Delivery System Reform Incentive Payments(DSRIP)

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Just a word about PROS and Health Home

	Outreach Recipients			Active Recipients		
Region	June	July	August	June	July	August
Central NY Region	39	37	40	129	135	121
Hudson River Region	84	98	97	607	658	543
Long Island Region	177	180	162	975	992	998
NOT AVAILABLE	3	0	2	57	53	46
New York City Region	136	154	154	826	848	813
Western NY Region	174	156	150	477	443	459
Statewide	**613**	**625**	**605**	**3,071**	**3,129**	**2,980**

PROS and BIP

The Balancing Incentive Pan (BIP) allows OMH to use federal funds to support individuals transition to community based settings.

PROS Regulations have been modified to define the BIP target population to include individuals who have lived in one of the following settings for longer than six months and have been recently discharged to the community:

- ☐ **Adult Homes**
- ☐ **Nursing Homes**
- ☐ **State Psychiatric Center or**
- ☐ **State Operated Community Residence**

BIP: An Opportunity for PROS Programs…

Highlights of PROS and BIP:

- **Pre-admission Service:** Enhanced rate for target population and extension of timeframe allowable for pre-admission billing.
- **Enhanced CRS Services:** New payment for certain CRS services off-site to members of the target population.
- **IR Services**: IR claims for services for the target population are not counted toward the 50% cap calculation.

For PROS & BIP Guidance and BIP rates, go to:

http://www.omh.ny.gov/omhweb/pros/bip/

PROS & BIP webinar information will be distributed soon.

DSRIP Funding

$6.42 Billion for Delivery System Reform Incentive Payments(DSRIP) – including DSRIP Planning Grants, DSRIP Provider Incentive Payments, and DSRIP Administrative costs

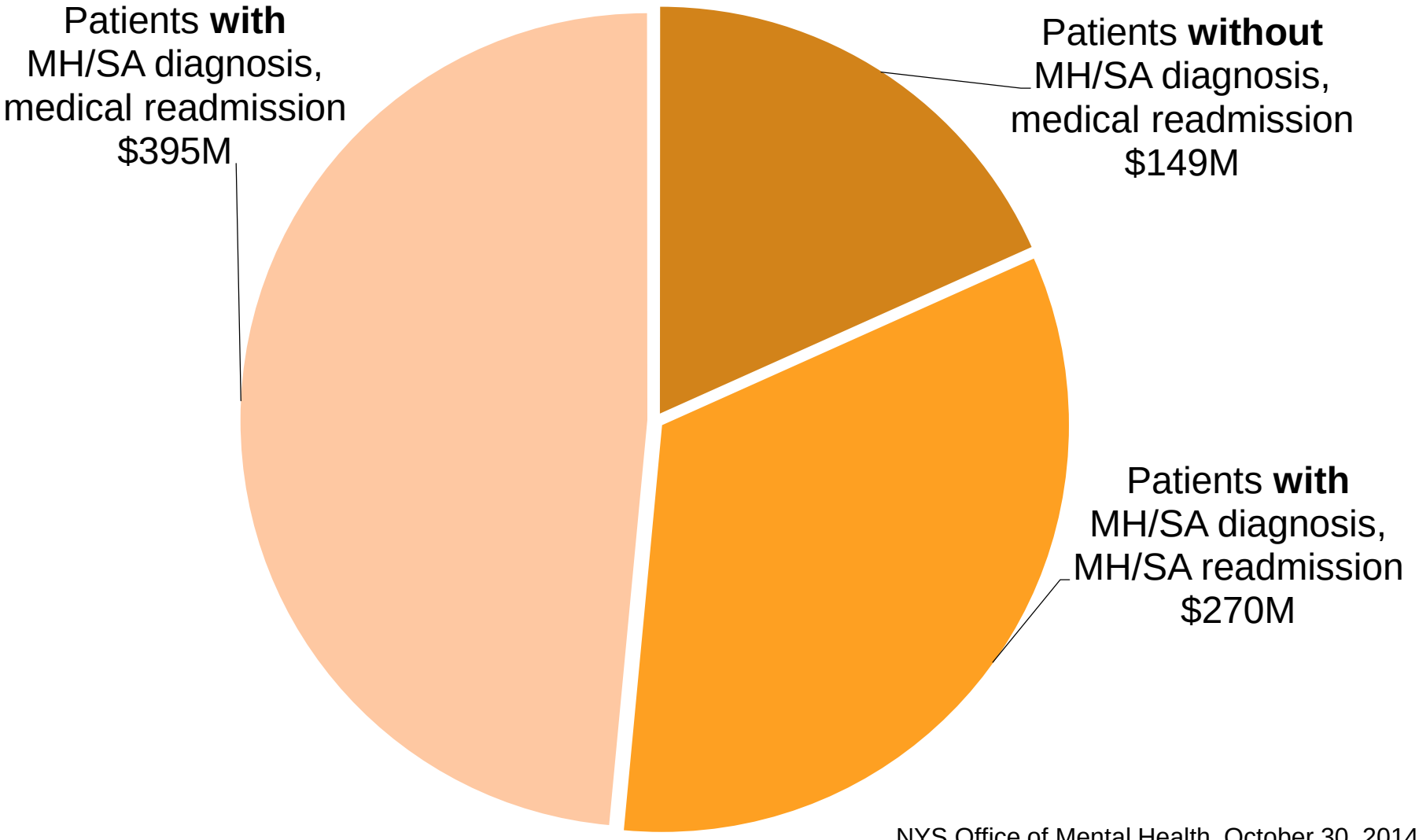
What is DSRIP's Purpose

- The DSRIP program will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years.

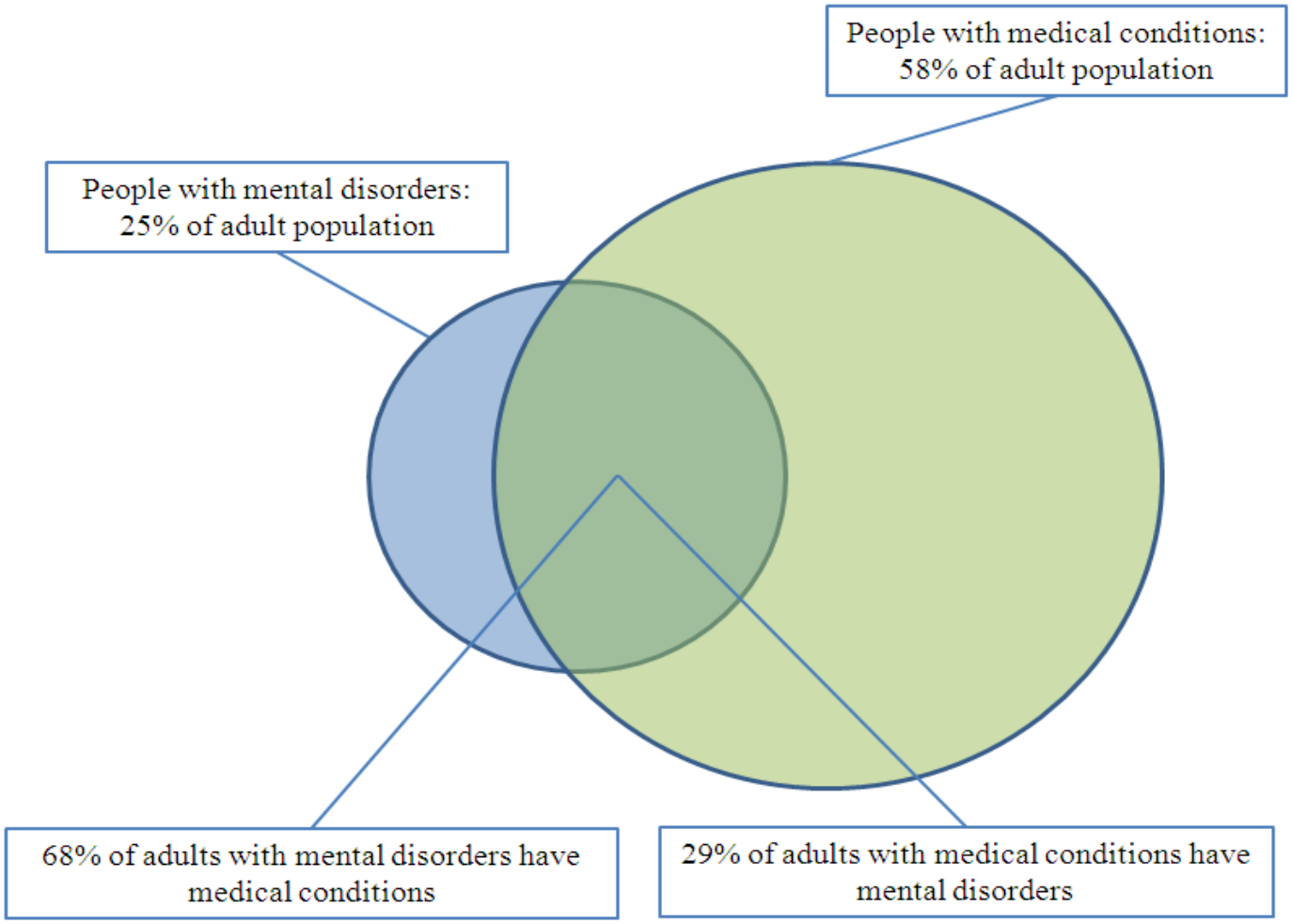
- Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement.

- Single providers will be ineligible to apply. All DSRIP funds will be based on performance linked to achievement of project milestones.

The Case for Integration:
Potentially Preventable Readmissions, NYS Costs (2007)

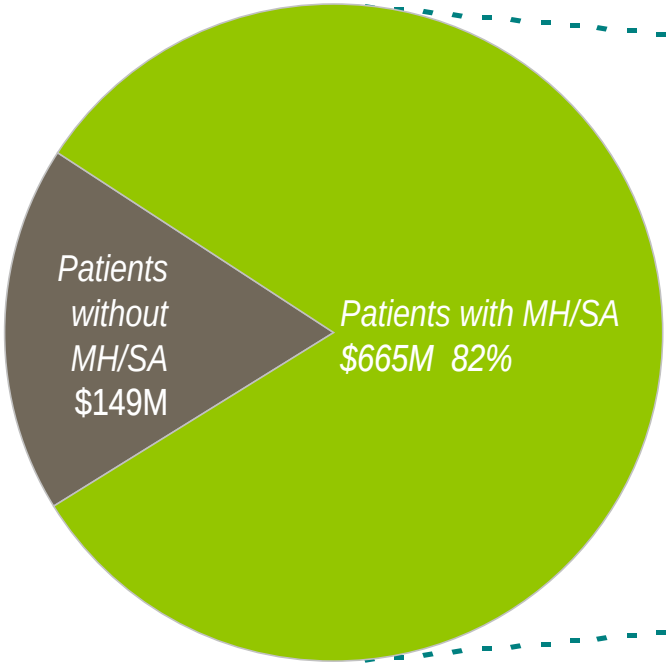


NYS Office of Mental Health, October 30, 2014

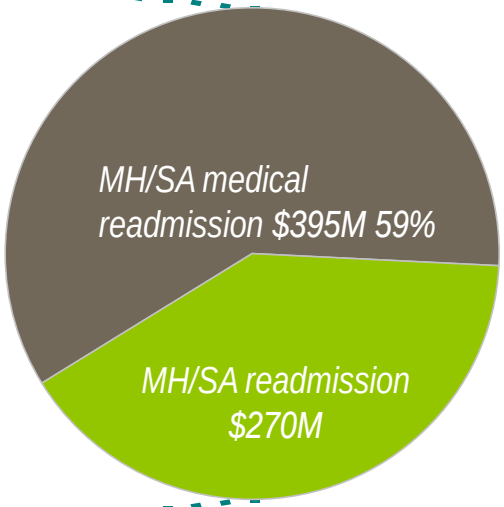

People with medical conditions:
58% of adult population
People with mental disorders:
25% of adult population
68% of adults with mental disorders have medical conditions
29% of adults with medical conditions have mental disorders

Most Readmission $ for Medical Reasons for Patients with Underlying BH DX

All Readmissions* ($814M)

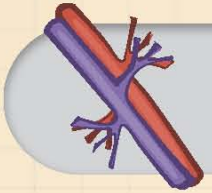


Readmissions for Patients with MH/SA Conditions ($665M)



*Readmissions within 30 day from original admission date

Co-occurrence between mental illness and other chronic health conditions:



Mental Illness	21.9%
No Mental Illness	18.8%

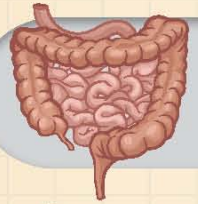
High Blood Pressure

Mental Illness	36%
No Mental Illness	21%

Smoking

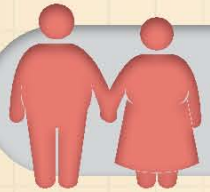
Mental Illness	5.9%
No Mental Illness	4.2%

Heart Disease



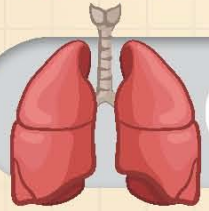
Mental Illness	7.9%
No Mental Illness	6.6%

Diabetes



Mental Illness	42%
No Mental Illness	35%

Obesity



Mental Illness	15.7%
No Mental Illness	10.6%

Asthma

Health Home Highest Risk Population –
Multiple Co-occurring Complex Disease so Care MUST Be Integrated

Chronic Episode Diagnostic Categories
Health Home Eligibles Adults 21+ Years
With a Predictive Risk Score 75% or Higher (n=27,752)

Percent of Adult Recipients with Co-Occurring Condition

Condition	Total	Severe Mental Illness	Mental Illness	Subst-ance Abuse	Hyper-tension	Hyper-lipidemia	Diabetes	Asthma	Congest-ive Heart Failure	Angina & Ische-mic Heart Disease	HIV	Obesity	Osteo-arthritis	COPD & Bronch-iectasis	Epilepsy	CVD	Kidney Disease
Severe Mental Illness	43.5	100.0	**74.7**	**77.2**	33.8	28.1	23.2	34.1	6.8	8.5	9.6	14.8	23.2	13.9	20.1	31.9	10.9
Mental Illness	46.2	**70.4**	100.0	**70.9**	42.0	33.7	28.0	35.8	11.0	12.6	8.7	16.9	29.9	17.8	19.4	41.0	16.4
Substance Abuse	**54.4**	**61.9**	**60.3**	100.0	35.4	25.9	21.4	32.8	7.5	9.4	11.2	10.7	23.1	14.5	16.4	34.4	11.2
Hypertension	37.6	39.1	51.6	51.1	100.0	47.4	41.4	30.7	28.2	22.1	5.6	17.8	29.3	22.6	13.9	62.2	30.8
Hyperlipidemia	29.8	41.0	52.2	47.1	59.8	100.0	54.9	37.7	27.8	33.4	5.6	23.6	30.9	25.1	15.0	70.4	31.5
Diabetes	27.8	36.3	46.5	41.8	56.0	58.8	100.0	35.4	25.7	25.3	5.4	24.3	28.1	22.8	13.2	64.9	34.3
Asthma	28.3	52.4	58.5	62.9	40.8	39.7	34.8	100.0	15.3	17.4	12.3	22.0	34.3	33.0	16.7	47.7	18.4
Congestive Heart Failure	13.4	22.1	37.9	30.6	79.5	61.9	53.5	32.3	100.0	41.2	4.1	21.1	26.1	33.9	8.9	100.0	50.3
Angina & Ischemic HD	12.2	30.5	47.8	41.8	68.2	81.5	57.6	40.3	45.1	100.0	4.6	24.1	33.8	31.5	11.7	100.0	41.9
HIV	8.3	50.2	48.4	73.5	25.2	20.0	18.1	41.9	6.7	6.8	100.0	4.9	26.6	16.4	13.2	31.1	17.9
Obesity	12.7	50.5	61.4	45.8	52.6	55.4	53.1	49.0	22.2	23.1	3.2	100.0	39.3	25.7	16.5	60.1	27.2
Osteoarthritis	22.1	45.7	62.7	56.8	49.9	41.8	35.5	44.0	15.8	18.7	10.0	22.7	100.0	25.5	15.1	52.0	24.9
COPD & Bronchiectasis	15.5	38.8	53.0	50.6	54.7	48.1	40.7	60.1	29.2	24.8	8.7	21.0	36.1	100.0	14.0	67.2	27.0
Epilepsy	13.5	65.1	66.6	66.3	38.8	33.2	27.2	35.1	8.9	10.6	8.1	15.6	24.8	16.2	100.0	41.1	16.3
CVD	41.9	33.2	45.3	44.6	55.9	50.2	43.1	32.3	32.0	29.2	6.2	18.3	27.4	25.0	13.2	100.0	35.4
Kidney Disease	18.8	25.2	40.4	32.4	61.5	49.9	50.6	27.6	35.8	27.2	7.9	18.3	29.1	22.3	11.7	78.6	100.0

Tobacco Use and SMI: The Problem

People with SMI die up to 25 years younger than the non-SMI population

•Over ½ of this early death is attributable to preventable smoking related diseases. (Callaghan et. al. *Journal of Psychiatric Research, September 2013).*

Traditional Public Health tobacco cessation approaches have failed to reach the SMI population (Williams, Miller, Willet, *JAMA Psychiatry*, pending publication)

•Smoking rates in the general population have dropped from 45% in 1965 to < 20%.

•Yet, in the SMI population, rates have remained steady at 50% -60%

•>40% of cigarettes smoked in the US are smoked by people with a history of mental illness

NYS OMH promotes Collaborative Efforts to deliver evidence based tobacco cessation interventions to the

Smokers with SMI want to quit, can quit and do quit

•Evidence supports that assessment, counseling and medication therapy that is integrated with behavioral health treatment can significantly increase successful quit attempts by people with SMI

Increased clinical intervention is needed to assist people with SMI to successfully quit

•Counseling: More intensive, longer duration

•Medication: Higher NRT dosing; combination NRT therapy; and longer treatment time are often required

•Relapse requires persistent focus from behavioral health providers as well as primary care providers

Center for Practice Innovation at Columbia Psychiatry (CPI) provides distance based learning to all NYS behavioral health providers on integrated tobacco cessation : Counseling; Medication; Organization Change

Domain 2

2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management

2.b.ii Development of Co-Located Primary Care Services in the Emergency Department (ED)

2.b.iii ED Care Triage for At-Risk Populations

2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions

2.b.vi Transitional Supportive Housing Services

2.c.i To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently

2.c.ii Expand Usage of Telemedicine in Underserved Areas to Provide Access to Otherwise Scarce Services

Domain 3

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

3.a.ii Behavioral Health Community Crisis Stabilization Services

3.a.iii Implementation of Evidence-Based Medication Adherence Program in Community Based Sites for Behavioral Health Medication Compliance

3.a.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community-Based Addiction Treatment Programs

3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only)

3.b.ii Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease (Adults Only)

Domain 4

4.a.i Promote mental, emotional, and behavioral (MEB) well-being in communities (Focus Area 1)

4.a.ii Prevent Substance Abuse and Other Mental Emotional Disorders (Focus Area 2)

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

4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)

Year 0 Timeline – remainder 2014

November 24	**Scope and Speed of Application template** released by DSRIP Support Team to PPS Leads
November 24	Leads to submit **final partner lists** in Network Tool
November 28	**Project Plan Application Tool** published (other than Section 4)
December 1	Optional: **Project Plans Applications** completed by PPSs for DSRIP Support Team review
Early December	**VAP Exception Results** published
December 8	**Project Plan Application Tool (Section 4)** published
Mid-December	**Final attribution results** released **(no later than)**
December 16	**Scope and Speed of Application** responses due from PPS Leads to KPMG
Mid-December	**Capital Restructuring Financing application due**
December 22	**Project Plan Application** completed and submitted by PPS Lead
December 24	Independent Assessor completes **DSRIP Project Plan checklist review** of each application
December 24	**DSRIP Project Plan Application PDFs** posted to web**, public comment period** on Project Plan Applications begins

Year 0 Timeline – 2015 (January 1 – April 1)

January 26 **Public comment period** on Project Plan Applications ends

February 2 **Independent Assessor recommendations** made public

Mid-February **DSRIP Project Approval & Oversight Team** public hearings & meetings re: IA recommendations, makes final recommendations to state

March 1 **Implementation Plan** due from PPSs

Early March **DSRIP Project Plan** awards made

Mid-April **First Year 1 Payment** to PPSs

April 1 **DSRIP Year 1 begins**