4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)

Project Objective: This project will help to strengthen mental health and substance abuse infrastructure across systems.

Project Description: Support collaboration among leaders, professionals, and community members working in MEB health promotion to address substance abuse and other MEB disorders. MEB health promotion and disorders prevention is a relatively new field, requiring a paradigm shift in approach and perspective. This project will address chronic disease prevention, treatment and recovery, and strengthen infrastructure for MEB health promotion and MEB disorder prevention. Meaningful data and information at the local level, training on quality improvement, evaluation and evidence-based approaches, and cross-disciplinary collaborations need to be strengthened.

Project Requirements: The PPS must show implementation of three of the four sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population. For each sector project, specific potential interventions are identified on the Preventive Agenda website under "Interventions to Promote Mental Health and Prevent Substance Abuse" (http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/interventions.htm).

1. Participate in MEB health promotion and MEB disorder prevention partnerships.
2. Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.
3. Provide cultural and linguistic training on MEB health promotion, prevention and treatment.
4. Share data and information on MEB health promotion and MEB disorder prevention and treatment.

Partnering with Entities Outside of the PPS for this Project
Please provide the name of any partners included for this project outside of the PPS providers. This may include an entity or organization with a proven track record in addressing the goals of this project.

Entity Name

Project Response & Evaluation (Total Possible Points – 100):

1. **Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 100)**

    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. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

In NYC, high rates of substance abuse, addiction, poor mental health, and serious psychological distress contribute to high, and often preventable, health system costs (see CNA need 4). Nearly one-third of NYC residents reported moderate or severe psychological distress in the CNA. More than 9% of Medicaid beneficiaries have been diagnosed with an SA-related condition in: six neighborhoods in Manhattan (including Chelsea-Clinton and East Harlem), three in the Bronx (including Hunts Point/Mott Haven and Crotona-Tremont), and two in Brooklyn (Bedford/Stuy/Crown Heights and Downtown/Heights/Slope).

CNA data also showed high levels of utilization of MHSA services in NYC, which are also reflected in ED visits and inpatient admissions for MHSA issues. Citywide, 42% and 58% of Medicaid beneficiaries with MH and SA diagnoses had at least one ED visit, with an average of 2.98 and 4.34 ED visits, respectively.

Gaps in care are pronounced, as approximately half of CNA respondents noted that SA services were unavailable. Gaps are compounded by provider shortages, limited provider training in MHSA issues, and silos between provider types and programs that prevent coordination. Patients who have co-occurring MEB conditions often do not receive appropriate diagnosis, treatment, and care coordination. Also of concern is the lack of attention to adolescents, a vital group to engage in prevention and early intervention efforts.

To close these gaps, our PPS, together with CCB and BPHC, will undertake sector projects 1-3 with the goals of: promoting evidence-based practices in MHSA care; breaking down silos in care to enable health professionals to collaborate and address the population's full range of MHSA needs; and, targeting adolescents with MHSA education and outreach (see CNA need 6).

Under Project 1, the PPSs have established, and committed via a Charter, to a citywide MHSA Workgroup that will bring together a cross-section of MHSA providers to develop infrastructure and programs to transform MHSA services across NYC, and to develop a methodology to assess programs' impact on MHSA service utilization and care.

Collaborating with State and City agencies as appropriate, the Workgroup will identify and promote evidence-based programs that extend the reach of education, screening, and early intervention into existing health service footprints. In one such program, the Workgroup will adapt or develop culturally-sensitive educational materials (see CNA need 3) that inform adolescents about the nature of and risk factors for MHSA diseases (i.e., the fact that diseases frequently co-occur and begin during adolescence) and early warning signs.

Under Project 2, the PPSs will support the adaptation of the Collaborative Care (CC) model, which was designed to target adults and has demonstrated less clinical efficacy in adolescents, to specifically meet adolescent needs. The group will evaluate successful adaptations of the CC model for adolescents, such as Reaching Out to Adolescents in Distress (ROAD) (see CNA need 6.)

Under Project 3, all activities and programs will consider cultural and linguistic factors, including: differences in views regarding mental health and use of addictive substances; intra-cultural issues; circumstances linked to MEB health such as trauma/violence; and, language access-related issues (see CNA need 3).

Our PPS will also coordinate its activities with work under Project 3.a.i., Integration of Primary Care and Behavioral Health services, and identify options to deliver services in community-based settings (e.g., withdrawal management).

While our PPS is not undertaking project 3.a.iv – Development of Withdrawal Management Capabilities and Appropriate Enhanced Abstinence Services within Community-Based Addiction Treatment Programs, the CNA has identified a need for these services and our PPS will explore whether and how we may be able to develop these capabilities in the future.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population *must be specific and could be based on geography, disease type, demographics, social need or other criteria.*
Our PPS expects to engage the following populations: all attributed patients ages 12 and above with MEB health diagnoses or substance use disorders (SUDs), as well as those at high-risk for developing SUDs, other MEB health diagnoses, and other health and social consequences linked to risky substance abuse and MEB needs (see CNA needs 4, 6.)

Specific targeted sub-populations include adolescents ages 12 - 25, a critical group for prevention and early intervention efforts given that up to 20% of adolescents experience an episode of major depression by age 18, yet few receive evidence-based treatment for their depression. In NYC, 32.9% of Medicaid beneficiaries are under age 19, according to the CNA, and key experts consulted in the CNA reported significant gaps in MHSA care in NYC for adolescents.

We will also engage the criminal justice re-entry population, which has dramatically heighted MHSA needs upon release and is a focal population of Mayor DeBlasio's administration (DeBlasio is dedicating $130 million over the next four years to address this population's health needs).

Lastly, we expect to enhance outreach to dual-eligibles and Medicaid patients with MH and SA diagnoses in geographic areas with heightened need for and utilization of MH and SA services based on CNA and focus group data. Collaborating with partner PPSs, we plan to emphasize work in "hot spot" areas such as Rockaway, Crotona-Tremont and Hunts Point-Mott Haven in Queens, East Harlem and Chelsea-Clinton in Manhattan and Crown Heights and Bushwick-Williamsburg in Brooklyn. Census data indicated that 17.7% of NYC's population consists of non-U.S. citizens and 23.2% of persons speak English "less than well." Based on the composition of the PPS's attributed population, we will work to ensure that all interventions and approaches are culturally sensitive.

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.

We have a number of assets and resources to support our effectiveness in this project. First, we have extensive experience in delivering services to this population, given that our PPS provides more than 30% of inpatient detox and more than 41% of mental health inpatient care in NYC. We also have a significant foundation of MHSA providers and community programs upon which to build. Across NYC, there are 49 general psychiatrists and 231 social workers per 100,000 residents. The distribution of these professionals varies by neighborhood (e.g., Fresh Meadows in Queens has no psychiatrists that accept Medicaid patients). There is a wide range of MHSA programs throughout NYC, including mental health residential programs, mental health outpatient programs, alcohol and drug use services, and youth-targeting programs.

NYC's broader mental health support infrastructure is also extensive, with supportive case management programs and targeted case management programs serving patients with mental health needs. We work closely with programs such as Parachute NYC which provides alternatives to hospitalization for people experiencing emotional crises. In addition, organizations like the National Alliance on Mental Illness - NYC (NAMI-NYC) provide critical advocacy and education services that will inform our activities.

Despite this strong base of providers, as documented in CNA focus group, many programs have operated in silos and there has been no citywide coalition to promote much-needed MHSA infrastructure development. Through the Workgroup, we will convene key stakeholders (e.g., providers, payers, subject matter experts) to adapt, develop and disseminate resources such as training materials and educational programs. The Workgroup will also develop approaches to assessing progress. There are successful models of adolescent-focused CBO activities to explore and consider adapting, including the Turnaround for Children program, the Peer Health Exchange's peer-based mentoring, YMCA wellness programs, and middle- and high-school-based health curricula that could be expanded to more robustly address MHSA prevention and early intervention. In developing educational models for adolescents and adults (e.g., parents, teachers) on MHSA needs, our PPS will aim to develop and support partnerships among health professionals, CBOs, and/or middle and high schools that have strong experience in this arena, including the aforementioned programs.

MHSA project activities are also intended to support new and existing sites that are implementing the Collaborative Care/IMPACT model under project 3.a.i. Many clinics within our PPS have implemented this model. While valuable, the model almost exclusively targets adults and does not include the use of SBIRT. PPS partners will explore opportunities to develop and pilot adolescent-targeted adaptations of the Collaborative Care model using developmentally sensitive materials and structured involvement of adolescents and parents in education and treatment (e.g., the ROAD model). These activities will enhance our ability to deliver services through the IMPACT model to a broader population.

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.

We anticipate a number of project challenges. First, there is a lack of patient education and engagement around risk factors, causes, and treatments for MHSA disorders (see CNA need 6). In many communities there are significant obstacles to care (e.g., misunderstanding of diseases, stigma associated with MHSA disorders, insufficient social supports). Parents of adolescents may also be reluctant to actively engage in MEB health promotion efforts due to their own biases or constraints. To address these concerns, MEB health promotion programs will need to be culturally responsive, particularly for ethnic minorities and immigrant populations, in order to effectively serve the target population. We will also work closely with community programs (e.g., the Arthur Ashe Institute) to address these concerns, looking for peer leaders and others to facilitate patient engagement and break down pronounced barriers to care.

There are also challenges in targeting adolescents with MHSA services, given that not all adult-appropriate MHSA models can be seamlessly applied to adolescents. To address this challenge we will develop adolescent-specific adaptations of the Collaborative Care model. This process will include the evaluation of practices that have reported success in reaching adolescents with similar demographics and needs as those in our service area. Further, to develop adolescent training materials that are used in a schools or other setting, we will consider evidence-based models such as peer-mentor programs and programs that leverage social media outlets to disseminate messages.

Finally, we are challenged by the fact that MHSA services are often siloed. As such, we will need to emphasize coordinating and integrating care through active prevention efforts, routine screenings to assess co-occurring conditions, and developing comprehensive treatment plans. Through the Workgroup, and in collaboration with State agencies, our PPS will identify particular obstacles to care coordination and then work to remedy those deficits.

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

Throughout the DSRIP planning process, our PPS has participated in various MHSA joint planning sessions with CCB and BPHC to achieve consensus on the selected Sector Projects 1-3, with the goals of: promoting evidence-based practices in MHSA care; breaking down silos in care to enable health professionals to collaborate and address the population's full range of MHSA needs; and, targeting adolescents with MHSA programming.

Through the citywide MHSA Workgroup, and guided by the Workgroup Charter, the PPSs have agreed to select this MHSA Infrastructure Project and align key programs related to its

implementation. Specifically, we will bring together a cross-section of MHSA leaders in the citywide Workgroup to develop programs and resources under Sector Projects 1-3 that can more comprehensively support MHSA infrastructure. The Workgroup will research and propose evidence-based models to implement across NYC and its boroughs, with the models subject to borough-specific tailoring with sensitivity to social and cultural factors. Further, we will collaborate to review and expand upon existing Collaborative Care trainings to more appropriately address adolescent groups. And, consistent with Sector Project 3, all resources and programs will be culturally responsive in order to meet the needs of NYC's diverse communities.

During the 2015 implementation planning period, we intend to continue further collaboration with PPS partners and stakeholders to ensure alignment and coordination of standardized protocols, development of workforce strategies, workforce training efforts, and selection of culturally responsive patient education resources to support this project. We will also collaborate with other PPSs that have selected this project.

f. Please identify and describe the important project milestones relative to the implementation of this project. In describing each of the project milestones relative to implementation, please also provide the anticipated timeline for achieving the milestone.
Important implementation milestones:
Leadership & Coordination: Organize structure for citywide Leadership Workgroup meetings and identify participants and organizers (Q1/Q2 DY1); convene Workgroup meetings (Q3/Q4 DY1)
Gap Analysis: Review existing programs and CBOs to identify gaps and strengths (Q1/Q2 DY1)
Adolescent-Targeted Programs: Review evidence-based models to adapt the CC model (Q3/Q4 of DY1); develop curriculum (Q3/Q4 DY2); share curriculum with PPSs to integrate into the CC model (Q1/Q2 DY3); identify Dept. of Education contact; develop/implement school-based curriculum (Q1/Q2 DY3)

Adult-Targeted Programs: Review and revise educational materials and outreach initiatives targeting ethnic groups and high-impact neighborhoods, as needed (Q3/Q4 DY2); launch initiatives (Q1/Q2 DY3

2. <u>Project Resource Needs and Other Initiatives</u> (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.

b. Are any of the providers within the PPS and included in the Project Plan PPS 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
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.

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)	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.
MetroPlus	Health and Recovery Plan (HARP)	2015	Ongoing	Creation of HARPs for the severely mentally ill population.
Comunilife	Health and Recovery Plan (HARP)	2015	Ongoing	Comunilife is testing new payment models for integrating behavioral health care and physical health services.
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provide services to NYS Medicaid Health Homes under subcontract, including coordination of behavioral health services for patients with chronic medical and behavioral conditions.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	CMS Innovation Center Health Care Innovation Awards (HCIA)	April 2014	March 2017	As part of this CMMI Round 2 grant (ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use), HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. The target population for this initiative is patients with ambulatory sensitive conditions.
CAMBA	CMS Innovation Center Health Care Innovation Awards (HCIA)	2012	2016	CAMBA provides Health Home care management services, under subcontract, to individuals with serious mental illness as part of Maimonides Medical Center HCIA initiative.
Comunilife	SAMHSA Treatment for Homeless	2010	2015	Comunilife provides supported enriched housing services for homeless persons with serious and persistent mental illness (SPMI).
Community Health Project, Inc. d/b/a Callen-Lorde Community Heatlh Center	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Currently, Callen-Lorde has been assigned approximately 150 patients of whom 85 are actively enrolled. The program is growing, with two new Health Home positions anticipated to open in the next two months. The program will scale up to 300+ patients by 2016.

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.
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees as deemed necessary by HHC, to the HHC Health Homes as part of this initiative.
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.
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.
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.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
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 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.

Funding provided through the SAMHSA Treatment for Homeless program is not duplicative of activities described in DSRIP because our PPS does not intend to provide supported enriched housing to persons with serious and persistent mental illness through the MHSA project.

3. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project. 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 populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due by 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.

a. **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.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. 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.