Project 3.a.i (Model 1) Integration of Primary Care & Behavioral Health Services

Project Goal: Integrate mental health and substance abuse with primary care services to ensure coordination of care for both services.

Actively Engaged

Actively Engaged Definition	*The total number of patients receiving appropriate preventive care screenings that include mental health/SA.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The PPS is expected to utilize the preventive care screening based on nationally-accepted best practices determined to be age-appropriate.
- Any staffer working at a PCMH/APCM Service Site who is qualified to perform a preventive care screening can do so. However, preventive care screenings conducted with a patient via telepsychiatry alone will not count within this active engagement definition.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.
- The expectation of a co-located primary care-behavioral health site is that there is a licensed behavioral health provider on site engaged in the practice.

Project Requirements & Metrics/Deliverables

	Project Requirement	Metric/Deliverable	Due Date
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 DY 3.	All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	3/31/18
		Behavioral health services are co-located within PCMH/APC practices and are available.	3/31/18
2	Develop collaborative evidence-based standards of care including medication management and care engagement process.	Regularly scheduled formal meetings are held to develop collaborative care practices.	3/31/17
		Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.	3/31/17
3	Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Policies and procedures are in place to facilitate and document completion of screenings.	3/31/18
		Screenings are documented in Electronic Health Record.	3/31/18
		At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).	3/31/18
		Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	3/31/18
4	Use EHRs or other technical platforms to track all patients engaged in this project.	EHR demonstrates integration of medical and behavioral health record within individual patient records.	3/31/17
		PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	3/31/17

Quality Measures

Measure Name	Numerator	Denominator
Potentially Preventable Emergency Department Visits (for persons with BH diagnosis) ±	Number of preventable emergency visits as defined by revenue and CPT codes	Number of people with a BH diagnosis (excludes those born during the measurement year) as of June 30 of measurement year
Antidepressant Medication Management – Effective Acute Phase Treatment	Number of people who remained on antidepressant medication during the entire 12-week acute treatment phase	Number of people 18 and older who were diagnosed with depression and treated with an antidepressant medication
Antidepressant Medication Management – Effective Continuation Phase Treatment	Number of people who remained on antidepressant medication for at least six months	Number of people 18 and older who were diagnosed with depression and treated with an antidepressant medication
Diabetes Monitoring for People with Diabetes and Schizophrenia	Number of people who had both an LDL-C test and an HbA1c test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia and diabetes
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	Number of people who had a diabetes screening test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	Number of people who had an LDL-C test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia and cardiovascular disease
Follow-up care for Children Prescribed ADHD Medications – Initiation Phase	Number of children who had one follow-up visit with a practitioner within the 30 days after starting the medication	Number of children, ages 6 to 12 years, who were newly prescribed ADHD medication
Follow-up care for Children Prescribed ADHD Medications – Continuation Phase	Number of children who, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits in the 9-month period after the initiation phase ended	ages 6 to 12 years, who were newly prescribed ADHD medication and remained on the medication for 7 months
Follow-up after hospitalization for Mental Illness – within 7 days	Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 7 days of discharge	Number of discharges between the start of the measurement period to 30 days before the end of the measurement period for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders
Follow-up after hospitalization for Mental Illness – within 30 days	Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 30 days of discharge	Number of discharges where the patient was seen on an ambulatory period to 30 days before the end of the measurement period for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders
Screening for Clinical Depression and follow-up	Number of people screened for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen	Number of people with a qualifying outpatient visit who are age 18 and older
Adherence to Antipsychotic Medications for People with Schizophrenia	Number of people who remained on an antipsychotic medication for at least 80% of their treatment period	Number of people, ages 19 to 64 years, with schizophrenia who were dispensed at least 2 antipsychotic medications during the measurement year
Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	Number of people who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode	Number of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)	Number of people who initiated treatment AND who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Number of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence