address this issue. On the provider side, some PCPs may be reluctant to screen for BH disorders due to past difficulties connecting with BH providers and/or a lack of experience with BH disorders. To combat this concern, the project will add BH staff to clinic sites and develop PCP training and an Implementation Toolkit to facilitate cultural/age competent use of PHQ 9 and SBIRT so that PCPs are comfortable screening for BH disorders. Our region's RHIO and tools to be centrally developed by our PPS will support electronic documentation of clinical assessments, tracking of patients, project implementation and outcomes. Our PPS will also develop and implement a process to obtain patient consent for information sharing among providers.

**e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve and overlapping service area. If there are no other PPS within the same service area, then no response is required.**

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and state. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council to support development of a regional system of efficient and effective care, patient safety, and quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project and implementation plans and make recommendations to align overlapping approaches. Region-wide coordination, requirements, and expectations will minimize providers' implementation burdens and create consistent, high quality patient experiences. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and payers.

Continuing the cooperation that resulted in the creation of a common CNA, the PPSs in our region have embraced collaboration throughout the selection, design, and development phases of their respective DSRIP projects. The PPSs have committed to coordination with local County Departments of Health and Mental Health to support the expansion of integrated BH and primary care in our region.

## **2. Scale of Implementation**

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*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:*

**2a. Please indicate the total number of sites, programs and/or providers the PPS intends to include in the project by the end of Demonstration Year (DY), or sooner as applicable. These numbers should be entered in the table as Total Committed.**

***See accompanying Speed & Scale Excel document***

**b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the Expected # of Actively Engaged Patients. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4.**

***See accompanying Speed & Scale Excel document***

### **3. Speed of Implementation/Patient Engagement**

*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:*

**3a. Please indicate the Demonstration Year (DY) and Quarter by which all participating providers will achieve project requirements. Project speed is measured by how fast all the project requirements for all chosen locations are met.**

**PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS “total committed” scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.**

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**See accompanying Speed & Scale Excel document**

**b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of targeted patients will be actively engaged by the end of Demonstration year 1, 50% by the end of Demonstration year 2, etc.**

**See accompanying Speed & Scale Excel document**

**4. Project Resource Needs and Other Initiatives (750 word limit, Not Scored)**

**4a. Will this project require Capital Budget funding? (Please mark the appropriate box below)**

Yes	No
X	

**Please describe why capital funding is necessary for the Project to be successful.**

Our PPS will require capital funds for the renovation and expansion of clinics to support physical co-location of behavioral health services into primary care sites. Funding will support new construction, repairs, and renovation of fixed assets, equipment costs, and other asset acquisitions to expand existing and create new co-located sites as well as providing the appropriate tools for performing PHQ-9 /SBIRT screening.

The WMC-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations for enhanced behavioral health and primary care activities. The capability will be shared across all 11 DSRIP projects and is central to our IDS development.

**4b. 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
X	

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**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.**

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.
Orange County DOMH	Port Jervis Connections Project - "Court Connection Program"	10/1/2013	9/30/14 with No Cost Extension through mid-2015	The Court Connection Program targets individuals in the criminal justice system and provides medical services to individuals court system exhibiting signs of mental illness to improve public safety, reduce corrections costs, and improve quality of life for participants.
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying

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				condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mount Vernon Neighborhood Health Center Network	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	HRSA Behavioral Health Integration (BHI)	2014	ongoing	HRSA Behavioral Health Integration grants support health centers to improve behavioral health services and capacity, and to employ integrated models of primary and behavioral health care.

**4c. 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.**

This project will require coordination and cooperation between and among providers. The services provided in our region will serve as instrumental in this project. However DSRIP funds will not supplant or replace current funding as this project will build on what has already been done to expand the reach of the project to the attributed population. For example, our PPS will build on the experiences that come out of the Court Connection Program to apply treatment and intervention strategies to the target Medicaid population.

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The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a larger group of Medicaid patients, including those who are not currently eligible for Health Home services, and will expand the reach of the care management knowledge, techniques and experiences to populations not served by Health Homes.

Our PPS will build on the experience of the Institute for Family Health which has already begun work to improve behavioral health care under HRSA Behavioral Health Integration grants. However, this DSRIP project will extend to many additional mental health/behavioral health and primary care settings, allow us to reach a broader population than is currently being targeted. DSRIP funding will not be provided to HRSA BHI participating providers if doing so would supplant or duplicate funding.