



## 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):**

### **2. 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.

Our PPS has chosen to implement all three models for primary care and behavioral health (BH) integration in order to address the high prevalence of BH diagnoses among Medicaid beneficiaries in the PPS (see CNA need 4), as well as the population's inappropriate use of ED and inpatient services (see CNA needs 1, 4).

The CNA documents the prevalence of mental health (MH) and substance abuse (SA) diagnoses across NYC neighborhoods. Eight of ten Manhattan neighborhoods have MH diagnosis rates above city and state averages (19.5% and 22.8% respectively). Of these, six have MH rates above 30% (Chelsea/Clinton, Gramercy, Park/Murray Hill, Upper West Side, Lower Manhattan, Upper East Side, and East Harlem), and one (Chelsea/Clinton) is above 50%. The prevalence of MH diagnoses in the other boroughs is lower, with three neighborhoods in the Bronx above the state average (Kingsbridge/Riverdale, Hunts Point/Mott Haven, Crotona/Tremont), two neighborhoods in Brooklyn (Downtown/Heights/Slope, Coney Island/Sheepshead Bay) and one Queens neighborhood (Rockaway). Of the adults with BH disorders discharged from inpatient



facilities in 2013, 83.5% had one or more chronic medical conditions.

SA trends are similar, with the highest prevalence occurring in Manhattan; nine of ten neighborhoods experience higher than city and state averages (6.2% and 6.4% respectively), and the same six neighborhoods have prevalence rates above 12%. In the Bronx, one neighborhood has rates above 12% (Hunts Point/Mott Haven), and four have above average rates. In Brooklyn, four of eleven neighborhoods have above-average rates. SA is not as prevalent in Queens, where all rates are below the average.

New York's Medicaid beneficiaries with MH and SA diagnoses are high users of inpatient and ED services: 42.3% and 58.4% of MH and SA patients had at least one ED visit and 32.3% and 65% had at least one admission. Readmission rates for individuals with MH diagnoses are high as well: 23.3% in NYC and 20.9% for NYS.

The CNA documents low utilization of BH resources and CNA participants noted that resources are difficult to access. The CNA also notes that individuals may not access resources due to stigma, inconvenience or lack of knowledge (see CNA need 3). The CNA indicates that almost one-quarter of the population in the PPS (24.6%) speak English "less than very well." In eight neighborhoods across the PPS—which combined represent one-third of the total PPS service area population—more than one-third of the residents speak English "less than very well" (CNA need 3). Immigrant populations may be more likely to experience stigma around mental, emotional, and behavioral (MEB) health and may be less familiar with their communities' health resources.

To address the needs of individuals with co-morbid physical and behavioral health needs (CNA need 4), our PPS will pursue all three models described in the application: (1) physical co-location of behavioral health providers into primary care sites; (2) physical co-location of PCPs into behavioral health sites; and, (3) expanding implementation of Improving Mood – Providing Access to Collaborative Treatment (IMPACT) model for depression across the PPS service area.

- 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.

Based on CNA findings and by leveraging existing capacity and expertise in providing Collaborative Care, the target population for all three models—(1) physical co-location of behavioral health providers into primary care sites; (2) physical co-location of PCPs into behavioral health sites; and, (3) expanding IMPACT—will be individuals ages 12 and older receiving care at HHC or SUNY primary care clinic sites, community-based BH sites, federally qualified health centers and diagnostic and treatment centers. Our PPS will focus on patients with serious mental illness (SMI) and serious emotional disturbance, taking into account those with high medical service utilization (see CNA need 4). These patients are overwhelmingly low- and moderate-income, with one-fifth (20.9%) below the FPL.



Co-occurring chronic diseases, including diabetes, COPD, asthma and cardiovascular disease are common among the target population. These populations also tend to have high ED and inpatient utilization. As such, our PPS will coordinate these efforts with activities occurring within 2.b.iii, 2.b.iv, 3.d.ii and 4.a.iii (see CNA needs 1, 4, 5).

Our PPS will prioritize integration among sites that meet the following criteria: achievement of 2011 Level 3 NCQA PCMH; patient population of at least 1,500, experience with either IMPACT or co-location, and location in areas with a high prevalence of BH diagnoses and/or documented barriers to access.

- 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 has a range of assets and resources that will enable us to achieve the goals of this DSRIP project. Our PPS will leverage the extensive experience and expertise of PPS members that have implemented IMPACT and co-location models. Sites participating in NYS's Medicaid Collaborative Care Program, part of the Hospital-Medical Home Demonstration Program, will build on this capacity to add SBIRT, invest in systems that address DSRIP patient tracking requirements, and facilitate the development of integrated treatment plans and service delivery information between primary care and BH clinicians. Some sites will serve adolescents and/or transition to an on-site service model.

Many of the sites within our PPS have achieved 2011 NCQA PCMH recognition and/or provide some degree of co-location and/or the IMPACT model for depression: 36 adult primary care sites have some form of co-location, of which 29 have 2011 NCQA Level 3 PCMH recognition; 37 of 54 pediatric sites have 2011 NCQA Level 3 PCMH recognition and one has received 2011 Level 2 PCMH recognition; and, 17 adult clinics and two family medicine clinics are in some stage of implementing IMPACT for depression, with the family medicine clinics having achieved 2011 NCQA PCMH Level 2 recognition.

Our PPS has strong provider- and community-based resources that will be mobilized to enhance access to behavioral and physical healthcare, improve health outcomes, and reduce inappropriate ED and inpatient utilization (see CNA needs 1, 4). Because of the work done to achieve PCMH recognition, sites will be ready to quickly implement components of this project to establish co-location and/or implement the IMPACT model.

The PPS also includes four Health Homes—HHC, CBC, CCMP, and CHN. Our PPS worked with these organizations throughout the planning period to lay the foundation of joint development of services, staffing and training standards. Their expertise in care management for individuals with BH issues and co-morbid conditions will be leveraged as needed during implementation planning and throughout the DSRIP performance period. Our PPS will also continue to enhance our relationships with CBOs in order to improve social determinants of health.



- 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.

While our PPS has a range of assets and resources to support implementation and operations, we anticipate a number of project challenges. We anticipate challenges with implementing co-location given that readiness varies across sites. We will address these challenges by developing more detailed approaches to transition existing Collaborative Care sites to co-location models. This will include a staged implementation and prioritizing sites that meet minimum criteria.

We also anticipate health IT challenges, including varying EHR capabilities, care management tools, and RHIO connectivity. To address this concern, we will develop an enterprise-wide care management platform that will support data sharing across the PPS. We will also help critical partners expand health IT/EHR/HIE capabilities to support linkages and data sharing across the PPS.

We expect that the process to gain consent to share patient information will be challenging. To address this challenge we will develop a process to obtain patient consent, and we will support the implementation of this process at all project sites.

Finally, we anticipate challenges around capacity to provide services (see CNA need 2). To address this challenge we will take a multi-pronged approach, including implementing one or more of the following strategies: increasing staffing levels, increasing hours, and contracting as needed. In addition, we will work to ensure appropriate use of psychiatrists so that psychiatrists treat the most serious BH disorders and stable patients are transferred to PCPs with psychiatric consultation available as needed.

- 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.

HHC has worked collaboratively with Bronx Partners for Healthy Communities and Community Care of Brooklyn to align project selection. During the January - March 2015 implementation planning period, we intend to collaborate further with our PPS colleagues to ensure alignment and coordination of standardized protocols, development of workforce strategy, workforce training efforts, and selection of culturally competent patient education resources to support this project. Post-application, we intend to broaden this collaboration to other PPSs in our



service area,

Additionally, a critical component of 3.a.i is the ability to share data not only within each individual PPS but also across PPSs to collect information about patients who may access care outside of our PPS network. We anticipate working collaboratively with other PPSs to address these issues during implementation planning.

**3. Scale of Implementation (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)*

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input type="checkbox"/>

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

Capital funding will support space reconfiguration for sites that implement or expand co-located services.

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?

<b>Yes</b>	<b>No</b>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

**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
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.



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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups.
New York City Health & Hospitals Corporation (HHC)	NYS Hospital-Medical Home Demonstration Program	2011	2015	The purpose of this program is to improve the coordination, continuity, and quality of care for individuals receiving primary care services in outpatient primary care settings.
New York City Health & Hospitals Corporation (HHC)	Health and Recovery Plan (HARP)	2014	Ongoing	HHC facilities have applied to the NYS Office of Mental Health to become approved HARP providers. It is expected that all HHC facilities currently offering BH services will participate with MCOs and specifically HARPs once BH is transitioned to managed care.
SUNY Downstate	NYS Hospital-Medical Home Demonstration Program	2011	2015	The purpose of this program is to improve the coordination, continuity, and quality of care for individuals receiving primary care services in outpatient primary care settings.
MetroPlus	Health and Recovery Plan (HARP)	2015	Ongoing	Creation of HARPs for the severely mentally ill population.





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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
AHRC New York City	Developmental Disability Care Coordination Pilot (Part of an 1115 Waiver)	2014	2015	The purpose of this pilot is to provide MLTS without capitation (i.e., primarily care coordination) for people with intellectual and developmental disabilities.
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provides services to NYS Medicaid Health Homes under subcontract, including coordination of behavioral health services for patients with chronic medical and behavioral conditions.
Comunilife	Health and Recovery Plan (HARP)	2015	Ongoing	Comunilife is testing new payment models for integrating behavioral health care and physical health services.
Community Health Project, Inc. d/b/a Callen-Lorde Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Callen-Lorde has been assigned approximately 150 patients and 85 are actively enrolled. The program is growing, with two new Health Home positions are anticipated in the next two months. The program will scale up to 300+ patients by 2016.



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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Harlem United (HU)/ Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United is a member of the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home program.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children.
MetroPlus	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes including HHC and VNSNY.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to between 300 – 900 members per month.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

- 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.

The Hospital-Medical Home (H-MH) Demonstration Program supported many of our PPS facilities in achieving NCQA 2011 PCMH recognition and in implementing Collaborative Care. As part of DSRIP, we will build on this expertise to support these facilities in meeting 2014 Level 3 recognition. Our PPS will also expand the use of Collaborative Care to other disease states, beyond the focus areas supported by the H-MH program.

The experience and capacity of our participating Health Homes and downstream care management and care coordination agencies, is a strong foundation for this DSRIP project. Our work will build on work already underway, but will serve a larger group of Medicaid patients, including those not currently eligible for Health Home services.

The HARP program offers specialized managed care products with integrated medical and behavioral health services and expanded recovery-oriented benefits. HARP service providers and behavioral health enrollees are likely to participate in this project. However, this DSRIP project will extend to all of our actively engaged population, not just those enrolled in HARP plans.

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.