NYAPRS
Rehab and Recovery Academy

CBHS

Access: Supports for Living

Partnering with 3 Hudson Valley PPSs in efforts to redesign delivery system

- MHVC Steering Committee
- WMC Health Executive Committee
- Clinical, Quality, Workforce and Financial Committees and Project Taskforces
- **Coverage and workload shared with partners**

Opportunities and Obstacles

Hospital dominated system leading change process

We need to bring principles of recovery to projects

- Demonstrate pathway to shared goals
- Invest in the process – ensuring a voice for people with complex needs
- **Infuse Recovery Principles everywhere**

Infuse Recovery Principles in Projects

PPS Projects – Our input is essential

Direct Project Assignments

- Integrated Delivery System
- Integrated Physical and Behavioral Health
- Crisis Stabilization
- Tobacco Cessation

Impact on other Deliverables

- Emergency Department Utilization
- Hospital Readmission
- **Lead with role of recovery in changing health outcomes and costs**
- Rehabilitation and Integrated Clinical Treatment
- Care Management and Social Supports
  - Housing, Employment ,Social supports for meaningful relationships
  - Methods to mitigate the impact of poverty

Infuse Recovery Principles in Projects

PPS Projects – Our input is essential

Project Name	Participating
2.a.i Integrated Delivery System	X
2.a.iii Extended Care Management	X
2.a.i.v Medical Village	
2.b.iv Care Transitions	X
2.d.i Patient Activation	X
3.a.i Primary Care/Behavioral Health Integration	X
3.a.ii Behavioral Health Crisis	X
3.c.i Diabetes Management	X
3.d.iii Asthma Management	X
4.b.i Tobacco Cessation	X
4.b.ii Cancer Screening	X

Reporting AEPs	
2.a.iii Extended Care Management	X
2.a.i.v Medical Village	
2.b.iv Care Transitions	
3.a.i Primary Care/Behavioral Health Integration	
3.a.ii Behavioral Health Crisis	X
3.c.i Diabetes Management	
3.d.iii Asthma Management	

Exhibit 4: DSRIP Projects

Project ID	Project Name	Project Objective
2.A.I	Integrated Delivery System	Build an integrated, collaborative and accountable service delivery structure to end service fragmentation and increase the alignment of incentives.
2.A.III	Health Home At-Risk Intervention Program	To expand access to community primary care services and develop integrated care teams (physicians and other practitioners, behavioral health providers, pharmacists, nurse educators and care managers from Health Homes) to meet the individual needs of higher risk patients who otherwise do not qualify for care management services from Health Homes under current NYS HH standards (e.g., patients with a single chronic condition but at risk for developing another).
2.A.IV	Create A Medical Village Using Existing Hospital Infrastructure	To transform current nursing home infrastructure into a service infrastructure consistent with the long term care programs developing in the state to help ensure that the comprehensive care needs of this community are better met.
2.B.III	ED Triage for at-risk populations	To develop an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of health condition, improve provider to provider communication and provide supportive assistance to transitioning members in the least restrictive environment.

Infuse Recovery Principles in Projects

PPS Projects – Our input is essential

3.A.I	Integration of behavioral health and primary care	Model 1 (3.A.IM1): Develop behavioral health services onsite at the 2014 NCQA level 3 PCMH or Advance Primary Care Model practices. Model 2 (3.A.IM2): Placement of primary care services within behavioral health clinics. Model 3 (3.A.IM3): Integration of behavioral health and primary care
3.A.II	Community Crisis Stabilization	To provide readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis.
3.B.I	Cardiovascular Health	To support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions
3.D.III	Evidence-based medicine guidelines for asthma management	To ensure access for all patients with asthma to care consistent with evidence-based medicine guidelines for asthma management.

Infuse Recovery Principles in Projects

PPS Projects – Our input is essential

4.B.I	Promote tobacco use cessation, especially among low SES populations and those with poor mental health	To decrease the prevalence of cigarette smoking by adults 18 and older; Increase use of tobacco cessation services including NYS Smokers' Quitline and nicotine replacement products.
4.B.II	Improve access to high quality chronic disease preventative care and management in both clinical and community settings.	To increase the numbers of New Yorkers who receive evidence based preventive care and management for chronic diseases.

Integrated Physical and Behavioral Health Care

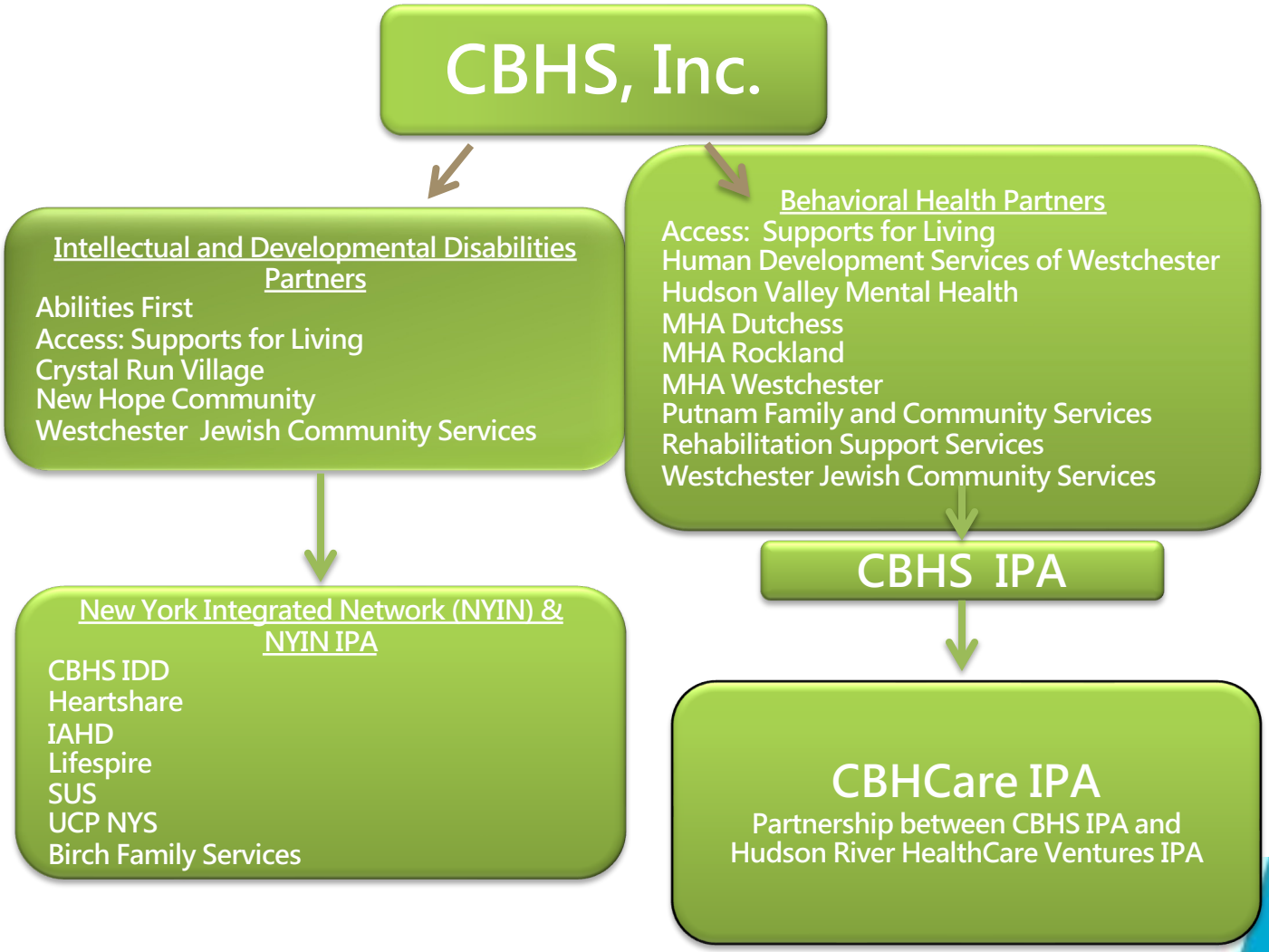
Leading change - a work in Progress

Opportunity through DSRIP to enrich and expand work already underway through

CBHCare the CBHS partnership with HRHCare

CBHCare Clinical Committee – practice innovation

- Care Management
- Co-location of primary and behavioral health
- Embedded behavioral clinicians in primary health
- Children and Families Trauma component care


CBHS, Inc.
Intellectual and Developmental Disabilities Partners
Abilities First
Access: Supports for Living
Crystal Run Village
New Hope Community
Westchester Jewish Community Services
Behavioral Health Partners
Access: Supports for Living
Human Development Services of Westchester
Hudson Valley Mental Health
MHA Dutchess
MHA Rockland
MHA Westchester
Putnam Family and Community Services
Rehabilitation Support Services
Westchester Jewish Community Services
CBHS IPA
New York Integrated Network (NYIN) & NYIN IPA
CBHS IDD
Heartshare
IAHD
Lifespire
SUS
UCP NYS
Birch Family Services
CBHCare IPA
Partnership between CBHS IPA and Hudson River HealthCare Ventures IPA

New Opportunity – MHVC PPS

Integrate Primary Care into Behavioral Health

Medicaid Accelerated Exchange (MAX)

- Sponsored by NYSDOH
- Rapid Cycle Change Coached by KPMG
- Clinical Expertise Coached by National Council for Behavioral Health

Our Project Through MHVC PPS

Model 2- Reverse Co-location

Primary Care Provider Integrated into Behavioral Health Site

- **We are not yet funded**
  - **Access and HRHCare fronted the funds**
  - **Because it is Important**
  - **The process to fund these types of initiatives is pending at MHVC**

Heath Integration Goals
HRHCare and Access MAX Project

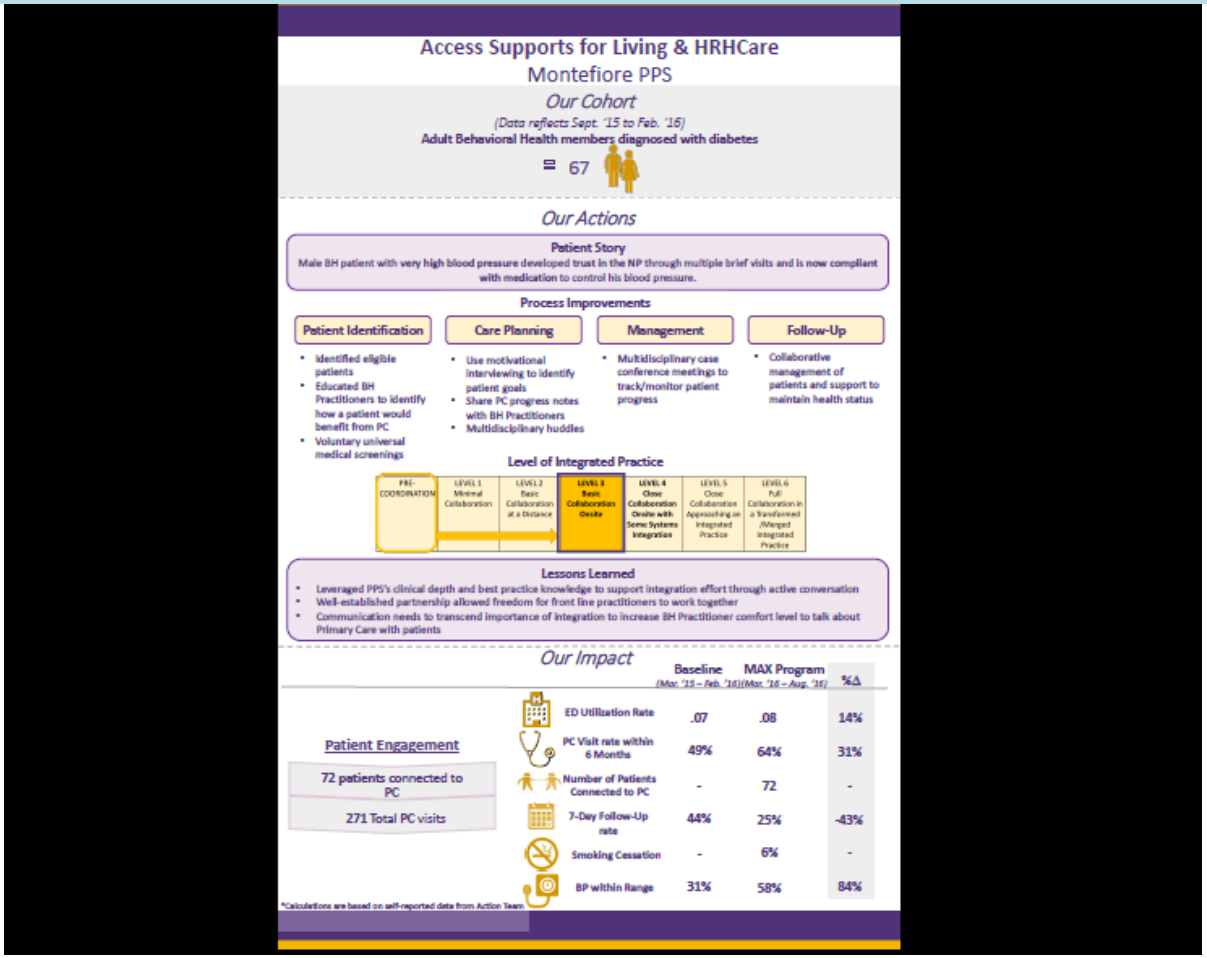
- **MAX 8 month Goal**
  - People with serious behavioral health needs and diabetes will improve overall health through integrated care
- **Project Goals**
  - Whole population with serious behavioral and physical health needs will have improved access to a collaborative team of practitioners
  - Shared care will improve health outcomes for whole population of people with significant and complex needs
  - **The practice will be sustainable and replicable**

Health Integration
Process and Learning

- **HRHCare and Access Teams aligned immediately on values and possibilities**
- Harder than we thought to align workflows of 2 practices
- We needed to stay diligently focused on assessment of what was really occurring and **BUST BARRIERS**
  - Weekly call with leaders and practitioners at all levels
- **Direct Practice Champions are the key to change**

Health Integration Outcomes

Poster –MAX 8 month result



Access Supports for Living & HRHCare

Montefiore PPS

Our Cohort

(Data reflects Sept. '15 to Feb. '16)

Adult Behavioral Health members diagnosed with diabetes

= 67

Our Actions

Patient Story

Male BH patient with very high blood pressure developed trust in the NP through multiple brief visits and is now compliant with medication to control his blood pressure.

Process Improvements

Patient Identification	Care Planning	Management	Follow-Up
• Identified eligible patients • Educated BH Practitioners to identify how a patient would benefit from PC • Voluntary universal medical screenings	• Use motivational interviewing to identify patient goals • Share PC progress notes with BH Practitioners • Multidisciplinary huddles	• Multidisciplinary case conference meetings to track/monitor patient progress	• Collaborative management of patients and support to maintain health status

Level of Integrated Practice

PRE-COORDINATION | LEVEL 1 Minimal Collaboration | LEVEL 2 Basic Collaboration at a Distance | **LEVEL 3 Basic Collaboration Onsite** | LEVEL 4 Close Collaboration Onsite with Some Systems Integration | LEVEL 5 Close Collaboration Approaching an Integrated Practice | LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice

Lessons Learned

- Leveraged PPS's clinical depth and best practice knowledge to support integration effort through active conversation
- Well-established partnership allowed freedom for front line practitioners to work together
- Communication needs to transcend importance of integration to increase BH Practitioner comfort level to talk about Primary Care with patients

Our Impact

Patient Engagement

72 patients connected to PC

271 Total PC visits

	Baseline (Mar. '15 – Feb. '16)	MAX Program (Mar. '16 – Aug. '16)	%Δ
ED Utilization Rate	.07	.08	14%
PC Visit rate within 6 Months	49%	64%	31%
Number of Patients Connected to PC	-	72	-
7-Day Follow-Up rate	44%	25%	-43%
Smoking Cessation	-	6%	-
BP within Range	31%	58%	84%

*Calculations are based on self-reported data from Action Team

Health Integration Outcomes

Dashboard – today's results

Metrics	Target	Baseline	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
ED utilization rate	0.035	0.03	Data Not Yet Available	Data Not Yet Available				
Primary Care visits within 6 months	90.0%	68.7%	Data Not Yet Available	Data Not Yet Available				
7 day follow up appointment	70.0%	45.5%	Data Not Yet Available	Data Not Yet Available				
Smoking cessation	21.0%	5%	Data Not Yet Available	Data Not Yet Available				
Blood pressure within range	61.0%	70.1%	Data Not Yet Available	Data Not Yet Available				
Number Enrolled	600		129	168				
Appointment Utilization Rate	Data Not Yet Available		57%	51%				
Average Productiviy (ALL)	Data Not Yet Available		6.86	5.93				

Health Integration Outcomes

Access HRHCare Project

- **People who had not been engaged in care became engaged – we are inspired by the stories**
  - PROS participant – medications are understood
  - MH Clinic participant - agrees to see PCP and blood pressure is controlled and smoking reduced
- **Behavioral Health RN and Care Manager Champions engages people in meaningful consideration of their physical health needs and impact on behavioral health**
- **Enrollment and utilization is improving because it is better care**
- **Sustainability and replication is in sight**
  - **we are compelled forward to deliver integrated care**

During and Post DSRIP

Partnership through CBHS and HRHCare (CBHCare) For Value Based Payment Contracts

- Contracts with MCOS – one pending DOH approval
  - **Integrated Care – recovery oriented solutions**
    - Care Management
    - Integrated Physical and Behavioral Health
    - Trauma competent care
    - Evidence based Practices
      - Impact, Co-Occurring Disorders, Zero Suicide
  - **MAX Train the Trainer**
    - Rapid Cycle Continuous Improvement (RCCI) methodology

Participate in Next MAX Series
Trainers are being trained in Communities

in Rapid cycle change improvement techniques
NYSDOH

The MAX Series will focus on "Improving Care for High Utilizers"* with the goal of reducing 30-day readmissions and overall hospital utilization

**High Utilizers are defined as any patient that has 4+ Inpatient Admissions in a 12-month timeframe*

The goal of the TTT program is to scale and sustain MAX Series successes across New York State and equip TTT participants with tools and frameworks to independently lead RCCI workshops

What Should Providers Do?

- **Volunteer for PPS Projects**
  - Volunteer for Taskforces and workgroups
- **Inform the changes that needs to occur**
- Engage in learning and establish your organization as a go to agency for innovation
- **Get on the MAX High Utilizer Team in your PPS**
- Expect to share in the work, results and funds
  - order to be determined