4.a.iii. – Strengthen Mental Health and Substance Abuse Infrastructure Across Systems

Summary	Resources in Place	Challenges	Resource Needs
• Address mental health-related problems within the clinical practice setting • Health promotion and disease prevention programs (HPDP) address mental health poorly. • Two task forces – Children and adult. • Develop cross-systems partnerships for a holistic approach. • Public education programs to destigmatize mental illness/ educate about the dangers of prescription drugs.	• Strength-based parenting and coaching support, such as early childhood home visit programs, circle of security programs, positive parenting programs, Strengthening families programs. • School based wellness promotion programs. • Clinical information available through the Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid	• The cost of care managers and consulting psychiatrists. • Training primary care doctors to screen for, identify and talk to patients about behavioral health.	• Telepsychiatry • Technologically enhanced web chat capability. • Regulatory relief for consolidation of services operated by article 28, 21 and 32 clinics. • Decrease billing complexity. • School-based behavioral health clinics. • Space in primary care sites that are implementing the IMPACT model. • Enhanced IT • Additional Psychiatrists and social workers.

Domain 4 Projects

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
Nassau Coalition for Behavioral Health Providers Nassau Alliance For Addiction Services (NAFAS) Criminal Justice System – Nassau County and the Borough of Queens Nassau County Department of Mental Health Chemical Dependence and Developmental Disability Services New York State Office of Mental Health Long Island Field Office

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

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (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.

NYS Office of Mental Health (OMH) estimates there are 154,200 individuals with serious mental illness (SMI) and 74,245 individual with serious and persistent mental illness (SPMI) in Nassau and Queens. OMH reports that 10% of the population with SMI is served by public mental health services. Long Island Federally Qualified Health Center's (LIFQHC) one-month study, using a Public Health Questionnaire-4 screening on patients with no known behavioral health (BH) diagnoses found 27% had a score that warranted referral for evaluation for anxiety and/or depression.

The Community Needs Assessment showed the PPS service area had 25,422 Medicaid beneficiaries who were hospitalized/visited the Emergency Department (ED) for substance abuse (SA) services in 2012, accounting for 47,000 inpatient admissions/54,000 ED visits. This is more than beneficiaries with respiratory illness or diabetes. PQI data showed the highest rates of SA ED visits in the Rockaways.

In stakeholder forums they spoke about many BH gaps in services. Crisis services are not accessible after hours/on weekends, and aren't always linguistically/culturally appropriate (race/ethnicity, faith, LGBTQ, age). Existing respite programs exclude the homeless, making it difficult to find services for high-utilizing patients. No uniform standards exist to evaluate need for admission, or for extended services post-discharge. Under the current system, patients in crisis are brought to the ED after hours, and are often admitted to locked inpatient psychiatric units. This has also been a growing problem for the child/adolescent population. Schools have lowered their thresholds for certain behaviors in the wake of national episodes of violence in schools. Psychiatric EDs have experienced consistent growth in child/adolescent presentations that could be adjudicated at a lower level of care if available. Peer supports/health coaches have demonstrated success in facilitating connection to the delivery system, yet peer services are not widely available, nor generally, reimbursable.

The BH infrastructure needs repair. This project will address the problem. By working on a population-based level and a clinical interaction level, the way BH disorders are understood, identified and treated will be transformed.

The project focus is culturally competent mental, emotional and behavioral (MEB) Health Promotion and Disease Prevention HPDP). The most recent Nassau County Community Health Improvement Plan identified Promote Mental Health and Prevent Substance Abuse as an important prevention agenda. The need for improvement in this area also emerged as a theme throughout the analysis of community response data.

A project committee will be created and representatives from state and local government, community-based organizations (CBO) in the child welfare, corrections, police, fire, juvenile justice, probation, social services, child welfare, education and affordable housing systems and faith-based organizations will be invited to assist with this.

One proposed initiative is the establishment of culturally/linguistically appropriate training in the basics of BH; basic understanding of the diseases, symptoms, warning signs and how to approach someone who may be entering the early stages of a crisis.

The strength of this initiative is the ability to convene partners to evaluate what should be done to strengthen care, so that efforts are coordinated and reflect a common agenda.

- Survey initiatives across the organizations participating to identify duplication for the purposes of better coordination.

- Expand school-based BH services so children have immediate, convenient access to BH services.

- Public awareness campaign to de-stigmatize mental illness and promote MEB.

- Public awareness campaign about the dangers of prescription drugs (particularly opioids) and easy, convenient and safe medication disposal.

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.*

The HPDP project will focus on all Medicaid beneficiaries and the uninsured of the PPS service area. A special focus will be targeted to children and families who are involved in social safety net services, such as Department of Social Services, housing agencies, Persons in Need of Supervision Courts and Family Courts, who are at greater risk of developing behavioral health problems, such as depression, anxiety, conduct disorders and substance abuse disorders. As a component of this process, Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs have been implemented in EDs in the LIJ and its affiliates, will be expanded to other EDs serving NQP. SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was initiated due to an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

The IMPACT portion of this project will target people with mild to moderate, sub-diagnostic, or undiagnosed behavioral health disorders. As highlighted in the CNA, targeted communities include Jamaica, Richmond Hill and the Rockaway Peninsula.

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.

In 2012, OMH launched the first BH-focused readmission quality collaborative in the country. The document "Reducing Behavioral Health Readmissions: Strategies and Lessons Learned" includes resources, recommendations and lessons learned from the collaborative as well as nationally. This document will be used to inform the development/strengthen efforts in the PPS region.

A disproportionately high number of individuals with mental health (MH) and addictions have contact with the criminal justice system. In Nassau County, coordination of care between the criminal justice system and the community healthcare system is improving with recent mandates that require communication about the incarcerated population, resulting in better care coordination.

Health Homes are charged to facilitate an electronic exchange of clinical information, and expand case management to include MH, chemical dependence and physical health. Key informants indicated that this proposed higher level of communication is still required across health and social services, similar to communication requirements to which the criminal justice system is held.

Clinical information is available through the Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES-M). PSYCKES is a HIPAA-compliant, web-based set of tools designed to support quality improvement and clinical decision-making in the State's Medicaid population.

Recovery networks including peer groups are important part of the MH and substance abuse (SA) infrastructure. Currently, there is an informal recovery network with associations and gatherings, e.g., the Long Island Recovery Center and the veteran's community. These networks will be built upon, as it was acknowledged in stakeholder forums that peer services are lacking.

In Queens, this project can help strengthen the local mental hygiene system and can support with the help of an array of community- and hospital-based services, individuals with MH and SA problems; including crisis, stabilization, supportive and prevention.

The current Nassau Community Health Improvement Plan identifies promoting mental health and preventing substance abuse as an important prevention agenda item. The need for improvement in this area emerged as a common theme by the stakeholders. The fact that this has been identified in the Improvement Plan will provide additional collaborators/resources to support the project.

Examples of MEB resources in Nassau and eastern Queens that can assist with this project include:

Strength-Based Parenting/Coaching Supports
- Early Childhood Home Visiting programs, e.g., Nurse-Family Partnership; Healthy Start
- Circle of Security–parent-child interactions and secure attachment
- Positive Parenting Program–prevention and treatment model through parenting support in home environment

- Strengthening Families–parenting skills training reduces risk of emotional, behavioral, and academic problems and substance useSchool-based MEB wellness promotion
- Parent Corps–family-centered intervention in early care and education settings to promote healthy early childhood development
- The Incredible Years–3 complementary training programs for children, parents, and teachers
- Life Skills Training–to prevent alcohol, marijuana, and tobacco use, and violence in school setting.
- Strengthening Families–youth development and substance use prevention

These assets make it possible to implement the IMPACT collaborative care model in about a year. Likewise, the availability of FIT (Focus on Integrated Treatment) training will facilitate rapid training of clinicians, staff and administrators throughout NQP.

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 largest anticipated challenges to the implementation of the IMPACT model in primary care practices are financial, training and regulatory. The cost of care managers and consulting psychiatrists is considerable. We anticipate utilizing telepsychiatry to expand consulting psychiatrist capacity and reduce associated costs, although the availability and efficacy of telepsychiatry will be limited until reimbursement and licensing issues are resolved. Telepsychiatry should be reimbursable across location, not just one state licensed environment to another, and include multiple services/providers such as non-prescribers. Currently, various managed care plans including Medicaid/Medicare do not reimburse across the board for telemedicine. Regulatory issues that relate to the different oversights for primary care (DOH-Article 28), mental health (OMH-Article 31) and substance abuse (OASAS) need to be addressed. Legislation is pending for multiple licensing with one lead agency on the horizon in early 2015.

We expect to use technologically enhanced care management that utilizes face-to-face interventions supplemented with telephone, SMS and webchat as a means of expanding access and reducing cost. Training primary care doctors, especially pediatricians, how to screen for, identify and talk to patients about BH is consistently a challenge to the implementation of collaborative care. We intend to leverage simple screening tools and projects, like the PHQ-9, the CAGE and SBIRT (in collaboration with the OASAS SBIRT Policy Advisory Group) as well as the FIT training to overcome these barriers. On the regulatory side, we require relief from regulations that make it difficult to consolidate the services currently offered by article 28, 31 and 32 clinics and regulations that make preventive care and collateral visits difficult to bill. We anticipate that relief will be forthcoming.

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.

NQP has no overlap in Nassau or Suffolk. Advocate Community Partners (ACP) has included eastern Queens in its service area, but not Rockaway Peninsula. The New York Hospital of Queens and Health & Hospitals Corporation are PPSs in Queens. Due to their location overlap is possible

if the same projects are chosen (not known presently). Maimonides and NYC HHC plan to pursue this project.

LIJ's affiliate has ACP Board representation. Leveraging the LIJ role in the NQP and in the ACP PPS, LIJ will be able to rapidly communicate and share information and best practices with the NQP ACP does not plan to pursue this project.

For this project NQP has experienced hub members with developed population health models collaborating with PCMH, primary/specialist physicians, BH and SA providers and the health home. These hub members are experienced in value based payment programs. This project will focus on enhancing the BH and SA infrastructure. This is most important in Rockaway Peninsula. Stakeholder forums in the CNA indicated great concern for behavioral health (BH) and substance abuse(SA) problems. Linking partners to the RHIO to share patient information to benefit the patient is a feature of the infrastructure. ACP/other PPSs utilize the RHIO. This common platform that will enable the PPSs to communicate about their patients' clinical needs. The RHIO is the vehicle for PPSs to share patients, understand patients' clinical history, and care plans.

PPSs will share partner organizations, e.g., BH providers and SA agencies that care for Queens communities. If this project is chosen by more than one PPS in the service area, the shared partner may become overwhelmed and confused about the activities of multiple PPSs. PPSs will have to coordinate how to best achieve DSRIP goals to decide which PPS the partner is best suited for. Criteria for choosing which PPS can be based on partner attribution, shared clinical/operational infrastructure, current affiliations, locations, what is the least disruptive and most complimentary to partners' and the patients' interests.

Other collaboration will include quarterly or more frequent meetings, to discuss implementation difficulties and garnering shared resources to meet community need/objectives of DSRIP shared projects.

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.

Key milestones and metrics that we will track are:

- The establishment and bi-monthly meeting of the project team – by end of DY1

- The metrics evaluated as part of the Learning Collaboratives – by end of DY1 and monthly thereafter

- 911 calls regarding overdose and the number of saves resulting from those calls – by end of DY1 and quarterly thereafter.

- Practices that have implemented the IMPACT model and number of patients treated – by end of DY2 and monthly thereafter. We will target 10 practices treating 40,000 patients by end of DY2.

- The numbers of front-line workers trained in programs implementing IMPACT – by end of DY1 and quarterly thereafter. We will have 20% of front-line workers trained by end of DY1 and will train an additional 20% per year.

2. 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.

Three major capital funding needs will make it possible for this project to succeed. The first is the construction of school-based behavioral health clinics. These clinics need not be elaborate, but they will require dedicated space in which the staff can have private conversations with children and adolescents in a warm, welcoming, therapeutically appropriate environment. The second is the development of space in the primary care sites that are implementing the IMPACT model. These locations will require the construction of therapeutically appropriate space for behavioral health professionals and care managers. Clinicians will need private spaces in which to meet with patients. In addition to the general physical plant and IT needs that are consistent with any clinical space, these spaces need to be different from traditional clinical treatment rooms in that they are warm, comfortable, welcoming, therapeutically designed spaces, not the cold, sterile, rooms in which most clinic visits occur. The Information Technology/Electronic Health Record system and associated infrastructure needs to be developed to facilitate the appropriate sharing of data across all of the clinicians in the PPS (including those located in schools). The Mental Hygiene law, as well as federal laws on sharing of substance abuse information at the patient level makes information sharing difficult without consent. The Information Technology implementation solution for interoperability will need to address this.

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
North Shore University Health Home (participating partner and LIJ affiliate) ; FEGS Health and Human Services System	Health Homes for Medicaid Enrollees with Chronic Conditions	9/1/12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital.

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.

These initiatives differ from this DSRIP initiative because they are for distinct services and populations, not the entire Medicaid and uninsured population. These initiatives do not involve the entire delivery system in accomplishing their goals either – they are largely about care management. They require managing the care of subpopulations, particularly those with chronic illnesses to improve outcomes and reduce costs. These initial population health programs, however, have given members of the PPS substantial experience in managing high risk patients. The infrastructure underlying these program and the expertise gained will serve as the foundational building blocks for the PPS. These programs will accelerate the success of the PPS. They are good opportunities to learn from and to guide the development of the IDS.

3. 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. 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.