The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) Program is to restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. In partnership with hospitals, public health agencies, physicians and community-based organizations, the North Country Initiative is advancing state-wide projects to transform the healthcare system, coordinate care, and improve the health and wellness for our population.

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 on page 2).

Patient Population:

All Medicaid patients or recipients with specific focus on those receiving Behavioral Health services

Identified Community Need:

Mental illness is the single highest cause of preventable inpatient admission and emergency department visit. In addition, it is clear that there is a disconnect between behavioral health services and primary care services. PCs report being unable to get their referred patients appointments for BH care and BH providers report being unable to get access to primary care for their behavioral health patients. BH patients have high rates of co-occurring diabetes, cardiac and respiratory diseases. The suicide rate for the region is nearly twice the state rate and Medicaid beneficiaries surveyed indicated that mental illness was the number one health concern in their community. There is clear and compelling evidence that integrating PC and BH at the primary site of care for the patient is needed.

NORTHCOUNTRY INITIATIVE

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Integration of Primary Care and Behavioral Health Services

Project Milestones	
PCMH Service Site:	1. Co-locate behavioral health services at primary care practice sites. All participating primary care practices 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-3 or 9 for those screening positive, SBIRT) implemented for all patients to identify un-met needs. 4. Use EHRs or other technical platforms to track all patients engaged in this project.
Behavioral Health Service Site:	5. Co-locate primary care services at behavioral health sites. 6. Develop collaborative evidence-based standards of care including medication management and care engagement process. 7. Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those testing positive, SBIRT) implemented for all patients to identify unmet needs. 8. Use EHRs or other technical platforms to track all patients engaged in this project.
IMPACT:	**This is an integration project based on the Improving Mood - Providing Access to Collaborative Treatment (IMPACT) model. IMPACT Model requirements include:** 9. Implement IMPACT Model at Primary Care Sites. 10. Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement. 11. Employ a trained Depression Care Manager meeting requirements of the IMPACT model. 12. Designate a Psychiatrist meeting requirements of the IMPACT Model. 13. Measure outcomes as required in the IMPACT Model. 14. Provide "stepped care" as required by the IMPACT Model. 15. Use EHRs or other technical platforms to track all patients engaged in this project.